Fall, 2007
Volume #8, Issue #2

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THE INTERNATIONAL SOCIETY
FOR THE PSYCHOLOGICAL TREATMENTS
OF THE SCHIZOPHRENIAS AND OTHER PSYCHOSES
UNITED STATES CHAPTER

Patient Abuses in Hospital Settings: A First-Hand Account by a Case Manager

Mirel Goldstein

I work as a case manager for a State program that aims to help clients who struggle with severe and persistent mental illness to maintain successful community living. My job involves helping clients with all of their needs in the community and with recovery from their illnesses. Clients are generally referred to our program when they are admitted to either a short-term care facility or a State hospital. We work with clients during their hospitalizations and after discharge for as long as they need us to achieve goals that they set for themselves or to address other needs that they identify.

We strive to provide services that are client-centered, respectful, empowering, recovery-oriented, and collaborative. I consider myself fortunate to be part of a work environment that truly is on the "side" of the client. I am grateful to our program supervisor who is clear with outside treatment providers that we put clients' needs first and advocate for clients, even if other providers dislike our stance.

One of the painful realities of my job, however, involves working in State and County hospitals where clients are treated in very demoralizing ways. I witness this regularly on a first-hand basis. The power differential is vast in these large, institutional systems of care. The clients that I work with have little power when they have been involuntarily committed to the hospital and will remain there for as long as the treating staff see fit.

I would like to shed light on some of the experiences I have had recently in these hospital settings, with the hope that we can collectively find ways to improve clinical care for individuals with mental illness. The bullying that I witness is simply not fair. For example, I recently worked with a very paranoid man at a county hospital who was not talking to the staff. The psychiatrist said to him during a meeting, "Your not talking is not going to get you out of here! If you want to get out of here, you need to start talking to us." The client began responding to her questions but was looking down and appeared very anxious. The psychiatrist said to him, "Look up at me!" (Why anyone would tell an anxious, paranoid person to look her in the face is beyond me.) I felt terrible sitting there and didn't want to exacerbate the confrontation, but I didn't want to sit by and watch it silently either. So I said, "Maybe he's not comfortable looking at us." She waved her hand at me, saying, "He is perfectly capable of doing it if he wants to."

Whereas many staff and physicians try to help their clients with the tools they have available to them, others play out pathological needs to control others, to "fix" them according to their own terms, to exploit those who are vulnerable for their own self-esteem enhancement, and to "show off" their skill at confrontation. What is done in the name of "tough love" is even more appalling.

I went to see another client that I work with who came into the hospital in a deep depression and would not talk to anyone for a few weeks. Even though she did not talk to me much, I continued talking to her and, every now and then, she would actually respond to something I said. One day, her psychiatrist saw me through the window of her room. I am guessing that he was terribly jealous because the patient was talking to me and not to him. The reason I say this is because he barged in the room and barked at me, "What is the plan?" in a very aggressive, loud voice. I had no idea what he was

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Shifting to Primal

Diana Gonzales

I have a picture taken at the hospital on intake (1991, self admitted): I am smiling, looking into the camera—no indication as to what is going on inside. I have always kept it nearby to remind me of a promise I made to myself then: It Would Be The Only Time.

I was paying for my stay myself, and it made no sense to pay $1,500 a day for what I was getting—no great room, blah food, so-so company and little guidance. Yes, my world was falling apart, but it was still a lousy deal. The only good thing I got was a good space to FEEL what I had so hard fought to disown: TERROR of my parents, excruciating pain for abandoning myself in the unavoidable shift to self destruction.

The systems dislodged (brain, heart, spirit, body) in order to make staying possible. I went home 10 pounds lighter, $15,000 in the red, with a shattered sense of self and two prescriptions.

I remember the second time my parents visited—the inner picture was shambles—and my mother said, "You better get well soon; your kids need someone to take care of them!" and in one instant I

"I went home 10 pounds lighter, $15,000 in the red, with a shattered sense of self and two prescriptions."

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

Harold F. Searles (1979)

Why Do People Become Psychotic?

Kevin Krummer
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In this day of technology, it appears that answers to the way the world works are coming to light, but we may be more confused than we think. I think we are too impatient when trying to find a reason for something, and when we do find a reason, we stick to it without wanting to change. We do not let psychosis run its course but, instead, treat it with drugs that may not help the schizophrenic when he returns to reality. My psychosis was reckless, but at the same time it brought me a relief from life. Now, through meditation, reading and reflecting, I have had glimpses back into the psychotic state, and it would appear that the psychotic state is a type of nirvana. There are certain advantages to being psychotic.

When I wasn't psychotic, life was very coarse. I felt oversensitive to things. I was tired; even my vision was fuzzy. I felt incapable of doing things. This sounds not like an oversensitivity to dopamine but a dysfunction of dopamine. When I became psychotic, it was like becoming a different person; the fuzziness of my vision became the glitter of gold. I was capable of doing things. I enjoyed getting up in the morning.

After my first episode, I had recovered and was being treated by a psychologist. One day, I told him I had been dreaming of a way that my consciousness could carry on in the future. I knew I would die but I wanted to live on, resurrected in a machine. I knew that the universe would end and I didn't know how they would recapture my consciousness. This was bringing up many metaphysical problems and other questions about life.

The doctor thought this was a bizarre thought, and I agree with him. But now that I have made my mind functionally psychotic, I now feel like I will live forever, that my mind will carry on. I now have a theory that our minds can operate in either an entropic way or a neguentropic way. Most of the time, they operate in an entropic way, so we see "reality" and build things. We create subject and object and are at odds with things. I believe we are like the man pushing the stone up the mountain. When our minds operate neguentropically, we are non-dual; we may die, but the mind carries on, regenerates. We stop creating ambitiously and instead focus on social order.

When we are children, our minds operate neguentropically. I remember as a kid asking my mom about death; I thought that I would live forever. I also remember thinking about who the special person would be to whom I would finally get married. Nowadays, there are things like match.com, but I do not use them. I still enjoy just thinking about the special person I will marry as I look at the trees and watch the day take place. Spiritual awakening brings us to a neguentropic state of mind. It is a non-dual awareness, and it can manifest in the most pleasant and subtle ways. Because it is non-dual, it does not seek rewards here and there. Everything is a dopamine reward.

Can mind see reality? If it can, all it will see and do will be entropy. If the mind can see itself, then one can start to build harmony in one's life, and life takes on a new meaning with a broader range of goals. Mind seeing itself could be the neguentropic force in an entropic universe. The psychotic is mind seeing itself.

Bert Karon

Garry Prouty

Bert Karon is a good man, an honorable man and brilliant scientist. He was a pioneer who established the scientific validity of psychoanalysis as a treatment for schizophrenia. I was fortunate enough to be introduced to him in the 1980s by Eugene Gendlin, the founder of Experiential Psychotherapy. Gene described Bert as encyclopedic.

Gene met Bert at a press conference that Bert had given for Carl Rogers and his schizophrenic research at the University of Wisconsin. It was that press event that led to my understanding of the intellectual greatness of Bert Karon, his ability to transcend theoretical boundaries in his understanding of severe psychopathology. This really showed me the meaning of a search for truth.

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talking about, so I asked, "What do you mean?" Actually, first I asked him if he was the social worker I had talked to on the phone, and I guess that didn't do much for his ego since he glared at me and said, "I am the psychiatrist!"

He asked me what the discharge plan was for the client. I said that I didn't know (my job is to help clients when they are out in the community, not to plan their discharges from the hospital). He then asked me, in front of the client, "Is she always like this?!" and "Do you know her from before?" I explained that I had worked with the client during a previous hospitalization a few months ago but had not had contact with her out in the community (she was lost to contact). He demanded to know when and for how long she had been previously hospitalized.

I couldn't talk about the client in front of her as if she wasn't in the room, so I turned to her and asked, "Is it okay if I look in my notes for when you were in the other hospital and tell it to the doctor?" Apparently that question wasn't very good for the psychiatrist's ego either, because he demanded, in a hostile voice, "Why are you asking her permission?" Again, I didn't want to get too confrontational in front of the client but didn't want to let the psychiatrist bully me in front of her either, so I said, off-handedly, "Oh, just to make sure she's comfortable."

The psychiatrist then asked me why I would want to hide information about a patient. I said, "Well, maybe it's just a style thing, but out of respect for the client, I just thought I should ask her permission." He said, snidely, "Well, this is my style!" and stormed off.

The next day, I arrived again at the hospital, planning just to see the client. When I discovered that her treatment team meeting was about to take place, I joined it. The same psychiatrist glared at me when I walked in the room. Someone introduced me to him and he didn't look up. I looked at him evenly, smiled, and said, "Yes, we've met." Then he started bellowing at my client (and I wondered if he was again showing me his "style" or if the bellowing was in fact meant for me), "What is today's date!" and "Why are you here?!" The client didn't answer.

The nurse turned to the client and said, "Why are you here?" The client whispered that she hadn't taken her pills. The nurse said, so patronizingly, "And do realize now that you need to always take your pills?" The client nodded; what else was she supposed to do? The nurse said, "You must always take your pills. If you take them in the morning and the night, no one even has to know you are on them. Okay? You must always take them." She spoke in a tone that you would use with a two-year-old (I wouldn't even talk to a two-year-old that way, personally).

I have sat in many treatment meetings right after a client of mine has been admitted to the hospital. One meeting went like this (and this is rather typical of my experiences):

Psychologist to client: Do you know why you're here?

Client: My cousin called the police on me.

Social Worker: Please read your treatment plan.

Client: I will understand and state the harmful effects of my marijuana use.

Social Worker: Do you understand what is wrong with smoking marijuana?

Client: No. I've smoked it for years and nothing happened.

Psychologist: Is that why you were acting crazy (and goes on to describe what client's chart said about her behavior leading to hospitalization, details will be spared out of respect for the client).

Client: That wasn't me. You're reading from the wrong chart.

Psychologist: I guess you don't have insight into your problems yet. You're going to be here for a long time if you keep up this attitude.

When the meeting ended and the client had left the room, the psychologist turned to me and said, "She'll never get better; she's so resistant." At that point, I let him know that I saw the situation quite differently. He waved his hand dismissively and walked off.

This particular client has now been out of the hospital for a number of months and has had no problems since then. To leave the hospital, she had become very "compliant" and submissive. At her next treatment team meeting, when asked about marijuana, she described how bad it was and stated that she would never use it again. She spoke about the importance of taking her medication. I could see her paying "lip service" to the doctors' advice, but I could feel that there was something false about what she was saying.

When we met alone, I let this client know that I could see that she had a lot of other feelings that were undercover by this point. She looked amused, but it wasn't until much later (after her discharge) that she came to trust me enough to talk about how she really understood what had happened to her. She was afraid for many months that if she said the wrong thing to me, I could have her re-hospitalized.

This client did eventually come to trust me. She now tells me honestly that she does not take her medications. She talks at length about how lethargic all of the medications made her in the hospital and how much better she feels now. She tells me sincerely that, "They shouldn't treat people like that. It was horrible the way people were treated in the hospital." This client has been off of drugs since her discharge as well. She says that the thought of ever having to go into a hospital again is enough to keep her off of drugs for life (she had in fact had a drug-induced psychosis from a drug other than marijuana, which she hid from the staff at the State hospital during her entire stay there).

I have seen, time and time again, clients told that they must take all of their medications or they will never leave the hospital. Some clients are given incredible cocktails of drugs. I have one client who was discharged from a hospital on two anti-depressants, two anti-psychotics, and a benzodiazepine (of which 42 pills had been taken in four days). Clients do not, for the most part, take these medications consensually; rather, they are bullied into taking them. They take medications that make them feel terrible and seem terribly frightening so that they can have some hope of leaving the hospital where they are committed against their will.

One of my co-workers once went to a psychiatrist with his client, and the client asked the psychiatrist about various side-effects of the medication prescribed to him. The psychiatrist told the patient, "I am the doctor; I ask the questions, not you!" and sent the client on his way.

It is true that blatant abuse can be reported to corporate compliance hotlines, but even in those cases, the abuse is often not believed because the clients are thought to be "crazy." Many abuses are simply accepted, such as daily attacks on clients' self-esteem during which doctors, nurses and others patronize clients, boss them around, tell them what is good for them, give them diagnoses with no expla-

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Brain, Mind, and Culture: Sociocultural Factors in the Development of Schizophrenia

Brian Koehler
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In a recent review of the relevant research, Jane Boydell, Jim van Os and Robin Murray (2004), in their "Is there a role for social factors in a comprehensive developmental model for schizophrenia?" (contained in an excellent 2004 volume "Neurodevelopment and Schizophrenia" edited by Keshavan, Kennedy and Murray), noted: "In the 1950's and 1960's, there was much extravagant discussion of the role of social factors in the etiology of schizophrenia. However, there was little scientific basis to this speculation, and it was swept away by the demonstration that people with schizophrenia showed abnormalities of brain structure on computed tomographic scans (Johnstone et al 1976). A decade later, the neurodevelopmental model of schizophrenia was proposed, and it subsequently became the dominant etiological and pathogenetic model (Murray and Fearon, 1999; Murray et al., 1992). As a result of these two developments, researchers have come to regard schizophrenia as a brain disease, and social factors have been largely ignored as putative etiological agents.

It is increasingly clear, however, that the neurodevelopmental model, an essentially neurological concept, does not explain all the available data about schizophrenia. One consequence has been a revival during the 1990's, particularly in Europe, of research into the role of social factors as causal agents in schizophrenia" (p.224).

Boydell et al (2004) pointed to the neurobiological effects of isolation rearing and social stress in animals. For example, rats raised in isolation demonstrated structural and physiological differences from controls in the hippocampi. Isolation raised rats demonstrate anxiety, learning deficits (analogue of working memory, hypofrontality?), sensory changes, dopaminergic dysfunction, etc. In terms of human development, social relationship experiences may alter prefrontal neural systems which mediate emotional self-regulation (Lyons et al 2002). The early social environment impacts on various levels of psychobiological and neurobiological development. The early social environment has been demonstrated to induce synaptic changes that may be indicative of, and perhaps the cause of, alterations in behavioral and cognitive functioning (Ovtscharoff and Braun 2001). There is evidence that the early social environment can mediate the establishment of neural networks that regulate a child's response to stress and emotional self-control (DiPietro 2000).

Boydell et al (2004) have identified the following broad categories in which social factors have been implicated in the initiation and course of the schizophrenias: family factors (mother-child relationship, unwantedness, family communication deviance, dysfunctional family environment, communal upbringing, early parental loss, expressed emotion, childhood abuse, etc.); an urban effect (city birth, city upbringing, etc.); social isolation (during childhood, moving schools in adolescence, in young adult life, at time of onset, migration and ethnic minority status, discrimination, unemployment, etc.); life events (socioeconomic factors, deprivation, inequality, etc.); interaction between social and other etiological factors (gene-environment interaction, social factors and cognitive processing, social causation versus social selection, etc.).

Boydell et al (2004) concluded: "It is now clear, however, that, in order to understand the causes of schizophrenia, the role of the social environment cannot be continued to be ignored. In saying this, we are not proposing an oppositional social instead of biological approach, which we consider as futile as arguing whether poverty or mycobacteria cause tuberculosis! Rather, we suggest that both social and biological factors need to be studied as well as their interaction.

We need to recognize that (i) social factors can impact on brain development, (ii) some social factors give rise to psychological vulnerabilities, and (iii) many social factors act over the life course, creating developmental liabilities...It is possible that the social environment creates psychological vulnerabilities that act additively to the risk function in combination with genetic or non-genetic neurodevelopmental impairments…

The challenge for schizophrenia researchers in the coming decade is first distinguish those candidate social factors that do contribute to schizophrenia risk from those that do not and, second, to identify the interplay between these factors, genetic susceptibility, and their respective effects on, and interactions with, brain development" (PP. 239-240).

Bibliographic references available on request from the author

Shifting to Primal, cont.

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shifted, started joking and smiling and following the cue. I couldn't make sense of what had happened, for the scenarios were totally different!

I remember, too, seeing my daughter, age 10, who asked me shyly when I was I coming home. I said, "When your grandma changes, I'll go back, okay?" totally burdening a child with an impossible (even for me) task. The baton of Betrayal was passing on, and it made no sense to stay for repeating and multiplying the ordeals.

I had told a friend and neighbor (my kid's pediatrician) that if something would happen to me to take care of my kids... and one time, when I was overwhelmed with my kids, my father came over and started lecturing them in the living room while I went to walk around the block. I got angry at seeing them now in my shoes, so I went back and asked him to leave. I would take care of things. Exiting was no solution, for I knew what would follow. So I stayed.

I have never seen a skin wound healed by applying any kind of pill to it. I have seen it heal when it is washed, disinfected and covered in ointment or a gauze. I know no pill can heal the heart and soothe the pain of abandonment and betrayal—fruits of the hardened heart. I know they help to keep the delusions (of doctors and patients) going; I know they hurt the brain and thus hide the evidence of a system's complicity in human destruction. I know the disturbance has mushroomed from the (micro) local/family level to the city/systems arena and is currently enacted at the macro level with our war and our environmental decay.

Feeling is life-sustaining—it is a communication device and a gauge for where one is. Its healing properties are available at the flick of a switch. An inner switch that is...

Please consider a submission to the upcoming issue of the ISPS-US quarterly newsletter. We seek submissions on a variety of topics related to the experience and treatment of psychosis.

For information, e-mail the editors at: Newsletter@isps-us.org

Patient Abuses, cont.

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nation, disparage them, and make jokes about them. To whom do we report this? What do we do when psychiatrists are in so much demand and have so much power to commit our patients to hospitals against their will, to control their treatment unilaterally, and to prescribe serious drugs without a moment's hesitation?

In the case that I described, I spoke up in the presence of the psychiatrist much more than I was comfortable with. I was in "foreign territory" as a visitor to a hospital that I don't work in, and the aggression and coldness of the psychiatrist was a little frightening to me. However, I thought to myself that I could not just stand by weakly and let the patients see that no one is strong enough to speak up, so I spoke up, albeit in a relatively mild way. My "punishment" was more aggression directed my way from the psychiatrist, a lot of aggression towards my client, and some serious bullying in my presence towards the other staff members present.

I reminded myself that, since I don't work at the same hospital, the psychiatrist can't hurt me, even if he *can* hurt my clients while they are in his hospital. For the most part, when I can, I try to model client-centered, respectful behavior; I have succeeded in making comments that soften the atmosphere for many patients during their treatment team meetings.

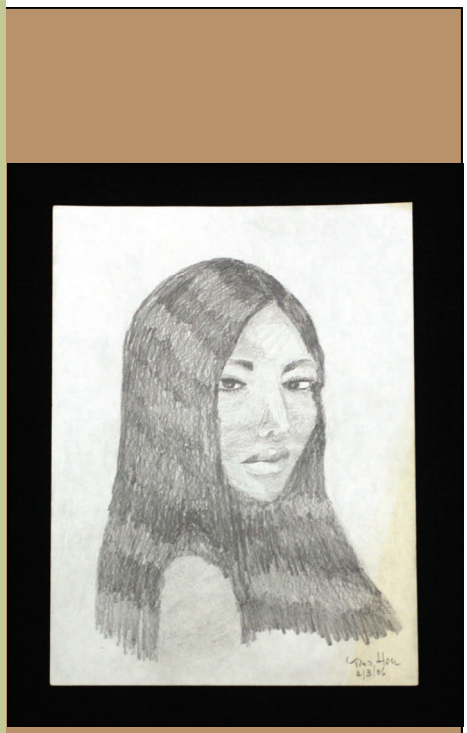
Many times I have the sense that psychiatrists or psychologists think I am being presumptuous and patronizing when I educate them about more helpful ways to approach the client. For example, I explained to the psychiatrist who insisted that the patient look at her that it might be less frightening for the client if he didn't have to look us in the face and if we met with him for small bits of time for information-gathering until he became more comfortable with the contact.

In situations such as those I described, I must face the fact that I am colliding with a very large system that accords both me and my client no power at all. However, many of my clients talk at length with me about how traumatic their hospitalizations have been; at the very least, I can validate their experiences and not repeat the traumatization. I can speak up in forums like this and hope that, together, we can create momentum for change.

Patient Abuses: A Response

Brooke Morrigan

I'm fuming about the article, entitled "Patient Abuses in Hospital Settings: A First-Hand Account by a Case Worker," on the pompous, self-important, abusive psychiatrist at the hospital of the author's two clients, and the equally abusive patronizing nurse's scolding for not taking medications. I could simply quiet down and "move on" to my chores, but I want to register my questioning of the notion that we should tolerate this type of abuse without protest. I realize we fear that if we speak up we might 1) jeopardize our client (these types of abusive people are no doubt capable of punishing our client in retaliation against us) and/or 2) jeopardize ourselves (be banned from the hospital, have complaints lodged against us, etc.). However, if we don't speak up, are we not colluding in the abuse? Are we not adding to our clients' sense of powerlessness, making it even harder for them to conceive an idea of their own inherent worth? Are we not sending a message to everyone who witnesses the abuse and our silence in the face of it that what is happening is either OK or inevitable and unassailable?



I realize that even if we protest, nothing may change for the better. There are many powerful cultural forces at work in a man such as Mirel has depicted that make it unlikely his abusive behaviors can be easily modified. Certainly he (and the many like him) won't be changing due to the protests of one challenging therapist. I'm thinking more of the effects on the client and on the witnessing staff-because there are assuredly effects, whether the therapist is silent or protests.

These comments are not meant at all as criticism of the author of the article! I think most of us-especially those of us who are social workers, not psychologists or psychiatrists-have found ourselves in your situation and anguished over what to do. I am raising these questions because I think they are urgent and becoming more so, as medicalized approaches to mental suffering steadily gain dominance in our country. In my view, psychiatry for many years now has been steadily abandoning any pretense of being anything other than a cog in the pharmaceutical/insurance-industry machinery. They (psychiatrists) are still necessary to the machinery because it is not yet possible for those who manufacture and sell the drugs and those who (partially) pay for them to directly prescribe them and enforce their consumption. From the point of view of the drug/insurance industrial complex, the latter would be the ideal state, but so far they still need a medically-trained person to complete the operation. The complex is working hard to "educate" and influence them to be more efficient and compliant servants, but so far that is as far as the complex can go toward complete domination and self-sufficiency. I am bringing all this in because I sometimes wonder if one of the forces at work in people like Mirel's abusive psychiatrist (and nurse) is shame, humiliation. At some level these folks may sense their own disempowerment in the new age of medicalized "therapy." Perhaps they abuse the disempowered clients in a kind of projective identification. In this sense, I think it becomes even more crucial for the therapist to stand up to the abuse: protest against disempowering behavior is a profound message not only to the client and the witnessing staff but also to the disempowered psychiatrist/nurse. Such protest is a naming of what has been denied, a real-izing of what has been dissociated, a facing-up-to what has been feared. It serves to open up the spaces in the heretofore closed-down system; it creates "potential space" in which reorganization and new movement can begin to be realized. Of course, these potential effects of protest are precisely what a person in denial, dissociated, fearful, finding safety in stasis may both long for and dread. It's unlikely anyone in the scenario (including the protester) will unambivalently welcome the protest, with its message of possibility, of "lifting the lid," of "blowing the cover," of "breath of fresh air." However, I feel that even if the protest is ignored or (more likely) violently repelled, we must find ways to continue protesting the abuse we witness.

> "In my view, psychiatry for many years now has been steadily abandoning any pretense of being anything other than a cog in the pharmaceutical/insurance industry machinery."

Beginnings and Endings in Therapy

Michael Eigen

Marin: "I jumped out the window three times today. Saw seven times seven devils. Chewed a mango that imprisoned a toad. Did you ever eat a toad in a mango? A beautiful mixture of colors. And here I am with you. What did you do today? Anything exciting?"

Mike: "Marin, I saw the sea when I woke up. I saw the sea from my window and feared it was going to sweep me away. I feared drowning. Your day sounds better. But here I am with you now. We're both here. And there's 40 minutes left to our meeting. Will we be here then too?"

I often wonder what the end of a session will turn out to be, given its start. How one starts determines so much. That goes for life in general. The way one constitutes oneself at the beginning sets a course that widens and deepens in time. Yet I do feel there is room for new beginnings, that one is not totally stuck on the road on which one finds oneself. It is hard to reset oneself, to find a better starting point. There is much pressure against it.

Marin blinks at me. No, now I just think she's blinking. She's having a blinking fit. Is she doing this partly on purpose or is it just happening? Should I say something? Will I be nosy, intrusive, bothersome? I remember old movies from childhood, words like blinking, blimey, parts of mild swearing, strong feelings, although not too strong. My own eyelids are slits, semi-shut, as if I'm peeking out of a fortress afraid of an enemy. I often feel I'm about to be attacked. I appreciate being with Marin. I like it a lot. We're both threatened creatures. It has taken years for us to reach this point, at ease with our threatened states together.

We look forward to sharing the little time of 45 minutes a week together. We used to see each other five times a week the year she came out of the hospital when she began work with me. I call it work, but I'm not sure what it is, hanging out together. It's fun to have someone you like to hang out with. More than fun. It's a relief.

Part of the relief is that we speak the same language. Neither of us is limited to the language we speak together. Each speaks other languages, too, with other people or just with ourselves, inside our very alone selves. I think that's another good thing we each share, how alone we are, *very* alone in some profound way. Was it Hegel who said only one person ever understood me and he didn't understand me? Marin and I both feel this way. It's not all we feel, but we feel this, too. That's another reason we like to be together. Neither of us makes the other upset about our aloneness. As Winnicott said, we're alone together, perhaps not quite the way Winnicott meant, but not too far away either.

> "Was it Hegel who said only one person ever understood me and he didn't understand me? Marin and I both feel this way."

Marin continues: "I'm broken."

Mike: "I'm broken, too."

Marin: "I doubt you're broken the way I am."

Mike: "How are you broken?"

Marin: "I'm broken different ways on different days. Today I'm shattered green glass, a green bottle that was found in the earth when Con Ed men were digging near the foundations of a building. They found a little blue bottle and a little green one. I'm the little green one. They gave me the bottle as a keepsake and it seemed very strong. I didn't think it would break. It slipped out of my hand and shattered on the sidewalk. There are pieces of me on the sidewalk, alive on the sidewalk. Like a segmented worm, only they are not organic. They have no skin, no thing that bleeds if you step on them or cut them. Just pieces of glass that can cut you if you touch them the wrong way."

Mike: "Am I the blue bottle I wonder? I don't feel much like a blue bottle today. Not too blue."

Marin: "You don't have to be the blue bottle. I think the blue bottle is me being left out of everything, me all alone. And the green bottle is me shattered, all broken, shards."

Mike: "Yes. I feel what you're saying. They're both important. They're both real."

Marin: "I'm glad you said that they're real. They really are. To be really real is important to me."

Mike: "To me, too, although I often don't do a good job of it. I get scared of being too real."

Marin: "I know. I've seen that. I scare you when I'm too real."

Mike: "You're being very nice to me."

Marin: "I have to keep you in good condition. Someday you may be less afraid of me."

In this case the session ended well, better than it started. I feel I was given another chance to do it better. We left our worlds in better shape than we found them, always a blessing. It doesn't always go this well. It was as if a deep meditation gong sounded inside and the ripples said that having another chance is part of living. That's part of what Marin and I are about, being broken and giving each other chances.

Michael Eigen is the author of the book, "Feeling Matters."

From the President

Ann-Louise Silver
(President@isps-us.org)

ISPS-US had one exciting summer, with our great adventure to Europe organized and hosted by Françoise Davoine and Jean-Max Gaudillière. Everything rolled along smoothly, with the deep philosophic stimulation we expect from anything French. On Thursday morning, June 28, we met at the EHESS, L'École des Hautes Études en Sciences Sociales, The School for the Advanced Studies of the Social Sciences, where our hosts have taught for years. The central message was that psychosis is the place to study the social link; the patient is the researcher, working to discover the real story of the therapist, while the therapist studies the interference. The therapist's disclosure can be the turning point, giving back the patient's pride, both individuals having been traumatized or carrying a specific history of trauma, often in commonality. And we were reminded that Benedetti has said that whatever you write about a therapy, even if it is ten years later, this is still part of that therapy. Françoise commented that when she reviewed vignettes with her former patients, described in *History Beyond Trauma*, they often ask, "Why didn't you use my real name: I am the author of that." We talked about our own experiences of trauma in the course of therapies, arriving at greater intimacy with each vignette. That evening, Françoise and Jean-Max hosted a splendid informal dinner at their home which overlooks the joyfully illuminated Eiffel Tower. Their distinguished friend, harpsichordist Mario Raskin, taught us about the instrument and gave a beautiful recital.

On June 29, Françoise led us through a bit of Laurence Sterne's 1759-1769 comic novel, *Tristram Shandy*. "Madness is a war against the monsters, and sometimes we, the analysts, are the monsters." We then walked together, the whole gang, to the train station for our 4 ½ hour scenic ride (filled with wonderful conversations) to Vevey, Switzerland, to join in the launching of ISPS-Francophone, at the spot where, in Lausanne, ISPS began fifty years ago. Christian Müller, co-founder with Gaetano Benedetti of ISPS, was in attendance. Dag Söderström organized and chaired this two-day meeting on psychosis and trauma, and will be heading this new ISPS chapter. Probably the most memorable case presentation was by Larry Wetzler, "The piano speaks when words are impossible." He interwove piano excerpts which he had actually included in that therapy at pivotal moments. We had dinner outdoors overlooking Lake Geneva, all of us happy to be there and to be together.

Our annual meeting in New York City will be the grandest and fullest yet, a product of the almost fifteen years of Brian Koehler's and Julie Kipp's hosting of monthly meetings on psychoanalysis and psychosis. I recommend that *everyone* in ISPS-US attend, and that we all publicize the event to our colleagues. I will not summarize the program here, but urge everyone to consult our website, www.isps-us.org for details.

We are in the final stages of development of our ISPS-US entry into the Routledge/ISPS Series, with a wonderful book co-edited by David Garfield and Daniel Mackler, *Medications are Not Enough: Working One's Way Out of Psychosis through Relationships*. The contributors are all ISPS-US members (listed in the order of the book's chapters):

Preface: A Book of Basic Principles and Practices (*Bert Karon, PhD)*

Introduction: The Patient Needs to Be Strengthened (*David Garfield, MD, Daniel Dorman, MD)*

Emergency Room, Inpatient, or Outpatient: The Entry Process (*Elizabeth Faulconer, MD, Ann Silver, MD)*

The role of the therapeutic alliance in the treatment of seriously disturbed individuals (*Warren Schwartz, Psy.D, Frank Summers, PhD)*

Making Contact with The Inside of the Patient (*Garry Prouty, PhD)*

The Mechanism of Therapeutic Change in the Psychotherapy of Psychosis (*Brian Koehler, PhD)*

Technical Challenges in the Psychoanalytic Treatment of Psychotic Depression (*Patricia Gibbs, PhD)*

Sustaining Relationships: Cure, Care and Recovery (*Frank Summers, PhD)*

Sustaining Relationships from the Point of View of Milieu Treatment: A Corollary to Dr. Summers (*Julie Kipp, PhD)*

The Experience of Being Medicated (*Robert Foltz, PsyD)*

Practicing the "Impossible Profession" In Impossible Places (*Daniel Mackler, LCSW)*

True Stories of What Has Really Worked *(Catherine Penney, RN, Joanne Greenberg, DHL)*

Support for the Healers (*Ira Steinman, MD)*

Meanwhile, Daniel Mackler has been moving ahead with his ambitious documentary. He is a phenomenal interviewer, and as everyone knows who heard his presentation in Santa Monica, he knows

(Continued on page 10)

ISPS-US Executive Council

From the President, cont.

(Continued from page 9)

how to hold an audience's attention. I am confident the video will be excellent. Daniel wrote the following summary of his documentary, *Take These Broken Wings.*

"The purpose of *Take These Broken Wings,* a full-length documentary video presently in production, is to show that it is possible to recover fully from schizophrenia (that is, to become completely symptom-free) and ultimately live without any psychotropic medication. The film documents the lives of two ISPS-US members: Joanne Greenberg, whose best-selling autobiographical novel, *I Never Promised You A Rose Garden,* chronicles her recovery from schizophrenia through her therapy with Frieda Fromm-Reichmann, MD; and Catherine Penney, whose story of recovery from schizophrenia has been told in *Dante's Cure* by her therapist, Daniel Dorman, M.D., also an ISPS-US member.

> "The purpose of *Take These Broken Wings*...is to show that it is possible to recover fully from schizophrenia"

Through in-depth interviews with Joanne Greenberg and Catherine Penney, the film shows not only that both women were in fact once schizophrenic and no longer are, but also highlights the process by which they recovered. Additionally, the film explores, vis-à-vis their recovery process, the pros and cons of the various psychiatric medications and psychiatric treatments they received. The film also addresses the question of the potential universality of their stories of recovery, that is, the degree to which their stories might apply to others with schizophrenia.

The film also aims to place these two stories of recovery in an historical context, first being the history of American treatment of schizophrenia and second being present-day society's view of schizophrenia. As regards the first, the film will interweave footage of a variety of therapists, psychiatrists, and mental health lawyers and advocates, most of whom are ISPS-US members, and all of whom have devoted a significant portion of their professional careers to the study and treatment of schizophrenia and advocacy for people diagnosed with schizophrenia. Those professionals already interviewed include Bert Karon, PhD (author of *Psychotherapy of Schizophrenia*), Ann Silver, M.D. (*Psychoanalysis and Psychosis*), Robert Whitaker (*Mad In America)*, Peter Breggin, M.D. (*Toxic Psychiatry*), Grace Jackson, M.D. (*Rethinking Psychiatric Drugs*), Jim Gottstein, JD (of psychrights.org), David Oaks (director of MindFreedom), Toby Tyler Watson, PsyD, Jessica Arenella, PhD, and Kurt Langsten, M.D. As regards the second, the film will interweave video footage of over 100 street interviews conducted with strangers in New York City regarding their opinions on schizophrenia.

Lastly, this film will be presented in a non-academic format, making it optimally accessible to the general public. To accomplish this I, the filmmaker, intend to make it emotionally gripping, fast-flowing, not overly technical in terms of psychological terminology, and with an arc to its storyline. I consider it vital to present the documentary non-cynically, non-attacking, and with an honest, straightforward, respectful, reasonable, and non-strident tone – presenting facts but respecting patient choice, especially as regards medication. I believe that any deviations from this would detract from the film's healing message."

The executive committee of ISPS-US has decided to launch a fund-raising drive to support Daniel Mackler's magnificent project. Daniel will be showing excerpts at our next annual meeting. We will probably include video clips at our website and on YouTube. This project should benefit ISPS-US and our mission enormously. We are asking you, the membership of ISPS-US, to consider a tax-deductible donation to ISPS-US earmarked entirely or in part for this project. Ninety percent will reimburse Daniel for the expenses he has incurred: consultation, travel and accommodations, and equipment expenses. We will not reimburse him for time spent on the project. Ten percent will go to ISPS-US for administrative expenses. Also, we are asking for your help in reaching out to those you know who are not in ISPS-US who may want to donate either to Daniel's video project or to ISPS-US.

Meanwhile, the nomination letter for our new slate of officers has gone out. With this, I officially gave notice to the membership that I am stepping down as president. I have served in this role since ISPS-US formed in 1998, and have felt for some time that a non-profit volunteer organization cannot thrive with the same person at the helm year after year. The ambitions of the others who are working for the group become stifled, and they find other things to do. Meanwhile, I feel increasingly guilty regarding the various goals I have set for myself but have not reached. I am basically shy, and have avoided the campaigning necessary to give ISPS-US a more public presence. I have not spoken at NAMI meetings, have not testified to Congress, and have not done aggressive fundraising, meeting with heads of foundations or with wealthy individuals about donating to us.

While the next president may feel that these are not part of his new volunteer job description, he will set his own goals, and have his own burden of guilt and shame at not fulfilling whatever these goals might be. Leadership is like that. Kenneth Artiss taught in my psychiatric residency training program on aspects of leadership. People who campaign for office make promises which form their platform. This is a sane thing to do. They approach insanity when, once elected, they believe it is possible to fulfill these promises, or that it is their obligation to do so.

For me, an example comes when I observe that our membership has stayed between 250 and 300 in the past few years, but these are not the *same* 250-300. People are with us, and then they leave, sometimes returning in a few years, sometimes not. I have taken their leaving personally, as if they left out of dissatisfaction with me. I do know about the sociological phenomenon documented by Robert Putnam in *Bowling Alone.* Since the 1960s, ever fewer people join groups of any sort, from professional groups such as ours to bowling and gardening groups. If we do join groups, we tend not to "stick." Probably in the grand scheme of things, we are doing much better than "the average group" but I still take it personally when I see that one or another dedicated person is no longer "with" us: they don't like what I'm doing. I have spoken out perhaps too forcefully against the influence of the pharmaceutical industry in the treatment of severe mental illness. I feel very good about our group and what we are accomplishing together, and will enjoy it even more when I watch our next group of leaders setting their own sights on overly ambitious goals. I have many very close friendships that have developed in the ISPS-US context and I'm staying with you.

From the Secretary

Julie Kipp
(Secretary@isps-us.org)

In late June, about twenty-five ISPS-US members met in Europe for a very special once-in-a-lifetime event. A conference was held in Paris, France, and Vevey, Switzerland on the banks of Lake Geneva, in the Alps. This special meeting of ISPS-US was organized by Françoise Davoine and Jean-Max Gaudilliere, our French colleagues and loyal ISPS-US members.

After our arrival, we met with the students of Françoise's and Jean-Max' seminar at the Ecole des Hautes Etudes en Sciences Sociales in Paris and participated in the last class of the season. The subject of their seminar was "Madness and the Social Link," continuing their important focus on how the history of trauma is passed through families, and how that may interact with the analyst's history of trauma as well. Françoise presented her recent work on the 18th-century novel, Tristam Shandy, by Laurence Sterne, the latest of her explorations of madness in literature. One evening, Françoise and Jean-Max held a marvelous champagne party at their apartment atop a building on the Boulevard du Montparnasse. From their terrace we could see all of Paris, including la Tour Eiffel, which sparkles with a million flashing lights for a few minutes every hour. We were treated to a harpsichord concert by Mario Raskin, a friend and teacher of Jean-Max.

After our second meeting at EHESS, Jean-Max herded us all onto a bus in Paris, which passed the Salpetriere Asylum where Philippe Pinel famously released the madmen from their chains. (Françoise shared an interesting story about the fit of the britches on the statue of Pinel!) Jean-Max got us all onto a train for the five-hour trip to Vevey, Switzerland. The train traveled through the French Alps, providing an opportunity to get to know each other better as well as to watch the awesome mountains and Van Gogh-esque fields of sunflowers going by.

From ISPS Paris-Vevey trip.

In Vevey, we joined in the end of a conference entitled, "Psychose & Trauma," held at a small public psychiatric hospital called Nant, which is located in a lovely old Swiss chalet. Dag Söderström, a Swedish émigré to Switzerland, and a friend and former student of Françoise and Jean-Max, is the director of Nant. We celebrated with them the kick-off of the new ISPS Switzerland chapter. Americans Larry Wexler and Ann-Louise Silver presented, along with Jean-Max who read a paper by Lawrence Hedges. Edmond de-Gaiffier and Brian Koehler presented cases in which "the abyss in the patient called out to and evoked the vulnerabilities and abyss in the therapist." After the conference we were served wine from grapes grown on the grounds of the psychiatric hospital, which is served to the patients as well. The esteemed elder, Christan Müller, founder of ISPS with Gaetanno Benedetti, put in a brief, informal appearance. During the evenings, we walked on the shores of Lake Geneva, took pictures with the Charlie Chaplin statue (he lived in Vevey), and ate outside at a wonderful restaurant where we watched the summer light darkening across the town square.

Our sincere thanks to Françoise Davoine and Jean-Max Gaudilliere for the organizational feat of putting together the first ISPS-US meeting in Europe, for lending us warm clothes and pouring plentiful champagne, and for sharing their profound work on the history of trauma. Thanks to Dag Söderström and ISPS Switzerland for paying for our train tickets and charming hotel rooms, for being such warm hosts, and for allowing ISPS-US to share our work with them.

From the Editors

Warren Schwartz
Ayme Turnbull
(Newsletter@isps-us.org)

We hope you enjoy this issue of the ISPS-US newsletter focused on first-hand accounts of profound psychological disturbances and the experience of working in systems of care for people with such disturbances in the United States. It is our hope that future issues of the newsletter will, similarly, contain content related to specific themes relevant to both the experience and treatment of psychosis.

We would also like to introduce a new feature beginning with this issue: artwork by individuals with profound psychological disturbance. If you would like to submit artwork of your own or on behalf of someone else (with permission of the artist), we welcome e-mailed digital images. Please contact us for more information.

Another feature that we would like to begin involves profiles of ISPS-US members. We would like to focus on new members especially, although we welcome profiles of long-time members as well. Information that you might consider providing to us includes your name, professional degrees, current and past work experience, motivation for ISPS-US membership, and a digital photograph of yourself (head shots are preferable). Some of you may already have been invited to submit information for a member profile, and we will be sending out additional invitations over the coming weeks.

From the Executive Director

Karen Stern
(contact@isps-us.org)

As ISPS-US approaches our 10th anniversary, our Ninth Annual Meeting and our first election of officers, I hear a growing sense of frustration from members who say that they are working hard but not making progress, that we don't know where we are going and that apathy is creeping in. I am not a therapist, but I imagine that this is what many of you experience on a daily basis, doing the difficult work with people who seem so lost that recovery feels unattainable. But then one day there is a breakthrough, and suddenly progress is made, the way seems clearer, and you're not even quite sure how you got there. I think that is how growth happens—it is awkward, painful and difficult and not always apparent, sometimes one step forward and two steps back, sometimes one leap forward. I see my job as a coach, keeping track of the details, remembering how we did it before and how well that strategy worked, keeping the big picture in mind and saying, "Come on, you're doing fine, we're almost there."

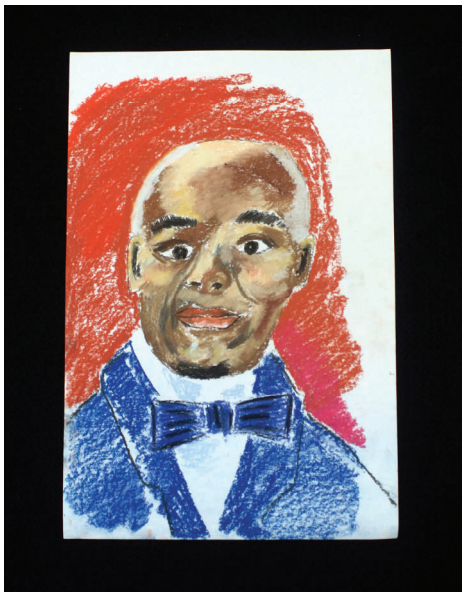
Our hard-working Program Committee, under the leadership of Brian Koehler, is putting in long hours to come up with a great Annual Meeting that will show our group and the public how it is possible to recover from psychosis and how important the relationship with the therapist is in that process. But to put it all together, there is a lot of soul searching about the date, theme, speakers, location, how to cram it all into the schedule, bagels vs. muffins, tables, microphones and projectors, and many other details, and how to best meet the needs of a growing membership. If the committee has done a good job, which I'm sure they will, when you arrive in New York on March 14th, you will find a rich program and an incredible opportunity to network with others who support the work that you do, and you won't even care if it's bagels or muffins. So the next time you talk to a committee member, thank him or her for working so hard to make it all happen! And I will actually be at this meeting, so I'm excited to meet so many of you for the first time and see others again.

With our 10th anniversary coming up, we are holding our first board election. The nomination committee, headed by Warren Schwartz, has announced an official slate of candidates in a letter to members, and members are welcome to nominate additional candidates according to the process outlined in the letter. Nomination petitions have to have been received by our Secretary, Julie Kipp, by November 15th. The balloting process will happen in the winter, and the new slate of officers will be chosen before the Annual Meeting. (No hanging chads, I promise.) We have some capable candidates for president, secretary and treasurer but we are still looking for candidates for vice president (and any other office they want to run for). As I said, change is not always easy and I know that we will be sad to see our current officers move on, but I'm confident that our new leadership will guide us well through the next phase of our growth. Note that you must be a paid up member in good standing in order to nominate, run for office or vote, so please send in your dues if you haven't yet this year!

As far as seeing the way clear to our future, we are still working on a business plan that will enable us to focus better, set goals and apply for grants. We welcome any members who would like to assist with this project. We need a small, dedicated group to come up with a plan to propose to the Executive Council. Julie Wolter, our Treasurer, has gotten the ball rolling, but it's too big of a job for one person and we need input from other members. Come on, you're doing fine, we're almost there.

A note on the artist:

The artist whose drawings are featured in this issue wishes to remain anonymous.



ISPS-US Website Update

Marty Cosgro
(webeditor@isps-us.org)

Our website, www.isps-us.org, continues to grow as a resource for people throughout the world wanting to learn more about the work we support. Recent data indicate that we have been visited by people in 31 countries, with 65% of our visitors coming from the USA. This speaks well of the important role we play in the global mission to provide meaningful treatment to people with psychosis. Five percent of our visitors spend longer than one hour on the site, which confirms that we are providing a valuable resource. Google searches for ISPS-related topics and ISPS-US members are the most common means by which our site is discovered. Also, our home page features six volumes from the ISPS book series, all of which can be ordered via a link to Amazon.com.

Speaking of Amazon.com, we continue to raise much-needed income for our organization through Amazon.com purchases made via the link on our website. Our profits from this have increased dramatically since last year; we make money simply by having you and your family and friends remember to go through ISPS-US.org on your way to making Amazon.com purchases. Thank you to all the members who continue to support ISPS-US in this way.

ISPS-US
Ninth Annual Meeting

Recovery from Psychosis:
Healing through Relationship

Friday and Saturday,
March 14th and 15th, 2008

The Kimmel Center, New York University
60 Washington Square South; New York, NY 10012
www.nyu.edu/kimmel.center

Hosted by ISPS-US New York City

Co-sponsored by the NYU Postdoctoral Program, the NYU School of Social Work and the Lifespan Learning Institute, which will provide comprehensive CE credits.

Keynote Speaker:
Ronald Bassman, Ph.D.
Abandoning Occam's Razor: The Art of Reconstructing the Self

Registration forms will be mailed to all ISPS-US members
and are available at www.isps-us.org

Hotel Information

ISPS-US has not reserved a block of rooms at a particular hotel, but New York University has accommodations information at www.nyu.edu/about/hotels.html and they offer discount rates at:

Club Quarters Downtown
52 William Street, New York, NY 10036
Reservations: (212) 575-0006

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40 West 45th Street, New York, NY 10005
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To find out more about APHS, please visit our website at www.abcmedsfree.com or call Dr. Toby Tyler Watson, Psy.D. at 920-457-9192. Dr. Watson can also be reached by email at: tobytylerwatson@charter.net

ISPS-US would like to thank the following people for their generous donations (beyond dues) in 2007:

Jessica Arenella, PhD	In memory of Alex R.
Kenneth Blatt, MD	
Susan Burland, PhD	
Thomas E. Fink, PhD	
Juliana D. Franz, MD	
Patricia L. Gibbs, PhD	
Maurice Green, MD	In memory of Harry Stack Sullivan
Joanne Greenberg, DLH	
Marvin Hurvich, PhD	In memory of Elaine Schwager-Hurvich
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Robert I. Kurtz, MD	
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Ann-Louise S. Silver, MD	
Jean Silver-Isenstadt, MD, PhD	On behalf of Ann Silver
Daniel D. Storch, MD	
Charles Turk, MD	
Miltiades L. Zaphiropoulos, MD	

We count on your donations! To make a tax-deductible contribution to ISPS-US, please use the membership form in this issue or click the donation button on our website, www.isps-us.org. Thanks so much!

Note: If you made a donation but your name is not included, it's because you did not give us permission to print your name. Please let us know if we may thank you publicly! *—ISPS-US is a 501(c)(3) nonprofit organization.—*

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