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THE INTERNATIONAL SOCIETY FOR PSYCHOLOGICAL AND SOCIAL APPROACHES TO PSYCHOSIS
UNITED STATES CHAPTER

Proceedings from
The ISPS-US Twelfth Annual Meeting

Beyond Pandora's Box: Exploring Integrative Approaches to Treating Psychosis

October 14-16th, 2011

Keynote Speaker: Richard Bentall, Ph.D.
Author of Madness Explained and Doctoring the Mind
"The Psychology of Paranoid Delusions"

Honoree: Ann-Louise Silver, M.D.
Founding President, ISPS-US
"Early Onset Psychosis: Do We Want It in the DSM-5?"

PROGRAM COMMITTEE
Ira Steinman, MD, Chair
Ankhesenamun Ball, PsyD, Martin Cosgro, PhD, Kate Hardy, Clin.Psych.D, Matthew Morrissey, MA, MFT, Trisha Ready, PhD, Jonathan Roth, MA, Madhu Sameer, MSW, Rochelle Suri, PhD, Sue von Baeyer, PhD

ABSTRACTS

Film and Discussion:
Healing Homes: An Alternative, Swedish Model for Healing Psychosis, a film by Daniel Mackler, LCSW-R (Mr. Mackler will not be present at the meeting.) http://www.iraresoul.com/dvd2.html

Discussion led by Matthew Morrissey, MA, MFT.
Healing Homes, a feature-length documentary film directed by Daniel Mackler, chronicles the work of the Family Care Foundation in Gothenburg, Sweden -- a program which, in this era of multi-drug cocktails and psychiatric diagnoses-for-life, helps people recover from psychosis without medication.

The organization, backed by over twenty years of experience, places people who have been failed by traditional psychiatry in host families -- predominately farm families in the Swedish countryside -- as a start for a whole new life journey.

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

Harold F. Searles (1979)

Editor's note on newsletter submissions.

Submissions are welcome to the ISPS-US newsletter. The following are some areas of particular interest.

* Book reviews: a number of our members have published recently, and I would like to have them reviewed. In particular: Diana Semmelhack's book on group work; Paris William's book Rethinking Madness; Marilyn Charles' book on working with trauma. I would note that Diana requested a review some time back, and I wasn't able to find a reviewer by back channel means. Please consider doing a review for one of your ISPS colleagues! And, as an incentive, may I humbly suggest that if you want your own book reviewed, please offer to review another's as well, and the universe may be pleased to grant your wish!

*Newer members: If you are a newer member, 3-4 years or less, please consider submitting something. We want to hear from you. If you have any question please contact me directly. (If you don't know what to write about, consider a book review!)

* The public sector: I believe this is a relatively neglected area for us. So many people work in the public sector, or receive services there. Is there something new, different, better or worse at your agency, from your perspective as client or worker? So much in this field is driven not by private encounters in the consulting room, but by public policy decisions. Let us know what is going on.

* What are *you* doing? Maybe you don't think you revolutionized the field this year (or maybe you think you did). But, you did something. What was it? What are you up to? I would like to have a short list of people's doing's in each issue if possible. Give us a sense of the diversity within ISPS-US

Looking forward to hearing from you!

~Ross
rtappen@mindspring.com

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Host families are chosen not for any psychiatric expertise, rather, for their compassion, stability, and desire to give back. People live with these families for upwards of a year or two and become an integral part of a functioning family system. Staff members offer clients intensive psychotherapy and provide host families with intensive supervision.
The Family Care Foundation eschews the use of diagnosis, works within a framework of striving to help people come safely off psychiatric medication, and provides their services, which operate within the context of Swedish socialized medicine, for free.

Healing Homes weaves together interviews with clients, farm families, and staff members to create both a powerful vision of medication-free recovery and an eye-opening critique of the medical model of psychiatry.

Jeffery Gehring
CASE PRESENTATION AND DISCUSSION I:
A Beginning Care Manager's Experience with Milieu Treatment

This presentation will attempt to elucidate the significant role that paraprofessionals play in milieu treatment. Case material will be presented that highlights the way in which a Care Manager creates a safe, containing, structured environment for a resident with mental illness at Elpida House in San Rafael, CA. The presenter will discuss the ways in which he works with the resident's symptoms in the milieu, and how this differs from, yet compliments the work being done by other members of the clinical team.

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Keynote Address:
Richard P. Bentall, PhD

The Psychology of Paranoid Delusions

Richard P. Bentall, PhD

Persecutory (paranoid) delusions are one of the most common symptoms of psychosis, present in up to 90% of first-episode schizophrenia patients. However, less severe forms of paranoid thinking are common in the lives of ordinary people. Nevertheless, there seem to be some important differences between the paranoid thinking of patients with psychosis and that of ordinary people. Specifically, patients with paranoia most often experience 'poor-me' beliefs in which they feel themselves to be innocent victims of undeserved persecution whereas paranoid non-patients typically have 'bad-me' beliefs in which self-esteem is low and in which they feel that persecution is deserved.

Research showing that paranoid symptoms often occur against a background of insecure attachment and experiences of chronic victimisation suggests that they co-opt normal psychological mechanisms involved in the anticipation and avoidance of social threat. At the neurophysiological level, these mechanisms may involve dopamine circuits in the basal ganglia. At the psychological level, the evolution of paranoia during the lifetime of the individual from 'bad-me' during the prodromal phase to 'poor-me' during an acute psychotic crisis can be understood in terms of the development of internal working models (or schemas) about the self and others, and also defensive self-regulatory processes which become important in the transition from bad-me to poor-me

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ISPS-US would like to thank the following people for their generous donations (beyond dues) for 2012:

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in memory of Joseph Barnett, M.D.

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In memory of Joan Kirst Tappen

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on behalf of Le 388 - GIFRIC

Paul V. Williams, MD

Thanks so much for your generosity. 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. One area in which donations are especially needed is the fund to allow low-income people to attend the annual meeting.

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!

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paranoia. Hence, research on paranoia provides a bridge between biological and psychological approaches to psychosis, and between cognitive-behavioural and more psychodynamic models of symptom development. The clinical implications of these observations will be discussed if time allows.

Jessica Arenella, PhD, Heather-Ayn Indelicato, PsyD, Ross Tappen, MA
Doing the Work: A Practical Guide for Students and Early Career Professionals

Internship is over, you have to pay your student loans, and everyone thinks you're crazy for listening to patients talk about hearing voices. Perhaps you have been inspired by the epic tales of recovery from Chestnut Lodge or the innovative rehabilitation models in Europe, but your current work / internship situation seems light years away. This panel of a recent psychology graduate and two ten-year veterans will address these issues and provide an insight into current institutional and private practice work with patients diagnosed with psychosis. Mr. Tappen will detail his work creating and maintaining therapeutic integrity in a state psychiatric hospital, including running trauma services and cognitive skills groups, as well as his involvement with internship and group training. Dr. Arenella will recount her early tumultuous encounters with institutional work and the establishment of a full-time private practice with patients diagnosed with schizophrenia and bipolar disorder. She will address how to obtain referrals and navigate the Byzantine world of health insurance and social services. Mr. Tappen and Dr. Arenella will also discuss strategies to cope with stigma and to weather clinical and ethical crises on the job. Dr. Indelicato, a very recent graduate of Nova Southeastern University, will reflect on her struggles to translate her desire to provide treatment for individuals enduring severe psychiatric disabilities and the challenging realities that emerge when configuring these concerns into a viable career. She will discuss the importance of connecting to a larger community and pose questions to the other presenters.

Ronald Abramson, MD, Irene C. Coletsos, MD, MS, Thomas Nowell, LICSW, Burton Norman Seitler, PhD
There is More on Heaven and Earth Than the DSM

Recent decades have seen a change in dominant psychiatric thought from the psychoanalytic/psychodynamic, with an assumption that mental disorders can be best understood and treated by understanding individual psychopathology, to the biological/psychopharmacological, understanding them as brain diseases. This change has been driven by exciting advances in bio-genetics, neuro-pharmacology, and brain imaging technology. The publication of the DSM-III in the early 1980s signified the change in the basic paradigm of psychiatric practice from "behind the couch" psychoanalytic psychotherapy to a practice resembling primary care. The currently reigning practice methodology consists of making a diagnosis followed by 15 minute monthly medication visits. This model is sustained by a conviction that there is a firm scientific basis for it, and that there is a poor scientific basis for psychoanalysis and psychotherapy. There are also strong economic forces that support it.

This panel is based on the theme that reducing Psychiatry to its biological substrate is having unfortunate consequences for clinical practice. Psychiatrists engaging in this clinical practice can't possibly know their patients well psychologically. "Management" replaces "treatment" with the goal of recovery not in sight. The panel will discuss the limitations in the "DSM" paradigm as well as a scientific basis for adapting an approach to treatment that takes into account the psychological and social dimensions of treatment as well as the biological. Different experiences in the treatment of patients who have psychotic problems will also be presented.

Paul U. Alexander PhD
Collective Metabolization of Psychotic Elements in a Therapeutic Community

The focus of this paper presentation is a group-dynamics application of the famous paper by Harold Searles, The Patient as Therapist to the Analyst. In a psychoanalytic treatment center for chronically mentally ill adults that was run as a therapeutic community, the fate of un-metabolized emotional experience in the entire com-

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munity is traced through a series of encounters at the group level. Both patient and staff groups, feeling the strain of psychotic anxieties that were at once independent of and constructed within the respective groups, reached a point of de-compensation in functioning. In the particular case example offered, it could be seen that the patient group, unconsciously mindful of staff vulnerabilities, presented a series of enactments, or dramatizations, that required the staff to take up their proper containing functions and resume a bounded relationship with the patient group. The idea of unconscious communication between patient and staff groups is considered, such that the "healers" are asked to make repairs to their group mind so that the "patients" can then be tended to. A process, termed collective metabolization, is proposed as a way to understand one form of the unconscious "use" of psychotic experience in a treatment community.

James E. Gorney, PhD, Beverly C. Gibbons, PhD
Wounds Speak, Objects Scream: Whereof One Cannot Speak, Thereof One Cannot Stay Silent

In History Beyond Trauma (2004), Davoine and Gaudilliere delineate the complex links between memory, trauma, symbolization and madness. This panel will draw upon two clinical cases to illustrate how trauma can be represented, remembered and worked through via the social link of the psychotherapeutic dyad. In both instances, traumatic memory was first expressed through the spontaneous production of symbolic, visual images,

For Davoine and Gaudilliere, symptoms of trauma are markers pointing toward a Place; a place of unspeakable catastrophe inhabited in the past and still relived in the present. The symptom both masks and begins to communicate the unspoken horror of this as-yet-unsymbolized location. The unsymbolized trauma comes to haunt the subject, while at the same time foreclosing free access to individual, familial or social history. It is only when this place can be represented and inserted into the symbolic order of language, or art, via the human relationship that the catastrophe can be remembered, and not just re-lived repetitively as if branded or carved into one's very being.

Davoine and Gaudilliere assert that within the therapeutic encounter both participants bring shards of their own traumas and histories with them. In both cases to be described surprising points of connection emerged which generated artistic re-creations of traumatic experience. These powerful images will displayed to illustrate ways in which trauma becomes branded in memory - the place of the Real, where even material objects come to speak and scream.

Kate Hardy, Clin.Psych.D., Fanya McDaniel, Melissa Moore, PhD, Demian Rose, MD, PhD
Providing Early and Integrative Intervention in Psychosis: The PREP Model

The Prevention and Recovery from Early Psychosis program (PREP) is a program that delivers cutting edge evidence based interventions to individuals with a recent onset of psychosis. The aim of PREP is to prevent psychosis from becoming severe and disabling and to minimize the disruption and impact of a psychotic episode in the life of young person. PREP is a recovery-oriented community-based service providing interventions to young adults with a recent onset of psychosis or those who may be at risk of developing psychosis.

This presentation will describe the development of PREP in two different geographical locations and the innovative funding that was secured to finance this project. The program is the result of a community-academic partnership and the process involved in the establishment and maintenance of this partnership will be reviewed. The panel will include members from the two different PREP sites and will provide an overview of the services
offered through PREP including medication management, CBT for psychosis, case management, and multi-family groups with a particular focus on the integration of these different treatment approaches. Preliminary data will be presented from these programs and a description of how PREP engages in outreach to this young and notoriously difficult to engage population will be addressed. A consumer, who will be identified closer to

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the conference date, will be in attendance to portray their journey through, and experience of, the PREP service.

Charles Knapp, MA, LPC, Anne Marie DiGiacomo, MSW, LCSW
A Whole Person Approach to Family Integration and Recovery Within a Windhorse Therapeutic Environment

The Windhorse Therapy approach was developed in 1981 by Chogyam Trungpa and Dr. Edward Podvoll. It is based on the Buddhist understanding of fundamental health, fundamental sanity, and the inseparability of one's entire life from one's environment, while integrating applicable Western psychology. The primary activity involves creating whole person, individually tailored, therapeutic living environments for people with a wide variety of mental health recovery issues.

This presentation will focus on how the path of recovery involves synchronizing the body, speech, and mind of the therapeutic environment, which is an integration of the entirety of the client's life. Significantly, besides the clinical team, this includes the client's family and all aspects of their relationships: physical and financial support, relationship dynamics, communication, expressed emotion, attitudes, expectations, spirituality, love, forgiveness, mutual recovery and the eventual acceptance of the unique sanity and gifts of the client and each family member. We will present an overview of these concepts from the perspective of the beginning, middle, and end phases of recovery, and will include a brief case presentation that illustrates this integrated recovery process for the client, clinical team, and family.

Nick Luchetti, MS
Common Ground: Recovering the Natural Infrastructure of Compassion

…the experience of compassion and the impulse to cultivate its expression always remains as a basic element of our human nature…made possible by taking hold of what is already there: the spontaneous ebb and flow of exchange, our natural infrastructure of compassion. We need only to seize it in the service of caring for others."--Edward Podvoll M.D.

At its heart psychotherapy is an expression of compassion. Recent developments in a variety of fields have re-

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vealed compassion is an innate human faculty. However, our awareness of this inborn tendency for interpersonal connection is typically obscured by opposing developmental agendas of separation and individuation. As psychotherapists we are faced with the dilemma of attempting to employ a skill for which we have developed a diminished capacity. Our own process of recovery of our potential for compassionate presence may be essential to our effectiveness at helping those recovering from the alienation and loneliness of psychosis. The therapeutic relationship can then become the common ground for mutual recovery.

This presentation will explore the vital role of compassion in the process of recovery from psychosis. I will present the work of the Windhorse Project - a unique approach utilizing Buddhist principles of mindfulness and compassion to create healing physical and social environments for recovery. Meditations for rediscovering our intrinsic potential to send and receive compassion will be presented, as well as ways to integrate these practices of exchange into our therapeutic service.

Brian Koehler, PhD

Relational Psychosis Psychotherapy: A Neuropsychoanalytic Model

Cichetti (2010), from a developmental psychopathology perspective, emphasized that the abnormalities in the broad domains of genetics, neurobiology, cognition, emotion and interpersonal relationships in severe mental disorders do not exist in isolation. He encouraged researchers to strive to comprehend the interrelationships between the biological, psychological and social in these disorders. I have conceptualized this as a non-reductionistic, translational, more three-dimensional approach, which is integrative across the domains of brain, mind/self and culture. In this paper, I will attempt to demonstrate that looming threats of non-relatedness expressed in annihilation anxieties may be the core situation, which helps to explain some of the neuroscience, epidemiological, sociocultural, and clinical findings in many persons diagnosed with a severe mental disorder. Although this model includes both "bottom-up" neurobiological processes, such as the effects of various polymorphisms and neural alterations on psychological and psychosocial functions, and "top-down" processes, such as the effects of the environment on gene expression and neural morphology, it privileges the latter in its hierarchy of etiological factors. Relational psychosis psychotherapy (RPP), which will be broadly described, is one form of psychosocial therapy that seeks to address the terrifying threats of unrelatedness, the effects of relational trauma and social isolation. Relational psychosis psychotherapy is built primarily on contributions from such attachment-oriented psychoanalysts such as Christian Muller, Gaetano Benedetti (Benedetti, 1987; Koehler, 2003) and Otto Will (Sacksteder et al., 1987), contemporary relational psychoanalysis, attachment-based cognitive-interpersonal psychotherapies (e. g., Gumley & Schwannauer, 2006), compassion focused therapy (Gumley et al., 2010) as well as the current attempts being made by CBTp clinicians/researchers to link emotions, cognitions, trauma and the social world with the emergence and maintenance of psychotic experiences (Fowler et al., 2006; Bebbington et al., 2008). RPP is an approach that places the capacity for relatedness and containment of the dual terrors of unrelatedness and emotional closeness, i.e., loss of a sense of self, at the center of its model of care. The relational psychotherapist attempts to not lose sight of the forest for the trees by keeping in close contact with the anxieties and terror of unrelatedness embedded in psychotic symptomatology.

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Noel Hunter, MA
Does Risk of Violence Account for Resistance to Utilizing a Trauma-Informed Framework for Treating Psychosis?

Patients with schizophrenia often do not voluntarily seek treatment or they disengage from treatment early on in spite of the disruption this illness often brings to one's life. Recent publications have called for a renewed focus on psychotherapy and psychosocial interventions, including the need for trauma assessment and trauma-specific models as part of a comprehensive treatment plan for schizophrenia (Read & Ross, 2003). Taking a trauma informed, accepting, therapeutic approach has been shown to be effective across several studies, and is the first line approach for treatment of PTSD. Yet, standard practice for treating schizophrenia continues to rely on a biological model that tends to preclude psychotherapeutic measures, and may result in stigmatization and less effective treatment for this patient population. There may be a perception that individuals with schizophrenia present a greater danger than do patients with PTSD. This review attempts to compare rates of violence between these two patient populations. Although there is a risk of increased violence associated with acute psychosis, this association is minimal. However, there is a direct risk of violence, especially domestic violence, associated with symptoms of PTSD. If patients with schizophrenia are not more likely to be violent than those with PTSD, then an empirically validated, therapeutic, normalizing approach, as is standard in the treatment of PTSD, should be incorporated into treatment for patients suffering from schizophrenia who may benefit from such an approach.

Clancy D. McKenzie, MD
Research into Origin of Serious Mental and Emotional Disorders

Longitudinal studies are described in which peak age-of-origin and age range-of-origin of each symptom and each diagnostic category related to infant trauma can be identified.

These are precise measurements, calibrated to the month of origin and using statistical analysis of hard data. Implications of such findings are far reaching in the field of mental health.

Laura McCormick, PhD, Kristin Felch, PsyD, Nikki Sachs, LCSW
An Integrated Approach to the Treatment of a Psychotic Process: The Secret's in the Team

This hour will use a case as a starting point for a conversation about the benefits and challenges of working with psychosis as a treatment team. We'll observe how a man came to depend less on delusions to explain his world and protect himself from unbearable feelings as a result of residential treatment at Elpida House in San Rafael, CA. A unique aspect of his treatment is a comprehensive team of providers including an individual therapist, a group therapist, and a care manager who coordinates services and acts as an agent for integration. This comprehensive team allows the client to use these relationships as a container for fantasies, projections, delusions and re-enacting old relationship patterns. The team works together to hold different aspects of the client, to offer several practical and psychic functions, and to provide each other with new perspectives and respite. We'll observe how the team treatment process was transformative for members of the team and ultimately, for the client.

Our hope is that vignettes from this case will spark a rich discussion, addressing the following questions: 1.) What is the etiology of the psychotic process: organic, traumatic, defensive or all of the above? 2.) How does fragmentation manifest in the client's thinking, experience of self, and amongst providers? 3.) How do you provide insight-oriented therapy to someone with limited insight? 4.) How do optimism and hope thrive in the face of acknowledging a mental illness with its inherent stigmatization? 5.) Can a psychotic process remit or even be cured?

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Michael O'Loughlin, PhD, Marilyn Charles, PhD, ABPP, Jay Crosby, MA, Almas Merchant
A Qualitative Inquiry into the Experience of Persons with Chronic and Delimiting Psychiatric Disabilities

Recent studies in psychoanalysis, medical anthropology and phenomenological psychiatry have expanded our understanding of schizophrenia and the psychoses, and the implications of these studies are just beginning to emerge in the areas of diagnosis and treatment. However, while each of these perspectives offers important strands of knowledge to the field, no one study has attempted to combine these perspectives – the psychodynamic, the psychosocial and the phenomenological – under one umbrella, thereby bringing out the historical, social and subjective dimensions of schizophrenia within a single research study. We report on preliminary data from 20 persons designated schizophrenic who participated in three one-hour interviews exploring respectively (1) core dynamics; (2) traumatic antecedents and psychosocial stressors; and (3) experience of "being a patient" including phenomenological and cognitive understandings of psychosis, and notions of internalized stigma.

Criteria for participation:

- Having had a formal diagnosis of schizophrenia or other severe psychosis in adolescence/adulthood
- Having had at least one hospitalization for schizophrenia or other severe psychosis in adolescence/ adulthood
- Be functioning currently at a level that precludes sustaining gainful employment and long-term inti mate partner relations. On the GAF scale [Global Assessment of Functioning] this will be reflected in a score of 55 or less.
- Reside in a residence and participate in day-treatment or partial hospitalization for the ongoing treat ment of chronic schizophrenia or other psychotic disorders.
- Not be currently experiencing florid episodes of psychosis or in need of hospitalization.

Qualitative analysis of transcribed data will begin in Summer 2011.

Sarah St. Onge, MA, MMEd, Nathan Trice, Discussant: Marilyn Charles, PhD, ABPP
One's Trilogy: Dancing in the Spaces Between Self and Other

This work is part of a therapeutic inquiry into the relationship of a son and his mother who struggled with childhood abuse, paranoid schizophrenia, homelessness, therapy, and relapse. We are a therapist-in-training and dancer/choreographer who spent the past year discussing and reflecting on the dancer's (the son's) journey to understand himself, his mother, and their relationship. The dance is an interpretive theatrical work based on the narratives that emerged from the therapeutic sessions. Nathan Trice, dancer/choreographer, is the founder and artistic director of Nathan trice/RITUALS, a project-by-project dance theater company in New York City. Sarah St. Onge is a doctoral candidate in clinical psychology at Adelphi University, where she is supervised in this undertaking by Michael O'Loughlin, Ph.D., a professor at Adelphi. In the dance, Nathan plays both his mother and himself. Three other dancers portray the therapist and mother at various points in her life. The work, entitled "One's Trilogy," explores the sociohistorical and psychodynamic underpinnings of self and other. Following a viewing of the dance performance, the therapist and choreographer will engage in a dialogue that elucidates their process and the process of creating the piece. Marilyn Charles, Ph.D., staff psychologist at Austen Riggs Center, will serve as discussant. A video of the dance performance will be shown.

Marilyn Charles, PhD, ABPP
CASE PRESENTATION AND DISCUSSION II: Meetings at the Edge: Working with Psychosis

When working with individuals who struggle with psychosis, it is important to ways in which trauma ruptures language, so that the unspeakable often manifests through sign, symbol, or psychotic language. In this work, the therapist is called upon to enter into the universe of the other and learn to speak their language. This proc-

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ess entails our ability to accept the 'signs' that are markers of meaning that have not yet been integrated sufficiently to be useful as symbols, so that we can begin to make meanings together. To illustrate this interactive process, I will present the case of a young woman who had been designated psychotic and had come to the limits of what medication and traditional psychotherapy could offer. She came asking whether or not I might meet her halfway rather than insisting, as had been the case with her previous therapist, that she engage only in my way, on my terms. This woman's world was configured according to concepts that were not unfamiliar to me, having lived part of my adulthood on the Navajo Reservation and in Santa Fe, New Mexico, where there is an openness to 'new age' ideas and eastern religions. My willingness to step outside of conventional practice - and enter into this woman's universe – allowed for the elaboration of important nodes of meaning. Recognizing together the signs and symbols of the negative entities and energy fields through which emotional and relational complexities were marked and negotiated helped this woman to build her internal and external resources in sufficient fashion to be able to move forward in her life.

Michael Robbins, MD
Hide and Seek: The Creation and Resolution of a Mutual Psychosis

A sequential summary will be presented based on detailed notes I made after each of more than 1100 sessions spanning more than 11 years work with Sara, who met the criteria for chronic paranoid schizophrenia. In prepuberty Sara began to have auditory and visual hallucinations and to live her life according to a ritualistic delusional system. She had numerous hospitalizations during her adolescence and early adulthood. I met her at age 28 and our work included an 18 month hospitalization at McLean. Sara had internalized the destructive psychotic hostility of her mother and come to believe it was the best and only way to take care of herself in a dangerous world. She was more comfortable in a world of destructive people and activity than a world of caring, and enacted paranoid hostility both toward herself and anyone who attempted to care for her. Compliance was her disguise and her chameleon quality and cyclical oscillations between what seemed to be progress and dismaying regressions, as well as her effective efforts to convince me that my perceptions were inaccurate and to destroy my efforts to reach her, forced me to struggle with my own sanity at the same time I tried to help her understand hers. The remarkable outcome of our work became evident at the time of termination and was confirmed when she came to see me two decades later.

Martha Rose, MBA
Transinstitutionalization of the Mentally Ill: The Consequences of Social Policy, Social Deviance and Economics

We have changed from a society of social welfare to a society of mass incarceration. The mentally ill have been moved from the state mental hospitals of the 1950s to the criminal justice system of the 21st century.

The US prison population is now the largest per capita in the world. There are currently over 7 million people in the criminal justice system, with 2.3 million, or 1/3 currently serving time in prisons and jails, and an additional 5 million on probation and parole. The Bureau of Justice (2006) estimated that 1.2 million inmates had some form of mental illness, and of those between 10 to 24% experienced delusions and hallucinations. This would mean about 600,000 people in jails and prisons, and 1.3 million on probation and parole are considered seriously mentally ill.

What is the collateral damage to society? How has this transfer of people from the medical system to the criminal justice system redefined treatment, social policy, and the social construct of mental illness, and schizophrenia in particular? How has social deviance been redefined that people who are outside the norm are now locked up rather then treated? What is the relationship of deviance to trauma? To what extent does incarceration add secondary trauma to people who are already severely traumatized?

This paper and presentation will examine changes in criminal justice law and enforcement,

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as well as the re-definition of public mental health policies. It will present findings from a range of studies and key economic data to help us better understand the costs of transinstitutionalization.

Ira Steinman, MD
CASE PRESENTATION AND DISCUSSION III: Intensive, Curative, Psychotherapy of Previously Hopeless and "Untreatable" Schizophrenia

This presentation emphasizes that in this era of treating schizophrenic and delusional patients with a primarily antipsychotic drug oriented approach, there may be a better approach via an Intensive Psychotherapy. These cases demonstrate that an exploration of the meaning to the patient of his psychosis - with judicious antipsychotic use, when indicated - leads to internal character and external behavioral change that is far more lasting than that achieved with antipsychotic medication alone. With such a psychodynamic approach, these previously chaotic, disturbed and heavily medicated people were able to integrate delusional systems that had persisted for many years and give up previous extensive antipsychotic medication, as they understood and worked through psychological issues underlying their psychotic orientation.

Paris Williams, PhD
An Exploration of the Existential Underpinnings of the Psychotic Process, from Onset to Full Recovery

The purpose of this presentation is to present the research carried out in 2010 that culminated in the presenter's doctoral dissertation. The aim of this research was to explore the psychotic process at the most fundamental level of human experience, with the hope that such an inquiry may offer some guidelines and perhaps even a more or less universal map that can be of service to others struggle with psychosis.

Qualitative multiple-case study methodology was used to inquire into the experience of six participants who had suffered from long-term psychosis and who are now considered to be fully recovered. Data analysis consisted of developing individual and cross case themes for each of six prefigured categories: description of the anomalous experiences, the onset and deepening of psychosis, recovery, lasting personal paradigm shifts, lasting benefits, and lasting harms. After exhaustive analysis of the data, a theoretical model was formulated that assisted in discussing the implications of the data. The results revealed that all six participants had striking parallels in their experiences with regard to all six categories of experience, with the most central implications as follows: an overwhelming existential threat to the self apparently played an important role in the onset of psychosis; the psychotic process was likely initiated by the psyche as an attempt to regain equilibrium in the face of this threat; recovery was primarily assisted by reconnecting with hope, meaning, a sense of agency, and the cultivation of healthy relationships; psychiatry generally caused significantly more harm than benefit in the process of recovery; and the successful resolution of the psychotic process apparently involved a profound reorganization of the self along with significantly more lasting benefits than harms.

Alexander Zinchenko, PhD
Transference: Total Institution

It has been over fifty years since Erving Goffman immersed himself into St. Elizabeth's psychiatric hospital and coined the term "Total Institution." Recent treatment models, while focusing on 'Wellness and Recovery' and underlining the value of patients' individuality and personal choice, when come in contact with psychotic phenomena often acquire such characteristics of "Total Institution" as identity trimming and submission to over-all rational plan of various enforced activities. Drawing from his clinical experience of working at Napa State Psychiatric Hospital, the presenter will suggest looking at this transformation of treatment model as an enactment of institutional counter-transference to psychoses: The treatment model both adjusts to salient features of psychoses and inadvertently reproduces patients' traumatic past. The staff often uses this structured treatment approach to distance themselves from the overwhelm feelings caused by a close contact with psychotic patients. However, the techniques used often resemble the very phenomena of psy-

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chotic communication in its emotional flatness and incongruence, disregard for the experience of the other and use of words that are devoid of meaning. Examples of patients' reality- and transference-based reactions to Total Institution will be discussed. They will be contrasted with patients responses to staff's attempts to make real contact.

Jeanne Lee Seitler, PsyD
A Novel Integrative Model Illustrating the Etiology and an Approach to Treatment of Psychotic States

Psychotic states are viewed not as a physiological aberration needing adjustment through the use of medication, nor a maladjusted pattern of behavior to be extinguished, but instead as a signal that the individual finds himself operating at the perimeter of his current psychological viability. Contrasting with other treatment modalities that focus on symptom remission, this model does not focus on the eradication of symptoms, because the symptom is likely to hold valuable information as to the location and nature of a person's problem in successfully construing him self, others, and the world. The pain experienced with a symptom is viewed as what motivates the client to risk construct reconstruction. It is, therefore, important not to rescue the client from what might be much-needed discomfort. Symptoms and painful emotions will be ameliorated when construct revision is achieved. The intense, often terrifying and disorganizing symptom cluster known as Psychosis can be understood as signaling a crisis in construing at the level of core identity constructs. Psychosis arises when confusion exists in understanding one's self and how to organize novel, overwhelming or invalidating experience. In order to identify the etiology of psychosis for a given person, situational, developmental, and characterological factors must be explored. This model provides a framework and process by which these factors can be conceptualized so that the person who suffers from psychotic states may receive individualized treatment appropriate to his unique psychosis etiology.

Objectives:
-Participants will learn a new, non-biological, integrative model for conceptualizing the etiology of Psychotic States.
-Participants will be able to articulate what factors predispose certain individuals, rather than others, to having repeated psychotic episodes.
-Participants will learn several techniques for assisting clients with the self-reorganization necessary for the resolution of psychotic states.
-Participants will discuss the integration of paradigms this new model embraces.

Honoree: Ann-Louise S. Silver, MD

Early Onset Psychosis: Do we want it in the DSM-5

What would the risks and benefits be, regarding the introduction of the suggested new syndrome "early onset psychosis"? What do we know already about the reliability of the implicit prediction of a deteriorating course for the identified individuals? Should ISPS-US come to a consensus and contribute to the American Psychiatric Association's debates on this issue?

Ann-Louise S. Silver, MD

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Sue Saperstein, MFT, PsyD
Possession: From Delusion to Transitional Space

Possession and madness are medieval terms saturated with religiosity and referring to evil: daemonic possession. Yet, Winnicott in his imitable way termed the origin of being " the first not-me possession." In the primal land of first possession lies the potential for intermediate space - a place of illusion - the madness that is a kind of antidote to insanity. In a critique of Winnicott, Green focused on childhood horror and the destructive creativity of delusions and the necessity for play. The therapeutic approach suggested is not a direct confrontation between the internal space of the mind and external space, but engagements that facilitate the move from the space of delusion to transitional space. The remedy would not be reality but rather play in the sense in which Winnicott uses the word applied to psychoanalysis.

Clinical studies recommend that the alchemy of psychoanalysis of psychosis holds possibilities and potential for these impossible states of possession and their transformations.

Burton Norman Seitler, PhD
Suicide Attempts: Possible Wishes to Kill Off "Bad" Introjects and Thus Achieve Rebirth

Many assume when people attempt to kill themselves they are in pain that is so unbearable they would rather sacrifice their lives than endure another moment. Sometimes what is missed is a common belief/wish that underlies many suicidal attempts, one which rests on the fantasy of rebirth, in which, much like the Phoenix, a brand new person will arise out of the ashes of the "destroyed" introject. Such is the case of Benedict, who was plagued by "devilish" voices which persistently humiliated him, telling him he would be tortured, commanding him to end it all, and rebuking him for being a weakling if he did not do it. He felt driven to suicide. He sought comfort in the belief that the "demons" that taunted him would die in the process, but that he would be reborn. Our work felt precarious and tumultuous. One perceived wrong word, an experienced slight, or misattunement on my part left him with a mix of despair and fury. He moved rapidly between wanting to kill himself and me. When I refused to die in the face of his emotionally driven verbal barrage, or give up on him, he was ultimately able to identify with my dogged determination to both survive his fierce attacks and to locate the source of the voices (introjects) that were waging "their" attacks on him (and on me). After the storms subsided, he could begin to relinquish his delusional system and combine forces with me to face and overcome his fears.

Ron Unger, LCSW
Dialogs at the Edge of Reason: Addressing Spiritual Issues Within Treatment for Psychosis

Mental health professionals are trained to empathize with clients, and to use the client's own language and metaphors where possible. Yet these same professionals most frequently base their explanations on reason and on empirical knowledge of bio-psycho-social factors, while those diagnosed with psychosis often speak in ways that defy reason and empirical knowledge, and use spiritual concepts or metaphors instead. Professionals are likely to view such spiritual talk as "hyper-religiosity" or simply as part of the disorder, or at best as something they lack the expertise to discuss. These differences create a barrier to an effective therapeutic relationship.

There are ways, though, to overcome this divide. Professionals can learn to humbly recognize the limits of their own reason and knowledge, and the potential validity, in some sense, of even odd spiritual perspectives. At the same time, they can learn how spiritual language and metaphor can be seen as another way of discussing complex dynamic processes and emergent phenomena related to trauma, attachment, and identity, so that even atheistic professionals can perceive spiritual discussions as related to the core issues of psychosis. Then, professionals can gently and non-dogmatically deepen spiritual dialogs by using methods

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similar to Jung's "archetypal amplification," helping clients identify possibly useful alternative spiritual perspectives while also preserving self esteem and positive aspects of otherworldly experiences.

When recovery does occur, people often report that spiritually played a key role. By becoming willing and skillful participants in discussing spirituality within psychosis, professionals can make recovery from psychosis more likely.

Wilfried Ver Eecke, PhD, Eva Lingström Eriksson, MD, Christina Norman Villemoes, PsyD
Egostructuring Method Created by Villemoes for Treatment of Persons Afflicted by Schizophrenia

According to Lacan the psychotic person isn't linguistically structured. (S)He has not reached the Oedipal dimension, and hence lacks a metaphorical dimension. The strategy of ego-structuring psychotherapy uses narcissism to introduce a temporal dimension in the structure of the ego. The psychotics are not able to be dialogue partners. Personal pronouns are not handled normally. Past and future are not firmly located.

In the working phase the history of the psychotic person will be written. The patient has the facts, and is asked to present them in as much detail as possible. The therapist has the Oedipal logic and must help the patient write his (her) history piece by piece, as a puzzle, until it becomes a narrative, where the patient is the main character.

The working-alliance is called the "best-pal" -relationship. Best-pals have a relation only because of a common interest. They also identify with each other and think in the same way. In ego-structuring psychotherapy the common interest will be the history of the psychotic patient. The Oedipal thinking and comments from the therapist, given in a non-polarizing manner, will give the pieces from the psychotic's history a meaning and will also give a temporal structure to the ego.

Carolyn Quadrio, MD
Intensive Psychotherapy with Bipolar Disorder

The author presents an intensive psychotherapy with a 35 year old woman who had been diagnosed with rapid cycling bipolar disorder. She had been treated over several years with a range of psychotropic medications, cognitive psychotherapy and several courses of ECT. Her illness was severe and relapsing, episodes were predominantly of major depression and there was a significant risk of suicide. She was referred to a special mood disorders unit where she was eventually assessed as treatment resistant and after lengthy consultation with several experts she was finally recommended for leucotomy. At that stage a trial of intensive psychotherapy was undertaken by the author. The therapy took four years with four sessions weekly in the earlier phase and progressively diminishing in frequency. The theoretical framework was one of developing an internal working model of a secure attachment relationship and the capacity to self soothe; there was also exploration of a highly complex family system and issues of childhood trauma that were relatively subtle. Leucotomy did not proceed and at 15 year follow up she remains well.

Elizabeth Waiess, PsyD
The Traumatic Flashback as One Basis of Misunderstanding between Patients and Law Enforcement Officers

(Written with Bert Karon, who will not be present.) A patient in psychoanalytic psychotherapy reported to the analyst that the patient recently had been forced by satanic cult members to commit a murder. After discussion, the patient and analyst agreed to inform the police. The police could not find evidence for the occurrence of the crime. Continued psychoanalytic work revealed that it was not a contemporary murder, but a flashback of a childhood horror. Since flashbacks of past traumatic experiences are not an uncommon phenomenon, they would account for some of the gruesome events reported by patients, but which law enforcement officers can-

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not validate as having recently occurred.

Judith V. Parker, PhD
Treating Psychosis Through the Understanding of Dreams–An In-Depth Case Presentation

This in-depth presentation will focus on the treatment of one individual whose history included several psychotic breaks and hospitalizations. Detailed process notes of several serial sessions will be presented to illustrate the value of dreams and their interpretation in highlighting and relieving the confusion and fragmentation caused by the deep conflicts and resistances that lie at the heart of psychosis.

Chris Burford, April 2 2012

By Ann-Louise Silver

Chris Burford, MD, a general psychiatrist from London, died on April 2, 2012 ,age 67, having struggled for six years, first with renal cancer and then chronic lymphocytic leukemia, dying suddenly in his home from a pulmonary embolus. He was a vigorous contributor to ISPS, creating its ISPS-INT listserve and then serving as its moderator and active contributor, posting new and relevant articles, posing timely questions, and seeing to the larger group issues. He was a loyal attendee at our ISPS-US meetings, serving as our European emissary.

Chris Burford, MD

He grew up in Wimbledon where his home served also as his mother's school for children up to age 8. He then studied history at the Peterhouse College, Cambridge. He travelled to mainland China during its closed years, campaigned against apartheid and world poverty, and was active in the Quakers. He studied German at the Goethe Institute, and the bond its members felt with him was evident in their participation in the post-funeral discussion tribute. Chris took on the big issues around the world. The treatment of psychosis and the public's attitudes toward the sufferers was central. As his own problems progressed, he felt growing urgency and thus insistence on action, and this very urgency led to problems in his functioning in groups, his work group at St. Ann's Hospital in Tottenham, and in our ISPS board.

He was a noble fighter and a friend. I remember the long conversation we had at the ISPS-US annual meeting in Boston. The fire alarm went off at about 2 a.m. and we all gathered on the sidewalk outside until we were told everything was under control. Chris and I then sat in the lobby and talked for maybe an hour or more, knowing we would have to be awake and functional by 7 for the next day's meeting. I hope we can establish a Chris Burford Memorial Fund, which could facilitate the flow of information to ISPS-US members.

Current Research

Abstracts on Psychotic Disorders from The British Journal of Psychiatry and Acta Psychiatrica Scandinavica
Brian Koehler PhD New York University

The British Journal of Psychiatry (2012) 201: 83-84 Antipsychotics: is it time to introduce patient choice? Anthony P. Morrison, Paul Hutton, David Shiers and Douglas Turkington

Summary Evidence regarding overestimation of the efficacy of anti- psychotics and underestimation of their toxicity, as well as emerging data regarding alternative treatment options,suggests it may be time to introduce patient choice and reconsider whether everyone who meets the criteria for a schizophrenia spectrum diagnosis requires antipsychotics in order to recover.

British Journal of Psychiatry September 2012 201:252;
Symptomatic remission in psychosis and real-life functioning

M. Oorschot, T. Lataster, V. Thewissen, M. Lardinois, P. A. E. G. Delespaul and I. Myin-Germeys

+Correspondence: Dr Inez Myin-Germeys, Department of Psychiatry and Neuropsychology, Maastricht University, PO Box 616 (VIJV), 6200 MD Maastricht, The Netherlands. Email: i.germeys@maastrichtuniversity.nl

- Declaration of interest
  None.

Abstract

Background: In 2005 Andreasen proposed criteria for remission in schizophrenia. It is unclear whether these criteria reflect symptom reduction and improved social functioning in daily life
.
Aims: To investigate whether criteria for symptomatic remission reflect symptom reduction and improved functioning in real life, comparing patients meeting remission criteria, patients not meeting these criteria and healthy controls.

Method : The Experience Sampling Method (ESM), a structured diary technique, was used to explore real-life symptoms and functioning in 177 patients with (remitted and non-remitted) schizophrenia spectrum disorders and 148 controls.

Results: Of 177 patients, 70 met criteria for symptomatic remission. These patients reported significantly fewer positive and negative symptoms and better mood states compared with patients not in remission. Furthermore, patients in remission spent more time in goal-directed activities and had less preference for being alone when they were with others. However, the patient groups did not differ on time spent in social company and doing nothing, and both the remission and non-remission groups had lower scores on functional outcome measures compared with the control group.

Conclusions
The study provides an ecological validation for the symptomatic remission criteria, showing that patients who met the criteria reported fewer positive symptoms, better mood states and partial recovery of reward experience compared with those not in remission. However, remission status was not related to functional recovery, suggesting that the current focus on symptomatic remission may reflect an overly restricted goal.

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Footnotes

• Funding
I.M.-G. was supported by a 2006 NARSAD Young Investigator Award and by a Dutch Medical Research Council (Vidi) grant.

Acta Psychiatrica Scandinavica
Volume 126, Issue 4, pages 266–273, October 2012 Early trauma and familial risk in the development of the extended psychosis phenotype in adolescence
J. T. W. Wigman, R. van Winkel, J. Ormel, F. C. Verhulst, J. van Os, W. A. M. Vollebergh

Objective: Both genetic and environmental factors are thought to play a role in the development of psychotic outcomes; however, their respective contributions over time, including possible developmental interactions, remain largely unknown.

Method: The contribution of parental general and psychotic psychopathology as proxies of genetic risk to the development of subthreshold psychosis and its hypothesized interaction with childhood trauma were studied in a general population sample of 2230 adolescents, followed from age 10–16 years. Outcome measures were: i) level of psychotic experiences at age 16 years and ii) persistence of such experiences over the total follow-up period.

Results: General parental psychopathology was associated with CAPE score (OR = 1.08; P < 0.043 for highest quintile) and suggestively predicted psychosis persistence (OR, 1.16; P < 0.072). Psychotic parental psychopathology was suggestively associated with CAPE score (OR, 2.25; P < 0.063 for highest quintile), predicted membership of the Persistent group (OR, 3.72; P < 0.039) and suggestively predicted membership of the Decreasing group (OR 2.04; P < 0.051). Childhood trauma was associated with CAPE score and with all developmental trajectories of subclinical psychosis. No evidence was found for an interaction between trauma and parental psychopathology.
Conclusion: The development and persistence of subthreshold psychotic symptoms may be conditional on non-interacting proxy genetic and environmental influences.

Acta Psychiatrica Scandinavica
Volume 126, Issue 4, pages 282–289, October 2012 Symptomatic and functional remission in patients with first-episode psychosis.
S. Verma, M. Subramaniam, E. Abdin, L. Y. Poon, S. A. Chong[1,2]

Objective: For patients suffering from psychotic disorders and their caregivers, 'recovery' remains important. Our study aims to examine the rates of both symptomatic and functional remission in first-episode psychosis (FEP) patients at 2 years and identify sociodemographic and clinical factors associated with recovery.

Method: In this naturalistic study, all consecutive FEP patients presenting to an early psychosis intervention programme were recruited. Symptomatic remission was defined by the Schizophrenia Working Group's criteria; functional remission was defined as a Global Assessment of Functioning (GAF) disability score of ≥61 with engagement in age-appropriate vocation. Simple and multiple logistic regressions using stepwise method were used.
Results: Out of 1175 patients, 636 (54.1%) met criteria for symptomatic remission, 686 (58.4%) for functional remission, while 345 (29.4%) met for both. Multiple logistic regression revealed female gender (OR 1.47; 95%CI, 1.12–1.93), those married (OR 1.49; 95%CI, 1.02–2.18), younger age (OR 0.98; 95%CI, 0.95–0.99), tertiary education (OR 1.56; 95%CI, 1.02– 2.38), shorter DUP (OR 0.99; 95%CI, 0.98–0.99), lower baseline PANSS negative scores (OR 0.97; 95%CI, 0.95–0.99), and early response at month 3 (OR 1.78; 95%CI, 1.31–2.42), as significant predictors of recovery at year 2.

Conclusion: Our results indicate that strategies to reduce DUP and achieve early response could improve remission rates in FEP patients.

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Acta Psychiatrica Scandinavica
Volume 126, Issue 4, pages 243–255, October 2012
A systematic review of psychological interventions for excessive alcohol consumption among people with psychotic disorders

A. L. Baker, S. A. Hiles, L. K. Thornton, L. Hides, D. I. Lubman

Baker AL, Hiles SA, Thornton LK, Hides L, Lubman DI. A systematic review of psychological interventions for excessive alcohol consumption among people with psychotic disorders.
Objective: Excessive alcohol consumption is common among people with psychotic disorders. While there is an extensive literature on the efficacy of psychological treatments for excessive drinking, few studies have examined interventions addressing this issue among people with psychotic disorders.

Method: Systematic searches in PubMed and PsycINFO were conducted to identify randomized controlled trials comparing manual-guided psychological interventions for excessive alcohol consumption among individuals with psychotic disorders. Of the 429 articles identified, seven met inclusion criteria. Data were extracted from each study regarding study sample characteristics, design, results, clinical significance of alcohol consumption results, and methodological limitations.

Results: Assessment interviews, brief motivational interventions, and lengthier cognitive behavior therapy have been associated with reductions in alcohol consumption among people with psychosis. While brief interventions (i.e. 1–2 sessions) were generally as effective as longer duration psychological interventions (i.e. 10 sessions) for reducing alcohol consumption, longer interventions provided additional benefits for depression, functioning, and other alcohol outcomes.
Conclusion: Excessive alcohol consumption among people with psychotic disorders is responsive to psychological interventions. It is imperative that such approaches are integrated within standard care for people with psychosis.

Join us for the
ISPS-US Fourteenth Annual Meeting
What's in a Name? Emerging Perspectives on the Intersection of "Schizophrenia" and "Recovery"

October 4-6, 2013
Preconference workshops Sept. 30-Oct. 4
At the Hyatt Regency New Brunswick
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Keynote Speaker: Debra Lampshire

Experience-based expert at the University of Auckland, project manager for Auckland District Health Board in New Zealand, chairperson of ISPS New Zealand and member of the ISPS Executive Committee

Honorees: Marius Romme, MD, PhD and Sandra Escher, PhD

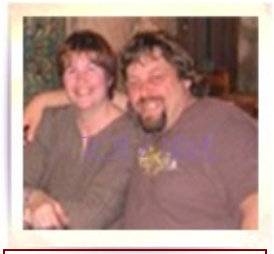
- Dr. Romme: Dutch psychiatrist, best known for his work on hearing voices (auditory hallucinations) and regarded as the founder and principal theorist for the Hearing Voices Movement. Founder and former Chair of Intervoice, the International association for voice hearers.
- Dr. Escher: involved in the Hearing Voices Movement from the very beginning, organized many hearing voices conferences, has done research with children hearing voices, author of a book on children who hear voices, board member of Intervoice.

The Call for Papers and Registration Materials
will be posted on www.isps-us.org and sent to ISPS-US members. If you are not a member but would like to be on the mailing list for this meeting, e-mail Karen Stern at contact@isps-us.org with your name, e-mail address and mailing address.

ISPS Offers Workshop on Voice Dialoging with Ron Coleman

Ross Tappen

On June 25 ISPS-US presented a full day workshop with Ron Coleman and Karen Taylor in NYC. We had over 80 attendees, from New England and Long Island as well as New York City. There were several service users, some of whom had traveled quite a distance; a large number of peer specialists, as well as dance, music and art therapists, psychologists, social workers and at least one psychiatrist. A number of agencies, including Catholic Charities, Goodwill, PSCH, and NYS Office of Mental Health, sent groups of people. All of the psychology interns from my facility, Manhattan Psychiatric Center attended as well as my department head and another senior colleague. Ron was particularly pleased at the representation from so many different disciplines and front-line agencies, because, "I want to help people examine their practice and change their practice right where they are." Jessica Arenella was the principal organizer with significant help from Leah Rokeach and several others.



Ron Coleman and Karen Taylor

In the morning program, Ron contextualized and normalized the voice hearing experience generally, but made some particular links between problematic voice hearing and posttraumatic experience; directed an experiential exercise in voice hearing for the participants; and told some of his personal story. In the afternoon session he used his work with a woman to illustrate "voice profiling" and "voice dialoging" techniques. In these techniques one assesses and categorizes a person's voices on different dimensions, and then begins to make contact and work with them in a way that struck me as rather like family therapy.

Coleman's own fascinating story involves a series of lengthy and largely unhelpful conventional treatments, some of which were involuntary, being cajoled into attending a voice hearer's support group by particularly persistent and hopeful social worker; meeting and making alliance with Marius Romme and becoming active in the Hearing Voices movement. His website is www.**workingtorecovery**.co.uk/. He currently lectures and consults internationally with his wife Karen Taylor on recovery and voice hearing; they also maintain a farm respite at their home in northern Scotland.

Postscript: As of this writing there is a new voice-hearing group at Manhattan Psychiatric Center, based on the June workshop. It is called Voices and Visions, co facilitated by a peer specialist, a psychology intern, and myself. We are three weeks old and currently involved in formulating ground rules around confidentiality and our relationship to the surrounding institution.

A message from the Leston Havens Trust

Dear ISPS-US members -

I've received a communication the Leston Havens trust. Les of course was one of our honorary members who died last year. The trust is looking for any recordings of his lectures and workshops they can organize and archive them.

There is special interest in a lecture series that Les did at Mass Mental in the 1980s; the 23 tapes they are looking for are from the Spring of 1981 and the Autumn of 1982. The series was the Language and Mind of Psychotherapy. Howevever anything could be helpful.

If you have or know about any of the lectures, can you please contact Amy McCollum at the Leston Havens Archives: amyemcc@gmail.com.

with thanks

Ross Tappen
ISPS-US Newsletter Editor.

How to avoid Jared Loughner kind of tragedies.

By Kerrie McKie & Wilfried Ver Eecke
Georgetown University

Kerri McKie was a student in my class in the Spring 2011, when Jared Loughner killed, in Tucson, Arizona, six people and wounded severely Representative Gabrielle Gifford. Ms McKie, as many students, started my class with the conviction that schizophrenia was mainly, if not exclusively, a genetic disease. I presented the psychoanalytic understanding of schizophrenia by Lacan (Ver Eecke 1988) and of depression by Vergote (2003). A GUROP research assistant grant, gave Ms McKie the opportunity to study the issue further. She read the research of Harding on the healing effect of work. She then related Harding's research with the claim of Hegel that work is an essential tool for affirming one's humanity. Thus, Ms McKie concluded that schizophrenia is not exclusively a genetic illness. It is a bio-psycho-social dysfunction. Ms McKie then discovered research confirming that psychotherapy, including psychoanalytically inspired therapies, were effective (Karon 2003).

In studying one psychoanalytically inspired therapy for schizophrenics, developed by Villemoes, MD, she discovered that a "confrontational approach does not help the patient." Indeed, Villemoes recommends a non-polarizing approach. This allowed Ms McKie to see how the tragedy of Jared Loughner could have been avoided, but only if the college administrators and the police had known that dealing with Loughner's problems and symptoms demanded a non-confrontational, non-polarizing intervention. Thus, the availability of a psychoanalytic understanding of schizophrenia to college administrators and police departments may in the future contribute to the avoidance of Loughner kind of tragedies. Ms McKie demonstrates that such knowledge can be acquired as part of normal college education.

Report on the use of Psychotherapy in treating Schizophrenia:

In 1998, when the Schizophrenia Patient Outcomes Research Team (PORT) made recommendations for the treatment of schizophrenia, the team included an explicit denial of the use of psychotherapies. The PORT report recommends the withdrawal of psychodynamic psychotherapeutic techniques from schizophrenia treatment, explicitly stated in Recommendations 22 and 26(PORT, 1998). In discrediting the use of psychotherapeutic techniques, the report promotes only pharmaceutical treatment of schizophrenia in its recommendations. Presumably the publishing of the PORT report would dictate the accepted treatment of schizophrenia for years to come. However since the publishing of PORT public online forums recognize the inclusion of psychotherapeutic approaches to treating schizophrenia. Both Mayo Clinic and WebMD deliver information regarding the treatment of schizophrenia, including both medicinal and psychotherapeutic approaches including psychoanalysis. Studies since the PORT report have demonstrated the success of including psychoanalytic therapy in the treatment of schizophrenia. This paper will provide a summary of a number of sources indicating the proper use of psychoanalytic therapy in treating schizophrenia and additionally support the need for proper training for those interacting with schizophrenic or psychotic patients.

The National Institute of Mental Health (NIMH) provides information regarding treatment of schizophrenia. In addition to presenting the different antipsychotic medications, the NIMH also explains the use of psychosocial treatment in conjunction with pharmaceutical usage. The importance of the therapy, the NIMH claims, is to help schizophrenic patients cope with the everyday challenges of the disease including communication, care, work and relationships. The psychosocial therapies help the patient to understand and live with the disease and additionally to keep the patient on their medication regiment. Other medical resources such as the Mayo Clinic also stress the use of psychotherapies in helping the patient improve communicative and vocational skills and identify warning signs. This public advocating for psychotherapy as a supplementary treatment for schizophrenia has historical and more recent support.

There are several psychotherapies that differ in the ways in which each helps the patient in living with and overcoming the disease. According to the NIMH, psychoanalysis aims to understand the behavior of the patient by understanding the subconscious of the patient. In his master-slave dialectic, Hegel states that a person defines himself through the work that he performs (Hegel, 1977). Courtenay Harding supports work as a self-identifying feature of human existence in the studies, which followed groups of patients thirty years after therapy that included the development of work skills. By focusing on aspects of the patient's life regardless of his

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disease gives the patient a sense of himself as more than his disease (Harding, 2002). Other psychotherapeutic techniques focus on the schizophrenic's improper use of language properly, as indecipherable monologues often accompany schizophrenia. In fact, Jacques Lacan identified a break in the use of language by the schizophrenic (VerEecke, 2002). Other psychoanalysts including Palle Villemoes have focused treatment of schizophrenia on mending this break in language by the use of 'talk-therapy' (Villemoes, 2002). Villemoes' work outlines the proper use of therapy in order to help the patient establish mastery over language by allowing the patient to describe objects in the room around him. This gives the patient control over his own thoughts by having him focus on things, which exist in the common reality of the patient and therapist. The sense of control over language and the conversation, give the patient control in his life, as work does as suggested by Hegel and Harding. Villemoes' suggests that the therapist slowly give the patient more control over the proceedings in therapy, resulting in not the therapist asking prodding questions, but allowing the patient to share as he is comfortable, establishing a relationship of trust. Villemoes' therapy therefore allows the schizophrenic to control language and practice forming relationships with others (Villemoes, 2002). Therefore, the several approaches to psychotherapy focus on helping the patient gain vocational and communicative skills, overcoming the obstacles of living with the disease. Other psychotherapies include family therapy and cognitive behavior therapy, which additionally help the patient with common interactions and understanding himself. Regardless of the specific psychotherapeutic treatment chosen, the aim of each helps to define the patient and the control gained gives the patient that definition for his life without schizophrenia as a prominent feature. Harding claims, as others do as well, that the idea that the disease does not control the patient's life, and the hope of overcoming the disease is important in the patient's recovery (Harding, 1995).

Villemoes outlines a guide for the therapist in proceeding with a psychotherapeutic approach. In outlining a procedure for other therapists to follow, Villemoes indicates an important part of treating schizophrenia with psychotherapy: the therapist assigned to the schizophrenic must be properly trained in the technique he/she uses in order to effectively help the schizophrenic. Effective psychotherapy requires an establishment of a relationship with the patient, who is characterized by mistrust and withdrawal (Bachmann, Resch and Mundt, 2003). The training of the therapist must be specific to psychotherapy and to the understanding of schizophrenia in order to treat the patient properly. In order to further this idea, we examine an example of an improper interaction with a schizophrenic person.

Before the January 11, 2011 shooting, there were warning signs and actions taken to have Loughner's mental health evaluated by a psychiatrist. As a student at a local community college, reports from other students who felt threatened by Loughner suggested possible symptoms of psychosis. However, the school's attempts to have Loughner removed from the classrooms and college and evaluated were done by law enforcement officials. Even after repeated suggestions for evaluation, none occurred. In the aftermath of the shooting, it is easy to say that an evaluation would have prevented the January 11th events, however, what can be said is that there could be a more beneficial way to recommend mental health evaluations. Villemoes' outline of interacting with a patient indicates that a direct, confrontational approach does not help the patient. Law enforcement officials are not equipped with the training to properly help the person who has been deemed a risk either to himself or others. Therefore, in addition to advocating for psychotherapy in treating schizophrenic or psychotic patients, proper training of professionals involved with the patients is necessary to properly help the patient.

Studies since PORT have advocated for more research into specific types of psychotherapy. Eugen Bleuler noted a three-fold discharge rate of patients on treatments that include psychoanalysis. Others note the benefits to psychotherapy in general in maintaining social and work relations and adhering to pharmaceutical regiments. One study concludes that the methods used to treat schizophrenia cannot be restricted to one method but rather should be dictated by the patient's condition (Bachmann, Resch, Mundt, 2003). Psychotherapeutic techniques must conform to the patient's needs, therefore the professional must have a thorough understanding of psychotherapy and the disease itself. Schizophrenia and psychosis have biological, psychological and social factors, all of which cannot be addressed by medication alone (Bachmann, Resch, Mundt, 2003). In order to target and understand the psychological and social manifestations of the disease, psychotherapy must be employed (Karon, 2003). Not only will the therapy help understand the manifestations of the disease, but also will help with coping and overcoming the symptoms that hinder the life of the patient.

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