Conference Abstracts: 2008

ISPS-US Ninth Annual Meeting: Recovery from Psychosis: Healing through Relationship
March 14-15, 2008, New York University, New York City

Sessions

Abandoning Occam's Razor: The Art of Reconstructing the Self (Keynote Address)
Ronald Bassman, PhD ron@ronaldbassman.com

Annihilation Anxiety, Dissociative Identity Disorder (DID), and the Trauma Crucible
Dawn Brett, PhD, BCETS, FAAETS traumaconsultants@comcast.net

Be social! What kind of "relationship" can help psychosis to recover?
Jean-Max Gaudillière, PhD gaudilliere1@hotmail.com

Beyond Countertransference: The Therapist's Experience in Relationship with a Schizophrenic Patient
Jessica Brooke Radder, PsyD jbradder@yahoo.com

Cognitive Behavioral Therapy (CBT) Approaches to Recovery from Psychosis
Yulia Landa, PsyD, David Kimhy, PhD, Michael Garrett, MD, Page Burkholder, MD

Deciphering Psychotic Communications
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Dianna: A Case in Reverse Psychoanalysis
Alberto Montoya, MD montoya1psi@hotmail.com

Downside Up and Outside In
Courtenay Harding, PhD (Honoree) charding@bu.edu

The Eclipse of the Person in Contemporary Psychiatry : Challenging Neurobiological Reductionism-an Integration of Neuroscience, Psychosocial & Phenomenological Perspectives
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Entropy of Mind & Negative Entropy: A cognitive and complex approach to schizophrenia and its therapy
Tullio Scrimali, MD tscrima@tin.it

Essential Precursors to Effective Transference Interpretations with Psychotic Clients
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Establishing A Therapeutic Relationship While Not Knowing Anything For Sure
Robert Kay, MD 215-629-1924 (no e-mail)

Ethics, Authority, and 'Standards of Care': Meetings at the Edge
Marilyn Charles, PhD, ABPP mcharles@msu.edu

From Autism to Motherhood
Anni Bergman, PhD aerbergman@aol.com

The Future of a Delusion: The Denial of Death in Psychosis and its Treatment
Warren E. Schwartz, PsyD WrrnSchwrt@aol.com

Getting to "Ordinary": The Therapeutic Relationship Leads the Patient Back to the Real World
Ronald Abramson, MD Rona976@aol.com

Hallucinations and Delusions: The Experience and the Meaning
Eric R. Marcus, MD erm4@columbia.edu

Healing Relationships in the Milieu Setting
Julie Kipp, PhD, LCSW julie_kipp@psychoanalysis.net, Bruce Reisman, LCSW *et al.*

Healing through Relationships-A Theory of Psychological Investment
Dorothea Leicher, LCSW, NCPsyA, CCDP dleicher@dleicher.com

The Human Affective Environment and the Role of Psychoanalysis and Psychosis Within It
David Garfield, MD dasg@aol.com

I and Thou: Addressing Self-Other Permanence Struggles Within the Therapeutic Relationship
Alexandra L. Adame, MA adameal@muohio.edu and Larry Leitner, PhD

Interpretation: Auditory and Visual Hallucinations
Alan J. Ward, PhD, ABPP ALANw28981@AOL.COM

It Takes a State Institution: An inter-relational view of violence, fragmentation and symbiosis in recovery from schizophrenia
Ross Tappen, MA rtappen@mindspring.com and Christina O'Brien, PsyD

"It Takes a Village" to Cause and Cure Madness: A Report from Norman Rockwell's Town
Paul Lippmann, PhD lippmannp@aol.com

Lost in psychosis, lost in language: A meeting of minds through translation
Jayoung Heo, MA jayoung.heo@gmail.com and Cress Forester, PsyD

Mutual Healing Through Relationship in Psychodynamic Therapy
German Cheung, PsyD German.psyd@gmail.com

On Aliveness in Psychosis and other Dead Places
James Ogilvie, PhD jogilvie@psychoanalysis.net

The Organizing Transference and Psychotic Signifiers

Lawrence E. Hedges, PhD, ABPP lhedges@pacbell.net

Paranoid Paradoxes
Danielle Knafo, PhD dknafo@liu.edu

The Psychoanalytic Treatment of Psychotic Depression: The Role of the Creative Process
Patricia L. Gibbs, PhD patricialgibbs@aol.com

Psychosis and Moral Conflict
Andrew Lotterman, MD andyl1978@aol.com

Psychotherapy for Schizophrenia: A Therapist and Patient Discuss their Work
Monica Carsky, PhD carskym@aol.com

Recovery from Psychosis in Ancient Times
Manuel González de Chávez, MD MGCHAVEZ@teleline.es

Recovery from psychosis in group psychotherapy
Manuel González de Chávez, MD MGCHAVEZ@teleline.es and Ignacio García Cabeza, MD igcabeza456@gmail.com

Relationship Factors in the Recovery of Borderline Patients at the Psychotic Edge
Marvin Hurvich, PhD, ABPP marvin@hurvich.com

Successful Psychotherapy of Schizophrenia: What Went Right: A Dialogue with the Patient and Her Therapist
Daniel Dorman, MD ddorman@ucla.edu and Catherine L. Penney, RN

Take These Broken Wings
Daniel Mackler, LCSW dmackler58@aol.com

Treating the "Untreatable" with an Intensive Psychotherapy of Psychosis: Recovery, Healing, Cure
Ira Steinman, MD irasteinman@pol.net

Trilingual psychoanalytic psychotherapy of a psychotic immigrant woman: becoming a person
Esther Rapoport, MA esther_rapoport@yahoo.com

Volunteers in Psychotherapy: Sanctuary for analysis of "psychotic" metaphors as clues to traumatic experience
Richard Shulman, PhD, Lic. Psychologist ctvip@hotmail.com

Wittgenstein's guideline for the healing of psychosis
Françoise Davoine, PhD gaudilliere1@hotmail.com

Abstracts

Abandoning Occam's Razor: The Art of Reconstructing the Self (Keynote Address)
Ronald Bassman, PhD ron@ronaldbassman.com

Through the prism of personal experience with madness, the elements integral to the reconstruction of self will be examined.

Apart from a handful of alternative practices, people encountering diverse crises are offered only two less than adequate means for addressing their altered states: psychotherapy and/or medication. Some have learned to make the best of the strengths and weaknesses manifested in their unique being, others have recovered, and some like the presenter have used their experience for transformative growth. The presenter will examine the multiple elements and conditions that enhance possibility for those who encounter madness in its multiple incarnations. Discussed will be how these experiential insights can be utilized by therapists to propel, support and enhance what is ultimately most important for one's clients --the actions he or she engages in outside the professional office.

The goal of this presentation is to embrace complexity and abandon our unrequited love of parsimony in favor of the openness so necessary for more creative ways of building opportunity for becoming.

Annihilation Anxiety, Dissociative Identity Disorder (DID), and the Trauma Crucible

Dawn Brett, PhD, BCETS, FAAETS traumaconsultants@comcast.net

Annihilation Anxiety involves various aspects of disintegration of the ego and the self. DID is a disorder due to extreme early Trauma and one in which the most consistent and extreme form of splitting of the ego and Annihilation Anxiety is experienced. The therapeutic relationship in which DID is treated becomes a Trauma crucible into which various aspects of the person seeking help are placed, to be examined and understood- but only if there is an experience of safety and trust. The heat of the past Traumas have "branded" certain dissociated ego states to experience certain affect, cognitions, and behavior when confronted with specific Traumatic cues. The helper bears witness to the other person's unraveling, experience of annihilation, and reliving of unspeakable horrors. As most of these Traumas are interpersonal in nature, the therapeutic relationship becomes a process for mastery, to rework the past interpersonal Traumas. The therapeutic relationship can be healing if the therapist is trained; aware of their personalized countertransference and Trauma-specific countertransference, and can face their own Annihilation Anxiety. Since DID and Annihilation Anxiety are intertwined, the therapist may easily be overcome by the disintegration of the person seeking their counsel- by witnessing dissociated ego states disappearing like grasping at smoke rings evaporating in the wind. It is important to be able to sit with horrific Traumatic material, inconsistencies, lack of control, and annihilation. The therapist is needed to ground and orient the person seeking help, while remaining human and compassionate with safe boundaries.

Be social! What kind of "relationship" can help psychosis to recover?

Jean-Max Gaudillière, PhD gaudilliere1@hotmail.com

Since the beginning of psychoanalysis, transference/countertransference relationship has been conceived as a social relationship.

Professionally organized around a special knowledge supposedly situated « into » the skills of the therapist, this relationship is constantly defeated by and through the traumatic reviviscences reenacted in the treatment.

Through clinical examples, I will explore how transferential interferences are able to reveal disappeared social relationships, which is the true aim of any psychotic research. A disappeared war encountering another

war, from another time, another continent, an outdated unmemorized profession encountering another bizarre glance; therapeutic social relationships are not so easily socially accepted.

Beyond Countertransference: The Therapist's Experience in Relationship with a Schizophrenic Patient
Jessica Brooke Radder, PsyD jbradder@yahoo.com
Literature on the analyst's positive countertransference with a schizophrenic patient is scarce. This study aims at shedding light on the analyst's experience in the therapeutic relationship with a schizophrenic patient, specifically the integrative or transformative properties of such an experience for the analyst. This study proposes that while in a therapeutic relationship with a schizophrenic patient, an analyst may find insight into himself or herself. This may be due to several components specific to the schizophrenic patient: certain interpersonal mechanisms, an unfiltered access to (collective) unconscious operations, and/or their unique social position. The study draws on phenomenological interview data collected from five psychoanalytic clinicians across the United States who are asked detailed questions about a therapeutic relationship they've had with a schizophrenic patients. The clinician's experience is addressed through the context of countertransference, which refers to the entirety of a therapist's reaction to the therapeutic process, holding the possibility of this experience as positive for the therapist. Analysis of the results reveals both transformational and learning experiences of psychoanalytic psychotherapists who have worked with schizophrenic patients on a long-term basis. Further interpretation of the findings of this study point to a schizophrenic patient's ability to illuminate the human condition.

Cognitive Behavioral Therapy (CBT) Approaches to Recovery from Psychosis
Yulia Landa, PsyD, David Kimhy, PhD, Michael Garrett, MD, Page Burkholder, MD
Studies have shown that stress, negative self-schemas and specific cognitive biases play an important role in the formation and maintenance of psychotic symptoms (Blackwood et al., 2001; Chadwick & Birchwood, 1994; Freeman et al., 2001). Drs. David Kimhy, Michael Garrett, Page Burkholder and Yulia Landa will discuss cognitive model of psychosis and specific CBT interventions for self-esteem, stress reduction and paranoia.

Presentation 1
David Kimhy, Ph.D. dk553@columbia.edu
Assessment of Stress, Arousal, and Psychosis during Daily Functioning: Application with CBT

Previous studies have linked increases in stress with elevations in psychosis. However, little is known about the pathophysiology associated with this link. We used Experience Sampling Method (ESM) with Palm computers along with ambulatory measurement of arousal to assess interactions between psychosis, stress, and arousal in schizophrenia patients. Psychosis, stress and parasympathetic activity fluctuated markedly across time of day. Psychosis was associated with reduced parasympathetic activity. Finally, a case report will be presented describing the integration of ESM with a Palm computer in CBT with an individual at high risk for psychosis.

Presentation 2
Michael Garrett, MD Michael.Garrett@downstate.edu
Approaches to Self Esteem in CBT for Psychosis

Insight into mental illness may encourage treatment adherence and lead to a better quality of life, or it may lower self esteem, and lead to depression, and even increased suicide risk. In the cognitive behavioral

treatment of psychosis it is extremely important to understand how each patient regulates self esteem to help them develop a recovery narrative that does not engult the Self in the mental illness label. Dr. Garrett will discuss clinical approaches to self esteem in CBT for psychosis."

Presentation 3
Yulia Landa, Psy.D yul9003@med.cornell.edu
Combining Group and Individual Cognitive Therapy in Treatment of Paranoid Delusions
Paranoid delusions were found to be the most common delusional belief that is frequently acted upon. Studies have shown that patients' reasoning styles, cognitive biases, and isolation contribute to the formation and maintenance of paranoid beliefs. Dr. Landa will discuss the CBT treatment model where group and individual therapy is combined to address specific for paranoid delusions cognitive biases and assist patients in mastering new, more adaptive ways of processing information and relating to others. The preliminary assessment of this method showed a statistically significant reduction in delusional conviction, and an increase in ability to dismiss a delusional thought.

Discussant: Page Burkholder, MD

Deciphering Psychotic Communications
Mirel Goldstein, MS, MA mkrasner2002@yahoo.com
This presentation will discuss the ways in which psychotic symptoms and "nonsensical" language, can be understood as metaphors and meaningful communications, and related to for their communicative intent. Psychotic communications will be discussed in terms of the defense mechanisms they may be representing, possible metaphorical meanings, and as communications of affect. The predominance of subconscious functioning in these communications will be discussed. Clinical vignettes will illustrate various ways to relate to the communications posed by psychotic individuals.

Dianna: A Case in Reverse Psychoanalysis
Alberto Montoya, MD montoya1psi@hotmail.com
Dianna was living in the city of New York. She was barely 18 when she underwent a psychotic episode. She claimed to be an alien coming from the sun. She was predicting the end of the world–the end of the century was approaching–she said that in the year 2000 the children and the toys were going to start a war against the adults. Human beings were evil and it was necessary to finish the adults. Dianna also said she was a Japanese animae.

Days after, Dianna was having breakfast at her father's house with her father, her stepmother and her stepsister. At that very moment she heard a voice telling her "the moment has come." She went toward the kitchen, grabbed a big knife and stabbed her father in the back. The wound wasn't critical; that day Dianna spent her first night at the psychiatric hospital.

That is where her treatment started. There have been two critical moments when I have practiced psychoanalysis backwards (as proposed by Benedetti, Davoine, Gaudilliere). The first one was after Dianna escaped from the clinic. Unexpectedly, without knowing she had run away from the clinic, I met her on the street in the neighborhood where my office is. What to do with a circumstance like that? "What you don't tell you show." The second crucial moment was when she started to draw while she was staying at the clinic, another way of showing things one cannot utter with words. She started to paint that trauma coming from

the three prior generations (a war history).

Dianna improved when at the transference she turned me into a rabbit with three ears, and with that I entered into her private language/communication. I will conclude my presentation by showing you some of the paintings Dianna made, as well as paintings from other cases, since I believe it is very important to work with iconography in clinical work with schizophrenic patients.

Downside Up and Outside In

Courtenay Harding, PhD (Honoree) charding@bu.edu

After delivering a plenary paper in the Washington Meeting of ISPS, someone in the audience stood up and asked if Dr. Harding was "from a different planet?" The presentation had revealed that, contrary to our expectations from the past 100 years, the accumulated evidence from across the world showed that persons with schizophrenia and other serious and persistent problems could and did reclaim their lives through significant improvement and even full recovery. Now, national, state and program initiatives use the word "recovery" but interventions often appear to be "old wine in new bottles." She will express appreciation for all the theoretical and treatment contributions made by various schools of thought but will suggest that while everyone has a "piece of the pie," no one has the whole pie as is often thought. Working for nearly 3 decades trying to puzzle out what are some of the other ingredients involved, Dr. Harding has participated in several short and very long-term studies and clinical work asking questions. Over time, she has proposed aspects such as: resilience, neuroplasticity, and collaboration as well as the role of temperament, persistence, a home, a job, friends, and even luck. In this presentation, Prof. Harding will challenge our preconceptions about the timing and efficaciousness of current treatment strategies which ironically often appear to inadvertently promote more chronicity and other unfortunate iatrogenic effects (e.g. the Metabolic Syndrome and untimely deaths). She will present further clinical and research evidence which change our interventions by 180 degrees and may actually remap the brain and help reclaim lives before more years go by.

The Eclipse of the Person in Contemporary Psychiatry : Challenging Neurobiological Reductionism-an Integration of Neuroscience, Psychosocial & Phenomenological Perspectives

Brian Koehler, PhD brian_koehler@psychoanalysis.net

Psychiatry, as well as psychoanalysis, is the science and art of the person. It is not just the science of DNA, proteomics, and the brain. It is reductionistic and significantly incomplete to view mental disorders in essence as proteinopathies. John Strauss, WHO researcher and psychiatrist, has called attention to how the "science of the night" has been eclipsed in contemporary psychiatry by the "science of the day," i.e., the science of the quantifiable. For me, the "science of the night" refers to all of those places and states of being which are only incompletely known to oneself and others, and can only become better known through close and continuous relationships which can bear and make meaningful those states of being. The person's soul, hopes and fears, loves and hates, joys and sorrows, what we refer to as psychic reality, cannot be seen on fMRI, PET scans or with the newer neuroimaging techniques such as near-infrared spectroscopy or two-photon microscopy. In this paper, I shall challenge the neurogenetic and neurobiological reductionism in contemporary psychiatry using recent research from within molecular neuroscience itself, as well as epigenetics, developmental psychobiology and phenomenological first person narratives of severe mental illness. It is incorrect to split off neurophysiology from the living, experiencing human subject. In the proposed model, the embodied emergent person is held to be superordinate to the medical soma, and to be absolutely unique at the level of DNA, brain and psyche, while, at the same time, meaningfully embedded

within relational and sociocultural contexts. Psychotic symptoms such as delusions and hallucinations, which cannot be reduced to molecular interactions without losing vital information and meaning, will also be approached from within the perspective of embodied, meaningful, personal states of being.

Entropy of Mind & Negative Entropy: A cognitive and complex approach to schizophrenia and its therapy
Tullio Scrimali, MD tscrima@tin.it
Schizophrenia is the main issue in psychiatry as far as clinical, psychopathological, rehabilitative and therapeutically aspects are concerned. A very important topic, which must be considered too, is that schizophrenia is a privilege of homo sapiens, since it does not affect any other creature living in our planet. For this reason, understanding schizophrenia means understanding something more of the human mind too!

The presentation is focused on the development of a theory of mind (Coalitional Mind as a process of a Modular Brain) a model of schizophrenia (Entropy of Mind) and a protocol for therapy and rehabilitation for schizophrenic patients (Negative Entropy).These three topics will be illustrated and discussed.

Negative Entropy is an integrated, multimodal and multiconstestual protocol strategically oriented but treatment which includes:

Crisis intervention
Cognitive Therapy
Rehabilitation
Cognitive Remediation
Family Therapy
Social and Work intervention

Essential Precursors to Effective Transference Interpretations with Psychotic Clients
Martin Cosgro, PhD mcosgro@charter.net
This presentation outlines several necessary precursors to effective transference interpretations while working with psychotic individuals. A sound therapeutic alliance, some semblance of self-integration, and evidence of the capacity for observing ego are all required before a transference interpretation is likely to be meaningfully utilized by clients in psychoanalytically informed treatment. Many clinicians struggle to engage a client with transference interpretations long before they are mentally ready to make use of the best formulations their therapist can offer. When proper attention is paid to when a client is actually mentally prepared to make use of these deep and meaningful interventions, the desired progress: insight and subsequent change, is more likely to occur. If offered prematurely in treatment, the client is unable to effectively integrate the transference based intervention and may actually reinforce their defensive posture with respect to threats to internal security/ stability. By carefully monitoring a few basic constructs,as well as being patient, clinicians can develop more consistently effective strategies for offering transference interpretations.

Establishing A Therapeutic Relationship While Not Knowing Anything For Sure
Robert Kay, MD 215-629-1924 (no e-mail)

Since we've no objective, valid, verifiable data with which to firmly establish diagnosis, dynamics, mental state, ideal treatment, or the results, we usually end up TRYING to understand what the patient and significant others have CHOSEN to reveal after which they usually CHOOSE what to do about our recommendations and then CHOOSE what to tell us about the results.

Meanwhile, the assumption is that, given some genetic-loading/vulnerability, that most dysfunction/symptoms are the result of brain-impacting traumas beginning in childhood.

Then, in treatment, feeling cared for by an important person shifts the hormonal and immunological systems in the direction of homeostasis while the addition of psychic-pain-relieving medications, insight/understanding, suggestions re pleasureable, neurogenesis-promoting experiences, and specific psychotherapeutic/psychosocial techniques,
are very apt to result in a certain amount of recovery.

In the meantime, given the centrality of hope and a caring relationship, the therapist and/or the psychiatrist should be available by beeper 24/7 while our not knowing anything for sure is acknowledged in the beginning by stating that, "You know far more about your head than any of us will ever know. But we have a great deal to offer, so let us know what you feel we need to know, and we'll ask a few questions, and then we'll advise YOU while you advise US so that together we can figure out how to relieve the pain, repair the brain, promote connections, and find the way to a better life."

Ethics, Authority, and 'Standards of Care': Meetings at the Edge

Marilyn Charles, PhD, ABPP mcharles@msu.edu

Psychoanalysis requires courage, as we move beyond the known onto an uncertain edge of experience. If we believe in the Subject as uniquely unknowable, then that edge is the point at which we can begin to find an other as Other, rather than as a caricature of what we believe we 'know'. We yearn for simple solutions, but increasingly find ourselves in a world in which 'standards of care' do not necessarily reflect our own ideas regarding 'best practice,' and concerns over 'risk management' can obscure ethical considerations in ways that may not serve our patients or our profession. In this presentation, I would like to offer a case in which standards of care were at odds with the patient's experienced needs. In working with an individual whose experience was of 'losing her mind,' I found myself invited to move into a space in which I might also lose my mind (thus offering hope that one can lose one's mind and re-find it). In spite of theories that warn of the perils of fragmentation and splitting, however, there is a temptation to decline the patient's invitation, turning a blind eye on our common humanity and designating the patient as a devalued 'other' in false reassurance regarding our own vulnerability. I hope to encourage a discussion that may enliven, enlighten, and support our struggles in our work with patients who demand entry into that shaky but essential territory of the unknown.

From Autism to Motherhood

Anni Bergman, PhD aerbergman@aol.com

This paper will describe a case of emergence from autism through psychosis and eventually to genuine object-relatedness. Treatment began when the patient was a young child of about 3, and was seen jointly with her mother in intensive analysis. The work continued through childhood and adolescence, during which she achieved the capacity for mentalization and self-reflection. The therapeutic relationship was kept alive for more than a decade, during which the patient lived in a faraway country, where she married and had

children. Upon her eventual return, psychoanalytic psychotherapy was resumed and is ongoing.

The Future of a Delusion: The Denial of Death in Psychosis and its Treatment

Warren E. Schwartz, PsyD WrrnSchwrt@aol.com

What I am concerned with here is how, or if, the traumatized psychotic patient and the practitioner can share a universal human pain - specifically, the helplessness and anxiety associated with the knowledge that we will someday die and that this death may be, despite what our myths tell us, the absolute end of existence. I am interested in how the two parties deal with this very possible truth and the illusions or delusions they employ to defend against it. It is understood here that the evolution of popular treatment paradigms for seriously disturbed individuals, which are characteristically distancing and destructive, are motivated by a human tendency to seek out the comfort of such explanatory systems when faced with reminders of mortality. The traumatized psychotic patient poses as a mortality reminder of great force, not only because of his history of terrifying trauma and a tendency to repeat them, but for two other reasons: 1. His development did not permit the maturity of sufficient defenses to manage the universal human terror associated with the awareness of the possibility of finitude. This terror seeps through the cracks of his permeable and fragile symbolic buffer system. 2. He does not follow the rules of our deeply held symbolic order, thus reminding us of its arbitrariness and potential invalidity.

Just as broad cultural meaning systems have evolved to mitigate death terror in the human animal (Becker, 1973, 1962/1971, 1975), our more local mental health system worldview has adapted to its constituents' 'job hazard' of annihilation anxiety (as transmitted and evoked by the patient) by providing them with a worldview that encourages maximal psychological distance from the patient. We rely on neuroreductionistic etiological explanations for severe psychopathology and on related treatment paradigms which provide the practitioner with psychological equanimity in the face of the patient's terrified and terrifying subjective state.

These claims will be examined from the perspective of Terror management theory (for a comprehensive review, see Pyszczynski, Solomon, and Greenberg, 2002), a strongly empirically-supported theory of human behavior based on the works of psychologist/ anthropologist Ernest Becker (1973, 1962/1971, 1975). This paper will serve as a theoretical basis for future Terror management experimental research.

Getting to "Ordinary": The Therapeutic Relationship Leads the Patient Back to the Real World

Ronald Abramson, MD Rona976@aol.com

People become psychotic because living in the real ordinary world has become unbearable to them. Their psychotic world, bizarre and frightening as it may be, is still less terrifying than the annihilation and loss of self threatened by living in the conditions they have experienced in their ordinary lives. How can we help them get back?

Given their traumatizing experiences, it is understandable that psychotic people do not easily trust their therapist. The first necessity is the establishment of a safe and trusting atmosphere within which patients can find words to meaningfully explain their predicament. As patients gain trust, the therapeutic relationship becomes more meaningful to them. In the safety of the therapeutic relationship, the patients become increasingly able to leave their psychotic world and live in the "ordinary."

Three patients will be presented to illustrate different aspects of this process. Patient 1 utilized the safety of the therapeutic relationship to soothe her fears and stay out of the hospital. Patient 2 gained trust and real

world functionality rather quickly as the therapist and she exchanged views of religion. Patient 3 was able to leave her "cold lonely glacier" behind as her intensive therapeutic relationship became a conduit back to the real world which she had hated.

Theoretical considerations from Kohut, (transmuting internalization), Robbins, (validation), and Lacan, (*jouissance*) will be discussed.

Hallucinations and Delusions: The Experience and the Meaning

Eric R. Marcus, MD erm4@columbia.edu

Hallucinations and delusions are more than just psycho-pathological signs of psychosis. They are human experiences and have compelling meaning. They are awake dreams and tell the story of the person and their experience of meaning in the context of their lives and their emotional adaptations and conflict. This talk will review the psychological structure of these phenomena and give case examples with the goal of strengthening the therapist's ability to empathically connect and understand.

Healing Relationships in the Milieu Setting

Julie Kipp, PhD, LCSW julie_kipp@psychoanalysis.net, Bruce Reisman, LCSW *et al.*

"Go to the people. Live with them. Learn from them. Love them. Start with what they know. Build with what they have. But with the best leaders, when the work is done, the task accomplished, the people will say 'We have done this ourselves.'" Lao Tsu

"All real living is meeting." Martin Buber

Many people with mental illness are treated in milieu or group settings of public or private social service agencies. One such place is Bronx REAL, a network of services which is part of the Jewish Board of Family and Children's Services of New York City. The Jewish Board has a long tradition of a psychodynamic approach to the problems of a range of populations, including people with mental illness. In this panel presentation, staff and clients from two sister milieu programs of Bronx REAL will present their work in creating a community of healing relationships, focusing on a psychodynamic and recovery-oriented approach. Special attention will be given to the importance of creating a safe environment, along the lines of Sandra Bloom's Sanctuary model, and to the democratic values of the therapeutic community.

Healing through Relationships-A Theory of Psychological Investment

Dorothea Leicher, LCSW, NCPsyA, CCDP dleicher@dleicher.com

The workshop translates psychodynamic concepts into a theory of psychological investment to explain healthy and pathological functioning. Responses to trauma (regression, splitting, repetition for mastery) are conceptualized in a "harm reduction model" (survival of the body factually or symbolically) from which psychiatric symptomatology and self-injurious behavior can be explained. Psychosis is understood as early form of PTSD, which gives it a function and highlights the potential for recovery.

Learning is a social process, which involves gambles (investments). Research with animals and humans shows the primacy of the need for affiliation (before hunger etc.). Conversely, profound sense of personal isolation

is the common denominator in all mental illness.

Healthy interpersonal relationships provide a universe of variable ratio reinforcement schedules in response to our behaviors, which over time sharpen the discrimination between "not-yet-successful opportunities" which need to be pursued persistently and genuinely "bad deals" which should be abandoned. (Having a number of sustainable relationships would be the psychological equivalent of a well-diversified investment portfolio - as protection against catastrophic loss).

The entraining of these skills occurs via primary process, usually pre-conscious and pre-verbal, through mirroring and identification. The workshop hypothesizes that our capacity for art developed as a proto-linguistic tool to sharpen our ability to perceive the patterns and rhythms of these contingencies, which are symbolized in our experience of emotions, and to allow us to synchronize with our social groups.

Therapy provides a process to (re-) establish these connections both intra- and inter-personally.

The Human Affective Environment and the Role of Psychoanalysis and Psychosis Within It

David Garfield, MD dasg@aol.com

The Natural Environment and The Human Environment sit at two ends of a continuum. The natural environment is defined by movement and the laws of nature govern that movement. The Human environnment is defined by emotion and the laws of affect govern that emotion. Change in the natural enviroment requires movement. Change in psychotherapy and psychoanalysis requires emotional reconfiguration and development. Distortions in time and space in the natural environment conform to the laws of relativity. Distortions in internal time and space conform to the laws of subjectivity which are identical to the laws of affect. There is an interface between between the subjective and objective worlds and much about a patient's internal emotional state is gleaned by his or her movements. At the same time, a patient's behavior is conversely predicted by an understanding of his emotional state. Culture bound, body based metaphor gives us important emotional information about our patients who are psychotic. This information helps us chart and track psychoanalytic recovery.

I and Thou: Addressing Self-Other Permanence Struggles Within the Therapeutic Relationship

Alexandra L. Adame, MA adameal@muohio.edu and Larry Leitner, PhD

Experiential personal construct psychotherapy (EPCP) (Leitner, 1985, 1988) holds that meaning is co-constructed in our dialogical relationships with others. More specifically, EPCP focuses intimate relationships in which each person comes to understand the other's processes of construing the world. This relational stance is similar to Martin Buber's (1958) notion of an I-Thou encounter in which one person opens his or her heart to another, and both stand in reverence of the profound gift it is to both give and receive one's core sense of being. However, by engaging on such an intimate level also means that one's core sense of self could be profoundly disconfirmed by the other person. When a child's core construal processes are disconfirmed at an early age he or she may not develop reliable constructions of self and other to engage the world. From the perspective of EPCP the phenomena associated with psychosis or schizophrenia such as hearing voices may be conceptualized as profound struggles in the permanence of self and others. We contend that these types of experiences, though often painful and disturbing, are important communications to the person about their lives and may be safely explored within the context of the therapeutic relationship (Leitner, 1999). In this paper, we will explore the concept of healing through meeting from the perspectives of EPCP and the philosophy of Buber. We will use clinical case material to illustrate therapeutic interventions

in our work with people who struggle with self-other permanence.

Buber, M. (1958). *I and thou*. New York: Scribner.
Leitner, L. M. (1985). The terrors of cognition: On the experiential validity of personal construct theory. In D. Bannister (Ed.), *Issues and approaches in personal construct theory* (pp. 83-103). London: Academic Press.
Leitner, L. M. (1988). Terror, risk, and reverence: Experiential personal construct psychotherapy. *International Journal of Personal Construct Psychology*, 1, 261-272.
Leitner, L. M. (1999). Terror, numbness, panic, and awe: Experiential personal constructivism and panic. *The Psychotherapy Patient*, 11, 157-170.

Interpretation: Auditory and Visual Hallucinations

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This is a presentation detailing the impact of psychoanalytically oriented interpretations upon the presence, function and dissipation of auditory and visual hallucinations in an adult Indian male immigrant patient and an adolescent , African-American male patient. Although the view has been expressed that "…Few clinicians feel that the exploration of and interest in the content of a patient's hallucinations and delusion is of much therapeutic worth" (Bellak, 1979); it is acknowledged that "…hallucinations are useful as signals of some immediate stress…defenses against the expected distress which should be attended to"(Arieti, 1971; Schulz, 1975).However, it has been been suggested that "… the auditory hallucinatory experience of a chronically schizophrenic woman…function, during the therapy sessions, to provide her with the responses from another person at a time, when he [therapist] was not supplying any comments to her"(Searles, 1979). Inasmuch as interpretation has been defined as "…the art…which takes on the task of freeing…the repressed thoughts from…the unintentional ideas" (Lowenfeld, 1904), it seemed appropriate to make direct interpretations to alleviate and explicate the patient's distress at the invasion of foreign, invasive, out of control auditory and visual hallucinations.

This report details the response of these patients to direct interpretations that were associated with the diminution in intensity and frequency of these auditory hallucinations, as they made progress in the integration of these foreign and repressed ideas into their conscious functioning. One patient refused the use of antipsychotic medication while the other reluctantly agreed to its use. Each patient was seen on a 1-2 /week basis over a period of two years.

It Takes a State Institution: An inter-relational view of violence, fragmentation and symbiosis in recovery from schizophrenia

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In a 1959 essay on "Integration and Differentiation in Schizophrenia: an Overview," Harold Searles discusses "the kind of group-relatedness which the patient fosters…on the hospital ward." Searles observed that problems of identity integration and differentiation in individual patients are made manifest within, and are influenced by the attitudes and behaviors of the surrounding group of ward staff. This can be seen a "group symbiosis" in which individual staff members may have rigidly held, incompatible views of the same patient. The resulting conflict, in which each member of the staff regards his or own view as the way the patient "really is," can be seen as an externalized representation of the patient's own fragmented sense of self. While this configuration can result in a disturbed, counter-therapeutic group relatedness, it is also true that such a situation a) instantiates and meets needs of both patient and staff; and b) also has therapeutic potential if one accepts the idea that integration of a patient's fragmented ego needs to happen "externally in the

persons of those about him before those processes can
be taken into himself."

Almost 50 years later, the processes Searles described are still powerfully at work. This panel will explore states of integration and differentiation in the contemporary state psychiatric facility. We will do this through telling a sample of stories that comprised the network of relationships with and surrounding one patient, a man in his 30s who spent an entire year on the acute care ward, while acquiring the reputation as one of the most intractable cases in this hospital. We will offer perspectives of ward clinical staff, administration, as well as inter-team and inter-shift conflicts. Through a series of key relationships and his involvement in a special training group, the patient was able to teach the staff how to teach each other about what he needed to get better.

"It Takes a Village" to Cause and Cure Madness: A Report from Norman Rockwell's Town

Paul Lippmann, PhD lippmannp@aol.com

While recovery from psychosis can often occur within a psychotherapy relationship, this paper will explore the potential significance of other factors (e.g., the surrounding community) both in provoking and in healing severe psychological disturbance. A growing general consensus about the central value of the relationship in psychotherapy need not keep clinicians from considering critical aspects of the entire range of bio-psychological-social interactions involved in the mysteries of psychosis. Some of these factors, which reach far beyond contemporary two-person psychology, include interactions between (a) relations with the natural and non-human world, (b) relations between generations, including those between the living and the dead, and between the individual and the gods (i.e., the spiritual dimension), (c) relationship to history, to zeitgeist, to political-cultural conditions, and (d) relationship to one's own biologic nature. In this paper, I will attend particularly to the impact of the social field on the causes and cures of psychosis. Mainly, I will discuss the experience of clinical work with severe psychological disturbance in a small New England town (Stockbridge, MA, the town that Norman Rockwell lived in and painted.) Aspects of the Interpersonal perspective (including the pioneering psychoanalytic work with psychosis of Fromm-Reichman and Sullivan) will be interwoven in these considerations. Many examples from the relationship between individual clinical work and community will be discussed.

Lost in psychosis, lost in language: A meeting of minds through translation

Jayoung Heo, MA jayoung.heo@gmail.com and Cress Forester, PsyD

A 3-year therapy and supervision is discussed, involving a Korean female client, a Korean female therapist, and a British female supervisor in a community mental health setting. The treatment is presented in four stages; (a) Psychotic phase: Psychotic client, therapist learning about psychosis, supervisor as a teacher. "Yankees are trying to destroy the Universe. I am a savior, I am a survivor of vivisection". (b) Traumatic phase: client as trauma victim, therapist as victim of racism, and supervisor as perpetrator and savior, "You are wrong. The name of my illness is not Schizoaffective disorder but 'having an abusive family'. But please don't destroy my family like the Yankees did." (c) Depressive phase: Depressive client, helpless therapist, supervisor as a witness; "I am the one who made my soul go away… I lost my soul… it didn't want to go." (d) Forced termination phase; "What I've lost in the last 10 years is my thinking", "you are the mother who I am free to love and hate. I can't hate my mother because my mother is the matrix."

The case is presented through both a Western Psychoanalytic lens drawing on Bion, Searles, Loewald, Milner and Eigen, and an Asian perspective on transformation using the 'Ox-herding' metaphor based on Kawai's

theory. The discussion focuses on how the relationship between therapist and client transformed during the course of therapy as the therapist's internal relationships changed. The impact of the supervisory relationship and cultural tensions on the therapist-client relationship will also be discussed.

Mutual Healing Through Relationship in Psychodynamic Therapy

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This paper will present a two-year-long psychotherapeutic encounter between an older Chinese-American chronically psychotic woman and a young Chinese male therapist who, at the start of this journey, had limited experience with the psychotic population. The discussion will highlight how in this unique therapeutic relationship healing in the therapist preceded and allowed for the transformational progress in the patient.

Initially, the therapist's intense desire to understand the patient was met with pervasive psychotic defense against being understood. Her psychotically disorganized speech left the therapist unable to think during sessions and suffering from stomach problems before and after them. Through supervision and readings, the therapist learned to empathize with her by tuning into his evoked feelings instead. This preserved his own mind and allowed him to become aware of his countertransference resistance against the "toxic" patient. Eventually, his symptoms ceased as he became able to accept the patient's delusions as an attempt to train him to become her idealized "doctor" with whom she could ally to fight the hallucinations. Subsequently, the patient's speech became more organized and relational. Remarkably, she also became able to see the real nature – and irony – of this unique therapeutic relationship. Earlier in the treatment, the patient only made references to her therapist through her relentless delusional talk about his "thousand PhDs." By contrast, in one of the recent sessions, the patient humorously likened him with a rather unlikely helper, the film character Ratatouille – a young, novice rattling who helps a hapless chef to succeed by staying inside of the chef's hat and instructing him on his cooking.

This presentation will conclude with discussions of the mutual healing in treatment through Peter Goldberg's and Harold Searles' ideas on "actively seeking the holding environment" and "patient as therapist to his analyst."

On Aliveness in Psychosis and other Dead Places

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This presentation will seek to focus our attention on the ways in which concern with states of deadness and "coming into being" can be seen be central within certain psychotic states. Ours will be a phenomenological exploration with the intention of opening empathic contact within a particular neighborhood of psychotic experience, that which may show itself in experiences of apartness, deadness, or inertness as well as in their counterparts, the yearning for and terror of aliveness, immersion, and relationship. The states to which we seek access will be evoked through case material from the clinical literature and the presenter's practice. We will link up with the work of various explorers of these regions, among them W. Bion, G. Benedetti and L. Wittgenstein. From Bion we will draw upon the idea of the two-way movement between the paranoid/schizoid and depressive positions, as well as upon the notion of "O," the "psychoanalytic vertex," as this is related to "K," the position of knowing. The value of an "unsaturated" stance in relation to the deadening effect of psychotic knowing will be explored. A suggestion of the relational opportunities opened by our awareness of our own deadening K states will be offered. In Benedetti we will see the encouragement of a deeply compassionate meeting of states of fragmentation and deadness in the practice of joining patients in the "realm of death." Finally, from another vertex, we will encounter in Wittgenstein a

philosopher whose work brings us inside a world of extreme apartness while pointing us toward liberation therefrom. Our intention in this discussion will be to bring life and clinical relevance to what may seem to be rather abstract knotty notions. Some implications of the self-referentiality which characterizes our concerns will be considered.

The Organizing Transference and Psychotic Signifiers

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From Freud's analysis of Judge Shreber through Lacan's analysis of the function of language in the Shreber case to Devoine and Gaudillière's History Beyond Trauma (2004) there is general consensus that psychotic states are not psychologically accessible by means of classical verbal interpretations. Grotstein (1994), however, reviews numerous reports of contact with and transformation of psychotic states that have indeed been achieved by psychoanalysts using expanded or modified forms of psychoanalytic technique. How can we understand that psychotherapy can indeed be accomplished with primitive mental states although it is not achievable with traditional verbal-symbolic techniques? What considerations must be addressed in devising alternative techniques? And what considerations need to be made to accommodate the relational dimension of contemporary psychotherapy and to understand the expectable countertransference regressions?

This paper presents the cumulative findings of a large group of Southern California therapists who for more than thirty years have been working with psychotic or "organizing" transferences using relational techniques and relational signifiers that emerge from the therapeutic process. The theory of how the organizing transference develops in infancy and re-emerges in the therapeutic transference relationship will be outlined along with considerations regarding the regressive countertransference.

An extended clinical vignette illustrates not only the workings of the organizing or psychotic transference, but more importantly, how in a given moment it became necessary for the therapist to drop into primitive disorganization in order to sustain contact and for the two to further understand their regressive histories. The pioneering work of Sechehaye (1951) as well as the cutting edge work of Devoine and Gaudillière (2004) are foundational to the presentation.

References

Davoine, F. and Gaudillière, J. (2004). *History Beyond Trauma*. New York: Other Press.
Ekstein, R. (1984). *Prolegomena to study the languages of psychoanalysis and psychotherapy*. Paper presented at the Newport Center for Psychoanalytic Studies, Newport Beach, CA. October.
Grotstein, J. (1994). Foreword. In *Working and Organizing Experience* by L. Hedges, pp. xvii-xxxiii. Northvale, NJ: Jason Aronson.
Hedges, L.E. (1983,2003). *Listening Perspectives in Psychotherapy*. Northvale, NJ: Jason Aronson.
——— (1994a). *In Search of a Lost Mother of Infancy*. Northvale, NJ: Jason Aronson.
——— (1994b). *Working the Organizing Experience: Transforming Psychotic, Schizoid, and Autistic States*. Northvale, NJ: Jason Aronson.
——— (2000b). *Terrifying Transferences: Aftershocks of Childhood Trauma*. Northvale, NJ: Jason Aronson.
——— (2005). "Listening Perspectives for Emotional Relatedness Memory." *Psychoanalytic Inquiry*, 25:455-483
Sechehaye, M. A. (1951). *Symbolic Realization*. New York: International Universities Press.
Shepard, B. (2000). *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century*. Cambridge, MA: Harvard University Press.

Paranoid Paradoxes

Danielle Knafo, PhD dknafo@liu.edu

This paper will describe the analytic treatment of a man who began therapy as a paranoid schizophrenic (his label). Over a period of five years, George became more and more aware of his paranoid defenses. A very bright man, he developed a keen interest in his paranoid mechanisms, both experientially and theoretically. I would like to describe George's incredible transition from being a man on the verge of suicide, convinced that he had no one and could trust no one, to someone who could face his lifelong paranoia head on, primarily because he learned to trust me and the therapeutic process. I will use his words to convey the incredible insights he arrived at regarding his paranoia, insights that demonstrated both positive and negative elements. Among these insights is the realization that his paranoia kept him attached to the world to counter his schizophrenic detachment, yet it maintained an optimal distance from others who could hurt him or discover his true nature. In spite of its many deleterious effects, paranoia meant never having to be alone.

The Psychoanalytic Treatment of Psychotic Depression: The Role of the Creative Process

Patricia L. Gibbs, PhD patricialgibbs@aol.com

The analyst's wording and interpretation of the patient's hallucinations, delusions, and dreams will be examined, with an attempt to specify the details of such work. The therapeutic value of creativity will be emphasized in terms of containing unconscious murderous hate within the symbiotically-organized transference/countertransference. Material of two patients will presented; the first engaged in art work during sessions, the second was a writer.

Anita was frequently non-verbal in her first years of therapy. Clinical material will describe long periods of silence, and illustrate my attempts to put into words the subjective experience of her inner life. Anita reported hearing condemning and hateful "voices," and seeing "visions," which will be discussed.

Dissociative features were pronounced in Mr. C., who recalled traumatic memories of abuse, only minutes later to say: "I can't remember what I just said . . . did you say something? Dissociative aspects of Mr. C's depression will be compared to the hallucinations, delusions, and dissociation seen in Anita's treatment. Three of Mr. C.'s dreams will be the basis of understanding Mr. C.'s unconscious murderousness, symbiotic identity, and mourning associated with termination.

Death of one of the symbiotic partners in the transference will be discussed as the work of mourning associated with patients emerging from psychosis. Slides of art done by patients in out- and in - patient settings will be used to illustrate psychotic depression and its treatment. The patients' experience of the creative process will be discussed as facilitating the resolution of psychotic depression.

Psychosis and Moral Conflict

Andrew Lotterman, MD andyl1978@aol.com

This talk will explore the way in which psychotic religious certainties are connected with the course of psychotic illness. The experience of psychosis is characterized by the experience of a shattered self. Patients experience themselves to be in pieces. They also experience themselves to be bystanders in a social world which has no meaning, intensifying their loss of identity and self esteem.

The conviction of having a personal relationship with God helps these patients adapt to the psychological and social losses caused by psychosis. Whereas in everyday life they feel profoundly alone and not understood, now God personally accompanies them everywhere, and appreciates their every thought and deed. Whereas in everyday life they cannot muster a coherent set of personal goals to guide action, now God tells them what to think and how to act. Whereas in everyday life, they may be horrified and feel devastating guilt about their intense aggression, now they are arrive at a safe moral harbor where God's approval reassures them against an often brutal conscience.

I will also trace the connection between fantasies of being the Messiah, and the developmental experience of guilt about being born, and debt concerning the gift of life that I have described in neurotic patients. In normal development, there can be a feeling of guilt about not repaying the debt related to having been created, which may lead to a need to serve and to repay the parents, and to a pernicious form of guilt if this is felt to be unsuccessful. In psychotic patients, this may be the basis for delusions about having a Messianic mission to save the world.

Psychotherapy for Schizophrenia: A Therapist and Patient Discuss their Work

Monica Carsky, PhD carskym@aol.com

In this talk a patient with schizoaffective disorder, and her therapist, describe and discuss their 21 years of working together. During that time the pt returned to college and graduated with a double major, was employed full time for 15 years, and completed a master's degree in information systems. Nonetheless, she still has significant symptoms.

The patient will describe her subjective experience of psychosis and of psychotherapy, and the therapist will describe stages of the treatment and types of interventions used. A particular focus will be on the development of the therapeutic relationship, from lack of differentiation to individuation and healthy dependence with "object constancy," eventually making possible the interpretation of transference and marked improvement in the patient's relationships with her family, and mourning of the losses due to her illness.

Recovery from Psychosis in Ancient Times

Manuel González de Chávez, MD MGCHAVEZ@teleline.es

Psychosis and psychotherapy are not experiences or forms of help of only a little more than one hundred years old but rather thousands of years old. They have probably existed during all the history of mankind and we can find information about them since the beginning of written history.

In this presentation, with abundant illustrations and photographs, we go through the history of the psychotic disorders, their evolution and recovery as well as the therapies used with them, including talking therapies, going from the primitive populations up to the beginning of psychoanalysis.

We will observe the continuity and discontinuity of approaches that would seem to be present-day ones to us, even though they are expressed in other languages and we will be able to recognize the existence of therapeutic approaches or practices in ancient times that we would have believed to be recent ones.

Throughout history, recovery from psychotic experiences has been greatly conditioned by the view of these

disorders in successive social contexts and by the more or less scientific ideologies dominant in their institutions and in those in charge of the caring for these patients.

Recovery from psychosis in group psychotherapy

Manuel González de Chávez, MD MGCHAVEZ@teleline.es and Ignacio García Cabeza, MD igcabeza456@gmail.com

The recovery process of the psychotic patient in group psychotherapy is presented from three levels: theory, research results and practical approach.

The features that make this therapeutic modality a specific instrument with significant value in the recovery of the psychosis, such as group context, mirroring and group therapeutic factors, are explained.

The studies that document the efficacy of group psychotherapy in psychotic patients are analyzed and our own study on the 6-year naturalistic follow-up of first psychotic episodes will be presented with a comparative analysis of the patients who followed a therapeutic program with group psychotherapy and who followed conventional treatment.

Those who came to group therapy had a better course, with fewer positive and negative symptoms, measured with the PANSS (U=32.0; p=0.004), better GAF (U=24.5; p=0.000), and better results in all the aspects analyzed: insight, grip on life, adherence, neuroleptic dose, need for depot treatment, hospitalizations, use of rehabilitation resources, etc..

Finally, the way in which we approach the different aspects of recovery of the psychotic patients will be explained from the practical point of view through the analysis of some group sessions.

Relationship Factors in the Recovery of Borderline Patients at the Psychotic Edge

Marvin Hurvich, PhD, ABPP marvin@hurvich.com

Individuals who live at the brink of psychosis, struggle with the terror and chaos of madness, while being drawn to it. Many gravitate toward near-death experiences, while harboring intense death anxiety. Their dread of being overwhelmed, merged, invaded, disintegrated, abandoned and destroyed, and of being re-traumatized, plays an important role in the need for safety and the dangers of loss of self/ identity and the inability to function. They attempt to structure the therapeutic relationship in line with these central survival apprehensions. Efforts to deal with intolerable affect states and unreliable controls against forbidden desires are associated with a range of problematic homeostatic/defensive attempts, and in the therapeutic relationship with dependent/parasitic, hateful and erotic components that challenge the therapeutic setting and the counter-transference. Ways of dealing with these challenges in the relationship are discussed for patients at this level of functioning, and with regard to some key individual differences, based on the dependent/erotic components, the extent to which the aggression is ego syntonic or alien, the narcissism is grandiose/derisive or self-devaluing, the impact of guilt and shame, and the status of dissociative tendencies and possession states.

Successful Psychotherapy of Schizophrenia: What Went Right: A Dialogue with the Patient and Her

Therapist

Daniel Dorman, MD ddorman@ucla.edu and Catherine L. Penney, RN

Catherine Penney, suffering from catatonic schizophrenia, was treated psychotherapeutically for eight years. No drugs were used. After Ms. Penney recovered, she met with her therapist, Dr. Dorman, to record her impressions of how the therapeutic relationship allowed her to develop a self. It was Ms. Penney's opinion that schizophrenia developed as a result of having no "central self."

Ms. Penney's treatment affirms Ludwig Binswanger's contention that selfhood emerges from mutual recognition. Binswanger emphasized " the importance of finding out what a patient means by a symptom, or any other aspect of their expression. . . . The psychotherapist is never allowed to interpret anything in accordance with a pre-established system of meaning that is of the therapist's invention . . . . The underlying specific meaning is . . . explored and never guessed at." (Van Deuzen-Smith) Dr. Dorman and Ms. Penney will illustrate these ideas with examples from Ms. Penney's therapy.

We would like to provide examples of other issues that were central to Ms. Penney's recovery: Schizophrenic symptoms as expression of self and creative adaptation to preserve the self (Julian Jaynes); Buber's "I-Thou" as opposed to "I-It."; Love in psychotherapy (H.S Sullivan, Buber); Pathological and healthy symbiosis (Searles, Benedetti); The reality of betweenness (Binswanger's Dasein, Buber); Buber's requirement of staying in the moment; The therapist as patient (Searles); Therapeutic intrusion; Despair experienced by patient and therapist; The therapist as reality representative

Dr. Dorman and Ms. Penney welcome discussion about any aspect of their relationship.

Take These Broken Wings

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Take These Broken Wings, a full-length documentary, shows that it is possible to recover fully from schizophrenia (that is, become completely symptom-free) and live without psychotropic medication. The film documents the lives of two ISPS-US members: Joanne Greenberg, whose bestselling autobiographical novel *I Never Promised You A Rose Garden* chronicles her recovery from schizophrenia through her therapy with Frieda Fromm-Reichmann; 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.

Through in-depth interviews with Greenberg and Penney, and with various people close to them (i.e. Daniel Dorman, MD; Joanne Greenberg's husband; Catherine Penney's boyfriend; various friends and acquaintances), the film shows not only that both women were in fact once schizophrenic and no longer are, but 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 treatments they received, as well as the potential universality of their recovery, that is, the degree to which their stories might apply to others with schizophrenia.

The film also interweaves footage of a variety of top therapists, psychiatrists, and mental health lawyers and advocates, most of whom are ISPS-US members, including 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), and David Oaks (director of MindFreedom).

Treating the "Untreatable" with an Intensive Psychotherapy of Psychosis: Recovery, Healing, Cure

Ira Steinman, MD irasteinman@pol.net

Intensive psychodynamic psychotherapy offers a potential for recovery, healing and cure in previously "untreatable" psychotic patients across the delusional and schizophrenic spectrum. Such a treatment approach emphasizes exploration and interpretation of the meanings of hallucinations, delusions, bizarre thought processes, unconscious motivation, resistance, transference and counter transference in the transformative container of psychotherapy. The presentation will offer an overview of the utility and efficacy of such a therapeutic approach when all else has failed.

Several clinical examples of schizophrenic patients, who had been repeatedly hospitalized for years and had very good relationships with supportive psychotherapists, yet remained floridly psychotic even on high regimens of antipsychotic medication, will demonstrate the point that a good therapeutic relationship is not enough, in and of itself, to cure severely delusional or schizophrenic patients. What is required for recovery and cure is a psychodynamic approach that clarifies to the patient the meaning and object seeking quality of his previously incomprehensible thoughts and behaviors.

These purportedly "untreatable" schizophrenics, culled from my upcoming Karnac book *Treating the Untreatable*, responded to an interpretive dynamic psychotherapy. Where the best previously achieved in a supportive psychotherapy was a revolving door of hospitalization, and chronic psychosis, such an intensive psychotherapy led to recovery, healing, and, in the cases presented, a lasting cure off all antipsychotic medication.

Trilingual psychoanalytic psychotherapy of a psychotic immigrant woman: becoming a person

Esther Rapoport, MA esther_rapoport@yahoo.com

I will present a case of a chronically mentally ill immigrant client whom I have seen for psychoanalytic psychotherapy for the past 3 years. The client, whom I shall call Mara, was diagnosed with Schizoaffective Disorder and had been hospitalized numerous times prior to presenting for treatment. Aged 45, she had taken Haldol for over 20 years. She was not working and required daily in-home support.

Mara and I share numerous aspects of our cultural and linguistic backgrounds, and the therapy has been conducted in three languages. Cultural, linguistic and historical issues have been central to the treatment. Mara's awareness of our shared cultural background led to an early idealization in the transference, which for a long time served as a primary organizing mechanism for her. The cultural similarities were vital for this often-suspicious client to be able to form a strong working alliance. (She had in the past been distrustful of therapists who were culturally dissimilar.) While sufficiently fluent in each of her three languages to communicate in just that one language, she has repeatedly emphasized the importance to her of being able to mix languages in therapy, which I see as symbolic of her attempts to integrate the periods of her life spent in different cultures. My first-hand knowledge of the historical events that had affected her family allowed me to speak to the heretofore unacknowledged intergenerational traumas, often producing cathartic effects.

Mara, who was initially profoundly disorganized, has made remarkable progress. Her reliance on grandiosity, sexualization and manic defenses has decreased, and while still holding on to many of her delusional beliefs, she has also developed a realistic identity based on her personal and family history. Her capacities for self-reflection, mourning of losses and affective self-regulation have improved dramatically, as have her social skills and her ability to empathize and connect with others. In my presentation, I will focus on the ways in which Mara has utilized the therapeutic relationship to overcome the isolation and chaos of her psychosis.

Volunteers in Psychotherapy: Sanctuary for analysis of "psychotic" metaphors as clues to traumatic experience

Richard Shulman, PhD, Lic. Psychologist ctvip@hotmail.com

To understand the experience of a person labeled "schizophrenic," we must listen thematically rather than literally, and grasp metaphorical communications. While seemingly illogical or incredible on a surface level, those camouflaged and ambiguous communications (which earn the client their clinical label) can be seen as cogent indirect commentaries, relevant to the therapeutic context. Initially inscrutable statements and actions often reveal clues to formative traumatic and conflictual experiences which may be at the core of the client's enduring emotional upset or confusion. Harold Searles, Robert Langs, Bertram Karon and others delineated how a client may communicate indirectly, "as a therapist to their analyst" (Searles, 1975); providing thematic commentary that critiques the therapist's actions from the client's personalized perspective.

This presentation highlights how we can more successfully decipher schizophrenic clients' ambivalent attempts to express their experience; adding to the perspective I presented at ISPS94 [subsequently published (1996)].

Such psychotherapeutic work is impeded in many medically-oriented public institutions, or settings which downplay important aspects of an analytic framework (maintaining real privacy and client choice; renouncing coercion; requiring some responsibility or contribution from the client).

Volunteers in Psychotherapy (www.CTVIP.org) is an innovative nonprofit, constructed in 1999 to maintain a functional analytic/psychotherapeutic framework. VIP clients earn their therapy by doing independent but privately-documented volunteer work elsewhere (for the charity of their choice). Clients are only seen within VIP's strictly private, voluntary and autonomous setting – preserving a therapeutic framework anyone can afford, with charitable funding of therapy fees. VIP is easily replicable in other communities.

Searles, H.F. (1975) "The patient as therapist to his analyst," in *Tactics and Techniques in Psychoanalytic Therapy. Vol. II: Countertransference*., Giovacchini, P., ed., N.Y.: Jason Aronson.

Shulman, R. (1996) "Psychotherapy with 'schizophrenia': Analysis of metaphor to reveal trauma and conflict." *The Psychotherapy Patient*. (9:3/4) 75-106.

Wittgenstein's guideline for the healing of psychosis

Françoise Davoine, PhD gaudilliere1@hotmail.com

Since the 90s, I have been using some of Wittgenstein's teaching regarding psychotic and traumatized patients, for whom I have now follow up information about their recovery.

Through the lenses of some clinical vignettes, I will present my relationship with some therapeutic issues found by the philosopher : he used to consider his philosophy as a practice, even as a therapy. I was stricken also by his influence on Lacan's teaching, and will give some clues about it.

Therefore my presentation should start from the last sentence of the "Tractatus" : "Whereof one cannot speak, thereof one must stay silent", written on the front during the First World War, toward its transformation ten years after :"Whereof one cannot speak, thereof one cannot stay silent", and show it to some other, giving a way to a possible transference.