

ISPS - US Newsletter

United States Chapter of the

International Society for the Psychological Treatment of Schizophrenia and Other Psychoses

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

Harold F. Searles (1979)

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From The President

Ann-Louise Silver, MD

At the recent ISPS meeting in Stavanger, I was appointed to the ISPS executive board. In Stavanger, Christine Lynn and others of us in the ISPS-US contingent began to firm up plans for our second annual ISPS-US meeting. Thus, in the past month, I have become clearer about the current mission of ISPS and its US chapter. Our second annual ISPS-US meeting will exemplify this mission. Please make plans to attend this meeting, on Saturday, October 7, at the Washington School of Psychiatry. The Chestnut Lodge Symposium will be held the day before.

Its theme is group process in the mental health workplace. Our ISPS-US meeting will address the place of dyadic work in the treatment of schizophrenia. We will begin the day taking an historical perspective. Wayne Fenton, former medical director at Chestnut Lodge, and now at NIMH, will speak on the history of the asylum, and will show a video. I will speak on psychoanalysis and psychosis in the U.S. Then Betty Oakes, a long-time therapist at Austen Riggs, will present a case study. We will have lunch served on site, with ample time for networking.

In the afternoon, Anthony Lehman, senior author of the famous PORT Project, will speak on the current challenges in providing psychological and psychosocial treatments to people with schizophrenia. Wilfried ver Eecke, a philosopher of psychoanalysis, will respond to the PORT Report. Bill Gottdiener, author of an elegant meta-analysis of studies of the effectiveness of psychotherapy, will complete the afternoon panel. There will be ample time for panel and open discussion.

This cohesive program promises to be a stimulating and memorable event, well worth a trip across the country. We may well outgrow the size of the conference room at the Washington School of Psychiatry. Please register promptly, bringing along colleagues who are new to our group. This meeting is open to the entire mental health community, so please pass the word along. We need a sense of audience size, so that we can find a larger hall if need be. Please notify Christine Lynn, LCSW-C, Program Chair, ISPS-US, 5324 39th St., NW, Washington, DC 20015, or call her

at 202-244-7073 or e-mail her at L699@erpls.com. (That's L, as in Louise, not the numeral 1).

As was clear at the Stavanger meeting, ISPS hosts a wide spectrum of theoretical perspectives and a rich array of socio-cultural matrices. Each meeting brings greater diversity. We would profit from an even wider cultural spectrum and a broader range of theoretical approaches to the treatment of psychosis. Clearly, we all work chronically with a chronic disorder. Despair and loneliness are intrinsic in this specialty, whatever our orientation. We all want to improve conditions for our patients and ourselves, and we strive for real continuity in relationships, whether we practice insight-oriented psychotherapy, cognitive-behavioral therapy or other modalities. We need cohesive treatment settings that provide adequate support to its staff members, so that they experience adequate physical and mental security, and so that they choose to stay a while. Staff turnover and the loss of a sense of community within a given setting resonate destructively with the sense of isolation and defeat endured by our patients or clients.

Staff members need opportunities to learn from each other, in conference settings, seminars, supervision, in training programs that may often include an experience of therapy for themselves. If we feel we are reduced to cogs in a problematic machine, our own

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From the President *from page 1*

sense of dehumanization inexorably defeats constructing a trustworthy treatment alliance. Security is central not only for our patients but for ourselves as well. We cannot afford to feel anxious about our safety, angry at being abused, or given clinical responsibilities that preclude work we can be proud of. When we are in settings where morale is low, employees stay for too short a time to form collegial relationships.

Without a community team spirit, there is no safety net for either patient or clinician as they attempt their fragile partnership.

In the past, ISPS brought together clinicians who felt more contained by their places of employment than is currently the case (whether they worked in institutions or maintained private practices). Many of us felt that at the recent ISPS meeting there were far fewer reports of ongoing work than at preceding ISPS meetings. I doubt that the organizing committee rejected such presentations. Instead, I suspect we saw evidence of a world-wide crisis in the amount of direct treatment for people who have suffered psychotic breakdowns. We are relying too much on medications and brief, group programs which attempt to educate clusters of patients to the parameters of their disorders.

Clinicians seem not to know their patients or clients as well as they did earlier, and so, they do not have the daily records of interaction to pull together into a thoughtful presentation of their work.

In the US we are caught up on a carousel whose speed has increased steadily over the past twenty years. Unfortunately, our patients are not riding beside us. Instead, they stand by, watching as we reach out to catch the golden ring of each new pharmacological agent. We hand off prescriptions as we zoom by. The home visit is not only rare for the doctor, but for the social worker and case manager as well.

In the 1970s, I attended a conference at the Hunter Auditorium in New York City, where Otto Kernberg, Harold Searles, Peter Giovacchini, and James Masterson each addressed an audience of over 3000. Kernberg delivered his stimulating and challenging talk too quickly. A woman called from the balcony, Slow down, PLEASE! and the audience applauded her. Kernberg did slow down. But her interruption and the applause cost him minutes from his allotted time. Like a train pulling out of the station, he accelerated, reading ultimately more quickly than he had before the interruption.

We are all living in such pressured times; our patients suffering from schizophrenia are least able to accommodate. One of my patients has been pleading with me and her family to lighten up, and not pressure her so much to establish some regular connection with the community. I suspect that my exhortations derive

in part from my envy of her isolation. I often yearn to retreat into a state of reverie freed of deadlines, required paperwork and nagging worries that I don't adequately understand my patients complex medication regimens, or their underlying dynamics and self-destructive potential.

We cannot waste our efforts competing over which school or orientation is most valuable, most right. Instead, we must get together on a shared mission to improve the quality of care for those with mental illness. This involves advocating for quality in our program, improved living conditions for our patients and improved working conditions for ourselves. In the process, we will find that our various methods are all more simply humane than otherwise.

ISPS-US can improve the conditions of mental health workers by facilitating support groups, conferences, and supervision for individuals and programs around the country. Schizophrenia is an illness of isolation. A society that supports treatment for such disorder must by definition provide support to its own members. It must become a working and vibrant community for its mental health professionals. We need containment, whatever our role in this complex field. I hope you will come to our October 7 meeting, and I hope you experience the meeting as a place of renewal and enhanced professional connection. ♦

Ann-Louise S. Silver, M.D.
4966 Reedy Brook Lane
Columbia, MD 21044-1511

410-997-1750

fax: 410730-0500

ASILVER@psychoanalysis.net

Thanks to David Garfield for putting together the ISPS-US panel to be presented at the American Psychiatric Association 2000 Institute on Psychiatric Services to be held in Philadelphia
October 25 -29, 2000

Out of Psychosis and Into Life: Psychotherapy in the Field

Chairman: David Garfield MD

Co-chairman: Brian Koehler PhD

Presenters: Joel Kanter MSW, Julie Kipp MSW, Mary Moller MSN, Michael Robbins MD

Discussant: Wayne Fenton MD

Contact the APA at (202)682-6000, or at
1400 K Street, N.W. Washington, D.C. 20005
for registration information.

From The Editor: *Interview with Gaetano Benedetti, MD, ISPS Co-Founder*

Brian Koehler, PhD

While in Stavanger, Norway attending the 13th International Symposium for the Psychological Treatments of the Schizophrenias and Other Psychoses, June 5 - 8, 2000, I had the honor to spend time with Gaetano Benedetti, MD and his younger colleague in the field of schizophrenia, Maurizio Peciccia, MD. For six months prior to my encounter with Professor Benedetti, I had been meeting with several colleagues on a biweekly basis to discuss the clinical theories of Drs. Benedetti and Peciccia and to compare these with the work of Harold Searles, MD. I would like to thank those colleagues and friends who participated in that seminar: Paul Carroll, Joyce Epstein, Larry Freeman, Julie Kipp, Christine Miller, James Ogilvie, and Janet Ottmann.

In this column, I will present excerpts from an interview I did with Drs. Benedetti and Peciccia on the morning of Professor Benedetti's address to the congress and a panel discussion in which Dr. Benedetti's work figured prominently. This panel consisted of myself, and Drs. Peciccia and Gary Bruno Schmid, all of whom including my New York colleague, Julie Kipp CSW, participated in the interview. Dr. Schmid assisted Professor Benedetti in translating German into English. Although the interview was primarily with Gaetano Benedetti, his responses seem to be also the product of a fruitful collaboration with his colleague, Maurizio Peciccia. The fuller transcript of this interview is being prepared for publication in a psychoanalytic journal.

Before presenting some biographical details of Gaetano Benedetti, I would like to inform our members that in future issues of this newsletter, I plan to report on an interview with Joanne Greenberg, noted author of *I Never Promised You a Rose Garden* and patient depicted in that story with Freida Fromm-Reichmann as her therapist, as well as interviews with other significant contributors to our field, such as Martti Siirala, MD. I would also like to address from a theoretical and clinical perspective, the psychotherapeutic needs of persons with a bipolar disorder.

Gaetano Benedetti joined the psychiatric staff at the Zurich University Clinic Burghölzli in Switzerland in 1947 (two years prior to Harold Searles' joining the staff at Chestnut Lodge). It was at the Burghölzli Clinic that Eugen Bleuler (1857-1939) created the term "schizophrenia" and studied the psychodynamic life of schizophrenic patients in close cooperation with Carl Gustav Jung, and also Sigmund Freud. Manfred Bleuler, the son and successor of Eugen Bleuler as director of the Burghölzli, described Benedetti as a "highly valued member of our staff" and that the staff

"were increasingly touched by his devotion to schizophrenic patients and by his ability to understand their psychodynamic life." Bleuler noted that Benedetti's empathy for his patients was similar to that of his father's.

As the era of psychopharmacology began, reserpine from India came into use at the Burghölzli in the 1950's, Benedetti increasingly focused his work on the psychoanalytic psychotherapy of psychotic patients. He worked closely with Gustav Bally, Medard Boss, Marguerite Sechehaye, and Christian Müller (with whom he founded the International Symposium for the Psychotherapy of Schizophrenia in 1956 at the psychiatric clinic at the University of Lausanne). In 1956, Benedetti was appointed professor of psychotherapy at the University of Basel. He continued his work with schizophrenic patients until he retired in 1985. Benedetti has remained active until the present in his teaching and supervision of clinicians involved in the psychotherapy of schizophrenia.

Bleuler noted that "Benedetti discovered again and again that, behind his psychopathology, a schizophrenic person has an intellectual and emotional life as do normal people... It is a great task to break through the isolation of the schizophrenic, whether permanently or only for a brief time. This great experience plays an important role in Benedetti's therapy and teaching."

Benedetti, later in his career, regarded his work with schizophrenic patients to be devoted not so much to the transmission of insight, but to "transitional subjects, of therapeutic dreams which straighten out the negative images of psychosis, of mirror phenomena arising from the creation of symbols of progressive psychopathology of therapist-patient symmetries, of transforming images." Benedetti calls for an integration of our "wandering with the patient in the desert of his psychosis with the growing concerns of social psychiatry."

BK: Dr. Benedetti, how would you define the basic problem in schizophrenia from a psychological perspective?

GB: In schizophrenia, the transference and countertransference affect has devastating effects, because the peripheral part of the self seems to be missing, that part which has developed through object relations [Ed. note: similar to Peter Fonagy's dialectical model of self development] and which can be metaphorically represented as the protective membrane of the cell which has differentiated itself so as to absorb

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the impact with the outside world. Our impression is that the protective membrane of the self is composed of a mirror image of the self which is formed approximately during the phase of Lacan's (1966) mirror, and which develops until it becomes the symbol of the self. Just as, upon interaction with the environment, the membrane changes in order to preserve the inner part of the cell, so the symbol of the self is transformed upon contact with the world in order to preserve the central nucleus of the self, protected, unchanged, always the same as it was.

The basic biological conflict of all living beings - how to modify themselves upon contact with the surrounding environment and, at the same time, maintain unaltered their own structure - is exacerbated and becomes dramatic in psychosis. Here, the lack of membrane - of symbols of the self exposes the inside of the cell - the center of the self - directly, and without any mediation, to the impact of the world. The center of the self thus pours out and spreads itself projectively outside. The central nucleus of the self, when it is faced with and directly modified by the emotions of interpersonal relationships, loses its function as an organizer and structuralizer of world experience within those space-time coordinates which give us the sense of our existential continuity, the sense of always being ourselves, whatever the situation.

BK: *How do you understand such symptoms as auditory hallucinations and delusions, as well as more "negative" symptoms, such as alogia, anergia, etc?*

GB: Negative symptoms like anergia, apathy, etc., express the breakdown of the exhausted psychotic ego, the loss of its resources, and the widening of the chronic schizophrenic existence. Their psychotherapy needs the mild and slow stimulation of the still present resources as well as the possibility of nourishing the patient's ego by means of a constant, reliable, but not too active countertransference. Negative symptoms may also be defenses against every form of activity by severely injured patients.

So called "positive symptoms" indicate the impact of split-off parts of the patient's Self, which cannot be repressed by the weak psychotic ego into the Unconscious and which appears therefore to the patient as events of the outer world, as the activity of persecutors, etc. It is possible that the therapist introjects the split-off feelings and drives of the patient in order to transform them into positive symbols, to humanize them and to give them back to the patient in a new form.

BK: *How do you define "Therapeutic Symbiosis" and is it a necessary part of the work?*

GB: Therapeutic symbiosis can be considered as the therapeutic sublimation of that pathological symbio-

sis, which lies at the very core of schizophrenia a which Eugen Bleuler termed "transitivism" a "appersonation," where the patient, because of symbiotic need and the disorder of his "ego boundaries" (Federn), confuses himself with the world, with the objects, upon which he projects the bad parts of Self. The sublimation of this process in therapy is possible in so far as the therapist projects back to his patient the positive mirror-image of himself. The identification of the patient's ego with the object upon which he had projected the bad side of himself, in order to rid of it, fragments the ego, while the therapist tries continuously to nourish the patient's ego.

BK: *How do you define "therapeutic images," "transitional subject," and the use of dreams in therapy?*

GB: In my efforts to focus the concept, I have decided to make use of the metaphor "transforming images" would like to start off by saying that, at any point in our psychological efforts, whether in individual, family or group therapy, it is the germination within the therapist of transforming images which shifts the self from oppressive, delirious, anxiety-provoking images to images of the patient. And it is by taking notice of these negative images, not by contradicting them, but by extending them towards new horizons, that a common thread can be woven in the psychotherapy, a push towards "positivisation" of the psychotic experience; towards the "progression" of the psychopathology, the creation of "transitional subjects" between us and the patient.

Therapeutic transforming images, as I see them, derive from our ability to identify ourselves with catastrophes occurring within the patient, to "live" them as if they were, in a way, our own - perhaps even dreaming about them at times; they derive from our ability to absorb the patient into ourselves, to the point that our latent psychotic nuclei are mobilized to some extent. These nuclei then lose all their power to harm us, precisely because they are now part of a dialogic interweave.

This is how the patient enriches our minds with symbolic images, while he thinks he is exhausting his energies, and how we can restore to him what he has awakened in our unconscious. Our "absorbing" of the sick person, which must precede the transformation process, amounts to the act of internalizing the split-off and negativized parts of him. This absorption which may manifest itself (at certain stages of therapy) in the therapist's dreams about death, enables the patient to gain a therapeutic awareness of the positive parts of himself, which would otherwise be completely buried by the negative aspects. It is these parts that the therapist forms a virtual image of the oneness of the patient, which is then continuously projected onto him, as a transforming image. There is perhaps nothing so stubborn as the resistance

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schizophrenic puts up against therapeutic positivization. It is as if the persecutor within him would not permit it at any price; and indeed, at times it is possible to positivize the patient only through the time and space we share with him. The positivizing image cannot, therefore, reach the patient unless we provide the vehicle for it, by concentrating on it in his presence.

As for "transitional subjects," let us think of a voice, hallucinated by the schizophrenic patient, which however tells the patient how to overcome his fears, or which gives good interpretations of his symptoms. In a case where the patient was afraid even of singing birds (they knew him, they persecuted him), the voice said: "go into the garden and listen there to the voice of God." This hallucination was still, as such, a psychotic symptom; but, as I used to say, a "progressive one," a psychotic symptom with a communicative, antipsychotic intention. The voice was, as the patient soon said, also a personification of the therapist, it was his presence in him. This transitional subject was a hallucination of the patient (a dissociated part of the self), as well as the presence of the therapist in his unconscious; it was both, the patient and the therapist.

BK: *How do you understand the countertransference and its' place in the therapy process?*

GB: The positive countertransference is the very motor and source of the therapeutic process. Within the countertransference can be distinguished the awareness of the therapist's conflicts, which have been mastered by the therapist and can therefore increase his sensitivity for symmetric conflicts of the patients', from what, I would call simply the human relatedness to a tragic and dying existence. [Ed. note: Drs. Benedetti and Peciccia's comments on hate in the countertransference are extensive and will be published in the fuller transcript of the interview].

BK: *How do you define psychosynthesis and how does this differ from psychoanalysis?*

GB: Psychoanalysis is the uncovering of the unconscious layers and backgrounds of the psychotic symptoms (like hatred, narcissistic wounds, rage, delusions, hallucinations, etc.). It helps to discover at their origins, dangerous life experiences. Psychosynthesis is the patient - therapist common building of a new self - identity, out of the experience of the therapeutic relationship.

BK: *Have you had the experience of seeing patients recover?*

GB: Yes, this is a great and moving experience. As well as in the treatment of an acute psychosis, where "suddenly," even during a therapeutic session, the psy-

chotic self - identity changes, as in the slow development of chronic schizophrenics, where creative possibilities of the patients lie not side by side with their psychotic symptoms, but are extracted from the very core of the symptoms themselves as the patients recover. [Ed. note: Here Dr. Benedetti's theory is different from a Bionian and Post - Kleinian understanding of the psychotic and non - psychotic personalities as co - existing, for Benedetti, from the dialogic interweave a psychotic core can be therapeutically transmuted]. See also the enclosed follow-up of 10 patients recently treated by Dr. Peciccia [Ed. note: See M. Peciccia & G. Benedetti, 1998, "The integration of sensorial channels through progressive mirror drawing in the psychotherapy of schizophrenic patients with disturbances in verbal language," in *The Journal of the American Academy of Psychoanalysis*, 26(1)109-22]. ♦

From the Secretary-Treasurer

Julie Kipp, CSW

I wish I could convey some of the excitement of the international meeting of ISPS which took place this past June in Stavanger, Norway. Norway is beautiful, certainly - a mix of wild untouched natural beauty and cities of medieval antiquity. The light was amazing in June, still twilight at 11 p.m., although the weather was a little too much like April for my summer vacationing tastes. The international conferences are always inspiring-although hundreds of people are in attendance, there is opportunity to meet and talk with heroes and heroines: the theorists and clinicians whose work we have read and been inspired by. And it's no less exciting to meet the less famous - mental health professionals from all over the world, and compare notes on how treatment is done elsewhere. It is difficult to see outside our own zeitgeist, even for those of us who are critical of much of prevailing American practice in the treatment of mental illness. Yet so much of our work could be done in other, perhaps better, ways, and is done in other ways on the rest of the planet. For example, on the issue of our accepted uses of medication in this country, this was a short interaction between Maurizio Peciccia, MD of Italy, Gary Bruno Schmid, PhD of Switzerland, and myself:

M.P.: So in the U.S. they really keep patients on medications for their whole lives?

J.K.: Sure, a lot of the time. It's not uncommon to hear that a client has been told: "you have to be on medication for the rest of your life, just as if you had diabetes." They don't do that in Italy?

M.P.: No, maybe 5 years average patients would be on medication. What about you, Gary, in Switzerland?

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G.S.: Right, five years would be about normal.

M.P.: Five years, maybe seven years in some cases. Never for life.

Whether you like the idea of that approach or not, it is mind-expanding to see that there are alternatives to the way we do things in the United States. I hope that you will all get the chance to be exposed to the rich mix of an international ISPS some time. The next one will be in Melbourne, Australia in 2003, at a so far unannounced month of the year.

To return now to the home front – our own developing United States chapter, I want to stress that this is really a grassroots organization, and everyone's contributions are not only welcome, but vital. Why did you get interested in ISPS-US? Where would you like to see us go? Some plans for future which are well within our grasp at this time include a membership directory, a journal of the psychoses, and more frequent conferences in other parts of the country. The previously published US Newsletters may be already posted on the international website by the time you read this, at www.isps.org (be sure to check out the Web site, which also includes the international newsletter, among other information).

Our second annual national conference "Creating Space to Talk to Patients," is planned for October 7 from 9 a.m. to 4:30 p.m. at the Washington School of Psychiatry in Washington, D.C. – see elsewhere in this newsletter for details. What else would you like to see happen? How about some sort of ongoing training, even David Feinsilver's idea of an Institute for the Psychoses? How about treatment centers that reexplore such diverse ideas as Soteria House or Chestnut Lodge? Could we fund some sort of political clout, to advocate for more extensive and humane treatments for our patients? Or maybe, closer to present-day reality, just access to good supervisors who can help us apply decent humanistic, perhaps even psychoanalytic, principles to the settings in which we practice currently?

This leads me to a recurrent theme of this column: if you receive this newsletter and you value the approaches that are expressed here, please take the time to pay your dues. Dues are \$40 a calendar year (January to December) for mental health professionals and \$20 for all others. This reasonable amount includes your membership in both the international and United States organizations, a subscription to this newsletter, access to the lively ISPS-US listserv, and the opportunity to connect with people around the country who are committed to humanistic and integrated treatment of people with serious mental illness.

Perhaps you wonder how your dues are being used. Most of our money has gone to the xeroxing and postage for mailing the Newsletter. We continue to be grateful to the clients of Bronx REAL Continuing Individual Treatment Program and Intensive Psychiatric Rehabilitation Program for doing the folding and stamp for a tiny wage. And for this current issue I am pleased to be able to give up my layout responsibilities, and turn the job over to professional services, a result of our last newsletter having inspired quite a number of people to pay their dues. Some of our money is used to create the yearly US chapter conference, coming soon as mentioned above. Twenty per cent of our dues goes to the international organization, for membership and all of the work done on the Newsletter, listserv, membership, conference, and organization is voluntary work – none of us are receiving any wages. All of your dues money goes into building the organization, and with your support we can expand our possibilities.

So if you like what you see here in the Newsletter and you haven't yet joined, please pay your dues for the year 2000. Send checks to ISPS-US, c/o Julie Kipp CSW at 80 East 11th Street, #439 in New York, NY 10003 (order form on page 27). E-mail me julie_kipp@psychoanalysis.net with any questions about membership, or ideas about our chapter. ♦

CONGRATULATIONS **Ann - Louise Silver, MD,** **Our ISPS - US President,** **Elected to the ISPS** **International Executive Board**

Ann - Louise Silver, MD, president of our US Chapter of ISPS, has been elected to serve on the Executive Board of ISPS. Dr. Silver is on the medical staff of Chestnut Lodge/CPC and is an Adjunct Professor of Psychiatry at the Uniformed Services University of the Health Sciences and a Civilian Consultant to the Military Residency Program. She is on the faculties of the Washington Psychoanalytic Institute and the Washington School of Psychiatry. Dr. Silver is the immediate past President of the American Academy of Psychoanalysis and editor of "Psychoanalysis and Psychosis," published in 1987 by International Universities Press. Dr. Silver has edited two other volumes in our field, as well as having published many articles and chapters in books.

The ISPS-US Newsletter is now being professionally designed and printed by The Office Ink, Hastings-on-Hudson, NY

Sullivan The Clinician

Kenneth L. Chatelaine, PhD

"I probably shall not return, but remember this and do not forget it. I shall be controversial. There was no way to avoid it."

— (Sullivan's last words to his foster son, James Inscoe Sullivan on January 2, 1949)

INTRODUCTION

Sullivan, the Clinician, is first on the list of requests when I am asked to speak on Sullivan, notwithstanding the fact that he made other major original contributions to Psychiatry and Psychology, i.e., in the areas of anxiety, human development, and schizophrenia. But it is Sullivan the Clinician that people want to hear about first. Dr. Will Elgin told me that when he was assistant medical director of Sheppard Pratt and in charge of residency training there, the first thing the interns on arriving would say to him, "Oh, you were here when Sullivan was here; tell us about his special ward."

But how much do we really know about Sullivan the Clinician? Dr. Dexter Bullard, Sr., of Chestnut Lodge wasn't too encouraging. I've never gotten a clear picture of how he worked with patients - I think particularly schizophrenic patients. I've heard many vignettes about patients, but I've never had a very clear idea as to whether he saw them regularly for individual sessions or whether his emphasis was somewhat more on the total work. Well, more on the latter. He did very little individual work with patients - I remember him telling me once that he sat from 6 o'clock in the evening until 4 in the morning watching one mute catatonic trying to figure out what was going on from the lip oral dynamism that was in action. He had this knack of picking his staff quite carefully and then if an alienated patient was sitting over in the corner and happened to look up and follow with his eyes the passage of one of the attendants, Harry would go to that attendant, and coach him in the ways of making tentative advances to the patient, and his use of his staff was phenomenal, sensitive - and he had a recovery rate of about 86%. I think that's the figure; it is higher than any place I've ever heard of. He did not do much individual work in the years at Sheppard.

But we can be more precise than that. We have his own statements or theory on schizophrenia and the therapy he devised for it called treatment milieu. Then we have some data on the actual implementation of that therapy in the form of the special ward that he established at Sheppard in 1929, and finally, we have some actual recorded interviews of him working with schizophrenics, taken between the years 1925 and 1929. After the year 1929 not so much data is available on Sullivan the Clinician at work because in 1930 he left Sheppard for New York and private practice

with obsessional neurotics. But the two kinds of work in his thinking were not unrelated. For him, the obsessional dynamism was much closer to the schizophrenic dynamism than any of the other dynamism of difficulty (ways of dealing with anxiety, i.e., selective inattention, dissociation, paranoia and obsessionalism).

With that rather long introduction out of the way, my paper shall proceed in four parts:

1. Sullivan's concept of schizophrenia - a general theoretical approach;
2. Sullivan the Clinician on the Ward - treatment milieu, the concept and the implementation, i.e., the special ward he established at Sheppard for the treatment of schizophrenia.
3. Sullivan the Clinician in the Office - The Psychiatric Interview and Participant Observation.
4. Sullivan the Clinician at Work - selected recorded interviews.

(DYNAMISM - The relatively enduring patterns of energy transformation which recurrently characterize the interpersonal relations that exist between people.)

I. SULLIVAN'S THEORY OF SCHIZOPHRENIA

In his 1931 article "Environmental Factors in Etiology and Course Under Treatment of Schizophrenia," Sullivan states that the occurrence of this illness must be explained primarily on the basis of experiential rather than hereditary or organic factors. Because of personal experience some people, caught up in the course of difficult events, undergo a change in total activity, behavior and thought. This he identified as schizophrenic psychosis. Sullivan felt that, although heredity and genetic factors may contribute to a person's illness, *once* measured, these factors will be found to be of little importance in the etiology of the disease.

The basis of schizophrenia's etiology, according to Sullivan, must be discovered within actual events involving the person and other significant individuals. The realization that dealings with other people are decidedly the most difficult actions for anyone to handle does not occur until a person's early teenage years. While the individual may have learned to manage parents and other authority figures during childhood, it is only after a need for real interpersonal intimacy appears that delicate adjustments of personality are developed which foster relationships with others. Such a subtle level of personality growth is never achieved by the schizophrenic.

Sullivan stressed that *the most primitive and perhaps most important aspect of the personality is con-*

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tributed by the infant's mother or her surrogate. If these infantile portions of the self are too distorted, ensuing growth will be damaged as well, and a pathological personality may result. If distortions transmitted to the child are not too pronounced they may take, in boys, the form of an ongoing juvenile appraisal of the self as reflected by the mother. In such cases neurotic dependency upon the other is great, and weaning from it difficult even during adult years when mother substitutes may take the form of a marriage partner or "close" friend.

In an extreme case the boy may experience a wholesale incorporation of his mother's values and attitudes, and may find it impossible to progress to a normal interest in girls. Either the mother alone or only older women will then be attractive to him for what Sullivan refers to as "interpersonal intimacies." The boy will not be able to progress smoothly to biologically ordained heterosexuality, and may, in fact, be psychologically crippled in all of his future interpersonal relations. In Sullivan's experience, such lack of success in heterosexual adjustment often also led to failure in pre-adolescent socialization with other boys, and was of prime importance in causing the schizophrenic break.

Sullivan found that it was in mid or true adolescence, with the advent of "frank sexuality" that such youths begin having serious problems. Once they have established a good status within a peer group, it becomes necessary for them to proceed to an interest in girls. Such growth, however, is precluded by the stunted development and organization of the personality. As a result, the individual's status within his social group, and thus his self-respect, is seriously endangered. To preserve both status and esteem, the youth must either resort to lies about his sexual life, or isolate himself from the group and continue a nonheterosexual sociality with other such handicapped (non-developed) individuals. Due to increasing pressure of the sexual drive, the outcome of such a choice could well be a homosexual lifestyle. In other youngsters, coping may take the form of regression to an earlier type of interpersonal living, which stresses renewed dependence upon the parental and associated adult environment.

In Sullivan's theory, such an over-identification with the mother (or mother surrogate) coupled with a severe rebuff in interpersonal relations during adolescence, could result in what he calls the outcropping of schizophrenic processes. For the schizophrenic male who has suffered a disastrous loss of self-esteem, the universe is without integrity. It is to him unpredictable. To escape the anxiety brought about by this realization, he retreats into a dreamlike state, thus building a barrier between himself and other people who threaten him. And, since the development of such a

barrier deprives the individual of consensual validation, the schizophrenic becomes interpersonally competent. As his behavior becomes increasingly appropriate, he may begin to feel persecuted and behavior gradually deteriorates further. Sullivan prescribed a sympathetic environment as the cure for such progression of the disease.

II. THE CLINICIAN ON THE WARD

According to Sullivan, the persons with whom a schizophrenic patient has personal contact are of great importance in determining the course and outcome of his illness. Likewise, persons significant in causing the illness—usually found in the home situation in which the onset of the disease occurred—are likely to be helpful to the patient during the acute stages of the psychosis. All of Sullivan's clinical experience (of which he had considerable) in the institutional care of acutely schizophrenic males between ages of fourteen and twenty-five confirmed both deductions, as he reported in 1974 (p. 246): "I have come to feel that the personality qualifications of all those with whom the acute schizophrenic patients come in contact should be *primary considerations* in any attempt to achieve good results from treatment."

As demonstrated time and again in his clinical experience, Sullivan felt that even a great deal of good work done with a schizophrenic patient could be ruined by only a brief contact with unsuitable persons. This mode of thinking often precipitated the elimination of visits by relatives and others associated with the onset of the illness, and a restriction of visits during its acute stages. *This type of "segregation with strict monitoring of personal contacts, placed the patient in the company of only highly qualified personnel immediately upon admission to the mental hospital and was essential in arresting or stabilizing the schizophrenic state in process.*

Team treatment by specially chosen persons was essential to the successful care of the schizophrenic patients on Sullivan's ward. Since personality, to his way of thinking, was not a product of good intentions acquired later in life, trained mental health professionals—including his colleagues—were deemed *totally* inadequate for and incapable of handling the job to be done. More explicitly on this topic, Sullivan stated that physicians came to him seeking insight into problems of the mind. They came to him as untrained physicians and therefore, according to him, with an acquired inability to understand anything that he might say to them. He didn't believe that they stayed with him from now 'til Gabriel blows the horn that they would acquire much notion of what he was talking about—or privately give a damn. They were already educated, they had an MD degree, they had a whole system of ideas about psychiatry that had its origins in misunderstandings about physics and chemistry.

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Low Level Evidence in Rejecting Psychoanalytic Approaches to the Schizophrenic Patients in the PORT Report*

By Wilfried Ver Eecke, Georgetown University

*Part of this paper borrows from the research of Chapter I from *Phenomenology and Lacan on Schizophrenia, after the Decade of the Brain* by Alphonse De Waelhens and Wilfried Ver Eecke, to be published in 2000 or 2001.

INTRODUCTION

An authoritative, presumably well-funded report about treatment recommendations resulting from the Schizophrenia Patient Outcome Research (PORT)¹ has as stated: "to develop recommendations for the treatment of persons with schizophrenia based upon the best scientific evidence, with the ultimate goal of improving the quality and cost-effectiveness of care for persons with this diagnosis" (Lehman et al. 1998, 1). I will point out that the two recommendations attacking psychoanalytic approaches or approaches inspired by psychoanalytic insights are not based on scientific evidence.

The PORT report evidence for its' recommendations against psychoanalytic inspired approaches

The report formulates recommendations about "antipsychotic agents, adjunctive pharmacotherapies, electroconvulsive therapy, psychological interventions, family interventions, vocational rehabilitation, and assertive community treatment/intensive case management" (Ibid.).

Of the 30 recommendations, 18 are about pharmacotherapies; three recommendations concern electroconvulsive therapy; and 9 are about psychosocial approaches. Of these 9, two are devoted to psychological treatments; three to family treatments; two to vocational rehabilitation; and two to service systems.

One recommendation about psychological treatments and one of the three recommendations about family treatment are of direct relevance to psychoanalytic approaches and treatments. These two recommendations are both negative about psychoanalysis (either its practice or its theoretical insights). The recommendation against the use of psychoanalytic or psychodynamic approaches in the treatment of schizophrenia is recommendation 22 (Ibid., 7). The recommendation reads as follows: "Individual and group psychotherapies adhering to a psychodynamic model (defined as therapies that use interpretation of unconscious material and focus on transference and regression) should not be used in the treatment of persons with schizophrenia." The authors of PORT give the following as their rationale: "The scientific data on this issue are quite limited. However, there is no evidence in support of the superiority of psychoanalytic therapy to other forms of therapy, and there is a consensus that psychotherapy that promotes regression and psychotic transference can be harmful to persons with schizophrenia. This risk, combined with the high

cost and lack of evidence of any benefit, argues strongly against the use of psychoanalytic therapy, even in combination with effective pharmacotherapy" (Ibid., 7-8). The authors of this recommendation write that this recommendation is supported by "Level of evidence C" which the authors have defined as "minimal research-based evidence, but significant clinical experience" (Ibid., 2).

The recommendation against some basic insights of psychoanalysis is recommendation 26, which reads as follows: "Family therapies based on the premise that family dysfunction is the etiology of the patient's schizophrenic disorder should *not* be used." The authors of the PORT report give as rationale: "Research has failed to substantiate hypothesized causal links between family dysfunction and the etiology of schizophrenia. Therefore, therapies specifically designed from this premise are not empirically founded. Although there has been little or no randomized, controlled research on the impact of family therapies arising from this orientation, experts in the field have expressed strong caution against the use of these techniques. The presumption that family interaction causes schizophrenia, especially as an alternative to biological risk factors, has led to serious disruption in clinician/family trust without any evidence of therapeutic effectiveness. The repudiation of the theoretical premise of these therapies, the lack of empirical studies, and the strong clinical opinion raising concerns about the potential harm caused by these approaches lead to this recommendation" (Ibid., 8). For this recommendation, the level of evidence is also C (Ibid.).

Note that the evidence for the two recommendations against psychoanalytic theory or practice is called "level C evidence," the lowest level of evidence reported in the article. Level C evidence is defined as: "Recommendation based primarily on expert opinion, with minimal research-based evidence, but significant clinical experience" (Ibid., 2). Note also that the authors of this article praise themselves for giving only recommendations "based on existing scientific evidence" and "focus on those treatments for which there is substantial evidence of efficacy" (Ibid., 1). The authors also claim that their recommendations are "evidence-based" (Ibid.). Note also, lastly, that the authors of the PORT report object to psychoanalysis on the ground that "there is no evidence of the superiority of psychoanalytic therapy to other forms of therapy" (Ibid., 8). Why demand superiority from psychoanaly-

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sis? To demand proof of superiority for one approach is to raise the bar of statistical evidence of that one approach.²

Only psychodynamic/psychoanalytic approaches and their theoretical insights are evaluated and rejected on the basis of such low level scientific evidence. The two recommendations against the use of psychoanalysis as theory and practice are, indeed, both based on level C evidence. For recommendations about pharmacotherapies, 15.78% of the recommendations only are based on level C evidence. For recommendations about electroconvulsive therapy (ECT), 33% of the recommendations are built upon level C evidence. For psychological, family, and vocational approaches, 42.85% are based on level C evidence. This group includes the two recommendations against psychoanalytic approaches. If we disregard these two recommendations against psychoanalysis, the group on psychological, family, and vocational approaches has only 20% of its recommendations based on level C evidence (this constructed statistic is included in the table). For recommendations about systems of care, no recommendation is based on level C evidence. Here is the table of the level of evidence used in the different domains in which the authors make recommendations. Note that the report has only 18 recommendations about pharmacotherapies. I have 19 because recommendation 5 reports two different levels of evidence for the two parts of its recommendation. [See Table 1 below.]

Let me underline that, notwithstanding the level C evidence, the authors make strong and categorical claims and recommendations against psychoanalytic theory and practice.

In recommendation 22, the authors recommend without qualification that "psychotherapies adhering to a psychodynamic model... should not be used" (Ibid., 7). In recommendation 26, the authors recommend that no family therapy should be used that is "based on the premise that family dysfunction is the etiology of the patient's schizophrenic disorder" (Ibid., 8).

Conclusion

No recommendations about other kinds of therapy are based exclusively on the lowest level of evidence used in the study. Notwithstanding the level of evidence the condemnations against psychodynamic/psychoanalytic therapy and against family therapies derived from an insight of psychoanalysis are categorically rejected. The authors of the PORT report do give a rationale for their recommendations against psychoanalytic practice and theory that rationale they make scientific claims which I put in another paper.

Footnotes

¹ Anthony F. Lehman, Donald M. Steinwachs, and the Co-Investigators of the PORT Project, At Issue: Translating Research Into Practice. Schizophrenia Patient Outcome Research Team (PORT) Treatment Recommendations, *Schizophrenia Bulletin*, 24(1), 1998, 1-10.

² A meta-analytic review article by Mojtabai and his colleagues of 141 sources reporting on 106 individual studies states that "therapies based on various psychodynamic principles were not significantly less effective than verbal treatments based on other theoretical rationales" (Ramin Mojtabai, Robert A. Nicholson and Bruce N. Carpenter, Role of Psychosocial Treatments in Management of Schizophrenia: A Meta-Analytic Review of Controlled Outcome Studies. *Schizophrenia Bulletin*, 24, no. 4, 1998:583).

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Table 1
Level of evidence for recommendations in different approaches to schizophrenia

	Pharmacotherapies		Electroconvulsive Therapy		Psycho, Family, Vocational		Systems		Psy, Fam, Voc minus Psychoanalytic		Psychodynamic Psychoanalytic alone	
	Cases	%	Cases	%	Cases	%	Cases	%	Cases	%	Cases	%
A's	7	36.84	0	0	1	14.28	1	50	1	20	0	0
B's	9	47.36	2	66.66	3	42.85	1	50	3	60	0	0
C's	3	15.78	1	33.33	3	42.85	0	0	1	20	2	100
Total	19	100	3	100	7	100	2	100	5	100	2	100

Response to Harold Stern's "An Introduction to Modern Psychoanalysis and the Contributions of Hyman Spotnitz," in ISPS-US Newsletter, Winter 2000

Revella Levin, PhD

Through the years, I have heard many descriptions of the work of Spotnitz and the Modern School's work with schizophrenia, but I have never heard or read as clear a description of the theory and technique as Dr. Stern has written for the ISPS-US Newsletter. That clarity enabled me, in turn to write more clearly about the differences I have with that approach, as well as the agreements.

I am very glad to read that Dr. Lillian Belger Powers learned much about the treatment of schizophrenia from Freud. I have repeatedly heard that Freud said schizophrenics could not be treated successfully with psychoanalysis. Dr. Powers' statement is an important contradiction. Additionally, an even more direct contradiction is by Freud himself, who gives an excellent description of the possibilities of treatment in his paper, "Constructions in Analysis," however brief that exposition may be.

I also agree with Spotnitz that schizophrenics are pre-Oedipal. That is certainly a guideline that is helpful to the would-be treater of schizophrenia, so that he or she would not be taken in by sexual references of these patients which are in fact, defenses. Also helpful is the statement that we cannot expect a patient to form a working alliance.

In the following statements of my disagreement with the Spotnitz approach, I will follow Dr. Stern's outline, if the reader wishes to compare his statements with mine.

Stern says, "Without special training, tolerances for the patient's aggressive feelings can be difficult to endure." Certainly the therapist must be analyzed and expect a great deal of hostility from such patients. But "training" appears to me to be too intellectual to be very helpful. The analyst must have emotional conviction that the hostility which the patient displays is purely transference, if he or she is doing the work properly and not provoking the patient.

I also disagree with the idea that the object of the transference is the self. If one looks at the content of the transference, one can see that, in fact, what is being transferred is the superego, not the ego (self). Egos do not evince the blind, concrete hostility that schizophrenic transferences demonstrate.

But Spotnitz does make the important point that the analyst must carry full responsibility for the success or failure of the treatment. This remains true until the emergence of the patient from schizophrenia.

What I find most disturbing is Spotnitz' suggestion that we join the resistance. The examples given seem firstly to be a mockery of the patient which demonstrates the lack of understanding of the analyst. Secondly, there appears to be no attempt to try to understand the patient's resistance by such questions. In the example given, I would rather ask, "What would you be escaping if you went west?"

I am also concerned about the emphasis on counter-transference. I think it is far too easy to assume all of our own responses are healthy, instead of considering the possibility that we ourselves have little bits of unresolved pathology, or merely characteristics that are idiosyncratic to ourselves, healthy or not. It occurs to me that working with schizophrenics may support an inclination to grandiosity in some analysts, merely because our patients appear irrational. To counter that, I think it is important to remember, that all the irrationality does make sense, if we can only figure out in what way (For elaboration of that point see Von Domarus, 1954). Indeed, I think it is important to guard against one's narcissism in general, for fear of contaminating the expression of the patient's content. We want the patient to discover *himself*, not be reflections of ourselves.

The recommendation that the patient not be encouraged to free associate, is moot since the patient is not able to free associate. He will say whatever he wants anyway, and I find no danger of regression.

Most importantly, I think it is the analyst's job to interpret as much as he or she can possibly understand of the content. Those interpretations are what will not only prevent regression but will cause the patient to improve. The true difficulty is finding the correct interpretation. Most of the material must be treated as unconscious dream material. However, unlike with the neurotic, one cannot usually wait for free associations. The analyst must have a very good understanding of how the unconscious reasons, and puns and symbols (Levin, 1996). Such understanding certainly applies to hallucinations and delusions.

Comfort I consider a paramount issue. And to increase that comfort, one ought to schedule as many sessions as one can, in order to reduce anxiety. Schizophrenics, more than most patients, are terrified of separation. I will have more to say about comfort later. I also find such questions as "What year did this happen?" or "What did she say?" take the patient's focus away from the unconscious material that needs to be

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USING ANGER WELL: A Constructive Attitude Toward Aggression in a Milieu Setting

Michael Altshuler, CSW

No one who visits fails to sense it. And those who stay value it greatly. What everyone encounters when they walk through the door of Bronx REAL (a day treatment program for adults with severe and persistent mental illness) is a spirit of warmth, safety and comfort. This healing ambiance permeates our therapeutic community and acts as a nourishing influence on clients and staff alike. And while not easily quantified, clinical experience suggests that this unique climate fosters essential maturational conditions, instilling in our clients a feeling of hope (Yalom, 1995) and the promise of recovery (Anthony, 1993).

The presence of this therapeutic attitude is, of course, no accident, and to give a full account of its origins would take more space than I have. But one crucial element in preserving it, I believe, is the constructive attitude towards aggression that members of the community adopt (Spotnitz and Meadow, 1995). Throughout their stay (which may be as short as a few months or as long as a dozen or more years) clients are vigorously encouraged to channel their aggressive impulses toward personal well-being and healthy relationships, rather than toward injuring themselves or others.

We do this by proposing that clients think of anger as a vital form of emotional energy that will have good or bad consequences depending on how it is understood and used (Ormont, 1984). This corrective attitude within the milieu accords well with the Modern Psychoanalytic view that emotional well-being is an lifelong process of learning to have all of one's feelings, to know why one does, and to express them in ways that neither hurt oneself nor others (Sheftel, 1991). Ultimately, how clients perform each of these critical developmental tasks is the difference between anger handled badly and anger handled well.

Establishing a therapeutic attitude towards a widely perceived "difficult" emotion such as anger is no small task. Our clients have no "single story of suffering" (Breuer and Freud, 1893, p.6). Yet as a group they share common histories of problems with anger, encounters with violence, and recurrent episodes of emotional, sexual and physical victimization. And now in adulthood—whether "dominated by the aggressive drive" or by "defense[s] against aggression," (Spotnitz & Meadow, 1995, p.2)—they present many forms of destructive coping and relating including chronic suicidal depression, self-neglect and self-harm, and habitual losses of control tending towards explosiveness.

These pathological mechanisms of aggressive charge are inevitably revived in the program. What this occurs the progressive spirit of the milieu invoked in the community dialogue that emerges on any such event. For example, an incident that disrupts (or that has the potential of disrupting) the emotional equilibrium of the program will become the subject of wide-ranging discussion among clients and staff. Individually, in sub-groups and collectively reflect upon and address any act of aggression that undermines the vital feeling of sanctuary within the program.

This dialogue of clients and staff takes place in a variety of contexts including individual therapy sessions, psychotherapy groups and Community meetings. The discussion continues behind the scenes in staff meetings, supervisions and administrative meetings. And finally the exchange of reactions spreads across the complex web of friendship and contact that exists between clients. Whatever the setting, members of the community are encouraged to bear witness to any event that erodes the quality of life in the program.

Underlying this community dialogue is a belief that all emotional reactions deserve respect, and an effort will be made to acknowledge and verbalize them. We do this because experience has taught us that community sharing and processing of the origins and impact of "treatment-destructive" behavior is crucial to sustaining the psychological well-being of the milieu (Spotnitz and Meadow, 1995). And while the manner and pace of response may vary, there is one way one constant—namely, an abiding commitment to expressing in words the thoughts and feelings that events provoke.

Our goal is not to blame or punish, but rather to learn and grow. In our view optimal participative milieu life is a form of therapeutic citizenship, which is reflected in each person's engagement in learning about the self and others. The individual and the milieu mutually benefit from the opportunity for self-study and large group self-reflection. By collectively voicing our reactions to destructive aggressive behavior, we stimulate the observing ego of the milieu-as-a-whole and its individual members. We learn together to face the inescapable presence of anger in daily life. And over time clients (and staff) increase their capacity to respond constructively to the anger of others and to use their own anger well.

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Reflections on Stavanger

Grace E. Jackson, MD

The Airport

My first contact with Norway was Stavanger airstrip, which rose gracefully beneath the wheels of our descending Boeing jet. The hillside surrounding the airport was verdant, lush, and welcoming. Snowcapped mountains, visible in the distance, tempted an immediate truancy from any indoor captivity that might tarnish the days ahead. From my very first moments in Norway, I was struck by the power and poetry of this landscape. Arriving in the Nordic terminal, though, I found myself beginning my own descent ... into silence. I began to feel a heaviness in my chest, and felt cut off from the world around me, alone in a way that surpassed even my usual feelings of existential isolation. Part of this was attractive. After all, if the aging Frieda Fromm-Reichmann could tolerate the separation imposed by a gradually encroaching deafness, I should at least be able to endure the feelings of a temporary alienation which, I assumed, arose from my own linguistic ignorance. Somehow, though, this was different. Gone was the din of Schiphol % the Amsterdam through-way that seemed more shopping mall than airport, walls reverberating with the liveliness of Internet hook-ups and casino gaming and a cacophony of innumerable foreign tongues. Those energies seemed replaced here by a coolness, a stoicism, a sterility % perhaps reflective of long winters and icy fjords that were not so far away.

The Hotel

Maybe Fodor was wrong. Or outdated. Maybe I had come too late. The pages I had purchased at the American bookstore did not prepare me for a world of renovations. They omitted the scaffolding, which concealed the color and form of the edifice in such a way that its purpose was not immediately discernible. They omitted the plaster, and the drills, and the reupholstering which, in the name of modernity, threatened to improve upon the wisdom of the traditional structure. It took a moment to figure out the lift, as the door to the hotel elevator would not open on its own. In my first encounter, I was embarrassed as I watched and waited...waited, with others watching ME. The car arrived and departed, not pausing long enough for me to enter with my bags. What kind of system was this? Energy efficient, yes, with a non-electric door. I began to see the sport and humor in it all. A quick tug on the handle was demanded reflexively, before a would-be rider on another floor could summon this yo-yo with his unseen hand.

The Plenary Sessions

As a senior psychiatry resident nearing the end of her training, I had crossed the Atlantic feeling a bit like Dorothy on the way to Oz. Stavanger would be the

home to my Wizard: my Scarecrow would find his brain in the global validation that man's worst psychic problems could not be explained and treated by chemicals alone. My Tin Man would find his heart by meeting the masters of compassion, empathy, and unflinching hope. And my Lion would find his courage in the comradery of kindred spirits, united in the struggle to provide humanistic care while the political and economic forces of the world conspired against it.

Such had been my expectations. But, like the airport and hotel I discovered upon arrival, ISPS itself was shrouded mysteriously in stoicism, undergoing a sterile renovation. The scaffolding was the notion of early interventions, obscuring the long-term edifice I had intended to enter. The traditions of psychodynamic, insight-oriented therapy were like the elevator I had difficulty mastering: jerked away by an unseen hand, I was left watching...and waiting...for the return of something I felt I needed, if I was to transport myself and my baggage to a secure place of rest.

The first plenary speaker, Dr. B. Saraceno, presented the World Health Organization's priorities for a global strategy against mental illness. With evangelical zeal, he highlighted the WHO's goals of advocating, litigating (making policy), and administering (intervening) for the treatment of depression, suicide, schizophrenia, and epilepsy. He spoke about five myths of mental illness % that mental disorders were insignificant, untreatable, present only in industrialized countries, subject to no meaningful research, and statistically on the decline. Saraceno suggested that the World Health Organization was pledged to the clarification of these distortions. I wondered if many of the Stavanger presenters might not, themselves, be the best targets of the WHO's lofty campaign.

The second plenary speaker, Australia's Dr. Patrick McGorry, emphasized the need for "a phase-oriented approach to the treatment of psychoses." To his credit, McGorry mentioned the importance of identifying the strengths and resilience of patients, and challenged the traditional stereotype that severe mental disorders lay beyond the possibility of successful integration. Of concern to this Dorothy, though, was the emergence of a philosophy which appeared to be contagious:

— cognitive-behavioral therapy was seen as "active" and effective;

— psychodynamic psychotherapy was denigrated as "passive," *passee*, and impotent.

Comments were made relative to the dangers of allowing psychotic patients to abreact. With early

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medication (especially during pre-psychotic and prodromal phases....however these were to be discerned) and short-term therapies, the speaker believed it possible to prevent, as well as ameliorate, the first symptoms of schizophrenia and other psychoses.

My initial, unspoken reaction to the presenter's enthusiasm for early medication was sarcastic disbelief. I had fantasies of suggesting the development of a depot immunization...a combination SSRI, D2 blocker, anxiolytic which could be administered by all pediatricians at well-baby checks, thereby prophylaxing every mental disorder in the DSM. I imagined my return trip to Scandinavia in the near future, hoping that these Stavanger attendees might watch me claim my Nobel prize in Stockholm.

I was concerned, again, about my deafness or alienation from those around me. Perhaps I was not hearing things correctly. How could it be that the artistry of psychodynamic interventions ... the poetry of a Ferenczi, a Sullivan, a Searles ... was now dismissed as irrelevant or regressive? How was I to understand the paternalism, if not pessimism, of a philosophy which suggested that psychotic patients lacked the ego strength to tolerate insight-oriented work, or that therapists might not facilitate integration through the patient unfoldings of a dyadic relationship that could foster new patterns of attunement over months or years? If Frieda Fromm-Reichmann's dynamic listenings and interpretations were, for some observers, the equivalent of "her swinging from chandeliers", then the new approaches receiving priority here in Stavanger would have planted her feet so firmly in concrete, no such swinging could ever have occurred.

The third plenary address, delivered by Yale University's Dr. Thomas McGlashan, continued with the theme of phase-specific treatment. The speaker presented "the vulnerability to stress" model of illness, suggesting that the course of schizophrenia (and other psychoses) depended upon the relative predominance of strengths or liabilities in a patient's life. McGlashan mentioned four goals of psychotherapy, encompassing the clinical improvement of symptoms (mainly short-term, and relying primarily upon medication); rehabilitation (including family and community resources); public safety (preventing violence and aggression); and self-fulfillment. Curiously, this last goal — referring to "the humanistic domain of outcomes" — seemed to occupy the lowest priority. I wondered if earlier ISPS meetings might have attacked this position. I wondered why the world had become so accepting of those interventions that aimed only at the lowest of Maslow's hierarchy of needs, when the very legacy of our profession (in psychodynamic techniques) had not stopped short of pursuing the highest.

The fourth and final plenary presentation I attended was delivered by England's Max Birchwood,

who spoke about the challenges of "engaging" the psychotic patient within the context of cognitive-behavioral therapy. If, as Birchwood had found, the most psychotic of patients resisted attachment, disclosure, or compliance within the course of treatment, then it seemed to me it was possible that they protested the manner in which their psyches were being reduced to faulty cognitions and behaviors. If this were the case, I would suggest that the psychotic patients who resisted CBT were, in fact, more insightful and happily adjusted than the neurotic patients who embraced it.

The Symposia

If the plenary sessions were alarming for what they presented, then many of the symposia were disturbing for what they lacked. A notable exception, however, was found in Dr. Ann-Louise Silver's paper about the treatment of psychosis. Challenging the predominant theme of the conference, Silver suggested that the complexity of psychotic disorders rendered impossible their organization into neatly defined "stages". However, while psychotic disorders themselves might defy classification into distinct phases, the actual work and development of psychoanalysis % both for the individual practitioner, and for the discipline as a whole % might be understood through unique "visions" of reality. Silver drew on the work of Roy Shafer to describe developmental stages of the psychoanalyst according to certain categories in the humanities:

The comic stage: encompassing optimism, reform, and progress (reference was made to biographer Gail Hornstein's tribute to Fromm-Reichmann: "to redeem one person is to redeem the world")

The romantic stage: encompassing the recognition that life involves a series of quests, including fusion with a higher power (reference was made to Searles' psychobiosocial perspective that what the patient really wants from the analyst is a "series of deep feeling involvements")

The tragic stage: encompassing alertness to dangers and terrors, a linear concept of history, and the notion that individual choices entail sacrifice, remorse, and guilt (reference was made to the fact that medications have sometimes made patients more coherent, but at the risk of rendering them less 'authentic'), and

The ironic stage: encompassing self-deprecation, the readiness to seek out parapraxes, and the capacity to diminish the distance between therapist and patient, as we embrace the "utter impossibility" of our profession (reference was made to the irony of how biological formulations and treatments have sometimes undermined our patients' self-confidence).

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The Delaware Valley Mental Health Foundation

Albert Honig, D.O.

The Delaware Valley Mental Health Foundation was founded in rural Bucks County, Pennsylvania in 1959. A place to treat psychotic patients germinated from dream to reality, as I was completing a fellowship with John Rosen. I had spent five years with Dr. Rosen, and it was time to move on.

With the purchase of two old farms, and the invitation to Harold Fine PHD. to join, together we established the Honig - Fine Clinic, a predecessor of the Foundation. Dr. Fine chaired the outpatient department and I the inpatient. Dr. Fine left in 1964, taking a position at a university. At this time, all assets including the property, became the newly created Delaware Valley Mental Health Foundation, hereafter referred to as "the clinic."

For several years, I tried to treat my psychotic patients in any hospital or nursing home that would admit them. The private hospitals of the day were owned by one or two physicians who spent most of their time in their offices downtown. The running of the hospital was left to a registered nurse, who had ultimate power over the patients and staff. Although lobotomies and insulin shock was losing popularity, electric shock was the treatment of the day. Often I would work for several hours, only to have it all undone by the nurse saying, "all that talk is a waste of time, you need shock therapy." When I asked my colleagues why they didn't talk with their patients, as I was attempting to do, they would say that they had too many patients to care for.

I found the use of physical therapies inhumane and was determined to find a natural humanistic therapy for the severe psychoses and other mental illnesses. At the time, my thinking was influenced by many sources. Osteopathic philosophy taught that the body contained within itself all things necessary for one's own regeneration. Freud and his followers, especially Melanie Klein, and the object relation theorists, and the attachment work of Bowlby were influential. The eclecticism of development psychology, ego psychology, and milieu therapy, family dynamics, and community networking became extremely important to my thinking. The newer findings in infant psychiatry had been extremely useful in understanding my patients. I have also borrowed from the discipline of psychodrama and story telling, including the use of narrative, metaphor, and simile. With the help of theatre I developed action techniques.

The original goals of the clinic were; 1) service to the community, 2) research into the cause and treatment of mental illness, and 3) education

I now believe that surrogate parenting with extremely psychotic individuals had its beginnings at

the clinic. I know of no other facility that takes extremely disturbed patients from other facilities and places them with real families. Many places claim that they work within the family model, but on closer observation, we see that these facilities are more like a family, than a true family. Single people, and not married couples live together with patients.

Although no system is perfect, the family is the still recognized as the best place to bring up children, and it might be also said, it probably is the best way to bring up regressed patients- all over again.

In the treatment units, each patient becomes an integral part of the family. They have chores according to their ability. With no central cooking, patients learn to cook within a family. The kitchen is considered the hearth, and it isn't uncommon to find a regressed patient sitting in front of the warmth and humming of the refrigerator motor. Each unit, with up to 6 patients, becomes its' own hospital. In such a complex illness, the simplest methods are often the most successful. I often have said that all you need for a hospital is a tent, a family and several patients.

In the beginning, most of our patients came from state institutions. The clinic offered another chance, and presented an alternative treatment. People who, in large hospitals or jails, had peculiar living habits and often were violent, were admitted. Violence in institutions may be self protective, but is out of place in a family home. Often, house parents had their own children of various ages living with them. Never was a child hurt, and many grew up extremely tolerant of others, and academically sound, for at an early age they included themselves in the home bound instruction that their patient-family co - members received.

Trust and time are probably the most important two factors in treatment, especially of the chronic patient. The clinic, small and mobile, always existed as part of the greater community. Teachers came from the local schools, ball games were arranged with other groups and agencies, such as child welfare and even local tavern teams. Patients and staff participated along side of each other.

The clinic received international acclaim. In 1966 an article "Breakthrough in Psychiatry-" appeared in *Look Magazine*. "Emerging from Schizophrenia-" was a lead story in *New York Magazine* in 1977. The film "Other Voices-" nominated for an Academy Award, was made at the clinic in 1973. All brought much renown and many visitors.

People sought the clinic for several reasons. Many wanted their family member to live in the therapeutic home atmosphere. Others were attracted to the holis-

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tic, non-biological treatment. The simplicity of the modus operandi, made the treatment cost effective. Rarely was medication used, and mostly for those patients who were unable to respond to human touch and those who raged uncontrollably. Patient stays varied from 8 months for younger patients, to 6 years for the very chronic.

With the advent of hospital regulations and managed care, costs increased. Increased paper work, and the regulations calling for trained nurses added to the cost of admission. The lay families that we trained to live with patients were mostly displaced (At present one couple remains, and they have been with the clinic for over 8 years.)

It was always my dream to have one unit in every community of 3-5,000 people. Manned by a couple, and when needed, volunteers and students serving as family assistants, supervised by professionals, it would serve as the center for mental health, treating patients, doing research and educating the community. ♦

albhon@aol.com
616 North Street
Doylestown, PA 18901

Letter to the Editor:

Martti Siirala, MD

Dear Brian:

Your e-mail letter of 21 June is most welcome and delighting in all the issues it deals with. I also enjoyed meeting you in Stavanger. Isn't it something fundamentally encouraging that concern for schizophrenic man brought over 700 people there together!

Quite some part of my energy also is taken by the extensive field of action of the Tartu Peace Association, the chairman of which I am since its' founding 10 years ago. I hope you permit me (as briefly as possible) to explain what it is about. If it succeeds my explanations should arrive at making obvious, that and how my motivation there is in harmony with the concern for man's basic rights, say in the human situation schizophrenia and in the psychoanalytic therapy with those individuals whose vicarious fate has been to get manifestly caught by it.

The peace treaty contracted 14 October 1920 in Tartu, Estonia between Finland and Soviet Russia defined the borders of the independent Finland, the one having declared its' independence 6 December 1917 (the corresponding treaty between Estonia and Soviet Russia had been signed 2 February the same year). The association works, peacefully and non - fanatically for the simple restoration of the Finnish basic rights - the ones grossly violated by the Stalin Soviet, starting by its' military aggression Nov. 30, 1939 (the s. c. winterwar enjoying a worldwide sympathy for the Finnish defence) and leading to annexation (only 1/3 of

it had become conquered by the soviet troops) of 1/8 of Finland. Although the League of Nations (the organization preceding the UN) immediately doomed the attack and discharged the Soviet from its' membership, even the western nations, UN etc., have never questioned the legality or right of that annexation.

That massive human neglect within the family of nations has resulted in a grave traumatization to the Finnish sense of self and identity. Not only loss of trust into right of equality with other nations as to each one's legal domicile (inhabited in our case nearby only by Finns since more than a thousand years) resulted, but even a Finnish identification with the aggressor ad absurdum etc...Recently, on the "pilgrimage" trip of the Tartu Peace Association to Tartu, the rooms where the peace treaty of 1920 was signed, President Meri received our delegation. He told us having made in the General Assembly of the UN the proposition, that the small nations shall have one representative in the Security Council with equal voting and veto rights as the superpowers. I told him having written to Kofi Annan about the need for manifestly acknowledged equality between the small and the big in questions of right as a survival condition for mankind.

My engagement by this challenge I find organically in harmony with my work as a psychoanalyst, also pertaining to the way I understand schizophrenia and its' therapy. In 1991, I wrote a book about the Finnish case (not yet translated into any other language) by the title: "Caught Deep on its' Trails - the Journey of the Finnish National Sense of Self." I sketched the genesis of what I call the "Finnish disease" against a comprehensive historical background. I preferred that name to the one given to us from outside, "the Finlandization." What is here absolutely needed, is a socio - pathological horizon, also rendering place for a sense by the subject that he is the sick one.

One of the next days I will send to you by mail two copies of my book "From Transfer to Transference" [Ed. note: this book is a profound interpretation of the collective and social pathology impacting on individual psychopathology and is written in a language which reflects its' philosophy of therapy and human encounter, it is available from the Therapiea Foundation, Töölöntorinkatu 4 B 38, 00260 Helsinki 26, Finland] and eventually some unpublished English and German texts of mine.

Well, I could not anticipate the form my reply to your e-mail letter would take. It just emerged this way. Not to neglect to mention one thing: I shall be happy to get on the mailing list of the ISPS-US Newsletter!

Warm regards Martti

[Ed. note: an interview with Martti Siirala, MD will be published in a future issue of this newsletter]

Column: Mind and Brain

Brian Koehler, Ph.D.

[I would like to thank Drs. Wayne Fenton, James Ogilvie and Ann - Louise Silver for their helpful comments on this column]

I have for many years been impressed by the large convergence of research findings in the neuroscience of schizophrenia, bipolar disorder, depression, PTSD and in the neuroscience of stress and anxiety. In this issue of Mind and Brain, I will examine the role of stress in neural function and structure and in future issues continue to explore the relationship between this research and that of the schizophrenias.

In the hippocampus alone, a key structure implicated in research in schizophrenia, stress has been shown to affect synaptic plasticity, dendritic morphology, neurotoxicity and neurogenesis (Kim & Yoon, 1998). Sharma and colleagues (1998) challenged Selye's concept of stress as a non-specific response of the organism following a homeostatic challenge. With the rapidly increasing knowledge of the molecular mechanisms of the central nervous system (CNS), it has become clear that various neuronal processes can selectively be activated by different kinds of stress, e. g., c-fos, an immediate early gene (IEG) and marker of neuronal activation, is upregulated (increased) following immobilization stress. Neuronal responses to stress can be divided into early and late phases. Early responses are induced by first messengers like neurotransmitters or growth factors. These first messengers then bring about a cascade of neural events which can create gradual and permanent changes in the neuron itself which are contingent upon alterations in gene expression. Sharma and colleagues concluded:

"There are now scientific evidence that sensitization to stressors are encoded at the level of gene expression. This alteration in gene expression will in due course of time eventually manifest into major affective brain disorders [this is similar to the kindling model of affective disorders researched by Post and colleagues]. Various kinds of neurodegenerative diseases and mental abnormalities are classified as long-term stress disorders. This is evident with the fact that the upregulation of various kinds of stress proteins in these diseases has been demonstrated... Stress induced alterations in neurochemicals has the capacity to influence gene expression and thus induce short-term or long-term encoding of the stress experience which in turn can lead to reversible or permanent changes in the brain function. Current data indicate that almost all neurochemicals and their metabolites are altered under stressful situations" (pp. 263-264).

For a long time now, I have been intrigued by the convergence between the neurobiological findings in stress, especially at a molecular level, and in schizo-

phrenia. Perhaps it is not "psychosis" per se that is neurotoxic, but the long term effects of chronic and profound anxiety and stress. For the clinical symptoms of psychosis, e. g., delusions and hallucinations, may be the organisms' attempt to defend against psychic disintegration or what Ping - Nie Pao (1979) called "organismic panic." Even such a putative marker of neuronal integrity as hippocampal N-acetyl-aspartate (NAA) has been observed to be reduced in individuals with schizophrenia-as it can be in Vietnam veterans with PTSD (Schuff et al, 1997). Ventriculomegaly and reduced hippocampal volume has been observed in schizophrenia, PTSD, and affective disorders. Ventriculomegaly is observed in the normal aging brain and perhaps this robust finding in schizophrenia may reflect on a premature aging of the brain due to the complicated neural effects of stress, even in utero (see Marta Weinstock's 1998 research, "Long-Term Effects of Gestational Stress on Behaviour and Pituitary-Adrenal Function"). It is currently believed that tissue atrophy can be directly caused through an excess of glutamatergic and serotonergic stimulation, excess calcium and glucocorticoids (McEwen, 1997), and indirectly through the negative effects of stress on neurogenesis (e.g., reduction of BDNF - brain derived neurotrophic factor). Autoimmune phenomena observed in schizophrenia (Strauss & Printz, 1996) are also seen in stress (Watkins & Maier, 1998). Perhaps, the later evolutionary development of the body's stress response made use of the phylogenetically earlier biological machinery mediating the bodily response of inflammation or infection to a pathogen. Watkins and Maier (1998) hypothesized that the "stress response redirected the sickness machinery to a new purpose: all that was necessary was to now activate the machinery from a new source - external threat rather than a pathogen" (p. 192). I sometimes wonder, could other persons be unconsciously reacted to as threatening non - self pathogens particularly in poorly differentiated or interpersonally traumatized individuals? If this is partly the case, we may have a kind of psychodynamics of neuroimmunomodulation or a neurobiology of the paranoid-schizoid position. The issue of the massive and complex neural effects of stress and anxiety are beyond the scope of this piece. References or responses to any questions can be provided by contacting me at (212) 533-5687 or bkoehler7@compuserve.com

Interested readers are referred to the following sources:

McEwen, B. S. (1997). Possible mechanisms for atrophy of the human hippocampus. *Molecular Psychiatry*, 2, pp. 255-262.

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APPROACHING GUILT:

Winnicott and the Treatment of a Mentally-ill Forensic Client

Martha M. Crawford, MSW, ACSW

This case has been particularly difficult to organize for presentation because there has been little change or evidence of development within the course of treatment or that matter, over the course of the patient's life. The patient, "Terry" remains in the original sense, in a state of almost absolute dependency upon a mother who surely "maintains a muddle in those who are in contact with her" (Winnicott, 1965, p. 147). The reason I chose to try to apply Winnicott to this particularly overwhelming case, is that, more than any other theorist, he helped me to understand where Terry is in the positive sense, and to discover exactly where the potential for maturation exists.

Moreover, Winnicott's description of the primary tasks of case work - (which are reproduced below, in full) felt to me to be an essential expression of my aspirations for my work with mentally ill ex-offenders, and especially with Terry:

You apply yourself to the case

You get to know what it feels like to be your client

You become reliable for the limited field of your professional responsibility.

You behave yourself professionally

You concern yourself with your client's problem

You accept being in the position of a subjective object in the client's life, while at the same time you keep both of your feet on your ground.

You accept love, and even the in-love state, without flinching and without acting-out your response.

You accept hate and meet it with strength rather than revenge

You tolerate your client's illogicality, unreliability, suspicion, muddle, fecklessness, meanness, etc. etc. and recognize all this unpleasantness as symptoms of distress. (In private life these same things would make you keep at a distance.)

You are not frightened, nor do you become overcome with guilt feelings when your client goes mad, disintegrates, runs out in the street in a nightdress, attempts suicide, and perhaps succeeds. If murder threatens you call the police to help not only yourself but also the client. In all these emergencies you recognize the client's call for help, or a cry of despair because of the loss of hope of help (Winnicott, 1965, p.229).

Winnicott's model defines developmental landmarks as occurring and reoccurring throughout life, and in each and any relationship. In this way, the therapist is able to assume full responsibility for the pa-

tient's capacities with in the context of the treatment relationship. For example, the capacity to be alone is not attained at one fixed moment in time, but must be re-negotiated each time the patient needs to define himself as separate, in the here and now, from the therapist or any other significant relationship. From this perspective, we are not reviewing or replaying earlier events, or blaming primary caretakers, but creating opportunities for new developmental achievements in the present moment. I am going to try to describe the moments which revealed Terry's potential for development, by exploring the Winnicottian conception of the capacity to be alone, true and false self development, the holding environment, and most importantly, the capacity for concern and guilt.

IDENTIFYING DATA

Terry, a handsome thirty-year-old African American man, is always quite fashionably dressed, as thirteen-year-old boys defined fashion. He wears a ball cap at all times to conceal a large, bald, bump high on his forehead; a reminder of the day after his thirteenth birthday, when his father hit his head into the dinner table. His mother buys him expensive clothes that she cannot afford, dresses him each day, in the hopes that it would stop the gang kids in notorious housing projects from threatening and humiliating her adult son.

Well over six-feet tall, with a lumbering gait, Terry is a target in his neighborhood. His body was often wracked by outbursts of bizarre, maniacal laughter. An enormous uncoordinated child-man, he is always eager to make friends, volunteering to run errands for drug dealers and "crack ladies" who reward him with a free hit of crack or a brief sexual contact.

When pressed past the point of tolerance, he explosively threatens to "cut" or "stomp" people he believed to be teasing him. He can not distinguish between real episodes of harassment and the overwhelming ideas of reference, which plague him especially when riding the confined New York City subways. Believing that bystanders are laughing at him, whispering about his appearance or calling him "a bum" or a "retard", Terry will shoot back a long cold glare, which suddenly erupts into a screaming charge: "What are you laughing at? I'm no clown! I'll cut you!" He runs toward his startled victim, tearing off his jacket and thrusting his hand deep into his back pocket. He has never thrown the first blow; he does not carry a knife, and reports that he "can't really fight at all." When his victim has the presence of mind to try to reassure Terry that no one was talking about him, he

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quickly reorganized and apologizes; "I'm sorry, I get messed up thoughts sometimes." When he has unfortunately singled out a young man or adolescent boy Terry usually ends up "stomped" himself.

PSYCHIATRIC AND FORENSIC HISTORY

Terry carries a diagnosis of chronic paranoid schizophrenia, polysubstance abuse, and anti-social personality disorder. He is compliant with a complex and ever-shifting medication cocktail, which generally included a small quantity of anti-depressant medication combined with large doses of several anti-psychotics. He often seeks out adjustments to his medications, and is eager to try every "new pill" that he hopes will "fix messed up thoughts."

He experienced several year-long hospitalizations usually at state facilities, as well as participation in a variety of outpatient rehabilitative programs. A great deal of his psychiatric treatment took place in the mental observation unit on Riker's Island. He has been arrested and incarcerated fourteen times for a variety of offenses including strong-arm robbery, menacing, and assault. These crimes were committed either in the service of his drug addiction ("stealing ladies purses" for crack money) or in response to paranoid ideation (threatening or striking out at strangers for laughing at him).

FAMILY DATA

There are ten family members living in a two-bedroom apartment: Terry's mother and her boyfriend, a maternal uncle, his two sisters and their four children. Terry shares a bedroom with his uncle. Uncle Jim is often verbally abusive to Terry, as is his mother's boyfriend, taunting him, calling him "the 'r' word" (retard). They have, in the past, inflamed Terry to the point of retaliatory violence.

Terry's monthly SSI check covers the rent, as the adults in the household work irregularly. There have been several attempts to offer family support services to the household, all of which were rejected.

Terry's mother is by her own description "over-protective." She attributes this to the years of physical abuse they both suffered at the hands of Terry's father. The abuse began shortly after Terry's conception and continued until she divorced over fifteen years ago. She experienced some relief from the battering when Terry reached elementary school age, and began to attract most of the abuse. After the divorce Terry's father was forbidden to enter the apartment by a restraining order, but Terry often willingly met him outside. Such visits often resulted in trip to the emergency room for stitches. His father has a history of incarceration for assault, and several members

of Terry's household have been incarcerated for violent crimes including rape and murder.

TREATMENT SUMMARY

Mandated to our MICA day treatment program as an alternative to incarceration, I met Terry in the summer of 1995, and worked with him until spring of 1999. We met twice a week for individual treatment, three times a week for group therapy, in addition to informal contact through out the day on the treatment floor. I maintained monthly parental guidance and collateral contacts with his mother, usually by phone. She was always superficially agreeable and almost friendly by the end of our three and a half-year relationship.

Despite the realities of Terry's life, he made significant improvement over the three and a half years that we worked together in day treatment. Most substantially, it was his longest period without incarceration. He was able to achieve two years of continuous sobriety in a particularly challenging environment.

There were many smaller achievements as well. He began to dress himself. He improved in his ability to protect himself from his father; meeting him only when escorted by his uncle or sisters, and avoiding him altogether if his father appeared to be in a "bad," potentially explosive mood. He became more able to control his response to paranoid ideation and has begun to accept that the large doses of psychotropic medication that he takes daily may not be the ultimate solution to the apparently fixed ideas of reference which torment him. His ability to distinguish between healthy fear and paranoia, between safe and dangerous situations became more accurate and reliable, enabling him to take steps to preserve his own safety.

He took on a task at the program, watering the plants for extra spending money. He has also formed friendships in program, with supportive, encouraging peers. He developed a sense of humor, and a capacity to play in group. He chose to attend a psychosocial club after program and on weekends, to keep himself off of the streets, and beyond the battle-zone.

THE CAPACITY TO BE ALONE

Over the course of our work together, Terry's conversation was riddled with repetitive, exasperating questioning. They were formally rhetorical, yet his tone demands a specific answer. The others in group became quickly bored and annoyed. Despite the similarities in their diagnosis and backgrounds, he was clearly much younger developmentally than the rest of the group. Terry apologized: "I guess I always ask dumb questions." Early in the treatment, I withheld my own answers, and threw the questions back to Terry, tossing in a few of my own.

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T: I shouldn't carry a weapon, Right? That's bad Right?

M: Are you thinking of carrying a weapon?

T: No! That would be dumb! I might get killed!
(Explosive laughing and rocking)

M: What feeling is making you laugh?

T: I shouldn't laugh right? It's not funny right? But I shouldn't carry a weapon Right? (Rocking increases)

M: Well, what did you just say? You answered your own question I think.

T: That would be a bad idea Right? Right? (More explosive laughter)

Sexuality was a particular concern for Terry in this early phase. In group, he complained bitterly about the humiliation, expense, danger and ultimate frustration of frequenting drug prostitutes. The men in group suggested that Terry masturbate, and might be able to find some privacy in bathroom or the shower, and that this might be a cheaper, safer, less exposing way to take care of his "sexy" feelings. Terry appeared sad and confused. As weeks passed, it was clear that our discussions were having no impact. Worse, he experienced additional shame and worry that he was now disappointing the group and me by continuing to solicit these women, and felt compelled to conceal it for a time.

If I had a better understanding of the level of sophistication that is required to be alone with erotic feelings, or of Terry's real capacities, I would have known that the groups prescription would be useless to him. Winnicott explains:

"In masturbation the whole responsibility for the conscious and unconscious fantasy is accepted by the individual child. To be able to be alone in these circumstances implies a maturity of erotic development... it implies the fusion of the aggressive and erotic impulses and ideas, and it implies tolerance of ambivalence..." (Winnicott, 1965, p. 31)

Clearly, Terry was unable to assume such responsibility for himself. He did not have the capacity to be alone and therefore required the assistance of a consistent object to assist him in better sorting out and neutralizing sexual impulses. Moreover I initially failed to respond to the sexualized aspects of Terry's growing attachment to me. In the presence of his female therapist, and several women in the group, Terry opted for an involved discussion of his sexual behavior with prostitutes, in order to avoid involving us in his masturbatory fantasies. Rather than helping Terry verbalize the ways in which he was experiencing humiliation, danger, and sexual frustration in his treatment relationships, I and the group opted to prescribe privacy and masturbation - essentially abandoning him to his own limited capacities.

As I realized my error, I was able to adjust my approach, and eventually help the group listen to Terry as he expressed his wish to have us serve as a private "harem of nice girls" who might one day replace "the crack ladies."

THE HOLDING ENVIRONMENT

The capacity to be alone is contingent upon the earlier achievements of the holding phase, the integration of the individual as a unit, an ability to distinguish between internal and external life. (Winnicott 1965, p. 32) I now believe that Terry's questions are really pleas for holding, for the creation of a space where he can distinguish between his inside and outside, between Terry and not-Terry, between his thoughts and mine.

In addition, he is asking me to be reliably there, his "Rights?" are his way of checking to see if I am still with him, and if I have noticed that he is experiencing a thought or an impulse.

"... Holding the patient... often takes the form of conveying in words at the appropriate moment something that shows that the analyst knows and understands the deepest anxiety that is being experienced, or waiting to be experienced" (Winnicott, 1965, p. 240).

Winnicott's explanation of the needs of the holding phase helped me to adjust my responses to Terry's questions.

T: I shouldn't ask Jim for advice. Right?

M: That's a good question. You're wondering how you feel about talking to him. You sound a little worried.

T: He's sometimes mean to me. He calls me the 'r-word'

M: He hurts your feelings sometimes.

T: A little bit. He's a drunk anyway. An alcoholic Right?

M: That would be important information. Do you want to know if I think he's an alcoholic, or do you have an idea yourself?

T: What do you think?

M: It's hard for me to say, but from what you've told me before, he really does seem to be hurting himself.

T: The doctor says his liver doesn't work right. He could die like Uncle Mickey, and then there won't be any men left but me.

By viewing his ability to organize these questions as an achievement in itself, I could nurture his ability to consolidate a sense of his own thoughts, feelings and impulses and help him to express much deeper experiences of loss.

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He was then able to use me for soothing, for confirmation of his perceptions, as an auxiliary source of judgment and discernment to help him to avoid trouble. "I" did not exist for him, and he was not too aware of my anxieties or concern for him or of how hard I was working on his behalf. When I asked him how he felt about our relationship he replied "I'm used to you." He hovered on the verge of the awareness and a growing confidence that I would be consistently nearby.

TRUE AND FALSE SELF DEVELOPMENT

For reasons both socioeconomic and characterological, Terry's environment was unable to hold him in the Winnicottian sense. Traumatic abuse, lack of privacy, inadequate housing, and his mother's demand, that he never stop needing her all amount to a pronounced impingement, creating intense persecutory anxiety. Physical survival required that Terry become prematurely and excessively attuned to events in his environment, at the expense of his own authentic subjective existence.

"But in practice the infant lives, but lives falsely. The protest against being forced into a false existence can be detected from the earliest stages" (Winnicott, 1965, p. 146). In health, the False self can be described as the conforming socialized aspects of the self which protect our more vulnerable, primitive and creative impulses. False self pathology is experienced as a kind of ineffective rigidity, which ultimately allows disruptive breakthrough of unsocialized impulse. (Winnicott, 1965, p. 147).

To myself as well as his fellow group-members, Terry's unspontaneous false self presentation was stifling in its repetitiveness, and secretiveness. Long periods of monotonous over-compliance were punctuated by sudden and startling episodes of impulsive acting-out. He would abstain entirely from alcohol and other drugs for four or five months at a time, then "blow it all" on a one night crack run. His career as a mugger involved three separate incidents in which Terry, with no forethought, would suddenly shove a middle-aged black woman, snatching her purse. In this light, Winnicott might describe Terry's anti-social behavior as a protest of the True Self, an attempt to steal back what rightfully belongs to him.

THE CAPACITY FOR CONCERN

Following a significant relapse, in response to Terry's request, I tried to help negotiate residential treatment. Through months of applications, preparation and interviewing, his mother was superficially supportive, almost excited: "Whatever Terry wants, I want. I think he is really ready for this now!" After he moved into the residence, she withheld all contact from him, failing to return his phone calls, and repeatedly canceling visits. He grew increasingly panicked, begging her answering machine for some response. Af-

ter three weeks, she arrived at the residence and brought him home.

He then entered a period of more regular substance use. His gesture toward growth and maturity had been stifled. Getting high offered a denial of his external environment, and an attempt to withdrawal further into the state of absolute dependence and hallucinatory wish fulfillment.

After this defeat, I found myself particularly exhausted by Terry and his mother. The innumerable phone calls, mounds of paperwork, hours of subway rides to sites all over the city, and the strain of "selling" a difficult client to wary residential providers, left me feeling ill-used, on the verge of used-up. Terry required even more soothing, holding and reassurance than ever. He as he regressed, small tasks that he had performed autonomously, such as reading his daily group schedule, or filling out his elevator pass, became overwhelming to him. I felt drained and devoured, not only by Terry, but also by the various crises with the rest of my caseload, and an intensification of my administrative duties. On my last good nerve, I walked into group.

It was the birthday of one of the group members, and a general discussion began of birth dates, astrological signs, and ages. As the group speculated on my age in particular Terry became excited and spoke up:

T: Martha was a little baby once! A little baby that I could hold in my arms like this! (He cradles and coos to the imaginary baby) Hello baby Martha! If you ever cry or feel bad, I will keep you safe and make you feel better! I would rock you like this! (He laughs and rocks the imaginary baby. The group laughs and they all begin rocking babies back and forth in their arms.) [Ed. note: see Searles, 1979, "The patient as therapist to his analyst," in *Countertransference and Related Subjects*]

I felt unbearably seen. I'd tried to hard to hide my depletion. Now suddenly, they were carrying me. I felt a deep sense of relief, and then panicked, terrified by the role reversal. "Why is everyone worrying about me? That's not your job to take care of me, I'm supposed to do that." Terry looked stung:

T: You don't like it that I care about you?

I quickly reversed my position:

M: I'm sorry. I do appreciate your caring for me. You do affect me and I feel very moved and impressed by your concern."

T: (smiling and nodding) "That's nice. That's good."

For Winnicott, concern is a capacity that indicates a significant level of maturity, corresponding to Klein's depressive position. It implies not only a secure good internal object, and an understanding that

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the object can be hurt, but also an ability to accept responsibility for instinctive impulses. (Winnicott, 1965, p. 73) Terry was building the foundation for concern at an earlier stage; he was developing a sense of guilt.

As stated earlier, Terry's impulsive, anti-social protests against these state of affairs can be viewed as a creative attempt. He could be said to have "reached back to a creative relationship to external reality, or to the period in which spontaneity was safe even if it involved aggressive impulses" (Winnicott, 1986, p. 98). Yet, these attempts at a creative solution ultimately fail in that do not acknowledge other objects, or himself, as whole integrated beings.

Terry's expression of caring for "baby Martha" was the first reparative gesture to have emerged in our treatment relationship; the first instance of what Winnicott describes as "innumerable repetitions spread over a period of time" (Winnicott, 1965, p. 24). Had I committed to my initial impulse, rejecting restitution, I would have hindered his growth, losing an opportunity to help him begin to move from ruthlessness toward "ruth." (Winnicott, 1965, p. 24). In this view, Reparation is seen as a creative response to healthy guilt. A deepening understanding of Winnicott helped me to find the smallest instances of maturational potential, and to value them.

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COLUMN: MIND AND BRAIN

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Art Therapy in the Treatment of Psychosis

Sylvia T. Honig MA, ATR

The thesis is that art therapy used in a positive, realistic, structured, and supportive way, such as displayed in self contoured drawing sessions, can help alter psychotic projections of the self, and aid in the overall psychotherapeutic rehabilitation of persons with schizophrenia. Specific symptoms, and how they appear as characteristics of the artwork of patients are related to specific art therapy methods for improvement. This description was from my article, "Art therapy used in treatment of schizophrenia," published in 1977 in *Art Psychotherapy*, listed in National Institute of Mental Health Literature Survey Series No.3, *Art Therapy in Mental Health*.

That quote was a description of the kind of art therapy that I have done for about 25 years. This type of therapy has been different from the spontaneous open-ended approach practiced by many art therapists. I have developed a series of art therapy sessions that are reality oriented, directed away from chaos and aimed toward self actualization and self esteem (for example, self contour drawings).

In conclusion, I have found that art therapy used in a positive, realistic, structured and supportive manner can help alter psychotic projections, and help aid in the psychotherapeutic rehabilitation of the schizophrenic population.

I plan to have more elaborate drawing examples to demonstrate in future issues. ♦

SULLIVAN THE CLINICAN

(continued from page 8)

Sullivan thus insisted on training his own personnel and, for the most part, excluded highly trained professionals from his ward. He, instead, turned to sub-professionals for work and interaction with his patients, claiming that the capacity of these staff members to do more than wish the patient well was a product of personality which had been established years before they became interested in caring for the mentally ill. He coordinated a team selected on the basis of personalities, which were suited in his mind to dealing with schizophrenics. The utilization of such a treatment team, he felt, could achieve results at complete variance (at least in cases of acute onset) with the schizophrenic patient's poor prognosis. ♦

[Ed. Note: This is the first of a three - part series]

Book Review



Several months ago, in one of our weekly telephone conversations, Ann-Louise Silver suggested that we do a book review of Paul Schilder's *On Psychoses* (ed. Laretta Bender, MD). I immediately resonated to this idea as I had been reviewing this book for myself to use in various papers and courses that I teach. I felt Ann and myself to be on the same wave-length in regards to those who are the significant historical figures in our field. The latter is an area of particular interest to Ann, and I have learned a great deal through her scholarship. It is quite humbling to me to see that many of the issues that we are struggling with today have been explored, and in some instances resolved, by our predecessors, e. g., the issue of primary narcissism in infants and in severely mentally ill individuals or clarification of the false dichotomy between functional and organic processes. In a recent interview between Marc du Ry and Donald Meltzer (1999), the latter included Paul Schilder in his list of clinicians who have made deeply creative contributions to our field. Meltzer counted Schilder among the likes of Freud, Abraham, Klein, and Bion. What attracted me to a study of Schilder's work is partly as a result of the time I first entered the field, his influence was felt in New York City through his colleague Laretta Bender, and partly because of my interest in exploring the mind-brain interface in general, but especially in the area of severe mental illness.

This volume covers a range of topics, including Schilder's views on the psychoanalytic theory of the psychoses, in particular, schizophrenia and manic-depression, and psychological factors in organic brain disorders. Rather than presenting an in-depth review of the collected papers included in this volume, I will focus on some key concepts in his thinking, particularly in relationship to his views on the psychotherapy of the psychoses. But first I will present some brief biographical details which are included in the preface by Laretta Bender.

Paul Schilder worked as a psychiatrist in the psychiatric division of Bellevue hospital in New York City between 1930 and 1940. Between 1928 and 1940, he wrote, in English, over 100 papers on psychiatry, neurology, psychoanalysis, and psychology, as well as five books. Prior to coming to the USA, Schilder had written over 200 papers and 10 books in German. Some of his books in English include: *Introduction to Psychoanalytic Psychiatry* (1925); *Medical Psychology* (1924); *Image and Appearance of the Human Body* (1935); and *Psychotherapy* (1938). Schilder died at the age of 54 in 1940. Books published subsequent to his

Paul Schilder, MD

On Psychoses

Brian Koehler, PhD

death included: *Psychoanalysis, Man and Society* (1951); *Contributions to Developmental Neuropsychiatry* (1964); and *On Psychoses* (1976). The latter was published by International Universities Press, Inc.

In an article on the psychology of schizophrenia, Schilder credited Eugen Bleuler for documenting the "overwhelming evidence...concerning the psychological determination of the majority of schizophrenic manifestations" (p. 310). In this article, Schilder challenged the traditional psychoanalytic view of narcissism, i. e., that the perception of one's own body takes place prior to the perception of the world or that the child has no interest in the outside world (this observation was made 40 years before Dan Stern's critique of traditional psychoanalytic theory on infant development). Schilder adhered to a Freudian metapsychology, but not without challenging concepts that did not match his extensive clinical experience with psychotic patients. Schilder concluded:

"We have come to a unified attitude concerning schizophrenic psychology. The schizophrenic threatened in early childhood withdraws into more secure positions. He tries to heighten the importance of the strength of his own personality...he uses primitive methods of defense...immobility and catalepsy or by negativism. He may also use the technique of violent attack...Primitive types of libidinal development occur...we find primitive stages of ego-ideal development. The primitive attitude also appears in the formation of language and thought processes...The primitive threat is revived by dangerous situations of everyday life. The threat of being destroyed leads to outbursts of aggressiveness which appear particularly clearly in the schizophrenia of children...One may speak with Jelliffe of 'a death threat overcome,' if one keeps in mind that this death threat comes from the depth of the organism and is a reflection of organic occurrences...Schizophrenia can be understood, at least in some degree, from a psychological point of view, and we may state that the organic process of schizophrenia is modifiable in some degree by psychological methods. The organic methods of treatment are at the present time even more effective, and it is to be hoped that their psychological analysis will help us to a deeper understanding of schizophrenia and will improve our psychotherapeutic and organic approach" (pp. 328-329).

In regard to the latter points of view expressed by Schilder, if as Luc Ciompi (1997) has suggested, that the therapeutic effects of neuroleptics have to do with their anxiolytic action, then anything that can help the patient reduce her/his sense of terror, will be ther-

On Psychoses from page 23

apeutic, including psychological, social, environmental and pastoral counseling interventions. One approach to a psychological understanding of the therapeutic action of psychotropic agents was described by Searles (1979): "...if the drug is of sufficient affective meaning for the therapist to have the function for him (and, presumably, for the patient also during some phase of the work) of a transitional object, then such drug therapy need not necessarily represent the kind of subjectively nonhuman intrusion into the psychotherapeutic or psychoanalytic relationship which I have tended to regard it as being" (p. 560). Psychotropic agents can be used as transitional object phenomena in the reduction of profound separation anxiety depending on the inner psychological/emotional stance of the prescribing physician.

In a chapter on the role of psychotherapy in schizophrenia, Schilder noted that although schizophrenia is an organic disease:

"...we must not believe that an organic disease cannot be provoked by psychic causes and cannot be influenced in a psychic way. We can understand any organic disease from a psychological point of view, especially organic diseases of the central nervous system" (p. 390).

Even if one were to assume a "pure psychogenesis" of schizophrenia, Schilder pointed out that we are dealing with a psychic and somatic situation. If schizophrenic symptoms represent a regression, Schilder suggested that this regression "proceeds to such deep layers that we may even consider this very primitive psychic nucleus of schizophrenia in terms of an organic change" (p. 391). Gustav Bychowski (1963), another Freudian psychiatrist-psychoanalyst, made a similar point.

Specifically in regard to treatment, Schilder listed three principles of psychotherapy in schizophrenia: psychic adaptation, organic utilization and organic change of compensating organs. He described the value of the psychotherapeutic process in schizophrenia: "psychotherapy takes away energies that are necessary to put pathological brain mechanisms into action" (p. 392). Schilder noted that every process in the body is dependent upon blood flow, which in turn can be regulated to some degree by the psyche. This means that there is at least the possibility that psychotherapy could positively alter organic processes (reparatory or inflammatory) or even change the conditions for a bacteriological infection. Psychotherapy, Schilder believed, could influence the immunization processes directed against viral infections or create favorable conditions for the recovery of an organic process (I believe that the field of neuroimmunomodulation is demonstrating that these conjectures of Schilder have a scientific basis). Schilder also observed that certain organic processes do not create

symptoms as such: "the symptomatology of an organic process will largely depend on the patient's psychic attitude" (p. 393).

In reference to a psychoanalytic approach, Schilder believed that with some patients, this could help lead to the "primary psychic conflicts." Ego and superego support need to be given as well as a fostering of the transference. One must help remove factors which provoke "excitement" in the patient and therefore pull her/him back from reality. Schilder concluded:

"One sees that psychotherapy is obligatory in every case of schizophrenia. The general principles involved concerning influencing organic changes have to be applied carefully with regard to the specific problems of schizophrenia. It is difficult to apply statistical methods to the problem of therapeutic results in schizophrenia at the present time. There is no question that one can do a great deal for the schizophrenic patient, but it cannot yet be decided whether we cure the schizophrenia or whether we help the patient to a better adaptation to reality and to his life problems" (p. 396).

When it comes to the actual therapeutic interaction between patient and therapist, Schilder is not a Searles, but his theoretical and clinical optimism is congruent with my own experience in a state psychiatric hospital and private practice setting. Schilder was not afraid to take on very difficult theoretical challenges, e.g., the mind-brain relationship, and the extent of his clinical theorizing and knowledge of psychiatry and its therapeutic import was encyclopedic. Schilder, is one of those clinician-theorists who, in the words of Leon Eisenberg from the Department of Social Medicine at Harvard Medical School, steers his theoretical boat between a "brainless psychoanalysis" and a "mindless psychiatry." This volume of his collected papers is a classic and Schilder's humanism shines through its pages. I hope this book does not get relegated to the dustbin of historical psychiatric texts.

Bychowski, G. (1963). The psychoanalysis of the psychotic core. In H. Azima, & B. Glueck (Eds.), *I. Psychotherapy of Schizophrenic and Manic Depressive States. II. Contributions of Basic Science to Psychiatry*, pp. 1-12. Washington, DC: Psychiatric Research Reports.

Ciampi, L. (1997). The concept of affect logic: an integrative psycho-socio-biological approach to understanding and treatment of schizophrenia. *Psychiatry: Interpersonal and Biological Processes*, 60(2), pp. 158-170.

du Ry, M. (1999). An interview with Donald Meltzer. In B. Burgoyne & M. Sullivan (Eds.), *The Klein-Lacan Dialogues*, pp. 177-185. NY: Other Press.

Searles, H. F. (1979). *Countertransference and Related Subjects: Selected Papers*. NY: Int'l. Universities Press, Inc. ♦

[Ed. note: "Psychotherapy of Schizophrenia: The Treatment of Choice," by Bertram Karon & Gary Vandenbos (1981), will be reviewed along with other selected texts in future issues of this newsletter].

POETRY

HIV Wars

Grace Jackson, MD

I know I'm not over it
when the note,
taped to the TV screen...

"We'll be back son...
Mom and Dad"

becomes the message my
parents should have written

the legs look the same —
sallow and thin
they speak to me
of the multiple tragedies that
have ravaged this HIV body
taken too soon

a military artist without my easel,
I study this landscape
laid waste in a way most people
associate with war...

staples, like tank tracks,
dot a stomach that was once secure...

stoma from the surgeons,
not a land mine...
but I bet it feels the same
to this soldier
who still shrinks and quivers
as much from fear
as a visceral torment
he seems to feel grenade blasts
in all those hands that will not touch...
all the ears that will not listen...
all the eyes that do not see

who meets his soul with the
gentle wondering
and the shared pursuit for meaning?

do we seek to slay the enemy
whose persona — in our ignorance —
we at times assume?

he feels the conflict of friendly fire
in small betrayals ...
each innocent oversight
or delay
becomes the combat
of his nasogastric impalement,
next gas attack
from the bowel distending

pain increasing,
he is made to feel guilty...
guilty about each morphine demand
until his PCA Elephant Man
cries out to us

"I am not an addict"

after rounds
I am back from the front again
sharing his battle fatigue.
I call the shell shock
of my final rotation

daily, the wave rolls over me
each time trying to hold me under...
threatening to wet my cheeks
with the streams of salt water
that never quite flow on their own ...

...never forming the scab
over the scar of separation
from the brother I loved
who lost his war
before I could prove
he was my hero.

Bridges

Reiko John Imazaki

there comes many times
when the bridges we cross
seem like the other end is out of reach
the bridge you are standing on
might be shaky and unsteady
and every step you take
seems to make the bridge sway back and forth
sometimes a title wave
might sweep you under
but your foundation
must be strong
don't lose your composure
search for the surface
and ride the wave out
down river it shall calm
that's when you stand and continue your path
and when you come to that bridge
which shivers with every step
take the time to show respect
as you place your foot
take it one at a time
you don't need to look at your destination
don't lose sight
just break it on down.

Musings of Bill*Bill Greene***Poem #6**

I am hiding because I don't want you to see
 My invisible self
 I am cautious of any sound
 That might make me
 Slip
 Out utterances I don't you to hear
 Or my moans when I hurt
 And passions I seek in silence

My nervous electricity can only be seen in my eyes
 But you must look deep or else you will despise
 The statue I appear to be
 Only please
 Don't disrespect me.

Poem #7

I wither when the sun shines
 But I'm a flower in the dark

I grow among the weeds
 Entangled in the marsh
 Wetness absorbs my energy
 Giving me the fluidity that release my passion

Sometimes I seek out the sun
 Just for a moment
 To remind her that lightness may be darkness
 In another life
 That black could be white
 And pureness, gray.

Untitled*Kathy Belarge*

She took my heart
 Maybe she needed it
 She replaced it with pain
 She did not know
 She would leave me
 With pain I live
 With emptiness
 I bear no cross
 I have no soul
 She got what she could
 And now she is gone,
 Where am I?

Untitled*Kathy Belarge*

Summertime comes and summertime goes
 But what I remember most is how I grew
 And how I learned to love the person with-
 In me and realized that my exterior is what
 I choose to let people see because the
 Tenderness inside of me cannot be let loose
 For fear I may melt away.

International Federation
 for Psychoanalytic Education
 IFPE Eleventh Annual Interdisciplinary Conference
 Psychoanalysis and Psychosis
 November 3 - 5, 2000
 Palmer House Hilton Hotel, Chicago, Illinois
 For information on this conference
 please contact:
 Michael Guy Thompson, PhD,
 Program Co - Chair
 2196 Union Street
 San Francisco, CA 94123
 (415) 346-0409
 Fax: (510) 524-4646
 email:michaelguy@aol.com

THE SECOND ANNUAL MEETING OF ISPS-US

The U. S. Chapter of the International Society for the Psychological Treatments
of the Schizophrenias and other Psychoses

Saturday, OCTOBER 7, 2000, 9 a.m.- 4:30 p.m.

**THE WASHINGTON SCHOOL OF PSYCHIATRY
5028 Wisconsin Avenue, Washington, D.C. 20016**

Creating Space to Talk to Patients

(In Memory of L. Bryce Boyer, M.D.)

- 9:00 **Christine Lynn, MSW** Program Chair. Welcome.
- 9:15 **Wayne Fenton, M.D** A History of Asylum in the U.S.
- 9:45 **Ann-Louise Silver, M.D.** Psychoanalysis and Psychosis in the U.S.
- 10:15 **Betty Oakes, Ph.D.** A case presentation.
- 10:45-11:45 **Panel and Open Discussion. Lunch will be served on site.**
- 1:00 **Sue von Baeyer, Ph.D.** Remembering L. Bryce Boyer, M.D.
- 1:15 **Anthony Lehman, M.D.** Current Challenges in Providing Psychological and
Psychosocial Treatment to Persons with Schizophrenia.
- 2:00 **Wilfried ver Eecke, Ph.D.** Philosophical Reflections on the P.O.R.T. Project.
- 2:30 **William Gottdiener, Ph.D.,** The Benefits of Individual Psychotherapy for
Schizophrenic Patients: a Meta-Analytic Review.
- 3:00-4:00 **Panel and Open Discussion followed by Reception.**

Registration: 8:30 a.m. Breakfast and Lunch included in the Registration Fee.

Fee: \$55 nonmembers; \$45 for members. \$85 join and register.

Information: Christine W. Lynn, M.S.W., Program Chairman, (202) 362 4852 or L699@erols.com.
Co-chair: Bonnie Oppenheimer, M.S.W.

Registration by Mail: Christine W. Lynn, MSW; 5324 39th St., NW; Washington, DC 220015, with check payable to ISPS-US.

We will offer continuing education credits to psychologists and social workers, through the Washington School of Psychiatry, and hope to provide these also for psychiatrists. Please register promptly, since we will move to a larger nearby hall if response warrants. The Washington School is approved by the American Psychological Association to offer continuing education for psychologists. The Washington School of Psychiatry maintains responsibility for the program. Continuing education credits are also available for social workers for 5.5 hours of credit.

The Modern Psychoanalytic Approach To Working With The Resistances: The Pre-Oedipal Patient

Harold Stern, Ph.D.

Introduction

In the previous article an introduction to the Modern Psychoanalytic theories and techniques of Hyman Spotnitz was provided. Its special application to the pre-oedipal disorders such as perversions, schizophrenia, and other psychosis was outlined and how Modern Psychoanalysis differs from the classical psychoanalytic technique developed by Sigmund Freud for the treatment of the neurotic disorders was discussed.

The prominent interpreter of Freud, Otto Fenechal, wrote that, "Everything that prevents the patient from producing material derived from the unconscious is resistance."¹ In his 1914 paper on remembering and working through, Freud made the point that the working through of resistances was now the heart of analysis. Although the topic was crucial, Freud never elaborated on it in any technical paper.

In his 1926 paper, Freud² conceived of five resistances to understand better the dynamics of his neurotic patients. He ordered these resistances in terms of his newly developed structural model of the mind, i.e., id, ego, superego, transference and secondary gain. Although his model was dynamic, Freud's specific resistances are not always clinically useful. For example, recognizing that a patient is manifesting a superego resistance does not in itself direct us to an effective intervention, especially when an interpretation would not be appropriate as with pre-oedipal patients, particularly schizophrenic ones.

In Modern Psychoanalysis, we welcome resistances as ways of assisting our patients to make progress in the treatment. There are certain clues and signs that can guide our recognition of these resistances. This paper will attempt to describe them.

The range of possible clinical resistance issues in working with disturbed patients is too large to categorize all of them. This would not only be futile, but would have little theoretical or clinical value. It would be more useful to take a different approach and paint with a broad brush that would include some special kinds of resistances that can confront us when working with the pre-oedipal patient (schizophrenia, psychosis, manic depression, etc.). First, however, we need to be able to recognize and then use these resistances as our tools to make progress with our patients. To begin, it may be useful to distinguish the pre-oedipal personality from the more mature Oedipal personality. One way to look at this is to compare the role of the teacher who works with the pre-school child to the one working with first graders. In contrast to the first grader, the pre-school child needs much direction,

can usually not follow instructions, has to be taken care of, and is often not yet completely toilet trained. This age level demands much more attention from the teacher who may employ emotional communication by expressing feelings and empathy for and with the child rather than intellectual direction. The first grader is much more capable of sitting quietly in his seat, following directions, and being cooperative with the teacher. Some teachers prefer and are much better working with younger children, while others cannot easily tolerate the younger child and need to work with older children. We can make a rough comparison of the younger child with the pre-oedipal patient and the older child with the Oedipal patient. Similarly, the different techniques used by teachers with different age groups are not unlike the different approaches used by therapists according to the emotional maturity of their patients. Going further with these analogies, some therapists are comfortable, or at least can tolerate working with pre-oedipal patients, while others are not. Therefore, the technique must be adjusted to the nature of the patient and often also to the personality of the therapist.

For pre-oedipal patients interventions may be needed that utilize emotional factors rather than, intellectual. If, for example, the patient says, "I cannot come here, this place has a bad smell," the analyst might reply, "I am thinking about calling a company and having this whole place fumigated." This is a response that is object-oriented which means that the analyst avoids directing stimuli towards the patients ego. If successful, the intervention may retard the patients wish to leave treatment.

After many years of working with many schizophrenic patients, Spotnitz² has delineated five pre-oedipal resistance patterns that can be dynamically more suited to working with more disturbed patients. They are described as follows:

The treatment destructive resistance.

Most pre-oedipal patients lack object constancy, often have a history of broken relationships with people, and usually have difficulty staying in treatment long enough to make any progress. They may have a history of having seen many therapists. The patient who threatens to leave the treatment because of a "bad smell" presents an example of a treatment destructive resistance. The therapist's object oriented response is an example of emotional communication designed to resolve this resistance. Expecting this kind of resistance prepares the therapist for the process of confronting and resolving it.

Continued on page 29

The status quo resistance

When the treatment destructive patterns are no longer operative and the patient is accustomed to the routine of coming to the analyst's office and just chatting, the analyst can begin to sense that although there is some minimal activity, there is little movement forward. The patient in this phase is mainly interested in maintaining where he is. He does not want to change what he has for something that is unfamiliar and possibly dangerous. He clings to what he has like a child clings to his blanket and the therapist may welcome the security of not having to cope with his patient trying to destroy the treatment. The therapist may also wish to leave things as they are.

As this pattern becomes evident, the analyst must begin to explore how the patient feels about just "drifting". Where might this lead? (Should the analyst do something about this or let the treatment just drift?) The analyst might inquire, "How am I doing conducting this treatment? Am I earning my pay?" "Why am I not helping you make more progress?"

The resistance to progress

The change for the patient from holding on to the old and familiar to considering undertaking anything new, is a formidable task for the analyst and the patient. The patient communicates the idea, "Leave me alone. I do not want things to be different." There are many ways that the patient can express his aversion to moving forward. There may be pleas of "tell me what to do". But at the same time, patients often cannot talk about their thoughts and feelings without promptly inserting negative fantasized consequences. One must also be alert for those patients who are negatively suggestible and if given advice will do the opposite. Examining all of the possible consequences of a feared new activity is important in resolving this resistance.

The resistance to cooperation

Studying the patterns that interfere with cooperative functioning between patient and analyst are of little use before the previous three resistances have received considerable attention. By this point, the patient will have learned to express himself freely, consider and absorb the comments given by the analyst, be able to stay in the present, rather than escape into the past, be able to reflect on the past without losing his orientation to the present, and have some control over feelings of hostility both towards the self and the analyst. He is now able to become a willing and attentive participant in the understanding and solving of his difficulty with his internal problems and external relationships ... A patient complaining that he cannot find employment is asked by the analyst, "Would you like me to help you find a job, or find one for you?" The patient may respond, "Isn't this something I should be

doing for myself?" The analyst says, "Why can't I help? A pilot can fly the plane himself, but he can fly it better with a co-pilot." Often inherent in this resistance are elements of transference.

The resistance to terminating

This period is also one of testing the ego development of the patient. Old conflicts thought to have been resolved can re-appear. Issues that have been dormant can raise their heads and new ones can develop. This is not so much a time of stopping as much as examining the issues connected with stopping. Stresses thought to have been worked through can now come up again causing anxiety about separation. It is a period of thoughtful study and examination. The working through of the issues in the previous phases brings about a maturational state that allows for either the continuation of the treatment, (if there is a mutual understanding of how this can be beneficial) or termination, if both the analyst and patient agree on this. It should be a decision cooperatively agreed upon.

Summary:

In this article an attempt was made to describe the Modern Psychoanalytic theories and techniques that Hyman Spotnitz developed and his special resistance formulas for the treatment of the pre-oedipal patient. Freud's focus on resistance as a fundamental aspect of psychoanalytic treatment remains a primary leg upon which the treatment stands. This approach may be considered an earlier step that would lead to the possible use of Freud's id, ego, superego, transference, and secondary gain resistances for the final phase of treatment.

Footnotes

- 1 Fenichel, O. 1945, *The Psychoanalytic Theory of Neurosis*, New York, W.W.Norton.
- 2 Spotnitz, H. 1985, *Modern psychoanalysis of the schizophrenic patient* (2nd Edition) New York, Human Sciences Press, Inc.♦

Contributions to ISPS - US Newsletter

The Newsletter is a reflection of our individual members, therefore contributions are highly welcome. Contributions can include clinical and theoretical papers, interviews with significant figures in our field, poetry, book reviews, program descriptions, conference announcements, letters to the editor, etc. Only material on disk or e-mail are accepted for publication. Please direct all questions or contributions to:

Brian Koehler, PhD
 Editor, ISPS - US Newsletter
 80 East 11th Street, #339
 New York, NY 10003
 (212) 533-5687
 e-mail: bkoehler7@compuserve.com

**DEADLINE for Fall Newsletter
 October 31, 2000**

The Psychoanalytic Psychotherapy Study Center
New Perspective Series presents

**Storm Warning:
Recognizing and Treating Mild to Moderate Forms of Manic
Depression in Analytic Patients**

All day Saturday & Sunday Morning, NOVEMBER 18-19, 2000

The Auditorium at the New York Blood Center
310 East 67th Street between First and Second Avenues, New York City

PROGRAM

Saturday, November 18, 2000

- 8:15-9:00 am Registration and Continental Breakfast
9:00-9:10 am Welcoming Remarks: Judy-Levitz, PhD, Director of the Psychoanalytic Psychotherapy Study Center
9:10-9:30 am Opening Remarks and Introductions: Harriet Pappenheim, CSW, BCD, Chair
9:30-10:15 am Differential Diagnosis of the Manic-Depressive Spectrum, Paul Geltner, DSW
10:15-10:45 am Discussion 10:45-11:00 am Coffee Break
11:00-11:50 am **Keynote Address: Psychological Aspects of Manic-Depressive Illness, Kay Redfield Jamison, PhD**
11:50-12:30 pm Discussion
12:30-2:00 pm Lunch
2:00-2:10 pm Introduction of the Afternoon Program
2:10-2:55 pm A Psychoanalytic Framework for the Psychotherapy of the Manic Depressive Patient, Jeffrey Deitz, MD
2:55-3:25 pm Discussion
3:25-4:10 pm The Razor's Edge: The Struggle to preserve Self and Object Relations, Brian Koehler, PhD, followed by Discussion (4:10-4:40 p.m.)

Sunday, November 19

- 9:00-9:30 am Continental Breakfast
9:30-9:40 am Introduction to the Morning Program
9:40-10:20 am Psychopharmacological Consultations, Ivan Goldberg, MD
10:20-10:40 am Discussion
10:40-12:30 pm Brief Clinical Vignettes presented by psychoanalysts describing their experiences treating patients with a range of manic-depressive conditions
Discussion and interchange with the panel and with the audience
12:30 pm Closing Remarks

Using Anger Well *from page 12*

Footnote

¹ Bronx REAL is located at 55 Westchester Square, Bronx, NY. An outpatient site of the Jewish Board of Family and Children's Services, the REAL provides long-term psychiatric, psychosocial and rehabilitative services to adults with Axis I diagnoses of psychotic and/or mood disorders, as well as adults with Axis II diagnoses of incapacitating personality disorders.

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21 Jefferson Avenue
Hastings-On-Hudson, NY, 10706
Email: micaltcsw@msn.com

Response to Harold Stern from page 11

resolved. I, on the contrary, stay away from such practical issues as much as possible, so that the patient will feel I am in his world not trying to force him into my world. The metaphor I frequently use in regard to the Spotnitzian questions is: it is rather like trying to make someone grow by pulling his hair up. Even if one did that, the problem that is preventing him from growing is still an obstacle.

In general, I find Spotnitz overly concerned about regression. I think that if one really understands that the conflict is within the unconscious, regression is not a problem. When unconscious conflicts are resolved, the ego will make its appearance on its own. I think that like plants, once the seed is planted and nourished, they will fulfill their own genetic destiny. It seems to me that if the analyst constantly addresses the resistance, it is similar to giving a baby a diet of only cod liver oil, rather than nourishing milk.

This brings us to the all - important questions of comfort. As one of my patients once said to me, schizophrenia is the concentration camp of the mind. Why make the patient, who is already suffering so acutely, suffer even more by constantly working on resistances and not offering interpretations? For example, why put a patient on the couch where he will be more anxious because he can't see the analyst?

Getting well is so difficult and so painful for the patient. Surely it seems more sensible to me, that if we are to achieve the least amount of resistance and the fastest progress, it behooves us to help the patient get as comfortable as possible. Of course, the patient must face his or her fears eventually. Anger, shame and guilt must finally be confronted, but why not make it happen with the least amount of distress?

Again, I wish to express my gratitude to Dr. Stern for making such a clear presentation of Dr. Spotnitz's work.

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Reflections on Stavanger from page 14

The Lesson of Geographical Determinism?

My feelings about Stavanger and ISPS are ambivalent, but not despairing. I feel like Dorothy who travelled to Oz, only to find that the Wizard was not home. I was disappointed to find a lack of easygoing, casual interaction among the program participants, but I was uncertain if this distance or aloofness was a product of my own withdrawal. I did not know if the "silence" into which I found myself sinking was my own creation, fact, or fiction. Now, it seems, the deafness or isolation I felt may have reflected the emotional and spiritual containment of those attendees who, like myself, watched in horror as they witnessed the minimal attention accorded the psychodynamic ideals which they expected the conference to obstreperously defend.

There is, throughout history, a curious phenomenon that geography co-creates destiny. Put another way, the land can shape the man. It seemed that one lesson of Stavanger was the way in which the darkness and coldness of the long Norwegian winters (metaphorically capturing the pendulum swing to short-term therapies, programmed interventions, and phase specific treatments) might lead to the dampening of man's humanistic interactions. It made me hope that the next ISPS meeting in Australia might have a boomerang effect which would be true to its Southern Hemisphere surroundings. ♦

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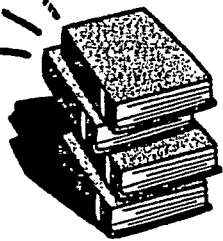
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