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

ISPS-US Thirteenth Annual Meeting
Making Contact with the Depths: Psychosis as it is Lived

October 26-28, 2012
At the Chicago School of Professional Psychology
325 North Wells St., Chicago, IL 60654

ABSTRACTS
(In chronological order)

Friday, October 26

5:45-7:15 p.m. Daniel Mackler, LCSW-R, Film and Discussion: *Open Dialogue*
The film *Open Dialogue*, by Daniel Mackler, will be screened, and he will lead a brief discussion of this and similar programs in the world.

Saturday, October 27

9:30 a.m.-10:45 a.m. Keynote Address: Danielle Bergeron, MD, FRCPC, FAPA
From Psychotic Experience to Civic Responsibility
For the last 30 years, the psychoanalysts and psychiatrists of GIFRIC together with a multidisciplinary treatment team have risen to the challenge of treating psychotics elsewhere than the hospital and otherwise than with medication. Their clinical work consists in guiding patients from psychotic experience to civic responsibility. In order to work in this manner, they refuse the form of discrimination that consists of supposing psychosis to be a deficiency due to a brain disease. For the young adults who ask for treatment, the Center for the Psychoanalytic Treatment of Psychotics in Québec, the 388, offers comprehensive treatment apparatus founded upon a psychoanalytic practice that has been renewed with them specifically in mind. Such an approach opens a space in which it is possible to speak about experiences lived in utmost solitude, beyond the field of language, tormenting the body and dismantling the imaginary. To uphold a place within the social bond for a wish that haunts the patient's unconscious, to give psychotics the freedom to think, to speak, and to act, in active negotiation with others—such is the objective of our work. The entire organization of the Center is conceived in view of this objective. Examining some examples, then, my lecture will discuss the organization of the 388, how it operates, the concepts that underlie psychoanalytic practice with psychotics, and the results obtained through this practice.

11:00 a.m.-12:00 p.m. Concurrent One-Hour Papers
A. Joanne Greenberg, DHL. *Waiting for Tonto: Making the Best of What We Have*
Two currently prevalent beliefs have been circulating within the mental health community for a while now, which have increasingly concerned me. One belief is a fundamentally messianic one: That if we can only hold out long enough, our health care system will see the light in such a way that we will finally have the resources we need to provide real treatment. The other is fundamentally paranoid: That social orders are purposely, on some broad or organized scale, standing in the way of efforts to provide mental health services where they are needed. Alternatively, I plan to orient my talk along a more positive path, by offering a discussion of the ways

in which we might at present make the most of the resources we currently have. I will highlight peer counseling models, the potential for volunteerism that makes a difference in the mental health field, and groups such as the Hearing Voices Network as potential resources that can move our community from a state of helpless waiting to a more active growing force for health.

B. Ronald Abramson, MD. *Mind, Brain, and the Nature of Psychiatry: Principles of Treatment*
Psychiatry is the medical specialty that deals with the diagnosis, treatment, and prevention of mental and emotional disorders: that is, disorders of the mind. On a more conceptual basis, the mind is said to be an emergent property of the brain. But it has also been suggested that consciousness is a fundamental property of the Universe and the brain is like an antenna which receives and focuses this property into a mind. The activities of the brain can be objectively observed using the methods of physical science, but the activities of the mind can only be observed subjectively either through introspection of one's self or through empathic communication with another.

In the early and middle twentieth century, disorders of the subjective mind were the focus of mainstream psychiatry and psychoanalytic thinking was the chief mode of understanding these disorders. However, problems in diagnostic reliability and scientific rigor, advances in pharmacological treatment, and the development of new technological methods of imaging the working brain have led to a shift in emphasis to biological reductionism. Now in mainstream psychiatry, mental disorders are defined as "brain diseases," with the subjective mind relegated to "maladaptive thoughts" or to not even exist. Powering this change is not only a mindset toward "hard science" but a result of economic forces which make it more profitable to prescribe drugs than to spend time listening to patients in order to understand the structure and function of their mind.

Although the biological reductionistic focus may seem more scientific, excluding the consciousness, the mind, from consideration is not scientific at all and may, in practice lead to clinical error. Cases will be presented that will document how exclusive reliance on DSM objective criteria led to mismanagement and put patients at risk. Psychiatry must recover the subjective mind.

C. Anne Marie DiGiacomo, MSW, LCSW and Blake Baily, MA, LPC. *Cultivating Openness, Awareness, and Compassion in our Deep Relational Experience Within a Windhorse Therapeutic Environment*
The Windhorse therapeutic approach was developed in 1981 by Chogyam Trungpa and Dr. Edward Podvoll. It is based on the Buddhist understanding of fundamental health, fundamental sanity, and the inseparability of one's entire life from one's environment, while integrating applicable Western psychology. The primary activity involves creating whole person, individually tailored, therapeutic living environments for people with a wide variety of mental health recovery issues.

Within this therapeutic approach, we recognize that one's psychological depths are home to health, intelligence, compassion, fears, loneliness, madness, as well as robust interpersonal activity. We can intuit and experience this interpersonal activity, and through relatively recent brain research, our deep relational interconnectedness is being born out more concretely. As psychotherapists with our clients, we are continually in contact with each other in these depths, whether we are aware of it or not. The contemplative practice of TONGLEN, sometime referred to as SENDING AND TAKING, offers a way for the therapist to bring intention, compassion, and awareness to the process of deep interelatedness. This then cultivates openness and invitation to the relational depths, fostering trust, alliance, mutual recovery, and resilient health for the therapist in the face of his or her own madness and that of the client.

In this presentation we will briefly describe the Windhorse therapeutic approach, then discuss the principles and therapeutic implications of TONGLEN in psychotherapy with people in extreme mental states. We will also introduce the actual practice in an experiential period.

D. James E. Gorney, PhD. *The Psychosis Of Everyday Life: Clinical Implications*
In 1901, Freud charted the many ways in which unconscious conflicts can explode into the fabric of everyday life. In 1947, Sullivan observed that because "we are all much more simply human than otherwise," psychotic

experience "is made up of interpersonal processes with which each one of us is or historically has been familiar". This panel will draw upon clinical material to demonstrate how traumatic unconscious conflict activated within psychoanalytic psychotherapy can precipitate the emergence of psychotic phenomena in otherwise non-psychotic individuals.

Following Sullivan, many previous investigators, such as Harold Searles, Otto Will, Francoise Davoine and Jean-Max Gaudilliere have deeply illuminated multiple aspects of the psychotic state as an extreme human response to unsymbolized trauma. In the clinical material to be presented here the focus will be upon how such extreme states explode as episodes of madness within the lives and therapies of otherwise non-psychotic subjects. That we all live on the edge of madness is a truism which can emerge with dramatic force within the crucible of transference/counter-transference struggles within the psychoanalytic/psychotherapeutic situation.

Such episodes of unexpected psychotic experience will require the clinician fluidly and flexibly to modify his or her technique. A willingness to engage in symbolic enactment, the creation of transitional space, and other forms of active engagement with the fabric of madness may all become necessary in order to respond to the collapse of normative symbolic, therapeutic exchange. This panel will contend that when psychotic experience erupts into the everyday life of the individual, a fruitful possibility emerges for understanding and resolving a zone of previously unrecognized trauma. Through permitting psychotic phenomena to emerge within the social link of the psychotherapeutic dyad, it may then become possible to integrate this madness into the fabric of everyday life.

1:00-2:30 p.m. Concurrent Panels

A. Frank L. Summers, PhD, ABPP and Katherine Taylor, MA. *Live Supervision/Case Presentation*
This program will consist of a case presentation of a severely disturbed patient with psychotic anxieties and/or psychotic symptoms. The case will be discussed from the object relations viewpoint. Emphasis will be placed on the application of Winnicottian and neo-Winnicottian ways of thinking about patients suffering from psychotic anxieties. Although theoretical concepts will be utilized, the focus of the program will be on the application of these theoretical ideas to technique. The goal of the discussion will be to provide concrete ideas on how to intervene with such patients. The primary emphasis will be clinical strategy and how to utilize the therapeutic relationship in the treatment of patients suffering from psychotic anxieties and symptoms.

B. Michael O'Loughlin, PhD, Duygu Secil Arac, MA, Jay Crosby, PhD, Almas Merchant, MA, and Katharina Rothe, PhD. *Psychosocial and Phenomenological Inquiry into Chronic Psychiatric Disability: Preliminary Reports*
Participants in this session share common interests in phenomenological and interpretive approaches to understanding the psychoses; they are committed to interpretive qualitative inquiry, and where possible, to collaborative research that involves psychiatric sufferers as co-inquirers. All are part of the same research team. Following three years of collaboration at Austen Riggs Center, Marilyn Charles and Michael O'Loughlin have initiated a project to collect new data at Austen Riggs Center and at Fountain House in New York City. The focus of the research inquiry is on (1) core dynamics; (2) traumatic antecedents and psychosocial stressors; and (3) experience of "being a patient" including phenomenological and cognitive understandings of psychosis, notions of internalized stigma, and facilitative or non-facilitative effects of the care currently experienced in each setting. The conceptual and methodological framework of the research will be explicated and preliminary results will be presented by Michael O'Loughlin, Secil Arac and Ally Merchant. Jay Crosby will present a complementary clinical case study. Katharina Rothe is developing a complementary inquiry into the perspectives of professionals who treat the psychoses and she will present her methodology and some preliminary results from her ongoing work. Time will be reserved for audience questions.

C. Aaron Mishara, PsyD, PhD, Kelsey E. Clews, MA, Megan Kolano, MA and Natasha Reynolds.
Self, Depths and Spirituality: Phenomenology of Psychosis and Healing
1. Spirituality, Psychosis and Healing: A Case report of Living on the Edge. Megan Kolano, MA and Aaron Mishara, PhD., PsyD

For the whole of recorded history, humans have narrated stories of mystical happenings, contact with other worlds, and visionary spiritual experiences of transcendent and maddening proportions (Lukoff, 2011). In many cultures, such contact with the divine signifies the beginnings of a healing spiritual journey; while in others, a "spiritual emergency" is easily reduced to and mistaken for an undesirable psychotic process. Where does transcendent mystical experience overlap with psychosis? And at what point does the difference become clear? Through a clinical presentation of a young woman's journey into and out of a world of angels and demons, we will explore the transpersonal concept of spiritual emergency within the medical culture of our time and wonder how one traverses the precarious landscape of spiritual madness in doing clinical work from a psychodynamic perspective.

2. Distinguishing Spiritual Emergency from Psychosis in Early Schizophrenia: How Phoenix Arises from the Ashes. Kelsey Clews, MA and Aaron L. Mishara, PhD., PsyD

Phenomenological Psychiatrists (Binswanger, Conrad, Jaspers) describe a prodromal period of delusional mood which gives way to delusions of self-reference that eventually resolve the crisis of loss of self in early schizophrenia. In comparison, there is a long tradition of healers who deliberately put themselves into psychiatric crisis, including altered states of consciousness (ASC), which often resembles psychosis, as part of their initiation ritual (Lukoff, 2011; Mishara and Schwartz, 2011). What is the difference between the healer's self-induced spiritual emergency and the onset of psychosis in schizophrenia. We propose that what is present in the spiritual journey of the healer but lacking in the psychosis of schizophrenia is following a period of fragmentation or death of the ego, there is a transformation of self that allows for a greater connection between internal experience and transcendent being beyond the self. The delusions of self-reference in schizophrenia suggest the loss of the ability to transcend one's current perspective (Binswanger, Conrad, Jaspers) by attempting to reestablish the self without spiritual healing, without rebirth of the self from its own ashes. We use the metaphor of death and rebirth of the self (Tibetian Book of the Dead, Jung's depth psychology) to distinguish the qualitative differences of the phenomenology of self in the two states. We also bring similarities and differences in the neurobiology of these different types of ASC.

3. Does Depersonalization have the same phenomenology, unconscious depth processes and neural mechanisms in psychotic and non-psychotic disorders: The case of Delusional Misidentification Syndromes? Natasha Reynolds and Aaron Mishara, PhD, PsyD

The construct of human self and how it is affected in different mental and neurologic disorders is complex. One approach to self is to examine the phenomenology of depersonalization in which the experience of self is directly affected. While depersonalization disorder is a unique disorder that stands alone in the DSM IV TR, symptoms of depersonalization are present in the phenomenology of both non-psychotic and psychotic states. Nevertheless, it is not known whether depersonalization is the same phenomenon across disorders. Is it the same phenomenon experienced more intensely on a continuum, or is the experience of depersonalization qualitatively different in psychotic vs. non-psychotic disorders? To what extent do unconscious structures contribute to this phenomenology? The answer to these questions has implications for the treatment as well as understanding the underlying neural mechanisms. As an extreme form of depersonalization, we examine Cotard's and Capgras' syndromes, which are delusional misidentification syndromes (DMS). Notably, a "delusional mood" (Jaspers, Conrad) in which the self is already experienced "as somehow" different or transformed is present in prodromal and in the early course of schizophrenia, just prior to the onset of delusions. Phenomenological descriptions of patients' subjective experience are presented. By employing qualitative-phenomenological research method to these accounts we attempt to determine to what extent the same structure of depersonalization is implicated across the disorders as well as the role that unconscious processes may play a role in the experience of disrupted embodied self in depersonalization.

D. James Ogilvie, PhD and John Shaw, PhD. Discussant: Jean-Max Gaudillière PhD

Contact with "the Problem Itself: "Introducing Bion's Approach to Psychosis

This panel will consist of two presentations, exploring Wilfred Bion's account of psychotic experience. Bion is consistently suspicious of any understanding of psychosis that is not rooted in direct experience. The difficulty describing psychotic experience is of great significance to him. He notes that though he is not confident he can describe the emotional experience of psychosis, he is confident he can evoke it in us. The need to evoke in us

what cannot be more directly articulated is linked, for Bion, to his understanding of psychosis as fundamentally involving a crisis in the possibility of experience itself. Through vivid metaphor and startling imagery, Bion brings us to places where the capacity to mind, to think, to feel is in question or under attack. He reveals a dimension of being within which the fundamental capacity for a sense of aliveness is in doubt and, as the panelists will seek to show, in a basic sense under investigation. We are introduced, as Bion puts it in Cogitations, to experiential states where "the problem of emotional experience is itself the problem." Here, "there is...no way of regarding the problem 'as' anything at all." Strikingly, it is by virtue of bringing us into direct contact with such states in ourselves, by questioning our illusions of knowledge in these areas, that Bion's work may open access for us to a different point of view--one described by him as the "psychoanalytic vertex," which in an important sense cannot be known or captured, but can be felt and lived. The panelists will develop several of Bion's key images of psychosis, seeking to foster a reflective atmosphere in which a therapeutic resonance with psychosis might be found. Some clinical implications of Bion's approach will be considered in discussion with the audience.

2:40-3:40 p.m. Concurrent One-Hour Papers

A. Bertram P. Karon, PhD, ABPP. *Who am I to Treat This Person? What We Feel When Treating Seriously Disturbed Patients*

Who am I to treat this person? That's what came to mind every time I treated a seriously disturbed patient. I don't know enough and I have hangups. But no one knows enough, and every therapist has hangups, although our own analysis helps. We may feel confused, frightened, angry, or hopeless because these are the patient's feelings. Discussed are creating rational hope, dealing with feelings (including terror), depression, delusions, hallucinations, and suicidal and homicidal dangers. Theory is helpful, but it is not enough. Tolerating not knowing often leads to effective improvisations. Best results were obtained with psychoanalysis or psychoanalytic therapy without medication. Next best was psychoanalytic therapy with initial medication withdrawn as rapidly as the patient can tolerate. Electroconvulsive therapy is discouraged.

B. Paul Gedo, PhD. *Transference/Countertransference Repetitions of Traumatic Affects*

This paper addresses technical challenges in working with patients who cannot describe their affective experiences in discursive language. I explore certain moments of shared affective experience—first expressed either as enactments, as concordant or complementary countertransference reactions, or as powerful but wordless mutual feeling states—and ways these foster therapeutic growth. These patients require assistance in naming, describing, and thinking about their affective reactions. Their defenses against emotional experience create deficits in cortical control. The difficult dyadic work of naming, containing, considering, and modulating affects gradually ameliorates these deficits.

C. Elizabeth A. Johnson, PhD and Kathy Steinmetz, MS. *Swimming in the Deep End: Using Behavior and Insight to Guide a Life Well-Lived*

Schizophrenia occurs four times more often in people with intellectual disability than in the general population. The presentation of schizophrenia in people with intellectual disability is similar, with the exception of increased behavioral changes. Persons with schizophrenia and mild mental retardation have been shown to benefit from psychotherapy and other psychological treatments such as psychosocial and behavioral therapies.

One benefit of studying schizophrenics with intellectual disability is the knowledge about the illness gained by studying behavior that may otherwise be inhibited. Unusual, cause-related behavior is another language that can assist in telling the lived experience of someone with schizophrenia. Behavior is particularly informative if the individual shows openness and insight into his/her behaviors and if his trained caretakers can bring additional observations and theories into the equation.

This presentation features a case study of a man with paranoid schizophrenia and mild mental retardation who has demonstrated extraordinary fortitude in the face of multiple adversities. Diego's psychologist is the leader of his treatment team and works with him in individual psychotherapy. Together they also design behavior treatment plans that are followed by everyone on the treatment team. Diego has the difficult task of managing a relationship with a therapist who invokes behavior plan consequences for him as well as works with him in

psychodynamic therapy. Diego's illness is stable but his residual paranoia results in odd and sometimes bizarre behavior in the community. His insight allows for the language of his life to be accessible and unusually informative.

This presentation includes information from the members of Diego's treatment team as well as segments from his therapy sessions. The presenters attempt to integrate the elements of Diego's treatment and to make contact with the depths of his psychosis as it is lived.

D. Susan E. Mull, PhD. *Protest Language of the Abject*
In the experiential territory shared between states of trauma and madness, abjection often holds a central place. In the place of abjection one feels reduced to the position of the sub-human, the cast-away, to the unholy and defiled one. Often, in the presence of the Other, a personal-sense-of-being dissipates and disassembles, and the ability to communicate one's pain in coherent language falls away. The only language accessible is often the pre-language of cries, screams, whimpers, word-fragments, and concretized images.

Within this experiential language lies a discourse of pain, but also a discourse which precedes pain, a root language embedded in the vastness of human communication. The purpose of this paper is to demonstrate how the language of the abject is best understood as not simply a language of unsymbolizable pain, but as a language of protest, calling humanity to struggle against forces of the abject, as they manifest psychologically , socially and culturally. Two cases are presented for discussion. In each, the focus is on the pre-language of the abject and how it functions as both a cry of resistance, and a call for solidarity.

Please Note: this presentation includes some disturbing visual and verbal material, and may not be suitable for all conference participants.

4:00-5:00 p.m. Concurrent One-Hour Papers
A. Patrick B. Kavanaugh, PhD. *On the Mystery, Magic and Muscle of Communicating with the Madness of Self and Other*
Each of us has a story to tell. And in its telling to another, we reveal something about the history and mystery of who we are, where we come from, and how we have imagined ourselves into being. This paper is about the story of how he came to be as told over a five year period of time by a man on the inpatient unit of an inner-city state hospital. It reflects the palpable and mysterious experiences of psychic transformation as it is lived in the telling of his story to another.

In the context of illustrative material, this paper is organized around a shamanic way of thinking, being and presencing that, in effect, allows–and encourages–the practitioner to make contact and communicate with the madness of the other (of self). Its focus is on the process of listening, understanding and responding to the madness of self and other when premised on the Freudian unconscious. Its emphasis is on a magical (as opposed to a medical-scientific) visionary experience. In so doing, it invites the voice of madness into, at once, the practitioner's psychology, space, and discourse.

Along the way, consideration is given to some of the more prevalent institutionalized fears of madness that are so deeply embedded in the master narrative of the medical-scientific tradition, are embodied in our mainstream psychoanalytic psychologies, and come together to foreclose on making contact -much less, communicating- with the depths of madness.

B. Annie G. Rogers, PhD. *Ghosts from the Ineluctable: Psychosis and the Enigma of Language*
In this presentation I will speak to my own experience of psychosis as a teenager and young adult, and my life beyond that time following psychoanalysis. My experience involved hearing voices, working to transform language, and a conviction that various beings inhabited my body through invasive objects. These ghosted workings of the ineluctable have changed for me over time–and I will attempt to describe how I understand them now. I will use this experience from the depths to consider how language transformations create ghosts

that are, in fact, truths from psychosis-drawing on the micro fiction of Robert Walser, the poetry of Tomas Transtömer, and the writings of psychoanalysts Jacques Lacan and Willy Apollon.

C. Ann-Louise S Silver, MD. *Chris Burford Memorial Lecture: Christopher Burford, MD: His Contributions to ISPS*
Chris Burford contributed mightily to ISPS, predominantly through his creation of and contributions to the listserve of ISPS. He served on the Executive Committee of ISPS, and regularly flew across the Atlantic to attend our annual ISPS-US meetings, all this while struggling with a chronic and ultimately fatal illness. This talk pays tribute to his contributions, acknowledging the intensity with which he raged against the dying of the light.

D. Daniel Mackler, LCSW-R. *The Underlying Principles of Various Successful Psychosis-Oriented Programs*
I have spent the last two years traveling around Europe and North American visiting about a hundred different psychosis-oriented programs. I have spoken with clinicians, consumers, former consumers, and family members and at each program have been studying what works and what doesn't. What I have observed is that most of what is out there doesn't work particularly well. However, there are a few programs that do work fairly well, and some that work beautifully. I have examined these programs carefully in order to parse out the principles upon which they are based. My talk will explore these principles and the ramifications of each. Interestingly, these principles are not very complicated and in most cases are quite logical -- even to non-professionals, and sometimes especially to non-professionals. This highlights a main problem hindering a wider acceptance and use of these principles: that by and large they go against the mores of the traditional psychiatric and mental health field as well as the training of so many mental health professionals.

5:10-5:40 p.m. Concurrent Half-Hour Papers
A. Bill Gorman, PhD, ABPP. *The Helper's Balance When Encountering Trauma and Suffering*
The helper engaging with an individual in distress may be confronted by two opposing dangers. The first is enmeshment in which one becomes overly absorbed experientially into the person's plight with the consequences of transgressing essential boundaries or developing secondary trauma. The second is detachment in which one becomes defensively removed from any real appreciation of the plight with the potential for connective failure or burnout. The solution for avoiding both outcomes is to work figuratively with "one foot in and one foot out," a dualistic stance often easier cited than effected. It is also a balance constantly shifting, within and between meeting intervals, and even more so from one individual to another and one cultural framework to another.

This complementarity can require acute self-awareness, self-care, and flexible equilibrium on the part of the helper. In one classic therapeutic system, it was referred to by Harry Stack Sullivan as the dynamic process of participant/observer. It encompasses the dialectic simultaneously of seeking subjectively to understand phenomenologically, or from "within," the other's reality while also maintaining objectively a more critical monitoring of theory, context, and one's own reactions, including counter-transference. The former aspect is a function of one's empathic and relational capacities, and the latter draws upon one's psychological knowledge, self-reflection, and use of training, consultation and supervision.

Both sides present challenges of continued development for the helper, demanding honest humility in acknowledging that in every endeavor to engage there can be more to learn, about both oneself and the other. And it is all the greater when the other is in some respects in extremis, for example, by reason of a psychotic condition, a severe trauma, or a significant cultural difference. However, this presentation will argue that the common existential grounding and a disciplined compassion for the other can bridge many such chasms with benign effect.

B. Mihaela E. Bernard, MA, LPC. *A Case of Childhood Psychosis: The Emergence of the Subject*
The paper presents the ongoing treatment of a case of childhood psychosis with respect to the question of the emergence of the subject via imaginary play with a counselor in a residential milieu treatment setting. The paper outlines an attempt to make contact with the subject of an 11-year-old boy, diagnosed with Schizoaffective

Disorder and inhabiting a body marked by the jouissance of the Other that knows no limits and has to fight in order to find them. It describes a counselor's attempt to listen beyond the obsessive and narcissistic defenses of an otherwise powerless boy and to provide a venue for symbolization through play of that, which cannot be spoken about. What was Real and impossible for verbalization found its way to the symbolic order in the encounter of the subject with the desire to know of the counselor.

The presentation includes drawings, produced by the patient in the course of the treatment, that mark the developments of the unconscious image of his body from the depths of psychosis to the space of the social link. The paper also poses questions regarding the early psychoanalytic treatment of childhood psychosis as well as the early prevention and intervention of psychotic illness in children from a Lacanian psychoanalytic perspective. It raises the questions of diagnosis of childhood psychosis and explores the symptom as the voice of the subject addressed to the Other.

C. Emily B. Ogden, PhD. *Thinking and Being in the Hospital: The Psychodynamic Inpatient Group*
Research on the exacerbating effects that psychiatric hospitalization has on patients has been present in the field since critical psychiatry first appeared (Laing, 1960; Szasz, 1987). Many clinics and hospitals, however, have clung to the medical model of mental illness, and have persevered in their outdated and dehumanizing modes of treatment. Psychotherapy groups on inpatient psychiatric wards have the potential to serve as a reflective space for patients.

Vignettes are provided from the psychodynamic psychotherapy group that the author runs on a short-term inpatient psychiatric ward. The group's content and process illustrate the patients' desire to understand the meaning of their symptoms and subsequent hospitalization. The psychodynamic group (Bion, 1961) offers space for the leader to make interpretations that aim to metabolize the unthinkable experience of being a "mental patient". This theoretical understanding and practice of groups adds a necessary dimension to what have historically been symptom management or psychoeducational inpatient groups, which can have the destructive effect of further distancing the patient from his or her own suffering.

I use Kleinian theory to argue that psychodynamically-oriented group interventions allow patients to move from the paranoid-schizoid position of isolation of affect and avoidance to a depressive position of being able to locate self in relation to the patient role. The patient's chance to reflect on his experience while in the hospital is the beginning of a longer process of the patient integrating his psychiatric crisis into his life narrative and identifying his suffering as a valid aspect of his self system.

The author seeks to dispel the myth that short-term psychiatric inpatients cannot tolerate psychodynamic interventions, and that interventions aimed at encouraging the subjectivity of patients while in the hospital is integral to the treatment of these individuals.

D. Trisha Ready, PhD. *Where Marshall Mathers Matters More*
This presentation will focus on the use of self-selected music on a portable I-Pod stereo system for patients experiencing psychosis as a means of helping patients tolerate the stress of being in a hospital and to help patients manage voices, as well as overwhelming emotional states. This writer has been facilitating psychodynamic music-based groups with patients on the acute unit of a psychiatric hospital for the past 2.5 years. She has also focused individually with patients on the use of music as a means of therapeutic connection, expression and containment. Self-selected music can serve as a bridge and a subterranean passageway between the inner world of the patient and the therapist's inner world. This therapeutic resonance, or linking, is similar to attachment/attunement dynamics between infant and caregiver, with the overarching concept of music serving as a kind of auxiliary mother. The work of such psychological theorists as Winnicott, Beebe, Trevarthen, and Bion will be explored, as will the work of ethnomusicologists, psycho-biologists and neurobiologists who posit that music is our first language, and that the urge to attach and socially bond is historically our first urge toward music. Vignettes and examples from individual and group sessions featuring patients using self-selected music to help manage voices, tolerate distress, and express affect will be presented. These vignettes will illustrate song choice (from Eminem to Creedence Clearwater Revival to Bach) as a form of communication, and as an initial

attempt to cope with affect. We will also explore several case studies focused on using self-selected music as a means to build a therapeutic connection with patients in early stage psychosis. This presentation will explore how some implicit memories may be more accessible through music than speech, such as may be the case for people who have experienced early, and ineffable childhood trauma.

Sunday, October 28

8:30-9:30 a.m. Concurrent One-Hour Papers

A. Brian Koehler, PhD. *What I Have Learned from Long-Term Relational Psychosis Psychotherapy and Social Neuroscience Research: Challenges and Therapeutic Efficacy*

The author will present his experience in working with a large number of persons diagnosed with psychotic and borderline disorders in long-term relational psychosis psychotherapy, particularly the challenges and difficulties involved, as well as the opportunities for therapeutic action and efficacy. Relational psychosis psychotherapy will be described, as will relevant research in social neuroscience, including research on the dynamic social genome and epigenome. An integration will be attempted along the lines of therapeutic efficacy.

B. Patricia L. Gibbs, PhD. *Pre-Verbal Realities: Artistic Primacy in the Contemporary Psychoanalytic Treatment of Psychosis*

I will be discussing what I call "Artistic Primacy" in the treatments of hospitalized and out-patient borderline, psychotic and schizophrenic patients. We will view the artwork and verbal psychotherapy passages from several individuals. Contemporary psychoanalytic treatments for psychosis often utilize creative therapies that do not focus exclusively on verbal psychotherapy. I will argue that this "Artistic Primacy" is essential in the successful treatment of these conditions.

Because an understanding of attachment theory and object relations development is crucial to understanding these contemporary treatments, I will begin with a brief overview of object relations research. The initial developmentally normal merged sense of self and other is retained over the lifespan to a greater or lesser extent in all of us. Psychotically organized patients hold onto this subjective state by enlisting psychotic defenses of denial and infantile omnipotence to retain the blissful union with the other, and resist the reality of separation and loss.

The one hour presentation will consist of digital reproductions of patient artwork. The artwork was collected from my work in the in-patient ward of the Detroit Psychiatric Institute, a Detroit-area Community Support Clinic for psychotic patients living in group homes, and from long-term outpatient psychoanalytic psychotherapy and art therapy from my own private practice. The therapeutic process of techniques privileging Artistic Primacy will be followed through several case summaries which will include artwork and verbal exchanges. Finally, the confluence of factors that I believe laid the groundwork for these successful pre-verbal therapies privileging Artistic Primacy will be reviewed during the slide presentation. During the 15 minute Discussion it will be possible to review artwork that reveals the diagnostic features of psychotic functioning, such as symbiotic- relatedness, paranoia, permeable ego boundaries, grandiosity, thought and identity fragmentation, suicidal ideation, and the failure to grieve.

C. Paul S. Saks, PhD and Maria Tsepilovan, MS. *In the Forests of the Night: Psychodynamic Treatment of Schizophrenia Through the Lens of Matte-Blanco's Bi-Logic*

The title of this paper takes its inspiration from Blake's The Tyger, and the notion of "fearful symmetry" as a way to conceptualize the inner world and experience of psychosis. In his six years of working with an inpatient population diagnosed with severe psychotic disorders, the primary author of this paper has found Ignacio Matte-Blanco's work with bi-logic and symmetrical experience to provide an invaluable matrix for beginning to understand the language and symbols of psychotic thought process while working collaboratively with those whom are often regarded as untreatable. In seeing psychosis as a symmetrical fusion of time, space and identity, the author has been able to step into "the forest of the night" and create a point of highly personal therapeutic contact through language, art and ritual. The author will provide case material to highlight the therapy.

D. Paris Williams, PhD. *An Exploration of the Existential Underpinnings of the Psychotic Process, From Onset to Full Recovery*

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

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

9:40-11:10 a.m. Concurrent Panels

A. Michael O'Loughlin, PhD, Patrick B. Kavanaugh, PhD and Ingo Lambrecht, PhD

Psychoanalyst as Shaman: Creative Engagement: Integrating Past and Present Wisdoms

The healer is an archetypal figure that has been with us for most of recorded history, acting as an intermediary between the world of the flesh and the world of the spirit. In some ways, the psychoanalyst of today takes up the position of the shaman of indigenous cultures, Charged with the ability to creatively engage with inchoate forces and unformulated experience, the clinician needs to be able to attune his or her unconscious to these forces and trust in what ensues. For the psychoanalyst, much like the shaman, our ability to be creatively engaged, through our reverie and dreams, with inchoate and unspeakable experiences provides a leading edge in our work with our patients. In our scientistic culture, pragmatic reality is overvalued despite our knowledge that reality can be like shifting sands, depending on one's vantage point. How then, we meet respectfully those who come to us weathering what one of patient calls 'the dark night of the soul'? perhaps requires us to step back from our medicalized culture and to appreciate the wisdom of indigenous healers as we undertake the difficult journeys required.

B. Gregory Concodora, MA, MEd, Robert Foltz, PsyD and Peter Myers, PsyD. *Storm and Stress: Understanding and Facilitating Effective Relationships with Adolescents Diagnosed as Psychotic*

Clinical work with adolescents has long been identified as one of the more difficult endeavors within psychological practice. In cases where the adolescent in question has demonstrated severe levels of psychopathology these difficulties have been noted to multiply, causing many therapeutic professionals to shy away from such work. And when the patient has been identified as experiencing symptomatology associated with psychotic functioning, along with the conclusion that intervention is likely to provide little benefit there is also often the appraisal that such persons are unable to form relationships with care workers. This state of affairs has led to inadequate intervention opportunities for adolescents demonstrating psychotic symptoms, overreliance on medication regimens and behavioral management techniques, and a significant lack of optimism with regard to prognosis.

This panel discussion will explore the development and progression of human relationships between clinical staff and adolescents diagnosed with psychotic disorders within residential treatment settings. It will include two doctoral level clinicians with over 20 years of combined experience working at residential treatment facilities within the Chicagoland area. Topics covered will include the subjective experiences of adolescents diagnosed with psychotic disorders, the nature of the therapeutic relationship, and experiences of transferrence and countertransferrence.

C. Ira Steinman, MD and David Garfield, MD. *In Depth: The Development of the Self During the Intensive Psychotherapy of Schizophrenia*

The Intensive Psychotherapy of schizophrenia and delusional disorders is hardly practiced and rarely taught. Yet such a therapeutic approach may succeed and cure severely disturbed schizophrenic patients. To demonstrate the efficacy of an Intensive Psychotherapy and the attendant changes in the Self, several severely ill schizophrenic patients will be presented in depth. One had been heavily medicated with antipsychotics. given ECT, and repeatedly hospitalized for seven years. Diagnosed schizophrenic on psychological testing , the patient has been off antipsychotic medication and free of psychotic thought, hallucinations, delusions and behavior for more than thirty years since engaging with one of us (Steinman) in an Intensive Psychotherapy. Another was considered catatonic schizophrenic, yet functions in the community off all medication. Another came directly from the hospital for the criminally insane, against medical advice. Still another had multiple suicide attempts while pursued by voices; she has been symptom free for more than 20 years. These happy conclusions are the result of an Intensive Psychotherapy of schizophrenia, as made amply clear by David Garfield's analytic commentary and historical perspective on these highly successful psychotherapies. This Panel will teach the benefits and the methods of Intensive Psychotherapy, with Steinman presenting the psychotherapy and Garfield doing the analytic commentary and exegesis. Our focus will be on the development of the Self during the course of an Intensive Psychotherapy of schizophrenia. Our forthcoming book, when finished, will have the same title as this presentation.

D. Diana Semmelhack, PsyD, Larry Ende, MSW, PhD and Clive Hazell, PhD, DN

Psychotic Thinking in Our Social Groups

A group in a psychotic-like state can be a devastating phenomenon. We are sometimes shocked to hear of groups that are said to take extreme and irrational actions, radically undermining the values on which they had previously relied. The Inquisition and the Holocaust present horrifying examples of this. A similar pattern was followed when American soldiers designed humiliating tortures for prisoners at Iraq's Abu Ghraib prison. Evidence for psychotic-like thinking is also present in our mental institutions, which frequently perpetuate psychopathology in psychotic individuals rather than treat it. Special attention will be given to how psychotic tendencies in these institutions can be harnessed for creative rather than destructive purposes.

Writers often explain such events as a result of particular social conditions. We believe such conditions include psychotic-like thinking which, as Bion (1954) shows, already tends to characterize our social groups. Unspeakable events such as the Inquisition or the tortures at Abu Ghraib can then be seen to occur not only because unusual circumstances have led a group to become irrational, but also because these circumstances have mobilized the psychotic-like thinking already inherent in our social groups.

An everyday example of a group psychosis is when members hold a rigidly unquestioned (i.e. delusional) belief in the superiority or need for precedence of their own group. Under ordinary circumstances, this belief may not seem to be damaging to the group. (Similarly, an individual may think delusional thoughts and not appear to cause himself harm, especially if these thoughts are not put into action.) Under stressful circumstances, however, a psychotic process in a group, often defending against intense anxiety, may come to play a dominant role and dramatically interfere with the group's functioning. A group can avoid a catastrophe by keeping a check on its psychotic thinking.

This discussion will utilize lecture, demonstration and discussion to illustrate the core concepts related to the psychotic process in social groups.

11:20 a.m.-12:20 p.m. Honoree Address: James B. Gottstein, Esq.

A Human Rights Lawyer's Perspective On The Mental Health System

It has become increasingly clear that drug company dissembling regarding the efficacy and safety of psychotropic drugs has resulted in massive harm, and caused an epidemic of people diagnosed with chronic mental illnesses and becoming debilitated. This talk will present a summary of this evidence and discuss the implications for clinicians.

1:45-2:45 p.m. Concurrent One-Hour Papers or 2 Half-Hour Papers

A. Françoise Davoine, PhD and Jean-Max Gaudillière PhD. *Beyond Lacan's Structural Approach of Psychosis*

Beyond Lacan's structural approach of psychosis, we met the depths of our patients' experience, thanks to the interdisciplinary tradition originated in Chicago around Jane Addams and others. Our own position in between being researchers in an advanced studies school for social sciences, and our psychodynamic work, as psychoanalysts for psychosis and traumas in public psychiatric hospitals and private practice, meets what H.S. Sullivan calls "the fusion of psychiatry and social sciences". This encounter seems to us particularly timely today, when research on a particular case in the long range, appears recently as a way of healing, also in the realm of biology. Clinical vignettes will illustrate our talk.

B. Suying Ang. *Co-constructing Personal Narratives Towards Recovery Amongst Peers*

This presentation is a reflection on a discourse of meaning making that took place during a 4-session, once weekly peer support closed group, under the aegis of the Early Psychosis Intervention Programme (EPIP) in Singapore. It delved into struggles of participants who spoke about their bewilderment when first diagnosed with psychosis, thus impacting on their sense of selves. Facilitators were a peer support specialist with lived experience of psychosis and a case manager from the EPIP service.

Illness narratives and how it affected one's identity took up a large part of the discussions with participants seeing psychosis as narrative wreckage to their lives. Some participants brought to the group implicit expectations of wanting to seek restitution with the chaos and fear they were experiencing in their lives while others, including the peer support specialist, spoke of their recovery process as quest narratives; in their ability to rise above their challenges to gain more strength and belief in themselves.

Other recovery-oriented themes like hope, coping and well-being were expanded with participants expressing social connectedness in their relationships outside and within the group in the process of healing even while they faced obstacles from the stigma, discrimination and oppression that took place within an Asian collectivistic culture. Participants took on a dual perspective of being a wounded storyteller and a wounded emphatic healer in the group. The idea that having psychosis is one of the many aspects of their 'selves' is then reinforced.

The use of a 'here and now' approach of group facilitation and the involvement of a peer specialist encouraged self-disclosure and sharing. The presenter will also further reflect on her position of being without a lived experience of psychosis as she journeyed with the group into making contact with the depths.

Jagan s/o Rama Sendren. *Integrating Peer Support Specialists into Social Skills Training for Clients in Early Psychosis Intervention Programme*

Background: EPIP was initiated in April, 2001 under the auspices of the Ministry of Health (MOH), Singapore. The programme includes medication management, psychological and psychosocial interventions for a period of two years by a multidisciplinary team. Suitable clients are selected for social skills training which is co-facilitated by case managers and peer support specialists. The inclusion of the peer support specialists in providing support for the clients started in January 2010 to instill hope through encouragement. Studies have shown that peer support groups are useful intervention for people suffering from psychosis by improving their social network (Castelein, et. al., 2008). In another study, Forchuk et al (2005) found that participants who received peer support demonstrated improved social support, enhanced social skills and better social functioning.

Aim: To look into the impact of integrating peer support specialists into social skills training for clients in the Early Psychosis Intervention Programme (EPIP), Singapore

Method: Focus group was conducted at the end of the 6 weekly training sessions to gather feedback on the impact that peer support specialists had on clients who attended social skills training. There were a total of 7 participants of which 2 were males and 5 females with a mean age of 28years old.

Result: The respondents felt supported by the peer support specialist's guidance, could relate and share about having similar illness. Peer support specialists contributed by making the clients feel encouraged and motivated to achieve their objective(s) of attending the social skills training.

Conclusion: The findings provide evidence that peer support specialists' involvement in social skills training had positive psychological impacts on the clients. Further investigations could be devoted to determine if the impact was due to ability to relate with peer support specialists or because peer support specialists were seen as role models.

C. Jeremy Ridenour, MPsy. *Psychodynamic Treatment and Model of Schizotypal Personality Disorder*
This paper will focus on the psychotherapeutic treatment of schizotypal personality disorder (SPD). SPD is the least treated of all the personality disorders (Gabbard, 2005); consequently, there are a lack of useful theoretical models and treatment approaches when working with this group of individuals. Of particular interest are the cognitive and disorganized symptoms of SPD, including: paranoia, odd thinking and speech, magical thinking, ideas of reference, odd behavior or appearance, and ideas of reference (Raine et al., 1994). Modern structural theory's integrative approach recognizes how ego deficits and intrapsychic conflicts explain psychological phenomena. I discuss how to address the positive and disorganized symptoms of SPD in the context of ego supportive psychotherapy (Stone, 1985) conceptualized through the lens of modern structural theory (Druck, 2011).

First, I will highlight the importance of emotional deficits (Kerns, 2005) in schizotypy and how they are related to the positive and disorganized features of the syndrome. I will argue that focusing on the role of emotions with schizotypal individuals can help improve reality testing and judgment. Second, I will describe the role of conflict and defense, along with the weak inner ego boundaries and how these contribute to the compromised reality testing of the schizotypal individual. Third, I will analyze the cognitive and disorganized features of SPD from the perspective of primary process material and primitive defense mechanisms. Finally, I will evaluate whether modern structural theory is the most effective way to understand and to treat individuals with SPD in psychotherapy. I will present the long-term treatment of Ms. X who suffered from SPD in order to describe the various interventions I used to minimize the impact of positive and disorganized schizotypal symptoms along with a discussion of how I conceptualized her problems from perspective of modern structural theory.

D. David Downing, PsyD, ABPP *On the Demise of Delusion: Working with Certain Vicissitudes in the Aftermath of Psychotic Collapse*
Considerable attention is given, understandably, to the treatment of psychotic persons at the point when the spectrum of symptoms [positive, negative] is most in evidence. What has received a lesser degree of focus has been in the aftermath of the more acute phases of the onset of psychosis and associated treatment. For purposes of this paper, the author will focus especially on the phenomenon of delusion. Whilst offering a perspective on working with delusions during the period of acute crisis, and subsequent elaborations, especial focus will be given to the work in the space wherein the delusion begins to dissipate, and the state of the patient in relation to its demise.

Many contemporary structures and models for treatment, when not coercive and highly controlling, still generally employ, in the main, exhortative, intrusive, 'educative' methods and often take place in highly-structured psycho-social rehabilitation programs. While many psychotic patients may well be helped by such approaches, the fact that large numbers are repeatedly hospitalised, over-medicated, and come to languish in 'human warehouses', makes it obvious that these interventions do not arrest the psychoses or improve the situations of a great many patients.

Unlike the usual current forms of treatment that attempt to control psychotic symptoms, like many psychoanalysts, the presenter approaches the patient in an entirely different way. Instead of viewing the delusion as the irrational by-product of a disordered brain, he views the nature of delusion as containing a valuable record of what disaster befell the subject. By means of persistent and considered listening, this record can be extracted from the delusion, and the patient assisted to assimilate this new knowledge. When this occurs,

the individual begins a journey to take leave of his psychosis and become someone who can take his place in a world that had given up on him, and from which he had withdrawn.

It has been observed that a number of individuals then experience a different crisis of sorts, usually marked by considerable despondency or even clinical depression. Although the patient may now feel [re]connected with his or her personal narrative, and begin to feel themselves as having 'returned' to their Self, something eludes them, and is felt to be at a remove – the cohering and salvific functions afforded by the delusion. A period of re-viewing the delusion[s] in this new light is important to undertake with the patient, as opposed to assume that, in the absence of 'the symptom', all is well [in this regard, the pragmatism of American mental health models, including psychoanalysis, with an emphasis on adaptation to social norms and reality can hinder the clinician working within this space.]

Vignettes of two psychotic persons will be offered, illustrating the depressive aftermath of the demise of delusion. In this period, the patient is afforded a new opportunity for greater insight and to re-appropriate aspects of the self that, whilst psychotic perhaps, have represented something of value and assisted in lessening the agonies associated with the collapse into psychosis.

2:55-3:55 p.m. Concurrent One-Hour Papers

A. Ron Coleman. *Victoria Conn Memorial Lecture: Hearing Voices: What's the Problem?*

In this presentation I will explore whether the voices that people hear are actually the problem. The research of Romme and Escher concluded that the vast majority of people who were diagnosed with a range of mental health problems clearly rooted their voice hearing experience in what had happened in their lives. Given that that this research has now been replicated with similar outcomes the challenge for us it answer not only what is the problem, but what can we do about it? The main focus of the session will be to give participants a taste of the types of work that can be used with voice hearers that creates the opportunity for voice hearers to move on in their lives. Drawing on my own experience as a voice hearer and the work I have done with other voices hearers I will show how the process of working with voice hearers can be developed.

B. Mark Richardson, MA. *Disorder or an Order of its Own: Analysis and Interpretation of Incoherent Psychotic Speech*

That speech and other actions are imbued with meaning is a fundamental tenet of psychoanalytic thought (Freud, 1901; Jung, 1914). Furthermore, to consider psychosis within a psychoanalytic frame is to presume that "psychotic phenomena make sense" (Castoriadis, 1996, p. 931; Freud, 1911/1963; Karon & VandenBos, 1994). While many have sought the meaning of sensory hallucinations and delusions (Arieti, 1974; Atwood, 2012; Karon & VandenBos, 1994), fewer have demonstrated a similar degree of interest and ingenuity in the analysis and interpretation of very disorganized psychotic speech (Bion, 1967; Lysaker & Gumley, 2009; Szasz, 1993), also known as incoherence (Andreasen, 1986) or word salad (Arieti, 1974). This is due in part to the absence of a useful mechanism for decoding what most experience as incomprehensible speech (Chaika, 1990; Rochester, Martin, & Thurston, 1977). Nevertheless, therapists are encouraged to persevere in the discovery of meaning (Karon & VandenBos, 1994).

In my paper, I will introduce a framework for developing the meaning of incoherent psychotic speech. Comprehension of incoherent psychotic speech is significantly challenged because the utterances do not conform to linguistic rules, particularly rules of syntax (Andreasen, 1986; Chaika, 1990). Proceeding from a psychoanalytic perspective, the "erroneous application of syntactic rules" (Chaika, 1974, p. 267) found in incoherent psychotic speech is reframed as symbolic alterations in the structure of language (Lacan, 1956; Spero, 1992). Analysis of syntax is therefore proposed, not only because its disruption is central to incoherence, but because this particular stratum of linguistic structure presents an opportunity to integrate linguistics and cognitive science with psychoanalytic theory. Informed by the work of Steven Pinker (2007) and Ray Jackendoff (2002) exploring the correlates of linguistic structures and thought, I will demonstrate how the comprehensibility of incoherent psychotic speech may be increased when syntactic structure is analyzed and interpreted in light of mentalistic models of language.

C. David W. Wilson, MEd. *The Role of the Transference as a Therapeutic Tool to Address Active Substance Abuse in the Treatment of Psychosis and Severe Mental Disorders*
In any psychotherapy we are confronted with significant difficulties in understanding as we attempt to work together with our patients. Patients who also misuse substances present us with additional levels of complexity. Not all models of psychotherapy readily adapt to the issues raised when patients may also be actively using substances of abuse. Frequently models of treatment of mental disturbance and substance misuse treatment are incompatible or contradictory. Variable and shifting mood and self states with concomitant impaired comprehension interfere with attempts to communicate in a coherent way that extend beyond periods of acute intoxication. Attempting to solve problems by substance use rather than verbalization inhibits change and maintains self-destructive patterns. Our attempts to understand by transference or mentalization may be insufficient and make it difficult to establish a reasonable level of understanding and assess the effects of our treatment efforts.

Many suggest that the interference introduced by substance use issues make it necessary to refer patients for treatments primarily designed for substance use before psychotherapeutic work directed to mental functioning can then begin. However, many patients fail to follow through with additional referrals and receive treatment from neither system.

In this paper a transference based system of treatment will be presented that will enable professionals to work productively and successfully with patients presenting with severe mental disorders and substance abuse problems. The emphasis will be upon the successful resolution of complicated clinical encounters in which it is revealed that denied or previously undisclosed substance use has been ongoing or when patients attend in an intoxicated state. Clinical examples from the presenter's practice will be discussed.

D. Carina Håkansson, Lic. Psychotherapist. *Ordinary Life Therapy.*
I will tell about practice and research I have been a part of during the last 25 years in a collaborative work between family homes (a kind of foster homes), those we call clients and their families and professional helpers.

Family Care Foundation originated from an idea to try together with others to create space for change; by talking, acting and finding ways to live in peace with oneself and others. Those we call clients come to our organization since they have given up hope, they can't find their own voice or way of living life. Many have been in institutions for many years, they are described in terms of psychiatric diagnosis and prescribed medication. We work with young people, adults and parents coming together with their children.

Over the years we have experienced the importance of inviting people, including and counting on each and every one, yet in different ways. By working together we have found out that many of those defined hopeless are indeed not hopeless, but humans as you and me.

Just as life itself our work is not without struggling, doubts and hard times, but it is also full of joy, trust and love. And it has convinced me that there are no easy ways, but lots of possibilities as long as we both work together and take a personal responsibility for ourselves and each other.

Nowadays our organization is part of a huge international network with people sharing the same visions and ideas about how to create a better world by taking part in our different experiences, stories and ways of living.

4:10-5:10 p.m. Concurrent One-Hour Papers (1 CE hour)
A. Robert Foltz, PsyD. *The Adolescent Experience of Antipsychotic Medications: Results from the ASET Study*
The use of antipsychotic medications has skyrocketed in recent years. As part of this use, children and adolescents are increasingly prescribed these powerful medications in an effort to "treat" psychotic symptoms, behavioral difficulties and emotional dysregulation. But the widespread use of these medications in young people is not firmly established with an "evidence base." As a result, the effectiveness of these interventions is largely based on adult studies or anecdotal reports.

The Adolescent Subjective Experience of Treatment (ASET) study surveyed 74 adolescents related to their perceptions of treatment effectiveness. The majority of these severely troubled youth are prescribed antipsychotic medications. This presentation will review the current trends in antipsychotic use, and highlight the perceptions of effectiveness, as articulated in the ASET study, by adolescents. While some of these participants were given diagnoses reflecting a psychotic disorder, across all youth prescribed antipsychotics, many study participants had an overall negative impression of being on medications. Their perceptions of medication effectiveness related to specific symptoms will also be examined.

B. David Garfield, MD and Jeff Mirsky, MD. *Subtypes of Pathological Accommodation in Psychosis:* Black Swan *and* Shine
Through illustrations from two movies: *Black Swan* and *Shine*, two different types of patholollgical accommodation can be discerned that lead to psychological vulnerability to psychosis. In *Black Swan*, Nina's existential existence required her to meet overwhelming mirroring selfobject needs of her mother which subsequently left the daughter with pervasive developmental arrest. In the movie *Shine*, the father-son relationship depicts the pervasive use of the son for the father's idealizing selfobject needs which leaves the son vulnerable to his manic-catatonic breakdown. The films depict the role of the pursuit of perfection and the fall into psychosis at the point of achievement of lifelong goals in these two parallel but very different same sex parent problems--one which leads to death and the other to recovery.

C. Garth Amundson, PsyD. *Tor-Mentors: Delusional Companions, Fellow Travelers, Guides, Masters, and Other Daemonic Figures Encountered in the Psychoanalytic Treatment of Teenagers and Young Adults*
This paper addresses the meaning(s), developmental role(s), and treatment(s) of the phenomenon of delusional sub-personalities existing within the mind of the teenager or young adult. Typically experienced by the patient as daemonic companions, tormentors/mentors, and/or helpmates, these delusional entities serve numerous developmental and/or defensive functions within the psyche. While diagnostically "psychotic" in nature, these figures do not dominate the entire personality, as in the case of schizophrenia and other, more serious psychotic disorders, but, rather, are circumscribed in nature, acting as defensive responses to specific developmental failures and challenges. To my knowledge, this is a subcategory of psychotic phenomena that has never been discussed in depth in the literature and hence is poorly understood; this paper is a preliminary attempt to articulate the nature of this syndrome.

The daemonic inner objects are usually hidden from detection behind a façade of superficial normalcy and/or passable social adaptation. They are present in the young person's psychic economy as directors of certain aspects thought, intentionality, and action. They may be single or multiple entities, each one of which may subdivide into multiple beings or become united with others across time. They are generally described by the patient as existing as uncanny presences, eerie, ghost-like beings about whose objective existence the young person is more or less convinced based largely on intuition rather than on the experience of auditory or other hallucinatory events. However, on a positive note, the circumscribed nature of the delusions means that the young person usually retain a semblance of self-critical doubt about this intuition, one that can be worked with therapeutically over time.

These inner objects act as perverse "mentors", offering various forms of modeling of effective social behavior, seductions to engage in psychopathic acts, and/or warnings of others' secret intentions, among other directives and (alleged) insights. The young person's relationship to the daemonic object is highly ambivalent and organized along sadomasochistic lines: hence, the daemonic presence is generally perceived by the young person as benevolent, sadistic, or, most often, some combination of the two, and, further, is encountered experientially with various mixtures of allure, idealization, dread, and/or shame.

Speaking metapsychologically, I propose that the delusional inner figures are created from the operation of splitting and/or mild dissociative phenomena, many of which are associated with the operation of hysterical defenses as described by Freud (1893/1908). The daemonic internal objects act as fantasied "containers" of intolerable affects, serving to help the patient avoid, isolate, and make controllable (through concretization) the upsurge of heretofore repressed need, desire, and fantasy initially occurring in early adolescence, particularly

that related to the depressive affects related to separation anxiety and uncontainable sexual and aggressive feelings. I have invariably encountered the presence of an objectively unempathic, emotionally shallow home environment in my patients who suffer from this form of delusional disorder, what I deem a key factor in the genesis of exaggerated splitting defenses.

The theories of Melanie Klein (1975) and W.R.D. Fairbairn (1952/2006) are particularly useful in conceptualizing the genesis of these delusional figures and settling on helpful technical stances toward the young patient beset by this condition.

D. Charles Turk, MD. *You've Done it Your Way for Years – Now it's Our Turn.*
This presentation is organized around a clinical case of a very disturbed young woman who had been continuously medicated for seven years with little improvement in her dysfunctional state. From this derives the first part of the title: "Your way" – a reference to the prevailing contemporary treatment of psychosis based on a "scientistic" ideology. The young woman's family, seeking alternative care, arrived with a request that their daughter's medication be discontinued and that she become engaged in another form of treatment. "Our turn" refers to that form, an approach oriented along the axis of a search for her humanity and potential agency, in contradistinction to one that regards her simply as an object of care.

The case will serve as a clinical reference point to illustrate the theoretic basis of the work at "388" - the psychoanalytic treatment center for young adults developed by the analysts at GIFRIC, in Quebec City. When the young woman encountered the first of the expectable crises intrinsic to such treatment, she had to be hospitalized. The contrast between current hospital care and an alternative setting will be drawn and discussed with respect to the difficulty of attempting to construct a frame within which to receive and work with delusion - as distinct from attempting to suppress it by means of medication.

Delusion is viewed as symptomatic, not of a disordered brain producing cognitive distortion, but rather as an attempted explanation for a psychic disaster as well as the formulation of a solution to it, and where its failure to provide a solution is manifest in recurrent crises. The dearth of settings that can sustain a "holding environment" to support such psychoanalytic work requires a response.