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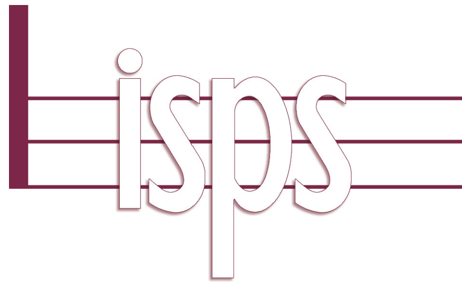

THE INTERNATIONAL SOCIETY FOR THE PSYCHOLOGICAL TREATMENTS OF THE SCHIZOPHRENIAS AND OTHER PSYCHOSES
UNITED STATES CHAPTER

ISPS-US
P.O. Box 491
Narberth, PA 19072
contact@isps-us.org
www.isps-us.org
(610) 308-4744

Editors' Note

Warren Schwartz, Psy.D.
Peter Austin
ISPS-US Newsletter Editors

We are pleased to present, in this issue, the abstracts of the presentations from our Tenth Annual Meeting, held in Rockville, Maryland. The meeting honored the legacy of (and helped us mourn the loss of) Chestnut Lodge, which was a beacon for the psychodynamic treatment of severe psychological disturbances. The Lodge was located an easy walk from the site of our meeting and many of us were able to visit the grounds.

As you will see, the presentations were diverse. All were rich and grounded in a profound respect for individual experience. The meeting was stimulating, hopeful and sustaining, bringing together members from around the country who are often otherwise isolated as a result of the type of work they choose to do.

We hope you enjoy this issue.

The ISPS-US Newsletter Editors apologize for the delay in the publication of this issue. After Ayme Turnbull-Lilly went on her leave of absence, we had much difficulty finding a reliable layout editor. Fortunately, Peter Austin is now with us.

Old tree with charred remains of the Chestnut Lodge "main building" in the background.

Our 10th annual meeting in Rockville, MD

Ann-Louise S. Silver, M.D.

We had a pretty swell 10th annual ISPS-US meeting. I had worried that our subtheme, "The Living Legacy of Chestnut Lodge," would cast a funereal tone over the event. This worry exploded with the fire this past June in which the Lodge's Main Building, the setting for Joanne Greenberg's classic autobiographic novel, I Never Promised You a Rose Garden, burned to the ground. The news footage reminded me of the conflagration of the Warsaw Ghetto. I had chosen the historic Red Brick Courthouse as the site of our meeting since it was built within a few years of the Main Building (which had been the Woodlawn Hotel) and was just a few blocks away. The stained glass windows and high ceiling set the right tone (although the echo effect led to only fair acoustics in that grand courtroom).

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President's Column

Brian Koehler Ph.D.

I welcome this opportunity to share with my friends and colleagues some of my recent thoughts on our ISPS-US group, including past, present and future developments. We have been a structured group since 1998 and the international group has been in existence since 1956. As many know, the international group was initiated by Drs. Gaetano Benedetti and Christian Müller in Switzerland in order to form a group devoted to the psychotherapy of persons with severe mental disorders. I formally joined the international group in 1994 and started, along with many dear colleagues, a New York local group in 1996-1997. We continue, for the most part, meeting monthly at New York University. I witnessed the growth of our international group from primarily a psychoanalytic society to a much more clinically and theoretically diverse group, e.g., with representation of CBT, psychopharmacology, need-adapted treatment, Open

Dialogue, and psychosocial interventions of many kinds, etc. Recently, the international group published an excellent journal, "Psychosis: Psychological, Social and Integrative Approaches," with John Read as editor, and members are encouraged to submit pieces to this publication. The US group had its annual conference chaired by Ann-Louise Silver, past President of ISPS-US, in Rockville, MD on the theme of interpersonal approaches and the living legacy of Chestnut Lodge Hospital.

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

Harold F. Searles (1979)

President's Column, continued

Brian Koehler Ph.D.

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Our next annual meeting will be chaired by Marilyn Charles and held at the Austen Riggs Center in Stockbridge, MA.

I would like to share with you a few subjects which have concerned me for many years: adopting a non-reductionistic model of the more severe emotional disorders which pays attention to research and clinical experience on the levels of brain, mind and culture; the role of medications; and potential new developments of ISPS-US.

First, it seems to me that if ISPS-US is to be true to our calling, i.e., providing humane and comprehensive therapies to persons diagnosed with severe mental disorders, we must bracket our preferred models of illness and treatment and let clinical experience and research speak for themselves. There continues to be mounting evidence that social factors significantly contribute to the inception, course and outcome of these disorders, ranging from urban birth and living to migration, relational traumas (physical, sexual and emotional abuse as well as emotional neglect), expressed emotion (primarily hostile criticism) and social isolation/exclusion and social defeat. ISPS-US needs to educate clinicians and researchers on these marginalized areas of research in order to help counteract the myth of Jasperian incomprehensibility which is often conferred on

our most disturbed patients. We also need to educate the public, students and clinicians on the reality of recovery. In contemporary psychiatric culture, there remains an impoverished view of human biology and neuroscience in which the very powerful effects of interpersonal relationships and wider cultural influences are excluded. Currently, I am integrating findings of evolutionary psychiatry, social neuroscience and long-term psychotherapeutic experience with many individuals diagnosed with the major psychoses, in order to arrive at a more valid model of these syndromes. Personally, I think social isolation and social exclusion, despair and the terror of non-relatedness (self-loss) as well as the colonization and invasion of boundaries of the self, utter helplessness, being overly controlled, etc., account for a large share of the neuroscience findings. There is a wealth of neuroimaging correlates observed in persons with relational trauma histories as well as profound and chronic stress conditions. I observed the overlap between these and the neuroscience of severe mental disorders in the early 1990s and reported such findings in a paper I gave at an ISPS meeting in London, 1997. Since then the emerging research seems even more confirmatory of the overlap. Stephen Sharfstein, a past president of the American Psychiatric Association, in 2005 lamented that the biopsychosocial model has become the "bio-bio-bio model."

As to the role of psychopharmacological agents in the treatment of persons with a diagnosis of severe mental disorders, I believe that we need to walk a fine balance between not risking serious side effects or compromised longevity and depriving individuals of potentially helpful interventions. One of the primary problems in the field of neuropsychopharmacology is that we are lacking important information on models of action including detailed information on compensatory processes which take place as a result of the adaptations made in the central nervous system due to chronic exposure to various agents. Robert Whitaker (http://www.madinamerica.com/Mad In America/Home.html) and myself are very interested in the subject of tardive supersensitivity psychosis. We have been researching this subject. In brief, it proposes that as a result of chronic dopaminergic blockade in the mesolimbic pathways, a compensatory upregulation of dopamine receptors occurs which creates a biological vulnerability to psychosis, analogous to tardive dyskinesia as a result of compensatory upregulation of dopamine receptors in the nigrostriatal pathways.

In terms of recent developments, I will only briefly mention four and leave to my ISPS colleagues to describe other new developments occurring in ISPS-US. First, we are planning to form a closer liaison with The International Network Toward Alternatives and Recovery (INTAR). This group recently held their annual conference at New York University entitled "Rethinking Psychiatric Crisis: Alternative Responses to First Breaks." I will be meeting with INTAR (http://intar.org/) staff including founder Peter Stastny. In addition, we are planning to create a closer liaison with the Gaetano Benedetti Institute for Existential Psychoanalytic Psychotherapy (http://istitutobenedetti.org/). As noted, Gaetano Benedetti is a co-founder of ISPS in 1956. His colleague, Maurizio Peciccia, medical director of the institute, and I will be planning an exchange of lecturers between ISPS, ISPS-US and the Benedetti Institute. We are also planning to co-write a series of articles on Benedetti's psychosis psychotherapy.Thirdly, many persons besides myself in ISPS-US would like to see the empirically demonstrated Open Dialogue approach of Finnish psychologist Jaako Seikkula be adopted in US settings. To this end, attempts will be made to have Seikkula and his colleagues participate in our conferences and provide guidance and supervision to our clinicians. Lastly, I have begun to compile a list of bibliographic references demonstrating the efficacy of a wide range of psychosocial therapies in psychosis. Please send to my email address any such references that you are aware of. This list will be made available to our members.

I welcome your feedback on my vision for the future of ISPS-US as well as your own hopes, suggestions and comments on the development of our group.

Brian Koehler - 212.533.5687
brian_koehler@psychoanalysis.net

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Our 10th annual meeting in Rockville, MD, continued

Ann-Louise S. Silver, M.D.

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I wanted a meeting that would recapture or even amplify the restorative, even spiritual, mood of the Lodge's annual symposia. Mental health professionals came to these symposia by the hundreds and usually said it was like a religious retreat. Brian Koehler and Julie Kipp attended regularly and became friends of mine and of our founder, David Feinsilver. David and I had worked together as co-chairs of the Lodge's symposium committee. It was no coincidence that our recent meeting was scheduled for the first weekend in October. We knew from decades of experience that the weather would probably be perfect—sunny, comfortably cool, the air sparkling, and the foliage beginning to turn. One big difference was that Symposium Day was free and included lunch and CE credits. ISPS-US can't afford to replicate that.

Outside of the Frieda Fromm-Reichmann Cottage: Ann Silver, Former President and founder of ISPS-US.

At our recent meeting, panel after panel came together with a remarkable coherence and without redundancy. Sometimes, as in the Sunday morning panel with presentations by Orna Ophir, Susan Mull and Mary Tibbetts, the effect was deeply moving. We all were celebrating the variety of interpersonal approaches to psychosis, the art and science of reaching out to a fellow human who is suffering so intensely that he or she has lost a grip on reality. John Kafka's keynote address, "Harvesting Today the Fruits of Chestnut Lodge" gave a vibrant view of Lodge work and its larger relevance. He had more to say than time permitted, but he has given us permission to consider his talk for our book proposal, so we will have an opportunity to study his much foreshortened theoretical section. And our honoree, Daniel Mackler, gave a thrillingly open account of his work with one of his patients, telling us a great deal about himself as well. He set a necessary example for all of us. We grow much stronger by being open about our frailties.

I cannot adequately acknowledge the many spectacular presentations I heard, and the great things I heard about the panels I could not attend. Having three simultaneous tracks inevitably leaves one feeling, "I made a wrong turn again." Hopefully, we will be able to hear these presentations soon, and then read them. Edmond de Gaiffier has been working on developing a DVD of many of the talks, and may develop a site where people can listen at their computers. And he, Maurine Kelly, and Jean Jerardi, who co-chaired our meeting, are working with me as co-editors, hoping to have a book of papers from this meeting to present for consideration in the ISPS-Routledge series. We are very pleased with the rich variety and yet coherence of the papers we've received, and are optimistic about the ultimate success of this venture.

Everyone should reserve the first weekend in November, 2010 to come to the Austen Riggs Center for our 11th Annual Meeting, chaired by Marilyn Charles. Her committee is working amazingly efficiently to bring us a splendid meeting on the theme, "Psychosis, Trauma, and Human Connections: Community-Based Models of Healing." The panel she and Michael O'Loughlin, Jill Clemence and Gail Newman gave at our recent meeting gave a wonderful opportunity to experience the depth of thought given at Austen Riggs to the issues of psychotic thought. I am especially intrigued by Eric Peters' plan to organize a panel on Otto Allen Will's life and work. Will was a valued Chestnut Lodge staff member, an analysand of Harry Stack Sullivan and then of Frieda Fromm-Reichmann. Frieda had been visiting at Otto's home the evening before she died of a heart attack. We have here a very human bridge from one annual meeting to the next, following in the footsteps of Otto Will as he moved from Rockville to Stockbridge, from Chestnut Lodge to Austen Riggs.

ISPS-US Executive Council

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President@isps-us.org

Vice-President: Martin Cosgro, PhD
VP@isps-us.org

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Treasurer: Kay Ellen Lowenthal, Esq
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Newsletter Editors: Warren Schwartz, PsyD, Peter Austin,
Newsletter@isps-us.org

Listserv Moderator: Matthew Morrissey, MA, MFT
List@isps-us.org

Website Editor: Martin Cosgro, PhD
Webeditor@isps-us.org

Research Chairs: Courtenay Harding, PhD, Brian Koehler, PhD, and Yulia Landa, PsyD
Research@isps-us.org

Membership Chair: Jessica Arenella, PhD
Member@isps-us.org

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Heads of Local Branches

Baltimore-DC: Ann-Louise S. Silver, MD
DC@isps-us.org

Berkshires: Marilyn Charles, PhD, ABPP
Berkshires@isps-us.org

Boston Area: Ronald Abramson, MD
Boston@isps-us.org

Central California: Martin Cosgro, PhD
CentralCal@isps-us.org

Northern California: Matthew Morrissey, MA,MFT
NoCal@isps-us.org

Southern California: Mary Madrigal, PhD
SoCal@isps-us.org

Chicago: Sheila Curren, PhD, LCSW
Chicago@isps-us.org

Michigan: Patricia L. Gibbs, PhD
Michigan@isps-us.org

New Jersey: Jessica Arenella, PhD
NJ@isps-us.org

New York City: Brian Koehler, PhD
NYC@isps-us.org

Preconference Institute Seminars:

Effective Interventions with Psychotic Clients

Martin Cosgro, PhD

Effective Interventions with Psychotic Clients is an entry level to early/mid career level presentation with the aim of giving the attendee a working knowledge of the basic tenets of effective psychotherapy with this population. The following major topics will be covered: Re-framing the biological perspective, medications issues from a psychotherapeutic perspective, understanding psychosis as a defense, assumptions of underlying trauma dynamics, and simple ego building techniques. Concrete explanations and case material will illustrate the material and allow the participants to grasp what is often perceived as difficult issues to master. Some familiarity with psychodynamics will give attendees

ABCs of CBT for Psychosis

Yulia Landa, PsyD

Over the past decade, dozens of studies have shown that when added to antipsychotic medication, Cognitive Behavioral Therapy (CBT) significantly improves drug-resistant psychotic symptoms and facilitates recovery of patients suffering from schizophrenia. CBT enhances a person's ability to function despite difficult symptoms and experiences and equips patients with a set of tools they can use to be in control of the symptoms long after the termination of therapy. The emergence of CBT for schizophrenia conveys optimism to the treatment and for the future of services for individuals experiencing psychosis. This 3-hour course is designed for mental health professionals who treat patients with schizophrenia spectrum disorders. No prior expertise in CBT is required. Participants will learn key concepts of CBT for Psychosis, and will become familiar with CBT interventions for delusions and auditory hallucinations.

Keynote Address:

Harvesting Today the Fruits of Chestnut Lodge

John Kafka, MS, MD

For decades, Chestnut Lodge made possible prolonged and intense clinical work with schizophrenic and other severely disturbed patients. Therapists were encouraged to develop and experiment with their own approaches, to present them to, and discuss them with, their colleagues in organized small groups. These individual approaches frequently combined psychoanalytic, dynamic, and what, today, would be labeled behavioral and cognitive elements. Chestnut Lodge was not only a hospital but also a clinical research and educational institution that, besides scheduling staff time for formal and informal discussions, offered group supervision, mutual supervision, and individual supervision by the most senior staff members. Such an organization attracted a staff who shared the vision that no human being is so different from us as to be inaccessible, incomprehensible, permanently isolated, and unresponsive. It is a fact that many major discoveries in all of science are based on the study of the "exception" that is neglected by a statistical approach that characterizes much of current psychiatry. The importance of the single case study, of the exception, was recognized at Chestnut Lodge.

John S. Kafka, M.D. Keynoter and Chestnut Lodge alumnus, spoke on "Harvesting Today the Fruits of Chestnut Lodge".

The fruit of Chestnut Lodge includes the lessons learned from therapeutic successes, therapeutic limitations and failures, the recognition that diagnoses can change during longitudinal studies of a patient. Close observations for a long period allowed therapists to witness patients' descents into, and emergences, from profound psychotic states in which they seemed inaccessible. Those moments offered unique therapeutic and research opportunities then, but the recorded observations can now guide research using new neuro-scientific tools. In this presentation, I will also describe and discuss how insights gained by therapists in their work with psychotic patients can enrich and deepen the treatment of non-psychotic individuals. In this paper, I will summarize some hypotheses, theories, and therapeutic approaches generated by clinicians who benefited from the opportunities offered at Chestnut Lodge. New vistas have opened up. Today, we can build bridges that connect old and new thinking and insure that the humanistic psychiatric tradition that informed the psychoanalytic and psycho-dynamic approach to schizophrenia and other disorders will not be lost.

Plenary Session:

Doing the "Impossible" Work in a Nearly Impossible System

Daniel Mackler, LCSW-R (Honoree)

This presentation, based on personal experience and clinical vignettes, addresses the extreme difficulties inherent in doing intensive psychotherapy with people diagnosed with psychosis within the context of the present American system that renders this work nearly impossible. The presentation will explore and analyze the system's desire, and at times incessant pressure, to put such patients instantly on heavy medications, be they mood stabilizers or antipsychotics (or both), and then essentially warehouse them for life. Patients are rarely given proper informed consent, much less any options other than medications, and if they are offered psychotherapy at all it is often provided by extremely new, unqualified therapists who have little knowledge or insight into anything other than the misinformation they have been taught in school by similarly uninformed teachers: 1) that deeper dynamic work is impossible and/or dangerous; 2) that full recovery is out of the question; 3) that to suggest full recovery is possible is foolhardy and unrealistic; 4) that their "illnesses" are biologically-based and thus permanent lifelong disorders; 5) that the therapist is just a functionary of this system, there to insure that the pa-

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tient takes his or her medications regularly; 6) that the therapist should quickly hospitalize any patient who becomes "too psychotic"; and 7) that medications are the therapists' best friend and deepest ally, and that any therapy is impossible without medication. A deep therapeutic alliance with a healing focus is not conceived of as a realistic possibility – and how could it be given such "therapeutic" parameters?

This presentation will also address the incredible stress incumbent on the newer clinician who wishes to buck this system and engage in the therapeutic work that has historically been known to be possible. The stress comes from many angles: lack of collegial support, difficulty making a living (psychotic patients generally cannot afford to pay much, if anything), professional alienation, the interpersonal pressures inherent in the therapy, the constant bugaboo of burnout, and the ever-present, lurking fears of malpractice should anything go wrong in the therapy, especially if the patient does not take antipsychotics or a mood stabilizer.

The presentation will conclude with a discussion of how a therapist motivated to do this type of healing work can persevere in spite of such a system and in spite of its pressures. This discussion will involve ways that the therapist find ways of: 1) reaching out for collegial support; 2) living a healthy lifestyle that optimizes hope, energy, and focus; 3) reading hopeful and informed psychotherapeutic literature to bolster clinical competency and positivity; 4) seeking out good supervision, if possible; 5) practicing good boundaries and limits with patients; 6) protecting himself or herself from malpractice and from debilitating conflicts with (and potential violence from) patients; and 6) diversifying one's practice to minimize stress and maximize interest, curiosity, perspective, and growth.

From left to right: Joanne Greenberg, Daniel Mackler (honoree), and Ann Silver.

Conference presentation abstracts:

"The Between": Antidote to Psychotic Loneliness

Mary Tibbetts - Cape, LICSW and Nick Luchetti

"…the isolated psyche…the self-encapsulated patient…must and can be broken through, and a transformed, healed relationship must and can be opened. A soul is never sick alone, but always through a between-ness, a situation between it and another existing being." - **Martin Buber**

Harry Stack Sullivan, founder of The Washington School of Psychiatry, identified loneliness as an important contributing factor in the development of the psychotic predicament. Shortly before her death, Sullivan's colleague, Frieda Fromm-Reichmann further articulated this insight when she described the "incommunicable" anguish of loneliness among those suffering from psychological disorders. Fromm-Reichmann's understanding of the remedy for the predicament of loneliness was largely informed by her spiritual orientation. Her friend, Martin Buber, the existential philosopher of dialogue, was a crucial influence on this orientation. Buber emphasized the importance of mutuality in "healing through meeting" and he stressed the need for "swinging over" and "feeling into" the other. Buber's concept of "the between" was derived from the value placed on community in the Jewish Hasidic tradition and the method of healing through dialogue practiced by Hasidic spiritual leaders. As such, Buber's "I-Thou" reflects a contemplative spiritual understanding that locates the sacred in the intersubjective field, rather than in the intrapsychic.

This focus on intersubjectivity characterized the clinical approach of the Washington School of Psychiatry and the work at Chestnut Lodge. Ed Podvoll, M.D. entered training analysis with Harold Searles and joined the staff of Chestnut Lodge in the mid-sixties. He went on to bring the importance of the interpersonal realm to his study of Buddhist philosophy with Tibetan Buddhist meditation master, Trungpa Rinpoche, at Naropa University in the late '70's. Founder of Naropa's program in Buddhist and western psychotherapy, Podvoll developed an approach to mental disorders, informed by his practice of meditation and his work with Trungpa. This therapeutic work, currently practiced at Windhorse Associates, underscores the importance of the symbiotic nature of relatedness, the permeability of self, the natural infrastructure of compassion and the idea of the "spontaneous ebb and flow of exchange" in the healing process.

In this presentation, we will trace the development of this contemplative, relational view in the history of Chestnut Lodge and in its contemporary manifestation in the clinical work at Windhorse Associates.

The Bridge Between Loneliness and Connection – The Practice of Exchanging Self for other (Tonglen)

Anne Marie DiGiacomo, LCSW & Eric Chapin, MA

Dr. Edward Podvoll consistently acknowledged his deep respect for the lineage of Psychoanalytic Psychotherapy as such renowned psychoanalysts as Frieda Fromm-Reichmann, Harold Searles, and Otto Will practiced it, and Harry Stack Sullivan lectured on it, at Chestnut Lodge. He began working at Chestnut Lodge in the mid sixties and remained there for seven years. During that period, he was supervised by Otto Will and was in training analysis with Harold Searles. These relationships played a significant role in Podvoll's training and development as a psychoanalyst. He was also deeply affected by Fromm-Reichmann's teachings and in particular her paper, "On Loneliness".

In his book *Recovering Sanity*, Podvoll speaks to Fromm-Reichmann's ability to understand and connect with the deep and despairing loneliness of her clients. She knew that their attempts to connect with something beyond this unspeakable loneliness were often met with failure, leaving them exhausted and hopelessly resigned to "ultimate isolation." Podvoll goes on to state that Fromm-Reichmann "believed that this state of almost nonbeing had become incommunicable through ordinary language but nevertheless it was the basic task of a psychotherapist to open up his or her own being to receive whatever despair and fear that might emanate from such a person, thus nurturing and protecting a precious and fragile human contact." Podvoll points out that if we are willing to experience as therapists, "intimate contact with someone so cut off, we will feel it- or the result of our rejection of it – one way or the other."

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It is not our natural tendency to allow this kind of suffering to enter our psychic and energetic field of experience. Instead we do what we can to avoid it, which is mostly a habituated response. In order to work with this we have to begin to make a concerted effort to shift this tendency – as Podvoll states, "we have to wish to do it." Then, the practice of exchanging self for others can become a discipline, which we can rely on and eventually engage, with more confidence and ease.

The practice of exchanging self for other or Tonglen is a fundamental practice of compassion found in Tibetan Buddhism. Podvoll was introduced to this as well as mindfulness awareness meditation via his relationship with the Tibetan meditation master Chogyam Trungpa Rinpoche in the 1970's. Podvoll was so profoundly impacted by these meditation practices that he worked the remainder of his life integrating his practice of psychoanalytic psychotherapy and mindfulness awareness meditation as a way of offering a more compassionate approach to caring for people in extreme states of mind. This work culminated in his becoming the Director of the Masters Program in Buddhist and Western Psychology at the Naropa Institute in 1978 and going on to found the Windhorse Project in the 1980's.
In this presentation we will offer a brief historical perspective of Dr. Podvoll's connection to Chestnut Lodge and his practice of meditation. In addition we will further illuminate the practice of exchanging self for others as the bridge to understanding and working with loneliness, both with others and ourselves.

Community Treatment of Persons with Psychotic Disorders: The Legacy of Chestnut Lodge

Joel Kanter, MSW, LCSW-C

Working in Maryland and studying at the Washington School of Psychiatry, I was privileged to be taught and influenced by many therapists who had either worked at Chestnut Lodge or had studied directly with a number of its most noted staff including Frieda Fromm-Reichmann, Otto Will, Harold Searles and its lecturer, Harry Stack Sullivan. As my first professional position was in one of Maryland's early community treatment programs, I found myself puzzling how to help a substantial caseload of clients with psychotic disorders with far less resources than were available in a resource-rich long-term inpatient setting. The writings of the pioneers at Chestnut Lodge provided useful insights into the psychological processes involved in schizophrenia and related disorders and offered me hope that I might play a useful therapeutic role in the lives of my clients. Yet, the beacon that Chestnut Lodge represented often seemed elusive in a community setting with limited resources. We could not offer a 24/7 therapeutic setting, nor could we contain the regressive experiences that seemed to play a critical role in the recovery processes documented in case reports from the Lodge. Nor could we see our clients for intensive psychotherapy on a near-daily basis. And we had to support the families and other caregivers who our clients lived with. Their tolerance for psychotic regression was limited and medications were often necessary to enable them to provide housing and support on an ongoing basis. Finally, I began to notice another important difference between the written and oral presentations of patients at the Lodge and the clients in our community program. Whereas the Lodge patients I learned about often seemed highly intelligent and imaginative, our community clients often had more ordinary capacities. Few were brilliant and most lacked any special creative talents. There were exceptions to this, of course, but I came to recognize that the Lodge patients were a unique cohort. The fantasy life of a Joanne Greenberg offered unique opportunities for analytic exploration that were not available in many other situations. Gradually acknowledging these differences in resources, treatment settings and client populations, I began a 30 year process of extracting the lessons from Chestnut Lodge about psychotic disorders and their treatment that could be usefully applied in ordinary community treatment settings; settings which, for the most part, are not facilitative of long-term, intensive psychoanalytic treatment. This presentation will outline the important lessons for community treatment of the aforementioned pioneers, Fromm-Reichmann, Will, Searles and Sullivan, as well as contributions from lesser known Lodge staff, including Clarence Schulz, Kenneth Artiss, and Wayne Fenton. Also, I will outline the central modifications of the Lodge's treatment protocols for community treatment.

Joel is offering to send his full paper to anyone requesting it. If you are interested, please email him at joel.kanter@gmail.com.

The Curious Case of Aimée

Steven H. Lipsius, MD

"Aimée" presented with the belief that she was not a human being. She believed she was a tree being, transmitted to earth from a dying planet of tree-like beings in a far off galaxy. Her essence was placed in a human baby to see whether "her kind" could live on earth. She was 42 years old when she first came to see me, and had harbored this belief for seven years. At that time, she felt increasingly distanced from her husband and from her mother. Aimée believed that she was four years old, related to how time was measured on her planet of origin. This understandingly presented problems in parenting her sixteen-year-old daughter at the time Aimée sought treatment with me. As an artist and poet Aimée documented her descent in identifications with giants, animals, trees and eventually extra-planetary tree-beings. At her insistence, I continued her on the same neuroleptic (Trilafon) and anti-depressant (amitryptiline) at the same dosages prescribed by the psychiatrist she had seen the previous nine years. Therefore, her recovery was unlikely due to medication alone. My treatment of Aimée coincided with my shift in recognizing the empathic stance as separate from the neutral stance. I believe this helped her internalize me in an empathic way, which helped her regain empathy for herself. The empathic stance promotes introjective identification processes and allows imaginative techniques to work-through fixations and conflicts directly with family-of-origin figures. The internal transference process is recorded in Aimée's poems, and her progress is shown through her drawings. As these psychopathological roots of her delusion were undercut, Aimée's "Dark Powers" emerged. The purposes of her delusion were discerned and their compensatory functions obviated, allowing her to relinquish the delusion. Attention then turned to restoring her relationship with her husband, and with her mother, with whom she had an anxious and insecure attachment. A pivotal session is described in detail, which involved what I call "subject relations," the innermost object relations processes. At the physical level, Aimée suffered from juvenile (primary) diabetes, discovered at age 7 when she was hospitalized for its treatment. She had her left leg amputated below the knee at age 49, while she was still delusional, which worsened her belief of being in a body alien to her. She had her right leg amputated at age 54, several months after the pivotal session described above. The joy in recovering her mind far outweighed the bodily loss of both legs.
With the relinquishing of her delusion, her neuroleptic was stopped. She terminated therapy after having been seen once to twice a week

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for thirteen years, minus two two-year periods around each amputation during which no dynamic psychotherapy occurred. She lived another ten years without emotional illness, dying from an accidental injury. At the memorial service, one of her friends commented that what she liked most about Aimée was that she was so human.

The Exit from Psychosis

Carla Jensen, PhD

Clinical material is provided from an 8-week, 5 times a week analysis which included a three month planned break in treatment, and nine months of once a week follow-up integration sessions. The patient as the teacher determined the sequencing, timing and dosage of treatment. In the integration phase of the treatment, the analysis leads to the "unthawing of "frozen" affects via the analysis of primitive omnipotence and the resolve of a transference psychosis. When Mr. Oliver was three months old and being breast fed, his mother went next door to a neighbor's home, broke a glass window pane with her fist, slit her wrists, and fell to the ground in a puddle of blood, proclaiming the birth of Christ. Mr. Oliver's mother was hospitalized in a mental institution for almost three years; Mr. Oliver and his father lived with the maternal grandparents.

Examples of clinical material and dream analysis are provided such as the following passages in the treatment. Mr. Oliver, forty-four-years-old, was a tortured soul suffering a split or 'other' in his personality, an 'other' that lived a completely separate and morally misaligned life from Mr. Oliver the primary. In a dream he reported that he was battling a man who represented the 'other' or the dark side of himself. He described this 'other' as only a head, purely logical, totally alienated from bodily input. For Mr. Oliver, the dream represented his struggle to let the double, the split in his personality, die. Doing so would leave Mr. Oliver feeling vulnerable to his wife and to his worst fear—total 'annihilation' by me. Sharing this vulnerability created a deep emotional release. He was experiencing such deep sadness in the center of his chest that the aching projected into the room with such magnitude that I experienced almost complete immobilization on two occasions. I tried to lift my arms or move my feet; they felt encased in concrete. I could hardly breathe from the weight of his projected feelings. He related his own sensations at the time as the return from an out-of-body experience, probably due to the temporary, albeit traumatic, loss of his mother as an infant. What Mr. Oliver terms as his "escape route" from me and my office then, results in the patient being able to rupture his symbiotic transference with me and propel himself to healing. Eventually, Mr. Oliver was able to successfully terminate, because for the first time in his life, he was in charge of the leaving; I was to be left behind, not him. The magnitude and intensity of this case are indelibly imprinted upon me, along with a deep respect for suffering and the will to heal catastrophic trauma. During our work together the patient, Mr. Oliver, progressed from denial to realization and grief, to acceptance and freedom. Seven year in person follow up and summary illustrates the successful clinical outcome of this case. Implications regarding technical stance and theorizing in the analysis of a psychosis are provided.

Exploring Psychological Catastrophe and the Interpersonal through Winnicott, Bion and Levinas

Susan E. Mull, PhD

I felt instantly enthralled, years ago, when I first heard about Chestnut Lodge from a senior colleague familiar with its vision and legacy. The Lodge's pioneering spirit, use of clinical innovation, and basic regard for the humanity of all individuals, struck a deep chord. Although the accumulated years of socio-cultural and bureaucratic changes eventually took its toll on undoing the operational life of the hospital, the existence of Chestnut Lodge lives on its symbolic powers. In quite a personal way, Chestnut Lodge and its reputation for creative investigation into the human experience of the psychotic individual, feels soul-stirring. In what often feels like a crooked world, the Lodge's approach offers a straighter path. Drawing upon the creative spirit symbolized by Chestnut Lodge and other psychodynamic approaches, the purpose of my paper is to explore psychotic experience and the realm of the interpersonal from two distinct vantage points: the ontological and the ethical. Most psychoanalysts and therapists are familiar with the clinical theories of D.W. Winnicott and W.R. Bion. Both men were deeply interested in understanding aspects of human experience concerned with emotional breakdown and psychological catastrophe. Psychotic experience is understood as the self-in-peril, pointing to primal ruptures within a basic sense of somatic-emotional(-mental) security and stability. In my discussion, I will explore the correspondences and divergences between these two men and their thinking, as well as the clinical utility of both. Unlike Winnicott and Bion, Emmanuel Levinas was neither a psychoanalyst devoted to developing a theory of emotional development, nor a clinician devoted to the treatment of psychological suffering. Levinas, on the other hand, was interested in formulating what he called a "first philosophy" – a way of apprehending human experience and personal relations that centers not around ontological concerns of the individual, but around ethical responsibility to the other. Through the face-to-face encounter, the intersubjective relation is constituted through a call from and towards the other. In my discussion, I will explore Levinas' unique notion of "transcendence" and its ethical relation to living in the world. As we continue to investigate the ontological insecurities of the human being, I believe our vision both requires, and is expanded by, the ethical perspective developed by Levinas. By bringing together the concerns and perspectives of Winnicott, Bion and Levinas, I believe an approach to understanding human experience is created that grants greater dimensionality, and wholeness. This approach may be akin to Bion's notion of working with shifting vertices to gain a fuller appreciation of the "whole."

From Body to Mind: Emotions and Art as Proto-languages

Dorothea Leicher, LCSW, NCPsyA, CCDP

This workshop is based on the clinical experience of the presenter, supported by research/theories from biology, psychology, philosophy and social work, and her realization that her experience of "truth" was based on aesthetic experiences. This realization led the presenter to recognize the importance of economic criteria in aesthetics (cv. "elegantia"): Art emerges as medium to model energy and change in complex systems. This is necessary to prepare the organism for future outcomes and/or strategies to maximize positive out-

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comes. The presenter's work in substance abuse relapse prevention led to these ideas. They also proved useful in work with depressive self-sabotage and repetition compulsion. While traditionally art has often seemed "immeasurable" , this workshop makes the argument that art has a very important mathematical function to orient us in a complex statistical environment: Good object relations protect us from Disraeli's trap ("there are lies, damn lies and statistics"). The workshop builds on the theory that language is rooted in gesture (which shares "movement" with "e-motion"). It will show parallels between our orientation in physical space and (sublimated) social, emotional or aesthetic "spaces". Breakdowns, (e.g. how the ability to represent space can be functionally destroyed during acute psychotic phases) will provide support for the validity of these links. Additionally, we will review parallels in the organization of color, sound and sign-language to illustrate first abstractions as part of language development. The workshop will outline the role of kinesis in symbolization and the perception of "meaning" and extend to Fonagy's research on factors fostering attachment. The importance of social relationships in the evaluation of "truth" and heuristic assessment of complex systems will be discussed in the context of clinical repetition compulsion and our current social crisis. The goal of the workshop is to show language evolving in a series of increasingly differentiated proto-languages. Effective communication (creating conviction) evolves as sampling and consistency evaluation of a variety of these proto-languages (with a side-note on hypnosis). Transference becomes a special subset in language development. This theory will lead to process-oriented techniques for client engagement which incorporate elements of hypnosis.

How the Rest of Us Can Do Psychotherapy for Psychoses

Ronald Abramson, MD

Treatment of psychoses necessarily must include psychological treatments for the mind in addition to biological treatments for the brain. There are various schools of psychotherapy, but psychoanalytic treatment is the only Western discipline devoted to a comprehensive understanding of the mind. Psychoanalytic authorities have written extensively on the psychodynamics involved in treatment of psychoses, but such approaches are limited by the realities of limited resources and number of therapists. Also, the techniques and understandings developed by prominent authors cannot always be implemented by many therapists who do not enjoy as robust a theoretical background. Presented here are five principles that "the rest of us" can keep in mind during the treatment of people with psychotic problems. These principles are: safety in the therapeutic situation, empathy as a means of understanding the patient and avoiding countertransference problems, validation in the therapeutic situation as enhancing safety and promoting ego strength in a fragile ego, being a "real person" with the patient rather than a taciturn traditional psychoanalytic "mirror," and "transmuting internalization" as the way in which the therapeutic process promotes the development of a stronger self able to live in conventional reality. These principles are easy to keep in mind and are compatible with Cognitive and Behavioral techniques as well as other psychoanalytic theories and approaches.

An Interpersonal/Relational Model for the Treatment of Sexual Offenders

Stephen Price, MA

This paper will explore the use of an Interpersonal/Relational model in an Intensive Outpatient Program for Sexual Offenders. It will pay particular attention to the way in which this approach deals with the thought disorders prevalent in clients organized at a psychotic or borderline level of personality organization. The Interpersonal/Relational model will be discussed as it is applied in both individual and group therapy.

The invention of the psychodynamic psychotherapy of psychosis in between Europe and the USA

Françoise Davoine, PhD & Jean-Max Gaudillière, PhD

Through clinical vignettes evoking the resonant teaching of Frieda Fromm-Reichmann, H.S.Sullivan and Lacan, we will show family resemblances with our practice regarding the psychotic transference. More specifically, Frieda's journey through History build a way to deal with madness out of our common background of wars and totalitarianism in Europe. We want to actualize, as a major stake for today in our work with psychosis and trauma, the fecund meeting between creative and bold researchers and practitioners, who have escaped from major upheavals.

Listening to the Dis-Ease of Psychosis: A Research Roundtable

Marilyn Charles, PhD, ABPP (Chair), Michael O'Loughlin, PhD & Gail M. Newman, PhD

There is little doubt that psychosis represents significant dis-ease for those who are designated psychotic. In fact, the disorder appears to induce sufficient dis-ease in those who witness it, and in the psychiatric establishment, there is often a rush to medication to mute the dissonant noises that psychosis represents. In addition to the quality of life issues this poses for patients designated psychotic, medication presents methodological difficulties for those who work therapeutically with psychotic persons. Are the confusions, the halting speech, the mutenesses that are present, and the non-sequiturs in speech, symptoms of psychic dis-ease, or are they merely manifestations of attempts to reach for meaning thorough a pharmacological haze? Can we reach through the speech of psychotic persons to comprehend the signifiers that may reveal a quest for understanding? The presenters in this group are an interdisciplinary group of scholars with interests in psychosis, intergenerational trauma transmission, and the nature of narrative who have come together to listen closely and collaboratively to trauma narratives of 44 patients designated psychotic at Austen Riggs Center. Longitudinal audio- and video-taped data are available and we have a number of guiding purposes as we engage in collaborative dialogue with each other as we listen to the patients

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speak. We are seeking, for example, to characterize the speech of these patients designated as psychotic. Putting pharmacological haze to the side, assuming that is possible, what are we hearing in the narratives of these patients? Is it possible to engage with these narratives in

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a sufficiently attuned way to recognize the purpose which drives the speech? Can we identify through the speech the point at which psychosis surfaced? Is this manifested in some form of silence or lack? Is there evidence of severance of social links or the inheritance of phantomic trauma trails in this interruption? The longitudinal nature of the data allows us a window into the efficacy of intensive psychodynamic therapy: In what ways have patients who have demonstrated improvement benefited from the therapeutic regimen? For patients who persist in their psychosis, are there indications as to why psychodynamic therapy has failed to engender new symbolic capacities in some patients? Are there clues from our listening as to how the needs of such patients might be more fruitfully addressed? Most important, perhaps, is there a way through this close narrative attention that we can bring back into the conversation about psychosis the narrative experience of the patient and the ways in which we can assist patients designated as psychotic in connecting the narrative threads of their own experience so that they may continue to live purposeful lives? Participants in this session will offer ruminations on psychosis, thoughts on the methodological implications of the narrative approach being developed, and preliminary information from the first six months of immersion in the narratives of the patients described here.

Madness In Psycho(analy)sis: The Ear-rationality of Treating Illusion as Reality

Patrick Kavanaugh, PhD

Ms. A. was in her early 40's when she first came to the office to tell her story. She related her history of frequent and extensive psychiatric hospitalizations at various state hospitals over the previous 22 years. And, she spoke of herself as having been 'a schizophrenic' all her life. Ms. A. wanted to meet for a while to talk as her hospital roommate had told her that talking about her childhood might be helpful. And so, we began meeting 2 - 3 times/week for the next 13 years. Madness In Psycho(analy)sis… proposes to address certain questions considered basic to the psychological treatment of schizophrenia. In contrast to psychosis as situated in a bio-medical premise of biology, medicine and the natural science, this paper speaks to the question of madness as situated in philosophy, the humanities, and the arts. And more specifically, it speaks to the dramatic meanings of madness in which psychological treatment is understood as a venture into communication via the associative-interpretive process in a contextualizing metaphor from the performance arts, the psychic theatre of mind. Each element of this synthesis and practice of psychoanalysis is considered in the theoretical-abstract and is illustrated in the specific with associative material from the first 7 months of our meetings. Several organizing questions basic to the truth of the theatre are considered; first, if madness is illusion treated as reality, then how do the therapist's philosophic premise and theoretical assumptions influence, if not determine, the ear-rationality by which (s)he might listen to the madness of the analytic moment? And secondly, how does one understand and respond to the reality of past traumatizing experiences as communicated in the present moment of the past? The focus of this consideration is on the process of listening, understanding, and responding to the madness of the self of other, and to the madness of the other of self; emphasis is placed on the rather primitive and archaic transference-counter transference experiences that unfolded on the stage of this semiotically constructed psychic theatre. And it is in this contextualizing metaphor of psychic theatre that psychological treatment takes place. The underlying assumptions of this venture into communication via the associative-interpretive process are situated in a philosophy concerned with language, systems of signification, and the personal meanings that derive from the associative context of Ms. A's life story; people are the makers and interpreters of meaning. From this philosophical perspective, all interactions are, at once, communicative and integral to semiotic discourse which is understood as one might understand a poetic text in which 'reality' is conjured from illusion -as in the theatre- by the use of signs and systems of signification. This paper concludes with some thoughts on the associative-interpretive process as being one of the most complex forms of human discourse in which several systems of meaning and signification are condensed with each system continually modifying the others and within which systems all thinking is considered to be radically metaphoric.

Medication-Free Treatment of DID and PTSD: Per Patient Request, After Medication Referral Completed–Case Study

Dawn Brett, PhD, BCETS, FAAETS

Safety, self-understanding, a better quality of life, and a good prognosis is possible to achieve without the use of Western medicine if the person(s) seeking treatment so desire(s) and they have been diagnosed with Dissociative Identity Disorder (DID) and Post Traumatic Stress Disorder (PTSD). Working from a psychodynamic understanding, valuing the therapeutic relationship, and incorporating Eastern philosophy, the progression of treatment can be relatively steady in spite of the amount of dissociation originally experienced. Trauma dehumanizes people. Survivors experience the horror of annihilation anxiety in various ways. In persons with the diagnosis of DID, they experience this internally as various dissociated ego states. For persons with PTSD, annihilation anxiety can be re-experienced in flashbacks through various senses. In good psychotherapy treatment, genuine, appropriate, consistent, stable, and respectful behaviors are lived by the therapist and interacted with the patient in healthy boundaries. These behaviors allow for a sense of safety and trust to develop. With dignity, respect, safety, enough time, and the therapist's knowledge of Trauma, and if there is a good fit between the therapist and the person seeking help, the patient begins to see him/herself as human. Teaching about being fully present and learning to appreciate things and soothe oneself teaches the ability to slow the mind down and allows a feeling to develop that there is beauty in the world. This also allows for blocking of negative intrusive Traumatic memories. Suggested for grounding and visualization are movement-oriented breath-focused practices used in the East for many years, as well as other items. The course of therapy is described for Mr. X. who has been in therapy for a little over 4 years and has been diagnosed with DID and PTSD. Within the course of the 4 years, he states that he has only 2 dissociated ego states from over 30 initial dissociated ego states. He had been referred for medications, spoke with a prescribing mental health professional and decided to be medication free. He is a recovering alcoholic. He spent time almost every day learning to "internally communicate" with dissociated ego states. For various reasons it was typical to use the "talking through" method

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during the therapy session to communicate with other dissociated ego states by the therapist unless safety was an issue. This facilitated good internal communication. This allowed the various dissociated ego states to see similarities and begin to "stand together" and then begin to integrate. He states that he feels stronger, less confused, and that there is more room in his head due to the internal changes. Mr. X. is a military veteran who not only had experienced childhood and adolescent Traumas, but adult military and civilian Traumas as well. He has attended a male Military Sexual Trauma (MST) group for approximately the last year facilitated by a male combat veteran where issues addressed include childhood and military Trauma.

This presentation does not mean to suggest that this is the only correct way, or that everyone can be treated in this way.

Narrating Madness: The Challenge of First-Person Accounts

Gail Hornstein, PhD

For more than 200 years, psychiatrists have claimed authority over mental life. They have drawn and redrawn the lines between "normal" and "abnormal" thoughts, feelings, and perceptions, and fought to legitimate their views within medicine and society. But at every point in psychiatry's history, patients have fought back with their own ideas about madness and treatment. The closing of public mental institutions across the US, UK, and Europe over the past 25 years has made it possible for current and former psychiatric patients to join together in an international political movement whose approaches now rival those of psychiatrists. Assumptions about diagnostic frameworks, a "biological basis" for mental illness, and the effectiveness of drug treatment are increasingly under attack as people with first-hand experience of madness develop their own strikingly effective theories and methods. In no other field of medicine could such a challenge from patients even be possible, so this phenomenon offers provocative insights into the history of science and the sociology of knowledge. Relationships between psychiatrists and their patients have always been complex. The insularity of asylums and a shared interest in the enigma of madness led both groups to write about the causes and treatment of psychological problems. Since the origins of madness remain elusive, and patients have always had their own distinct viewpoints, psychiatrists have never succeeded to the same extent as other physicians in establishing their claims as authoritative. More than 700 patient narratives have been published, providing a rich source of data about the mind and its workings. (I have compiled a bibliography listing all the accounts published in English.) People with AIDS or cancer or heart disease also sometimes write about their experiences, but they don't do so primarily to critique their treatments or challenge their doctors' expertise. But a surprising number of mental patients write for just these reasons. Their treatment hasn't worked or it has made them worse. Or their doctors have ignored information they consider crucial. Or they've figured out a better method of treatment and want others to benefit from it. Patient accounts of madness are a kind of protest literature, like slave narratives or witness testimonies, offering insights into the mind otherwise unavailable to us. Biological psychiatrists claim that these accounts are gibberish, the product of disordered brain functioning. Is that because so many patients contradict doctors' triumphant stories of "conquering" mental illness, choosing to write instead of trauma, insight, recovery, and resilience? In my new book, *Agnes's Jacket: A Psychologist's Search for the Meanings of Madness* (published March 2009 by Rodale Books), first-person accounts of madness in every form are considered -- published memoirs, oral histories, and visual narratives like the jacket on which Agnes Richter, my title character, stitched an autobiographical text while incarcerated in a German asylum in the 1890s. I want to offer ISPS members an opportunity to learn from the extraordinary works that patients -- past and present -- have created, so as to broaden our understanding of the mind and its workings.

On Fear and Reluctance in Working with Psychotic Persons

Paul Lippmann, PhD

For many years, I have been aware that early experiences with disturbed and psychotic persons have shaped my feelings about working in psychotherapy with such patients. We rarely discuss these influences as we focus in our writing and discussion on other matters. I believe that aspects of personal experience often lead to fear and reluctance to engage with psychosis. While we may overcome such feelings through professional training and subsequent learning, denial and reaction formation often play a role in submerging early anxieties. Young therapists, especially, are prone to hiding considerable shame about their fearfulness. A premature pose of expertise and adequacy often replaces genuine uncertainty and anxiety and makes it more difficult to engage in an honest encounter with patients who are often highly sensitive to falseness and artifice. In the interest of exploring rather than submerging these early experiences, I would like to open the area for consideration. In this paper, following a brief description of a clinical encounter, and of the setting for an Interpersonal analyst in private practice, I will speak personally about a series of early formative experiences with madness in many forms. I am led to conclude that it is entirely natural to become afraid of, distressed at, and angry at persons who display considerable psychological disturbance. For example, they don't follow the rules. They threaten to break the peace. They are often at odds with "civility." They can turn violent or be withdrawn in the extreme or regressed or inaccessible, irrational, unpredictable. They can seem to have little interest in anything but their woe, their plight, their revenge stories, their victimization, themselves. Their grief, anger, strangeness, and pain do not usually lead to a wish for contact, but to its opposite. For a child, therefore, encounters with madness can be nightmarish. Most anyone in his or her right mind has every reason to be afraid of, or at least to keep a wary distance from, madness. But still further, there is that underside of oneself, that terrible possibility, that shadow side to sanity, that craziness lurking beneath the surface in all of us—that plays its part in drawing us to and away from madness. Those who pretend calm in the face of the irrational unknown, in a patient or in oneself, seem to be whistling in the dark. There is much to be afraid of, much to wish to avoid. With some learning and through experience, fearfulness and avoidance can be lessened. I describe some of the influences that have aided in my attempt to work with very disturbed people. The Interpersonal approach, which from its origins has encouraged honesty in one's engagement with patients, can be of genuine assistance. The awareness of one's early experiences of fear and reluctance, rather than their suppression, make it possible, eventually, to make important use such experiences in identifying and understanding severe psychological distress.

An order of thought for psychotically being in the world

Frank Moore, MSW, P-LCSW

This author will explore the use of a relational approach to psychotically being in the world through a hermeneutic phenomenological lens. This approach will be presented as one alternative to the typical treatment of psychosis related to symptomatology rooted in a disease model. A case vignette will be used to illuminate some of the philosophical and psychoanalytic perspectives discussed in this paper.

Origin and Treatment of Schizophrenia, Based on Mahler's Finding

Clancy D. McKenzie, MD

Origin - This work began as a result of a 1966 child psychoanalytic training class with Dr. Margaret Mahler, when she said the origin of childhood schizophrenia was in the first 18 months of life.

I checked my then current adult patient population and noted that half a dozen of my schizophrenia patients had a sibling about one and a half years younger, and as many of my non-psychotic depressed patients had a sibling about two and a half years younger, and in no instance in that small patient population was this reversed. The mutual exclusivity of the two groups was one over two to the 12th power, or one chance in 4,096 by chance alone.

Birth of a sibling is only one of thousands of infant separation traumas, but it is common, is upsetting to many infants, and most importantly, the date it occurs is known and recorded. Thus it became the measuring stick for identifying age-of-origin specific symptoms and diagnostic categories. This allowed for the identification of other traumas, because we only had to search one month during infancy for when the trauma occurred. Nearly every trauma had one common denominator: a relative degree of physical or emotional separation from the mother – as experienced by the infant. Mahler's work first identified age of origin through prospective studies. In order to fine-tune the age-of-origin specificities, we had to use retrospective studies, on thousands of schizophrenic, borderline and depressed patients. A simple research method will describe how to identify peak age of origin and age range-of-origin of each symptom and diagnostic category, in future studies.

For audience participation, a few examples will be given in which the audience will be able to identify the month of origin of the symptom in the patient.

Mechanism - Twelve precise parallels between delayed PTSD from adult life and delayed PTSD from infancy are given, and reasons are presented as to why there is a one-to-one ratio between schizophrenia and infant separation trauma. This does not negate other contributing factors, predispositions nor biological results of the psychological process. Why should separation trauma to an infant be as overwhelming as war trauma to a soldier? Because for as long as mammals have populated the earth, separation from mother has meant death.

Treatment - The treatment modalities presented are based on the new understanding of origin, mechanism, precipitating and perpetuating factors. The recognition of the delayed PTSD mechanism enables the patient to recognize the partial shift to infant mind/brain/reality/feelings/behavior/chemistry/physiology/body movements/level of affective expression and neuroanatomic sites in the brain that were active and developing at the precise time of the original symptom-defining trauma.

The focus of treatment is to move out of infant mind and brain as fast as possible, as completely as possible, and for as long as possible. The patient learns what results in movement from infant to adult, and what causes movement in the opposite direction. Thus the patient can participate in his own recovery process.

Partial Hospitalization: The Psychotherapeutic Treatment of Severe Personality Disorders in the Lodge's Last Years

David Cooper, PhD

By the early 1990's, long-term inpatient stays were no longer philosophically or financially supportable in the United States. By 1993, the four newly built inpatient units at Chestnut Lodge Hospital were experiencing a dramatic decline in admissions, shortened hospital stays, and a growing census of discharged patients who continued to require long-term psychiatric care. Two of these units, the Frieda Fromm House for persons with borderline personality disorder and the Sullivan House program for persons with schizophrenia, developed disorder-specific, multimodal partial hospital programs for discharged patients that featured psychotherapeutic, medical, skills training, and vocational rehabilitation services. Both partial hospital programs – the Lodge Day Program (for persons with personality disorders and/or severe mood disorders) and the Life Skills Program (for persons with schizophrenia and related psychotic disorders) – opened in October 1993 and provided much of the active ongoing treatment of adults for the final eight years of the Lodge's existence. We, who designed and directed these two programs, will describe the evolution of each. The Lodge Day Program was designed to meet the long-term therapeutic needs of individuals who could be seen to exist on the border between psychotic, disorganized functioning and a more stable adjustment. Typical participants struggled with impulses to manage their chaotic inner lives by use of substances, self-mutilation, eating disorders, and other risk-taking behaviors; many were chronically suicidal. The design of the program responded to the needs of these patients by offering structured psychoeducational groups, along with more traditional psychotherapeutic groups and individual psychotherapy. Our experience over nearly eight years was that the key to successful treatment in our program was our capacity to engage our patients in the life of the community. Those who were able to attach, even if the attachment was extremely ambivalent, tended to do quite well; those who did not attach tended to remain at risk. We, and our colleagues on the Lodge Medical Staff, felt that this less restrictive model of treatment was well-suited to our patient population, who may at times have developed severe iatrogenic regressions in the old days of very long-term inpatient treatment. The Life Skills Program, organized around Psychiatric rehabilitation principles, was designed to address the cognitive, motivational, and functional difficulties that characterize persons with chronic psychotic disorders, primarily schizophrenia and schizoaffective disorder. Typical participants exhibited residual psychotic symptoms de-

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spite adequate pharmacotherapy, as well as varying degrees of deficit symptomatology. To address these problems, the program emphasized rigorous staff training in procedures for managing positive and negative symptoms, as well as recovery-oriented treatment plans, weekly therapeutic contracts, social and instrumental skills training, and contingent reinforcement to facilitate clients' independent functioning in the community. Over time, a variety of cognitive interventions were introduced to maximize learning within the treatment milieu, and to generalize adaptive responding in academic and occupational settings within the community. Data will be presented that support the principles of long-term, community-based treatment for schizophrenia, delivered by a consistent set of caretakers who respect and facilitate client's aspirations towards recovery of personhood and functional independence.

The psychodynamic meanings of delusions of Badness

Paul Gedo, PhD

This paper, based on my work at Chestnut Lodge Hospital, and on my subsequent clinical experiences, explores the functions of patients' delusions of Badness. Some patients struggling with severe character pathology eventually reveal a "psychotic core," consisting of an underlying delusion of utter Badness and destructiveness. This belief has a fixed quality; fills the patient with terror and dread; and is quite difficult to ameliorate, even with intensive treatment. The pathogenic belief fulfills multiple functions. It serves as a grandiose defense against feelings of helplessness and powerlessness. It allows the child/ patient to protect an idealized view of the caretakers, by assuming all aggression and badness derives from himself; this wards off traumatic disillusionment and the terrifying feeling that he is alone and helpless in the face of (perceived) malevolence or neglect. The delusion both reflects and motivates the patient's interpersonal alienation and isolation. In part, he maintains distance in order to protect others from his putative power and destructiveness. The delusion and the interpersonal isolation also represent intense, archaic forms of self-loathing and self-punishment, a psychological form of self-banishment, as the person feels unfit for human company. The delusion affects the transference/ countertransference matrix: if the patient experiences the therapist as accepting, he construes this as evidence either of the therapist's duplicitousness, or his incompetence. The patient considers it proof that the therapist cannot truly know him, as anyone who fully experienced his Badness would be driven off or destroyed. I will conclude with brief considerations of the technical challenge this dynamic presents to the therapist.

Recognizing and treating reported depression in bipolar patients

Michael S. Perlman, MD

This talk will describe the differential diagnosis of the bipolar patient's report of "depression," will encourage the clinician to be open to the possibility that a feeling-state other than depression is present, will describe some methods for determining whether such a feeling-state is present, and will discuss how to treat it.

When the bipolar patient reports "depression," the clinician must consider whether what's present is 1) major depression, and/or 2) dysthymia, and/or 3) a mixed state, and/or 4) a problematic feeling or ego-state such as those related to grieving, whether acute or chronic, or such as related to anniversary phenomena. Clinical examples of each will be given.

I often ask the patient where in her or his body the "depression" is felt, and then I ask the person to focus on that part of the body, give up control, wait and see what happens, and then put into words the feeling and/or picture that is experienced. This is a method I call affective association, a variant of free association in which the association begins from a bodily feeling. This method was inspired by the example of Elvin Semrad, MD, the most influential clinician in Boston from the mid-1950s to his death in 1976, who asked schizophrenic patients where in their body they were feeling emotional pain. By using this method the patient often becomes aware of previously warded-off feelings and memories, and, by bearing them with the encouragement and support of the clinician, has the opportunity to deal with them.

Resolving the Trouble with Schizophrenic Thinking

Leighton C. Whitaker, PhD, ABPP

Early in the 20th century, psychiatrist Eugen Bleuler declared that the primary and central disturbance in the newly named "schizophrenias" was a thinking disorder. Now, a century later, epidemiologic study shows that somatic treatments have not improved outcomes overall, particularly in terms of "negative symptoms," including the negative form of thinking disorder. The somatic treatments may dampen some "positive" signs of thinking disorder, such as manifest expression of delusions, but do not improve cognitive functioning in terms of adaptive thinking ability which is crucial for fully functioning constructive living.

Neither claims of better results since the 1950s, with neuroleptic drug treatment, nor claims of improved outcomes in the present "newer antipsychotics" era, nor the "disease" model of schizophrenia have been substantiated. Meanwhile, drugs are regarded as the standard of treatment in the United States and some other industrialized countries but outcomes are better in non-industrialized countries that seldom use drugs but emphasize supportive community relationships. Further, genuine diseases can be caused by the "medical" treatments, and long-term disability is a common outcome. Ironically, schizophrenia has been likened to a disease such as diabetes, another claim without substantiation, but the newer drug treatments have been shown to cause actual diabetes.

What remains characteristic of schizophrenic conditions is a dynamic gestalt of terror, whether latent or manifest, lack of communion with others, and inability to distinguish fantasy from reality. This inability --- a kind of thinking disorder characterized by illogicality, impairment relative to pre-breakdown functioning, and lack of witting awareness that one's thinking is deficient --- appears best treated interpersonally in ways that simultaneously reduce fear, foster communion with others, and promote a witting kind of rational thinking. In contrast to harmful somatic treatments incorrectly based on assumption of physical disease, humane interpersonal care is more effective, especially in the long-term, and does not harm brain or body.

This presentation will show how psychotherapy unhampered by drug treatment and focused on the central interpersonal issues, can

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lead to high levels of adaptive thinking ability, in what were severely psychotic persons, and consequent good outcomes. The approach begins by relieving the person's terror to make possible a partnership with the therapist. Examples of previously poor prognosis cases are given, including hebephrenic and paranoid persons.

The Role of Shame in Treating Maniacal Triumph and Paranoia

Patricia L. Gibbs, PhD

Paranoid patients have a tentative and impaired capacity to trust others, judge others intentions, and maintain interpersonal relations without disruptive projections and introjections of hostility and terror. Along with this, one will often observe a strong sense of justice and an impassioned pursuit for the "truth." This search for the patient's truth, I believe, is repeated in the transference/countertransference, as patients struggle to face painful affective realities in treatment. I will be looking specifically at the difficulty paranoid patients have with feeling shame in the transference.

It is noteworthy that all the patients to be reviewed reported childhood verbal, physical, and /or sexual abuse. Such conscious memories of violation would be expected to be extremely painful to bear affectively. Initially, the struggle for paranoid patients to face this awful truth was accompanied by intense feelings of terror, and then hate and murderous rage. The paranoia and feelings of terror, hate and murderous rage can be understood as related to the profound sense of betrayal associated with the unconscious violent persecutory anxieties that compromised the ability to establish basic trust.

The analyst will inevitably be drawn into the patient's paranoia. Slowly these patients came to trust me within the deepening paranoid transference/countertransference. The patient's unconscious experience of boundaries then took center stage in the clinical moment. A more reality-oriented state of depression might initially result from the unconscious repetition of boundary violations accompanying persecutory introjections and projections of the Self/Object. The persecutory anxiety of intense paranoia, however, would lead to the reliance on primitive defenses associated with psychosis. When this anxiety could be witnessed interpersonally, and contained in the safety of the transference/countertransference, paranoia could be worked through without retreat into psychosis. Yet, after periods of such progression, these patients defensively turned repeatedly to fantasies of maniacal triumph. Maniacal triumph fueled strong fantasies of vengeance, with the affects of hate and rage. I believe the defenses involved in maniacal triumph served to temporarily reverse the patient's fall into further paranoia and psychosis.

The Kleinian view of narcissism provided a conceptual link that helped re-direct technique to include working through affectively charged experiences of shame, as well as anger. This proved to be key in resolving the repetitive paranoid-maniacal triumph cycle. Klein did not see narcissism as an objectless state, but rather one of a symbiotically organized object relations capacity centered on possessing, merging with, and controlling the object. This view of narcissism illuminates the paranoid mechanisms of projection into -- and control of -- the Self/Object. I concluded that the affective integration of hate and rage, without the integration of shame was associated with the patient maintaining resolutions organized around narcissistic vengeance and maniacal triumph. My countertransference reactions became crucial for me to consider in light of Klein's understanding of narcissism. Clinical material will illustrate that combining work in an oedipally organized transference with affectively charged transferential experiences of shame helped patients transcend recurrent affective regressions to murderous rage and maniacal triumph. Over time, both affective volatility and paranoia were less pronounced, suggesting a mutative modulation of affect.

Co-explorers living on the margins: Schizophrenia, culture, and psychotherapy

Warren E. Schwartz, PsyD

While oppositional tendencies are not unique to the schizophrenias, they are common amongst those suffering with the disorders and create unique problems for these individuals. The schizophrenic individual's opposition to the cultural milieu is seen here as an act of will related to his or her perception that culturally defined notions of reality and prescriptions for behavior are terrifyingly imposing and negating. The schizophrenic individual, already not fitting into the higher cultural order, engages in active opposition to it in order to hold on to some shred of life.

The individual who opposes culture rightly senses that it is all a lie. But here we begin to see where a motivation toward clearer insight, often an aspect of healthy functioning, goes awry: what is beneath the illusion of culture is terribly unpleasant. Culturally constructed illusions function, in part, to obscure certain existential truths (the finality of death and ubiquitousness of emotional and physical pain and illness; the constant presence of choice and responsibility). Additionally, these highly symbolic illusions provide us with some sense of control over our physical and interpersonal environments (by naming things and people, assigning some things and people more important status than others, etc.). In a word, cultural meaning systems allow human beings to function with minimal levels of anxiety. So to protest and subvert the shared meaning system puts one at risk for being overwhelmed by the terror and disorder of real life. This becomes especially true for the schizophrenic individual, who is already weakened. In his or her opposition, the schizophrenic individual trades being overwhelmed by the imposition of the self-negating cultural meaning system for being (further) overwhelmed by life itself.

Cultural meaning systems not only provide us with a symbolic order and escapes from unsettling truths, but with opportunities and mechanisms for acquiring self-esteem. Beside physical survival and safety, there is nothing more central to psychological equanimity than the feeling that one is a valued contributor to a meaningful reality. Without such opportunities for acquiring primary value and meaning, human life is almost unimaginable. When the schizophrenic individual turns away from or against the system that offers him pathways for acquiring symbolic (illusory) value, he is compelled to create his own, and these attempts are destined to fail as we know from clinical experience. No one can sustain such a grand lie without the support of others who believe it too. Surely, his mental health workers won't support his delusional constructions! And those that populate his delusions don't quite cut it either - after all, they are not real flesh-and-blood individuals concerned with sustaining a shared and mutually necessary illusion - but are rather the shoddily fabricated symbolic constructions of a chaotic, terror soaked mind.

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The upshot of the schizophrenic individual's opposition to culture is a lack of a secure sense of meaning, order, and value. As such, the individual, with nothing left to hold himself together but his tenuous, self-constructed reality, falls apart. Here we have an individual, already weakened by his or her current and early experience, opposing that which is necessary for sustaining meaningful life.

A Technique For Preverbal Trauma Processing

Linda Gantt, PhD, ATR-BC

Patients with chronic mental illness may have unremembered trauma during infancy such as surgical procedures or extreme pain. It is possible to process the traumatic event with a graphic narrative (a series of drawings) that includes elements of the Instinctual Trauma Response and serves as a template to bring closure to the preverbal trauma.

When there is no identified preverbal trauma (such as early operations or invasive procedures), the patient begins with an imagined scene of himself or herself as an infant in distress. Usually the image is of a baby in a crib. The therapist encourages the patient to view the scene from the perspective of a hidden observer (Hilgard, 1977) and construct a narrative that contains images of the infant's startle reaction, the flight/fight impulse, the freeze, the sensations that will become body memories, the reaction of automatic obedience, and finally, the period of self-repair. The therapist suggests the essential plot of the story, which is the Instinctual Trauma Response (Tinnin, Bills, & Gantt, 2002), while the patient creates a script depicting the actors and actions responsible for the baby's distress. The therapist pins the drawings to a large corkboard for display and re-presents the narrative in words to the patient.

We complete the preverbal trauma processing with an externalized dialogue between the present person and the inner infant that may still be struggling for survival. The external dialogue can be done with video recording or simply by writing. The patient invites the infant to participate and then speaks for the infant in return. As they take turns a surprising effect happens. The infant seems to find its voice and speaks its mind. It becomes possible to debate, negotiate, and to give and receive solace. The present day person can nurture and heal his or her own past self.

In this presentation we will show a case illustration by power point.

To learn from a patient, who broke his 30 year silence into talking about himself

Yuko Katsuta, MD & Masaaki Fukagawa, MD

After suffering from schizophrenia for 30 years, Mr. T, a 45 year-old man, broke his autistic shell and initiated talking, for the first time in his life, about his experience fabricated with deeply seated psychotic symptoms and anguish.

Prompted by recently introduced medication, his isolated life at the hospital began to change. It was utterly moving and thrilling to observe the gradual transformations of his facial expressions, body movements, and finally his rich discourse. He disclosed what really happened when he was 15 and what he observed and felt after his hospitalization at the age of 33. It is a heart rending as well as rewarding experience to us, too.

In his adolescence, even though he was intensely influenced by a religion in which his family was involved, he was embracing uneasy feelings about their belief. Having no one to talk with, he eventually found a niche in his psychosis. He "created" his own religion when he was 21, but it has only an extremely minute difference from his parents' beliefs. We infer it must have been a way to hold on to himself to individuate and separate from the parents. Retaining a great deal of similarities to their beliefs, he ended up duplicating his parents' value system, which he had already internalized throughout his childhood. The religious sect to which the parents belonged is famous for aggressive rejection of other beliefs. He suddenly attacked his neighbors, thinking his thoughts of the new religion were transported via telepathy and aroused antipathy in them. This incident brought him to the hospital after his 18 year secretive life. And his secretive life continued for another 12 years.

When we took charge of him in 2007, he was regarded as having "residual schizophrenia" with no hope to improve. He spent hours glued to the TV with a slobbering mouth, which produced few words in a flat tone only when asked. His vacant eyes, cast downward without blinking, scarcely met ours. His body movement was minimal and mechanical. It was difficult to evoke his emotions, and his internal life was unattainable. In short, negative symptoms were in the foreground, though it was highly possible that side effects of antipsychotics aggravated the condition. Nobody expected he would crack out of a glacier to unfold raw personalities until new medication was introduced.

As he opens up his experience, it becomes clear how he shapes pathological object-relations instead of interpersonal relationships in reality. We allow him to let us reside in his delusional matrix for the sake of his safety and security. At the same time, we tentatively challenge his delusion to make him ready for departing from his familiar template. It is crucial to detect his delicate balance between his need of psychotic shell and his budding urge to relate to us. We are cautiously tapping into his past and present not exactly knowing where to go. Every step is a gift to learn a human process and a challenge to help him to create his future.

A Treatment for Command Hallucinations

Louis Tinnin, MD

People sometimes obey the commands of their hallucinated voices and this fact makes it urgent to do something about these command hallucinations. Many common attempts to do something are simply futile. One cannot close one's ears to the voices. Medications dull consciousness long before affecting the voice. Auditory hallucinations often persist even after electroshock treatment. Such treatment efforts are protracted and demoralizing to the patient and the end point is usually an uncertain claim that the voices are "gone." I recom-

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mend an entirely different approach to dealing with voices.

The patient's inner voice seems too close, too unmanageable, and even mystical with a commanding power. Obedience to the commands of the voice seems obligatory. A clinician can demystify the voice and reduce automatic obedience in the first interview. The clinician announces to the patient. "I will now ask the voice some questions and you tell me what you hear." Then proceed with authority, "Voice, I have three questions for you to answer. Question number one: Are you listening?" The patient may report hearing "Hell no," or some other words, or silence. Now say "Voice, question number two: Will you help the treatment?" After that answer, be it yes or no, the clinician might say, "Voice, can you learn new things?" The content of the answers that the patient reports doesn't matter. It is the patient's experience of the voice responding to another person that exposes that it as not God or demon. The presumed power of the voice has been reduced to simply that of another mortal.

The next step is for the patient to talk with the voice. This requires externalizing the voice, which is best done by video recording but can be done by writing a message to the voice, addressing it as "you." This will be the first of a series of taking turns, each addressing the other as "you" or by name. Now it is the turn for "Voice" to speak. The patient may have to write for the voice at first but before long Voice will speak for itself, the writing hand moving by its will.

The rules for the externalized dialogue are three: 1. Take turns. 2. Don't interrupt. 3. Write complete sentences. The dialogue with commanding voices can begin with an exploration of their roles and their origins. Usually the roles began as attempts to help the person. Unfortunately, according to their logic even suicide might be regarded as a helpful solution for the need to escape. A successful negotiation with the suicidal part can substitute less extreme solutions.

The external dialogue is easily mastered by the patient and becomes a self-help tool. The voices can be recruited "onto the team" and participate positively in the patient's life.

Treatment of Patients at Chestnut Lodge Hospital

Christopher Keats, MD

The author describes the milieu and approach to treatment at the Lodge over the last twenty years of its existence, with illustrations. This material was previously presented at the XII Curso Anual de Esquizofrenia, "Psicosis y Relaciones Terapeuticas," Madrid, November, 2007.

The Utilization of a Modified Fairweather Model and Group-as-a-Whole Treatment with Severely Mentally Ill Adults

Diana Semmelhack, PsyD & Tanya Gluzerman, MA

There are few housing options for severely mentally ill individuals other than long-term care facilities (Nursing Homes) in the United States. Recently, New Beginnings Community Services (NBCS) and National Alliance on Mental Illness (NAMI) launched an innovative housing option using original principles of the Fairweather lodge model with modifications. Particular emphasis was placed on establishing a living environment that was compatible to community living. In addition, this modification of traditional housing made unique use of a Group-as-a-Whole framework (based on the Tavistock Model). The Group-as-a-Whole component included bi-weekly, one hour meetings with a group consultant (psychologist) who directed comments to the whole group versus any given individual in the group. Concurrently, group members learned social psychology concepts believed necessary for effective functioning in the community during a 15 minute didactic portion of each group. Ultimately the house members formed a team (group-as-a-whole) geared towards problem solving and effective conflict resolution.

An initial investigation was conducted in which ten subjects completed a 16-week evaluation period in the control group setting (standard group home) and 7 subjects were evaluated during the group-as-a-whole treatment. Baseline measures of self-efficacy and cohesiveness before the start of treatment were compared between groups by unpaired t-test. Significant changes from baseline were determined in each group by repeated measures analysis of variance with Tukey Tests used for post-hoc testing. There was no difference between the control and experimental groups at baseline. After the 16 week treatment, self-efficacy did not change in the control group but increased by 50% in the experimental group from baseline to 16 weeks. The group-as-a-whole setting also produced a significant 35% increase in cohesiveness from baseline to 16 weeks of treatment. The control group showed no significant change in cohesiveness.

Following this study, more recent innovations have included the implementation of an interpersonal group therapy. This weekly group-as-a-whole treatment modality has included experiential, process-oriented, and skill based processes and exercises to facilitate awareness of boundary management, conflict resolution, self-disclosure, the awareness of healthy and unhealthy relationships, and how one defines oneself independently and in relation to others. Current research has begun to examine the effect of the treatment on the development of ego identity and social problem solving skills. Thoughts and reflections on the program as-a-whole are shared in addition to directions for future research and programming.

The Value of Individual Psychotherapy for Persons with Psychotic Disorders

Karen Bartholomew, LCSW-C

Individual psychotherapy with persons with psychotic disorders, such as schizophrenia, bipolar disorder with psychosis and psychosis NOS, has been devalued in recent years. The training and experience I received in my 14 years at Chestnut Lodge Hospital has enabled me to do this work in my private practice and see first hand the value to individuals, their families and to society. I will discuss psychotherapy with persons with psychosis from the perspectives of psychological and social theories, mental health policy, research and practice. I will use case examples of former Chestnut Lodge patients that I continue to see in my practice.

Villemoes' successful treatment of schizophrenia

Wilfried Ver Eecke, PhD

Villemoes observed that patients afflicted by schizophrenia could not always use pronouns properly. Also, they fuse so much with people that there is no I separate from the group I-concrete other to whom they make a promise. The separation part in the process of individuation-separation seems not to have happened so that persons afflicted by schizophrenia have not reached fully the stage of individuation.

Villemoes drew clinical lessons from these observations. Since patients cannot properly use pronouns, the clinician should not consider them dialogue partners. Hence they should not be put in front of the clinician. The patient should sit next to the clinician three feet apart, with a small table in between. The patient should sit closest to the door. These arrangements avoid putting the patient on the spot (not sitting face to face); avoid homosexual feelings (three feet apart with a table in between); and avoid paranoid pressures (patient sits closest to the door).

Villemoes also conceptualizes schizophrenia in the Lacanian way as the patient having a defective relationship to language. His treatment then consists of restructuring the ego of such patients by improving their relationship to language. In a first phase, Villemoes talks about objects in the consulting room, then about objects in the patient's room. One of the first indications that the treatment has an effect on the patient is that the patient is not anymore startled when material things change in the consulting room (a paper or a pencil falls). Next the patient starts to arrange his belongings in his room. Talking about objects in the patient's room gives the patient the position of being the authority about the truth: the patient and not the therapist knows where the desk and the chair stand in his room. In a second phase the therapist delegates further authority to the patient. Having taken off his watch, the therapist tells the patient that he is in charge of keeping time. From that session on, the patient has the last word in the session. The sessions are used to let the patient talk about the objects from her earliest memory. The therapist encourages talking about objects, not persons. Persons could have been a problem. The therapist allows the patient to talk about persons as the patient sees fit. Persons do appear in the descriptions by the patient. Slowly the patient develops the capability to show sympathy. Next, the patient starts reflections about himself, saying things like: "I used to... but now not anymore." This attitude prepares the way for the patient to identify with some word: e.g., I am not a liar. This is the beginning of identity formation. When the identity is formed a deep sense of loss overcomes the patient: she feels she lost her life. This is the occasion to start the third phase which prepares the patient to leave the therapy. Villemoes was able to let a person afflicted by schizophrenia move by himself into an apartment after treating him for one year, twice a week for half an hour.

In the workshop we will describe in more detail Villemoes' method. We will also present a Lacanian and philosophical justification and explanation for the method. Third, we will let the members practice the Villemoes method which requires that the therapist not ask questions and not use the pronoun you. Finally, I will give some examples of how I used the beginning of Villemoes' method successfully with regressed patients who were not diagnosed as schizophrenics.

What Do We Want from Our Clients: The Wish for "Cure" in Psychosis Therapy

Sol Pittenger, PsyD

It can be said that one of the major elements of our countertransference in work with clients with psychosis is our urge to cure or change them. Although there are likely to be positive aspects of this pressure, we have been criticized by some of our clients, those who have suffered from psychosis, and those in the self-help or recovery communities for some aspects of this motivation as well. Ron Bassman quotes an Australian aboriginal activist group as having said, "If you are coming to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together." As Sullivan has taught us, one thing for sure about psychotherapy with people who experience psychosis is that it is a two person process. For a client in the position of allowing another person to help, s/he is also accepting some aspect of a one-down relationship with him or her. Sometimes the aspect of health that may be forthcoming in rejecting this may be more significant at a particular time than the health that may be obtained in accepting it. Helm Stierlin wrote about the need to tolerate clients using us the way they need to use us, including tolerating what we may see as premature terminations or other actions which may seem anti-therapeutic at the time. He states that therapy of clients who have experienced psychosis should include a dynamic of, "…unendingly working toward closeness by observing distance and of establishing distance by recognizing closeness." I will review case material from long-term therapy with clients with psychosis, which illustrates patterns associated with the pressure to cure and to be cured. This discussion may be helpful in working with clients as well as in developing greater fruitfulness in our association with the self-help or recovery community.

When psychiatry aggravates psychosis by focusing on childhood traumata and ignoring key current problems

Nathaniel S. Lehrman, MD

Current or recent traumatic experiences have long been recognized as major causes of psychosis, but it is widely maintained that one cannot understand psychosis without exploring childhood traumata. When that exploration diverts attention from important current situations, tragedy can follow. The case of Arnold Parker Arnold Parker, a Jewish, Harvard-trained attorney, and a close college friend, was an active left-winger both before and after World War II, and a much decorated European theater infantryman during it. By 1952, he had married, fathered three children, and started his own practice. But those times were turbulent - communists Julius and Ethel Rosenberg had been sentenced to death for "conspiracy to commit espionage" and each week, ex-communist Herbert Philbrick unveiled in the Boston Globe new horror stories, with new names, of his Three Lives on the left. When Parker became increasingly frightened, and then disabled, he was referred to a distinguished Boston psychoanalyst. His treatment focused on his relationship with his father, as he told me then. But his current fears worsened. After months of mounting agony, and a week before Senator Joseph McCarthy's scheduled hearings in Boston, he hanged himself . (157) McCarthy in America/ Hitler in Germany The terrorism of the McCarthy period,

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both governmental and unofficial, produced an immense amount of mental illness among leftists and liberals. That era's psychological destruction of individuals through harassment repeated events in Germany 20 years earlier. Hitler's Mein Kampf described "spiritual terror"; how, "at a given sign, a veritable barrage of lies and slanders (is unleashed) against whatever adversary seems most dangerous, until the nerves of the attacked persons break down." Then, "just to have peace again, (his friends) sacrifice the (now-) hated individual." The "game" is then repeated "until... fear of the mad dog results in ... (the victim's) paralysis." Psychiatric opinion that the victim was mentally ill from unknown causes, probably dating from childhood, was a major aid to the creation of such "sacrifices." The harassment at Harvard of Dr. Perri Klass Harassment/terrorism against individuals is still part of our political world. During the 1980's, considerable unrecognized harassment occurred within the Harvard Medical School community. In 1984, several residents at two of its hospitals were targets of anonymous hate letters and recipients of neat packages of feces. The return address on one of those letters was that of Perri Klass, a medical student who was already a published journalist. She was the prime target of a similar attack two years later, which she described April 5, 1987 in the New York Times Book Review. Although she and the hospital authorities maintained that one disturbed individual was behind the attacks, examination of the details - as presented in the appendix to this submission - reveals a well-organized, evil group, which was apparently never identified or investigated. A more personal note In December, 1963, I was hospitalized for three months at New York's Mount Sinai Hospital for paranoid schizophrenia. That hospitalization saved my life; had I remained home, an explosion would probably have occurred. The essence of my illness was hypervigilance, the consequence of a series of increasing political attacks to which I did not respond properly. Although I was fully aware of the reasons for my breakdown, my therapists - psychiatric residents - carefully avoided my recent experiences while diligently exploring my happy and irrelevant childhood. My recovery, to which my psychotherapy contributed nothing, was due to my running a mile each day in the hospital gym, resuming playing the violin, and starting a historical research study in a nearby medical library, which I later presented formally.

Conclusion

Over concern with childhood experiences can blind psychiatry to subtle but potent attacks on patients in the present and recent past. Psychiatrists who ignore or deny such attacks do their patients no service.

Working with regressed mental states

Daniel Paul, PhD

A patient's readiness to allow himself/herself to regress is highly dependent on the analyst's emotional responsiveness to his regressed state. If the analyst conveys that he/she is not threatened by the regression and remains emotionally engaged with the patient, then he/she provides an atmosphere in which the patient will feel safe to allow himself/herself to further regress. However, if the analyst conveys through his interventions that he/she is threatened by the patient's regression and does things to placate, reassure and cover over what the patient has dared to expose, then the patient may conclude that the analyst cannot bear his pain, repress it and adopt a compliant posture of giving the analyst a more superficial picture of his mental state. Opportunity to benefit from treatment will be circumscribed.

Understanding the type of regression and disruptive countertransference responses to regressed mental states in the patient allowed me to recover and be more emotionally engaged. Three areas are explored. 1. Regression to dependency demands, 2. Regression to depression and suicidal behavior and 3. Regression to primitive fantasy.

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Eulogy for Garry Prouty

Gertrude Pollit
Co-Chair, Program Chair
Chicago Branch, ISPS-US

With great sorrow and deep regrets, especially to his beloved wife, Jill and his children, we eulogize the passing away of our dear friend and colleague Dr. Garry Prouty. Garry was a friend who stood by another person regardless of his needs. His empathy, patience, most sensitive understanding, and tolerance marked him way above the requirements not only as a friend but as an outstanding therapist. I experienced Garry as a real Mensch. As a colleague, Dr. Prouty's many attributes revealed themselves. I first met him as I had the pleasure to observe him professionally as the second Branch Leader of the Chicago Branch of ISPS-US, an organization in which I am an active member.

He was an excellent listener, with infinite patience. He had a special sensitivity to those needing his guidance and advice. As a lecturer, he was outstanding in his presentation of his subject. With humility, he revealed that he was easily able to put himself into the place of the listener. I have rarely met individuals demonstrating such outstanding communicative skills.

He engaged his audience, intellectually and emotionally, as soon as he started to utter a few words; a talent shown by only few. He was able to establish rapport with his audience and his open and frank personality came through well as did his understanding of the subject at hand. He presented his ideas in a simple and easily comprehendible manner.

Dr. Garry Prouty was world famous in Europe and beyond. He gave a lecture in Seoul, Korea and wrote a paper with Dr. Chan Hee Huh, a Korean psychiatrist. Some of his numerous publications were in the Netherlands, Belgium, Germany, Czech Republic, and the UK.

Dr. Prouty was best known for the concept which he called "Pre-therapy". He was able to reach severely disturbed patients, such as those suffering from catatonia, with his patience, perseverance and unique method of what I call psychotherapy and he called pre-therapy. This concept referred to his sense that he was preparing the patient for therapy. In my opinion, he administered therapy from the start.

Dr. Garry Prouty was trained in Person Centered, Experiential Psychotherapy by Eugene Gendlin at the University of Chicago and developed his own treatment approaches at clinics and hospitals dealing with psychotic and retarded clients. Dr. Prouty is a fellow of the Chicago Counseling and Psychotherapy Research Center, the Chicago Psychological Association and has served as an editorial consultant to domestic and international journals. Dr. Garry Prouty is well known for teaching, presenting, writing and research and is the author of several volumes of Pre-Therapy. He was the consultant to the American, English, Austrian and Italian client centered journals and was elected a Scientific Associate in the American Academy of Psychoanalysis and Dynamic Psychiatry.

The profession has lost an enthusiastic, well known clinician and a good and faithfully devoted friend to quite a few clinicians, especially to Dr. Bertram Karon. His sense of humor and his easy-going style endeared him to all of us and we shall miss him. However, Garry Prouty's work and spirit will continue to live within all of us.

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