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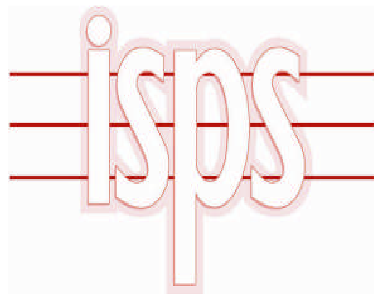

THE INTERNATIONAL SOCIETY FOR THE PSYCHOLOGICAL TREATMENTS OF THE SCHIZOPHRENIAS AND OTHER PSYCHOSES

UNITED STATES CHAPTER

ISPS-US Report from the President

Ann-Louise S. Silver
(president@isps-us.org)

I am continually pleased with the growing strength of ISPS-US. More of us are taking on projects, committing real time and effort to them. Jessica Arenella is leading the very active fundraising and grant proposal task force. She chairs its monthly conference calls, attends workshops on grant-seeking, and is working with her committee to increase our membership and receipt of donations. Leslie Wolowitz, who is on this committee, is developing a fundraising event to be held in Los Angeles. Comedian Jonathan Winters may be our featured speaker.

Our latest ISPS-US meeting in Santa Monica, on "Trauma and Psychosis," was really perfect: the program was cohesive and yet diverse, the speakers were captivating, and the setting was lovely. Dan Mackler was astounding. He opened the meeting with a gripping case presentation, and he did it without notes! I've never seen that before. Our keynoter, Dori Laub, guided us through videotaped interviews of chronically hospitalized survivors of the Holocaust, urging them to talk about their experiences. Previously silent and wooden creatures, they became living humans to those who heard them. Their place in the hospital community was transformed. The other presentations all reflected the theme of our meeting, that severe trauma can produce a chronically psychotic condition and that this may be more the rule than the exception. We owe it to every patient to take a careful, caring and truly inquisitive history; this may be our strongest treatment modality.

Our next adventure is our trip to Paris and Vevey, Switzerland, organized for us by ISPS-US members Jean-Max Gaudillière and Françoise Davoine. The meeting continues the theme of our meeting, which itself had been a tribute to their book, *History Beyond Trauma*, Other Press, 2004. We have a great crowd signing on for this exciting Lacanian view of the traumas of history and their sequellae in our patients and in the transference and countertransference. We will be talking intimately about this vital work rather than listening to polished papers. We will come back as ever closer friends.

And I am very pleased that Elyn Saks, J.D., psychoanalyst and Associate Dean and Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Science at the University of Southern California, and author of Interpreting Interpretations, may be joining ISPS-US. She has written on the topic of the legal issues in forced medicating. She was the dinner speaker at the recent meeting of the Washington Center for Psychoanalysis's New Directions Program. Each weekend meeting focuses on a particular theme, about which the participants write, workshopping their pieces at the meeting in small groups. The theme this February was "Madness" and Elyn Saks drew from her forthcoming book (August 2007; $24) *Going Sane or The Center Cannot Hold: My Journey Through Madness*. She vividly and eloquently described her work with psychoanalysts from various orientations – a Kleinian in London, a relational analyst at Yale – and how each helped. Her openness about her difficulties and her commitment to the value of psychotherapy make her an enormous asset to our group.

At that meeting, Danielle Bergeron, M.D. gave a stunning talk. She is a member of ISPS-US and a leader at GIFRIC (Groupe Interdisciplinaire Freudien de Recherches et d'Interventions Cliniques et Culturelles). She, Willy Appollon, M.D. and Lucie Cantin, M.Ps. direct "388," the center for the treatment of young adults struggling with psychosis, in Quebec City. She told me that they will be holding a meeting in May of 2008 in conjunction with the 400th anniversary of the founding of Quebec City, and are leaving room on the program for a panel from ISPS-US.

Meanwhile, Brian Koehler, Ph.D. and his committee are working on our March 2008 annual ISPS-US meeting. As expected, they are brimming with big ideas and lots of enthusiasm, networking with some key training programs in New York City. It is bound to be a big meeting. Start planning your submission!

I highly recommend Nancy Sherman's *Stoic Warriors: The Ancient Philosophy Behind the Military Mind*, Oxford University Press, 2005. On the faculty of the Washington Psychoanalytic Institute and a Professor of Philosophy at Georgetown University (on the faculty with Wilfried Ver Eecke), she was the inaugural holder of the Distiguished Chair in Ethics at the United States Naval Academy in Annapolis. Not only does she bring a brilliantly clear understanding of the military mind and its history from the days of Epictetus and Marcus Aurelius, she shows the reader how stoicism plays a role in our own lives. In ISPS-US, we have our own "political war" as we try to "hold the ground" for psychological treatments for people suffering from psychotic conditions, while Big Pharma with its "big guns" of weapons against the "brain diseases" of psychoses, tries pushing us into oblivion. Her book is helping me feel more grounded and historically oriented as I try remaining fierce but not irate, stubborn and not complacent. Most importantly, it is helping me understand how the military endures the realities of a brutal actual war in Iraq and Afghanistan.

> "Innate among man's most powerful strivings toward his fellow men… is an essentially therapeutic striving."
>
> *Harold F. Searles (1979)*

From the Executive Director

Karen Stern (contact@isps-us.org)

I am grateful for the huge pile on my desk of your membership dues for 2007, as well as some very generous donations. I am especially excited to welcome our first few lifetime members. Thanks for this wonderful response to our annual appeal—this is the bread and butter that allows us to keep operating and to extend our reach to those mental health practitioners, consumers, family members and other allies who have not yet found a community of people who believe in the power of psychotherapy to treat psychosis. For those of you who haven't yet renewed your membership for 2007, please do it today. We need you, your thoughts, your efforts, and yes, your money! You can send in the form included in this issue or pay by credit card at our website, www.isps-us.org. Note that dues are now $75 for *all professionals*, not just mental health professionals. Please fill out the form when you renew so I can make sure your information is up to date.

I am also very pleased to announce that the *2006 Membership Directory* is on its way to all of our members, or perhaps it is already in your hands by the time you read this newsletter. I hope it is useful for connecting with other members. We update our website member list once a month, too, so you can always check there for changes. Note that only members who ask to be listed on the Web appear there.

Our local branches continue to host high quality presentations and discussions, a real benefit of belonging to ISPS-US. There is a Berkshires branch in formation, so please contact Marilyn Charles (mcharles@msu.edu or 413-931-5233) if you are an interested member in Western Massachusetts or Upstate New York. We currently have active branches in Baltimore/DC, Chicago, Michigan, New England (Boston area), New York City, and Northern and Southern California. I encourage members in these areas to become involved, because nothing replaces the face-to-face contact with other members some of you only get once a year at the annual meeting. If there is no ISPS-US branch in your area, why not start one? I can help you out with the logistics. Just e-mail me at contact@isps-us.org. It will be worth the effort!

Finally, I am pleased to see new folks getting involved in ISPS-US projects. Daniel Mackler has done a great job of minding the Yahoo list. We have exciting plans for this year, and we need your involvement. The new fundraising group meets on a conference call once a month—contact Jessica Arenella to join them: jessarenella@yahoo.com. We are currently seeking a Membership Chair and a Research Chair, so please contact Ann Silver (ASilver@psychoanalysis.net) if you are interested. New initiatives are spawned on our Yahoo list, so join that if you want to be more involved. It's an education unto itself.

I hope to see many of you in New York City in March of 2008 for our annual meeting! Stay tuned for more details as Brian Koehler and his committee create a program that you won't want to miss!

Editors' Note

Warren Schwartz
Ayme Turnbull
(newsletter@isps-us.org)

Thank you for helping make your newsletter a continued success. We appreciate the thoughtful pieces members have submitted. We are strongly encouraging the readership to respond to printed pieces. One of the greatest qualities of ISPS-US is our willingness to enter into thoughtful and respectful dialogue with each other. This is evident on our listserv, where ideas build with each voice. We are committed to inclusiveness and would like to add your words, whomever you are and whatever you have to say.

From the Treasurer

Julie B. Wolter
(jwolter@centerforselfdevelopment.org)

I would like to start this report with an expression of gratitude toward those who volunteer their time and to those who donated to ISPS-US last year. We would not have the annual meetings, newsletters, website, listserv, or local meetings without the many individuals that dedicate time to these important activities. We had a 66% increase in members' contributions in 2006 over 2005. Of course, a big thanks to Karen Stern as her efficiency keeps our administrative costs within budget!

ISPS-US continues to grow, with total revenues of $37,361 and expenses of $38,485. This is a 9% increase in income and a 4% increase in expense over 2005. We ended 2006 with an overall loss of $1,124. This was quite good considering the annual meeting income came in at half the budgeted amount. Most of our income came from annual meeting receipts (37%), membership dues (38%), contributions (16%), and advertisements in our newsletters and directory (3%). Most of our expenses were annual meeting costs (45%), clerical (34%), and dues to ISPS (7%).

We were able to cut expenses to reduce the amount of revenue loss by e-mailing the newsletters and Ann Silver's donating her printing and binding services for mailings and the directory. We also did not spend as much as we had budgeted for the website or for the annual meeting.

The executive committee will be finalizing the 2007 budget during the March conference call. In 2007, we will be focus-

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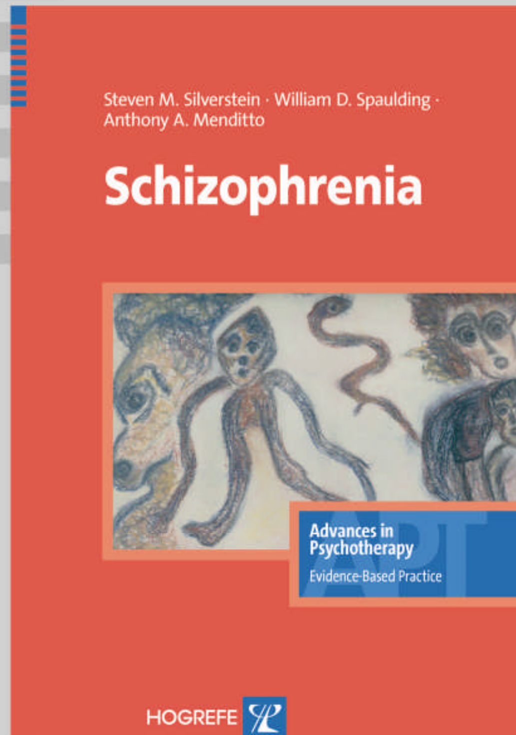

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Physician-Assisted Suicide in Switzerland

Daniel Mackler
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I recently read an article on the Internet (referenced below) which states that "A ruling by Switzerland's highest court [on 2/2/07] has opened up the possibility that people with serious mental illnesses could be helped by doctors to take their own lives." The ruling added that "It must be recognized that an incurable, permanent, serious mental disorder can cause similar suffering as a physical (disorder), making life appear unbearable to the patient in the long term."

Many of my patients who have been diagnosed with schizophrenia and bipolar disorder have been told – wrongly, in my opinion – that they have brain diseases which are "incurable" and "permanent." Am I to be surprised that many lose hope after being told this – and that some even become suicidal?! I find this all the more reason for us as therapists to keep our hope afloat, to learn about the realities of potential healing from severe "mental illnesses" – and to transmit this hope to our patients! I prefer to help relieve my patients from their suffering not by helping them to commit suicide but by helping them work out their problems.

The article goes on: "Various organizations exist in Switzerland to help people who want to commit suicide, and assisting someone to die is not punishable under Swiss law as long as there is no 'selfish motivation' for doing so."

I can't help but wonder if countertransference feelings count as "selfish motives?" Certainly many seriously depressed or psychotic patients I've worked with have kicked up all sorts of seemingly "selfish" feelings in me. I consider it one of my strengths that I admit them!

Reference: http://news.yahoo.com/s/ap/20070203/ap_on_re_eu/switzerland_assisted_suicide

Thanks to Daniel Mackler for his thoughts on the possibility of legal physician-assisted suicide in Switzerland. As he points out, this issue involves complex ethical, cultural, and more 'local' transference/countertransference considerations. Please take the time to respond to Daniel's thoughts and/or to the article for the next newsletter issue.

Mental Health System Due for Radical Reform

Ron Unger
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The following piece by Ron Unger was originally printed as a "Guest Viewpoint" in The Register-Guard, Eugene, Oregon, on October 12, 2006.

The mental health system is expected to care for people whose apparently mistaken beliefs, or "delusions," make them disabled or possibly dangerous. One might hope that mental health professionals would be the first to notice when their own beliefs become mistaken enough to be disabling or dangerous.

Unfortunately, nothing more illustrates the need for radical reform than the huge gap between the beliefs guiding much of the current treatment and the actual evidence about mental health problems and outcomes. This gap is most extreme with regard to the most serious and costly problems, such as those labeled with schizophrenia.

The beliefs shaping most current schizophrenia treatment might be summarized as follows:

> "These people have a brain disease. Their bizarre thoughts, emotions and experiences are not understandable and are simply due to the disease, not to their life experience. Psychotherapy is ineffective with them. Their best hope is to adjust to their disability, relying on modern medications for the rest of their lives."

These beliefs themselves qualify as delusional when compared to research evidence.

True, people diagnosed with schizophrenia often show brain abnormalities – but then again they often do not, and people not mentally troubled frequently show the same abnormalities. Trauma, especially childhood trauma, has been demonstrated to make a later diagnosis of schizophrenia more likely. Children who have been traumatized are also more likely to show the same brain abnormalities sometimes seen in people diagnosed with schizophrenia. Some forms of psychotherapy have been proven significantly effective and helpful.

In the long term, many people diagnosed with schizophrenia recover completely, eventually not needing any medication or other treatment. When people do recover, they credit a trusting relationship with someone who believed in them more frequently than they credit medical treatment. Such recoveries, according to two World Health Organization (WHO) studies, are twice as likely in less developed countries, which mostly lack our modern medical approaches.

If recovery from a particular cancer were found to be twice as likely in less developed countries, we would fundamentally question our treatment methods. Yet critical self-examination has been rare in the mental health field. Since the second WHO study was released in 1992, it has been mostly business as usual, with the emphasis on biology and more medications.

So how do we make the transition from ineffective mental health care based on misinformation to an effective system that actually helps people recover?

In many fields, consumer demand leads to changes in services. But the mental health field has discounted consumer opinions, has defined "mentally ill" people as incapable of making useful choices, and has insisted that diagnosed people passively accept whatever treatment is offered. When people resist, treatment is often forced, commonly resulting in emotional trauma that in turn increases emotional problems.

More recently, however, mental health consumers and ex-consumer "survivors" are organizing to resist this paradigm and are asking both for a voice and for a choice in the treatment they receive. While some see this push as disruptive, it seems more likely that it is our best hope for a transition to a more effective (and ultimately less costly) mental health system.

Perhaps our most fundamental human quality is our ability to choose. Psychiatrist Victor Frankl wrote that his ability to choose his attitude toward unfolding events was the one thing the Nazis could not take away from him in a concentration camp. Yet mental health treatment is designed to change people's minds and attitudes, and if it is delivered without consent or choice of alternatives, people feel dehumanized.

On the other hand, when people are given treatment choices, and especially when some of those choices involve collaborative relationships with others who assist them in learning to sort things out and make better choices in the future, people feel respected and real recovery becomes possible.

Film Review: "Sylvia" (2003), Part II of II

Patricia L. Gibbs
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From Part I:

The movie "Sylvia" is best seen as portraying a segment of Plath's life – that which was spent with Ted Hughes. Because of this focus, the film omits crucial aspects of Sylvia Plath's life and gives us a distorted and incomplete picture. Many of Plath's poems have been understood as having feminist themes; however, I believe the film does not reflect this interpretation adequately. Nor does the film understand the complexity of Plath's character from a sophisticated psychoanalytic perspective or describe adequately the toxic effects Ted Hughes had upon Plath.

The movie hints at the possibility of misogyny and sexism as a theme of importance in understanding Plath's life but falls well short of developing these into a clear themes or opinions. I believe this omission can be seen as reflecting the very sexism that still defines many aspects of our culture – including the sexism involved in biographical privilege in the film industry. Hughes' possession and control of Plath's work after her death, and his restriction and manipulation of it, is completely absent in the film. History is written, some would argue, by whoever owns history. In this case it is Hughes who owned Plath's story, Hughes who judged what was to be written and published.

Murderous Rage and Psychosis

The murderous rage that was such an important part of Plath's unconscious self-destructiveness is best understood in psychoanalytic terms. Aspects of Plath's relationship with her mother will help us understand some of this murderous rage. The movie does not reveal the enormous role Sylvia's mother had in her becoming a writer. Aurelia actively encouraged her daughter to become a writer, bought her diaries, and entered her in writing contests as an adolescent. Plath writes in her early diaries of hating her mother; however, her deep and frequent lifelong correspondence with her mother continued right up to her suicide. The movie illuminates none of this for us.

The failure to understand Plath in terms of her most widely known work, *The Bell Jar*, is, I believe, another major failing of the movie. This novel allows us to understand Plath's murderous rage much more meaningfully than does the movie. At one point in the novel, which Plath considered to be autobiographical, Ester sleeps in the same room with her mother. In the streetlight filtering through the blinds, Ester describes the pin curls on her mother's head as "a row of little bayonets." Sleeping with her mouth open slightly, her mother begins to snore. "The piggish noise irritated me," Ester says, and she tells herself the only way to stop it would be "to take the column of skin and sinew from which it rose and twist it to silence between my hands." Tragically, Plath's unconscious murderous rage motivated her to repeatedly seek revenge, destruction, and death, throughout her life.

Indeed, Marjorie Perloff, in reviewing Plath's work and life, states: "Plath's suicide was inevitable . . . it was brought on, not by her actual circumstances, but by her essential and seemingly incurable schizophrenia." Her novel *The Bell Jar* is considered by many to offer insight into the experience of schizophrenia and psychotic depression. It also reveals the impact that Plath's hospitalization and electroshock treatments had upon her. The movie, unfortunately, tells us little about Plath's work on *The Bell Jar* or anything at all about her nervous breakdown, hospitalization, and treatment.

Harold Searles is a psychoanalyst who has developed our most comprehensive psychoanalytic understanding of schizophrenia. Searles speaks about the schizophrenic's constant experience of what he calls "the inevitability of death." This aspect of the schizophrenic experience can certainly be seen throughout Plath's life.

Ronald `Hayman, in his biography of Plath, claims that the shock therapy Plath received after her 1954 breakdown changed her relationship with her mother forever, whom she blamed for authorizing the ECT. In The Bell Jar, Plath speaks about the shock treatments, saying: "When Ester tries to smile, she finds her skin has gone stiff, like parchment. The doctor fits metal plates on either side of her head, buckles them into place with a strap...She shuts her eyes,...something shakes her like the end of the world, shrilling through an air crackling with blue light . . . to make it feel like her bones would break and the sap fly out of her." The movie's avoidance of the pain involved in Plath's breakdown, suicide attempt, and psychiatric treatment is striking, and gives us an inauthentic reflection of her life.

Plath's Motherhood and the Unconscious

Finally, I'd like to offer a brief consideration of Plath's motherhood. The particulars of Plath's suicide force us to remember that she was a mother who killed herself. Hayman says that Plath's last poems were filled with hate towards her mother. I frankly see more man-hating than mother-hating in Plath's last poems, such as "Daddy" and "Lady Lazarus." But it doesn't matter, of course, since conscious experiences reflecting hate and murderousness are always associated with an unconscious experience of a hateful and murderous SELF. There is no difference between the self and the object unconsciously. So, perhaps Plath's last poems do help us understand something about her experience of motherhood.

Borrowing again from psychoanalysis, we know that those we consciously claim to hate, we unconsciously identify with. And every mother knows the mixed feelings involved in seeing one's own mother in ourselves as we mother our children. I believe that loving mothers commit suicide MOSTLY because they are convinced that their children are better off without them. Plath would be horrified to see herself filled with the very hatred and murderousness she saw in her own mother, Hughes, or anyone else.

The movie's focus on Plath's relationship with Hughes lends itself to an understanding of Plath that is incorrect and incomplete. Feminist themes are undeveloped and exclude Hughes's posthumous control and manipulation of Plath's work. Psychodynamic influences pale in the movie's understanding of Plath. A psychoanalytic understanding of her unconscious murderous rage and self-destructiveness would have added valid insight into the film's depiction of Sylvia Plath.

Why Clients Should Not Take Psychotherapists into Their Confidence

James (Jim) B. Gottstein
(jim.gottstein@psychrights.org)

The editors would like to invite readers to respond to the following thought-provoking piece by Jim Gottstein, Esq. It is quite literally disquieting that our work has become increasingly threatened by the pressures to release private information about our patients. Jim's points are in line with those of Bollas and Sundelson in "The New Informants" (1995, Jason Aronson). Please take the time to respond to Jim's piece with your experiences of these threats and how you have managed them in your work with patients or, if you are a patient, how these pressures have made (or not made) their way into your treatment. We look forward to your responses and hope to print some of them in our next issue.

The assertion that clients should not take psychotherapists into their confidence is provocative. It is meant to be. As an attorney, I have experienced and heard about far too many instances of psychotherapy confidences being breached to the extreme detriment of the client to be sanguine. Most psychotherapists are aware of *Tarasoff*-type reporting requirements and are also aware that client confidentiality has been made secondary to getting paid by third party payors. The problem is far more pervasive than that. I think it is fair to say that, with the exception of unique programs such as Volunteers In Psychotherapy in Connecticut, where confidentiality is taken extremely seriously, a psychotherapy client never has any reasonable assurance that confidences will be maintained. This can have disastrous consequences.

This is in sharp contrast to the impression given that confidences will be maintained. For example, in holding that there is a privilege against disclosure of psychotherapy information in federal courts, no less an authority than the United States Supreme Court has stated:

> "Effective psychotherapy...depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.
>
> * *
>
> [I]f the purpose of the privilege is to be served, the participants in the confidential conversation 'must be able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.'"

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At the same time, the Court said:

> "Although it would be premature to speculate about most future developments in the federal psychotherapist privilege, we do not doubt that there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist."

In coming to its conclusion that there should be a federal court psychotherapist privilege, the *Jaffee* Court relied on the existence of such privileges in one form or another in all 50 states. However, a perusal of just a small sampling of states reveals the following exceptions:

- In a proceeding to terminate parental rights
- All proceedings where competency is at issue
- Where the psychotherapist thinks their client should be hospitalized
- Circumstances under which privileged communication is abrogated under the law (whatever that means)
- Where the interest of justice would be served (whatever that means) when someone is charged with homicide or injuring person
- Court-ordered examination
- When the validity of a Will is at issue
- If a person's mental condition is raised
- In criminal cases of necessity (whatever that means)
- Witness against a criminal defendant

With respect to this last one, a majority of state courts have held that a criminal defendant, upon a preliminary showing that the records likely contain exculpatory evidence, is entitled to some form of pretrial discovery of a prosecution witness's mental health treatment records that would otherwise be subject to an "absolute" privilege.

Section 4.02 of the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct*, Standard 4.02 states, in part:

> "4.02 Discussing the Limits of Con-

fidentiality (a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)
(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant."

In light of the multitude of exceptions to confidentiality swallowing the rule, psychotherapy clients can have no assurance that their confidences will be kept and should be so informed. Does this really mean clients should not take psychotherapists into their confidence as suggested by the title? Not really. They can reasonably decide that the benefits outweigh the risks. However, the risk of severe adverse consequences, such as incarceration, loss of children, loss of autonomy, and ruinous financial losses are realistic possibilities and quite common. I advise extreme caution to clients when such possibilities are a reasonable prospect.

Is the plethora of ways in which psychotherapeutic confidences are breached a state of affairs with which psychotherapists should be comfortable? I think not.

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1. See www.ctvip.org
2. *Jafee v. Redmond*, 518 US 1 (1996)
3. *Id*

Psychosis: Psychological Approaches and Their Effectiveness

This book updates psychiatrists, psychologists and nurses on a range of psychological therapies for psychosis. The authors describe in clear language the differing contexts, aims and methods of various psychological treatment interventions and describes the integration of a range of these approaches used in early intervention, designed to improve the chances of full recovery in the community and minimize chronic disability. 306 pages

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Obituary of Wayne Fenton, M.D.

Ann-Louise S. Silver
(asilver@psychoanalysis.net)

Even three months after Wayne Fenton's murder on September 3, 2006, and after attending his funeral along with over 800 others, I still cannot absorb the horrifying reality that Wayne is gone. Wayne was only 53 when a 19-year-old "hard-nosed" ice hockey player pummeled him to death in his office. Wayne had met with him in consultation for a local psychiatrist and had told the patient's father he would try to persuade him to take oral medication for his psychotic disorder. The patient called later, pleading for a second appointment. Apparently, Wayne was concerned enough that he talked the situation over with his wife, who volunteered to go with him and stay in the waiting room, but Wayne decided this would not be necessary. His death has stirred the anxieties of the mental health community. Listservs are filled with discussions of potentially violent patients and how best to protect oneself from harm.

Wayne Fenton presenting at the 1994 ISPS meeting in Washington, D.C.

Wayne was a dynamo, always a rising star. He had published over fifty research papers on schizophrenia and related topics along with many textbook chapters. He could be counted on to give a polished and erudite keynote address, as he did at the 1997 ISPS conference in London. He had become a highly-esteemed second in command at the National Institute of Mental Health, and frequently served as a consultant on especially difficult patients. He consulted to troubled hospitals as well. Newspaper articles about his murder quote a 2002 interview he gave to the Washington Post, on the lack of appropriate care for those with schizophrenia, "All one has to do is walk through a downtown area to appreciate that the availability of adequate treatment for patients with schizophrenia and other mental illnesses is a serious problem in this country….We wouldn't let our 80-year-old mother with Alzheimer's live on a grate. Why is it all right for a 30-year-old daughter with schizophrenia?"

Wayne's self-confidence and firmness were always impressive. When the Medical Director of Chestnut Lodge, Dexter Bullard, Jr. (Rusty), was diagnosed with lung cancer, he named Wayne as the next Medical Director. He handled the job beautifully, rapidly getting the hospital's finances on much firmer ground.

Wayne joined the National Institute of Mental Health staff in 1999 as Director of the Division of Adult Translational Research and Associate Director for Clinical Affairs. He supervised the development of diagnostic instruments and interventions for mental illnesses, especially schizophrenia. He aimed to establish standard outcome measures of cognitive ability in those suffering from schizophrenia to find treatments which would improve cognitive impairment. Additionally, he served as Deputy Editor of Schizophrenia Bulletin and served as a consultant to the Department of Justice, Civil Rights Division. He was active in the National Alliance on Mental Illness, serving on its Scientific Council.

As NIMH's liaison to the American Psychiatric Association and World Psychiatric Association, he helped shape the research agenda for the forthcoming DSM-V diagnostic manual. He also worked to enhance training opportunities in patient-oriented research for psychiatrists, to develop and promote a neuroscience middle school curriculum, and to launch new NIMH treatment development initiatives. He received many national awards, including regular recognition in the Best Doctors in America.

Wayne had arrived at Chestnut Lodge from Yale, working as Thomas McGlashan's assistant at the Research Center. They co-authored many papers and book chapters together, many in the American Journal of Psychiatry. Examples include "Long-term residential care: Treatment of choice for refractory character disorder?," "Risk of schizophrenia in character disordered patients," "The prognostic significance of obsessive-compulsive

symptoms in schizophrenia," and "Sustained remission in drug-free schizophrenic patients." When Tom left Chestnut Lodge to become the Medical Director of the Yale Psychiatric Institute, an institution which had trained a large proportion of the Lodge's medical staff, Wayne took over as Director of Research. He led the first hospital-based study of the use of clozapine in the United States, as well as later studies of olanzapine and other atypical anti-psychotic agents. In an October 1987 paper, the two authors found a group of 23 largely chronically schizophrenic patients who "sustained good outcome without maintenance antipsychotic medication over an average of 15 years. Retrospective study of these patients revealed that their distinguishing characteristics at admission included better premorbid social and occupational adjustment, higher levels of accrued psychosocial competence and acquired skills, fewer hebephrenic traits, and the preservation of affect (depressed mood). Hence, even within a largely chronic patient sample, classic predictors of good outcome may also be useful in predicting sustained remission without medication." Naturally, I choose a quote that fits with my personal bias and emphasis within ISPS.

Wayne and I both grew up in Albany, New York, and our fathers worked together at the State's Department of Health. At a party recently, Wayne told me to close my eyes and figure out what he was putting in my palm. It turned out to be a token from the Albany bus system. We never met in Albany. I do not remember any department picnics, and he was 11 years younger than I. He moved to the Washington area in 7th grade and later married his high school sweetheart, Linda.

Wayne received his B.A. from Bard College in New York, majoring in experimental psychology. He graduated from George Washington University School of Medicine in 1979, interned at the Norwalk Hospital in Connecticut and completed a psychiatric residency at Yale University. He also completed a National Research Service Award Fellowship at the Institution for Social and Policy Studies at Yale.

His friends and neighbors will miss the sight of him on his porch playing country and western songs on his guitar and singing softly. And they will miss his enthusiasm for film and reports from the Sundance and Cannes Festivals. All who knew him will miss his energy, erudition and clear thinking. Wayne leaves three grown daughters and a 19-year-old son.

Tribute to Professor Bertram P. Karon

Leslie A. Wolowitz
(lwol215@aol.com)

Dr. Bertram P. Karon is an honorary "lifetime member" of the United States Chapter of the International Society for the Psychotherapy of Schizophrenia. Through his generous donation and many years of service to the cause of psychotherapy for the treatment of psychosis, Dr. Karon is an example for our group. It is my privilege to recognize the efforts of a man who has done so much for so many students, patients, colleagues, and families.

Bertram P. Karon has the unusual gift of being able to understand and construct scientific research and theory. He heals lives through his work as a brilliant psychoanalytic clinician. At Princeton, during his graduate studies, Dr. Sylvan Tomkins and Dr. Irving Alexander both decided that their student had the most "g" (general intelligence) of anyone they knew. By the time I got to graduate school at Michigan State University, a fellow classmate (Dr. David Rosenberg) called Karon a "wizard." He could interpret anything and one senior peer told me (from experience) that he was a saint for the transformations he had witnessed in Karon's work with psychotic patients.

Dr. Karon's perspective is that any kind of psychotic symptom is, in essence, an adaptation to psychological trauma, abuse, and neglect. Rather than seeing patients as diagnoses fated to the underworld of isolation and suffering, he sees them as fellow human beings (in the Sullivanian tradition), capable of realizing their potentials with the help of a trustworthy, strong, understanding therapist.

Dr. Karon was not content to develop his theory and clinical arts in a limited venue. He envisioned the importance of sharing his knowledge as widely and as powerfully as possible. With his landmark book, co-written with Dr. Gary Vandenboss: The Psychotherapy of Schizophrenia: Treatment of Choice, it is fair to say that he greatly influenced the course of treatment of psychosis in the United States and throughout the world. He has published hundreds of articles, taught countless undergraduate and graduate students, and analytic candidates.

Educated at Harvard, on scholarship (class of 1952), and Princeton (1957), Dr. Karon was so gifted in statistical analysis that he was awarded a fellowship at the Educational Testing Service (ETS) during graduate school. His dissertation on the destructive psychological effects of race relations was published as a book.

Bert truly embodies the scientist/practioner model. He has been recognized for his efforts by diverse professional organizations and has received the Distinguished Psychoanalytic Award (1988), The Raymond D. Fowler Award (1990) – for his graduate teaching, the Freida-Fromm Reichmann Memorial Lecturer from the Washington School of Psychiatry (2001), and the APA (Division 39) Scientific Research Award, in 2003. He has collaborated with Dr. Peter Breggin in helping to fight the "broken brain" model of mental illness and to study the harmful effects of ECT and neuroleptics.

Dr. Karon has had an enormous impact on our understanding and treatment of schizophrenia. He has helped us to locate our fear of coming in contact with psychotic process that is on a continuum. We are afraid of what lies in our own hearts and minds. In this sense, Dr. Karon has taken the best of Freud's work and extended it to a logical conclusion.

Finally, I would like to speak to some of my personal encounters with Dr. Karon, lest we forget the wonderful and unique qualities that are part and parcel of his professional contributions. I first met Dr. Karon on an interview (in the late 1980's) for a position at the doctoral clinical program at MSU. I was none too keen to be residing and studying in East Lansing, having been born, raised, and educated in Ann Arbor, Michigan. However, I had heard about Dr. Karon and was excited to meet a man who had the courage to advocate for psychoanalysis for schizophrenia.

That day, I was overwhelmed by his brilliance, integrity and generosity. We went to Arby's restaurant in his ancient, sea green Oldsmobile sedan (an Olds because it was manufactured in Lansing). Over a cup of coffee (the drink of choice for both interviewee and Professor), I proceeded to do a poor job of interviewing. Bert looked at me and said, "You know, Leslie, you are supposed to be selling yourself. Why don't you try again?" I was flabbergasted. The man was not only on to my neurosis, he was willing to actively help me and give me the opportu-

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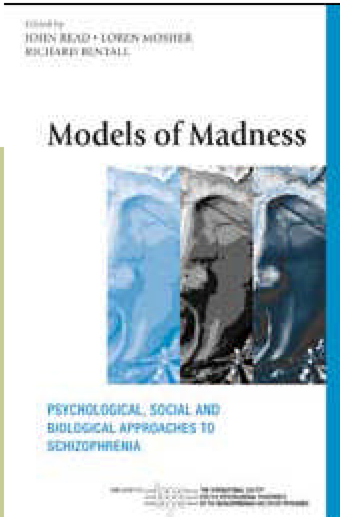

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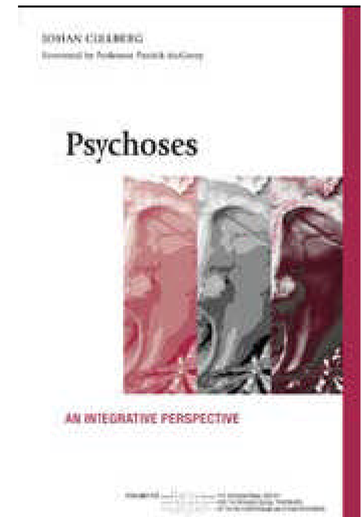

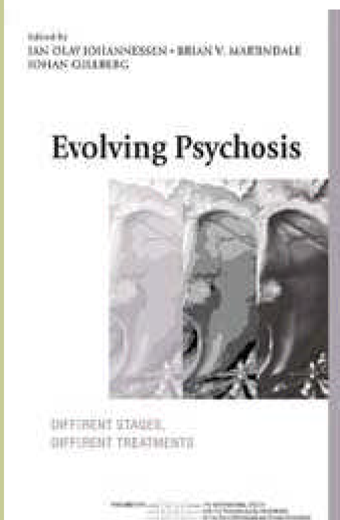

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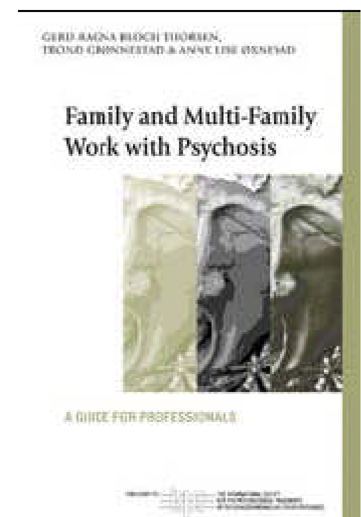

(Continued from page 8)

nity I needed to develop my potential. I think I rose to the occasion, because I was accepted into the program. The following five years (of course, in hindsight) were some of the most meaningful of my life.

I made every effort to apprentice myself to Dr. Karon. His enthusiasm for psychoanalysis was only matched by his enthusiasm for MSU basketball and football. With Mary Karon's ironic vision and sense of humor– I felt re-parented, mentored, and prepared for a career as a clinical psychologist who was not afraid to treat whomever walked into the 'consulting room.' I have learned from him how to teach, how to practice, how to mentor students, and how to be a better human being. ISPS-US has now become my intellectual and emotional "home" as well. Through Dr. Karon, I have a place to feel less alone in this hard work. Dr. Ann-Louise Silver has also served as a mentor and friend.

Dr. Bertam P. Karon has recognized ISPS-US in donating so much of his resources. It is our pleasure to recognize him as an honorary lifetime member of a unique organization. To Sir Bert, with Love!

From the Treasurer, continued

Julie B. Wolter
(jwolter@centerforselfdevelopment.org)

(Continued from page 2)

ing more efforts on philanthropy and grants, with these activities being handled by the fundraising committee, chaired by Jessica Arenella. The next annual meeting will be hosted by the New York branch in the Spring of 2008. We believe that the low membership numbers at the conference were due to the Fall's being a saturated time for conferences as well as the Southern California branch's being fairly new.

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An Analysis of the Shadow Side of Frieda Fromm-Reichmann, Part III of III

Daniel Mackler
(dmackler58@aol.com)

Based On *To Redeem One Person Is to Redeem the World*, by Gail Hornstein

[Unless otherwise noted all bracketed page numbers refer to Gail Hornstein's book]

Last paragraph of Part II:

And surely Frieda's blind spots, like all of our blind spots, extended into her work with her patients, at least those who had parents with significant narcissistic deficits, which I would presume was no small percentage – especially once she started working primarily with schizophrenics. Thus it is curious that it was Frieda Fromm-Reichmann who created the concept of the 'schizophrenogenic mother,' though Hornstein did introduce the valid possibility that although Frieda was likely expressing some hostility at her mother through the formation of this concept, she was also using it to unconsciously praise Klara for essentially having been a good enough mother *not* to drive her mad. One wonders, however, what madness Frieda did have to hold in check to survive in a family of origin whose behavioral norms severely circumscribed her needs and where, if I may repeat myself, "misbehavior earned Klara's look of disapproval, a punishment far worse in this intense household than any beating would have been." [p. 10] Perhaps it was safer for Frieda, with her idealization of her mother, to create the concept of the schizophrenogenic mother than it was to create a concept a little bit closer to home, such as the 'narcissistogenic mother.'

Hornstein tended to downplay most of the examples of Frieda's narcissism. Hornstein did, however, share many examples of Frieda's extreme entitlement in ordering others around and in feeling like the world literally existed to be at her beck and call. For instance, note the beginning of her friendship with Virginia Gunst, a rich housewife from nearby Richmond:

> Gunst attended a series of lectures Frieda gave at the Washington School of Psychiatry and went up at the end to express her appreciation. Frieda was preoccupied with finding someone to drive her to Santa Fe [from Maryland, a trip of two thousand miles] later that week for summer vacation; the friend who was supposed to accompany her had suddenly taken ill. After chatting politely with Gunst (whom she had never previously met), Frieda gave her a warm smile and asked, "Are you a good driver?" Gunst, taken aback, blurted out, "Well, I was head of the Army Motor Corps for four years during the war." Frieda was delighted. "Fine. We leave in four days…. Go home now and break the news to your nice husband and family. I do not believe they will object to your going with me or being away two weeks. You can take the train back to Washington." [p. 221]

This degree of entitlement is frightening. It struck me as eerily similar to the control and manipulation Frieda experienced under the rule of her mother. This was not the action of an adult who was respected in her family of origin. It is the behavior of an adult who was mistreated – and denied it and compulsively replicated it from the position of the aggressor, in a misplaced desire to heal. A person who was connected with her deepest sense of self would be repulsed by such entitled use of others, even if, as in Frieda's case, she was providing her new "friend" the opportunity to spend time with a famous and innovative psychoanalyst.

Likewise, Hornstein noted that Frieda had very few close friends who were not also her ex-patients. This is a total misuse of her patients – not to mention another likely repetition compulsion of her mother's entitled use of her for her own narcissistic purposes – and demonstrates just how much Frieda nurtured them with an unconscious intention of having them heal to be there…for her. Hornstein quoted Margaret Rioch, a colleague of Frieda's, as saying: "There was a particular quality to [Frieda's caring] that was totally unequal; Frieda helped you the way she decided you needed help." [p. 221] This again sounds reminiscent of Klara and

(Continued on page 11)

provides evidence for the dilemma Frieda faced as a child: that if you played along with the parental rules, you were "in" and received love, and if you didn't, you were "out." It also shows a flip side of Frieda's personality: if you were her patient she listened to your needs; if you were her colleague, or had graduated from becoming her patient into her friend, her role shifted, and she began inserting her own needs into the relationship and forced you – perhaps through giving "loving" perks in return – to meet them.

A good therapist does not befriend her patients. She instead – like a good parent – nurtures them for the sake of their own progressive independence and, when the time is right, lets them go free, with no strings attached. Thus, when a therapist has boundaries as murky as Frieda's, it's a clear sign that something is not going right in her personal life. Frieda herself agreed with this on paper, stating correctly in her Principles of Intensive Psychotherapy that the therapist:

> "must have enough sources of satisfaction and security in his nonprofessional life to forgo the temptation of using his patients for the pursuit of his personal satisfaction or security." [p. 7]

Likewise, Frieda's actual behavior contradicts Gail Hornstein's statement that "Frieda had an unerring eye for exploitation, and never used patients for her own ends." [p. xv] Certainly she failed the test here with Erich Fromm, whom she took to bed. And she failed as well with the highly paranoid "Mr. R.," a schizophrenic man who "constantly searched the [therapy] room for hidden cameras, wires in the walls, or other means of spying on him," [p. 263] yet whose sessions Frieda manipulatively and at times even cruelly insisted on tape recording completely against his will so she could share their work with her colleagues – and so she could assuage her own anxieties at her patient's expense [p. 266]. According to Hornstein herself, this bit of "psychic sabotage" by Frieda with Mr. R. only drove him further over the edge [p. 328].

Meanwhile, Hornstein never really labeled Frieda as depressed at all, much less connected her depression to her unfulfilled narcissism. Hornstein blamed her sadness and social isolation and lack of more open, healthy peer relationships on her cultural alienation in America and her trauma from having escaped the Nazis in 1933. The problem is, this interpretation, though partially valid – because clearly being forced on fear of death to give up her entire life, her country, her work, her family, and her language *was* a manifest horror – ultimately doesn't add up because Frieda's significant character flaws were evident in Germany long before the Nazis. After all, she seduced Erich Fromm in 1925, eight years before the Nazis even came to power. And she had been emotionally seduced by her own mother (and father) by the time she was three years old.

Thus I felt Hornstein couldn't sufficiently address Frieda's loneliness and isolation in America because she largely denied the deeper undercurrent of Frieda's unhealed wounds of childhood. This left Hornstein with no other option but to label that which exacerbated the problem as the problem itself. I suspect that loneliness and depression existed all along throughout Frieda's life in Germany but just weren't as overt then because she was more socially connected – that is, more overtly winning the professional contest. In America she was a fish out of water in so many ways – both in terms of her positives and her negatives.

The author, Daniel Mackler, presenting at the start of the ISPS-US 8th Annual Meeting in Anaheim, California.

It may be less than coincidental that Frieda's last paper, left unfinished, was on loneliness. This was her final frontier, and a wholly personal one, much as Frieda presented it in professional terms. From the evidence of the neglects and abuses she suffered in her childhood in her family system, her loneliness clearly predated her time at Chestnut Lodge, predated her social isolation in America, predated her fleeing from the Nazis, and predated her rape. Here she was facing the loneliness of her childhood. This was the deep and anguished emotional isolation of the child forced to abandon and split off her needs because her parents failed to adequately love, witness, and truly cherish her. Yet the fact that she only tangentially addressed this deepest loneliness at all tells more about Frieda's psychic state than what she wrote. It struck me as an emotionally incomplete paper, suggesting to me why it held her captive to the end.

But Frieda's real captors were her unhealed wounds of childhood. Her struggle to write the loneliness paper was an expression of her personal quest to heal, and its incompleteness sheds light on the incompleteness of her grieving process. She – like the rest of us, whether we consciously admit it or not – desperately wanted to heal her deepest wounds to the core of her being, and didn't have the tools to do it. Although Hornstein commented that "Frieda would have been quick to credit her mother for providing the grounding for her healthy development," [p. 134] I saw her misery in later life as proving quite the opposite: that Frieda had *not* received enough of a healthy grounding to be able *to* heal. She was still simply too emotionally identified with her introjected, troubled family of origin to be able to nurture herself toward a more emotionally integrated and well-rounded life. To have taken the leaps she needed to take, that is, to confront and heal her parental introjects, would have been tantamount to a betrayal of her mother from her mother's perspective. And add on top of this that in order to confront and heal her introjects Frieda would have had to betray more than six decades of her own unconscious replications of her parents' violations against her.

But I suspect that Frieda, at age sixty-six, just one year before her death, was starting to heal anyway – in spite of all the odds against her. Her grief process was starting to kick up, and in many ways by no choice of her own. She was going painfully deaf and could no longer function effectively as a working psychiatrist – and she was a confirmed workaholic, no less, who relied on a breathtakingly addictive work pace to maintain her emotional equilibrium. With the stripping of her professional adequacy, she was forced into withdrawal from her pill of grandiosity, which brought her deeper demons right to the fore. Combine this with the death of her repressive mother only five short years before, and I believe she simply lost her internal structure that had for so long allowed her to keep her repressed horrors

and loneliness safely buried.

That explained to me why a year before her death she finally started opening up emotionally – on the famous tape recordings in Palo Alto for her colleagues where "she spoke movingly of her long-buried guilt at her father's death and bitterly recalled the behavior of her 'Aryan' colleagues in the 1930s." [p. 320] She was desperate and willing to try new options. (This said, her introjected perspective remains evident on the tape by the fact that she still couldn't address her own role in having seduced Erich Fromm, and instead "laughingly recounted [it]." [p. 320]) I didn't take it as coincidental that she was sharing this in front of others and taping it on top of that. I felt she was doing that more for narcissistic than biographical purposes – she who rarely talked about her personal life at all and made "friends promise to burn [her] files at her death." [p. xx] I suspect she was telling others of her troubles in this non-private way because she, the unhealed child who was allowed no unauthorized needs, had mixed up her thirst to be privately witnessed in a healing way with her grandiose desire to be exhibitionistic, which is just an externalized and ineffective attempt to heal. This also parallels her own parents having inappropriately confided their troubles in her for the attempted purpose of their own healing, which never worked anyway, considering that ultimately her father – whom you might consider her first male patient – suicided. Hornstein also commented that Frieda had plans to see a psychiatrist herself in her last months of life [p. 331] – a clear sign that her grief and pain were entering her consciousness at a new level and that her previous methods of keeping them split off were no longer functioning as effectively.

From this perspective, it makes sense why Frieda never finished her loneliness paper. Her own history of loneliness was simply too painful and too overwhelming for her to face, much less process and then translate into a theoretical format. The anguish went too deep, was too buried, and too compounded under too many years of avoidance and externalization and replication. Despite her strength at handling and managing and channeling the pain of others, her own was too great for her. This is what leads me to believe that Frieda chose death instead – as an easier alternative to healing. I have witnessed this in others more than once: that when they open the doors to their deep unconscious and *feel* the immense horror that has been buried in there for decades – and recognize its magnitude – they simply die to avoid it. This to me forms the gray territory between committing suicide and simply emotionally giving up. And Hornstein did note the mysterious and potentially suicidal circumstances of Frieda's death, which shared an uncanny surface parallel with those of her father's seeming suicide, including their similar ages, loss of hearing, and loss of professional competence. I would not be surprised if their internal experiences were parallel as well. After all, her father was a traumatized child whose own needs were bypassed for the "good" of his family of origin.

So then we come to the whole matter of Frieda Fromm-Reichmann's gift for healing. Although Frieda's genius for working with schizophrenics is the stuff of which legends are made, which is what draws me to her still, I feel Frieda's real genius was that of the courageous pioneer, not that of the fully manifested healer. What I suspect is that at best Frieda could only take patients so far on the healing journey. Her gift was taking a very broken Humpty Dumpty and putting him back together again, and tenaciously assisting in making him into a reasonably good egg. (This is despite the fact that she failed with many schizophrenics, much as they realistically seemed to be beyond the help of almost anyone, so it seems unfair to fault her for that.) But had a reconstituted Humpty Dumpty walked into her office and wanted help to hatch and grow into a fully enlightened bird, I don't think Frieda would have been of much use, because she hadn't figured out that stretch of the healing road herself. Instead it seems that once Frieda helped her patients become good eggs she either let them go or converted them into personal friends. Either way, that is not hatching.

So while it is true that Frieda Fromm-Reichmann took some incredibly disturbed people a great distance on their healing journeys, perhaps more than anyone else of her time – which remains a testament to humanity's potential and to the raw power of psychotherapy, especially in this day and age of psychiatry's hopelessness regarding severe mental illness – she herself appears to have been too broken and narcissistic to lead them all the way to greater truth. Had she healed her own deeper wounds, she might have been able to do greater healing. To really "redeem one person" – much less "to redeem the world" – you have to guide people a lot farther than simply transforming them into adequately high functioning adults who work, enter relationships, raise children, and grow happily old. Huge amounts of pathology can still exist in the most seemingly normal and super-normal of people, and by failing to address the shadow side in one so truly special as Frieda Fromm-Reichmann, we do ourselves an injustice. In a world as troubled as our, denial of our shadows no longer has a place. The time has come for all of us to look our dark side in the eye and do all that we can to heal it. That is the new definition of redemption, and true redemption is the future of psychotherapy.

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