ISPS - US Newsletter

United States Chapter of the
International Society for the Psychological treatment of Schizophrenia and other psychoses

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

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From the President

Ann-Louise S. Silver MD

Now in its second year as a formal society, ISPS-US is growing steadily stronger. We are growing in numbers, and the number of our Branches is growing. But more importantly, we are getting to know each other, discovering our common ground and our intriguing diversity. We are developing into an actual society, an active forum. Our yearly meetings in Washington following the Chestnut Lodge symposia may well become a rallying point and quasi-religious retreat. We are planning our next meeting, scheduled for Saturday, October 7, and are considering hosting a panel discussion on the PORT study, stimulated by an article by our resident philosopher, Wilfried ver Eecke and the discussion on the list-serve generated by a posted section from that paper. Our quarterly newsletter edited by Brian Koehler is growing in size and readership. It seems increasingly likely that we soon will launch our journal. Now we have even daily discussion on our listserve established by Joel Kanter. There are 35 people currently subscribed to the listserve, half of which have posted, which Joel says is an excellent percentage. While many organizational chat rooms seem heavily invested in the organization's business or its guild concerns, our discussions contain a wonderful mixture of clinical and theoretical commentary. We come from diverse training backgrounds and work settings, but we share a commitment to psychological work with people suffering from severe mental illnesses.

Receiving so little external support, we are banding together, supporting each other, each of us defining our particular strengths and collaboratively consulting on problem areas. For example, I was gently taken to task by Larry Goldes regarding the final sentence in my piece in the last issue of this newsletter. I had said, "They (Fromm-Reichmann, Sullivan, Searles, and Havens) delineate the philosophy of the founders of ISPS, and now, of ISPS-US." On November 19, Goldes posted, "Much as I consider myself to be psychoanalytic in the most current intersubjective, relational and interpersonal ways, I don't think we should impose a theoretical loyalty test or have a creed or canon for ISPS-US. I certainly wouldn't want consumer/patient/client members to think they had to be committed in some way to a particular theoretical orientation. Here is one reason why. I have a young schizophrenic client that I see, whose mother wanted me to assure her that I wouldn't be treating her child 'psychoanalytically.' I suppose I could have refused to treat her son but that would have been a rather pretentious demonstration of self-importance in my opinion and wouldn't have accomplished anything. So I reframed what I do, in terms she found more acceptable, terms more congruent with her identity as a NAMI activist who views schizophrenia as a neurobiological disorder. From her angle, psychoanalysis didn't seem humanistic as we are sure it is. It is with folk like her that we need to be speaking and perhaps apologizing for past excesses. We cannot assume we are in the truth or present ourselves in that fashion." Well said. I sit corrected.

While we have not used the listserve forum for much personal disclosure, this is happening at our branch meetings, as we introduce ourselves to each other more fully. Our work often puts us in situations of personal danger and yet we persist. We ask ourselves why, as well as how, can we increase our own sense of security. Without it, our own defenses come into play and we contribute to the defeat of that particular endeavor. We in Washington have held two meetings, on the fourth Friday of the month, at the Washington School of Psychiatry. Our next meeting, on January 29 will feature a video of board member Joanne Greenberg's "Metaphor and the treatment of schizophrenia." This video can be rented for two weeks for $20, from the Columbia Study Group at 4966 Reedy Brook Lane. You must promise not to make a copy of the video.

This year, I will be giving the Frieda Fromm-Reichmann Lecture of the Washington School of Psychiatry, Friday evening, March 17, 7:30 p.m. at the Washington School lecture hall, 5028 Wisconsin Avenue, Suite 400. The registration fee is just $15. My

continued on page 2

Table of contents

	Page
From the President	1
From the Editor	2
From the Secretary-Treasurer	3
Volunteers in Psychotherapy	4
NY Chapter & Local Chapters	5
Modern Psychoanalysis/Spotnitz	6
The Place of Love in Treatment	8
Contributions of H.S. Sullivan	9
Column: Mind and Brain	10
Excerpt: Dorman & Penney	11
Book Review: *Psychoanalysis and Psychosis*	12
Poetry	14
Imperfect Empathy	15
Definition of Schizophrenia	17
Letter to the Editor	19

From the President, continued

talk is on "The Current Relevance of Fromm-Reichmann's Works." To register, call 202-237-2700. ISPS-US member and active listserver Bertram Karon, Ph.D. has accepted our invitiation to be next year's Fromm-Reichmann lecturer. We have not yet set the date for the event.

Since I like recommending books, I am urging everyone who hasn't already studied it to get a copy of *Psychotherapy of Schizophrenia: the Treatment of Choice*, by Bert Karon and Gary VandenBos. First published in 1984, it is now in paperback. I was sad to see, however, that one must pay $65 to get a copy from Amazon. DealPilot.com (Formerly Acses) had only new copies for $60, but Advanced Book Exchange (abebooks.com) which collates the inventories of very many used book stores from around the world, listed three copies, ranging in price from $14 to $20. (I recommend that the internet crowd add these resources to their list of favorites. Here is our quick access to food for thought.)

Here are the two reviews posted at Amazon regarding Karon's and VandenBos's classic: A reader from Detroit, Michigan, June 22, 1999: "I enjoyed the frank and honest language of the book. It cut through much that is misunderstood and unknown about people who have schizophrenia. I consider it one of the hallmarks of my personal psychology library. I highly recommend this book to practitioners, students and those who wish to broaden their knowledge of schizophrenia." A reader from San Luis Obispo, California, June 21, 1998: "Drs. Karon and Vandenbos have written a book that allows anyone with a serious interest in helping individuals who suffer from schizophrenia to better understand the psychology that is all too often overlooked. The simple truths conveyed in this book will illuminate the desperate lives of individuals who are unfortunate enough to have fallen into psychosis and have yet to find a way out on their own. It is an excellent stimulus that can trigger one's own creativity, which is essential in effective treatment with those caught in psychosis. I continue to rely on the lessons learned in this book after having read it 14 years ago!"

Now, many of us are preparing our contributions for the ISPS meeting in Stavanger, Norway, to be held June 4-9. We hope many of you will attend this grand event. The ISPS-US board is working on actualizing our constitution and by-laws and applying for official non-profit status. We want to conform this document with that of the recently developed documents of the ISPS. One of the big areas we are debating concerns the boundaries of membership. Are we to be an organization of mental health professionals, with associate membership group of "friends" or are we to count as full members anyone with an interest in psychosis. We need to hear from you by letter or e-mail with your opinions. And we welcome letters to the editor, or submissions of brief articles for future issues of this newsletter. Please consider making a few copies of this newsletter and sending them to colleagues (or, if you "circular file," please send this copy along to someone else).

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From the Editor

Brian Koehler PhD

David Feinsilver MD, founder of ISPS-US and a past president of ISPS, died in the winter of 1999. In the Fall 1999 issue of this newsletter, I reported on my first interview with David which took place on 4/22/95 in my Manhattan office. In this issue I will present my second, and final interview with David, which took place on 2/6/99 in his home as he was struggling with advanced cancer. Despite the effects of his illness, David and his wife, Mimi, welcomed me into their home.

David and I spent several hours together speaking of his theoretical and clinical work with schizophrenic patients, in particular, his newly developed mensch model. We also discussed recent developments in the psychotherapeutic treatment of psychosis in Europe and the future development of ISPS-US. David related that in his mensch model of comprehensive treatment, it was the therapist's ability to make a counteridentification with the patient's bad object experience which is the key to the "cure." The bad object experience gets enacted in the therapy in a way in which the therapist finds herself becoming what one doesn't wish to become vis-a-vis one's patient. It is the therapist's ability to rise above the bad object experience through an inner containment and eventual interpretive communications to the patient, which enables the patient to break free from the controlling aspects of her bad object experience.

David spoke of his admiration for Ping-Nie Pao, M.D. and Otto Will, M.D., both former Directors of Psychotherapy at Chestnut Lodge Hospital. We agreed on a strong need for further research on the use of a specialized form of psychoanalytic psychotherapy with schizophrenic patients, using the best outcome measures available to us. We spoke of the need for, and characteristics of, a treatment center and training institute for a psychotherapeutic approach to psychotic patients. David and I discussed psychotherapeutic developments abroad, particularly in the Scandinavian countries, e.g., the NIPS project, as well as in Italy, especially the clinical research being done by Maurizio Peciccia, M.D. and Gaetano Benedetti, M.D. We both thought it important to collaborate and dialogue with our more biologically oriented colleagues as well as with NAMI. Finally, David and I focused on the question of how to continue to grow as a more structured organization, and yet retain the intimacy of small group settings. David's vision included a multiplicity of theoretical perspectives and disciplines, in order to arrive at a more comprehensive model of the schizophrenic disorders.

I would like to conclude with a Hasidic tale that David liked to use as an illustration of schizophrenic breakdown and its' psychotherapeutic repair.

"Once there was a king who became very melancholy and despairing because his only son and heir to the throne had suddenly taken to hiding in his room and clucking like a chicken, crawling

continued on page 3

From the Editor, continued

naked on his hands and knees, and insisting that he be fed only corn. The king issued a decree offering the greatest reward to anyone who would come forth to save his son and cure him of this terrible affliction. All the greatest healers and magicians of the kingdom came and tried, but nobody was able to cure the prince. Finally, an old Rabbi appeared and boldly announced that he knew how to cure the prince. He requested that he be left alone with the prince for 40 days and 40 nights, and all would be well. The frustrated king, who by this time was intolerant of the prospect of yet another disappointment, told the Rabbi that he would permit him to try only if he agreed to the condition that if he should fail his head would be cut off. The Rabbi agreed, secluded himself with the prince for 40 days and 40 nights and, sure enough, on the 40th day the prince emerged from his room obviously very much his old self, hugging his father and declaring that he was ready to assume his princely responsibilities.

"After all the initial excitement had subsided, the astonished and delighted king wanted to know what kind of special magic the Rabbi had performed. The Rabbi assured the king that no magic was involved and that indeed the cure was based only on very obvious simple reason and logic. The Rabbi then described how he first went into the room with the clucking prince, proceeded to take off his rabbinic garments and crawl naked on his hands and knees, clucking and eating corn just like the prince. After several days of clucking and crawling together like this, when the servants came to bring in the daily corn the Rabbi asked if they would please be so kind as to bring him a little bread with his corn. The curious prince asked the Rabbi why he wanted to have bread with his corn. The Rabbi said, 'Well, I noticed that people eat it and seem to like it. So I tried it and found that actually it's really quite good. Here, try it. You'll like it.' The prince tried it and, indeed, liked it. Now he was crawling and clucking with the Rabbi, but also adding bread to his diet of corn. In this way, as the days passed, the Rabbi got the prince to add all the fine foods of men of the world, such as fish, steak, cakes, elegant cheeses, champagne-and all, of course, together with his basic corn. Soon the prince was even entertaining women (presumably beginning to take his own initiative). Finally, on the 40th day the Rabbi turned to the prince and said, 'Okay, now the time has come for you to go forth into the world and assume your princely duties.' The prince replied, 'But, I can't do that. I'm really just a chicken.' The Rabbi responded, 'No, don't be silly. Don't you see, just because you're a chicken doesn't mean you can't act like a mensch!'" (Feinsilver, 1989, pp. 205-207).

David saw this tale as depicting a basic aspect of any therapeutic process,especially with more severely disturbed patients. He interpreted this wise tale in psychoanalytic terms: "Essentially the Rabbi and the prince can be usefully understood as involved in a transference-countertransference interaction in which the Rabbi empathically identifies with the prince's 'chickenness' and then shows him that he understands his fear of 'menschness.' He says in effect, 'Although, I might seem to be a feared mensch I am really a chicken very much like yourself, therefore a part of yourself and under your control.' It is only after establishing himself as this kind of an object of comfort can the Rabbi begin to engage the prince with increasingly threatening aspects of his feared 'menschness.' In this way the Rabbi can be seen to serve as a transitional object for the prince - as does any therapist in establishing a basic alliance that will withstand the encounter with the threatening aspects of the transference that must be worked through" (p.207). (See Grinberg, 1997 for a Post-Kleinian perspective on the threatening aspects of the transference.)

David Feinsilver, who gave his energy and creativity to the very end of his life, was an inspiring and valued colleague and friend. I hope his open, ecumenical spirit and dedication to persons with a schizophrenic disorder lives on in us as we continue to develop the organization that he founded and nurtured. I will miss him.

Feinsilver, D. B. (1989). Transitional play with regressed schizophrenic patients. In M. G. Fromm & B. L. Smith (Eds.), *The Facilitating Environment: Clinical Applications of Winnicott's Theory.* (pp. 205-237). Madison, CT: International Universities Press, Inc.

Grinberg, L. (1997). Is the transference feared by the psychoanalyst? *International Journal of Psycho-Analysis, 78,* 1-14.

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From the Secretary-Treasurer

Julie Kipp CSW

In the last stages of helping to pull together our biggest newsletter yet, I have just one message for readers: It's time to pay your dues!

In the past, when ISPS was a loosely knit international group which met every three years, you paid your dues when you attended the symposium every three years. Now that the International has decided to build national chapters which can support our work throughout the time between international meetings, your membership in the International is established through your yearly dues to your national chapter - ISPS-US. At our first annual meeting this past October, we determined that dues will go from January through December. Therefore almost *everyone* is due to renew his or her membership now, very reasonable at $40/year.

If you have liked our newsletter or our listserve, or if you are new to the ideas presented here and intrigued by the possibilities of providing a more integrated and humane treatment to your clients, or if you are an experienced clinician who has been saddened by the decline of the use of psychotherapeutic approaches in our present treatment settings, then ISPS-US needs your support.

See the application form on page 19, or the enclosed flyer.

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Volunteers In Psychotherapy (VIP):
A Confidential Nonprofit Alternative to Third-Party Payment For Psychotherapy

Richard Shulman PhD and Mark Burrell PhD

People enter psychotherapy to try to understand awful things that have happened in their lives, to untangle personal problems about which they may be silenced by shame, and to sort out conflicted feelings which they choose to speak of nowhere else. These examples illustrate why psychotherapy conversations are kept private.

Should therapists send out private information about their clients to a third-party, so that the latter can decide whether to pay for the therapy? Until recently no dedicated, responsible psychotherapist would have agreed to that system; especially if that third-party could pocket any funds not paid out for therapy. But this is the way that psychotherapy is done in the era of managed care. The power of vast sums of money in a health insurance approach to payment has changed psychotherapy fundamentally, violating peoples privacy, and taking decisions out of their own hands.

When therapists send reports to insurance companies about their clients, privacy is spoiled and disappears. In subtle, but powerful ways, people do not speak openly about their personal and complicated difficulties when others are listening in. The current system of insurance payments and managed care tries to ignore this. Many people are justifiably concerned about divulging personal information in therapy that could become part of their permanent medical, insurance or employment records. There may be no guarantees about what happens to those records in the future. The openness and honesty of therapy discussions can be significantly undermined.

Years ago, psychotherapists spearheaded the effort to extend medical insurance coverage to psychotherapy. This was obviously financially beneficial to psychotherapists, and to some clients who could not afford to pay market rates for therapy. However, this subsidy further inflated fees for therapy and has proven to be costly in terms of client and therapist autonomy and privacy. In the last decade, employers and insurers required to pay for the psychotherapy of subscribers have realized that they could contain costs by denying and rationing access to psychotherapy services. Insurers have required participating therapists to submit reports and personal information about clients, so that insurers could decide which psychotherapy services are "medically necessary."

However, determinations regarding "medical necessity" do not apply to the sorts of problems in living that clients address in psychotherapy. These clients do not have underlying diseases of the body which are diagnosable like broken bones or malfunctioning thyroids. With few exceptions, psychotherapy clients are electively seeking help with emotionally troubling personal and interpersonal problems.

Currently, clients may contribute varying amounts to the payment for services they receive, but their third-party payer (insurance company, health maintenance organization, government agency or employer) may ultimately make the cost-benefit decisions about their therapy. Because that third-party payer has a financial interest in denying payments for psychotherapy and increasing its profits, it may limit what it pays out for psychotherapy.

Psychotherapy provided under a third-party payment system almost always involves a significant loss of privacy. Therapists are required to report on their confidential discussions with clients about their private lives, and to provide payers with potentially stigmatizing medical sounding diagnoses justifying treatment. To divulge such personal information violates the privacy of therapy and undermines its trustworthiness and helpfulness. People don't speak as openly as they do when they have real privacy. Third-party payers may pressure therapists to see clients less often, to limit the number of a client's sessions, to avoid certain topics with clients, or to encourage clients to use medications. Therapists in these situations are in a conflict of interest: they work for their clients, but they are paid by the insurance company (with whom they sign contracts, from whom they receive referrals, and by whom their services can be terminated). A therapist who does not cooperate with a third-party payer's decisions and policies can be dropped from that company's referral list.

Although many therapists feel increasingly uncomfortable about making these compromises, economic incentives and power favor the interests of insurance companies over the needs of individual clients. In this situation, the client's power, voice and choices are diminished.

Volunteers In Psychotherapy: Affordable, Private and Client-Controlled Psychotherapy

In Connecticut, a new nonprofit organization, Volunteers in Psychotherapy (VIP), takes the provision of confidential, affordable, non-medical psychotherapy as its mission. VIP is funded by grants from charitable foundations and private donors who recognize the need for its approach to psychotherapy. VIP clients earn their therapy by providing volunteer work to the charitable organizations of their choice.

For example, Carl wants to start psychotherapy, but he does not want to receive a potentially stigmatizing psychiatric diagnosis, nor to have that label or other private information about his personal life circulated through paperwork or computer records related to his insurance claim. He worries that his employer may have access to documentation about his therapy. Carl cannot afford the high cost of private therapy.

continued on page 5

Volunteers, cont.

Carl applies to VIP and learns that through the organization, he can help "pay" for his psychotherapy by providing volunteer services to a charitable or non-profit organization of his choice. For each hour Carl volunteers with an organization that fits VIP's guidelines, he will receive a partial credit toward psychotherapy with the psychotherapist of his choice who is affiliated with VIP. All that VIP requires is a copy of the legitimate documentation Carl receives about his completed volunteer hours. The organization where Carl volunteers need not know of his involvement in therapy. VIP-affiliated psychotherapists agree to receive a moderate fee (well below market-rates) that could be supplied in a mixture of direct payment by Carl supplemented by payments from VIP commensurate with Carl's volunteer work. The content of therapy discussions between Carl and his therapist are divulged to no one, and VIP maintains the privacy of its own minimal records (such as documentation of volunteer hours). In addition, volunteer work has its own benefits. It can reinforce a person's sense of purpose, worth and value to others, helping to build self-confidence and diminish feelings of helplessness or self-criticism. Volunteers may be brought into contact with other people who appreciate and respect their contributions, thus addressing common experiences of loneliness, isolation and alienation.

Conclusion

Seeing a psychotherapist through the managed care or health insurance system often involves a loss of privacy and a loss of control (by the therapist and the client) over what happens in therapy. Personal control and privacy should be the hallmarks of psychotherapy. Volunteers In Psychotherapy offers an affordable, confidential, and non-medical approach to therapy that puts the emphasis back on the privacy, autonomy, and responsibility of psychotherapy clients. Further, the clients' volunteer work demonstrates their contribution, commitment and valuation of their therapy, while also directly benefiting others in the community.

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ISPS-US New York Chapter

& Call for the Establishment of Local Chapters

Brian Koehler PhD

The NY Chapter has been meeting monthly on a regular basis since October, 1997. We are a group of about 20 active members from the various mental health disciplines. At our meetings, we each take turns presenting case material, articles, and papers we have published and/or presented at conferences, etc. Part of our meetings are devoted to administrative issues, in which we discuss plans and ideas for our organization. We struggle to maintain our individual and communal "selves" at the same time bound together by our commitment to each other and our task to provide psychotherapeutic and humane treatment to the seriously mentally ill and psychotic patient.

New members are welcome.

A local chapter of ISPS-US in the Washington, D. C. area has been organized by Ann Silver. Sidney Blatt, of Yale University, has informed me that Larry Davidson, also of Yale, is planning to organize a local chapter in New Haven, CT. There are possibilities developing in San Francisco, Los Angeles, Chicago, and Boston.

Please contact me to let our members know of other local ISPS chapters and/or for assistance in establishing them.

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next triennial ISPS international meeting:
June 5 - 8, 2000 · Stavanger, Norway
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An Introduction to Modern Psychoanalysis And The Contributions of Hyman Spotnitz

Harold R. Stern PhD

In his 1968 publication, *The Modern Psychoanalytic Treatment of The Schizophrenic Patient,* Hyman Spotnitz, M.D., introduced a new concept for the treatment of schizophrenic patients. He proposed an original approach for those patients usually considered to be outside of the possibility of successful outcomes using standard or "classical" psychoanalytic treatment. His teachings led to the founding of a new school of psychoanalytic psychotherapy, Modern Psychoanalysis.

He says, "Modern Psychoanalysis is a method to help the patient achieve reasonable goals in life by saying everything that he knows and does not know about his memory. The analyst's job is to help the patient say everything by using verbal communications to resolve his resistances to saying what he knows and does not know about his memory."*

Before describing aspects of his approach, some background and comments about Dr. Spotnitz are worth knowing. After graduating from Harvard University, Dr. Spotnitz attended medical school in Berlin at the Kaiser Wilhelm School of Medicine, then known to be an outstanding center for research, the field he was at the time most interested in studying. Finishing his medical studies, Spotnitz returned to New York to begin his residency in Neurology at the Columbia-Presbyterian Medical School. While there, he became interested in psychiatry and psychoanalysis, began a residency in Psychiatry and entered into psychoanalytic training at the New York Psychoanalytic Society. His personal training analysis was begun with Dr. Lillian Belger Powers, then Vice President of the New York Psychoanalytic Society. Dr. Powers had resided in Vienna for over one year during the early 1930's to be in analysis with Sigmund Freud. During that year she had 5 and 6 sessions each week with Dr. Freud. She later reported to Dr. Spotnitz, during his analysis with her, that Freud had greatly modified his earlier fairly rigid position and had become more flexible and optimistic about the possibility of curing schizophrenia using psychoanalytic approaches. Dr. Powers indicated that she had learned much about the treatment of schizophrenia from Freud himself. In turn, Dr. Powers was very supportive of Dr. Spotnitz in his treatment of schizophrenic patients. During his 5 & 1/2 years of analysis, 5 and 6 times each week, with Dr. Powers, she gave him much support and assistance in his work with very disturbed patients. She also reported to Dr. Spotnitz that Freud himself had also begun to modify his formerly strict position about the counter-transference phenomenon being a liability for the analyst and had begun to study the possible positive aspects of the analyst's counter-transference feelings. It is interesting to speculate that the lineage of Spotnitz's development of Modern Psychoanalysis actually had its roots with Freud by way of his personal analysis with Lillian Powers.

With this background we may examine some of the of Modern Psychoanalytic concepts developed by Spotnitz and subsequently by a legion of his students and followers. To my knowledge, seven analytic institutes have been started utilizing his teachings for working with patients fixated at primarily the pre-oedipal level of development as well as teaching the classic techniques using free association and interpretation.

It may be useful to divide his teachings into two parts: those concepts connected with theories and those connected to technique. We can note here that the psychotic person falls into the category of what we call the "pre-oedipal patient," an earlier and more primitive phase than with the oedipal patient. As a platform to understanding how these psychoanalytic concepts differ from the standard "classical approaches," in the treatment of the more disturbed individuals, we can make some general comparisons as follows.

Theories

1) In classical analysis we try to develop a positive relationship with the patient as part of the "working alliance," something the pre-oedipal patient is not capable of. Thus, in modern analysis we do not anticipate that the disturbed patient is able to cooperate and form a positive relationship. We endeavor rather, to create a therapeutic situation that places primary importance on studying and resolving the resistances that tend to prevent the treatment from moving forward.

2) In working with the pre-oedipal patient, we work hard to create a treatment atmosphere that will be conducive to allowing the patients aggressive feelings to emerge. Without special training, tolerances for the patient's aggressive feelings can be difficult to endure. Therefore we have the need for the special training including the analysis of the analyst in order to work successfully with these difficult to treat patients.

3) In treating the oedipal patient, we foster the development of an object transference that will lead into the transference neurosis. With the pre-oedipal patient, we strive to work first towards the development of the narcissistic transference. Here, the patient's self is the object, but is projected into the analyst. Freud originally believed that because the psychotic patient was incapable of object transference, he was not curable by psychoanalytic treatment. He believed it was the "stone wall of narcissism" that made an analytic cure impossible. In contrast, the modern analyst endeavors to first actually foster the development of the narcissistic transference, than works to resolve this and eventually to shift into an object transference relationship with the patient.

continued on page 7

Spotnitz, cont.

4) In classical treatment, the patient's verbal, often intellectual expressions are all important to the development of the treatment situation. However, in working with the more disturbed patient, we cannot count on this and thus need to work with more primitive forms of verbal communication.

5) In classical technique, the patient is responsible for the success of the treatment. In Modern Analytic treatment, it is the analyst who, like the early mother, must carry full responsibility for the success or failure of the treatment.

6) In classical treatment, we attempt from the start to resolve resistances. With pre-oedipal patients we are primarily concerned with strengthening the ego and its defenses. Therefore, we make sure the defenses are intact, before we try to resolve resistances in the treatment situation. We might join the patient to strengthen his resistances. (Pt.: "I can't stand New York. I need to go west to Chicago." Analyst: "Why go to Chicago? Further west might be better. Why not go to Los Angeles? Better still, why not Honolulu?")

7) In his book *Problems of Anxiety,* Freud formulated five basic resistances he found to be operative working with the oedipal patient. For treating the pre-oedipal patient, Spotnitz developed an alternative group of five resistances that seem particularly applicable to these more disturbed people. These special resistances are critical to the treatment plan for working with the pre-oedipal patient.**

8) Generally, in his earlier writings, Freud discouraged the development in the analyst of counter transference feelings and deemed them to be an obstacle to the analyst's neutrality and objectivity. In modern analysis we believe the analyst's counter transference feelings to be an important, if not a critical element in the treatment situation. We study the counter transference feelings as manifestations and clues to many of the dynamics in the treatment process.

Technique

Now we can turn to some issues connected with the technique:
1) The principal activity for the patient utilized in the classical approach is *free association.* The patient is urged to say whatever comes to his mind. In the Modern Analysis, we avoid this approach as it can lead to fragmentation of the ego and further regression. Instead, the patient is encouraged to talk about whatever he wishes to discuss. This is to avoid any tendency towards regression of the ego.

2) The principal intervention practiced by the classical analyst is interpretation. In contrast, the main technique in treating the pre-oedipal patient is the use, as with the early child, of emotional verbal communication. Interpretations are generally avoided with the pre-oedipal patient. Rather, strong feeling states are invoked. studied, and used to promote progress in the treatment.

3) The classical analyst resolves resistances by interpretation. The modern analyst resolves them by the use of many other forms of verbal communication.

4) With the neurotic patient, the analyst usually determines the frequency of sessions. With the pre-oedipal patient, the patient plans the frequency, with the help of the analyst. For many disturbed patients, too frequent sessions can lead to regression and further psychosis.

5) In classical analysis, the use of the couch is usually limited to those patients who have frequent sessions and are deemed to have a neurotic disorder. The modern analyst encourages the use of the couch with all patients, independent of frequency, and especially with the pre-oedipal patient.

6) It is usual for the classical analyst to address his questions and responses to the patient by formulating ego oriented interventions. The modern analyst treating the pre-oedipal patient will attempt to avoid interventions addressed to the patient's ego, and will instead, as much as possible, use object oriented interventions, i.e. those directed away from the patient's ego. "What year did this happen?" or "What did she say?"

7)While the classical analyst confines his technique to mainly interpretation, the modern analyst may use a wide array of techniques and interventions in order to foster progress in the treatment of the pre-oedipal patient. We are interested in *what will work* with a particular patient. No two patients are the same and unique interventions must be custom designed for each patient.

8) When working with a very regressed patient, the modern analyst will limit his interventions to 4 or 5 object oriented questions per session to limit any possible regression and foster the development of a narcissistic transference.

To be continued in subsequent issues

Footnotes:
* Personal communication from Hyman Spotnitz, M.D., December 14, 1999
** Spotnitz's five pre-oedipal resistances:1) The treatment destructive resistance, 2) The status quo resistance, 3) The resistance to progress, 4) The resistance to cooperation or teamwork, 5) The resistance to termination of the treatment.

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THE PLACE OF LOVE IN THE TREATMENT OF THE CHRONICALLY MENTALLY ILL

Zvi Lothane MD

The Christmas Day Metro Section of the *New York Times* carried a moving story of Jill Flesch's recovery from mental illness that lasted for many years. "Though born into wealth, Jill Flesch was broke, homeless and battling mental illness until she found lasting help." Police and passers-by in New York's East Village recalled the crazy homeless bag lady who screamed at people, "begged for change, or thrust her mad poetry into startled hands."

The story has a happy ending. After years of various medications with awful and painful side effects, punctuated by many hospital stays, a total of 32, where she was exposed to rape and beatings by other patients, Jill Flesch recovered from her illness and has moved to her own studio apartment in Ivan Shapiro House, a supported housing development of formerly homeless persons.

And here is a most significant aspect of this remarkable reportage: "Ms. Flesch's eyes filled with grateful tears as she spoke of Dr. Ralph Aquila, the staff psychiatrist at Project Renewal," who helped make possible the transition from madness into sanity, from life in the streets and shelters to her own place. "You know when yarn gets into a tangle," said Ms. Flesch, referring metaphorically to her tangled mind; "but with patience and time, all of a sudden you got brand-new, ready-to-go yarn."

It takes patience and time, both essential ingredients in any long-term relationship where charity, love, kindness, devotion and trust are tested severely, repeatedly, painfully, and where love and charity are necessary to do the job. This applies to all relationships, in health and disease. But it also applies to rational treatment of the chronically mentally ill.

There is a common misunderstanding about love: most people think of it as being loved like a child, of being on the receiving end, of being overcome by strong feelings and sensations. But something else is meant in this context, best defined by the mystics with a spiritual vision. As stated by William Law:

> By love I do not mean any natural tenderness, which is more or less in people according to their constitution; but I mean a larger principle of the soul, founded in reason and piety, which makes us tender, kind and gentle to all our fellow creatures as creatures of God, and for his sake.

Or, as expressed by St. Bernard:

> Love seeks no cause beyond itself and no fruit; it is its own fruit, its own enjoyment. I love because I love; I love in order that I may love.

People suffer psychologically in the two great areas of life: love relations and work relations, and disturbances in love and work create mental illness, and restoration of the capacity to love and work means a cure from mental illness. The pioneers of psychoanalysis understood the role of love as a therapeutic agent in the doctor patient relationship. Early on in their correspondence Sigmund Freud writes to Carl Jung: "Essentially, one might say, the cure is effected by love."

I have not met Dr. Aquila, but I imagine that he bestowed selfless devotion and dedication to his patient, that he was genuinely interested in his patient's welfare, that he did it in the spirit captured by the mystic. In spite of all her craziness the patient felt this gift of love, it remained for her a guiding star throughout her odyssey, and allowed her to muster the strength to finally overcome the demons in her soul.

I do not intend to use these remarks as a pulpit, nor to deny the importance of the other treatment modalities. We are fortunate in our times to have recourse to the fruits of brain research, biochemistry and pharmacology that gave us in impressive armamentarium of drugs to affect the emotions. They are an indispensable tool in the treatment of severe and chronic forms of mental disease. But they come to us at a cost, and for two main reasons.

Firstly, as impressive as they are, the long term use of neurotropic agents is an intervention in the natural order of the body paid for by serious side effects. It is not unlike the chemical and genetic manipulation of nature the distant consequences of which do not usually concern the technocrat bent on spectacular short term results. We have seen tardive dyskinesia as an example of such chemical manipulation of the body.

Secondly, they lull us into the belief that we have finally conquered mental disorders and no longer need the old-fashioned, unscientific, cost-ineffective modalities of psychotherapy. The latter is once again relegated to the status of an old wives' tale, an unscientific pursuit of the tender-minded, unsuited for the tough-minded, hard-hitting, cutting-edge tools of the scientist.

The first trend carries the danger of denaturing nature, the second of dehumanizing humanity. The example of Ms. Flesch and Dr. Aquila gives us pause to think otherwise. Healing is an art, not a laboratory science. Like any other art, it can use the advances of science to enhance its techniques, but it cannot be defined by science alone. The sick person who cannot cope with humanity needs that human healing touch in order to be able to benefit from the opportunities offered by science. It is not an either/or, but a this and also that.

Moreover, the long-term care of the mentally ill, who in this day and age swell the numbers of the homeless in the large urban centers, also requires the proper financial support to provide the necessary manpower and housing and work for those in need of rehabilitation. Ms. Flesch was fortunate in being able to get a devoted treatment team and a hospitable living environment. But what about those legions of people who still roam the streets, long

continuned on page 9

Love, cont.

after the state hospitals have been emptied in order to save money? Do we have the corresponding armies of good Samaritans, devoted doctors, nurses, and social workers needed to rehabilitate the needy? The task is truly daunting. It will require not just the legislators at the local, state and federal level, but an all out national effort, to come to terms with this great need of our society.

Associate Clinical Professor of Psychiatry, Mount Sinai School of Medicine
Member of the American and International Psychoanalytic Associations
Author of *In Defense of Schreber: Soul Murder and Psychiatry*

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TREATMENT OF SCHIZOPHRENIA: THE CONTRIBUTIONS OF H.S. SULLIVAN

Joel Kanter MSW

Sullivan's contributions to the modern treatment of schizophrenia have been largely not recognized because they have been absorbed into the conventional wisdom. His ideas are often ignored because they occurred before the use of neuroleptics and community treatment. His views are often mistakenly equated with the intensive psychoanalytic approaches used at institutions like Chestnut Lodge. His original ideas and findings included the following, most of which can be found in his 1929 paper "Socio-psychiatric Research" (in *Schizophrenia as a Human Process*, Norton, 1962):

1. Argued that schizophrenic patients were "more simply human than otherwise"--that their emotional reactions were essentially human responses to human situations. Empathizing with these reactions reduced anxiety and, in turn, psychotic symptoms.

2. Believed (revolutionary in the institutional climate of his time) that schizophrenic patients were worth listening and talking to; that there was always an intact psyche that could be addressed along side the disordered personality.

3. Observed that schizophrenic patients are responsive to changes in their environment, for better or worse, and were not the autistic creatures that many psychiatrists described.

4. Observed that schizophrenic symptoms were often a reaction to anxiety-provoking events in their social milieu. By providing interpersonal reassurance and support, these symptoms could be ameliorated.

5. Hypothesized that both genetic and psychosocial variables interacted in the etiology of schizophrenia: "a limitation doubtless arises from the hereditary factors as to the extent and direction of each individual's possibility of ndividuation by experience. In other words, there are probably a great many different sorts of personality not only because there have been a great variety of organism - environment complexes in which these personalities were formed, but also (Sullivan's emphasis) because there have been a variety of predetermined (hereditary, congenital, somatological) limitations as to evolutionary potentialities... ...some are born with the possibility of evolving a schizophrenic disorder, and some are not" (p. 26O).

6. Articulated the concept of "social recovery (that a patient may function adequately in society while maintaining residual schizophrenic symptoms) as a worthwhile and attainable goal (p. 266). This contrasts with both the therapeutic pessimism that preceeded him and the overly optimistic goals of therapists who strive for a complete reconstruction of the personality.

7. Demonstrated that acute schizophrenic episodes could be treated in a relatively brief period and the patients returned to the community.

8. Recommended focusing on the patient's latent capacities for growth rather than on manifest psychopathology: "(personality reorganization) is not an active interference from outside, such, for example, as that of a mechanic who takes out worn parts of a machine and replaces them with new (ones). It is a... proceedure more in keeping with the behavior of a (gardener) who removes the... mechanical, ...chemical, and biological obstacles... from the organization of a growing plant, and by providing optimum cicumstances, encourages superior growth..."(p. 268).

9. Recommended the utilization and training of paraprofessional staff in therapeutic roles (p. 264). Developed a collaborative treatment team, involving open-minded psychiatrists willing to listen to subordinates and milieu staff willing to assume therapeutic initiatives (p. 263).

1O. Recognized that more effective hospital treatment would lead to relapse when patients returned to unsupportive environments. Recommended that professionals "develop convalescent camps and communities for those on their way to mental health" more than 2O years before first day programs or halfway houses were established (p. 269).

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Column: Mind and Brain

Brian Koehler PhD

The philosophical and scientific question of the relationship between mind and brain in psychiatric illness has been explored intensively by Bolton and Hill (1996), a psychologist and psychiatrist respectively. They assumed the position that mental states characterized by "intentionality," e.g., beliefs, goal-directed plans, fears etc., could not be reduced to physico-chemical or neural processes without valuable information and meaning being lost in the process. Bolton and Hill use the example of deoxyribonucleic acid (DNA) to illustrate the pervasiveness of intentionality in biological systems. They concluded: "For the DNA molecule has significance only by virtue of the vast quantity of information that is stored within the molecule, and because it is linked in a systematic way with protein synthesis, a process that is characterized by intentional causality. Briefly, the sequence involves the reading (Transcription) of the nucleotide triplet codes in the DNA by the messenger ribonucleic acid (mRNA) molecule, which acts as a template for the assembly of amino acids in the synthesis of proteins. Amino acids are brought to the mRNA by smaller transfer RNA (tRNA) molecules, which have the task of delivering specific amino acids to the correct sites on the mRNA. This process is referred to as the 'translation' of the genetic code into proteins...An attempted elimination of the intentional account of DNA and protein synthesis would have to define in physico-chemical terms items such as triplet coding, the role of mRNA as a messenger, and the nature of correct functioning and mutations. Similarly, although the terms 'transcription' and 'translation' may seem to refer inappropriately to human language, in many respects the process more closely resembles that of human communication than it does physico-chemical processes" (pp 234-235).

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What is the function of the brain? Bolton and Hill hypothesized that the brain is crucially concerned with the elaboration of sets of rules in the form of beliefs, wishes, fears, and of internal models of relationships (what Bowlby would refer to as internal working models of self and other in interaction or what Stern would call RIGS). Since the brain elaborates these intentional processes, and these intentional processes are the explanations of behavior, the brain has to be considered in relation to these processes. Bolton and Hill criticized what is known as "biological psychiatry" for reducing biological processes to physics and chemistry and departing from an intentional-causal analysis which is essential in both psychology and biology. There are some, like Guze, who consider the term "biological psychiatry" an oxymoron, i.e., what other kind is there? While there are others, like Alanen (1994), who noted "An important starting-point for all integrated psychobiological psychiatry is the insight that interactionality with other people is part of human biology."

Whatever the role of experience in brain development, it is clear that the genetic code cannot specify the wiring of the brain. Hundert (1989) stated: "There is more intuitive evidence which argues against the proposition that its all in the genes. The total number of genes in the human is placed between about 200,000 as a low and about 1,000,000 as a very high estimate. The total number of neuronal interconnections in the human brain is now estimated to be between 100,000,000,000,000 and 1,000,000,000,000,000. The genes simply could not carry enough information to specify even a significant fraction of these connections, leaving the environment with an enormous task" (p.237).

Bolton and Hill (1996) also noted: "It is striking that only 1 per cent of the human genome differs from that of the ape, which suggests that the enormous differences in intellectual, aesthetic, and interpersonal capabilities are encoded in a general strategy for brain development which unfolds in relation to experience. There is substantial evidence that this proceeds via the creation of an internal environment in which a complex signaling process guides the formation of neuronal connections. It is possible that, as Wiesel proposed, this internal environment takes its cues from the external; after all, the function of the brain is to mediate through beliefs, emotions, and actions, between internal and external worlds" (p. 291).

And for psychoanalysts, one of the primary functions of the brain is to mediate between the internal and external worlds in terms of significant relationships and attachments and the affects linking them, both within the procedural (pre-verbal, unreflective, unconscious) and episodic-semantic-autobiographical (reflective, conscious) memorial systems.

Alanen, Y. O. (1994). An attempt to integrate the individual-psychological and interactional concepts of the origins of schizophrenia. *The British Journal of Psychiatry, 164*, suppl. 23, 56-61.

Bolton, D., & Hill, J. (1996). *Mind, Meaning, and Mental Disorder: The Nature of Causal Explanation in Psychology and Psychiatry.* NY: Oxford University Press.

Hundert, E. M. (1989). *Philosophy, Psychiatry and Neuroscience-Three Approaches to the Mind: A Synthetic Analysis of the Varieties of Human Experience.* NY: Oxford University Press.

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Excerpts from:
"Being together in the therapeutic relationship in schizophrenia"
Daniel Dorman & Catherine Penney (1999)
International Journal of Psychotherapy, Vol. 4, No. 1

Part 2 (Part 1 was published in the Fall, 1999 issue)

Miss Penney: Dr. Dorman has always said he calls a spade a spade. He has always been authentic. He has always told it like it is and I really feel it important to insert this because it expresses what I am saying now or it reflects what I am saying now.

Three months after being discharged from UCLA I moved into an apartment on my own. I started day treatment and I was just starting to get out into life again, and was learning the bus system in LA; that is pretty hard to do. I had to relearn how to drive a car although I knew how before I was ill. When I went back to school, I thought I could just read and study like I did before I got really ill. Well the first two classes I took in junior college, psychology and philosophy, I got straight F's because cognitively my mind wasn't there. When you have heard voices for 7 years, when that's all your life has been, voices night and day and then all of a sudden they are no longer there, my God, I mean it's like you really are on the Starship Enterprise. You really feel you are on another planet. When they are gone, it's like 'oh my God, where am I now, and who am I now? And so when I tried to go back to school the first time I just felt my brain was damaged. I thought 'oh my God I'm destined to have no future' and I remember going to our therapy session and I told D. Dorman this, and I remember what he said. He said 'Cathy, what happens to an old home or old house that hasn't been used? Dust, and mold gather. A new person or family comes into that home and they dust it, they fix it up and they use it'. He told me 'all your faculties you had before you got sick, they are still there, give them time'. Those were word of hope because hope, my hope, was crushed and hope is what kept me going in recovery. And I have to say also although I was suicidal and attempted it two times, once by hanging in the hospital, and once by drinking orange shellac, the worst waves of suicide came when I was in recovery because that's unknown. I knew mental illness; I knew schizophrenia. Losing that identity, giving that up was the hardest part of recovery. It was hardest because it was a sign to me that I was no longer a child; I was growing. And adulthood at one point in my life was scary; now I was seeing it had potential but without support I don't think I could have ever gone on. And I learned to listen to my own feelings and thoughts.

Psychosis is not anything to glorify. But it should be looked at as valid and see underneath it and get to the person, to the core. I haven't heard it mentioned and I guess there's a fear of religiosity, but soul death was the worst and I am not really a religious person, but soul death, spiritual death, was what drew me to thoughts of suicide as well as feeling not connected and fragmented. And I think that is something else I'd like to hear more talk of too. It has nothing to do with religion; it has to do with the gut, with your connection with whatever you know is great. It keeps one going.

Dr. Dorman: As Catherine has said, therapy was always a relationship to her healthy side. I knew, of course, she was swamped but my approach was that somewhere in her was a healthy side that likely would grow and develop if I could make contact with it, and as this conference is based upon the principle of building bridges, I saw myself as a bridge to the real world from her state of really arrested development. My own approach in treating psychotics, and I have done so for 28 years now, is to see myself as a catalyst for my patients' growth and development. To do that I have to address what healthy elements there are, to address them means to pay attention to them, to confirm them, to help explain why they have been overwhelmed. Addressing fears of being lost provides, as Catherine says, a bridge which is really a message of hope that one can grow and develop. My approach has been to see schizophrenia as a state of profound developmental arrest. In fact I don't see the schizophrenic as different from my healthier patients, at all, but for degree. Of course, there is the whole issue which has been talked about at this conference about the intense symbiosis that develops within the relationship and the strains on the therapist.

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Book Review:
Silver's *Psychoanalysis and Psychosis*

Brian Koehler PhD

Psychoanalysis and Psychosis edited by Ann-Louise S. Silver, MD (1989). Madison, CT: International Universities Press, Inc.

The collection of papers in this volume evolved out of the thirty first annual Chestnut Lodge Symposium commemorating the fiftieth anniversary of the arrival of Frieda Fromm-Reichmann to the Lodge. Much of the collection revolves around memoirs of Fromm-Reichmann and her contributions to the psychoanalytic therapy of psychotic patients. She was a pivotal figure in this field. Vamik Volkan, in reviewing this book, noted: "More than a fascinating retrospective, *Psychoanalysis and Psychosis* updates the treatment of psychosis to include recent advances. Even those clinicians who seldom deal with psychosis will gain much from the discussion this book provides of primitive mental functions and early object relations."

Ann-Louise Silver, editor of this volume, offered her hope that this collection will inspire younger colleagues to become more attuned to "...their own and their patient's unconscious as they proceed with their interviews," otherwise they may be "left with a feeling of uneasiness which can convert readily to boredom and helplessness." Silver proposed that if the trend away from in-depth psychodynamic understanding continues, "something very precious may be lost."

This collection is divided into six parts, which are as follows: Fromm-Reichmann as Supervisor and Researcher; Psychoanalytically Oriented Treatment of Schizophrenia; Psychoanalysis of Nonhospitalized Patients; Applications in History and Literature; Fromm-Reichman's Development as a Therapist; and A History of the Washington Psychoanalytic Institute and Society. The tone for this book is set by Ann Silver and Pollianne Freuer in the leading article "Fromm-Reichmann's Contributions at Staff Conferences." The authors noted that Fromm-Reichmann's comments at the weekly two hour long conferences "related to the exploration of the interrelationship of anxiety, hostility, and loneliness in the patient, the therapist, and other staff members" and that the more the patient could communicate "the extent of his or her anguish and confusion, the greater were the chances of recovery." Fromm-Reichmann was described as an interpersonal psychoanalyst who did not try to conceal her emotional reactions to what she heard and as someone who was very attuned to the unconscious anxieties of patient and therapist. She understood the dynamic bipolarity of psychiatric symptoms. Fromm-Reichmann concluded:

> If it's true that each symptom is an expression of innerness of which the patient wants to get rid of, but also the symptom is a means of warding off more serious things, namely anxiety, then by virtue of the therapeutic process, we are simultaneously the friend and the enemy of the patient. We are the friend of that part in the patient which wants to rid of [that] innerness and we are the enemy of that part which needs symptoms to defend itself. I believe that in our great effort to see the single experience in terms of transference and countertransference reactions, we are a little in danger to forget that it is due to the dynamic bipolarity of symptomatology, an equally inevitable bipolarity in the reaction of the patient to the doctor and in the reaction of the doctor to the patient.

Silver and Freuer, after reviewing Fromm-Reichmann's comments on Chestnut Lodge hospital charts, remarked that her "alertness to the vicissitudes of manifestations of anxiety informed perhaps every comment she made, and formed the core of her helpfulness, a helpfulness that has been so powerful that we are still expressing our gratitude over thirty years after her death." Silver and Freuer suggested that therapists, although prescribing medications, are also psychoactive agents themselves. The authors, in the tradition of interpersonal psychiatry, noted "whether things are going wrong, or, more challengingly,when they seem to be going along well enough, we must always be working, whether in a listening or an interpreting mode, with a psychoanalytic directedness, defining the patients' patterns of defenses, formulating what they seem to be defending against, and being continually alert to that which is being stirred in us." In Fromm-Reichmann's own words: "Hence we make the exploration of the dynamic roots of the schizophrenic's anxieties our potential goal through all phases of illness." These clinical viewpoints have been recently reiterated by Ogden (p. 130,1999): "...particular attention is paid to the ways in which countertransference is utilized in the process of creating analytic meaning, i.e. in the process of recognizing, symbolizing, understanding and interpreting the leading transference-countertransference anxiety."

Other contributors to Part I include: Clarence Schulz, Joseph Smith, Beatrice Liebenberg, Wendy Leeds-Hurwitz and Henry Brosin. Clarence Schulz in his "Recollections of Supervision with Frieda Fromm-Reichmann", noted:"One of the most important lessons I learned from her was to be respectful of the potential sense that could be made out of the fractured, pathological interactions with my patient." Beatrice Liebenberg attended Fromm-Reichmann's class 'Assets of the Mentally Handicapped' at the Washington School of Psychiatry. Liebenberg, in her short but enjoyable contribution to this volume, wrote: "...we learned to trace the roots of artists and philosophers, including Schumann and Nijinsky, Van Gogh, Strindberg, Oscar Wilde, Schopenhauer." Fromm-Reichmann emphasized that their emotional difficulties were also a source for the development of their assets, so that "aloofness might enable one to express himself in music, and muteness would be no deterrent in the dance."

The contributors to Part II include such prominent and experienced clinicians as Ott Allen Will, Jr., Bryce Boyer, Jacob

Continued on page 13

Psychoanalysis and Psychosis, cont.

Arlow, Robert Gibson, Ruth Lidz, John Fort and others. This part is a book within a book. Will's piece entitled "In Memory of Frieda," describes his experiences with Fromm-Reichmann and her significant impact upon him as his analyst and colleague. After Sullivan's death, Will became a patient of Fromm-Reichmann. Will asked if it's possible for the therapist to feel love for a patient? He thought so, keeping in mind Sullivan's (1947) definition of love: "When the satisfaction or the security of another person becomes as significant to one as are one's own satisfactions or security." Will noted:"With this in mind, I think of parent, teacher, and therapist...Each promotes attachment, furthers interest in learning, encourages growth, offers protection, and helps to enable the child, student, or patient to separate with affection and confidence."

Other contributors to Part II which particularly engaged me were Bryce Boyer's "Psychoanalysis with Few Parameters in the Treatment of Regressed Patients, Reconsidered," Ruth Lidz' "The Use of Anxiety and Hostility in the Treatment of Schizophrenic Patients," Robert Gibson's explication of psychoanalytic principles applied to hospitalized patients, and John Fort's "Present Day Treatment of Schizophrenia." Sam Thompson has an account of a very sick, hopeless prognosis patient's recovery and the impact of aging on persons in our culture.

Part III encompasses psychoanalytic therapy of non-hospitalized patients and includes an impressive list of authors: Harold Searles, John Kafka, Martin Cooperman and others. Searles' piece on borderline psychopathology as revealed in the patients' speech and language is an original contribution to this topic. Martin Cooperman's classic paper "Defeating Processes in Psychotherapy", elucidates an important component of the negative therapeutic reaction: "...a process to defeat the therapist by defeating the therapy." This reaction arises out of a perceived narcissistic injury on the part of the patient, which Cooperman attributed to his having "...precipitously and arbitrarily forced into focus our separateness." John Kafka in his "How Do We Change/" puts forth his central thesis "that a crucial factor in structural change is some contact during the course of treatment with life and death issues in a form which may hark back to the dawning of awareness in the infant of the differentiation of the inanimate and animate worlds." (See Searles, 1960).

Part IV examines psychoanalytic thought applied to the work of Strindberg (Donald Burnham), biblical figures and Jewish cultural history (Theodore Lidz) and post-traumatic stress disorder (Lawrence Kolb). This part entails a rich diversity of topics and theoretical perspectives. Part V returns to Fromm-Reichmann and her development as a therapist. Ann Silver edited a piece in which Fromm-Reichmann speaks of her personal memories of Europe. Benjamin Weininger's "Chestnut Lodge-The Early Years: Krishnamurti and Buber" begins with an emphasis on Sullivan's concept of an inner drive toward mental health in all people which gets compromised by such interpersonal experience as social foreclosure, rejection and isolation. Weininger noted: "In his relationships with others, a psychotic person has been hurt many times, and more intensely hurt than most of us. He or she feels rejected not only by a person but also by the social community. He feels exiled. The sense of being exiled is a catastrophic happening to any person."

Harry Stack Sullivan, who was a teacher and friend of Weininger for almost 20 years, once told him that "...although his theory of personality revolved around anxiety and the avoidance of anxiety at its center, one could as well place loneliness at the center of the theory of interpersonal psychiatry." In speaking of his first patient at Chestnut Lodge, Weininger commented: " I was sensitive and open to the slightest indication of contact with me. At first these contacts were momentary, followed by a withdrawal. She needed the contact, but she could not cope with the devastating effects of a possible rejection. I emphasize the importance of paying attention to the slightest evidence of contact because any move toward contact is the drive toward mental health and, in my experience, this is more important than being overly concerned with the patients pathology."

Weininger believed that even one contact with an acutely psychotic patient can initiate the process of recovery. A similar process is described in a highly engaging interview with Joanne Greenberg (aka Hannah Green of "I Never Promised You a Rose Garden") by Laurice McAfee. Greenberg was treated by Fromm-Reichmann when she, at the age of 16, entered Chestnut Lodge. When asked by McAfee what she felt was the most meaningful aspect of therapy, Greenberg responded that she was treated as an equal, a colleague in a vital endeavor. Use of a cold pack helped her establish a boundary between internal and external reality so that "inside then became available to me." As to the patient-therapist match, Greenberg believes "the personalities have to fit in therapy and if the symptoms are metaphors, the therapist has to be someone who understands those metaphors or at least is amenable to learning them so that when they appear in the therapeutic dialogue, the right amount of weight is given to them." In regard to symptoms, Greenberg noted: "If you perceive the symptoms as the illness, it seems to lower down on you, pushed on you from some outside force. Frieda was telling me through metaphor that the illness is inside you and because it isn't outside, because it's inside, it's fixable, it's surmountable."

For Greenberg, psychosis and health are not continuous states, or as two poles on a continuum. They are totally separate experiences with a dividing line between the two. McAfee summarized her interview with Joanne Greenberg as follows: " I came away from that experience with no doubts as a clinician that Joanne Greenberg had been schizophrenic, that she no longer was schizophrenic, and that she had in fact made the leap from sick to well and not only had survived but conquered."

Contiinued on page 14

Psychoanalysis and Psychosis, cont.

In summary, this volume, like its' editor, appreciates in value and clinical wisdom over the years. For those of you who endorse a biopsychosocial or psychosociobiological model of severe mental illness, this is a book to explore. It was published in 1989, a rare book then, and even more so today in our world of biogenetic isolationalist research models, and demonstrates why it should not be such a rarity now.

Ogden, T. (1999). Analyzing forms of aliveness and deadness of the transference-countertransference. In G. Kohon (Ed.), *The Dead Mother* (pp. 128-148). NY: Routledge.

Searles, H. F. (1960). *The Nonhuman Environment: In Normal Development and in Schizophrenia.* NY: IUP.

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Poetry

The Truth

Reiko John Imazaki

In this life time
we are in search of the truth
we have to take it a piece at a time
we are on a journey
from the day we are born
until we die
we can search for an entire life time
and not uncover every detail
we learn with the steps of trials and tribulations
we can find the right way
by doing the right thing
once we have found the true path
the truth slowly begins to unfold
some times the truth
is scary and unbelievable
and we try to hide behind the lies
which we have been exposed to
but one thing about the truth it will never blind
it can only make your vision crystal clear

(Editorial note-this is a very Bionian concept of mind)

(Please send your poems for possible inclusion in the ISPS-US Newsletter to:
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New York, NY 10003
(212)533-5687
e-mail: bkoehler7@compuserve.com)

Sister Africa Bound

Alyson Berry

It's not the right
time
to go!
Not ever do we know
of the birds
landing unless seen
from afar with a
glass! A wondrous
solstice thanks to
you and wishes
to keep you near!
May your joy
be within
this year!
And a test flight
be prepared for the air of the kindred.....

The Red Eye To Rome

Joseph Abrahams, MD

(Enroute to Rome, September 26, 1999)

Sated of talk, food, and drink
On the Delta Red Eye to Rome
Atlanta six miles below
And half a thousand distant
Atlanta, gracious urb
Emory, provident host
Of the Class of '39 Med

A reunion of but four
With family fond
We built an island of being, We rejoiced
But grieved our losses
To debility and death
In simple shock we were
At the silent withering

I cannot help but hold
That we are casualties
In a war most silent,
Whose nature we but glimpse

Long and hard we trained
The signs and symptoms
Of infectious invasions,
Stones, cysts, and swelling tumors
The ulcer and its perforation
Metabolism in all its forms
The vicissitudes of the psyche

And above all, passage
Passage through the birth canal

Manage, medicate, excise
And rejoin that which is spilt asunder

But what felled my comrades
What thinned our ranks
Till but four joined in joyful reunion?

I warrant the killers were prosaic and everyday
Midst the heroism of daily patient load
Bacon and eggs
The weekly swill
The comforting puff throughout the day
The long hour
Striving itself
The item we call stress
That flexing and wearing of the spirit
That wearying
Strangely relieved by prozac.

Doctors once drank, still do
But hardly smoke
Now fervently espouse care of self
The promise of the golden years
For more than a lucky few.

So, Class of '99,
So full of vigor and hope
On your now solid islands of being and becoming,
Look to our numbers and ways
Study us, and our dis-ease
That cut short the fulfillment
Of a plentiful 60th Reunion and beyond
Look to your present and future chance
We laid the way

Save the Date!

The Frieda Fromm-Reichmann Lecture
at the Washington School of Psychiatry

The Current Relevance of Fromm-Reichmann's Works

Ann-Louise Silver MD

Friday, March 17, 2000 • 7:30 p.m.

Washington School of Psychiatry
5028 Wisconsin Avenue, Suite 400
202-237-2700

Imperfect Empathy, Confusion, Internalization, and Insight

Bertram P. Karon Ph.D

It is necessary for a therapist to be confused. It is not "accurate" empathy which cures patients but our *attempt* at accurate empathy (whether or not we are successful). Change is produced in psychoanalytic therapy by insight and by internalization of the therapist.

We may or may not be capable of correctly understanding our patients, but we are capable of doing our damnedest to try to understand them. That is usually what they perceive and are responding to when they say and feel we understand them. This is especially important when working with psychotic patients whose defenses require them to be experts at not communicating clearly.

Sometimes we do succeed at understanding. As the late Richard Sterba used to say to patients: "All I have to offer you is understanding, but that is really a great deal."

Nonetheless, there is no way for a therapist to escape being confused. The confused therapist is not only able to learn by not excluding possibilities, but provides a model for the patient--that being confused is tolerable. As I sometimes say to patients who complain that therapy is confusing: "Good. You are not sick because you are confused. You are sick because you are certain of things which are not true."

Valuing confusion does not mean valuing arbitrariness. The patient has lived a life and wants to know what it was. It is frequently possible to reconstruct it. When I have reconstructed it wrongly, even when it was accepted by the patient, it was never helpful. But when all the material fell into place, and the patient improved, the reconstruction turned out to be true. In many cases, it has been possible to validate from external sources, such as family, the truth of helpful reconstructions of the repressed past. It may be, of course, that you cannot reconstruct the past. But even an uncertain past is bearable if you can share that uncertainty with an acceptant and tolerant other, and continue to think about it.

Central to change is the internalization of the therapist. The therapist is internalized into the super-ego so that the patient treats him or herself the way the therapist would, as opposed to the way the parents did. The therapist is internalized into the ego as a model for the self. The therapy relationship is internalized as a model for what a human relationship might be like. Sometimes therapists worry that the patient will internalize their defects. But, like an adolescent, the patient will eventually discard what is not useful. Therapists value patients who keep growing, who are different from them, and who can do better than they can; unlike the

continued on page 16

Imperfect Empathy, continued

parents of most patients (who are often more like the father of Oedipus or the mother of Snow White).

Once internalization is taken seriously, it becomes obvious why it is important that the therapist be tolerant of the human condition. It is especially important for the therapist to be kind, so that the patient dares to be kind to him or herself, and even to others.

The good therapist is stubborn. There is a part of you that just does not want to give up, no matter what it looks like. Rudolf Ekstein once described the ideal therapist for a psychotic child as "someone who knows as much as possible scientifically combined with an absolutely irrational belief that, no matter what, this child is going to make it." It's not a bad prescription for any therapist.

Indeed, the therapist must not only retain hope, but create hope in the patient. The patient has no reason to be hopeful and depends on the therapist to create and maintain hope, while often consciously trying to prove how hopeless is the world and worthless is the therapy.

We help patients think about their lives and their contradictory feelings. We allow them to discover their own complexity, and that their feelings are a necessary part of rational thinking. What they cannot remember or think about is important; what is unconscious does not change, but has the most control. What they can think about, they can control. With our help, they reconstruct their lives and their traumas including their fantasies, and they learn the defenses they use. They learn about transference and its ubiquity; and they learn to use their transferences as sources of information. Indeed, they learn to use all of their problems as sources of information that will make their lives better.

Psychotic patients are often the most dramatic examples. A patient, termed an incurable schizophrenic was brought to my office after his wife refused to permit electro-convulsive therapy and had withdrawn him from the hospital on my advice. He was not eating, he was not sleeping, and he was continuously hallucinating. He was from a middle-class family and had considered himself lucky to have had such good parents, particularly such a good mother. However, even before his psychotic break, he could not remember his childhood before the second year of high school; he did not think this was abnormal.

I immediately stopped all medications and started real treatment -- seven days the first week, six the second, and so on, until a regular three day a week schedule.

Four days later he was eating. Six months later he was working at an intellectually demanding job. A year later I could say to him: "Anyone can go crazy under enough stress, but under the normal stresses of everyday life, you will never be psychotic again."

He said, "This is better than I've ever been, better than what I used to call normality, but if you think living like this is good enough for me, you're crazy."

He saw me for 14 years. He is now (many years later) internationally renowned in his field. He recently sent me a magazine article about a prestigious award he received for his scholarship. His therapy did not make him a bright man nor a kind man, but it did keep his brightness and kindness from being destroyed. It did allow him to feel safe, perceive and think realistically and creatively, and use his intelligence and kindness to make his own and other people's lives more interesting.

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On the definition of schizophrenia*

Wilfried Ver Eecke

* This essay is extracted and adapted from a section of a chapter in a forthcoming book by De Waelhens & Ver Eecke . *Phenomenology and Lacan on Schizophrenia, after the Decade of the Brain.*

Nancy C. Andreasen, a well-known researcher in neurobiology, defines schizophrenia as “a disease of the brain that is expressed clinically as a disease of the mind.....[P]atients have a variety of symptoms and impairments in cognition. Behind this diversity, however, is a final common pathway that defines the illness. For schizophrenia, it is the misregulation of information processing in the brain” (646). This is a very helpful interdisciplinary definition confirming the dual epistemological approach I have defended in a chapter of a book length manuscript (De Waelhens & Ver Eecke, Ch 1). However, I agree with only one third of the definition as formulated.

The one third of the definition of schizophrenia by Andreasen that I agree with is the claim that the disease expresses itself clinically as a disease of the mind. This is confirmed by a clinical psychiatrist quoting a patient: “I had no sense of my being as self, that is I wasn’t aware that my feelings were related to myself” (Kafka, 26). According to Kafka, “What distinguishes the psychotic individual...is the fact that the person, the self, does not

contiinued on page 17

Definition, cont.

have a privileged position in the object world" (Ibid., 27).

If the disease is understood to express itself clinically as a disease of the mind, then the goal of therapy should be the healing of the mind–in the words of Andreasen, or in restoring a sense of self–in the words of Kafka. To be a self is to be able to tell some kind of consistent story about one's life. Treatment methods that make that more difficult should be understood as being problematic. Consider the following testimony of a patient: "I remember waking up after each ECTC electro-convulsive therapy and finding a little less of my memory remaining. I couldn't remember my friends in high school, my distant or immediate past was less clear to me. ... It was supposed to eradicate bad memories, yet the treatment showed no discrimination" (Ibid., 25). With such negative side-effect for the possibility of healing the mind and restoring a sense of self, the interdisciplinary definition of schizophrenia by Andreasen invites search for treatment methods with more positive contributions to the healing of the clinical symptom itself.

Subjective discontent of schizophrenic patients is not limited to electro-convulsive therapy. Clinicians have reported such discontent also with the use of neuroleptics. Such complaints are documented in several studies (Awad 743). If the subjective problem of the schizophrenic expresses itself as a problem of the mind or if schizophrenics have a problem with their sense of self, then it would logically follow that they also will need help with these psychic problems. Not to do so is disregarding the definition of schizophrenia itself as given by Andreasen and confirmed by Kafka.

The research in the previous mentioned chapter of book length manuscript invites me to broaden the definition of schizophrenia given by Andreasen. Indeed, the clinical expression of the disease is not just "impairments in cognition" or "misregulation of information processing" (Andreasen, 646). The clinical expression of the disease consists also in the schizophrenic's difficulty to include his body - with its sensations and its desires-- into the own image of the self and in relating as a human being--with desires, including sexual ones - to other human beings. These two problems involve more than cognition. They involve the emotions; they involve moral life; they involve the problem of human recognition. Such a broadened definition of schizophrenia implies that schizophrenics have ended up with profoundly disfunctional relations towards their own body, towards others, and towards language. Such a broadened definition of schizophrenia has also implications for therapy. Supporting therapy might be very helpful; it cannot be considered adequate since profoundly different relations towards the body, others and language need to be developed. Theoretically, one needs to defend "transforming therapy."

The research presented in the previously mentioned chapter demands that I disagree with the claim by Andreasen that schizophrenia is "a disease of the brain." That research demonstrates - so I believe - that a psychological cause is as necessary for the eruption of schizophrenia as a biological cause. I presented statistical evidence for that claim (Tienari 1992,163) and psychological mechanisms to causally explain the statistical evidence. The efficacy of the psychological mechanisms is supported by statistical evidence and by its conceptual explanatory power (communication deviance studies, the Fort study on proverb identification, Karon's pathogenesis intrafamilial risk variable (Karon & Widener, 47, 52-3) and studies on expressed emotions). Pointing to the psychological cause of schizophrenia helps to explain why the schizophrenic ends up with defective relations (towards the own body, towards language and towards others). It also explains why the combination of psychosocial treatments with somatic ones has demonstrable additive and supplementary effects with schizophrenics and why the beneficial effects of psychosocial treatments have durability (Mojtabai et al., 569, 574, 576, 580-82, 584).

Psychoanalytically informed therapy, in general, is aware that patients have a defective relation towards the own body and towards others. De Waelhens, informed by Lacan and contemporary philosophy, teaches us that the defective relation to language is the crucial defect of the schizophrenics. I argued that accepting a psychological cause for schizophrenia demands that one give to psychoanalytically informed therapy an important place in the treatment of schizophrenics.

To the objection that the psychic regression demanded by classic psychoanalysis is too painful, one can reply that the successful therapeutic interventions reported in this essay do not apply classic psychoanalysis. They actually violate several of the rules of classic psychoanalysis. They are therapeutic techniques adapted to the needs of schizophrenics but inspired by psychoanalysis. These therapeutic techniques have in common that they take the subjective position of the patient so serious that they take it as their starting point for their treatment (Castoriadis-Aulagnier, 219-220).

Because of the argument that schizophrenics end up with profoundly defective relations to their own body, to language, and to others, psychoanalytically inspired therapies will have to become again more important in the treatment of schizophrenics. They will become more important the more one pays attention to the subjective complaints of schizophrenic patients and the more one addresses the question of the quality of life in those patients, not just the containment of their symptoms.

Georgetown University

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continued on page 18

Definition, cont.

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The New York University Postdoctoral Program in Psychotherapy and Psychoanalysis

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Past President, Div. 39 Division of Psychoanalysyis of the American Psychological Association

Discussant: Brian Koehler, Ph.D.

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

Out of Psychosis and Into Life: Psychotherapy in the Field

Chairman: David Garfield MD
Co-chairman: Brian Koehler PhD
Presenters: Joel Kanter MSW, Julie Kipp MSW, Mary Moller MSN, Michael Robbins MD
Discussant: Wayne Fenton MD

More information to follow in the Spring issue of the ISPS-US Newsletter.

Letter to the Editor

"Whenever there's an incident like this, I take a look and think, 'My goodness. What can we, as a people, what can I, as a governor, do to protect individuals from themselves and to protect us as a society?'" George Pataki, Nov. 9 (quoted in "Pataki shut door, opened streets" by Jim Dwyer, *Daily News*, Nov. 21, 1999).

Many recent media reports and newspaper editorials have highlighted the plight of the mentally ill in New York City, due in large part to recent cutbacks in funding affecting access to both treatment and housing.

The strong response is encouraging even though mostly it has come only after the tragic deaths of bystanders. That there are unsupported angry and disturbed people "on the streets" (a very small number of whom have killed) is not a surprise to people working in the mental health field who are intimately familiar with the current devastation of hospital and community services, who know the consequences to the recipients, many of whom are basically defenseless when they are undermined and they are essentially forced into a state of social isolation by default.

For the most part to expect the group designated "SPMI" to suddenly and effectively advocate for themselves would be begging the question of mental illness. I think therefore it falls upon people and particularly professionals, knowledgeable about the changes in the field to speak up about the deplorable conditions faced by the people we work "for." I also think when clients inquire about the cutbacks or their effects they need to be given the basic political facts so they can understand changes affecting their lives and are potentially empowered to respond.

Equally important, mental health professionals need to be able to defend and created viable working conditions for themselves especially in regard to workloads. We should also be aware of the effects of demoralization and should be especially supportive of each other during hard times.

So far the response of most New Yorkers has been heartening: there is broad spread opposition to just virtually dumping the mentally ill homeless into (often outer borough) shelters or into the prison system. Most New Yorkers however understandably remain in the dark about the exact nature of the changes in treatment-philosophy and service cutbacks, as they often are done surreptitiously and without public announcement.

We who are knowledgeable are well positioned to advise people, and to hold elected officials responsible for policy. Most broadly effective is media communication: letters to newspapers, journal articles, videos, radio programs, etc., some of which people in our local chapter have already undertaken. And more can be done. It is also important simply to talk to as many people as possible including, especially friends, colleagues, administrators, and public officials about such issues as the seriously misguided and inadequate "Kendra's Law."

As we all know, both NYC and NY State (which has a budget surplus) currently are in exceptionally strong fiscal condition and there is no financial excuse or any rationale for cutting services to the mentally ill.

Winning the political battle about funding literally can mean saving the lives of some people with whom we work, and opens the way to doing the real clinical work, which is a founding purpose of ISPS, and which may also save lives.

Christine Miller MSW
New York City
12/14/99

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