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

# ISPS-US 14th Annual Meeting
# What's in a Name?
# Emerging Perspectives on the Intersection of "Schizophrenia" and "Recovery"

OCTOBER 4-6, 2013
At the Hyatt Regency, New Brunswick, NJ
Two Albany Street, New Brunswick, NJ 08901

Keynote Speaker: Debra Lampshire
Honoree: Daniel Fisher, MD, PhD

## ABSTRACTS & REFERENCES (Alphabetical by Lead Presenter)

**Ronald Abramson, MD, J. Tyler Carpenter, PhD, Steven Nisenbaum, PhD, JD, Janet S. Richmond, MSW, Ronan Wolfsdorf, MSW**
*Psychological and Social Approaches to Treating Psychoses in Different Settings: The Effects of the Setting*
Just as people who develop psychotic problems evolve these through various experiences, those of us who attempt to help such people recover through psychological and social approaches do our work in different settings. Each setting offers opportunities that enhance our work but also limitations that constrain and limit what we and our clients can accomplish.

We seek to present a workshop which will feature examples of approaches toward recovery in different settings, prison, physical culture, and private practice. Descriptions of the setting along with case examples will be presented with emphasis on the advantages this setting offers as well as the drawbacks.

Our plan is to leave plenty of time for discussion and our hope is that people who attend this workshop will feel free to share the experiences of their settings with advantages and disadvantages. It may be that from a lively discussion drawing on the experiences of all participants might emerge ways to cope with perceived limitations and enhance perceived advantages.

This workshop is presented by members of the Boston Area Group of ISPS-US.

Individual Abstracts:
Abramson: Presentation of Alexander
I am presenting the case of Alexander, a 23 year old single man living partly at home with his parents and partly in a college dormitory. He was referred to me because he seemed odd and because he was at risk of suicide. His initial presentation was quite puzzling, but it has subsequently become clear that he has an Autistic Spectrum Disorder (ASD) and has developed psychotic phenomena in this context. He has emerged as a brilliant individual who lives behind a sort of raw fearful psychic (as distinct from solid) wall that separates him from other individuals. Unable to connect with other people, he erects representations of these other people behind his wall with whom he then communicates and relates. Since his "interpersonal" life is carried on between him and his representations, there is little reality testing, and so he is predisposed to psychotic thinking. He has been

seeing me about once a week for three years. In my counter-transference, I tend to feel like a nervous piece of wood because forming a genuine connection with him feels impossible and he has had suicidal thinking, angry outbursts, and auditory hallucinations.

It is advantageous to see him in independent private practice because I am free to try various strategies for engagement. But it is disadvantageous because of the constraints of insurance coverage and because I am not part of a treatment team consisting of individuals with various backgrounds and skills that might form a better holding environment.

Carpenter: Treatment in the Prison Setting
Treatment in prisons is many things, both simple and complex, but above all it is a collective experience. None of it occurs in isolation from any other process by which it proceeds. This portion of the workshop presentation will consist of a framework for how one can think about working therapeutically in prisons. It will follow a well-established outline of comparative psychotherapy systems to set out the structure and contents of implementation. Audience participation and discussion will be part of the discussion.

Nisenbaum: A New "Resilience" Language and Approach to Treatment in State Hospitals
Inpatient programs for the mentally ill have generally reflected the ethos of one or more of the 5 influential paradigms and traditions in our understanding and efforts to provide services and protect against harm: 1) containment; 2) "moral treatment" in asylums; 3) psychodynamic therapies, and other treatments, rehabilitative therapies, and activities; therapeutic community and self-help paradigms; 4) cognitive behavioral contingency intervention programs; and 5) the biological (e.g., pharmacological, electroconvulsive, surgical) treatments. These each reflect particular assumptions about "mental illness" and human nature in conjunction with cultural and political values, as well as factors of available technology, costs, professionalizing, and competing demands. A New "Resilience" Language reflecting major changes in societal values and modern culture is now both possible, conducive to, and necessary to enhance efficacy and guide approaches in the early 21st Century. This portion of the panel presentation will consist of a framework for how one can think about this "Resilience Model" paradigm and preliminary observations from electronic audiovisual approaches to emotional coping, cognitive, and life skills for the seriously mentally ill and other patients in State Hospital and public inpatient facilities, working therapeutically in prisons. It will be augmented by an applicable set of epigrammatic principles for implementation. Audience participation and discussion will be part of the delivery.

Richmond: Emergency Department Setting
Agitation is a common presentation in the emergency department, and is an acute behavioral emergency requiring immediate intervention. It may present on a continuum ranging from anxiety up to and including violence.

This workshop will address techniques of verbal de-escalation that the emergency clinician can quickly learn and implement as an alternative to seclusion and restraint. Ultimately, successful verbal de-escalation empowers the patient and improves staff morale and patient adherence, because it utilizes a non-coercive, patient-centered approach. Verbal de-escalation enhances the doctor-patient relationship, while seclusion and restraint require more staff and take more time to implement, and reinforce to the patient that the only way to resolve conflict is through physical means.

The offering of medication can be considered part of verbal de-escalation, and methods of introducing the subject of taking medication can be done in increments.

This workshop is for the beginning or seasoned psychiatric clinician who is unfamiliar or uncomfortable with the intensity and urgency of a psychiatric emergency. Strategies of assessing and engaging verbally with agitated patients will be discussed, including offering of medications. These recommendations are in part based on the author’s clinical experience and a consensus panel of emergency psychiatry clinicians (American Association for Emergency Psychiatry-AAEP).

Wolfsdorf: Activity Based Group Therapy: Exercise and Sports
Milieu treatment involving activity-based group therapy, especially exercise/sports, can help clients with psychotic disorders recompensate. Such therapy offers benefits re: mind-body vitality and unconscious interpersonal relating, whilst potentially obviating some of the dyadic intensity (and transferential challenges) of private session talk typically antecedent to recompensation. This session will review theories of regression in psychosis, anecdotal material: client motivation for non-talk based versus talk-based group therapy, the benefits of "play" for young adults, and thus the adjunctive (or preparatory) value of such engagement. The session aims to facilitate exploratory discussion through audience participation and sharing.


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**Berta Britz, MSW, ACSW, CPS**
*My Liberations*
For me recovery is liberation. Liberation for me is moving from a state of disconnection and powerlessness to a state of connection and power. Marius Romme calls this "taking back the power or emancipation." As an American I associate "emancipation" with Lincoln's Emancipation Proclamation, something someone else declares for us; I use the term liberation because I view recovery as an experience one goes through personally, that no one can do for us or define for us. In my experience recovery required a social context to move from disconnection to connection – I needed to connect with myself, with other people, and with "God." For me this process began with the subjective reality of powerlessness. First, powerlessness in relation to my abusing caregivers as an infant and young child; later, powerlessness in relation to mental hospitals and other re-traumatizing experiences; and, for four decades, powerlessness in relation to the voices I heard. I experienced my most recent liberation six years ago when I learned about the World Hearing Voices Network approach to accepting and making sense of voices. I have accepted my voices as my own, am in ongoing dialogue with them, and accept responsibility for them. I own my power and am connected to others through love and hope.

Romme, M. and Escher, S. *Making Sense of Voices*.

Romme, M., Escher, S., Dillon, J., Corstens, D. & Morris, M. *Living with Voices: 50 Stories of Recovery*.

**Berta Britz, MSW, ACSW, CPS, Oryx Cohen, MPA, Lisa Forestell, Nev Jones, MA, Melissa McLean**
*Perspectives on the Hearing Voices Network Movement from 5 Facilitators of Hearing Voices Groups*
Members of the panel will speak about the history and values of the Hearing Voices Movement (HVM) and its impact on their voices and extreme states work in the USA. Panelists from different regions of the country will discuss the progress, process, and challenges encountered in bringing a hearing voices network approach to their communities. They will discuss how professionals/allies can be best involved in the work of networks and groups and different strategies for collaboration, partnership and community outreach. There will be ample time for discussion and the panelists hope to promote substantive dialogue between voice hearers, peers, clinicians and other session attendees about the future of the HVM in the US.

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**Marilyn Charles, PhD, ABPP**
*Working at the Edge: Meaning, Identity, and Idiosyncracy*
Humans come into being in relation to other people and to the world as it has been defined for us. As the language of psychiatry has come to dominate over other possible ways of making meaning in the arenas of mental health and psychological distress, normal developmental processes can become invisible over concerns regarding possible "disease entities" that may be taking of the human mind and being. Lacan recognized how much is embedded in Language, initially offering a model in which the "Name of the Father" is privileged along with a normative, somewhat constrictive model for human development. In his later seminars, however, Lacan puts forward the suggestion that the laws of Language and the "Name of the Father" may be the neurotic solution to questions of existence and identity. In contrast, he suggests, the solution of the psychotic (or the

artist) may be more idiosyncratic and, I would argue, potentially more creative. In this presentation, I will use the case of a young man who began to lose his mind in the process of trying to overthrow the Law of his father and install his own sense of values. As such, we can consider ways in which what might appear to be a psychotic diathesis may mark, instead, a turbulent struggle to establish and maintain an autonomous, creative identity. We can also consider the role of the therapist in establishing an environment in which that important work might be accomplished.

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**Gregory Concodora, MA, M.Ed.**

*From the Mouths of Babes: Adolescents Diagnosed as Psychotic Offer Their Perspectives on Human Relationships*

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

Despite these difficulties, there has been little interest within academic psychology to sit down with such persons and ask them what they think about issues related to self, the other, and human relationships so that professionals might learn more about why they seem to experience so much trouble with members of this population. Instead, researchers tend to prefer their own "expert" analyses rather than the opinions of this ignored and disregarded group, in the process missing tremendous insight into how these young men and women see themselves, others, and what really matters when forming connections between human beings.

This writer's dissertation project endeavored to give voice to this often marginalized and misunderstood population by engaging them in conversations about their ways of understanding and making meaning from human relationships. Phenomenologically based, semi-structured interviews were conducted with 6 adolescents between the ages of 16 and 19 who were in residential treatment at the time these conversations took place. This presentation will explore, using their own words, the ways in which these adolescents see themselves and their relationships with friends, family, and clinical care workers.

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**Mark Duffy, MSW, CPRP, Sandy Badmaev, Louis Blicharz, Jeanette Ellis, MA, Lois Miller, MSW, LSW, CPRP**

*Informed Choices (Making Informed Decisions about Your Treatment and Your Wellness Options)*

The panel will be made up of five persons (two users of mental health treatment and three providers of care) who made up the original learning and support group that developed the Informed Choices program.

The panel will present a description of the Informed Choices initiative at CSPNJ. Informed Choices is a learning and support program whose purpose is to provide education, support, and information about mental health treatment optimization and alternative approaches to wellness for persons who have the lived experience of mental illness and are users of mental health services. The mission is to help people in their recovery journey make choices for themselves that will improve their quality of life.

The participation goals of the program are to:

• Develop skills in making informed treatment decisions in cooperation/consultation with providers including an individual's psychotropic medication prescriber

• Build knowledge about a variety of ways to get and stay well using the 8 dimensions of wellness:
-Emotional – Coping effectively with life and creating satisfying relationships
-Financial – Satisfaction with current and future financial situations
-Social – Developing a sense of connection, belonging, and a well-developed support system
-Spiritual – Expanding our sense of purpose and meaning in life
-Occupational – Personal satisfaction and enrichment derived from one's work
-Physical – Recognizing the need for physical activity, diet, sleep and nutrition
-Intellectual – Recognizing creative abilities and finding ways to expand knowledge and skills
-Environmental – Good health by occupying pleasant, stimulating environments that support well-being

• Learn how to ask questions about treatment

• Write a personal wellness plan

• Learn about systems change and advocacy to make that change happen

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**Kateryna Dukenski, MA**

*Application of Modern Psychoanalytic Technique to Overcoming Resistance in an Inpatient Psychotherapy Group*

This paper introduces several modern psychoanalytic techniques and their application to group treatment with patients presenting with psychosis in an inpatient setting. Modern psychoanalytic approach to group psychotherapy, developed by Hyman Spotnitz, emphasized the therapist's use of his or her feelings induced by the group, as well as joining and reflecting rather than directly challenging group resistances. The author presents her experiences with the implementation of this approach in a local psychiatric hospital with patients who present with initial difficulty to be therapeutically engaged. The paper focuses on presenting techniques that allow resolving the resistance of group members to communicate their thoughts and feelings regarding their lives, their experiences on the unit, their reactions to each other and the group leaders. According to Spotnitz, just saying everything is a curative experience in itself, especially when this ability is compromised in case of severely mentally ill patients. The difficulty to communicate openly in the presented group was handled by group leaders by using the following modern psychoanalytic techniques: object-oriented questions, joining and reflecting resistance, emotional communication, consulting with the group, bridging and maturational interpretation. Based on the presented clinical work, the author argues that modern psychoanalytic techniques can be successfully implemented in an inpatient group setting with patients who are otherwise difficult to engage in most of therapeutic activities.

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**Larry Ende, MSW, PhD & Diana Semmelhack, PsyD, ABPP**

*The Importance of Social Interaction in Recovery*

Abstract not available

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**Daniel Fisher, MD, PhD**

*Dialogical Recovery Approach: Using Severe Emotional States (AKA Schizophrenia) for Self-Integration*

I was diagnosed with schizophrenia at age 26 while carrying out research at NIMH on the neurotransmitters supposedly responsible for mental health conditions. Through four episodes of extreme emotional states for which I was hospitalized, I was able to integrate at a deep level. I became a psychiatrist in order to humanize the mental health system, but found that larger systemic change was needed. Through founding the National Empowerment Center and being a member of the White House Commission on Mental Health, I assisted many others with lived experience of recovery to construct an inspiring recovery paradigm as the basis for policies to replace the deadening maintenance model. I have also learned that recovery is enhanced by a positive re-framing of distress as potentially growth promoting. Part of such a re-framing is to move away from diagnoses to more narrative-based descriptions. If instead of an individually-based, illness model, the person experiencing distress and those close to them understand their so called symptoms are attempts at deep integration as described by John Weir Perry, then personal growth is possible. I propose a synthesis of recovery and dialogue, called a Dialogical Recovery Approach, consisting of a combination of Open Dialogue, Recovery Dialogues, and emotionalCPR. We advocates find the Finnish Open Dialogue description of distress as residing in the space between the members of a person's social network as more conducive to growth of all involved. I will describe the 2-year training program in Open Dialogue, which I completed at the Institute for Dialogical Practice, and the application of this approach in private practice. I will also discuss the application of dialogical principles in systems change through recovery dialogues in a community mental health center. Lastly I will discuss the use of emotionalCPR as a vehicle for public education in personal growth through application of dialogical principles by the general population.

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**Jean-Max Gaudillière, PhD & Françoise Davoine, PhD**
*What to Do When the Tool with the Names is Broken?*
People familiar with Ludwig Wittgenstein will easily recognize his compelling question, as expressed in the "Philosophical Investigations". But we will also confront this matter-of-fact situation with specific moments of the transference with madness and trauma. The principal outcome of it is: when it is impossible to name something, there is not another solution than to show it. To whom, if the addressee is an analyst? And with which tools could he/she answer that critical situation?

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**Patricia L. Gibbs, PhD**
*Re-naming, Re-reading and Re-thinking: Psychotic Depression and Its Treatment and Recovery*
I will be considering three patients that I have treated in long-term psychotherapy or psychoanalysis who all struggled with typical features of psychotic depression. The central conceptualizations of psychoanalytic work that I have used to understand and now re-examine these long-term treatments are: Melanie Klein's work on mourning and manic defenses, Edith Jacobsen's work on the importance of superego development facilitating reality testing, and the contemporary clinical techniques centered on the use of projection identification and the countertransference in treating psychotic patients.

In considering clinical vignettes from three different patients, I will examine the common features of psychotic depression that overlap clinical work and current research coming from fields both within, and outside of psychoanalysis. Thus, the outcome studies of recovery from severe abuse and trauma, PTSD, schizophrenia, and psychotic depression will be briefly noted. The questions I have asked myself, and will invite the audience to consider during the discussion period, will include: "What are we saying when we conclude someone cannot

recover from any situation or mental disorder?" "How might this conclusion impact the therapist's countertransference – or unconscious identifications with the patient?" "What are we really saying when we conclude someone is 'unanalyzable'?" "What picture of the human condition results when we insist that psychological difficulties must be considered within the biomedical model of medication-only treatment?"

The presentation will focus on the power of the therapeutic alliance and the psychoanalytic transference/countertransference in achieving a "life worth living" – with or without the use of medication. The process of mourning, both in the analyst and the patient, will be highlighted in the clinical vignettes. Using treatment examples involving the mutative processes of mourning, I will demonstrates how manic grandiosity and the denial of human limits eventually gives way to improved judgment and the meaningful embrace of reality.

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**James E. Gorney, PhD**

*The Lost Tribe: Micro- and Macro-History in Recovery from Psychosis*

The Oxford English Dictionary defines the word recover in the following manner: "To get back again into one's hands or possession; to regain possession of something lost or taken away." This presentation will illuminate the means by which recovery from a psychotic state can be facilitated through initiating connection with generational trauma, history, and heritage.

It is now widely recognized that trauma can be transmitted intergenerationally, often without conscious recognition by the subject, and that such long-buried trauma can be a key factor in the emergence of psychosis. The disconnection of an individual's micro, or "little," history from his or her ancestors' macro, or "big," history can also be a key factor in precipitating, intensifying and sustaining psychosis. (Davoine and Gaudilliere, 2004.) This is not salient only in regard to trauma. This presentation will demonstrate that the reconnection of an individual not only with buried trauma, but also with the broader traditions and historical record of ancestors, can facilitate recovery from psychotic states.

The process of recovery will be documented via engagement in intensive psychoanalytic psychotherapy with a young woman of Native American ancestry. Initially encountered in a psychotic and severely traumatized state, this individual was almost entirely cut off from, and ignorant of, her unique heritage. Through the course of treatment, it was the therapist-facilitated reclaiming of her history, culture and traditions of ancestors which catalyzed the patient's emergence from psychosis, and eventually enabled her to make meaning of her individual history.

Evidence from this clinical case will be utilized to address the more general importance of forging social links in the process of recovery from psychosis. Not only does the recovering subject need to make a deep and meaningful connection in the present moment with an engaged other; the subject also can be engaged in recovery by forging a link to his or her place in the larger history and heritage of preceding generations.

Davoine, F. and Gaudilliere, J.-M. (2004). *History Beyond Trauma*. New York: Other Press.

Revel, J. (1996). Microanalysis and the construction of the social. In *Histories. French Constructions of the Past*, ed. J. Revel, R. Nadaff, and L. Hunt, pp. 492-502. New York: New York Press, 1998.

**Elizabeth A. Johnson, PhD & Kathy Steinmetz, MS**

*Benign Visual Hallucinations during Empathic Attunement in Psychotherapy*

What is and is not psychosis? As researchers, care providers and consumers have noted, the meanings of psychosis and even one of its often cited symptoms, hallucinations, can be widely varied and the experiences not part of an illness per se (Collerton, Dudley & Mosimann, 2012). Pixley (2012) suggested that work in psychodynamic psychotherapy with psychotic clients may involve an unconscious interplay between therapist and client that comes from the high levels of sensitivity involved in the interactions. The results for the therapist of such heightened sensitivity may be a blurring of reality that he or she is hesitant to share with other professionals, in spite of possible clinical insights gained.

This presentation features a self-report by a practicing clinical psychologist, who experiences benign visual hallucinations, especially while working with frightened and psychotic clients. The case of one particular client who has a psychotic disorder and is chronically afraid is examined. It is suggested that the therapist's hallucinations may be an embodiment of empathy, and that this sensitivity in psychodynamic psychotherapy may offer a unique opportunity for enhancing the effectiveness of the therapy. A model of empathic attunement is proposed that considers a therapist's subjective experience of clients with a psychotic disorder or who are otherwise highly sensitive.

Collerton, D., Dudley, R., & Mosimann, U. P. (2012). Visual hallucinations. In J.D. Blom & I.E.C. Sommer (Eds.), *Hallucinations: Research and practice* (pp. 75-90). New York, NY: Springer Science and Business Media.

Pixley, M.M. (2012). Some difficulties with psychodynamic psychotherapy attending to benign auditory and visual hallucinations and delusions. *Journal of Psychotherapy Integration*, 22(4), 382-392.

**Nev Jones, MA**

*Unpacking Early Intervention in Psychosis*

Over the past decade, early intervention in psychosis (EIP) has rapidly become one of the sexiest new areas of clinical specialization, service development, and intervention research (Edwards & McGorry, 2002; Bertole & McGorry, 2005; Birchwood et al., 2000). The presenter will describe major themes from an ongoing mixed-methods user-led longitudinal study examining clients' and clinicians' perspectives on engagement, the therapeutic alliance, and the role of heterogeneous cultural/clinical explanatory models in the context of early psychosis. In keeping with the 2013 ISPS-US conference theme, the presentation will specifically explore varying attitudes toward diagnosis, psychiatric labels, and medication use, the relationship between these attitudes and engagement with different aspects of the EIP program, and impacts on clients' perception of their own agency with respect to their symptoms/experiences (cf Larsen, 2004, 2007a,b).

Bertole, J., & McGorry, P. (2005). Early intervention and recovery for young people with early psychosis: consensus statement. *The British Journal of Psychiatry*, 187(48), s116-s119.

Birchwood, M. J., Fowler, D. R., & Jackson, C. (2000). *Early intervention in psychosis: a guide to concepts, evidence, and interventions*. New York: John Wiley & Sons.

Edwards, J. & McGorry, P. D. (2002). *Implementing early intervention in psychosis*. New York: Taylor & Francis Group.

Larsen, J. A. (2004). Finding meaning in first episode psychosis: experience, agency, and the cultural repertoire. *Medical Anthropology Quarterly*, 18(4), 447-471.

Larsen, J. A. (2007a). Symbolic healing of early psychosis: Psychoeducation and sociocultural processes of recovery. *Culture, Medicine and Psychiatry*, 31(3), 283-306.

Larsen, J. A. (2007b). Understanding a complex intervention: Person-centred ethnography in early psychosis. *Journal of Mental Health*, 16(3), 333-345.

**Bertram P. Karon, PhD, ABPP**

*Recovery of an "Incurable Schizophrenic"*

A patient diagnosed as schizophrenic was evaluated by all his psychiatrists as "incurable" after several years of unsuccessful outpatient and two months of unsuccessful inpatient treatment, both with medications. Electroconvulsive therapy (ECT) was strongly but pessimistically recommended. He was not eating, not sleeping, and continuously hallucinating. He began outpatient psychoanalytic therapy. All medications were stopped. After three days, he began eating. After four months he began working at an intellectually demanding job. After two years, he could be assured that he would never be psychotic again under normal stresses. But that was not good enough for him. He kept raising new issues: problems in living, difficulties writing his first book, psychosomatic problems, problems enjoying ordinary pleasures, marital problems, undoing problems he had caused his son. The total treatment took 14 years. More than 20 years after the completion of treatment, the patient sent a note indicating his continued professional accomplishments and thanking the therapist for "giving me my life back."

Karon, B. P. (1989). On the formation of delusions. *Psychoanalytic Psychology*, 6, 169-185.

Karon, B. P. (2003). The tragedy of schizophrenia without psychotherapy. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 31, 89-118.

Karon, B. P. (2007). The use of hallucinations in the treatment of psychotic patients. *Ethical Human Psychology and Psychiatry*, 9, 162-172.

Karon, B. P., & VandenBos, G. R. (1981). *Psychotherapy of schizophrenia: The treatment of choice*. New York, Aronson.

**Julie Kipp, PhD, LCSW**

*Evidence-Based Recovery: Overview and Report from the Field*

Evidence-based practices are currently considered an integral part of recovery-oriented practice in the state of New York. This paper will provide an overview of the EBPs considered relevant for working with people with serious mental illness, and will address these questions: What practices are considered evidence-based? What is the evidence? What is the process for implementing EBPs, and what is going on in the field currently? What ethical issues need to be considered in determining which practices are evidenced-based, and in putting them into effect in the real world? What is the response of practitioners and consumers to these new practices?

The author will give examples from a recovery-oriented program in New York, overseen by the state Office of Mental Health. This type of program is still developing, as it has only been in operation for about 3 years in the New York City area.

Gambrill, E. Evidence-based practice and the ethics of discretion. *Journal of Social Work* 2011 11: 26.

Nevo, I. and Slonim-Nevo, V. The myth of evidence-based practice: Towards evidence-informed practice. *British Journal of Social Work* (2011) 41, 1176-1197

Soydan, H.; Mullen, EJ; Alexandra, L; Rehnman, J; and Li, Y-P. Evidence-based clearinghouses in social work. *Research on Social Work Practice* 2010 20: 690.

Rubin, A. Improving the teaching of evidence-based practice: Introduction to the special issue. *Research on Social Work Practice* 2007 17: 541.

**Brian Koehler, PhD**

*A Contemporary Overview of Evidence-Based Psychosocial Therapies in Psychotic Disorders (Schizophrenias and Bipolar Disorder)*

A contemporary overview of psychological and psychosocial therapies for psychotic disorders, including the schizophrenias and bipolar disorder, will be presented. Both experimental (randomized controlled trials) and qualitative, quasi-experimental evidence will be discussed. This review will also include descriptions of such emerging psychosocial therapies as family focused therapy and interpersonal social rhythm therapy for bipolar disorder, compassion mind training, Open Dialogue, and acceptance and commitment therapy for the schizophrenias, and CBTp for both clinical disorders. Quasi-experimental evidence for psychodynamic therapies will also be covered. In addition, there will be a brief neuroimaging review of the effects of various kinds of psychotherapies on the brain, with implications for psychotic disorders.

Miklowitz, D. J. (2009). Psychosocial interventions for bipolar disorder: A critical review of evidence for efficacy. In L. N. Yatham & V. Kusumakar (Eds.), *Bipolar Disorder: A Clinician's Guide to Treatment Management,* Second Edition, pp. 575-590. London: Routledge.

Swartz, M. S., Frohberg, N. R., Drake, R. E., et al. (2011). Psychosocial therapies. In J. A. Lieberman, T. S. Stroup & D. O. Perkins (Eds.), *Essentials of Schizophrenia*, pp. 207-224. Arlington, VA: American Psychiatric Publishing, Inc.

**Debra Lampshire**

*A 360 Degree View of the World: An Expansive Approach to Madness*

How do we respond when two conflicting world views collide? Is it possible to navigate safely though the possible misunderstandings and hostility which can arise when equally deeply entrenched and polarised views present? How do we hold the tension and act responsibly so as to extend the hand of compassion to initiate

reconciliation and acceptance? What may we need to consider when endeavouring creating a mutually beneficial and productive relationship whilst establishing an environment conducive to recovery?

Lampshire, D. (2012). The sounds of a wounded world. In J. Geekie, P. Randal, D. Lampshire, & R. J. (Eds.), *Experiencing psychosis: Personal and professional perspectives* (pp. 139-145). London, England: Routledge.

Lampshire, D. (2012). Living the dream. *Psychosis: Psychological, Social & Integrative Approaches*, 4(2), 172-178.

Lampshire, D. (2009). Lies and lessons: Ramblings of an alleged mad woman. *Psychosis: Psychological, Social & Integrative Approaches*, 1(2), 178-184.

**Gillian Stephens Langdon, MA, MT-BC, LCAT, Alison Cunningham-Goldberg, ATR-BC, LCAT, Kelly Long, MS, R-DMT, Kristina Muenzenmaier, MD, Lisa Oliveri, Ricky Perry**

*A Bridge Between Trauma and Healing: Building Relationships Through Verbal and Creative Arts Therapies*

"Recovery can take place only within the context of relationships; it cannot occur in isolation." (Herman, 1992)

People in an urban, long term psychiatric facility have been found to have high prevalence rates of traumatic events throughout their lifespan. Clinically, in addition to psychotic symptoms, we observe not just high co-morbidity rates of PTSD (Muenzenmaier, 2005), but also complex trauma-related symptoms such as alterations in the regulation of affect, attention, consciousness, self-perception, relationships, somatization and systems of meaning (Herman, 1992). As a result survivors of complex trauma often feel disempowered and disconnected.

The therapeutic relationship plants a seed towards the development of safe relationships and secure attachments. Music, art, dance and words can provide enlivening experiences of relationships beyond labels and constricted formulas. These connections include relationships to the self and others, to the art, to the body, to the music, and to the spoken and unspoken. Each modality can serve as a pathway to a therapeutic relationship, allowing trauma survivors to express themselves individually or in a group. The group environment allows for understanding and support of each other and the creation of a new culture of unspoken symbolic meanings.

In this experiential and didactic presentation, participants will actively explore the process of the creative arts and the role of words in inspiring and untangling expression. In addition, clinical vignettes will be discussed, focusing on the healing process.

Borczon, R.M., Jampel, P., Langdon, G.S. (2010). Music therapy with adult survivors of trauma. In K. Stewart (Ed.) *Music therapy and trauma: bridging theory and clinical practice*.

Herman, Judith. (1992). *Trauma and recovery*. New York: Basic Books.

Muenzenmaier, K., Castille, D., Shelley, AM., Jamison, A., Battaglia, J., Opler, LA., Alexander, MJ. "Comorbid Post-Traumatic Stress Disorder and Schizophrenia". *Psychiatric Annals*, 35, 51-56, 2005.

Ogden, P., Minton, K., and Pain, C. (2006). *Trauma and the Body: A sensorimotor approach to psychotherapy*. New York: W.W. Norton & Company.

Wilson, L. (1985). Symbolism and art therapy: II. Symbolism's relationship to basic psychic functioning. *American Journal of Art Therapy*, 23. 1299-133.

**Town Hall with Brian Martindale, MD, FRCPsych, M Inst Psa**
*ISPS: New Name but Old Wine in a New Bottle? What is the future for ISPS-US within the ISPS international?*
As Chair of ISPS I will present an international perspective on ISPS. My aim will be to inform US colleagues of the wider work of the organisation, the changes that it has undergone in the last two decades (including the name change) and suggest where we might be able to get to in the next two decades by working together. I will emphasise some of our organisation's strengths and some of our limitations.

The creation of local networks has been crucial to the transformation of ISPS, and the US networks are excellent examples of that transformation from the ISPS of the 1990s.

I will make some challenging comments about the current needs of networks to make better or clearer developmental plans and I will give plenty of time for participants to comment and make suggestions.

The ISPS Constitution: http://www.isps.org/index.php/about/constitution

**Andrew Moskowitz, PhD (Chris Burford Memorial Lecture)**
*'What's in a name? Schizophrenia, Psychosis, Trauma, Dissociation, Recovery - Which Words Hold the Key to Our Future?*
Just over 100 years ago, Eugen Bleuler coined the term Schizophrenia partly because he found Dementia Praecox too pessimistic. He thought that recovery was possible, even if a "hint of schizophrenia" would always remain. A compassionate man and concerned physician, Bleuler would hardly recognize what his concept has morphed into over the past century. Heavily emphasizing psychotic symptoms and highly stigmatizing, the current diagnosis was wisely jettisoned by ISPS last year. But dropping the term schizophrenia should not make us forget the other reason Bleuler chose the term – he thought these persons were suffering from a split mind. The links between dissociation and schizophrenia that Bleuler raised, along with the importance of childhood trauma, are now being fleshed out through research.

In this talk, I will explore the historical and contemporary meanings of the terms schizophrenia, psychosis, trauma and dissociation, and the various ways in which they interact. I will suggest that, while there were good reasons ISPS dumped schizophrenia, the substitute "psychosis" is not without its conceptual and clinical limitations. Because whatever is unique to schizophrenia – or the "diagnosis formerly known as schizophrenia" – it's not psychotic symptoms. Losing the diagnosis makes it conceptually more difficult to characterize those persons who formerly met the diagnosis.

And finally, what about "recovery"? While the aims of the recovery movement, set against those of traditional psychiatry, are laudable, the term itself is restrictive. It begs the question "recovery from what"? Illness? What else does one recover from? "Recovery" primarily designates the state before psychosis as "less than" what comes after (and what came before). But is this really how we wish to conceptualize these experiences? Perhaps "recovery/discovery" movement would capture the spirit better?

This presentation will be a wide-ranging discussion and contemplation of these issues, leading to a consideration of which terms may point the field in a positive direction.

Moskowitz, A. (2011). Schizophrenia, trauma, dissociation and scientific revolutions. *The Journal of Trauma and Dissociation*, 12, 347-357.

Moskowitz, A., Heinimaa, M. & Van der Hart, O. (in press). Defining psychosis, trauma and dissociation: Historical and contemporary conceptions. *Psychosis, trauma and dissociation* (2nd Ed.). Moskowitz, A., Schäfer, I. & Dorahy, M.J. (Eds.). London: Wiley.

**Lois Oppenheim, PhD & Alice Lombardo Maher, MD**
*Film: How to Touch a Hot Stove: Thought and Behavioral Differences in a Society of Norms*
This film, co-created by Lois Oppenheim, Ph.D. and Alice Maher, M.D., and directed by Sheryll Franko, addresses the problem of stigma associated with the words "mental illness", "wacko", "psycho", "nut job" and others. By presenting different theories about the nature, origin, and treatment of psychic disorders, the film compares and contrasts the destigmatization movement with other social movements like women's rights, civil rights and gay rights, and empathizes with the dilemmas of struggling individuals and the people who employ, teach, live with, financially support, and love them. Our vision of the stove in the title is both "top-down and bottom-up": The stove is touched by putting on oven mitts while the flame is also turned down. We illustrate in the film how other social / civil rights movements evolved in that way: Uprisings happened, laws were changed from the "top down," while individual people reached out to other individual people (blacks, gays, women) in ways that increased understanding and empathy and decreased inflammatory reactions over time. Simple ideas, like "Don't look away, but don't stare," and showing the audience the problem in a way that makes them realize that people with mental disorders – the obvious ones talking to themselves on the street and the high-functioning people who need to remain closeted – are among them, maybe even ARE them, were the impetus for this film.

Flaherty, Alice W. (2004). *The Midnight Disease*. New York: Houghton Mifflin.

Sheryll Franko (2009). *Crazy Enough to Care*, documentary film.

**Narsimha R. Pinninti, MD & Betty Mabine**
*Journey from being a Client to a Counselor in the Same Program*
This is the story of the co-presenter who joined a partial hospitalization program with symptoms of depression, psychosis and self mutilation. Symptoms were only partially responsive to treatment. Then she received cognitive behavior therapy interventions as a part of her medication management visits. She went on to have complete symptom remission and became a helper and role model for other clients. She also became good support for many of the clients and was able to encourage clients who were ambivalent to attend the program. Observing her uncanny ability to connect with other individuals, the primary presenter advocated for her to be employed by the organization. She was employed as a peer specialist in the same organization and worked in the same program. She worked for a period of three years as a peer specialist, and was a bridge between the clients and the staff. She was awarded the NJ association mental health agencies annual courage and compassion award and current is employed full time in a new position and has moved on from the organization. The authors will share details of the process of recovery, factors that facilitated her transition from client to a counselor in the same program, her own reactions to the transition and reactions of the staff and other clients. There will be some discussion also about confidentiality issues that may arise in such a situation.

Deegan E, P. (1988). "Recovery: The Lived Experience of Rehabilitation." *Psychosocial Rehabilitation* 11(4): 11-19.

Liberman Robert Paul, K. A., Ventura Joseph, Gutkind Daniel. (2002). "Operational criteria and factors related to recovery from schizophrenia." *International review of psychiatry* 14: 256-272.

Neugeboren, J. (2008). "Personal accounts: more magic bullets?" *Psychiatr Serv* 59(2): 143-144.

Swarbrick, M. (2007). "A wellness approach." *Psychiatric Rehabilitation Journal* 29: 311-314.

**Peter Pretkel, PsyD, Adrienne DiFabio, PhD, Kristen Meyers, PsyD**
*Group Treatment for Psychosis in California Forensic Settings*
California has a large forensic population with serious mental illness that includes individuals who are incompetent to stand trial, individuals who have successfully pled not guilty by reason of insanity, prisoners, and individuals on parole but deemed dangerous and not in remission. Until recently, psychological interventions to treat aspects of psychotic experience left unaddressed by medications were unavailable to this

population. In 2010, psychologists working at California forensic facilities developed a group treatment manual for patients experiencing psychotic symptoms. The manual was primarily adapted from the current literature on Cognitive Therapy (CT) for psychosis, a well-researched and evidence-based treatment for a range of psychotic disorders. The manual emphasizes establishing a safe treatment environment, providing information about psychotic symptoms, medications, and coping strategies, and providing a forum for patient discussion of their subjective experience of voices, paranoia, and delusions. Interventions applied during use of this manual encompass the recovery model for the treatment of individuals housed in an inpatient forensic hospitals and inpatient forensic correctional settings. The manual is now in use in multiple settings. This presentation will briefly describe forensic treatment settings in California, outline the manual's content, and discuss patient, provider, and institutional response to the manual.

Beck, A., Rector, N., Stolar, N., & Grant, P. (2009). *Schizophrenia: Cognitive Theory, Research, and Therapy*.

Kingdon, D. & D Turkington (2005). *Cognitive Therapy of Schizophrenia*.

**Richard Reichbart, PhD**
*The Anatomy of a Psychotic Experience: A Personal Account of Psychosis and Creativity*
A relationship between psychosis and creativity will be explored via a personal presentation by a senior training and supervising analyst who will graphically describe his year-long psychotic experience over forty years ago, when he lived and worked on the Navajo and Hopi Reservations. He will discuss the development of a year-long psychotic experience when he lived and worked as a legal services attorney on the Navajo and Hopi Reservations, in Arizona and New Mexico, over forty years ago. He will show the dynamic and developmental roots of this experience, its creative as well as defensive function, how it made use of aspects of the Navajo culture and the haunting landscape of the Southwest, and finally, the denouement of the experience after a psychotic break and return to serious depressive neurosis. He will also discuss the intensive psychoanalysis that he underwent that permitted him to avoid an extended inpatient setting or reliance upon medication. Rarely do psychoanalysts speak of such personal psychotic experiences, which – if survived – add creatively to our understanding, in this case not only of a certain type of psychosis but of object relations in general.

In this respect, the difference between neurotic and psychotic reactions to object loss, including the effect of such reactions on memory formation and openness to sensual (including poetic) experience, will be explored. The exploration will involve detailed and graphic reconstruction of early childhood events as well as subsequent events that precipitated the psychotic reaction. The presenter also will argue that the term "psychosis" is often used so indiscriminately that it fails to differentiate between schizophrenia and other forms of psychosis, with the consequence that the type of psychotic reaction discussed here – amenable to intensive psychoanalytic intervention – does not appear sufficiently in our psychoanalytic literature.

Bell, M. D., Greig, T. C., Bryson, G., & Kaplan, E. (2001). Patterns of object relations and reality testing deficits in schizophrenia: Clusters and their symptom and personality correlates. *Journal of clinical psychology*, 57(12), 1353-1367.

Jackson, M (2001). *Weathering the storms: Psychotherapy for Psychosis*. London: Karnac.

**Jeremy Ridenour, PsyD & Jason Moehringer, MPsy**
*Defense and Recovery from a Psychodynamic Perspective*
Is psychosis a defense or failure of defense? There have been two primary ways of conceptualizing the relationship between psychosis, defense and truth from a psychoanalytic perspective. From the first perspective, the individual's "repression" barrier between the conscious and unconscious parts of the mind is too permeable (Federn, 1943a-c). Primitive material arising from the unconscious overwhelms the ego and is discharged in psychotic symptoms. Hallucinations and delusions serve to externalize these unconscious contents outside of the individual's mind and allow them distance from their unconscious wishes and fears. From this perspective, a more supportive approach is needed that can provide the individual with the appropriate skills and healthy defenses to re-repress unconscious material that overwhelms the ego. From a second perspective, psychosis is a

defense, an attempt by the individual to avoid some truth or trauma that is unbearable (Sullivan, 1927). Psychosis affords the individual the opportunity to avoid addressing a traumatic kernel, and psychotic symptoms allow the individual to escape into a private world in which they do not have to experience or communicate these experiences to the outside world (Bion, 1965). The appropriate intervention will require uncovering and exploring the unbearable reality that is being defending against so the individual can sacrifice the psychotic symptoms and integrate the trauma(s) that have necessitated the creation of psychotic symptoms. Research by Staring, van der Gaag and Mulder (2011) demonstrates that individuals who integrate their psychotic experiences rather than "seal over" have better chances for recovery. We will argue that both conceptualizations are valuable in promoting psychological integration and therefore helping the psychoanalytic clinician facilitate the individual's recovery. Additionally, through discussion of the origins of each perspective, we will establish guidelines and clinical indications that can assist clinicians in choosing effective intervention strategies when working with individuals who experience psychosis.

Bion, W. R. (1965). *Transformations*. London: Heinemann.

Federn, P. P. (1943a). Psychoanalysis of psychoses. Part I. *Psychiatric Quarterly*, 17, 3-19.

Federn, P. P. (1943b). Psychoanalysis of psychoses. Part II. Transference. *Psychiatric Quarterly*, 17, 246-257.

Federn, P. P. (1943c). Psychoanalysis of psychoses. Part III. The psychoanalytic process. *Psychiatric Quarterly*, 17, 470-487.

Staring, A. B., van der Gaag, M., & Mulder, C. L. (2011). Recovery style predicts remission at one-year follow-up in outpatients with schizophrenia spectrum disorders. *The Journal of nervous and mental disease*, 199(5), 295.

Sullivan, H. S. (1927). The onset of schizophrenia. The American Journal of Psychiatry, 7, 105-134.

**Paul S. Saks, PhD & Guy Ravitz, PhD**

*"An Absence of Darkness in Infinite Degrees": Recovery Through Psychodynamic Therapy in a State Psychiatric Center*

The title of this paper is derived from a quote by Leornardo DaVinci, "A shadow may be infinitely dark, and also an absence of darkness in infinite degrees. The beginnings and ends of shadow lie between the light and darkness and may be infinitely diminished and infinitely increased." State Psychiatric Centers are often perceived as places of darkness where overmedicated patients, their agency obliterated by a rigid system, are left to decay in bleak and sterile halls. The authors of this paper, while acknowledging that these hospitals can indeed be dark places, contend that they are more akin to Da Vinci's shadow. With an intensive program of psychodynamic psychotherapy (both group and individual), sensitive pharmacology and effective case management, there is indeed the possibility of recovery, thus allowing for remarkable individuals to emerge between the beginning and end of light and darkness. The presenters of this paper will present the case studies two such individuals, a young woman with a severe trauma history whose treatment extended past her successful discharge, and a man who believes he is a dragon. The presenters will speak for the efficacy of using psychodynamic psychotherapy with psychosis as a viable modality of treatment, even when faced with an environment rife with systemic issues.

Eigen, M. (2004). *The Psychotic Core*. New York: Karnac.

Klein, Melanie (1986). *The Selected Melanie Klein*. New York. MacMillan.

McWilliams, N. (2004*). Psychoanalytic Psychotherapy: A Practitioner's Guide*. New York: The Guilford Press.

McWilliams, N. (2011). *Psychoanalytic Diagnosis*. New York: The Guilford Press

Searles, H.F. (2005). *Collected Papers on Schizophrenia and Other Subjects*. New York: Karnac.

Shedler, J. (2011). The efficacy of psychodynamic psychotherapy. *American Psychologist*. March 2010. 98-109.

**Burton Norman Seitler, PhD, Lloyd Ross, PhD, Robert J. Sliclen, PhD**
*What's in a Name? What's in a Diagnosis: Deconstructing the DSMs*
Allen Frances, and before him, Robert Spitzer, both well respected Editors of, and contributors to earlier versions of the DSM, have come out against the latest American Psychiatric Association's (APA) manualized incarnation, the DSM V. However, as strong as their arguments are, they are not nearly sufficiently potent or come soon enough to avert the harm that they predict will ensue, or to undo the harm that has already occurred after the APA introduced the ADHD, childhood bipolar disorder, and other diagnoses. Now grief and shyness are going to be pathologized, along with other responses to the rigors of everyday living.

If the makers of the previous DSM versions had gotten it right the first time, why is there still the need for so many emendations? This fact alone illustrates the inaccuracy of diagnoses. This panel will show that applying medical diagnoses to emotional experiences contains serious inaccuracies, including lack of scientific validity and reliability.

We will present evidence of significant flaws in the rationale, reasoning, and research behind the DSMs and the consequent harm that they have created. Diagnoses simply serve countertransferential wishes for certainty in order to assuage therapists' anxiety regarding not knowing, ambiguity, and experiencing our own terror inherent in the conflicts that our patients induce in us. Alternative conceptualizations and practices will be considered. Finally, we will make a plea for redirecting our focus back to trying to understand and treat patients as unique human beings, as individuals, rather than labels.

Angell M (2010) *The illusions of psychiatry*. New York Rev Books 58: 20-22.

Bekelman J, Li Y, Gross C (2003) Scope and impact of financial conflicts of interest in biomedical research: A systematic review. *JAMA* 289: 454-465.

Cosgrove L, Bursztajn HJ, Krimsky S (2009) Developing unbiased diagnostic and treatment guidelines in psychiatry. N Eng J Med 360: 2035-6.

Cosgrove L, Bursztajn HJ, Krimsky S, Anaya M, Walker J (2009) Conflicts of interest and disclosure in the American Psychiatric Association's Clinical Practice Guidelines. *Psychother Psychosom* 78: 228-232.

Cosgrove L, Krimsky S, Vijayaraghavan M, Schneider L (2006) Financial ties between DSM-IV panel members and the pharmaceutical industry. *Psychother Psychosom* 75: 154-160.

Frances A (2010) Opening Pandora's box: The 19 worst suggestions for DSM5. *Psychiatric Times* 27: 9.

Lacasse JR, Leo J (2010) Ghostwriting at elite academic medical centers in the United States. *PLoS Med* 7: e1000230. doi:10.1371/journal.pmed.1000230.

Seitler, B.N. (2011). DSM Diagnoses for Emotional Dilemmas: Nothing More than Labeling and Name-Calling. *J. Critical Psychology, Counselling and Psychotherapy*, 2011, vol. 11, # 1, Jan., pp. 37-42.

**Steven M. Silverstein, PhD**
*Update on Risk and Resilience Factors, and the Nature and Effectiveness of Efforts to Prevent Schizophrenia*
Recent years have seen advances in our understanding of risk factors for schizophrenia, and the development of clinics for young people at risk for the syndrome. At the end of 2013, what have we learned from such efforts, and how close are we to being able to prevent schizophrenia from occurring? This presentation will address these issues by: 1) reviewing the latest data on risk and resilience factors related to schizophrenia; 2) describing approaches to identifying people at high risk for schizophrenia; 3) discussing methodological, societal and political issues involved in making changes that might reduce the risk of schizophrenia; and 4) describing data on the effectiveness of high-risk clinics, as well as suggestions to obtain better outcomes. Among other conclusions, it will be suggested that: 1) intervention must begin at an earlier age than is current practice, and this can be done in a non-stigmatizing manner; and 2) we may be able to improve our understanding of risk and resilience factors by examining other conditions where the prevalence of schizophrenia is far below that in the general population.

Brown AS, McGrath JJ. The prevention of schizophrenia. *Schizophr Bull*. 2011 Mar;37(2):257-61. doi: 10.1093/schbul/sbq122.

Yung AR, Nelson B. Young people at ultra high risk for psychosis: a research update. *Early Interv Psychiatry*. 2011 Feb;5 Suppl 1:52-7. doi: 10.1111/j.1751-7893.2010.00241.x.

Morgan C, O'Donovan M, Bittner RA, Cadenhead KS, Jones PB, McGrath J, Silverstein SM, Tost H, Uhlhaas P, Voineskos A. How can risk and resilience factors be leveraged to optimize discovery pathways? *Schizophrenia: Evolution and Synthesis*. 2013. Cambridge: MIT Press.

**Ross Tappen, MA & Gladys S. Valdez-Blake, PhD**
*Group Work Essentials–An Interactive Workshop*
While group treatment is omnipresent in inpatient and outpatient mental health settings, training in group work lags far behind. Many groups are topic based and clients are assigned to them based on their symptoms, life history or demographics. The panelists will present a workshop on conducting a process-oriented group psychotherapy treatment used in a long term state hospital inpatient setting. In this process group model, clients are chosen based on their interest in setting goals for themselves, their capacity to speak openly with the interviewer and their willingness to participate in the training model.

The training model attempts to provide a safe setting for psychiatric inpatients that creates optimal conditions for therapeutic change. At the same time, the model seeks also to provide an intimate, hands on, training experience for predoctoral psychology interns. The group begins with the trainers conducting the group and interns silently observing in an "outer circle" which is set up around the perimeter of the therapy circle. The trainee observers begin to rotate into the group as conductors. After each session the interns and senior staff meet to examine the process of the preceding hour. These kaleidoscopic roles shift over the course of hours and weeks throughout the training year and provide parallel vantage points for senior staff, interns and clients. Thus, each group member is being observed and treated, but also observes and teaches. Each intern observes and supervises from the outer circle, but is also observed and provides treatment from the inner circle. The supervisors are demonstrating to the interns, observing the patients and the interns, and supervising and being supervised by the interns.

The first part of the workshop will consist of an overview of the treatment / training model, including the particular elements necessary to create a safe therapeutic environment, including time, place, protocol and consent; a statement of the training goals of the model and presentation including an understanding of the feasibility of doing process oriented work with psychiatric inpatients; ability of the trainees to identify and work with essential elements of group process such they are able to replicate. In the second part of the workshop there will be an in-vivo demonstration of the model with panelists and workshop members engaged in group process, with other workshop members observing, followed by a discussion and processing the group experience.

Hinshelwood R.D. (2003) Group Mentality and Having a Mind, in *Building on Bion - Roots - Origin and context of Bion's contributions to theory and practice*, M. Pines and R. Lipgar, eds. London: Jessica Kingsley.

Oldham, J.M. (1982). The use of silent observers as an adjunct to short-term inpatient group psychotherapy. *International Journal of Group Psychotherapy* 32(4):469-80.

**Ross Tappen, MA, Rodney Waldron, Sara E. Zoeterman, MA**

*State Property, or Your Property? A Support Group for Voice Hearers in a Public Hospital Setting*

There is broad support for the idea of engaging people with psychotic and unusual experiences in a way that seeks to understand, accept, appreciate those experiences as a means to recovery. A partial sampling of authors from diverse perspectives and disciplines that in some way endorse this approach would include Romme and Escher (psychiatry), Karon (dynamic psychology), Turkington, Kingdon and colleagues (CBT), Peggy Swarbrick (Occupational Therapy), Bach and Hayes (Acceptance and Commitment Therapy) and Rufus May and Ron Coleman (Experiential, Peer-based).

However the idea that in psychosis distinctively, what the patient is experiencing should be downplayed, eliminated or suppressed, in the mind of the clinician as well as the client, remains ascendant and has influential representatives (Lieberman, President of American Psychiatric Association). The acceptance or rejection of meaning in the experience of people with psychotic experience constitutes a fundamental divide from which flow very different construals of recovery, as well as different ways and means to address the challenges of recovery.

The panelists will present a group, called "Voices and Visions", piloted in Fall 2012. The group is an example, in a structured institutional environment – a state psychiatric facility – in which people come together to exchange views, share inner and outer experience, in a nonjudgmental and noncoercive setting that allows for individual ownership of experience. It is a community based model that is taking place within a psychiatric institution. The panelists – peer specialist, psychology intern, and psychologist – will discuss their experiences in establishing the group with guidelines that diverge from the institutional norm. They will also discuss the process-oriented, clinical aspects of conducting the group and how they bring their individual perspectives to the session, as well as how the members' own use of the group has shaped the approach over time.

Romme, M. & Escher, S. (2000) *Making Sense of Voices: A guide for mental health professionals working with voice hearers*. London: Mind Publications.

Bach, P. & Hayes, S.C. (2002) The Use of Acceptance and Commitment Therapy to Prevent the Rehospitalization of Psychotic Patients: A Randomized Controlled Trial. *Journal of Consulting and Clinical Psychology* 70, (5) 1129-1135.

**Ron Unger, LCSW**

*Understanding Psychosis as an Attempt at Transformation: Integrating Perspectives on Trauma, Spirituality and Creativity*

While psychosis is commonly understood as something going wrong within a person, and while many treatment approaches attempt simply to stop that process, this workshop focuses on an alternative view that sees psychosis as resulting from attempts to resolve problems that preceded the psychosis. In this view, psychosis may be initiated by a dangerous type of experimentation or creative process, where people (especially young people) consciously or unconsciously try out new ways of seeing, believing and behaving to address life and spiritual dilemmas caused by their stressful or traumatic experiences. These are dilemmas which they were not able to master using tools provided by their family and their cultural background. Psychosis can deepen when this process of experimentation leads to errors in beliefs, perceptions and behavior, resulting in more trauma and distress, and then typically more misguided responses by self and others, in an increasingly severe vicious circle. There remains however the possibility that with assistance by people who understand this process, and with continued experimentation rather than suppression of experimentation, both the original difficulties and the

difficulties resulting from attempted solutions that backfired can be resolved in ways that lead to personal and possibly even cultural renewal and health.

Heriot-Maitland, C. P. (2008). "Mysticism and madness: Different aspects of the same human experience?" *Mental Health, Religion & Culture* 11(3).

Nettle, D. (2006). "Schizotypy and mental health amongst poets, visual artists, and mathematicians." *Journal of Research in Personality* 40(6): 876-890.

Phillips, R. E., Lukoff, David, Stone, Mary K (2009). "Integrating the Spirit Within Psychosis: Alternative Conceptualizations of Psychotic Disorders." *Journal of Transpersonal Psychology* 41(1): 61-80.

Ritter, S. M., R. I. Damian, et al. "Diversifying experiences enhance cognitive flexibility." *Journal of Experimental Social Psychology* 48(4): 961-964.

Sylvia Mohr, P. H. (2004). "The relationship between schizophrenia and religion and its implications for care." *Swiss Med Wkly* 134.

Watkins, J. (2010). *Unshrinking Psychosis: Understanding and Healing the Wounded Soul*. Melbourne, Australia, Michelle Anderson Publishing Pty Ltd.

Whitson, J. A. and A. D. Galinsky (2008). "Lacking control increases illusory pattern perception." *Science* 322(5898): 115-7.

**Elizabeth Visceglia, MD**
*Healing Mind and Body: Using Therapeutic Yoga to Treat Symptoms of Schizophrenia*
As the author of the first study performed and published in the US on using yoga in the treatment of schizophrenia, I have always been deeply interested in integrative approaches to mental health. I performed this study at Bronx State Psychiatric center with no funding, and although the study was small, we had remarkable results. I will conduct a session that is both experiential and theoretical. I will give an overview of the research on yoga and schizophrenia, psychological theories about why yoga is so effective, and biologic/physiologic explanations of likely mechanisms of action of yoga practices. In addition, there will be important experiential aspects, including teaching participants basic but extremely healing breathing and movement practices – practices that can be safely used by anyone for one's own benefit or taught to someone suffering with the symptoms of schizophrenia. I will also give case histories of people I have worked with over the years and share the way that practicing yoga has improved their lives, whether as outpatients or during long-term hospitalization. Through this workshop, we will all develop a deeper understanding of the ways that yoga can be a highly effective adjunctive healing modality for those suffering with schizophrenia, and the remarkable effects – biologically, psychologically, and socially – that yoga can have when properly utilized.

Visceglia, E. (2007). Healing mind and body: Using therapeutic yoga in the treatment of schizophrenia. *International Journal of Yoga Therapy*, 17: 95-103.

Bangalore, N.G. and Vrambally, S (2012). Yoga therapy for schizophrenia. *International Journal of Yoga*, 5(2): 85-91.

**Sharon Young, PhD & Matt Snyder, MA, LPC**
*Recovery Realized: A Conceptual and Outcomes Summary from a Progressive Therapeutic Community Environment*
CooperRiis Healing Community in Western North Carolina has made it a priority to collect outcomes data from its diverse resident population since its inception in 2003. This ISPS session will provide an overview of this unique healing environment which represents a conceptual hybrid of the traditional therapeutic community model and the progressive recovery model. Ten years worth of quantitative, qualitative and behavioral data will

be summarized with a particular emphasis on the subgroup of individuals that have experienced symptoms of psychosis. Along with reviewing the various types of data independently, the presenters will also point out the most salient findings that are supported by the convergence of different types of data.

Davidson, L.; Harding, C.M.; & Spaniol, L.: *Recovery from severe mental illnesses: Research evidence and implications for practice*. Volumes 1 and 2. Boston, MA: Center for Psychiatric Rehabilitation of Boston University, 2005 and 2006.

Harding. C. The Vermont Longitudinal Study of Persons with Mental Illness I, *American Journal of Psychiatry*, 144, 718-726 and Harding C. The Vermont Study of Persons with Mental Illness II, *American Journal of Psychiatry*, 144, 727-735.

**Jay Yudof, MS, CPRP**

*The Breadths and Strengths of Mental Health Peer Providers* (Victoria Conn Memorial Lecture)

People living with a mental health illness have been working in the mental health service fields since time immemorial in various roles. Some labor at the front lines, disclosing or non-disclosing. Some are in leadership or research positions. The range of roles peer providers occupy, and their influence on the system, appears to be increasing. This introductory talk will address the breadth of peer provider roles, possible future directions, and issues of disclosure, integration, and career growth. We will briefly profile some leading peer providers.

Peer Providers - Quo Vadis, in *Word of Wellness, the newsletter of the Collaborative Support Programs of New Jersey Institute for Wellness and Recovery Initiatives*. Volume 2, Number 14, April 18, 2009

The Expanding World of Peer Providers, in *Peer Connections, a publication of the Mental Health Association in NJ*. Volume 1, Number 4, September 2009.

Swarbrick, M., Schmidt, L., & Gill, K. (2010). *People in Recovery as Providers of Psychiatric Rehabilitation Services. Building on the Wisdom of Experience*. Linthicum, MD: USPRA.