Spring, 2007
Volume #8, Issue #1

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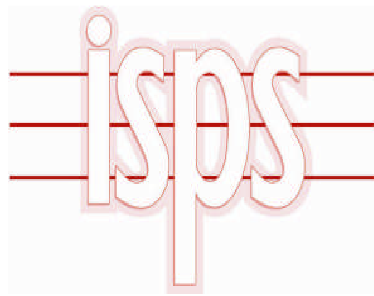

THE INTERNATIONAL SOCIETY FOR THE PSYCHOLOGICAL TREATMENTS OF THE SCHIZOPHRENIAS AND OTHER PSYCHOSES
UNITED STATES CHAPTER

The Use of the Term 'Schizophrenia'

Julie Kipp
(Secretary@isps-us.org)

As part of the planning for our next US meeting to be held in New York City in March of 2008, there was some revisiting of the controversy over the use of the term "schizophrenia," which is seen as inaccurate at best, and downright pejorative at worst. Of course, in Japan the term has actually been changed, in 2002, from *seishi buntetsu* byo, or "split-mind disorder" to *togo schicco sho*, or "loss-of-coordination disorder" (*Psychology Today*, Sept.-Oct. 2002).

I am open to using either "schizophrenia" or the more general "psychosis" in the title of our conference, or neither. However, the discussion reminded me of the very interesting work of Valerie Sinason, a British Tavistock psychoanalyst. She has worked with people who have what we call now, in the US, developmental disability, or in the UK, mental handicap. I believe that her ideas have relevance for our own field, and I have been inspired by her commitment to working psychodynamically with another population which has been deemed not capable of benefiting from such intervention.

In chapter 2 of Sinason's book *Mental Handicap and the Human Condition* (Free Association, 1992) she talks about the historical succession of words used to describe mental retardation: cretin, dullard, subnormal, moron, mentally deficient, and many more. The acceptable term for the condition has changed frequently over the years. In the beginning, each of these words was not pejorative, but merely descriptive. Each term starts out fresh, but the general public, e.g., the other kids in school, quickly turn the new word into a taunt: "moron" a few years ago turns into "retard" today. When this happens, the official term is changed again, in an attempt to be more specific and scientific, to mitigate the stigma, and to avoid giving pain.

Sinason does not think that "any name in itself, whether 'handicap,' 'disability,' 'learning problem,' or 'special needs,' is necessarily better than any other. But it is important for workers to be aware that abuse lies in the relationships between people, not in the name used... Each worker introducing a new term hopes that the new word brings hope and a new period of healthy historical change. Each time the new word is coined, it is coined honorably. It is not deliberately created as euphemism but becomes one because of *the painfulness of the subject*..." (italics mine).

"With regard to handicap, mental illness, and actual damage, we are often scared of facing differences because of guilt. The guilt of the worker at not being handicapped turns into a collusive identification with the omnipotent self of the handicapped client. A true understanding that we are all equal souls and all handicapped in different ways gets transmuted into a manic desire to erase difference. My handicapped patients often choose the word 'stupid' for themselves. The original meaning of 'stupid' is 'numbed with grief' and I feel the original meaning of the word does shine through because a lot of the pain and secondary effects of handicap is to do with the grief of internal and external trauma..."

So in our field, we are thinking that we need to change the term schizophrenia partly because the word has become so debased, so associated with despair and incurability. However, the grief is not only in the connotations of the word, but in the

(Continued on page 2)

Book Review: Psychotherapy as a Human Science

Matthew Morrissey
(matthew@fullspectrum.cc)

Psychotherapy as a Human Science, by Daniel Burston & Roger Frie. Published by Duquesne University Press, 2006.

In this admirable book, Burston and Frie provide a virtuoso overview of Continental philosophy, showing how many of the ideas that inform recent developments in psychoanalytic theory and therapy are foreshadowed by this tradition, especially in the area of existential phenomenology. If those last two words seemed forbidding, there is no need to worry: Burston and Frie write in a such a balanced and jargon-free expository style that by the end of the book you will understand precisely how existential phenomenology relates to psychoanalytic thought (along with the ideas of the many philosophers related to or in tension with this tradition).

Central to the book, as its title suggests, is the concept of a "human science." To conceive of psychotherapy a "human" science is to place it on an entirely different foundation than that of the "natural" sciences. The natural science model of psychology and psychotherapy is what has come to be known as the medical model: patients are viewed on the theoretical level

(Continued on page 2)

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

Psychosis:
Psychological Approaches and Their Effectiveness

— Putting Psychotherapies at the Centre of Treatment —

Edited by Brian Martindale, Anthony Bateman, Michael Crowe, & Frank Margison

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

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Book Review, continued

(Continued from page 1)

as being ruled by genetics, neurochemistry, and psychological laws. On the clinical level, the aim of the medical model is rapid symptom reduction. From the human science perspective, those labeled with mental disorders are seen as active agents, endowed with intentionality and embedded in particular social, cultural, and historical contexts. Clinically, symptoms are seen as communicative and the aim of treatment is to help the person develop new ways of being in the world.

No doubt the majority of clinicians in ISPS-US already think about and practice psychotherapy as a human science. However, I think the merit of this book is in its ability to help us link up our thought and practice to a rich and broad dialogue that has been occurring in philosophy since at least the late 18th century. Not many people appreciate the relevance of philosophers such as Blaise Pascal and Søren Kierkegaard to their psychotherapeutic outlook, not to mention more recent figures such as Wilhelm Dilthey and Max Scheler. In addition, readers receive an additional gem in the form of the closing chapter, entitled "Psychotherapy and Postmodernism." This chapter provides an up-to-date synopsis of such notions as agency, embodiment, gender, race, insight, authenticity, and alienation by drawing on ideas that have been fully explicated in previous chapters—so the reader is able to think along with Frie and Burston as they juggle an array of considerations.

It is easy to recognize the timeliness of this kind of a project. It's not that the human and natural science models don't at times complement each other (as Frie and Burston freely accede), it's the fact that the human science model—which should rightly take precedence to the extent that psychology and psychiatry deal with live human subjects—is rapidly disappearing from the field of mental health. Despair, indignation, and cynicism are fashionable reactions to our times; less so is a dedicated return to the pulse of life, to the invisible, to what a human face means. Thither are we invited.

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Schizophrenia, cont.

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condition itself, and its severe alienation from the rest of human society. We may approach our patients with a great deal of hope and optimism, but there are no guarantees that people with schizophrenic conditions will be healed by our efforts. It is a very sad and serious illness and not everyone recovers.

> "...we are thinking that we need to change the term schizophrenia partly because the word has become so debased, so associated with despair and incurability. However, the grief is not only in the connotations of the word, but in the condition itself..."

Sinason again: "Differences in gender, race, size, shape, ability, appearance, culture, voice are intrinsic to a rich experience. Otherwise we would all live in a world of autistic sameness. However, difference evokes envy (when we perceive ourselves to be lacking) or guilt (when we perceive someone else to be lacking). In Sonnet 29 Shakespeare understands the 'outcast state' where the poet enviously wishes he was someone else and loses all contentment with his own lot. *Then the thought of his love retrieves him from that state…*" (my italics).

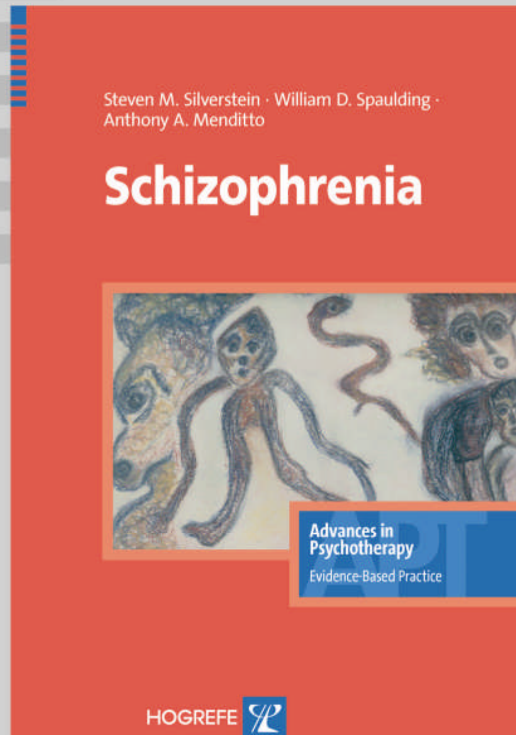
Perhaps there will come a day when we are able to differentiate better the probably several illnesses which are currently sloshing around together in the kettle called "schizophrenia," and then it will make sense to call them by different names. However, I would not change the word because of the stigma, but rather work to reduce the stigma, and to increase the understanding that schizophrenia, while a heartbreaking and awful illness, can be treated, and mitigated, and even cured, through relationships. It is the crucial contribution of ISPS: that we can explain and demonstrate how relationships can be created and used to help in recovery from schizophrenia.

Steven M. Silverstein, William D. Spaulding, Anthony A. Menditto

Schizophrenia

Advances in Psychotherapy – Evidence-Based Practice, Volume 5

Keep Up with the Advances in Psychotherapy!



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This highly anticipated volume provides a concise, practical, and up-to-the-minute view of evidence-based treatment of schizophrenia. Well-designed outcome studies have demonstrated the effectiveness of specific psychological interventions for schizophrenia for over 40 years. Despite this, schizophrenia is still misperceived by many people to be treatable only by medication.

This book reviews currently available treatments for schizophrenia, and the evidence for their effectiveness.

Practical guidance on comprehensive treatment planning of the condition is provided, along with reviews of current theories of schizophrenia, long-term outcome studies and associated remission rates, different classes and types of assessment instruments relevant to psychiatric rehabilitation, and research on mechanisms of recovery. A number of important conceptual issues are interwoven within the discussion, including the relevance of different models for treatment of schizophrenia, and the importance of a recovery-oriented perspective.

A concise, practical, and up-to-the-minute view of evidence-based treatment of schizophrenia.

"...an authoritative, concise, and practical synthesis of the nature and treatment of schizophrenia. This outstanding, compact guide deserves a place on the bookshelf of every clinician who treats individuals with schizophrenia." Kim Mueser, PhD

"A long needed practical and clearly referenced guide...an indispensable handbook for students, supervisors and new and seasoned professionals alike." Paul Lysaker

"This outstanding work should stimulate a breakthrough in case formulation leading to comprehensive biopsychosocial approaches known to improve outcomes of people with schizophrenia. A clinical manual of this scope is long overdue." Richard H. Hunter, PhD, ABPP

"...very overdue in the field...THE definitive book on schizophrenia...a wonderful resource for clinicians, consumers, researchers, and students. The comprehensiveness of this text is unparalleled." David Penn, PhD

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1. Description: Terminology • Definition • Epidemiology • Course and Prognosis • Differential Diagnosis • Comorbidities
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Is Psychosis a Type of Regression?

Kevin Krummer
(kevin367@sbcglobal.net / www.auspiciousappearance.com)

I can't speak for other people, but I can talk about my experience of the psychotic state. It took me to a world I hadn't seen for quite some time, a place with vividness that I had yearned for and almost forgotten. It seemed to have brought me back to my childhood in a way, except it was different; I was an adult and I may have been a bit paranoid.

I felt I had special powers. It's true that there weren't people after me, but what was I communicating? It wasn't regular social anxiety that I was experiencing; there was a battle going on. It was aggressive. I called my antagonist Jimmy or James. It was more like a team of people lead by a Man. He just followed me around trying to prove that he was the special person, not me. He was riding my fame in a way.

No matter where I went, James was a few steps away. He was often successful in his plots against my gaining friends and followers, but he could never do me in, his ultimate goal. This is why I could not be shaken by fear. I knew that James was only creating trouble for himself when he would organize schemes against me. It just made me angry. I wouldn't say it was pleasant being angry at James for his harassment, but it wasn't blood boiling anger I experienced. It seemed as if his plots against me were mindless and redundant.

Another thing about James and his team was their culture. There was something foreign and primordial about James. I didn't understand his antics and eventually dehumanized him into a robot.

When I wasn't thinking about James, I was thinking about Jessica. Like James, she was a team of people who interacted with me. Instead of aggression they were trying to communicate Jessica's love for me. They would act in strange ways, sometimes teaming up with James if I wasn't behaving the way she wanted me to. I felt very in love with Jessica and her manifestations. Jessica was much more blissful than James.

When I experienced my last episode three years ago, I had gotten to the point where I would just stare at people. I would crazily stare at men that I thought were James and I would blissfully stare at women I thought were Jessica. This obviously made people feel uncomfortable! But surprisingly I never got into trouble with the men and I was even called "sunshine" by some of the women. After the fact, I was embarrassed, but I notice that there is someone else who makes faces at people and sometimes stares. It is my two-year-old nephew.

"...I notice that there is someone else who makes faces at people and sometimes stares. It is my two-year-old nephew."

It seems like my psychotic experience was somewhere in the enchanting realm of childhood. I couldn't believe that I was still capable of feeling that way. As I started recovering and learning to live a sane life, I became interested in Buddhism for strength. A practical philosophy, I thought, but a little silly and mythological. As I became more enmeshed in Buddhism, I started seriously thinking about rebirth and the meaning of life. During psychosis I thought I was death itself.

It is interesting to note that although I was "delusional" during my psychotic episode, I was incredibly inactive. If a sane person had thought that somebody was playing tricks on them and out to get them, they probably wouldn't have gone a day without punching a hole in the wall or something. I went an entire year keeping my mouth shut about the situation. In psychosis, the bliss comes to you. The wrath comes to you. You don't have to pursue it externally.

Psychosis is a glimpse of death. Why does the psychotic go back to a death-like state? Because life doesn't work for them. His or her state of mind has gotten so painful and tangled that the mind ceases to function. Although I experienced this death-like state, I didn't know what it was. It was a spiritually profound state, but I was spiritually inept. It has certainly changed my life; I want to become spiritually adept. I understand that there is something more to our lives than the mundane but, like a psychotic wanting a cigarette, it can be so difficult to forget about the mundane. I hope that one day I will understand this better.

The **9th Annual**
ISPS-US Meeting
will be held on
March 14th and 15th, 2008
at New York University
in New York.

NYU's
Postdoctoral Program,
School of Social Work,
and
Lifespan Learning Institute
will co-sponsor
the meeting.
The latter will provide
comprehensive CE credits.

Our theme for this year is
"Recovery
from Psychosis:
Healing
Through Relationship."

Aaron T. Beck, M.D.,
psychoanalyst and founder
of cognitive therapy,
will be
the Keynote Speaker.

Psychodynamic Psychotherapy and Medication for Treating Schizophrenia

Eric Peters
(epeters4@utk.edu)

In September, 2007, Eric Peters will begin his one-year psychology pre-doctoral internship at the Bronx Psychiatric Center in New York City. Eric completed his doctoral studies at the University of Tennessee in Knoxville. His primary interests include psychodynamic psychotherapy and research related to severely disturbed patients, psychodynamic theory, dissociative processes, the New York Yankees, and his love of dogs.

In May, 2007, I defended my dissertation project entitled, *A Theoretical and Empirical Investigation of Psychodynamic Psychotherapy and Neuroleptic Medication for the Treatment of Schizophrenia*. My interest in clinical and empirical work with psychosis began while working as a case manager in a group home for people suffering with schizophrenia. During my two years at this job I became increasingly disillusioned and frustrated as a result of what appeared to be a blind allegiance to neuroleptic medications that seemed to do little more than numb my clients. I was flooded with drug-company pamphlets that touted the effectiveness of their products and claimed that psychotherapy was useless for working with psychosis. In contrast, at this time I was fortunate to read two books that reflect the diversity of solutions – for varying levels of psychopathology – that people might use to protect themselves from further assaults on their sense of self and place in the world. The first book, Gail Hornstein's autobiography of Frieda Fromm-Reicmann, *To Redeem One Person is to Redeem the World*, is an unforgettable account of this brave pioneer that has taught many of us how to engage psychotic processes not only in our patients but in ourselves as well. The second book, Bertram Karon's and Gary VandenBos' *Psychotherapy of Schizophrenia: The Treatment of Choice*, provided the inspiration and the data for my dissertation.

By taking seriously the disconnect between how little is known about the etiology of schizophrenia and the rigid certainty with which medical treatments are offered, it was the stated intention of my recently defended dissertation project to arrive at an empirically and theoretically sound understanding of current psychotherapeutic and psychopharmacological treatment practices.

Section I: *Emil Kraeplin, Degeneration Theory, and Philosophical Realism.* Since neuroleptic treatments overwhelmingly dominate the modern treatment approach for schizophrenia, it is helpful to understand the epistemology of the schizophrenia construct that continues to impact biological conceptualizations and treatment decisions. This section focused on two of the non-epistemic philosophical underpinnings of the schizophrenia construct originally developed by the founding father of modern psychiatry Emil Kraeplin: degeneration theory and philosophical realism.

Section II: *The Empirical Validity of the Degenerative Disease Construct.* Philosophical deconstruction of a prevailing construct does not invalidate its core assumptions. That is, simply because modern biopsychiatric conceptions of schizophrenia are substantially influenced by a multitude of non-epistemic factors does not necessarily mean that the illness is not biologically-based and degenerative. That being said, if the biopsychiatric notion that schizophrenia is a chronic degenerative brain disease is accurate, then naturally most if not all cases of schizophrenia would ultimately leave a person significantly incapacitated or dead. After all, biological medication treatments are only designed to slow this allegedly inevitable process and mask rather than cure the most striking features of the illness. To determine the validity of the degenerative assumptions of biopsychiatry I reviewed two interrelated empirical questions: 1) does the duration of untreated schizophrenia predict greater severity of illness, poorer overall outcome, and/or psychotoxic brain damage; and 2) are there longitudinal studies that report any degree of significant improvement or recovery for persons diagnosed with schizophrenia?

Section III: *The Effectiveness and Safety of Neuroleptic Medications.* Because neuroleptic medications are used as the frontline - and usually only - treatment of schizophrenia, it was imperative to summarize the empirical literature that has investigated the effectiveness and safety of these medications. The effectiveness of neurolepetc medications was evaluated on four fronts by: 1) presenting data regarding the effectiveness of typical and atypical neuroleptics; 2) presenting a critique of the methodological limitations inherent in the FDA and non-FDA randomized control medication trials specific to schizophrenia research; 3) summarizing the most recent, large-scale, naturalistic study investigating the comparative effectiveness and safety of the newer versus older neuroleptics; and 4) presenting the variety of side-effects resulting from exposure to typical and atypical neuroleptic medications.

Section IV: *The Effectiveness of Psychodynamic Psychotherapy of Schizophrenia*. This section explored the empirical effectiveness of the psychodynamic treatment of schizophrenia by summarizing previously conducted outcome studies.

Section V: *Pre- to Post-Treatment Change in the Object Relations of Schizophrenic Patients.* Data for this project were provided by Bertram Karon and the Michigan State Psychotherapy Project archives. The empirical section of this dissertation project applied a modern measure of object relations to pre- and post-treatment Thematic Apperception Test narratives of schizophrenic patients divided into two groups: individual psychodynamic psychotherapy without medication (Psychotherapy; n = 9); and routine medication-only (typical neuroleptics only) treatment (Medication; n =12) to determine clinically significant treatment effects. That is, it was the primary purpose of this study to investigate two particular research questions: 1) Can individual psychodynamic psychotherapy for schizophrenia - *without any medication* - result in positive outcome in terms of object relations; and 2) What is the comparative effectiveness of medication-only versus individual psychodynamic psychotherapy-only treatment of schizophrenia?

A truncated version of this dissertation will be submitted for publication in the coming months. Due to restrictions placed on authors seeking peer-reviewed publication, I unfortunately cannot discuss results here. However, at some point in the next few months I can provide electronic copies of the full dissertation following completion of the university copyrighting process. Briefly, I can state that the results of this dissertation project favored the psychotherapy patients. Patients in this group exhibited more consistent and greater degrees of improvement across an array of object relations constructs relative to their counterparts receiving only neuroleptics.

Mind / Brain / Culture: Social Neuroscience and Relationships

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We are continuously learning about the impact relational and social experience has on the developing person, including the CNS, gene expression (epigenetics), etc. Persons could usefully, according to Ernest G. Schachtel in his classic volume "Metamorphosis," be viewed as "embedduals," i.e., embedded in various relational and sociocultural frameworks. There is emergent research demonstrating that fetal cells in the rat could transform into neurons, astrocytes, oligodendrocytes, and macrophages-crossing the maternal blood brain barrier and responding to molecular distress signals if the mother's brain is injured (Choi 2005).The human mother's brain regulates to a significant degree, e.g., through the maternal-placental-fetal neuroendocrine system, the developing fetal brain, creating long-term predispositions towards stress reactivity, e.g., placental corticotropin releasing hormone/factor (Wadhwa 2005). The neurocircuitry for social pain draws on the neurocircuitry for physical pain. Social pain, e.g., social exclusion, is equivalent neurobiologically, i.e., through activation of the dorsal anterior cingulate cortex (dACC), to actual physical pain-words and social isolation are painful. Social status influences the actual structure of certain neural regions, e.g., "high-status" animals actually have greater degrees of neurogenesis, and more neurons, in the hippocampus, a neural region important in learning and memory. Mirror neurons help us to replicate and simulate within our own brains and minds the experience, goals and motivations/intentions of the other.Simulated embodiment, a prereflective grasping of the experience of the other, helps us to be affectively attuned to other persons. Marco Iacoboni, neurologist and mirror neuron researcher, has formulated an"existential neuroscience," in which the inherent relationality of the human being is highlighted. The split between self and other is called into question at the level of neuroscience.

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Social support and social bonds are negatively correlated with various 'physical' and 'mental' illnesses from cardiovascular disease to the schizophrenias. Social isolation is tied to a significantly enhanced risk of mortality and a heightened risk of both chronic and acute health disorders-one key factor mediating these associations may be stress. When people are socially isolated their SNS (sympathetic nervous system) and LHPA (limbic-hypothalamic-pituitary-adrenal axis) response to stress may continue unabated, leading to a state of immunological vulnerability. Social bonds promote reproduction, survival in the organism and its off-spring, healthy development and reduce stress reactivity. The presence of social bonds is most dramatically documented by the intense emotional reactions to separation from or the loss of attachment figures. Oxytocin (OT), a hypothalamic neuropeptide, is released both by loss of social bonds as well as social connection. Its loss during social disconnection can be viewed as a form of social homeostat in which the organism is motivated to seek affiliative connection. It may be that OT initially signals distress and then induces affiliative efforts-if those affiliative contacts are supportive, and not critical or antagonistic, then affiliation would result in positive feelings and less stress. OT has anxiolytic and analgesic properties; it reduces the release of stress hormones, e.g., cortisol, and the reactivity of the autonomic nervous system, including reductions in heart rate and blood pressure. The biological components of stress/anxiety depends significantly on two interacting stress systems, the sympathetic-adrenomedullary (SAM) system and the hypothalamic-adrenocortical (HPA) axis.OT expression downregulates the activity of the limbic-hypothalamic-pituitary-adrenal axis and the SAM system. There is an affiliative neurocircuitry which promotes affiliation, especially in response to threat and stress. Social contacts protect against the adverse effects of stress through a process which implicates OT-induced suppression of the HPA axis. The OT-opioid-dopaminergic system regulates social approach behavior. OT is released by touch (hence the importance of "keeping in touch") and during positive social interactions. It is released in breast-feeding mothers and reduces anxiety in the latter compared to bottle-feeding mothers. OT is present in human breast milk and may serve as a anxiolytic for infants. Dopamine and endogenous opioids play a significant role in social bonding. Dopamine-oxytocin, dopamine-vasopressin interactions and dopamine may be essential in the formation of social bonds. Dopamine antagonists which saturate dopaminergic receptors, therefore, may run interference with social bond formation, e.g., between patients and therapists. One essential question is whether antipsychotic agents interfere with the formation of social bonds more

than the interference arising from the un-medicated psychotic state.

Social relationships and pair bond formation play powerful roles in neural development, especially under conditions of challenge and stress. Evidence supporting intergenerational transmission of social experiences via changes in such neuropeptides as oxytocin also comes from recent research on maternal behavior in rats. The capacity of these neuroendocrine systems, e.g., corticotropin-releasing factor (CRF), to experience long-lasting functional modifications may help to explain the origins of what we call "temperment" and "gender." Understanding these psychobiological systems and how deeply they are tied to social experience will offer potential insights into the development of what we call pathological or maladaptive behaviors.

I highly recommend the following volumes on the above subjects:

Harmon-Jones, E. & Winkielman, P. (Eds.) (2007). *Social Neuroscience: Integrating Biological and Psychological Explanations of Social Behavior*. NY: The Guilford Press.

Farrow, T. & Woodruff, P. (Eds.) (2007). *Empathy in Mental Illness*. NY: Cambridge University Press.

ISPS-US is proud to offer copies of
The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry's special issue:

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Volume 31, Number 1, Spring 2003
Guest-edited by ISPS-US president, Ann-Louise S. Silver, M.D. and Tor K. Larsen, M.D. of Norway

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The NZ Branch of the International Society for the Psychological Treatments of Schizophrenia (ISPS-NZ) and the Psychology Department of the University of Auckland invite you to:

The 5th Annual
MAKING SENSE OF PSYCHOSIS
Conference

November 14 (workshops), 15 & 16 (conference), 2007

Keynote Speakers include:

Paul Hammersley M.Sc., R.M.N.
School of Nursing Midwifery and Social Work, University of Manchester, England
Coordinator of the Campaign for the Abolition of Schizophrenia as a Label (CASL)
"A Future Without Schizophrenia?"

Dr. John Read
Psychology Department, The University of Auckland
"What the Public Thinks about Schizophrenia: Does It Matter?"

If you would like to give a talk about your work, personal experiences with psychosis, research, etc., send an abstract of about 100 words by September 30th to ispsnz@gmail.com.
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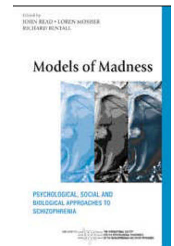
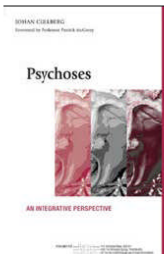


MODELS OF MADNESS
Psychological, Social and Biological Approaches to Schizophrenia

Edited by JOHN READ, LOREN MOSHER & RICHARD BENTALL

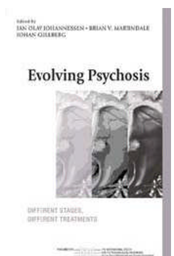
Models of Madness promotes a more humane and effective response to treating severely distressed people that will prove essential reading for psychiatrists and clinical psychologists and of great interest to all those who work in the mental health service.



PSYCHOSES
An Integrative Perspective

JOHAN CULLBERG
Foreword by Patrick McGorry

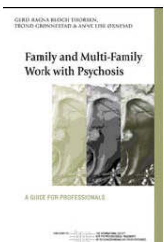
Psychoses provides a unique perspective on the challenges associated with understanding and treating psychoses, bringing together insights and developments from medicine and psychology to give a full and balanced overview of the subject.



EVOLVING PSYCHOSIS
Different Stages, Different Treatments

Edited by JAN OLAV JOHANNESSEN, BRIAN V. MARTINDALE & JOHAN CULLBERG
Foreword by Norman Sartorius

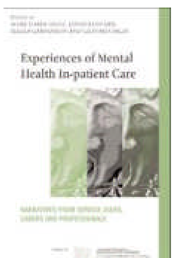
Evolving Psychosis explores the success of psycho-social treatments for psychosis in helping patients recover more quickly and stay well longer. This book incorporates new and controversial ideas which will stimulate discussion regarding the benefits of early, need-adapted treatment.



FAMILY AND MULTI-FAMILY WORK WITH PSYCHOSIS
A Guide for Professionals

GERD-RAGNA BLOCH THORSEN, TROND GRØNNESTAD & ANNE LISE ØXNEVAD
Foreword by Julian Leff

This accessible, jargon-free guide will be of great interest to anyone interested in investigating the potential for using family work to treat those with psychosis.



EXPERIENCES OF MENTAL HEALTH IN-PATIENT CARE
Narratives from Service Users, Carers, and Professionals

Edited by MARK HARDCASTLE, DAVID KENNARD, SHEILA GRANDISON, & LEONARD FAGIN
Foreword by Rachel Perkins

Experiences of Mental Health In-patient Care offers insight into the experience of psychiatric in-patient care, both from a professional and a user perspective. The editors highlight the problems in creating therapeutic environments within settings which are often poorly resourced, crisis driven and risk aversive.

New England Branch Report

Ronald Abramson
(NewEngland@isps-us.org)

The New England Branch of ISPS-US (ISPS-US-New England) has been meeting monthly at the home and with the kind hospitality of Max Day. Lately, the meetings have focused on the ideas of the celebrated teacher and clinician, Elvin Semrad. Max Day has led the discussions with readings that explain Semrad's ideas, and there have been illustrative clinical vignettes.

Following this, we have had Dr. Pierre Johennet introduce us to thinking of Lacan. Dr. Johennet plans to return in the near future. Also, Dr. Mark Schechter has introduced our group to his ideas about validation in psychotherapy. These are derived partially from the psychoanalytic field and partially from Dr. Marcia Linehan, who also founded Dialectal Behavioral Therapy. We are looking for experts to help us understand the utilization of Cognitive Behavioral Therapy in the treatment of people who have major mental illnesses.

Several new members and guests have joined this group, and this regional branch continues its growth. We welcome various points of view and different theoretical systems that contribute to understanding of the psychotherapy of psychoses and we hope to attract members from varied schools of thought and understanding.

Northern California Branch Report

Matthew Morrissey
(NoCal@isps-us.org)

The Northern California branch experienced a lull in its organizing efforts this past quarter due to the closing of Full Spectrum, which had been the base of operations as well as the meeting place for the group. We hope to reorganize and to find a new home soon, so stay tuned.

New York City Branch Report

Brian Koehler
(NYC@isps-us.org)

The New York Branch of ISPS-US has just completed its 12th year of monthly meetings. We continue to be co-sponsored by the Postdoctoral Program at New York University. Recently, the latter department moved to a new location so we are also moving to a new location on Fourth Street near Washington Square Park in the East Village. Our meetings will resume in the Fall 2007 with poet Karen Chase (author of "Land of Stone: Breaking Silence Through Poetry") presenting on her work with psychiatric inpatients. Our group is open to all persons interested in the subject of psychosis. Please contact Brian Koehler at brian_koehler@psychoanalysis.net or 212.533.5687 for further information on the group.

Please consider a submission to the upcoming issue of the ISPS-US quarterly newsletter. We seek submissions on a variety of topics related to the experience and treatment of psychosis.

For information, e-mail the editors at: Newsletter@isps-us.org

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