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UNITED STATES CHAPTER

ISPS-US 15th Annual Meeting
FROM REDUCTIONISM TO HUMANISM: MOVING FORWARD FROM PSYCHOSIS AND EXTREME STATES

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Boston University, Boston, Massachusetts

Target Audience, Abstracts, Learning Objectives, and References

Presentations are listed alphabetically by contact person.

Joseph I. Abrahams, MD *Circles of Change: An Adventure in Therapeutic Community at Atascadero State Hospital*
Intermediate
This book marks the culmination of a seven decade career in the analytic investigation of the worlds of psychosis, psychopathy, depression and narcissism. Towards the end of this profession I tested my previous analytic work at Atascadero State Hospital, which is a forensic facility housing those coincidentally psychotic and psychopathic. A key innovation prior to my work there was found through the therapeutic treatment of military offenders at the Fort Knox Center for the Rehabilitation of Army Prisoners during World War II. Critical there was my discovery of a messianic, saviorist phenomenon that enabled the transition of alienated populations to reconciliation with social and personal reality. Soon after the start of my experience at ASH the state of California mandated using the Quality Circle method of Williams Edward Deming to transform the mode of management. Deming, an engineer and statistician, revolutionized Japanese industry. The Quality Circle utilizes the free associative approach of group dynamics, with managerial and operational participation acting in equity. The analogous leveling of hierarchy and spontaneous collaboration in therapeutic community introduced by ASH's founder extended by the author, began instrumental change at the hospital. My work with seriously disordered, psychotic and paranoid patients, later became integrated with pastoral care. In a separate chapter is a detailed, in-depth report from several ministers and my exploration into the spiritual components of treatment. Additionally, each patient was studied individually, but a prominent aspect of this work is the illustration of two cases systematically detailed in the appendix. This integration of a new creative approach to management and productive participation of the patients points the way to transformation not only in mental health fields, but in other institutions and societies. Exemplification of these core aspects of therapy permeate the discussion of this volume.

At the conclusion of this activity, participants should be able to:
1. Evaluate the success of integration of therapeutic community and Quality Circle method, the reorganization of the management of an enterprise toward optimal action.
2. Identify the presence or absence of the spiritually relevant messianic component of the therapeutic alliance, in facilitating the integration of alienated elements.
3. Identify the absence or existence of prison mentality and the imperative towards its change in successful reintegration of the prisoner into society.

Brown, J., Miller, S., Northey, S., O'Neill, D. (2014). What works in therapeutic prisons: evaluating psychological change in Dovegate Therapeutic Community. Basingstoke: Palgrave Macmillan.

Foster, J., Bell, L., & Jayasinghe, N. (2012). Care control and collaborative working in a prison hospital. Journal of Interprofessional Care, 27(2), 184-190.

Sullivan, W. F. (2011). Prison religion: Faith-based reform and the constitution. Princeton: Princeton University Press.

Ronald Abramson, MD, Harold J. Bursztajn, MD, Irene C. Coletsos, MD, Susan G. Lazar, MD & Mark F. Poster, MD *The Mystery of Consciousness*

Introductory

Currently, the predominant paradigm in the understanding and treatment of psychoses is to consider them collectively as "brain diseases." Substantial advances in technology have facilitated the observation of brain functioning in real time and advances in genetics and the foundation and evolution of the field of Behavioral Epigenetics have deepened the understanding of the biology that inheres in the psychoses that we labor to understand. Yet it is clear that this new era of brain biology has yielded correlations with subjective experiences, but has not shown causality that certain brain states cause certain subjective conscious states. The subjective experiences of people, those who suffer from psychoses and those who do not, occur in the realm of consciousness, awareness of oneself and one's surroundings which is the subject of this panel.

Ronald Abramson, MD will present certain central ideas. One idea is to demonstrate that the subjective mind depends on the objective brain but is not reducible to it. Also, experiments in quantum physics have demonstrated that consciousness is a fundamental property of the universe.

Susan G. Lazar, MD will present an expanded view of the nature of mind. She will present data demonstrating the reality of paranormal phenomena including telepathy, clairvoyance, entanglement and action at a distance. These phenomena can be understood through the concepts of coherence, entanglement and a non-Newtonian model which describes the non-locality of all information making it accessible at any point. These concepts are broadly relevant to human interaction, including the psychotherapeutic situation and the evolution of increasingly mature societal values.

Mark F. Poster, MD will trace the evolution of concepts of unconscious communication from Ferenczi's "dialogue of the unconscious" (1909) to contemporary concepts about the dialectics of subjectivity.

Harold J. Bursztajn, MD and Irene Coletsos, MD will present information from contemporary clinical work showing the interplay of consciousness in the psychotherapeutic field.

At the conclusion of this activity, participants should be able to:

1. Explain the experiments in Quantum Physics that document that consciousness is a fundamental property of the universe.
2. Describe non-locality and experimental data demonstrating paranormal phenomena which explain how mind and consciousness are not limited by the Newtonian concept of local action.
3. Describe the evolution of the dialectics of subjectivity in psychoanalysis.

Crease RP, Goldhaber AS, "The Quantum Moment: How Plank, Bohr, Einstein, and Heisenberg Taught Us to Love Uncertainty," New York, Norton, 2014.

Lazar SG, "Knowing, Influencing, and Healing: Paranormal Phenomena and Implications for Psychoanalysis and Psychotherapy," in Unconscious Communication in Psychoanalysis, ed. Bornstein M. Psychoanalytic Inquiry, Vol 21, Num 1, 2001.

Nagel T, Mind and Cosmos: Why the Materialist Neo-Darwinian Conception of Nature is Almost Certainly False, Oxford University Press, 2012

Nunez P, Mind, Brain, and the Structure of Reality, Oxford, 2010.

Radin D, Entangled Minds, Extrasensory Experiences in a Quantum Reality, Paraview Pocket Books, 2006.

Rosenblum B, Kuttner F, Quantum Enigma (2nd ed), Oxford, 2011.

Alexandra L. Adame, PhD *The Psychiatric Survivor Therapist Dual Identity*
Introductory
This project focuses on mental health professionals whose lives are uniquely juxtaposed between the worlds of political activism of the psychiatric survivor movement–specifically targeted towards addressing abuses of power within the mental health system–and clinical practice in their chosen careers as therapists. This presentation explores the unique experiences of people who have experienced psychosis (as well as depression and anxiety) and also "survived" the literal and institutional effects of psychiatry such as involuntary commitment or being forcibly medicated. Psychiatric survivors constitute an international political movement working to advocate for people's rights in the mental health system and also providing alternatives to it in terms of peer-support and programs that do not typically adhere to psychiatric frameworks for understanding human suffering.

Interestingly, there are some psychiatric survivors that have gone on to become mental health professionals after their own challenging experiences as patients in the system. On the surface, it may seem paradoxical that someone who identifies as a psychiatric survivor would chose to re-enter and serve the field that they once found so oppressive. However, the survivor-therapists involved in this project (Ronald Bassman, Matthew Morrissey, and Kristina Yates) have a much more complex and largely complementary relationship between these two aspects of their identities. Our presentation will focus on the knowledge of lived experience born from our dual-identities as therapists with lived experience, and the presentation will focus upon themes such as healing, self-determination, self-disclosure, respect and inclusion. We hope that our project helps to facilitate further dialogue between the survivor movement and mental health professionals who ally with the goal of creating humane and empowering forms of care.

At the conclusion of this activity, participants should be able to:
1. Define the psychiatric survivor dual identity.
2. Discuss the benefits and risks of self-disclosure for therapists with lived experience.
3. Define healing from perspective of psychiatric survivor therapists.

Adame, A. L. (2014). "There needs to be a place in society for madness": The psychiatric survivor movement and new directions in mental health care. Journal of Humanistic Psychology, 54, 456-475.

Russo, J., & Beresford, P. (2015). Between exclusion and colonization: Seeking a place for mad people's knowledge in academia. Disability & Society, 30(1), 153-157.

Joseph, A. (2013). Empowering alliances in pursuit of social justice: Social workers supporting psychiatric-survivor movements. Journal of Progressive Human Services, 24, 265-288.

Chelsea H. Bagias, PsyD *Working with the Themes in Delusions and Voice Hearing*
Intermediate
This presentation addresses the underlying aspects of making sense of delusions and voice hearing. It emphasizes the experience of psychosis as an understandable phenomenon that is rich with symbolic content. The main tenets include identifying themes and parallels to the past, grieving losses, reinforcing the client's role in making successful change, and normalizing even very odd experiences. Primarily focused on therapy work in session, the techniques are also beneficial for family members and friends to enhance their awareness when interacting with the client or for the client specifically to begin to clarify their experience. The focus of the work is to return respect to the client and honor the threads of reality within the content of their experience.

Specific techniques include: alternative ways to reality test fixed delusions, inviting out affect, identifying common avoidance tactics, using humor to increase trust in the therapeutic relationship, and instilling hope. Additionally I will include the handouts for individual sessions, group work, and psychoeducation for clients and families.

At the conclusion of this activity, participants should be able to:
1. Identify opportunities to normalize odd or uncomfortable aspects of the client's experience and provide supporting psychoeucation and/or research.

2. Identify common parallels to the client's past that are presenting in the delusions or voice hearing.
3. Shift avoidance tactics into open discussion of fears and barriers to growth.

Adapting a Positive Psychological Intervention for People with Schizophrenia, Acacia C. Parks, Stephen M. Schueller, & Piper S. Meyer, 2014.

Acceptance and commitment therapy for psychosis: intent to treat, hospitalization outcome and mediation by believability, Patricia Bach, Brandon A. Gaudiano, Steven C. Hayes, & James D. Herbert, 2012.

Voice hearing in a biographical context: A model for formulating the relationship between voices and life history, Eleanor Longden, Dirk Corstens, Sandra Escher, & Marius Romme, 2012.

Charles Boisvert, PhD *Mind Stimulation Therapy - An Innovative Model for Working with Schizophrenia*
Introductory
Mind Stimulation Therapy (MST) provides an alternative way of conceptualizing psychotherapy using an "information processing" model with a focus on utilizing clients' "positive traits" in conjunction with a multimodal approach (using both auditory and visual modalities) in contrast to traditional psychotherapy that often relies primarily on the auditory mode of communication. The book is written by Mohiuddin Ahmed and Charles Boisvert, two clinical psychologists, and the Foreword to the book is written by a long-term practicing psychiatrist and the published reviews are by two noted psychiatrists associated with Harvard Medical School, providing the book with strong cross-discipline support and advocacy. The model will appeal to a large number of mental health clinicians of diverse clinical training backgrounds such as psychologists, psychiatrists, mental health clinicians, social workers, psychiatric nurses, occupational therapists, recreational therapists, who may be working in diverse clinical settings. Clinicians of all experience levels will find the model easy to adapt and implement in their ongoing clinical work with persons with schizophrenia and other "challenging mental health clients."

Mind Stimulation Therapy is characterized by stimulating and enhancing clients' "intact" areas of memory and cognitive functioning so as to enhance clients' information processing and engage in "reality-based discussions," and to promote recovery. MST is grounded in information processing and cognitive stimulation techniques and operates out of a "positive psychology" framework. The three core MST group activities include: 1) body movement–mindfulness–relaxation (BMR); 2) discussion of varied topics of information, including mental health and existential related issues; and 3) and use of paper–pencil cognitive stimulating "neutral" exercises to promote reasoning, thinking skills, memory, and associations, as well as self-reflection exercises on personal goals and assessment of progress. Additionally, computer-facilitated technique to enhance communication dialogue in therapy sessions and to help clients identify collaboratively with the therapist their personal goals, barriers to goals, and steps that need to be taken to achieve goals will also be presented.

At the conclusion of this activity, participants should be able to:
1. Discuss the historical and theoretical base of Mind Stimulation Therapy, and how to integrate elements of the model in their own clinical work with "challenging mental health clients," such as people with schizophrenia, as well as people with long-term substance abuse and people in nursing homes who are physically and psychiatrically compromised.
2. Explain how best to use different "mind stimulation" techniques and strategies in working with "challenging mental health populations," such as use of body-movement-relaxation exercises, paper-and-pencil cognitive stimulating exercises, and how to conduct "reality-based" discussion of various topics, including mental health issues, which may be impacting clients.
3. Use computer word processing technique to add element of visual representation of auditory based dialogue used in conversational therapy to enhance communication and collaborative dialogue in the therapy process.

Mohiuddin Ahmed and Charles Boisvert: Mind Stimulation Therapy: Cognitive Intervention for Persons with Schizophrenia, Routledge, 2013.

Mohiuddin Ahmed, Harold J. Bursztajn, and Ronald Abramson: Back to the Future. Article accepted for

publication in Psychiatric Services, to be published in May 2016.

Jay D. Paul. "The Vacuum of the Mind: A Self-Report on the Phenomenology of Autistic, Obsessive-Compulsive, and Depressive Comorbidity," Schizophrenia Bulletin, March 2014.

Ghislaine Bourdon & Ronald Abramson, MD *From Depths of Despair to Heights of Happiness*
Introductory
I have written an autobiography about how I became mentally ill, my behavior, hospitalizations, and self healing. I am a recovered patient, sharing my insights and inspirations with others that have a mental illness. My goal is to help them find themselves, their potential, self worth, and happiness, through my book, that I am contributing to society. I will give hope, and encouragement to even the most despairing.

Readers often find books written by mental health workers, about the treatments for their patients, but rarely do you find information, and much less books, from the ill, first hand, of their perspective of the psychiatrists treating them.

This book is a self help, descriptive, and inspirational true story of my hardships, that promises to help heal tormented minds.

This non fiction is written in an easy to read form, where victims can relate to my experiences of domestic violence, rape, anorexia, depression, suicide, drugs, self mutilation, and more.

Ronald Abramson:
I first met Ghislaine in 1988 in a psychiatry unit of a local hospital. She was communicative in some ways, but fairly non-verbal in other ways, and the thing that I remember from then, was that she had palmed some Ativan, which I had prescribed, and made an overdose with it. Nevertheless, we made a good start, and began meeting in my office. She was an imp!

In the years since, we have gotten to know each other well, and I might say, become good friends. In this presentation, she will be presenting her experiences at various points in her life, and recovery of significance to her. I will be contributing my own recollections, and perceptions of her, me, and the relationship between her and me at those times.

At the conclusion of this activity, participants should be able to:
1. Describe the amount of despair experienced by a person who becomes psychotic.
2. Explain how a person can self-heal with others' help.
3. Discuss the inspirations that lead to recovery.

Rosenbaum B et al, Supportive Psychodynamic Psychotherapy Versus Treatment as Usual for First-Episode Psychosis: Two Year Outcome, Psychiatry, 2012.

Schafer HL, Childhood Trauma and Psychosis-What is the Evidence. Dialogues Clinical Neuroscience 2011.

Killick K, Art, Psychotherapy, and Psychosis. 2013.

Steve A. Cadwell, PhD & James Tyler Carpenter, PhD *Wild & Precious: A Performed Case Study of Extreme States*
Introductory
Senior clinician, Steve Cadwell, Ph.D., LICSW, CGP will chair a panel discussion that follows his live performance of "Wild & Precious," a multi-media performance in music, photography, poems, and story of his experience of extreme states. Society can heal and society can harm. How can extreme social stigma kindle extreme emotional states in individuals? This presentation spans 60 years of gay liberation through one man's story: from isolation of the closet in the late 60s, to "nervous breakdown"/psychosis/extreme state which led to commitment at a state mental hospital in the early 70's. Lack of relational treatment is exposed. Healing follows

through Steve's connection in relationally-based mental health practice and social activism. The social & psychological resilience and attachments that helped our first gay generation come out of the "straight" jacket into a fullness of being is celebrated. Although dramatized through Steve's specific story, themes of sexuality, gender, shame, and extreme states are universal. (Please see the show's web site for a trailer, bio, and audience buzz. www.wildandprecious.org). The 55 minute performance is followed by 30 minutes of panel and whole group discussion of core issues of identity: gender, sexuality, relationships, and emotional states. The power of relational therapies to contain, engage, and integrate extreme states is affirmed.

At the conclusion of this activity, participants should be able to:
1. Educate how gender role constriction and homophobia can undermine secure attachment and precipitate extreme states.
2. Demonstrate relational therapy's capacity to promote secure attachment and integrate extreme states.
3. Manage fear of extreme emotional states, through understanding and affirmation of the fuller spectrum of human emotional experience.

Ball, S & Lipton, B (2011) Group work with Gay men. In Gerif, G and Ephross, P (eds.), Group work with populations at risk (34d ed. pp 339 to 355). New York: Oxford University Press.

Cadwell, S., (Fall, 2009) "Shame, Gender and Sexuality in Gay Men's Psychotherapy Groups." Group, The Journal of the Eastern Group Psychotherapy Society.

Lichtenberg, J (2008) Sensuality and Sexuality Across the Divide of Shame, The Analytic Press.

Miller, Rick (2015). Unwrapped: Integrative Therapy with Gay Men…The Gift of Presence. Zeig,Tucker and Theisen, Phoneix, Arizona.

Rosenblum, K. E., & Travis, T.-M. C. (2012). The meaning of difference: American constructions of race, sex and gender, social class, sexual orientation and disability (Sixth.). New York: McGraw Hill.

Sacks, Oliver, (2015). On the Move: A Life. Alfred Knopf, New York.

James Tyler Carpenter, PhD, Ronald Abramson, MD, Harold J. Bursztajn, MD & Brian Koehler, PhD
A Discussion: Psychotherapy and Neurobiology
Introductory
The material presented by Dr. Keshavan demonstrates that Cognitive Restructuring Therapy can improve the functioning of people who have schizophrenia and, in turn, can affect the way that portions of the brain operate. His discussion presents the possibility of building a bridge between concepts of neurobiology and concepts of subjective psychology. Here is a chasm between the two worlds of understanding and treatment, and the proponents of each world of understanding barely speak to each other. Proponents of biological psychiatry seek to build a solid scientific foundation under psychiatric treatment that would allow confidence that scientifically based approaches will benefit patients and, thereby, bring hope to their lives.

Proponents of treatments based on subjective psychological concepts seek to bring humanism and compassionate understanding to the lives of people who have suffered from psychoses and thereby promote hope and recovery.

Practitioners of these two ways of thinking often look at each other across the chasm with stereotypical ideas about each other, biological psychiatrists being regarded as inhumane robotic machines whose prescribing activities have been bought and paid for by the pharmaceutical industry, and psychoanalytic and other psychotherapists being regarded as unscientific adherents to a set of archaic irrational and unscientific ideas which are regulated by a medieval guild.

This panel discussion will revolve around the notion that there is reality on both sides and that in the current era neither side has a corner on conceptual or therapeutic truth. Patients are best served by clinical teams with feet in both camps.

At the conclusion of this activity, participants should be able to:
1. Speak more knowledgeably about biological and subjective psychological points of view.
2. Explain how biological psychiatry and subjective psychology intersect.
3. Treat patients from both points of view.

Walter H, "The Third Wave of Biological Psychiatry", Frontiers in Psychiatry, 2013, 4:582, published online Sept 5, 2013.

Graham G, The Disordered Mind. An Introduction to Philosophy of Mind and Mental Illness, 2nd Ed, New York, Taylor and Francis, 2013.

Whitaker R, Cosgrove L, Psychiatry Under the Influence: Institutional Corruption, Social Injury, and Prescriptions for Reform, New York, Palgrove MacMillan, 2015.

Marilyn Charles, PhD, ABPP *Women and Madness in Context: Social Versus Personal Constructions of Identity and Becoming*

Introductory

The woman's voice has been muted in a world in which history has been largely written by men, who have held the power in deference to the woman's ostensible fragility. In that context, the woman's place is relegated to the silent shadow that stands to the side and does not speak directly, leaving her in the somewhat "sinister" position of coming from the side. When she can be kept in her place, the unconscious motivations underlying that disjunction are relieved, making it unnerving when she insists on taking a more direct stand. This tension has made it even more difficult for women to realize their creative potential beyond whatever ambivalence they face in relation to the disparate demands of family, relationships, and work or avocations.

I will describe some of the ways in which women have been driven mad by culture forces that have silenced and constrained them, narrowing possibilities and defining inconvenient desires as bad or mad. To show that this longstanding struggle is not over, examples will be offered from history, literature, and the consulting room of creative women for whom cultural values have literally displaced their power and autonomy by rendering them as "mad". How, then, do we develop effective means for revisioning the possibilities that inhere in the uniqueness of women, given current tendencies to medicalize distress and medicate away the very symptoms that might otherwise be addressed and explored if they are recognized as reflecting legitimate questions about existence and possibilities? Psychoanalytic Bionian field theory offers one means for encouraging the type of dreaming-into-being through which the woman's creative engagement in her life and becoming might be restored.

At the conclusion of this activity, participants should be able to:
1. Describe one way in which women have been "driven mad" in a patriarchal culture.
2. Describe two ways in which psychiatric nomenclature can interfere with personal autonomy and self-definition.
3. Describe one example from their own experience - whether clinical, personal, or through literature - of a woman whose creative expression has been taken for "madness".

Charles, M (2012). Working with Trauma: Lessons from Bion and Lacan. New York: Jason Aronson.

Charles, M. (2014). Trauma, Fragmentation, Memory and Identity. In M. O'Loughlin & M. Charles (Eds.), Fragments of Trauma and the Social Production of Suffering. Lanham, MD: Rowman & Littlefield, pp. 25-44.

Charles, M. (2015). Psychoanalysis and Literature: The Stories We Live. Lanham, MD: Rowman & Littlefield.

Ferro, A. and Civitarese, G. (2015) The Analytic Field and its Transformations London: Karnac.

Fivush, R., Habermas, T., Waters, T. E. A., & Zaman, W. (2011). The making of autobiographical memory: Intersections of culture, narratives and identity. International Journal of Psychology, 46:321-345.

Martin A. Cosgro, PhD *Psychotherapy in Prison and the Community: Understanding the Developmental Implications of Trauma in Psychosis*
Intermediate
It is now well established that trauma of various forms is typically at the root of psychotic experiences. Being able to make sense of the significant, as well as subtle, impressions this leaves on development and resultant behavior is a crucial process in being consistently effective in helping people who struggle with chronic psychosis. A lack of early safety leads to underdeveloped conscience and its self-regulatory mechanisms which is often seen in forensic settings. Also, affective experiences often trigger similarly feeling past unresolved experiences which tend to undermine developmental strivings of even the most motivated clients. Helping clients to understand this dynamic process is central to their being able to take control of their emotions, behavior and ultimately their lives, breaking the previous bonds of unconscious conflict.

At the conclusion of this activity, participants should be able to:
1. List the basic experiences necessary to develop a conscience.
2. Describe the affective layering process which keeps clients stuck in unconscious conflict.
3. Discuss the importance of the psychoeducation necessary to teach clients about the dynamic process of affective layering.

Psychotherapy and Despair in the Prison Setting: A Phenomenological Exploration. Jo Gee. Lambert Academic Publishing 2014.

Psychotherapy in Prison. Shanon Edwards. New York Times, 12/31/2015.

What Are Emotional Triggers and Why You need to Understand Them. Margaret Paul. MindBodyGreen.com 4/17/2015.

Françoise Davoine, PhD *Making Sense of Family Tragedies Across the Generations: A Guide to Understanding the Role of Intergenerational Trauma on Your Family*
Introductory
In this presentation, renowned Lacanian analyst, Francoise Davoine, will share her understanding about how family traumas–from personal tragedies such as the loss of a child to social phenomena such as racism and war time, and the psychological stress of living in such a fast-paced world can impact vulnerable family members for generations. In her decades of clinical work with people diagnosed with psychosis, Dr. Davoine has unpacked the family secrets and tragedies that can manifest in symbolic form in the seemingly psychotic symptoms of a family member. Psychoanalytic notions of symbolism and reality will be plainly explained for the layperson, so that family members can have a new framework for trying to understand some of the more vexing aspects of their loved one's obtuse thoughts and behaviors. As they feel comfortable, family members will be encouraged to share and explore their own family stories for clues for understanding and empathy of a family member who may unconsciously be enacting a family tragedy from years ago.

At the conclusion of this activity, participants should be able to:
1. Explain what is meant by the term "intergenerational transmission of trauma".
2. Define what is meant by "the real" in Lacanian theory.
3. Identify one trauma that has occurred in her or his family and how it may have manifested in other family members.

Davoine, François. Mother Folly: A Tale (Cultural Memory in the Present) (2014). Translated by Judith Miller. Stanford University Press.

Davoine, François. Wittgenstein's Folly (2012). Translated by Willam J. Hurst. New York: YBK Publishers.

Davoine, François. Fighting Melancholia (2016). Don Quixote's teaching. Karnac Books.

Davoine, François and Jean-Max Gaudillière (2004). History Beyond Trauma. New York: Other Press.

Leader, Darian and Groves, Judy (2010). Introducing Lacan. A graphic guide. London: Icon Books.

Ross Ellenhorn, PhD & Tom Stockmann, MD *A Dialogue on Open Dialogue: Its Use Across Borders and Modalities*

Intermediate

Among those who are aware that treatment-as-usual has meant treatment-failure-as-usual for many of the most distressed patients, the Finnish Open Dialogue Method of addressing psychosis, and especially first-break psychosis, has offered renewed hope and excitement. Now, practitioners working in other settings, from clinic to private practice and across the globe, are investigating whether, and with what success, this method can be applied in a broad range of treatment situations. In this panel, Tom Stockmann aims to ask how the UK's National Health System might accommodate Open Dialogue into its repertoire of resources. In his paper on "UK Peer-supported Open Dialogue (POD) - Exploring a Thematic Analysis of POD Trainee Focus Groups," he follows staff from four UK NHS organizations who have completed the first wave of training in Peer-supported Open Dialogue. Through a thematic analysis of transcripts from semi-structured focus groups trained in this method, themes were isolated that had bearing on the ways in which Open Dialogue might most successfully be implemented within an NHS context. Meanwhile, Ross Ellenhorn has given thought to the ways in which Open Dialogue might best be integrated into the US mental health system, and in his paper on "Integrating Open Dialogue and Assertive Community Treatment: A Living Systems Approach," he pinpoints Assertive Community Treatment, or ACT, teams as potentially offering a vehicle for offering Open Dialogue-based treatment to individuals with psychosis. He highlights both the similarities between Open Dialogue and existing ACT principles and their areas of divergence, particularly at the site of actual treatment planning, where PACT/ACT offers little in regard to client voice, and Open Dialogue and its sister treatment, the Need Adapted Treatment Model (NATM), offer much. At this site, a more dialogic approach can radically influence PACT/ACT, from a "hospital without walls" in which the client is noticeably absent, to a truly polyphonic treatment steered by dialogue and the utterances of the person of concern.

At the conclusion of this activity, participants should be able to:

1. List the ways assertive community treatment and Open Dialogue can be synthesized.
2. Analyze Assertive Community Treatment within the context of "new" research on non-pharmacological approaches to psychosis.
3. Describe the organizational and practice principles of Peer-supported Open Dialogue.
4. Describe the main results of the thematic analysis.

Bracken P, Thomas P, Yeomans D, et al (2012). Psychiatry beyond the current paradigm. The British Journal of Psychiatry, 201(6): 430-434.

Drake, R, Merrens, M. and Lynde, D. Evidence-Based Mental Health Practice: A Textbook. New York: W.W. Norton, Co, (2005).

Ellenhorn, R (2015). Assertive Community Treatment: A "Living-Systems" Alternative to Hospital and Residential Care. Psychiatric Annals. 2015;43 (3): 120-125.

Mahlke C I, Krämer U M, Becker T, et al (2014) Peer support in mental health services. Current Opinion in Psychiatry, 27(4): 276-281.

Olson, M. Seikkula, J. and Ziedonis, D. (2014) The Key Elements of Dialogic Practice in Open Dialogue: Fidelity Criteria. University of Massachusetts medical School, Worcester, MA.

Priebe S, Burns T, Craig T K J (2013) The future of academic psychiatry may be social. The British Journal of Psychiatry, 202(5): 319-320

Razzaque R, Okoro E & Wood L (2015) Mindfulness in clinician therapeutic relationships. Mindfulness, 6(2): 170-174.

Seikkula J (2011) Becoming dialogical: Psychotherapy or a way of life? The Australian & New Zealand Journal of Family Therapy, 32: 179-193.

Seikkula J, Alakare B & Aaltonen J (2011) The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care. Psychosis: Psychological, Social and Integrative Approaches, 3(3): 192-204.

Seikkula, J. & Erik, T. 2013 Open Dialogues and Anticipations: Respecting Otherness in the Present Moment. Helsinki, Finland National Institute for Health and Welfare.

Lisa S. Forestell & Rebecca Miller, PhD *Experts by Experience Panel: Psychotic Experience in Life Context*
Intermediate
How does one not only live with psychotic experience, but live well with it? How do such first-hand experiences with what works and what doesn't work in psychosocial treatment inform our ability to help ourselves and others going forward? We draw upon our own insights, born of our efforts to accommodate psychosis into our lives, in order to offer perspectives to those who are engaged in treatment from both sides of the therapeutic situation. Lisa Forestell begins our discussion by asserting, in her paper on "Voice Hearing and Compassionate Relationships," that the pressure to ignore internal voices is counter-productive, serving only to cut people off from the fullness of their lives. Rather, as a life-long voice hearer, she has always reached to understand where her voices are coming from. "Why would he say something biting? Is something going on that he takes issue with? What does he mean by that?" In her discussion, she will encourage the audience to make space for multiple truths, contemplate metaphor as a window to insight, and be curious about frameworks, how they are understood and how they work or do not. Meanwhile, in "Thinking About Smiling," Rebecca Miller will speak from the unique perspective of someone who has managed both physical and psychotic distress, offering a narrative of her personal experience with psychosis in interaction with a chronic illness, Parkinson's disease. Diagnosed and hospitalized at age 19 for mental illness, she experienced trauma in the mental health system as well as negative messages, and internalized a sense of being damaged. In this paper, she compares the experience of diagnosis and treatment in the mental health system with that of a diagnosis of a physical illness, and describes her own experience of coming out about having experienced mental illness and hospitalization, and the challenges of doing so while working as a psychologist in a community mental health setting. She also describes her own journey to understanding these "illnesses" and how that has changed over time and with training in the field of mental health.

At the conclusion of this activity, participants should be able to:
1. Discuss voice hearing in a non-pathological framework.
2. Evaluate the efficacy of relational/dialogic therapeutic approaches in their own practice.
3. Explain the connection between mental and physical health diagnoses from an individual perspective.
4. Discuss the connection between initial messages at diagnosis and empowerment.

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the Hearing Voices Movement: Implications for research and practice. Schizophrenia Bulletin, 40 (Suppl 4), S285-S294.

Hultquist, A.M. (2013). Can I tell you about Parkinson's Disease? A guide for family, friends and carers. Jessica Kingsley Publishers: London & Philadelphia.

King, R., Neilsen, P. and White, E. (2013), Creative writing in recovery from severe mental illness. International Journal of Mental Health Nursing, 22: 444–452.

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Michael D. Garrett, MD *An Annotated Commentary on* I Never Promised You a Rose Garden: *Psychotherapy Theory and Technique*
Intermediate
I Never Promised You a Rose Garden by Joanne Greenberg is, in the view of many, the most engaging account ever written of the treatment of a psychosis with psychotherapy. Deborah, the central character in the book, is Joanne Greenberg, and her psychotherapist, Dr. Fried, is the well-known psychoanalyst, Dr. Frieda Fromm-Reichmann. The talk will present an annotated commentary that links passages in the book to significant aspects of the psychology of psychosis, and the theory and technique of psychotherapy for psychosis. Dr. Fromm-Reichmann used a flexible approach not rigidly bound to one theoretical model. The importance of a healing interpersonal relationship based on trust is apparent, as is the therapist's maintaining an unshakable belief in the patient's capacity to recover. Although Fromm-Reichmann's primary orientation was psychodynamic, she at times used what today would be considered cognitive behavioral techniques. The presentation will use passages in the book to illustrate a variety of themes, including the role of adverse life events predisposing to psychosis, CBTp and psychodynamic technique, psychoanalytic object relations theory, transference, the therapeutic alliance, and other themes. Twenty passages will be presented. The commentary will be available to attendees by email request; hopefully, a useful teaching tool. For example, Book Passage pg 14:

"One whisper of a secret name, one sign written, one slip of light could break into the hidden place and destroy her and both the worlds forever."
Theme: Adverse Childhood Events Predispose to Psychosis
Greenberg constructed a secret delusional world she named Yr where she could retreat from the real world. The lyrical and visual beauty of this world and its complexity testify to the power of her intelligence and creative imagination. She hid this world from everyone around her because letting anyone know about it would compromise the security of her safety zone....

At the conclusion of this activity, participants should be able to:
1. Quote passages from *I Never Promised You a Rose Garden* that illustrate CBT for psychosis technique.
2. Describe two or more factors that predisposed to psychosis in the main character in the book.
3. State how the book Rose Garden and the annotated commentary can be used as one element in teaching the theory and technique of psychotherapy for psychosis.

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Patricia L. Gibbs, PhD *Fighting the Stigma of Psychosis and Extreme States: Returning to the Liberal Arts*
Intermediate
The role of stigma associated with persons receiving a mental illness diagnosis has been widely documented in our professions and society. Feelings of shame, self-blame, anger and mistrust often compound and worsen pre-existing symptoms of depression, reality testing, and anxiety.

Today I am going to specifically address the importance of seeing psychosis; or extreme disturbance; as a treatable condition, one from which many can recover. It is my belief that as clinicians and researchers in all the mental health fields become united in this conviction, we will see more widespread recovery.

The Bio-Psycho-Social model will provide the explanatory scaffolding used to examine research and clinical approaches that provide evidence for recovery from severe disturbance and psychosis. In this paper I will focus on what I will call “a Humanities-based return to the Liberal Arts” in conceptualizing recovery from psychosis. A Liberal Arts education emphasizes a study of literature, art, music, history, religion, and philosophy. These are uniquely human endeavors; developed through the civilizing processes of people living together. Over many thousands of years, this psychosocial development further ensures the survival of humanity.

The theme of this paper was inspired by this Meeting’s Title: "From Reductionism to Humanism." To me it has personal meaning and relevance, as the Arts and Humanities have been a personal and professional guiding light.

The treatment programs I will discuss in this paper will reflect the importance of socialization in the recovery from psychosis. Several articles from the literature that have reported successful outcomes will be summarized. Two disguised clinical vignettes from my practice will also be used to explore the use of psychoanalytic techniques in working with severe depression, suicidality, psychosis, hallucinations, paranoia, or mania.

At the conclusion of this activity, participants should be able to:
1. Substantiate the author’s premise that persons diagnosed with psychosis and extreme states can recover.
2. Use the transference/countertransference psychoanalytic processes to help patients control and manage their feelings of anger and shame.
3. Refer to the Liberal Arts perspectives such as Literature, Philosophy and Religion; rather than to the Reductionism often involved in technology and purely scientific methods; in treatment of patients.

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Safran, J.D. (2016). Agency, Surrender, and Grace in Psychoanalysis. Psychoanalytic Psychology, 33, 58-72.

Waska, R. (2016). The Quest for Greatness in the Race Not to be forgotten. Psychoanalytic Psychology, 103, 17-40.

James E. Gorney, PhD & Ann-Louise S. Silver, MD *Hope and Hopelessness in the Treatment of Extreme States: Harold Searle’s Legacy and the Challenges of Addiction*
Intermediate
This panel offers a tribute to the life and work of Harold Searles, describing his contributions to the treatment of psychosis, alongside an appreciation of the disruptions to psychotherapy for psychosis that occur when addiction is embraced as failed self-cure of psychotic struggles. In her (auto)biographical overview of Searles’s contributions, Ann-Louise Silver, his supervisee and longtime patient, notes that we at ISPS owe Harold Searles deep thanks for his honesty, his intensity, his insight, his passion for the work of intensive psychotherapy with very troubled individuals, and perhaps no one owes him a deeper expression of gratitude than she. As a clinician, writer and colleague, Searles was a larger-than-life presence who opened up existing theory and technique to new ways of using the therapist's experience, the implicit or unconscious dimensions of the therapeutic relationship, and the inherent desires in people to heal. In this presentation, Silver offers a tribute to Harold Searles that can help him come to life for those who are just discovering his work as well as for those who knew him during his time at Chestnut Lodge or in the other contexts in which he worked. Although his passing in November of last year in some ways seems less of a loss than was his disappearance from professional life after his retirement, it marks an endpoint the recognition of which can help to re-vitalize an appreciation of the excitement and agony of the work, and its hopefulness at the core. In contrast with this sense of hopefulness conveyed to students of Searles’s work, James Gorney offers an account of how hopelessness can enter the consulting room on the coattails of addiction via a presentation of case material from the intensive psychotherapy of a multi-addicted physician fleeing from psychotic experience. Gorney notes that altered states can seem like an escape from underlying psychotic disorganization, but that embracing them in fact proves to be a Faustian bargain. Sullivan (1940) observed that the threat of breakdown induces a massive disruption of normative, adaptive defenses and "an acute failure in the dissociative power of the self.” The emerging psychotic state that then looms as an abyss before the subject evokes panic and unsymbolizable disorganization. Entry into serious substance addiction can be

understood for some as a desperate means of trying to medicate the self against an experienced vulnerability to psychotic disintegration. However, in addition to the well-known serious negative behavioral and social consequences of substance abuse, recent neurophysiological research demonstrates that while substances may be employed to medicate anxiety and stress, their chronic use over time actually creates further anxiety and stress within the chemistry of the brain itself. Consequently, those who turn to addiction as a response to the possibility of underlying psychosis are engaged in a dance of death. Thus, Searles's descriptions of the healing power of psychoanalysis stand in sharp contrast to Gorney's descriptions of the destructive power of addictions as failed remedies.

At the conclusion of this activity, participants should be able to:
1. Summarize evidence for the neurophysiological disorganization and damage resulting from chronic substance abuse.
2. Discuss their understanding of the challenges and pitfalls of psychotherapeutic work with substance abusing patients organized at a psychotic level.
3. Access with greater freedom those interpersonal indications of meaning that arise between therapist and patient.
4. Apply Searles' ideas about mature relatedness to allow for a greater appreciation of the relational capacities of patients.

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Potvin, S. (2014). Psychosis and Addiction: The Evidence Cemetery. Sante Mentale au Quebec: 39. 75-98.

Searles, H. (1960) The Nonhuman Environment: In Normal Development and in Schizophrenia. International Universities Press, New York.

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Wise, R.A. and Koob, G.F. (2011). The Development and Maintenance of Drug Addiction. Neuropsychopharmacology: 39, 254-62.

Marie C. Hansen, MA *Social and Psychological Approaches to Postpartum Psychosis*

Introductory

Postpartum psychosis is arguably one of the least understood psychological afflictions impacting women today. Although it is considered rare, in the two years following pregnancy, women have a 4-fold increase in likelihood of being hospitalized due to a psychotic disorder (Bokhari, et al., 1998). In fact, women are more likely to be admitted to a psychiatric unit after giving birth than at any other time in their lives (Doucet, Dennis, Letourneau, & Blackmore, 2009). In addition, postpartum psychosis affects 1 to 2 of every 1,000 deliveries (Kendell et al., 1987; Munk-Olsen et al., 2006). For sake of comparison, this is the same rate of occurrence as Down Syndrome (Twomey, 2012).

Despite a wealth of psychological approaches by means of which to understand psychosis, theories on the etiology of postpartum psychosis have relied primarily on the medical model. Specifically, the occurrence of postpartum psychosis is often attributed to hormonal shifts after birthing. The popularity of these hormonal theories, coupled with the general absence of psychological explanations, may be understood as reflective of wider social discourses that pathologize the female reproductive body. For example, hormonal theories of postpartum psychosis strongly parallel popular conceptions of the "unruly hormones"of premenstrual syndrome. Relying on discourses such as these fails to allow room for functional explanations of postpartum psychosis, and forestalls the development of psychosocial treatments and approaches.

Drawing from "matrescence" literature, I will describe current psychological theories on the passage to motherhood in order to contextualize how such an undertaking may result in psychosis. Likewise, I will use current psychological and psychoanalytic theories of psychosis to help illuminate factors at play in postpartum psychosis. Included will be explorations of spirituality and the shift to motherhood; self/other union through pregnancy and breastfeeding; and the traumatic nature of motherhood in a patriarchal society.

At the conclusion of this activity, participants should be able to:
1. Specify the current diagnostic categories of postpartum psychosis.
2. Relate postpartum psychosis to a greater literature on maternal development.
3. Identify the social and psychological contributions to the development of postpartum psychosis.

Bergink, V., Boyce, P., & Munk-Olsen, T. (2015). Postpartum psychosis: a valuable misnomer. Aust N Z J Psychiatry, 49(2), 102-103. doi:10.1177/0004867414564698

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Omar Sultan Haque, MD, PhD & Harold J. Bursztajn, MD *The Ethics of a Biological Psychiatry*

Introductory

Apparently trivial differences in the conceptual framings of the nature of mental illness can have profound ethical consequences. The rush to create and valorize a biological psychiatry has produced dramatic and unacknowledged ethical costs. Prioritizing biological explanations in psychiatry has the effect of exacerbating many endemic problems in the care of psychiatric patients. Indeed, what is diminished are the very things we ought to care about most in the profession. A primarily biological psychiatry worsens the therapeutic alliance and increases mental health stigma by dehumanizing patients by describing them as machines rather than persons; increases the perception of patients as essentially different, as Other; increases perceptions of patients as dangerous and worthy of social exclusion; induces patients to be more pessimistic about their ability to heal; leads patients to perceive clinicians as less warm; and actually leads clinicians to feel less empathy for the very patients they aim to help. These stigmatizing, dehumanizing, and pessimistic effects of the biological ascendance in psychiatry contribute to the dramatic underfunding of research in mental illness, the overuse of psychopharmacology beyond its evidence base, underutilization of psychotherapy and social interventions, and the rising suffering due to mental illness in America. Therefore, what has become commonplace in the lives as psychiatrists practicing in the 21st century, prioritizing the singular biological level of analysis and explanation, has had disastrous and unacknowledged ethical consequences for patients and the profession. This paper ends with ten proposed solutions to the ethical problems created by the recent ascendance of a primarily biological psychiatry.

At the conclusion of this activity, participants should be able to:
1. Explain the causes of the rise of biological approaches to psychopathology.
2. Discuss the consequences of this rise on stigma and the caregiver-patient relationship.
3. Discuss the consequences of this rise on treatment and patient care.

Haque, O. S., & Waytz, A. (2012). Dehumanization in medicine: causes, solutions, and functions. Perspectives on Psychological Science, 7(2), 176-186.

Kvaale, E. P., Haslam, N., & Gottdiener, W. H. (2013). "The 'side effects' of medicalization: A meta-analytic review of how biogenetic explanations affect stigma." Clinical Psychology Review, 33(6), 782-794.

Lebowitz, M. S., & Woo-kyoung, A. (2014). Effects of biological explanations for mental disorders on clinicians' empathy. Proceedings of the National Academy of Sciences, 111(50), 17786-17790.

Kevin Healey *What Does it Mean to Be "Expert by Experience" and How Might We Get There?*

Introductory

What limits our freedom is the stories and myths we tell ourselves and each other. We fear experiences our stories tell us that we cannot understand and doubly fear those from which our myths extinguish any hope of return.

Reductionism would have us fear ourselves and each other and put our lives in the hands of "experts" and adopt their words for us. That limited map of understanding is embedded throughout society, governs who we are, who we can be, and reduces us to grim, alienated lives. That story says: "life sucks".

A humanist approach would have us regard whatever we might experience as an adventure from which we can learn, grow and become more resilient and more connected with what it means to be alive. We can endure and find new strengths for future encounters.

What if we don't "come-back" but instead come-through, different and somehow renewed? What if we told ourselves and each other that story?

I will introduce a simple framework we might choose to build our own maps of understanding, name our world in our own words. Drawing on different ways of knowing old, new, and renewed, we can regard every experience as one from which we can learn - including those we fear the most.

This approach integrates three simple models: one highly original, one as old as the ages and one from systems thinking but with an original twist. Endlessly adaptable, it sets no limits to the different sources and ways of knowing we can plug-in, play with and draw wisdom from to help us make sense of our world and keep adding to our map so it remains as alive as we can be.

At the conclusion of this activity, participants should be able to:

1. Cast aside a diagnostic framework and imposed words to name their experiences using simple, everyday language.
2. Redefine experiences that get called "psychosis" as states of being: intimately connected with reality and also intensely personal, confusing and painful yet having essential qualities in common with their own.
3. Frame experiences - even and especially the most difficult ones we fear most - as something we might learn from to continually renew our map of how we understand the world.

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Lawrence E. Hedges, PhD, PsyD, ABPP *Erotization of the Transference-Countertransference Matrix*

Introductory

While Sigmund Freud (1900) courageously opened our collective unconscious by revealing his own erotic dreams about his patients, Ethel Person (1994) holds that few of us are yet ready to reveal our fantasies or daydreams – especially if they are sexual or aggressive in nature. But the current interpersonal/relational approach to reverie, the analytic third, and countertransference usage suggests that mutual study of sexual feelings, fantasies, and desires may at times be an important part of psychotherapy (Hedges 2013).

Harold Searles was the first to publish erotic fantasies about his relationships with his hospitalized patients (1959). He demonstrated clearly how countertransference erotic feelings and fantasies can be revealing of what is actually happening in the intimacy of the transference-countertransference matrix.

Searles' courage in delving into the erotic countertransference remained unmatched until the recent turn toward the relational in psychotherapy. We have Jody Meisler Davies' (1994) shocking her patient by telling him that the way he was relating to her was sexually stimulating to her and why. We have Florence Rosielo (2005) openly discussing her erotic feelings and fantasies towards her clients as well as her own sexual performances as a psychotherapist. We have Karen Maroda (1992) declaring that whatever is in the room must be potentially available for mutual discussion and analysis.

Dr. Hedges will review the literature on eroticism, sexual fantasy, and reverie, and how to go about raising our awareness of erotic fantasies, thoughts, and desires in order to enhance our therapy work while at the same time carefully avoiding the dangers of the slippery slope. He will present vignettes from his own psychotherapy practice illustrating the importance of countertransference experiencing and interpreting--especially with "difficult-to-treat" clients.

At the conclusion of this activity, participants should be able to:

1. Distinguish between sexualization and erotization in transference and countertransference.
2. Clarify the distinction between experiencing and interpreting eroticism in the transference-countertransference matrix from the slippery slope of sexual acting out.
3. Discuss how race, ethnicity and nationalism construct and interact with sex, sexuality and sexual identity.

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Davis, J. M. (1994b). Love in the Afternoon: A Relational Reconsideration of Desire and Dread in the Countertransference. Psychoanal. Dialogues, 4:153-170.

Ginot, E. (2015). The Neuropsychology of the Unconscious: Integrating Brain and Mind in Psychotherapy. New York: W. W. Norton & Company.

Hedges, L. E. (2010). Sex in Psychotherapy: sexuality, passion, love, and desire in the therapeutic encounter. New York: Routledge.

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Searles, H. F. (1959). Oedipal Love in the Counter-Transference. Int. J. Psycho-Anal., 40:180-190.

Stern, D. B. (2015). Relational Freedom: Emergent Properties of the Interpersonal Field. New York: Routledge.

Elahe Hessamfar, PhD *A Theological Interpretation of Psychosis*

Introductory

In this paper I will present a fresh interpretation of psychosis through a theological lens. The paper will be informed by my personal experience, and scientific research findings.

My daughter, Helia, was diagnosed with "schizophrenia"in 2000. In spite of many trials and errors with a variety of treatments, she continued a downward spiral into darkness until she became catatonic. I cared for her during those years, and observing her, day after day, her illness taught me much about the phenomenon of severe psychosis. After years of agony at seeing her in twisted and frozen states, she came out of her catatonia, and she is living today without any medication. She is not back to her normal self yet and the battle is not over, but the light at the end of the tunnel is shining more vividly.

Scientific research on the brain of those suffering from "schizophrenia" has shown hyperactivation of the Default Mode Network (DMN). It appears that such individuals take on the external stimuli from their environment, internalize it, and manifest it in the forms of "symptoms." We have seen this phenomenon, not only in those diagnosed with "schizophrenia," but also in the influential biblical prophets, such as Jeremiah, and Ezekiel.

Helia had become the manifestation of all that was wrong in our family. In her madness a mirror was provided in which we were forced to catch ourselves in the midst of our distractions, and in doing so, our family encountered our own illness in hers.

I will argue that not only is "schizophrenia" not pathological, but rather it touches on the most fundamental fragility of the human soul, and that madness ought to be recognized as a phenomenon, both theological and teleological, with a deep prophetic voice, demanding attention.

In extreme states, by manifesting signs, psychosis exposes the true human condition with vivid clarity. By overmedicating the individual to suppress the "symptoms," we silence the illness's prophetic voice.

At the conclusion of this activity, participants should be able to:
1. Apply a new perspective in interpreting "psychotic symptoms."
2. Formulate an action plan for helping the individual suffering from psychosis within the new perspective.
3. Discuss the possibilities for recovery within a spiritual model.

Hessamfar, Elahe. In the Fellowship of His Suffering: A Theological Interpretation of Mental Illness–A Focus on "Schizophrenia." Eugene, Oregon: CASCADE Books, 2014.

Northoff, Georg. "Resting State Activity and the "Stream of Consciousness" in Schizophrenia–Neurophenomenal Hypotheses." Schizophrenia Bulletin (August 23, 2014). doi:10.1093/schbul/sbu116.

Tuell, Steven Shawn. "Should Ezekiel Go to Rehab? The Method to Ezekiel's 'Madness.'" Perspectives in Religious Studies 36:3 (September 1, 2009) 289–302.

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Rebecca B. Jaynes, MA, LCPC *PIER Program of Portland, ME: Combining CBTp, Multi-Family Group and Multidimensional Treatment for Early Psychosis*
Introductory
The Portland Identification and Early Referral (PIER) Program is a multidimensional treatment team that works closely with young people and their families in the prodromal and first stages of psychosis, including clinical high-risk and first episode of psychosis. We combine Cognitive Behavioral Therapy for Psychosis (CBTp) with family psychoeducation, including Multi-Family Groups (MFGs), employment/education support, peer support, case management, occupational therapy services, and evidence-based psychopharmacology to help young people understand how these experiences interfere with learning, school/work participation and socialization. We work closely with family to support the young person in all stages of recovery. In this presentation, we will provide in-depth information on running effective Multi-Family Groups. We will explore the synergy in using CBTp and MFG jointly to address both positive and negative symptoms of psychosis. We will present a video we developed, called Many Faces, in which young people describe their symptoms and experiences in mental health delivery systems of care, schools and communities. We will also provide information on our outreach education in the community to reduce stigma and increase awareness about early warning signs of psychosis. The PIER Program is based at Maine Medical Center in Portland, ME. More information can be found at: www.mmcri.org/pierprogram.

At the conclusion of this activity, participants should be able to:
1. Describe early symptoms of psychosis.
2. Discuss multidisciplinary treatment for early psychosis, including MFG and CBTp.
3. Discuss community outreach education and involving family in treatment.

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Deborah Jordan, RN, MEd & Bill Cahalan, PhD *Recovery Needs Community: Creating a Grassroots Network for Advocacy and Support*
Intermediate
In recovery, healing is a community endeavor. This presentation will share stories and learnings from "building the road as we walk." Brain disease and medication is the main narrative for mental health in our Midwest area. We are lifting up a different narrative for mental health and recovery and sharing our fears, hopes and lessons learned.

The first story is of a family member's psychotic break and supported recovery at home using principles of loving dialogue and deep listening while searching for alternatives.

A second story is about starting a homegrown version of a "Windhorse therapeutic community" with another family in which an adult man continues to deal with the long term effects of an early mental health diagnosis and medication.

The third story is about how these 2 families created a holistic mental health network (HMHN) in order to share

ideas, inspiration, hope, deal with fear, find allies. The HMHN sponsors monthly programs as well as special events to raise the conversation about healing beyond the brain disease model. We have also sponsored larger programs such as an Introduction to Emotional CPR with Dr. Dan Fisher and a screening of the movie, Healing Voices.

Our plan is to sit in a circle, have a moment of silence and gathering, then an introductory go around as we do in our HMHN meetings, followed by the three stories with discussion at the end.

At the conclusion of this activity, participants should be able to:
1. Identify benefits of a holistic mental health network for individuals, families, and professionals.
2. Describe possible steps towards starting a network.
3. Network with others who are looking for support and allies in their own situations.

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Sarah Kamens, PhD, Ryan Scanlon, Frederick J. Wertz, PhD & Denise C. Maratos, EdM *Reconceptualizing Psychosis: Perspectives from Theory and Research*

Introductory

Recent discussion has questioned the usefulness of the diagnosis of "schizophrenia," a concept that encompasses vast heterogeneity and perhaps little specificity. Similarly, there are those who have questioned the usefulness of viewing psychosis as a diagnostic category at all, given an enhanced appreciation of its status as a sequela of trauma, its adaptive function, and its resemblance to transcendent states that are not associated with a disease model of diagnosis. In this panel, we interrogate the schizophrenia/psychosis concept from two different angles. First, Sarah Kamens, Ryan Scanlon and Frederick Wertz present on "A Transcultural, Phenomenological Approach to Reconceptualizing the 'Schizophrenia' Diagnosis." In their paper, they offer a follow-up report on a research study originally described at ISPS 2015 that aims to use phenomenological data to discern whether there are overarching structures characteristic of "schizophrenia" that are shared cross-culturally. Interview and other data from participants in New York and Jerusalem revealed a common two-fold experience of feeling (1) profoundly vulnerable and unsafe in an inhospitable world and (2) profoundly alienated and unacknowledged, such that experiential belonging to a human community was eclipsed or foreclosed. These findings diverge from orthodox diagnostic definitions of the "schizophrenia-spectrum disorders," supporting the contemporary movement to rename and reconceptualize the diagnostic class. Meanwhile, Denise Maratos, in "Psychosis as a Natural Reaction to an Abnormal Situation," argues that in light of the fact that many people experience their altered states of consciousness as anomalous experiences, and indeed often spiritual ones, we must consider that a "psychotic or schizophrenic episode" may be the natural reaction of a healthy mind to an abnormal situation or environment. She draws upon classics in the literature, from Jung's (1939) effort to trace "schizophrenia" as a self-healing process, in which the pathological complexes dissolve themselves, to Perry's (1982) emphasis on the inner free play of imagery through which the alienated psyche spontaneously reorganizes itself so that the conscious ego is interacting with the unconscious again in order to highlight the potential function of psychosis as a healing process. Questions asked in this discussion will include: Can healing occur through suffering? Can the

distress or anguish initiate a higher level of consciousness? Can a “breakdown” or “breakthrough” be called “normal”?

At the conclusion of this activity, participants should be able to:
1. Summarize recent scientific and grassroots-scholarly attempts to reconceptualize “schizophrenia” and related diagnostic categories.
2. Describe a phenomenological investigation of the lived experiences of persons diagnosed with “schizophrenia-spectrum disorders” in New York City and Jerusalem.
3. Describe the transpersonal experiences that people undergo.
4. Identify a “spiritual emergence” and a “spiritual awakening”.

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Wertz, F. J. (2015). Phenomenology: Methods, historical development, and applications in psychology. In J. Martin, J. Sugarman, & K. L. Slaney, The Wiley Handbook of Theoretical and Philosophical Psychology: Methods, Approaches, and New Directions for Social Sciences, First Edition. (pp. 85-101). Hoboken, NJ: John Wiley & Sons, Ltd.

Bertram P. Karon, PhD, ABPP *Who am I to Treat This Seriously Disturbed Person?*

Introductory

Who am I to treat this person? That's what came to mind every time I treated a seriously disturbed person. I don't know enough and I have hangups. But no one knows enough, and every therapist has hangups, although our own analysis helps. We may feel confused, frightened, angry, or hopeless because these are the patient’s feelings. Discussed are creating rational hope, dealing with feelings (including terror), depression, delusions, hallucinations, and suicidal and homicidal dangers. Theory is helpful, but it is not enough. Tolerating not knowing often leads to effective improvisations. Best results were obtained with psychoanalysis, or psychoanalytic therapy, without medication. Next best was psychoanalytic therapy with initial medication withdrawn as rapidly as the patient can tolerate. Electroconvulsive therapy is discouraged.

At the conclusion of this activity, participants should be able to:
1. Explain that schizophrenia is treatable.
2. Discuss how to form a relationship with the schizophrenic patient.
3. Reflect how to endure the unpleasant feelings when working with schizophrenic patients.

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Matcheri Keshavan, MD *Neuroscience, Neurobics, and Schizophrenia*

Introductory

Deficits in social functioning are present in early schizophrenia, may persist despite antipsychotic treatment, and tend to remain stable in severity or even worsen in subsequent phases of the illness. At the heart of the functional disability in this illness lies substantive cognitive impairment. Attention, executive function, verbal memory and social cognition may each contribute to functional outcome; in particular, social cognition measures have better predictive value for community functioning. Current pharmacotherapeutic approaches have limited impact on these deficits. Cognitive remediation approaches are being developed based on the principles of neuroplasticity; one of these is Cognitive Enhancement Therapy (CET) developed by Hogarty and colleagues. Recent data from our group has shown efficacy of this approach in early course schizophrenia and schizoaffective disorder. These effects on social cognition have translated into signficant improvements in functional outcome with regard to social adjustment, instrumental task performance, and work readiness. The beneficial effects appear to persist beyond the cessation of treatment. CET is accompanied by longitudinal changes in brain structure and function that may explain the therapeutic benefits. Several questions remain about the neurobiological mechanisms underlying CET effects, applicability of CET in community settings and predictive questions of who may be the best candidates of this intervention.

At the conclusion of this activity, participants should be able to:
1. Identify deficits in social functioning as prominent in the course of schiaophrenia.
2. Cite cognitive impairment in attention, executive function, and verbal memory as central in social functioning deficits in schizophrenia.
3. Describe Cognitive Enhancement Therapy as effective in fostering significant improvements in cognitive and social functioning.

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Brian Koehler, PhD *From Reductionism to the Person: Using a Convergence Science Approach to the Phenomena we call "Psychosis"*
Intermediate
Science does not explain or describe nature, only nature exposed to its tools of inquiry. This paraphrase of a comment by Nobel Laureate in Physics, Werner Heisenberg, will guide us as we do an updated review of clinical research findings in what is called "schizophrenia," a stigmatizing and outdated term, across the far reaching domains of the genome, epigenome, microbiota, brain, immune system, psychology, and social. It is proposed that these diverse, multiple, seemingly unrelated research findings fit into a fairly coherent model if one were to compare these observations with the robust contemporary research on the role of chronic traumatic stress in all of these domains. The qualitative aspects of this chronic stress will be described through the lens of long-term psychotherapeutic experience. The relevance of this model and approach will be applied to an understanding and therapy of such complex phenomena as distressing voices; beliefs of feeling controlled, invaded, colonized; social isolation, defeat and exclusion.

At the conclusion of this activity, participants should be able to:
1. Name three reliable neuroscience and/or immunological findings in research on psychosis.
2. Name three primary findings in the research on the effects of chronic stress on the brain and/or immune system.
3. Describe the role of stress in a corollary discharge model of auditory hallucinations.

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Sternberg, E. J. (2015). NeuroLogic: The Brain's Hidden Rationale Behind Our Irrational Behavior. NY: Pantheon.

Cooke, A. (Ed.) (2015). Understanding Psychosis and Schizophrenia. British Psychological Society.

Debra Kram-Fernandez, PhD, MSW, MS & Smita Ekka Ewan, PhD *Social Worker Attitudes Towards the Recovery Perspective for Individuals with Serious Mental Illness*
Introductory
Social workers provide the majority of services to individuals with serious mental illness (SMI), (Kirk, 2005). Studies demonstrate that workers who embrace a Recovery Perspective are more helpful to individuals with SMI. Research supports that those trained in Recovery usually do embrace these models. This study sought to understand social workers' adoption of a Recovery Perspective. Two measures were employed, the Recovery Knowledge Inventory (Bedregal, Davidson & O'Connell, 2006), and the Psychiatric Rehabilitation: Beliefs, Goals, and Practices Scale, (Casper & Oursler, 2003) to survey National Association of Social Work members.

Our first set of variables, professional characteristics, informed by literature related to social workers' embrace of evidence-based practice models, guided us to examine factors such as length of time in field, level of education, and theoretical frame of reference (Gray, Joy, Plath, & Webb, 2014).

The second category, agency characteristics, looked at respondents' perspectives of their agencies' embrace of a new model (Stanhope, Tuchman, & Sinclair, 2011). Sharif & Scandura (2014) suggest that workers need to trust the integrity of their leaders. Clinicians are more likely to accept a new model when it is perceived as being based on an ideal motivated by client's best interests.

We looked at one personal factor which asked whether the respondent had a family member or a close friend with SMI. MSW student attitudes towards schizophrenia have been studied, and it has been found that knowledge of and contact with persons with schizophrenia can have an impact on attitudes towards humanity and recovery (Eack & Newhill, 2008).

In our study, one's theoretical base emerged as significant on many analyses. In addition, those who practiced in Continuing Day Treatment Programs were more likely than those who practiced in clinics or private practice to

endorse these models.

Further examination and recommendations for educational institutions are indicated.

At the conclusion of this activity, participants should be able to:
1. Articulate key similarities and differences between beliefs, knowledge and practices, within the Recovery Perspective and Psychiatric Rehabilitation models.
2. Articulate agency variables that may impact embrace of a Recovery Perspective.
3. Articulate different views on the influence of a friend or family member with Serious Mental Illness on embrace of these models.

Anthony, W. (2011). Upping the ante. Psychiatric Rehabilitation Journal 34(3), 175-176.

Gray, M., Joy, E., Plath, D., & Webb, S. (2014). Opinions about evidence: Social Attitudes Towards Evidence Based Practices. Journal of Social Work 14 (1), p. 23-40.

Sharif, M. & Scandura, T. (2014). Does perception of ethical conduct matter during organizational change? Ethical leadership and employee involvement. Journal of Business Ethics 24 (2) p. 185-196.

Dalia S. Manjarres Cohen, Alyssa Fredrick, MA, Ewelina Lakomy & Sandra Steingard, MD *Psychiatric Heuristics: Contrasting Conceptualizations of Brain Functioning*
Intermediate
This panel explores two ways in which conceptualizations of the role of brain science lead to specific ideas about intervention in psychosis. One account speaks to the genesis of at least some cases of psychotic illness and the other to possible new ways of thinking about pharmacological treatment. First, Dalia Manjarres Cohen, Alyssa Fredrick and Ewelina Lakomy highlight TBI as a risk factor in the development of later psychosis, discussing brain changes evident in the neuroimaging studies of those with psychosis and the potential of TBI to create similar changes. They argue that distinguishing TBI-induced schizophrenia from other forms might lead to more specifically tailored and thus effective treatments, and also to increased understanding of both manifestations of psychotic illness. Then Sandra Steingard speaks to an increasing trend in psychiatry towards mechanistic understandings and treatments, as psychiatry has strayed from its original focus on the broad effects of psychopharmacological interventions in its search for specific and localized medication effects. As an alternative, Steingard's paper offers a proposal to reform modern psychiatric practice, following Moncrieff in arguing that psychiatry abandoned its initial focus of understanding the broad nature of psychoactive drug effects to shift towards a model that assumed these drugs had effects that targeted specific disease processes. This shift in focus has tended to minimize the risks of drug discontinuation and long-term use. The author applies the drug-centered concept to examining the history and current understanding of two classes of drugs: neuroleptics and psychostimulants. She concludes by suggesting that a need-adapted approach might be integrated with a drug-centered pharmacology to reclaim psychiatry and offer a way forward.

At the conclusion of this activity, participants should be able to:
1. Identify the modal neuropsychological profile of schizophrenia and psychosis secondary to traumatic brain injury.
2. Name specific neuropsychological tests for estimating the neuropsychological functioning of individuals affected with schizophrenia and psychosis secondary to traumatic brain injury.
3. Describe the distinction between the drug-centered and disease centered model of understanding psychoactive drugs.
4. Describe the model of integrating these two models to move towards a more humane and humble psychiatry.

Fuji, D. (2002). Neuropsychiatry of Psychosis Secondary to Traumatic Brain Injury. Psychiatric Times, 19(8), 33-33.

Lezak, M. D., Howieson, D. B., Bigler, E. D., Tranel, D. (2011). Neuropsychological Assessment (5th ed.). New York: Oxford University Press.

Molloy, C., Conroy, R. M., Cotter, D. R., & Cannon, M. (2011). Is traumatic brain injury a risk factor for schizophrenia? A meta-analysis of case-controlled population-based studies. Schizophrenia Bulletin. doi: 10.1093/schbul/sbr091.

Moncrieff, J, Cohen D, Porter, S. The Psychoactive Effects of Psychiatric Medication: The Elephant in the Room. Journal of Psychoactive Drugs, 45(5), 409-415, 2013.

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Silver, J. M., McAllister, T. W., Yudofsky, S.C. (2011). Textbook of traumatic brain injury (2nd ed.). Washington DC: American Psychiatric Publishing, Inc.

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Casadi "Khaki" Marino, PhD, LCSW, Diana Babcock, Lisa S. Forestell & Kevin Healey
Experts by Experience Plenary
Intermediate
Approaches to madness or extreme states of consciousness such as the Hearing Voices Movement and other peer driven frameworks maintain that expressions of distress through image and metaphor represent personal realities. These personal realities concern emotions, conflicts, or traumas and relate to life experiences. The significance of madness experiences can be explored and integrated into one's identity and life. An individual can grow through such experiences and identity can be reworked from a fragmented or devalued self to one that makes sense in life context. Madness calls for expressing one's story and deriving meaning from experiences. Experiences with madness become a dimension of one's life and part of the self-concept rather than all-encompassing or definitional (Longden, Corstens, & Escher, & Romme, 2012).

Individuals may withdraw in the face of devaluing and overwhelming experiences that are difficult to explain to others. Madness has been described as isolation and life disruption and recovery as understanding the contributors to distress and gaining social connection. Social support has been reported to be the most positive influence on recovery. Individuals need to have a sense of being valued by others and as being social included (Windell & Norman, 2012). The degree to which someone perceives that others regard relationships to him or her as important or close has been found to be a strong predictor of subjective recovery (Norman, Windell, Lynch, & Manchanda, 2013).

The Experts by Experience Plenary will provide testimonies of the lived experiences of madness and personal and social growth journeys. Individuals will explore experiences with distress and disconnection involved in extreme states and the importance of expressing personal realities and finding social connection for recovery.

At the conclusion of this activity, participants should be able to:
1. Explain how extreme states of consciousness may connect to life experiences.
2. Discuss the importance of personal expression and meaning making in recovery.
3. Discuss the importance of social connection in recovery journeys.

Longden, E., Corstens, D., Escher, S., & Romme, M. (2012). Voice hearing in a biographical context: A model for formulating the relationship between voices and life history. Psychosis, 4(3), 224-234.

Norman, R.M., Windell, D., Lynch, J., & Manchanda, R. (2013). Correlates of subjective recovery in an early intervention program for psychosis. Early Intervention in Psychiatry, 7(3), 278-284.

Windell, D. & Norman, R. (2012). A qualitative analysis of influences on recovery following a first episode of psychosis. International Journal of Social Psychiatry, 59(5), 493-500.

Uma C. Millner, PhD, Kimberleyann Green, Sarah Satguman, LCSW & Kathryn Vessel

Opening Doors: Using Career Guidance Strategies to Help Individuals with Psychiatric Conditions Find Meaningful Work

Introductory

While de-institutionalization enabled individuals in recovery from serious psychiatric conditions to return to community life, until recently the focus has remained on treatment and stabilization of symptoms. Work has taken on a more central role in the rehabilitation for adults with psychiatric conditions fairly recently through prevalent vocational rehabilitation services (e.g. Supported Employment, Individual Placement and Support) and legislative efforts aimed at addressing existing employment disparities (e.g. Americans with Disabilities Act). However, individuals with serious psychiatric conditions persistently experience low workforce engagement, poor job retention, and participation in menial and low-wage jobs (Martin, et al., 2012). A large number of individuals experience continued dependence on Social Security benefits and those who work, often feel "stuck in dead end jobs" (Frey, et al., 2011; Livermore et al., 2007). Evidence suggests that attention to job preferences and pursuit of a "dream job" contribute to job satisfaction, motivation, and job retention (Strickler, et al., 2009; Millner, et al., 2015). Increased attention is being paid to the career development of individuals with psychiatric conditions, particularly for young adults (Bond, et al., 2014; Ellison, et. al., 2015) since diagnosis of psychiatric conditions during young adulthood typically disrupts the career exploration and preparation process. However, little is known about the role of career development in promoting long-term vocational recovery for this population. This presentation will 1) provide an overview of employment initiatives for individuals in recovery from psychiatric conditions, 2) highlight the importance of career as a unique development process as applied to these individuals, 3) describe strategies for addressing employment disparities utilizing a career framework including an initiative called Opening Doors. We will present pilot data on Opening Doors including first-hand reports of participants and share exemplary materials from the curriculum. We will conclude with a discussion on barriers and strategies to guide individuals with psychiatric conditions find meaningful work.

At the conclusion of this activity, participants should be able to:

1. Articulate the career needs of individuals in recovery from psychiatric conditions.
2. Describe diverse approaches to address the employment needs of individuals in recovery from psychiatric conditions.
3. Identify 2-3 strategies to improve the employability of individuals in recovery from psychiatric conditions.

Blustein, D. (2014). The psychology of working: A new perspective for a new era. The Oxford handbook of the psychology of working. D. Blustein. NY, Oxford University Press: 3-18.

Bond, G. R., et al. (2014). "Employment and educational outcomes in early intervention programmes for early psychosis: a systematic review." Epidemiology and Psychiatric Sciences.

Butler, G., et al. (2010). "Characteristics of people with severe mental illness who obtain employment." The Psychiatrist 34(2): 4.

Campbell, K., et al. (2011). "Who benefits from supported employment: A meta-analytic study." Schizophrenia Bulletin 37(2): 370-380.

Ellison, M. L., et al. (2015). "Adapting supported employment for emerging adults with serious mental health conditions." The journal of behavioral health services and research 42(2): 206-222.

Fabian, E. S. (2014). Work and Disability. The Oxford Handbook of the Psychology of Working. D. Blustein. NY, Oxford University Press: 185-200.

Gewurtz, R. E., et al. (2012). "The shift to rapid job placement for people living with mental illness: An Analysis of Consequences." Psychiatric Rehabilitation Journal 35(6): 6.

Lent, R. W. (2013). Social cognitive theory. Career development and counseling: Putting theory and research to work. S. D. Brown and R. W. Lent. Hoboken, NJ, Wiley: 115-146.

Millner, U., et al. (2015). "Exploring the work lives of adults with serious mental illness from a vocational psychology perspective." Journal of Counseling Psychology 62(4): 642-654.

Smith, A. L. and A. Milsom (2011). "Social cognitive career theory with adults with psychiatric disabilities: Bringing theory to practice." Journal of Applied Rehabilitation Counseling 42: 20-25.

Solberg, V. S., et al. (2012). "Quality learning experiences, self-determination, and academic success: A path analytic study among youth with disabilities." Career Development and Transition for Exceptional Individuals 35(2): 85-96.

Torres Stone, R. A., et al. (2015). "Appealing features of vocational support services for Hispanic and non-Hispanice transition age youth and young adults with serious mental health conditions." Journal of Behavioral Health Services & Research 42(4): 13.

Lauren K. O'Connor *Dual Self-Stigma: Lesbian, Gay, Bisexual & Transgender Persons Diagnosed with Severe Mental Illness*
Intermediate
Self-stigma is understood as the internalization of negative public attitudes and stereotypes. Despite the increase in research pertaining to the self-stigma experiences of separate groups, research on individuals with multiple marginalized identities remains scant. One particular intersection of self-stigma that has received little attention is that of individuals diagnosed with severe mental illness within the lesbian, gay, bisexual and transgender (LGBT) community. This study aims to explore the experiences of self-stigma faced by members of these two marginalized groups. Thirty individuals will be recruited to participate in a mixed-methods study. Each participant will complete measures on self-stigma pertaining to mental illness diagnoses and sexual and/or gender minority status. Additionally, they will each participate in a focus group discussion that will aim to explore the nuanced experiences of these two forms of self-stigma and examine how these constructs may interact.

At the conclusion of this activity, participants should be able to:
1. Describe the clinical significance of self-stigma.
2. Distinguish the experiences and effects of LGBT self-stigma from those of self-stigma of mental illness diagnoses.
3. Cite three unique challenges faced by LGBT individuals diagnosed with severe mental illness.

O'Connor, L.K., Öngür, D.,Pingali, S.,Lewandowski, K.E., Shinn, A.K. (2014, September) Homicidal ideation and aggression in psychotic disorders: a hospital-based study. Society for Research in Psychopathology Annual Conference, Evanston, IL

Roe, D., Hasson-Ohayon, Mashiach–Eizenberg, M., Derhy, O., Lysaker, P.H. & Yanos, P.T. (2014). Narrative Enhancement and Cognitive Therapy (NECT) effectiveness: A quasi-experimental study. Journal of Clinical Psychology, 70, 303-312.

Sperry, S.H., O'Connor, L.K., Öngür, D., Cohen, B.M., Keshvan, M.S., & Lewandowski, K.E. (in press 2016). Measuring cognition in bipolar disorder with psychosis using the MATRICS Consensus Cognitive Battery. Journal of International Neuropsychology Society

Peter M. Pascatore, MA *A 21st Century Demonological Neurosis*
Advanced
Psychoanalytic diagnosis focuses on the structure of one's subjectivity, rather than symptom categories or how in touch one is with reality. This paper presents the case of a middle-aged man who presented to a community mental health clinic with a DSM diagnosis of chronic paranoid schizophrenia; the treatment was conducted in a Lacanian frame with a diagnosis of a psychotic structure. But after the conclusion of treatment, it became clear that his problematics are in fact better understood as organized by hysteria. This diagnosis is informed by a Lacanian distinction between psychotic and neurotic structures, as well as by Freud's cases of male hysteria (Dostoevsky and Christoph Haizmann). Although I discuss the clinical impasse resulting from this diagnostic misstep–and how treating the patient as hysteric might have prevented it – I do not consider this a 'failed case'. Rather, I discuss the impact my interventions had upon the patient with respect to transference and the adhesiveness of the libido, along with the patient's development of a new, phobic, symptom, which I take to be evidence of the patient's progress into a more developmentally advanced stage of the Oedipus Complex.

At the conclusion of this activity, participants should be able to:
1. Describe the structural difference between neurosis and psychosis.
2. Identify cases of male hysteria.
3. Critique phenomenological approaches to diagnosis.

De Clerck, R. (2011). Die Macht der Bilder?: Zur Bedeutung von Internetpornographie: Sucht, Perversion oder (männliche) Hysterie? Ein Fallbericht. Jahrb. Psychoanal., 63:37-65.

Mitchell, J. (2013). Siblings: Thinking Theory. Psychoanal. St. Child, 67:14-34.

Russell, F. (2012). Unity and Synthesis in the Ego Ideal: Reading Freud's Concept through Kant's Philosophy. Am. Imago, 69:353-383.

Anthony J. Pavlo, PhD, Larry Davidson, PhD & Sacha Alexander Tikhomirov-Lawrence, CPsychol AFBPsS *Collaboration and Constructive Listening: Perspectives on Diagnosis and Delusion*
Intermediate
While the DSM has undergone intensified critique recently, the power of diagnosis in determining treatment, insurance reimbursement and the socialization of stigma is still in ascendancy. But is there a way to use diagnosis not to reinforce the practitioner-patient divide, but rather to create a collaborative basis for treatment? And can the effort to listen to so-called symptoms rather than to dismiss them as "delusional" indications of illness yield new avenues for treatment among the members of Multi-Disciplinary Teams (MDT's), in which interdisciplinary collaboration between practitioners so often leads to a group opinion about individual patients? Anthony Pavlo and Larry Davidson, in their paper, "Toward a Collaborative Diagnostic Practice in Mental Health Care," present one possible account of a collaborative approach to mental health diagnosis, and offer a basic set of principles for a person-centered and recovery-oriented approach to diagnosis. They present an example of such an approach based in constructivist theory that emphasizes relational and existential concerns, and then review preliminary data from their own study of psychotherapist-client dyads who discussed both constructivist and DSM diagnoses. The qualitative findings of their study provide the basis for insight into the specific factors that clients and psychotherapists see as important for mental health diagnosis. Sacha Alexander Tikhomirov-Lawrence presents a complementary perspective on the need for a collaborative, non-objectifying approach to mental health treatment in his paper on "Delusional Communication in Multi-Disciplinary Teams." He notes that in the medical literature, delusions are defined and therefore predominantly understood by MDT as part of disease symptomology, are often perceived as manifestation of grandeur gestures, and are often dismissed as "false beliefs and opinions," generally leading to action on the part of the team to challenge and medicate the patient. Rather, an alternative outlook on delusional phenomena as attempts at client-team communication is offered. Clinical examples are provided in order to invite teams' thinking beyond the conventional by facilitating insight into the delusional aspect of clients' narratives. Appreciation of the communicative potential of delusions can, this paper suggests, lead to greater communication both between team members and between patient and team.

At the conclusion of this activity, participants should be able to:
1. Identify current limitations in diagnostic practice and current alternatives to traditional diagnostic practices.
2. Cite principles for a recovery-oriented and person-centered approach to mental health diagnosis.
3. Describe team insight.
4. Interpret psychotic narrative.

The British Psychological Society. (2011). Response to the American Psychiatric Association: DSM-5 development. Retrieved from http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5%202011%20-%20BPS%20response.pdf .

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Cosgrove, L., & Krimsky, S. (2012). A comparison of DSM-IV and DSM-5 panel members' financial associations with industry: A pernicious problem persists. PLoS Medicine, 9(3), e1001190. doi:10.1371/journal.pmed.1001190.

Demazeux, S., & Singy, P. (2015). The DSM-5 in perspective: Philosophical reflections on the psychiatric babel. New York: Springer.

Freud, S., (1913) The Interpretation of Dreams, A new translation by Joyce Crick. Oxford World's Classic. Oxford University Press. First published as an Oxford World's Classics paperback 1999, Reissued 2008.

Kamens, S. (2010). Controversial issues for the future DSM-V. Society for Humanistic Psychology Newsletter.

Laing, RD. The Divided Self: An Existential Study in Sanity and Madness. Penguin Books, London, England. First Published by Tavistock Publications (1959) Ltd, 1960.

Prins, L. (2015). The value of metaphor in psychotherapy. Psychotherapy Section Review No. 56 pp 19-26.

Watts, J. (2014). Making Space for the Meaning in Madness. Retrieved from Huffington Post http://www.huffingtonpost.co.uk/dr-jay-watts/understanding-psychosis-and-schizophrenia-_b_6221996.html

Zisman-Ilani, Y., Roe, D., Flanagan, E. H., Rudnick, A., & Davidson, L. (2013). Psychiatric diagnosis: what the recovery movement can offer the DSM-5 revision process. Psychosis, 5(2), 144-153. doi:10.1080/17522439.2012.699542.

Narsimha Reddy Pinninti, MD *Yoga and Mindfulness Based Cognitive Therapy for Psychosis (Y-MBCTp) as a Brief Therapy: Data and Training Implications*

Introductory

Psychotic disorders affect 6% of population and current treatments are only partially effective. Trauma and its adverse impact on the development and persistence of positive psychotic symptoms is an unmet need in this population. Yoga and Mindfulness Based Cognitive Therapy for Psychosis (Y-MBCTp) is an evidence-based translational mindfulness based cognitive therapy designed by Dr. Pradhan that addresses both trauma and positive psychotic symptoms associated with it. Y-MBCTp has 2 components: (a) the wellness component is directed towards stress reduction for clients and caregivers and (b) the symptom specific component targeted towards psychotic symptoms.

OBJECTIVES: We present a conceptual overview and pilot data on efficacy of Y-MBCTp as a brief therapy for clients with psychosis.

METHODS: In an open trial design with consecutive sampling, eight sessions (30 minutes duration each) of Y-

MBCTp were conducted by Drs. Pradhan and Pinninti at 2 clinical sites over a period of 14 weeks for 7 individuals who have chronic non-affective psychosis. Six of these clients had history of significant abuse and trauma (traumatic psychosis). In all 7 clients, the psychotropic medications, were continued at the same dose throughout this trial.

RESULTS: After eight sessions of Y-MBCTp, there was a significant reduction in participants' psychopathology, as well as an improvement in their level of functioning, as reflected by their scores on the PSYRATS and GAF scales respectively. There were high acceptability, utilization, and patient satisfaction and no drop out. Our preliminary data show that Y-MBCTp is feasible, acceptable, and is effective in inducing remission of psychotic symptoms. Although promising, significant limitations include the preliminary nature of these data, open trial design, and very small sample size and further studies are planned.

At the conclusion of this activity, participants should be able to:
1. Summarize Yoga & Mindfulness Based Cognitive therapy for Psychosis (Y-MBCTp).
2. Practice a standardized Yoga and meditation module to attain a mindful state and to reduce stress in daily life situations.
3. Summarize the data on effectiveness of Y-MBCTp in individuals with traumatic psychosis.

Pradhan, B.K. and Pinninti, N.R. (2016, accepted for publication). Chapter-5. Yoga & mindfulness based cognitive therapy for psychosis (Y-MBCTp): A pilot study on its efficacy as brief therapy. In: Pradhan, Pinninti and Rathod (Eds.): Brief Interventions for psychosis: A Clinical Compendium. Springer Publishers, Switzerland.

Pradhan, B.K. (2014). Yoga and Mindfulness Based Cognitive Therapy: A Clinical Guide. Switzerland: Springer International Publishers.

Rathod, S., Kingdon, D., Pinninti, Narsimha, Turkington, D., Pheri, Peter (2015). Cultural Adaptation f CBT for Serious Mental Illness: A Guide for training and practice.West Sussex, Wiley Blackwell.

Crystal C. Ramirez, PhD *Subjective Experiences of Treatment for Psychosis: A Phenomenological Analysis*
Introductory
Two hallmark symptoms for psychoses are hallucinations and delusions, indicating to mental health practitioners that the person is experiencing a form of nonconsensual reality. These patients are not given the same opportunities to collaborate in planning for their treatment as those being treated for other conditions. Psychosis is a condition with myriad controversial theories of etiology and treatment, leading to great variations in treatment outcomes. This research offers a perspective on the subjective experience of people being treated for psychosis in the modern mental health system in the United States by documenting how they think and feel about the treatment they are receiving. The method of inquiry was an interpretative phenomenological analysis with six people responding to 15 questions in a semi-structured interview that included questions about what has been beneficial and not beneficial in accessing therapeutic support for their distressing experiences and what advice they would give to mental health workers.

Advice participants wished to give to mental health workers included being more compassionate and expressing authentic caring, encouraging recovery as opposed to dependency, and instilling hope. This research indicates the following areas for improvement in the treatment of psychosis: focusing on the development of the therapeutic relationship, including active listening and authentic concern; including the patient in the development of goal setting and treatment planning; and focusing on recovery with an attitude of hope.

In order to improve the experience of people being treated for a psychotic disorder diagnosis, several issues need to be addressed, including further understanding of the etiology of psychosis, potential meaning an individual places on the experience of psychosis and the meaning for the community, an operational diagnosis and diagnostic system that allows for more accurate diagnosis and destigmatization, and funding and insurance to provide the care that is required for healing and recovery.

At the conclusion of this activity, participants should be able to:
1. Identify methods of therapeutic treatment that patients in the study cited as beneficial.
2. Discuss constructive advice to practitioners given by mental health patients.
3. Describe impacts of focusing on the development of the therapeutic relationship, including the patient in the development of goal setting and treatment planning, and focusing on recovery with an attitude of hope on mental health treatment.

Atwood, G. E. (2012). The abyss of madness.

Brissos, S., Balanza-Martinez, V., Dias, V. V., Carita, A. I., & Figueira, M. L. (2011). Is personal and social functioning associated with subjective quality of life in schizophrenia patients living in the community? European Archives of Psychiatry and Clinical Neuroscience, 261(7), 509-517.

Williams, P. (2012) Rethinking madness: Towards a paradigm shift in our understanding and treatment of psychosis.

Jeremy Ridenour, PsyD, Benjamin K. Brent, MD & Erin B. Seery, MD *Psychotherapy with Delusions: A Mentalization-Based Perspective*
Intermediate
Psychotherapy is an intersubjective encounter in which the therapist and the patient work together to create a meaningful narrative and context for the patient's difficulties and to deepen emotional understanding and improve awareness of the mental states of self and other (Hamm & Leonhardt (2016). However, deficits in social cognition are a well-documented finding in schizophrenia research (Green, Horan, & Lee, 2015) and can interrupt the formation of a therapeutic alliance. Additionally, individuals who experience psychosis report high rates of trauma, (van Nierop et al., 2014) which might contribute to insecure attachment styles (Liotti & Gumley, 2009). A mentalization-based approach to treatment can help bridge these research findings and provide a developmental context in which impaired thinking about the mental states of self and others might emerge from disturbed caregiving relationships.

Individuals who have fixed delusions are often mistrustful and possess limited insight into the nature of their illness (Lysaker et al., 2011). Therapists confront unique challenges when working with these individuals and often struggle to know how to position themselves in relationship to the delusional system. Should they challenge the delusion directly? How do they respond to paranoia and mistrust? Are they at risk of being incorporated into the delusional system? A mentalization-based approach can be an asset to psychotherapists who are looking to foster a therapeutic alliance with individuals diagnosed with schizophrenia (Brent, 2015). Given that individuals who experience psychosis frequently attribute malevolent intentions to others, a focus on mentalization can serve to decrease these negative attributions and promote social functioning. This panel will provide a theoretical overview of a mentalization-based approach to treatment, especially for individuals harboring delusions. A case example will be provided and mentalization-based strategies will be shared to offer technical advice for therapists working with individuals who have delusional beliefs.

At the conclusion of this activity, participants should be able to:
1. Identity the basic tenets of mentalization theory and its relationship to schizophrenia.
2. Explain how delusions impact social cognition.
3. Apply mentalization-based approached strategies to treatment to promote learning and metacognition for individuals who have delusional beliefs.

Brent, B. K. (2015). A Mentalization-Based Approach to the Development of the Therapeutic Alliance in the Treatment of Schizophrenia. Journal of clinical psychology, 71(2), 146-156.

Green, M. F., Horan, W. P., & Lee, J. (2015). Social cognition in schizophrenia. Nature Reviews Neuroscience.

Hamm, J. A., & Leonhardt, B. L. (2016). The role of interpersonal connection, personal narrative, and metacognition in integrative psychotherapy for schizophrenia: A case report. Journal of clinical psychology,

72(2), 132-141.

Lysaker, P. H., Dimaggio, G., Buck, K. D., Callaway, S. S., Salvatore, G., Carcione, A., Nicolò, G. & Stanghellini, G. (2011). Poor insight in schizophrenia: links between different forms of metacognition with awareness of symptoms, treatment need, and consequences of illness. Comprehensive psychiatry, 52(3), 253-260.

Annie G. Rogers, PhD *Incandescent Alphabets: Psychosis and the Enigma of Language*
Intermediate
Psychosis, an invasion of mind and body from without, creates an enigma about what is happening and thrusts the individual into radical isolation. What are the subjective details of such experiences? This book explores psychosis as knowledge cut off from history, truth that cannot be articulated in any other form other than a construction by the psychotic. Delusion is a new language made of 'incandescent alphabets' that the psychotic adopts from imposed voices. The psychotic uses language in a singular way to explain a strange experience he or she cannot exit.

In this talk I explore one chapter from my book, images of the body made by psychotic artists, configured as new alphabets. Whatever we can name and recognize of ourselves in language becomes a precursor for what we see and experience about our bodies. But when language itself changes and comes from voices imposed, the body becomes marked by the problematic of an invasion. The artist makes an expanding projection of unspeakable experience. As we look, the horizon between the image created and the world experienced comes toward us. The artists portray what we have not seen before. The body becomes fragmented; it has too many organs or has lost vital organs; it is made transparent; foreign objects control the body; and the body is re-inscribed to support a new universe, a new humanity. The artists present singular works that speak to any one who wonders about psychosis as a lived experience, anyone who believes in the power of art.

At the conclusion of this activity, participants should be able to:
1. Identify several distinctive characteristics of psychotic art.
2. Infer perceptions of the body from images and psychotic accounts of making art.
3. Explain how art by psychotics responds to the experience of hallucination.

Robinson, W. (2011). Demons in the Age of Light: A Memoir of Psychosis and Recovery. Port Townsend, WA: Process Media.

Rogers, A. (2016). Incandescent Alphabets: Psychosis and the Enigma of Language. London: Karnac.

Vanheule, S. (2011). The subject of psychosis: A Lacanian Perspective. NY: Palgrave, Macmillan.

Ashis Roy, MA *Limitlessness and Fragmentation*
Advanced
This paper reflects an engagement with a Muslim patient, Sarah, with an emphasis on the presence of and the emanations of her community arising from within the sessions. While focusing on her experience of abuse, and attempting to understand the impersonal and non-existent parts of herself which do not find a relational or familial container in her life, and engaging with her sense of fragmentation in a relational dyad, this paper examines the different shades of her psychic landscape through the concepts of the no-thing and annihilated self. While drawing from inter-subjective modes of therapeutic engagement such as the use of reveries, this paper is a reflection on the soulfulness in clinical living that is preserved in an engagement with a fragmented psyche, and the necessity of preserving soulfulness with clinical thinking. The writing style of this paper is an attempt at preserving much of the patient. Additionally, this paper shows a way of holding on to the emergence of psychic states in sessions as representative of an internal force which can withstand the repressive forces of a community and thereafter produce directions of selfhood which are needed for psychic growth, echoing the words of Andre Green - the psyche is not only inside but also outside.

At the conclusion of this activity, participants should be able to:
1. Describe self states that are observed and felt in clinical work as representing deeper resolutions which may lead to the formation of an identity.
2. Discuss empathy in working with psychotic states.
3. Explain a way of preserving the social context within a clinical engagement and not limiting clinical work as being intra psychic.

Eigen. M (2006) The Annihilated Self, *Psychoanalytic Review*, 93:25-38

Eigen, M. (2014) *Faith*.

Eigen, M. (2015) *Image, Sense, Infinities, and Everyday Life*.

Eigen, M. (1996) *Psychic deadness*. Northvale, NJ: Jason Aronson.

Resnik, S. (2016) *The logic of madness: on infantile and delusional transference*.

Burton N. Seitler, PhD *An Unassuming Rationale for the Creation of a Research Journal of Psychoanalytic Studies*

Intermediate

Why does psychoanalysis need a scientific research journal? It must seem counter-intuitive to found yet another psychoanalytic journal in view of a proliferation of publications over the last three decades and the pressures to increase readership levels and quality submissions, but (1) a journal which specifically addresses psychoanalytic empirical research does not exist. We also need one for the following reasons: (2) to demonstrate that--psychoanalysis as a theory has validity with regard to the existence of the unconscious, transference, countertransference, resistance, dream-work, free association, attachment, separation-individuation, castration anxiety, and a number of other psychoanalytic hypothetical constructs; (3) psychoanalytic praxis has demonstrable efficacy; (4) and to respond to "naysayers" who claim that psychoanalysis has no research to back up its claims, and even if it did, such claims are neither testable nor measurable, that is, they are not "falsifiable" (the so-called Popper critique). Nothing is further from the truth.

While Freud utilized free association, Jung developed word association and astutely observed that individuals took longer amounts of time to respond to certain words than to other words that seemed to have less of an emotional charge. He named these response latency phenomena, "complexes." In fact, these delays in response time are measurable. In these simple two approaches, free association and word association, we see the first attempts to quantify what goes on in the interior of an individual. But others from the ranks of psychoanalysis would also produce significant empirical data. The works of Rene Spitz on hospitalism and infantile marasmus, Bowlby's studies of attachment and loss, and Mahler's research and film documentation of separation-individuation issues are examples of this. These were the earliest systematic attempts to understand the inner workings of the mind, but they would certainly not be the last.

At the conclusion of this activity, participants should be able to:
1. List at least two fundamental reasons why there needs to be journal of psychoanalytic research.
2. List three ways psychoanalysis has been inaccurately criticized.
3. Define Popper's concept of "falsifiability."

Berlin, H.A. (2011). The neural basis of the dynamic unconscious. Neuropsychoanalysis 13.(in press)

Ebisch, S., Salone, A, Ferri, F, de Berardis, D, Romani, G.L., & Gallese, V. (2012). Out of touch with reality? Social perception in first-episode schizophrenia. Soc. Cogn. Affect. Neurosci. 7.

Solms, M. and Panksepp, J (2012). "The 'Id' knows more than the 'ego' admits: Neuropsychoanalytic and primal consciousness perspectives on the interface between affective and cognitivie neuro-science." Brain Sciences, 2, pp. 147-175.

Alexander W. Smith, MA, Zelda G. Alpern, MSW, Edward Altwies, PsyD, Lisa C. Dobkowski LCMHC, Amy Morgan, LICSW *Incorporating Open Dialogue and Needs-Adapted Network Approaches in Community Mental Health Services in the US*

Introductory

Over the past few years a small number of programs in the northeast US have piloted applications of the "Open Dialogue" approach developed in western Lapland as well as closely related "needs adapted" and "reflecting process" practices developed in northern Europe. These practices emphasize working with people experiencing extreme states in highly collaborative family and network meetings allowing time to cultivate a mutuality of understandings of different experiences without pre-imposing a clinical framework. The meetings are "needs adapted" in that services are planned together to fit the expressed needs of the person at the center of concern and their network vs. the other way around.

The naturalistic research findings from Finland over the past two decades have strongly indicated a high degree of efficacy with much less use of hospitalization, less use of antipsychotics, and better functional outcomes including much higher rates of employment vs. a comparison group in the region. Several other studies are underway throughout Europe and the US. These findings are also supported by the promising results from other early episode intervention models.

This panel will include representatives from teams of community mental health practitioners from Massachusetts, New York City, and Vermont. We will discuss how we've brought these practices into our respective publically funded community mental health contexts. We will share what we have learned from our successes and setbacks, and compare and contrast our different approaches to training, and how the co-creation of a regional practice development network has further supported our collective efforts.

The presentation will also include early indications from data, feedback and observations of the benefits and challenges of working in this way. We will each describe our subjective impressions that this is a very significant positive shift in practice with far reaching implications for the service systems within which we work.

At the conclusion of this activity, participants should be able to:

1. Distinguish different ways of incorporating open dialogue and related approaches into practice in community service systems.
2. Summarize key aspects of open dialogue and needs adapted approaches.
3. Reflect on early indications of data observations from staff and client experiences of these approaches.

"Open dialogues with patients and their families" Seikkula/Alakare in Psychosis as a Personal Crisis Ed. Romme/Escher ISPS 2012

Open Dialogues and Anticipations Respecting Otherness in the Present Moment Seikkula/Arnkil National Institute for Health and Welfare 2014

Understanding Psychosis and Schizophrenia Ed. Anne Cook British Psychological Society 2014

Michael Stein, JD, PhD: Keynote Address *Legal Capacity and Mental Disability: A Need for Cross-Disciplinary Dialogue*

Introductory

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) is the first human rights treaty of the twenty-first century, and the first one to specifically protect the rights of the world's one billion persons with disabilities. One of the fundamental rights contained in the CRPD, and one that is emblematic of the paradigm shift intended by the treaty, is that of legal capacity: the equal right of persons with disabilities to make their own decisions in all aspects of life, including health care provision. At the same time, this right is also the least understood in terms of practice, and the most controversial. The speaker was privileged to have participated in the CRPD's drafting and to have worked on implementing the treaty in over 40 countries. This talk will investigate and provoke discussions around involuntary confinement and treatment, a topic currently dominated by rights advocates but without consultation.

At the conclusion of this activity, participants should be able to:
1. Recognize the two counterveiling themes in mental/legal capacity law.
2. Differentiate between these two themes and their respective strengths and weaknesses.
3. Draw their own conclusions on the validity of these respective themes.

Melvyn Colin Freeman, et al, Reversing Hard Won Victories in the Name of Human Rights: A Critique of the General Comment on Article 12 of the UN Convention on the Rights of Person with Disabilities, The Lancet/Psychiatry (July 6, 2015).

Janet E. Lord & Michael Ashley Stein, Contingent Participation and Coercive Care: Feminist and Communitarian Theories Consider Disability and Legal Capacity, in Coercive Care: Law and Policy 31 (Bernadette McSherry & Ian Freckelton eds. 2013).

Michael Ashley Stein, Janet E. Lord & Dorothy Weiss Tolchin, Equal Access to Health Care under the UN Disability Rights Convention, in Medicine and Social Justice: Essays on the Distribution and Care 245 (Rosamond Rhodes, Margaret Battin & Anita Silvers eds. 2d ed. 2012).

Ira Steinman, MD *HEALING--perhaps CURATIVE--Intensive Outpatient Psychotherapy of Psychosis*

Introductory

Intensive psychodynamic psychotherapy, making use of the concepts of unconscious motivation, resistance to change, transference and counter-transference phenomena and the benefit of interpretation of these occurrences, is crucial in the healing psychotherapeutic treatment of schizophrenia and other psychoses. Here, the therapeutic goal is to aid the patient's understanding his or her own metaphor and symbolism that have taken on the concretized form of psychotic delusions and hallucinations. The current treatment approach to psychotic patients is to medicate with antipsychotic medication and try to keep patients on such medication along with supportive services like half way houses, hospitalization and day care. Often psychotic patients get little benefit from such a regimen. Such an approach omits helping the patient to understand and master his own symbolism. The field of psychiatry for the last 55 years has thought that schizophrenia is a brain disease with an organic and biological basis; hence believes antipsychotic medications are required for life…A closer look at the origins of psychotic thinking is that these people are very upset. With anxiety, with intense terror, with withdrawal from the world, comes a cascade of thoughts and swirling neurochemicals. that worsen the situation. I use antipsychotic medication if necessary but generally for a short period of time; a large percentage of my psychotic patients respond to psychodynamic exploration, often titrating down and stopping antipsychotic medication. This presentation, given at the Centro Psychoanalytica in Rome, and ISPS 2015 in NY, demonstrates the healing, at times curative, benefit of intensive psychotherapy in patients previously hospitalized and diagnosed as psychotic. All patients were able to titrate down and stop antipsychotic medication as they understood the meaning to themselves of their previous delusions and hallucinations. For some, the gains, off medication, have lasted for decades.

At the conclusion of this activity, participants should be able to:
1. Describe techniques for intensive psychotherapy of psychosis.
2. Describe healing benefits to an intensive psychotherapy of psychosis.
3. Evaluate current primarily psychopharmacological approaches to schizophrenia and psychoses.

Garfield, D, Steinman, I, SELF PSYCHOLOGY and PSYCHOSIS: the Development of the Self during Intensive Psychotherapy of Schizophrenia and other Psychoses, Karnac, London 2015.

Glover, J Alien landscapes: Interpreting Disordered Minds, Belknap Press of Harvard, Cambridge, 2014.

Plakun, ed. The Austin Riggs Reader: Treatment Resistance and patient Authority, Norton, New York, 2011.

Ross Tappen, MA, Tau Harris & Sara Markowitz, PhD *A Contrapuntal Understanding of Recovery: Three Voices*

Intermediate

This panel will present a treatment experience in a state psychiatric facility from three perspectives. One presenter was the clinical supervisor; another presenter was the treating therapist, one was the client. The therapy involved a combination of issues: voices, understood using the Maastrict interview; intense anxiety and OCD symptoms, addressed with CBT. Group work in trauma and a voices support group also played a role. The special relationship between the therapist and the client -- presently a co-facilitator of the voices group of which he was a member -- will be highlighted as well.

At the conclusion of this activity, participants should be able to:
1. Apply CBT techniques in anxiety and psychosis.
2. Explain application of the Maastrict interview in therapy of psychosis.
3. Enumerate the collaborative aspects of therapy of psychosis.

Geekie, J., Read, J. Randal P. & Lampshire D. (2011). Experiencing psychosis: Personal and professional perspectives. London: Routledge.

Read, J., & Dillon , J. Models of Madness: Psychological, social and biological approaches to psychosis 2nd edition. (2013) London: Routledge.

Romme, Escher S. (2011). Psychosis as a personal crisis: an experience based approach. London: Routledge.

Charles E. Turk, MD *A Lacanian View of the Resolution of an Impasse*

Intermediate

This paper was generated in response to a query a patient put to me, "I've been through so many unsuccessful treatments – don't you think professionals ought to learn about what worked for me? Whatever you call this - psychoanalysis if you will – it suited me." The paper – set in a Lacanian framework - was collaboratively written with Ms. M. When she began treatment, she exhibited borderline level psychopathology that rendered her unable to engage with others. This had its source in pervasive sexual, physical and verbal abuse during childhood.

Having had a succession of treatment failures and impasses, with great difficulty she entered into a lengthy and arduous course of treatment that eventually brought her to a place where she was able to consolidate a position from which she could engage with others in gratifying ways. One of her symptoms had been repeated acts of self-mutilation, but she was able to come to being able to co-operate with medical treatment that included several surgeries necessitated by chronic neuromuscular and orthopedic conditions.

One the analyst's side the problem of his uncertainty and fear and then that of building a framework specifically suited to Ms. M's difficulties in confronting the destabilizing effect of the work. From Ms. M's side, the question of transformation – how her experience of the treatment provided the fulcrum for change proved elusive. These issues are laid out in a description of the clinical course – with intercalations of theoretical commentary. These latter were derived from the author's assimilation of a Lacanian clinical perspective as transmitted to him during many years of affiliation with the analysts at GIFRIC.

At the conclusion of this activity, participants should be able to:
1. Explain the value of identifying one's own reactions to an immediate situation in order to extract information from them, not react to them, and thereby sustain a holding environment.
2. Seek what is enigmatically at work in the analysand and to respond in ways that can assist him/her to render it into words.
3. Explain the creative potential of the unconscious beyond it simply being the repository of traumatic inscriptions.

Anzieu-Premmereur, C. (2015) The skin-ego: dyadic sensuality, trauma in infancy, and adult narcissistic issues Psychoanalytic Revue. Vol. 102, No 5 659-681

Apollon, W. (2006) The Untreatable. Umbr(a) – the Journal of the Center for the Sutdy of Psychoanalysis and Culture. Online PDF.

Cantin, L. (2010) The borderline or the impossibility of producing a negotiable form in the social bond for the return of the censored. Konturen – Vol 3 Borderlines in Psychoanalysis – Borderlines of Psychoanalysis. The Knight Library Press. Oregon Digital: Oregon State Unversity and the University of Oregon.

Cantin, L. (2010) Preliminary questions to a reflection on clinical impasses. Sante Mental au Quebec Vol 35 No 2 31-60 .

Ray, N. (2015) Jean LaPlanche's masochism Psychoanalytic Revue. Vol. 102, No 5 719-753.

Rogers, A. (2015) The analytic act and the child's desire. Psychoanalytic Revue. Vol. 102 pp. 615-637.

Lauren A. Utter, PsyD & Liz B. Espinoza, LCSW *Early Intervention for Psychosis: A Participant's Recovery Journey*

Introductory

Early intervention programs for First Episode Psychosis (FEP) coordinated specialty care (CSC) have showed promising outcomes for young adults in recent years (Dixon et al., 2015; Srihari, et al., 2015). The authors will illustrate one young man's recovery journey in a CSC program for FEP in the Northeast. Overall improvements in the participant's mental health and quality of life as compared to before and after engagement with a FEP specialty care program, including but not limited to a reduction in psychiatric hospitalizations, symptom stabilization, sobriety, community re-integration, and improved family relationships will be elucidated. The authors will also explain how the use of shared decision making (Deegan and Drake, 2006) and a flexible, collaborative, and recovery-oriented treatment team approach fostered engagement and enabled treatment gains. Additionally, the authors will describe how the participant's utilization of evidenced-based, core components of the CSC model for FEP, including individual and group psychotherapy, supported employment and education services, family education and support, assertive case management, pharmacological intervention and coordination with primary care (Heinssen, Goldstein, & Azrin, 2014) facilitated his recovery. Examples of how the CSC model was tailored to the participant and family's needs, preferences, and goals will be provided, particularly as they relate to community-based interventions, supported employment, benefit counseling, and flexible engagement with a prescriber. Practical assistance provided to the participant and his family during periods of turmoil or instability and 24/7 on call coverage are also components that will be discussed. Lastly, common challenges in the implementation of CSC will be explored, with suggestions for how FEP treatment teams can overcome some of these obstacles.

At the conclusion of this activity, participants should be able to:

1. Identify at least three core components of coordinated specialty care for First Episode Psychosis (FEP) programs.
2. Describe at least two ways in which FEP programs differ in their engagement and treatment of participants as compared to "treatment as usual."
3. Identify at least two ways that the FEP program utilized a recovery-oriented, shared decision making approach with the participant described.

Deegan P.E., & Drake R.E. (2006). Shared decision making and medication management in the recovery process. Psychiatric Services, 57, 1636-1639.

Dixon, L.B., Goldman, H.H., Bennett, M.E., Wang, Y., McNamara, K.A., Mendon, S.J., Goldstein, A.B., Choi, C.J., Lee, R.J., Lieberman, J.A., Essock, S.M. (2015). Implementing Coordinated Specialty Care for Early Psychosis: The RAISE Connection Program. Psychiatric Services, 66(7), 691-698.

Heinssen, R.K., Goldstein, A.B., & Azrin, S.T. (2014). Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care. Retrieved from http://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf

Srihari, V.H., Tek, C., Kucukgoncu, S., Phutane, V.H., Breitborde, N.J., Pollard, J., Ozkan, B., Saksa, J., Walsh, B.C., & Woods, S.W. (2015). First-Episode Services for Psychotic Disorders in the U.S. Public Sector: A Pragmatic Randomized Controlled Trial. Psychiatric Services, 66(7), 705-712.

Ruvanee P. Vilhauer, PhD *Spontaneous Reports of Voice Hearing in the General Population: An Analysis Using a Novel Method*
Intermediate
Background: Studies of hallucinatory experiences in the general population have usually been conducted via surveys. One problem with survey studies is that demand characteristics could bias results. Another problem is that the full range of hallucinatory experiences present in the population may not come to light in surveys which pose specific questions. We know that there is considerable diversity in hallucinatory experiences in the clinical population, but we still know relatively little about these experiences in the nonclinical population because the stigma associated with such experiences poses challenges for studying them. A novel way to study hallucinatory experiences that circumvents these problems is to study spontaneous online reports of such experiences.

Method: One thousand and sixty nine online posts about voice hearing experiences were systematically collected from a community website. First-person reports among these were analyzed using a content analysis approach. A highly reliable coding system was developed, using a multi-step process. Codes examined the characteristics of individuals who posted and the phenomenology of voice hearing experiences.

Results: Codes were applied to posts to categorize the features of voices heard, including frequency, number, identity, location, form, content, complexity, clarity, controllability and similarity to thoughts, as well as posters' responses to the voice hearing experiences, such as emotions described, concerns expressed, and coping methods used. Analyses are expected to be completed shortly and results will be presented. Preliminary analyses suggest that this large-sample study will support and extend the results of a recent mixed-methods study (Wood et al., 2015) of voice hearing phenomenology.

At the conclusion of this activity, participants should be able to:
1. Discuss the range of voice hearing experiences described in the spontaneous online reports studied.
2. Discuss the range of reported responses to voice hearing experiences.
3. Develop hypotheses that could be studied using the dataset if conference participants wish to collaborate on further analyses.

Johns, L.C., Kompus, K., Connell, M., Humpston, C., Lincoln, T.M., Longden, E., ... & Fernyhough, C. (2014). Auditory verbal hallucinations in persons with and without a need for care. Schizophrenia Bulletin 40(Suppl 4), S255-S264.

Vilhauer, R. P. (2014). Depictions of auditory verbal hallucinations in news media. International Journal of Social Psychiatry. 61(1), 58-63. doi:10.1177/0020764014535757.

Woods, A., Jones, N., Alderson-Day, B., Callard, F. & Fernyhough, C. (2015). Experiences of hearing voices: analysis of a novel phenomenological survey. The Lancet Psychiatry 2(4), 323-331.

Rachel (Rai) Waddingham: Honoree Address *Rethinking Taboo & Violent Voices*
Introductory
Whilst hearing voices is often a taboo in western cultures, linked with media stereotypes and images of 'madness', there are some kinds of voices that are even harder to talk about – 'taboo voices'.

Taboo Voices may include ones that speak of violent and/or sexual themes - things that a person, and those around them, find very distressing. They can be extremely graphic, sometimes overlapping with violent thoughts, impulses or disturbing visions. This talk draws from Rai's personal experience of hearing taboo and violent voices, as well as her work with young people and people in prison and the principles of the Hearing Voices Movement. It explores how we can view them as an opportunity for growth and understanding, rather than a risk to be silenced.

At the conclusion of this activity, participants should be able to:
1. Reflect on their own reactions to taboo and violent voice content.
2. Identify three ways that taboo and violent voices may be opportunities for personal growth.
3. Describe three ways of working with someone who experiences taboo and violent voices.

Corstens D, Longden E. The origins of voices: links between life history and voice hearing in a survey of 100 cases. Psychosis Psychol Soc Integr Appr. 2013; 5:270–285.

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the Hearing Voices Movement: Implications for research and practice. Schizophrenia Bulletin. 40 (Suppl 4), ppS285-S294.

Dillon J, Hornstein GA. Hearing voices peer support groups: a powerful alternative for people in distress. Psychosis Psychol Soc Integr Appr. 2013; 5:286–295.

Waddingham - Symptom or Experience, Does Language Matter? http://www.madinamerica.com/2013/08/does-language-matter/

David W. Wilson, MEd *Engaging and Building Successful Therapeutic Relationships With Psychotic Spectrum Community Corrections Clients*
Intermediate
All levels of the criminal justice system have become more aggressive in arrest, prosecution, and post-arrest supervision. Criminal laws have been transformed defining more behaviors as criminal or at higher levels of criminality than in the past along with enhancement of sanctions. As a result, more persons are swept into the system than in past decades, including many who do not seem as if they belong there. Among those are many persons who may suffer from severe mental illnesses.

The challenges that exist in any outpatient treatment of those with severe mental illness are compounded by involvement in the criminal justice system. The greatest challenges in this work are therapeutic engagement and constructing successful treatment relationships. Suspicions about the motivations and loyalties of the therapist can impede the establishment of a therapeutic relationship and interfere with maintaining a helpful working alliance. Multiple life crises, substance use, and limited personal resources may derail meaningful progress.

For therapists, our ideas and internal images about crime and criminality have the potential to obscure our understanding and interfere with our abilities and willingness to engage empathically, particularly when the patients also have additional diagnoses such as antisocial personality disorder and psychopathy. Ethical dilemmas may emerge for therapists from treatment mandates that are often imposed, such as, treatment as a condition of continuing release in the community, or formal expectations to release all information about the patient and the treatment to community corrections authorities. Conversely, perspectives that view these clients solely as victims of persecution can limit understanding.

In this seminar we will discuss the complexities of treatments in these difficult circumstances. Treatment techniques to assist in developing and maintaining beneficial treatment relationships and strategies to address ethical dilemmas that often emerge in this process will be presented.

At the conclusion of this activity, participants should be able to:
1. Identify and develop functional strategies to address personal ethical dilemmas that emerge in the therapy.
2. Identify and utilize techniques to engage and build beneficial therapeutic relationships.
3. Identify and utilize techniques that maintain beneficial therapeutic relationships when clients have additional related difficulties, such as substance use.

Sarteschi, Christine M. Mentally Ill Offenders Involved With the U.S. Criminal Justice System. SAGE Open Jul 2013, 3 (3) DOI: 10.1177/2158244013497029.

Skeem, Jennifer L.; Winter, Eliza; Kennealy, Patrick J.; Louden, Jennifer Eno; Tatar II, Joseph . Offenders with mental illness have criminogenic needs, too: Toward recidivism reduction. Law and Human Behavior, Vol

38(3), Jun 2014, 212-224

Wilson, David W. Subject, Subjectivity, and Substance: An Application of Ferenczi's Mutual Analysis in the Psychoanalytic Treatment of Substance Abusers. Ferenczi 2015. Toronto, Canada. May 8, 2015.

Pat Wright, MEd, Georgia Case, Joan Fiset, MA, Judy E. Murray, RN & Cindy Peterson-Dana, LMHC
The First ISPS-US Family Plenary Panel
Introductory
We want to acknowledge the nearly impossible task of learning how to support our "loved ones" while taking care of ourselves in the most "family-centered" way recognizing that we are truly pioneers in this vision. We all know that historically families--especially parents--have been blamed for behaviors thought to be outside the boundaries of what the society deemed "normal" dictated by the time and place people lived in. The field of epigenetics in particular has been proving how certain genes are expressed depending on the "triggers" in the environment. At last the paradigm is changing and it's time to explore new ways of communicating as a team where equal respect is shared among: providers, family members and our "loved ones". We are inviting the audience to expand their awareness through understanding the complexities (as well as loneliness and isolation) within family roles when someone experiences extreme states, realizing that each family (and member) is unique.

At the conclusion of this activity, participants should be able to:
1. Discuss the complex nature of a family atmosphere that requires members (child, parent, sibling) to assess the on-going struggle, and develop coping methods of communicating and supporting the person in "extreme states" as well as care for themselves.
2. Incorporate specific feedback from family members regarding what professional supports and services have helped and what responses and supports are lacking or even cause harm for families faced with a mental health crisis, specifically the experience of psychosis in a family member.
3. Develop person/family-centered strategies that include various relationship possibilities within the family as well as with the members individually that utilizes some of the practices mentioned by the panel participants.

Colver, Monique. An Uncommon Friendship. 2012. Colver Press.

Fiset, Joan. Namesake. 2015. Blue Begonia Press.

Williams, Paris. Rethinking Madness 2012. Sky's Edge Publishing.