Winter 2017
Volume #16,
Issue #1

iSPS-US

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

How I learned to use Non-Violent Communication with my voices

By Kevin Healey

People like to ask questions like: "What has been the most useful thing for you about living with your voices?"

We have built a culture that places great value on the notion that every difficult complex situation has one thing – a quick easy fix.

So there isn't one, but there are a few, and I'd say one of them is learning to use non-violent communication, especially with my voices – but it's quite useful with people too.

I learned about it from my voices – they bugged me to watch a video of Rufus May over and over. Then I did some research and found more videos – of Marshall Rosenberg, its creator – and watched and listened to many of those over and over too. Then we started learning together. We now have our own version – LVC, less violent communication.

I hear many voices; many come from different places and speak with different accents and dialects. Many, especially those from a particular period in my life, tend to speak in what I can best describe to a polite audience as colloquial, or vernacular. Quite violent.

A wee WIKI- what I know about NVC. Wee because it's not very much, but then we don't actually need to know very much to get started.

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President's Column

By Jessica Arenella

From October 28th to 30th, ISPS-US had one of its most successful conferences to date in Boston, "From Reductionism to Humanism: Moving Forward from Psychosis and Extreme States." It was great fun to see many of you again and also to meet new people.

The Family plenary panel featured ISPS-US members sharing their experiences with the current mental health system and their journeys toward finding psychosocial approaches when the treatment as usual was insufficient. They offered some suggestions about how ISPS-US members might better reach out to family members.

The Experts by Experience plenary featured courageous and creative narratives of by folks who have traversed the bumpy road of extreme and unusual experiences and emerged with wise observations about effective and non-effective ways of approaching these experiences.

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ISPS-US • PO BOX 491 • NARBERTH, PA 19072
(610) 308-4744 • CONTACT@ISPS-US.ORG
WWW.ISPS-US.ORG

Non-Violent Communication

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NVC was created by Marshall Rosenberg. As he explains it, we are all born as experts in NVC, but we are taught very quickly that to get on in our culture we must learn VC – violent communication, in which we make demands of others. The language we use is so often inherently violent, and this gets in the way of really communicating. NVC is the language of the heart, of needs and of connecting with fellow humans.

Key principles: When listening to another, we try to listen through the violence contained within the language to the need being expressed. When talking, we seek to add the least amount of violence that we can.

An example: Marshal Rosenberg is a great teacher, often using examples. My favorite is one he shares from the time when he was first starting, still working it out and practicing at home with his family. His son was at home with a friend and in a rush to leave, Marshal [dad] had something he wanted to say and started in his new, non-violent way, then…

"D-A-A-D! How come it takes you so long to say anything these days?!?"

"If you like, I can say it the old way: "Do as I say or you're grounded!"

"Ok dad, take your time."

Steps: Whether human or "voice," in violent communication we tend to conflate these, and short-cut straight to the last – often expressing it as a demand, or a "command." In using NVC, we seek, with intention, to make them clear and distinct. Facts about what is happening. How we feel. What we need – that lies behind how we feel. What request we might want to make of ourselves or others to help us meet our need.

So how does it work with "voices"? People will often ask – when they hear it suggested that they can change their relationship with the voices they hear, "Why should I? When they are horrible to me?" I say, I have no idea what you "should" do, it's your choice. I chose to start because it was me who wanted things to be different. I can't change what my voices do with me. I can only change what I do with them.

So I started. Actually we started together, but I had to go first. For me, it was very much like one of Rosenberg's videos in which he uses two puppets – a giraffe and a jackal. I'd have a go at talking non-violently, and my voices would howl like a jackal. "H-o-o-w-w-l!!!"

"That's no f'ing giraffe speak!"

They can be tough coaches, but it's funny too.

With practice, we made progress. As I started to get more used to it, I found that it can work without all four parts being spoken, but that there are two parts that are almost always necessary: the need, and the request.

Sometimes, if it's a routine we've been in a lot, it can work with just one – so long as I frame it clearly: "I really need to focus on this right now. Can you talk amongst yourselves till later?"

It took a while, but as I got better, with practice and with them coaching me, they started to do it too – with me and with each other.

And sometimes it falls apart: "Enough with that non-violent bollocks!".

So why a giraffe and why a jackal? Giraffe represents language of the heart, since it is the land animal with the biggest heart. So a simple way to remember how to practice is listening through giraffe ears and talking in giraffe-speak. Jackal represents, well you know, not giraffe.

It often strikes me how often humans talk to each other in a way that is difficult to distinguish from what is sometimes called a "negative voice." As one of mine is now fond of saying: "What works wi' people can work with 'voices.' What works wi' 'voices' works wi' people."

So what is LVC? Think of it like harm reduction approach; less violent is a reminder it need not be perfect to be worth trying – NVC, but with a few swear words thrown in.

Inside this Issue

President's Column

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Videos of many of the presentations are available at a 50% discount for members and conference attendees. Until February 28, 2017, we have shared one free conference presentation on our new ISPS-US YouTube channel. We plan to launch future videos on the YouTube channel over the next year. From www.youtube.com, search for "ISPS US" to see what's there already.

Planning is well underway for our 16th annual meeting, to be held in Portland, Oregon from November 17-19, which will be co-sponsored by the EASA (Early Assessment and Support Alliance) Center for Excellence at Portland State University. Khaki Marino, Ph.D., is chairing the conference planning committee, and has announced the theme for the meeting: *Psychosis in Context: Exploring Intersections in Diverse Identities and Extreme States*. More details and a call for papers are forthcoming. Check www.isps-us.org for updates.

The theme of diversity fits in with the organization's recent efforts to address the issues and concerns of people with a variety of ethnic and racial backgrounds, gender identities, sexual orientations, mental and physical abilities, psychiatric diagnoses, economic means, and religions. We did not obtain the grant we applied for to help us with this project, but we are confident that we will be able to make substantial changes to make ISPS-US a more inclusive and safer space for all. If you would like to get involved, contact Julie Kipp (julie_kipp@me.com) or Karen Stern (contact@isps-us.org).

The annual retreat for strategic long-term planning for ISPS-US has been scheduled for June 3-4 in Washington, D.C. All are welcome, but must RSVP to Karen Stern (contact@isps-us.org). There is no cost to attend, but a small fee will be collected to cover the cost of meals. Members are responsible for their own transportation and lodging. We encourage people who are unable to attend to consider Skyping. Please let Karen know your Skype address and your time zone.

The classified section on the new ISPS-US website will be launched very shortly. It will be free for ISPS-US members to post ads for their services or to list job, research, or training opportunities. The ads will be open to the public, but only ISPS-US members can create ads.

Debategraph continues to draw large numbers of views. At last count there were more than 1250 views to the Moving Forward map. The Moving Forward map was created to develop innovative approaches to healing people in distress, without reference to the idea of mental illness. This means that there a many people out there, who are not necessarily ISPS-US members, who are interested in creating alternative models of care. This forum allows the generation of ideas to construct new models and systems that are helpful and client-centered.

The ISPS-US Dialogue Zone Facebook page has had a soft launch. This forum is designed to promote respectful listening and sharing with one another, particularly regarding the diversity of human experience and how we can successfully support those in distress. Contact me for more information (president@isps-us.org).

An ad hoc nominating committee has been formed to identify nominees for all elected offices (President, Vice-President, Secretary, and Treasurer). All current officers are eligible for re-election, should they decide to run. The candidates will be announced in late May. Please contact Karen Stern (contact@isps-us.org) if you are interested in running for an office.

Peace,

Jessica Arenella, PhD

Letter from the Editor

By Marie C. Hansen

Welcome to the Winter 2017 edition of the ISPS-US Newsletter! This newsletter is packed with information – from learning about Mind Stimulation Therapy (See Dr. Ahmed's article) to using Non-Violent Communication with voices (See Kevin Healy's article) to learning about the phenomenology of voice-hearing (See Gregory Shankland's second installment on MADsense).

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Letter from the Editor

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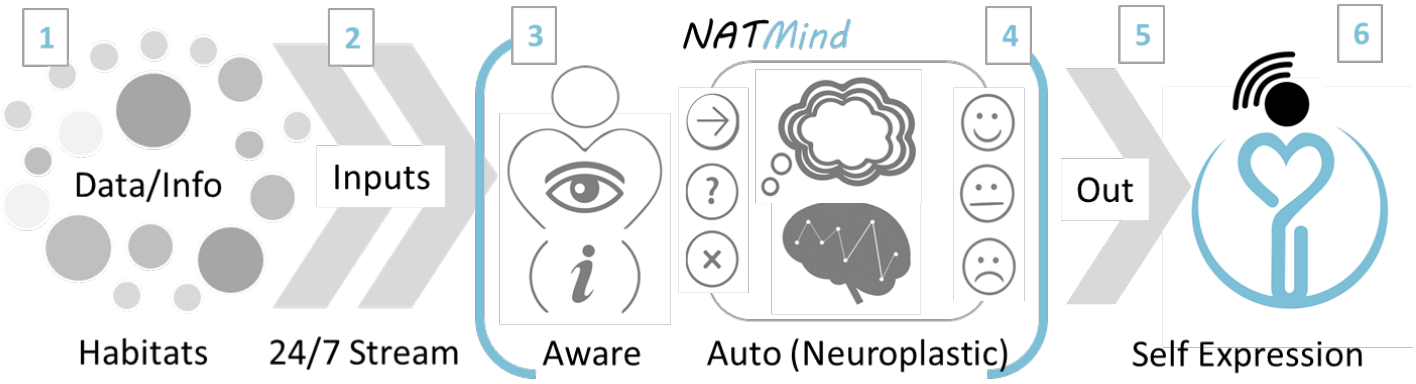
If you are interested in contributing to the next newsletter (to be published in Spring 2017), please email me: newsletter@isps-us.org. I am hoping to publish four newsletters per year, and highly encourage you to send in anything relevant to the psychological and social approaches to psychosis.

MADSense Article 2: Incredible Mind, MADBeliefs, MADExperience – the good, the bad and the ugly

Each of our Incredible Natural Minds is a product of the inputs we seek out, the habitats we live in and co-create. I use the word "natural" as the functional mind is best understood as both a product of evolution and our tool for shaping our evolution—no other species has the ability to shape and design the habitats we live in. We enjoy them in our aware minds, we make choices all the time, many of which we have automated as routine. Survival is a requirement to be in the game. Thriving is our driving force, we thrive together. Using principles of evolution theory we can decipher the functional mind processes we share—I call this NATMind.

It seems self evident that we spend most of our time in thrive mode—the pursuit of happiness. When we devote significant time to efforts we may not enjoy at the time, it is mostly an investment in our future. We tolerate a proportion of unhappiness, we may even acclimatize to it—the net balance must be happy, else we will make changes. Of course there are some who live in survival mode, given their circumstances; that is an unfortunate comment on society, not the mind itself.

The diagram below is a simple description of our Incredible Natural Minds, interpreting and co-creating our world, as a benchmark for discussing the "hearing voices/intrusive phenomena" experience, which plays out in the MIND.



[1], [2] Our minds are switched on 24/7—we have a constant flow of data/information streaming from our environment. The habitats we choose and the roles we play in each context shape what we take in.

[3] Our perception is a synthesis of data/information from our environment and from our minds—memory, as well as our hopes, dreams, and expectations. How we feel about the situation/context affects the data/information we seek out. Frame of mind—mood, attitude, feelings literally change the data/information set we select and focus on = perceive. Interactions with others co-create joined perceptions. We change our perception by changing frames of reference and the data we select.

[4] Our thoughts are a flow of information back and forth, comparing perception to an expected/desired outcome. We accept, interrogate, reject data/information in a process of ensuring that we derive the best value for me/us. We adjust and refine perception/outcome until the balance is a happy one, a smiley face or at least a neutral invest/do the right thing situation. This to and fro is shaped by our emotions, and wires our brain (neuroplasticity) and leads us (predictably) to a happy place from which to enjoy, speak, act, and share. Volume flow, frequency, significance, and emotion are key neuroplastic factors.

[5] Expressing ourselves is a social thrive process. We choose/adopt/learn guidelines around which we are happy to think, speak, act, and share based on principles of success: do the right thing, do it well.

[6] We express our best selves when we are secure in mind and body, the heart feels good, and the mind is free to roam. Happiness is when ***we*** enjoy freedom of mind in a stable state of Body | Mind | World equilibrium (B|M|W). ***I*** thrive when ***we*** thrive together. This also shapes our expectations of our habitats.

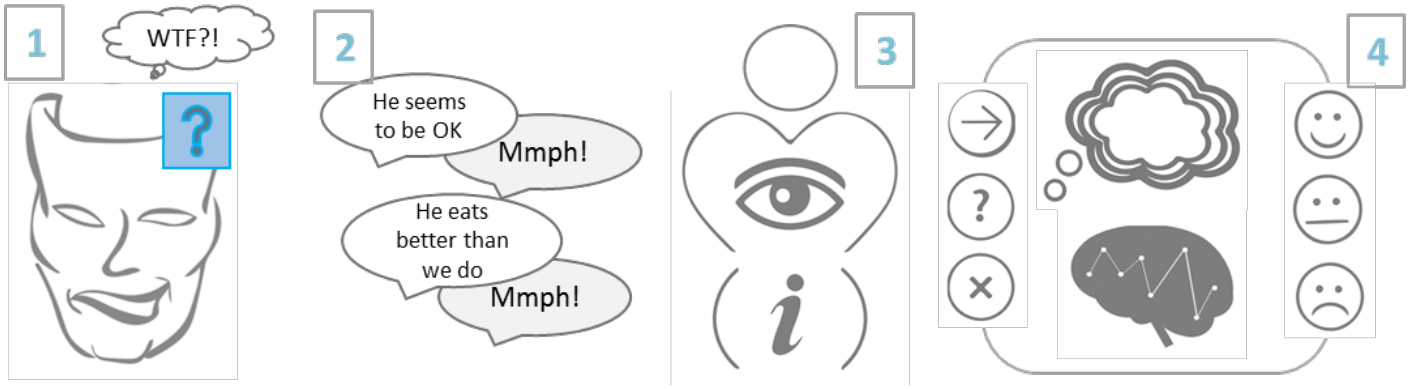
So, the **good news** is that our Incredible Natural Mind works to reliably and predictably engineer (ensure and assure) our happiness, simply by tracking the emotions in our aware mind to "program/update" the relevant factors into our routines to automate as much of it as makes sense. When the balance is off, the auto mind will send signals to our aware mind Happiness Quality Assurance (**HQA**) system indicating a need to explore the programmed routine for opportunity. This may be at the detail level—say nutrition, or the big pic level, who we want to be (inner voice/critique to some). We explore inwardly to choose how to express ourselves outwardly—from the inside outwards.

Inputs/feedback/appreciation (we distinguish at the accept/reject gates) come from the contexts and people interactions around us—an outside in perspective. Most often we choose contexts, some/sometimes we cannot. If our total HQA system predicts that less-than-desirable inputs are a constant feature of the environment, we learn to accept them, and we suppress alert signals, convincing ourselves we are happy given the circumstance. Still good news.

The **bad news**—we risk accepting circumstances when we can act to improve them, individually and collectively. When we accept limitations of circumstance and environment individually, we compromise our happiness and/or B|M|W optimum equilibrium as evidenced in the high incidence of "stress illnesses" that we accept as "normal," or the limiting beliefs that we may learn. When we do so en masse, we compromise the evolution of our species, as evidenced in several studies showing how enduring social trauma passes from one generation to the next[{1}].

Now, **the ugly.** Heard voices and other intrusive phenomena are best understood as **anomalous inputs** that destabilize B|M|W equilibrium**.** "Anomalous Perception" asserts/assumes that the problem is in synthesis of the perception. In fact, our perception synthesis process works well. Our Auto natural mind rates unusual inputs as significant, and presents them to the aware mind for analysis. Their intrusive nature IS significant to the hearer, and we accept the input as valid because we cannot choose it/avoid it as we ordinarily would. (Fortunately, we can retrain our seldom-used reject meme to interrupt and discard these inputs—the subject of further articles).

A series of diagrams help explain, using the beginning of my own experience of "hearing voices" (other intrusive phenomena came later). This will be familiar to many other voice hearers.



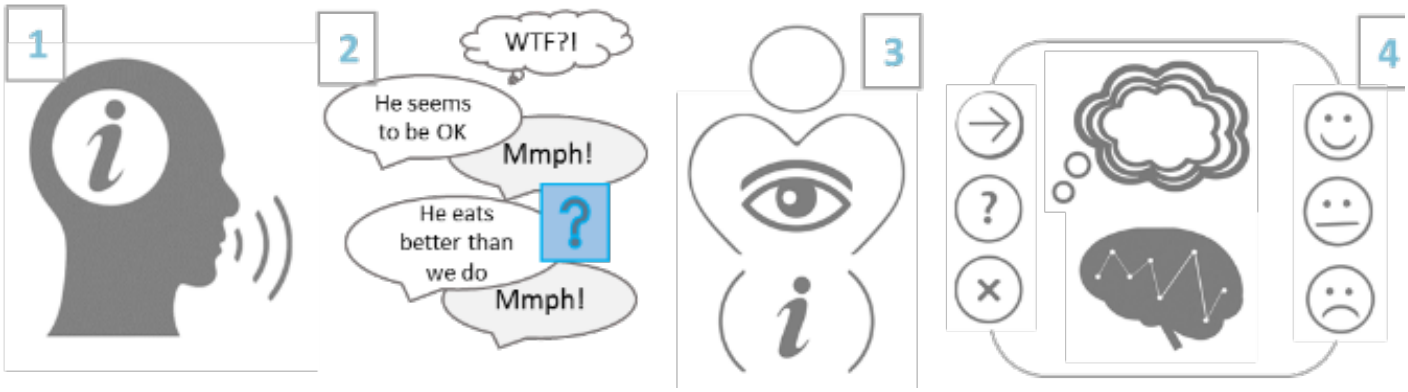
Note the shift in focus of the mind, from chosen real-world inputs to an "unreal," imposed *experience* in the mind, explained as the natural result of false, weird, and downright malign inputs. Our minds work just fine—it is the inputs that create confusion.

[2] Alone in my apartment in a small building in Hell's Kitchen, New York one evening, I heard a female voice say "He seems to be OK," followed by a male voice grunting disinterestedly.

[1] The unexpected input prompts (Auto) the obvious (Aware) WTF? question, "Who is this?" (**Focus**), denoted by the mask.

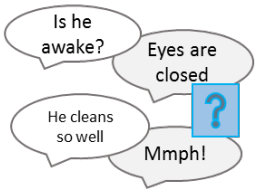
[4] My natural understand process *automatically* prompts a trace of origin with questions. "Who?" = blank. "Where?" A = the only accessible spot that could see into my apartment = the fire escape outside across the windows. "Who has access?" A = the only other people with access to the fire escape = upstairs neighbors. "Any verifying data?" = a couple speaking, a couple upstairs—I have confirming data.

[3] Neighbors are confirmed as the source. The info/logic is a building block firmly in place to work with. "It's the neighbors" is the working truth in my perception.



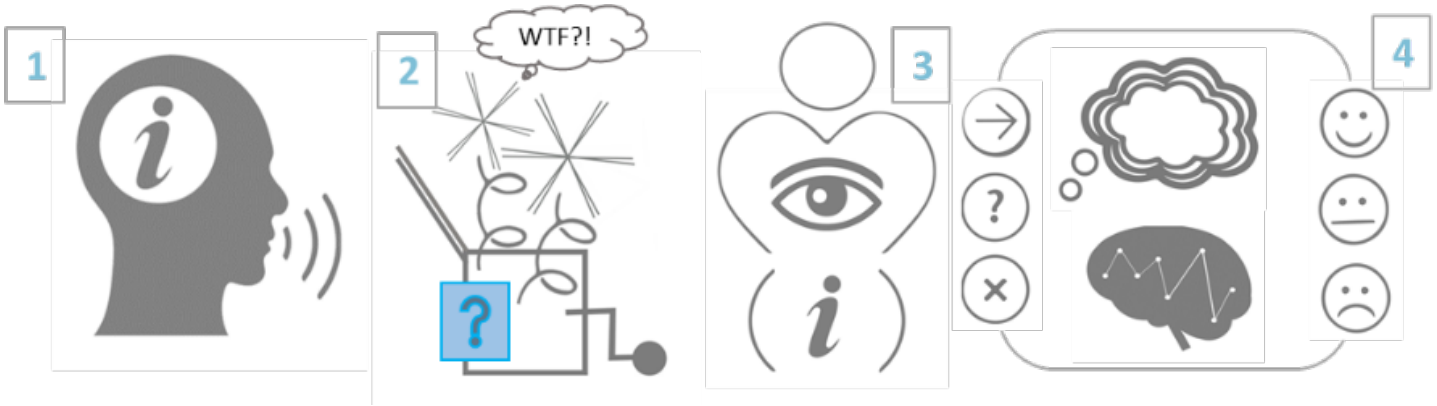
My paradigm now looks like the pic above. I have a reasonable answer to "Who?" = neighbors, which replaces the mask with an identity [1]. My data set for [1] still "makes no sense," i.e., a gap in expected data auto prompts the question "Why?" and I look to the voice content, the only immediately available evidence. Focus is [2].

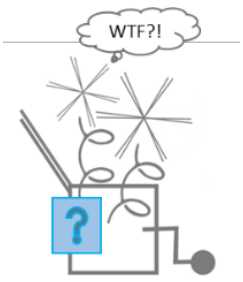
[2] I interrogate the context/sequence, and a quick to and fro confirms the content/context to be reasonable. I remember [4] that I had hurt myself in the bathroom a couple of hours earlier and made loud, painful noises for a couple of minutes. People care, [3] (a prevalent cognitive bias), neighbors might check in on me, and [2] checks out, confirming [1] as reasonable. One or two more seemingly mundane comments (e.g. "he eats better than we do") reinforce the "Who?" = neighbor idea, and I replace the mask and question mark with "confirmed" info in my data set. Later, I ran upstairs and knocked on the neighbor's door to let them know I am OK but there is no response. I remove the question mark from [2]. My need to understand meme is satisfied.



Except that the voices continue the next day with comments about my health, my work, how well I clean… my focus is now on the content of [2], and within a day or two, my neighbors have gone from caring, to nosy, to ridiculous, to spying on me, to harassing me in my home—the place we seek security, comfort, and relaxation. Their intent (something we naturally associate with people, and part of my natural data set) is now malign, without a doubt. Their methods are likely to be suspect and devious. My frame of reference is now the intent of my neighbors.

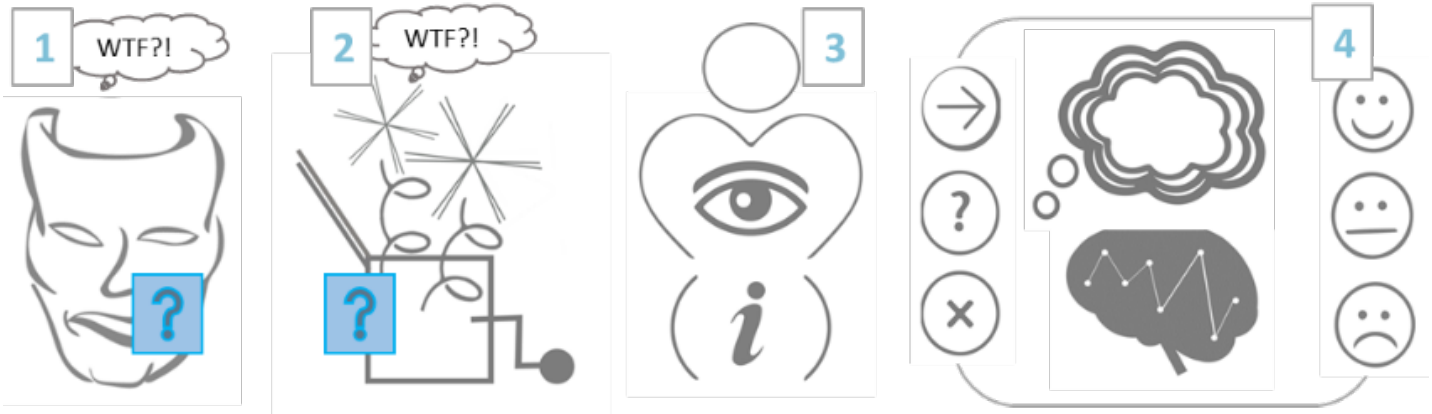
My paradigm now looks like this. I hear the voices only at home, where I now feel insecure, and my frame of mind [3] is hyper vigilant. My focus [2] is now a jack-in-the-box full of surprises and questions—How are they doing this? WTF?





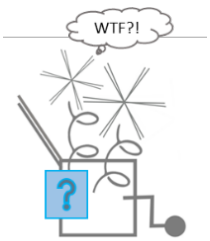
The jack-in-the-box [2] is now the enemy. I take extra precautions to manage the risks. When voices commented on which websites I was visiting, I was convinced my PC had been hacked. With my suspicions focused on electronic means, I needed evidence to confront them and I look for it. My neighbors could enter my apartment from the fire escape (just geography) —though they would just deny it, right? Some ridiculous activity ensued (not funny, though the story is). One evening I realized that if they could see my PC screen, I could write them a note. I opened notepad and wrote in firm language two paragraphs summarized simply as: "to whomever, not cool, show respect, get lost." My voices went quiet. Until morning—when they were back with a vengeance; at least six

voices pounced, yelling and issuing commands, and continued non stop. And I mean non stop! How would you explain that response?



My paradigm is now headlined "all bets are off!" [1] and [2] are questions with no answers to who, why, or how? In my case, this is only week two. The voices are now relentless in their attack. It is overwhelming my mind and I cannot think straight.

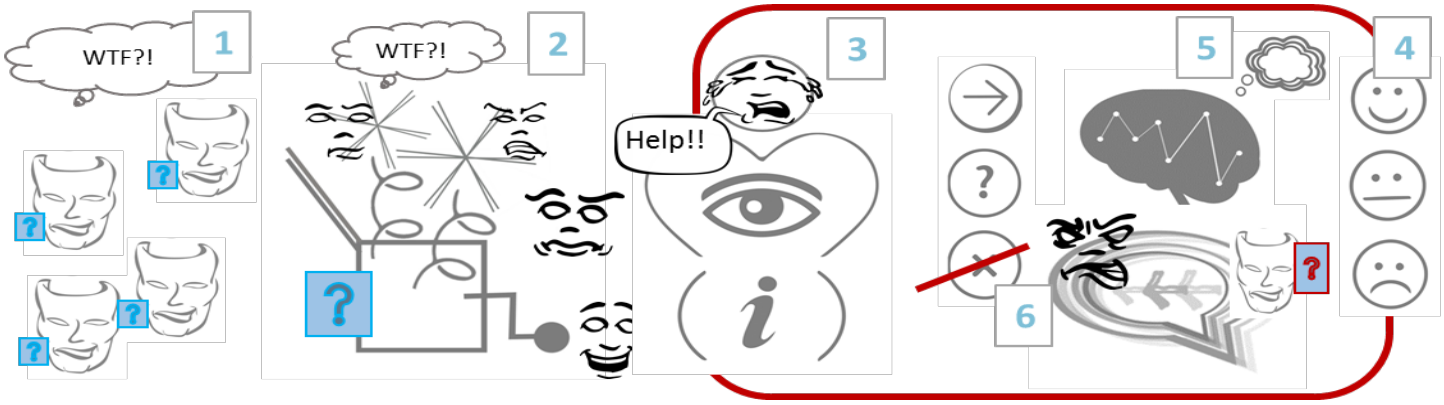
I ask a friend to come over, as well as my landlady. Trying to help, they challenge my conclusions, but don't have the accumulation of evidence that I do in my mind, which I cannot reproduce for them. I decide to move out. Relationships change from the day you have these conversations! (Although I am fortunate to have strong relationships that are not damaged).



This beast rapidly gets worse, bringing more special effects and drama to the party. The reach of voices slowly extends beyond my apartment, until within a few days, voices are following me everywhere, interjecting, interfering, claiming to be involved and have influence on everything in my life. All content is commanding, threatening. We're following you, tracking you, we can see everything. They work hard at making more noise (distraction), yelling louder, more threateningly at key moments (creating confusion) in an attempt to deceive you about what they can/cannot do. In the meantime, I have reformatted my hard drive, taken out memory cards, scanned the apartment for cameras, and arrived at a friend's in a panic.

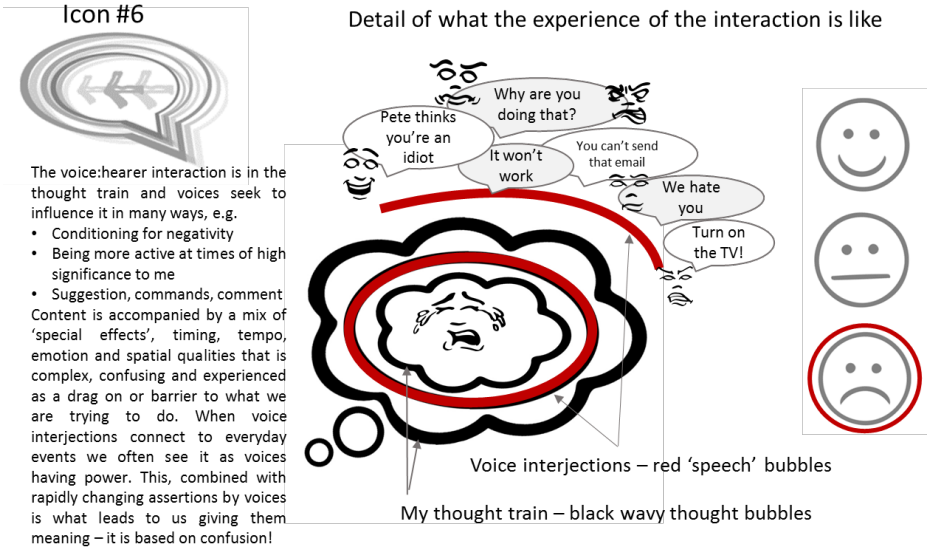
I move out (about week four). The voices very soon start in the new apartment, and I go and see my doctor (week 5 or 6). "Auditory hallucinations" he says, and prescribes anti-psychotics for a week. I had never heard of such a thing. This simple label turned out to be useful—I did not feel mentally ill, my acute and aware mind has always been a strength, so I dismissed the voices as irrelevant. They declared war and their determination to take over my mind.

Somewhere in those confusing two or three weeks, we had moved from one-way commentary/tell mode to two-way "communication." In one sense it was empowering; I could fight back and I did, dismissing everything the voices claimed as nonsense. In another, it was (still is) the most intrusive experience imaginable. These "voices" arrived, barged in, asserted power, violently imposed themselves on me in the most disrespectful and malign way—they are creatively evil. They have made themselves at home in my aware mind, uninvited. A constant presence. They have asserted an abusive relationship over me, policing, disrupting, redirecting every thought, overwhelming my usual day-to-day inputs. This goes on for years…it is the most vile, intrusive, intimate abusive relationship that is simply imposed on you—and you cannot walk away. It is torture. My paradigm now looks like this:



Inputs [2] and "unusual beliefs" [1] derived from them are an output of my understand meme, generating hypotheses, testing the logic, discarding and starting anew. With interference from voices at full throttle, this generates ideas and emotions that the voices use to manipulate and terrify me. Frame of mind [3] is a terrifying roller coaster, and my focus, the data I select, are all over the place. I CANNOT ignore the voices, I am forced to accept the inputs, and my mind is occupied trying to make sense of it all [4] and very busy. I am either concentrating on voices or trying to make these inputs fit into my usual day. Neither provides answers. Inadvertently (the deceit), I am connecting the voice experience to my life, wiring the voice bullshit and emotions into my brain.

I am being wired for fear—which limits everything I do or even think about. My usual thought train [5] has been pushed aside. The overwhelming majority of my inputs now come from [2] embellished by [1]. Instead of my thoughts flowing logically, I now have [6], with voices as personalities replete with malign intent, contexts full of uncertainty, and another world with unknown rules interjecting at every thought. I read a statistic recently that said the average person has about 50,000 thoughts a day. This experience increases that number dramatically, with opposing interference at every step. Imagine living with over 100,000 negative comments targeted at undermining your mind, at the level of every thought, every day, to get an idea of what a severe case or episode is like. The diagram below adds a layer of detail of the voice:hearer interaction.



[6]: My voices have worked hardest at undermining me whilst I have been working at making progress, especially this work, which is important to me.

That is how they seek to make themselves relevant—by interfering when my activity is important to me.

The interference is at the level of THOUGHT—voices are disrupting the process by which I process inputs into something useful to me.

To sustain relevance, there are themes they push, deceitfully, usually alternating between encouraging and discouraging me—building sensitivities to the themes around which they are most active.

First episodes such as the one above are instructive. The delusion that my neighbors were spying on me was very logically derived. Information was presented out of context. My mind filled in the blanks and reached a logical if unacceptable (therefore distressing) conclusion, which was reinforced as I gathered more data. Without knowledge of the hearing voices phenomenon, what opportunities were there to satisfactorily change my perception that my neighbors were behaving badly? Would you confront your neighbors? Would you believe their response?

It should be clear that the mind has responded to inputs exactly as you would expect. The associated belief was logically derived from the context. Distress arose from discomfort with this belief—and led to unusual behavior. This has nothing to do with stress. Nothing to do with childhood. It's about how we respond to unusual information and the thoughts it provokes. As the experience progresses, distress becomes more severe, unusual explanations multiply and become more complicated, leading to beliefs that are limiting—and influence behavior in predictable ways.

Breakthrough comes when we see that the flow from unusual input (phenomenology) to unusual explanations to behavior is logical and distressing. Unusual inputs provoke unusual thoughts; we can learn to take control of this natural flow and redirect our thinking in more pragmatic and positive ways.

MADSense

Greg Shankland is a voice hearer and business strategist. He is the founder of MADSense, bringing unique insights to the understanding of intrusive phenomena for those who experience unusual states, family/friends, and the professionals who support them, including researchers and academics.

Services include MADConsulting, research, seminars, talks and training workshops.

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Member Briefs

Robin S. Brown, PhD has opened a new practice location in the Wall Street area in association with the Psychotherapy and Spirituality Institute. He is actively seeking referrals to expand his practice at this time. www.robinbrownphd.com

Michael Eigen, PhD recently spoke at William Alanson White on themes from the online unfinished Bion movie, a tribute in memory of James Grotstein. The material presented is in a chapter from Image, Sense, Infinities, and Everyday Life. Mike has two papers coming out: (1) "The Psychopathy of Everyday Life" in The Psychoanalytic Review; (2) "Image, Fullness and Void" in Psychoanalytic Inquiry. His most recent book is Under the Totem: In Search of a Path. A book event is being planned at NPAP. Here is a link to Mike's talk at the recent NPAP graduation.

Leah Rokeach, LCSW has been co-facilitating a bi-monthly Hearing Voices Group for Jewish Orthodox men in the Boro Park section of Brooklyn for past two years. It is an open group and the co-facilitator is a voice hearer. The group meets on Mondays from 4 pm to 5:30 pm. Although there is still some fear of stigma to participate in this group, more people have shown an interest to attend. In mid February, Leah will start a new Hearing Voices style group for Jewish Orthodox women, which will include not only voice hearers, but also women experiencing overwhelming fears, dissociation, and seeing visions. It will meet bimonthly, on alternate Mondays. The co-facilitator of this group will be a young woman who is an expert by experience.

Member Spotlight: Mohiuddin Ahmed, PhD

Report on an 81-year-old ISPS member's recent (past 10 years) and current publications, activities, goals for the future, and more!

I joined the ISPS in 2011 at the recommendation of Ron Abramson, M.D., ISPS member, whom I met at the 23rd Cape Cod Symposium on Addictive Disorders (CCSAD). I was presenting with Charles Boisvert my work experience on the use of Mind Stimulation Therapy (former acronym, Multimodal Integrative Cognitive Stimulation Therapy-MICST) with dual-diagnosed substance abuse clients in two community residence programs. See my work experience and publications in my website: Psychology Mental Health Resource Links.

Charles Boisvert has been a long-time collaborator of mine. He was a former Student Extern Supervisee of mine for 6 years at a Community Mental Health Center in Rhode Island, when he was a student in Clinical Psychology Doctoral Program at University of Rhode Island. For 25+ years I have worked collaboratively with him in refining and further developing Mind Stimulation Therapy model, a model that I pioneered in the context of 40+ years of clinical work experience with varied clinical populations across life spans, and we have had several publications relating to the MST mode. Ron approached me after our CCSAD presentation, expressive positive comments, and he invited me to attend the monthly Boston-area ISPS-US branch meetings at the residence of Harold J. Bursztajn. Harold has been graciously hosting and co-chairing with Ron these meetings. I subsequently started attending these meetings, which I found to be highly stimulating, conducted in a very supportive framework. I subsequently did a presentation on Mind Stimulation Therapy to one of the meetings of the Boston-area ISPS-US branch, which was positively received by the members.

Soon thereafter, we signed a contract with Routledge to write our book, *Mind Stimulation Therapy: Cognitive Intervention for Persons with Schizophrenia*. I invited Ron whether he would be willing to write a foreword, which he graciously accepted. Harold, and another psychiatrist colleague of mine, David Osser (well known for algorithm medication management for schizophrenia and depression), who was my professional colleague at an inpatient facility in Massachusetts, and with whom I had participated in a longitudinal clozapine follow-up study on discharged hospital patients to the

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Community, agreed to write reviews that were included in the book jacket – attesting to a strong cross-discipline support and advocacy for the MST model. Subsequently, I presented to the Boston-area ISPS-US branch two papers written by one of my Community Support Program before his "accidental death." The NE-ISPS members present were impressed by his eloquent writings and insightful commentaries, and his narration of his personal struggles with the experience of hearing voices and in dealing with developmental "atypical experiences" in life, and I was encouraged to pursue publication of his writings by contacting his parents and getting their formal consent. Subsequently, I contacted the parents, who happen to come from the same part of the Indian Subcontinent where I was born, and where my family lived before Partition of India. I was able to get authorization from parents (it did require some supportive work, which I will not elaborate here) to submit his two articles to professional mental health journals. I then submitted the article dealing with his onset of experience of hearing voices to one journal that I thought would be most appropriate (I am not choosing to name it), and it was rejected.

I subsequently corresponded with Will Carpenter, Editor of *Schizophrenia*, about appropriateness for submission to his journal under the First Person Account, and he strongly urged me to follow through, and the article was accepted for publication in that reputed journal. (I was given a special consideration to write an extensive footnote, illustrating my use of the Mind Stimulation Therapy model with this client, which is not customary). The article is titled "The Vacuum of the Mind: A Self-Report on the Phenomenology of Autistic, Obsessive-Compulsive, and Depressive Comorbidity, *Schizophrenia Bulletin*, 41 (6): 1207-1210, 2014. Subsequently, a second article that I submitted on his behalf, was also published posthumously, also with a commentary note of mine, entitled: *Under-Stimulation Cerebellum in Asperger's Syndrome*.

This piece of JDP's writings, along with his previous article published, highlight how rationality and irrationality, the typical and normative, and "atypical thoughts," high level of intelligence and insights, and "social deficits," "creativity," and "obsessive adaptive thinking" all can co-exist to some degree in all of us in a compartmentalized fashion in our individual unique functioning, without inducing cognitive dissonance. But when such functioning is associated with any perceived presentation of "risk to self" and or to others, it may become problematic for the person, person's family, and the involved "significant others," as well as the community and society at large, which often triggers the need for special services and or attention.

JDP's productive engagement in writings, in some ways, I believe were promoted by the use of computer-facilitated therapy. This is a technique I pioneered and used in therapy sessions with various clients in my clinical work, and many of such scenarios are presented in our Mind Stimulation Therapy book. JDP had a tendency to "clam up" in the traditional conversation mode therapy or counseling that he had been typically involved in before; as such his inner thoughts and struggles were not as well verbalized or articulated in therapy or counseling or mediation consultation sessions as he did in our sessions.

In the course of being an active reader and contributor to the ISPS listserv postings by various members, I learned a lot from reading the various opinions expressed by ISPS members on diverse mental health topics, and from the various references to many useful links to articles and opinion blogs that were presented.

More importantly, this engagement increased greatly my appreciation of many members sharing of personal "lived and unusual (psychosis-type) experiences," and of many expressing strong advocacies against medical model and treatment interventions for "mental illness," specifically labelling "atypical experiences" as psychosis or schizophrenia. The interchange of opinions, as well as the opportunity for me to share my views and ideas, greatly stimulated and broadened my thinking in a variety of ways.

In one of the ISPS listserv discussion topics, I came across an Opinion piece written by Bill George and Aadt Klijn in the *Lancet Psychiatry*, suggesting psychosis susceptibility as an alternative name for schizophrenia that caught my attention. I was motivated to write a draft response to which I invited a number of other NE ISPS members to collaborate with me – Harold Bursztajn, Ron Abramson, and Seven Nisenbaum. (I have known Steve from my work in Massachusetts Department of Mental Health system, who had previously shown an interest in my work on computer-fascinated collaborative dialogue with mental health clients, including potential for its use in couple mediation conflict resolution situations).

Our collaborative response to Bill and Aadt's Opinion piece, highlighting the idea of "Atypical Thinking Psychosis" as an alternative name for schizophrenia, was published in the September 2014 issue of *The Lancet Psychiatry*. Bill George subsequently posted a request for the ISPS members to give opinions on the Listserv.

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In that Opinion piece response published, we presented a diagrammatic description of how Atypical Thinking shares creativity dimension, and presented some specific criteria associated with Atypical Thinking that trigger social concerns and need for mental health services.

Around the same time period, a close relative and a friend of mine, who after his retirement from a very successfully career as an engineering professional career, became severely depressed with "psychotic features" (e.g., expressing delusional thoughts, and hallucinations, along with suicidal ideation). In addition, he was showing some Parkinsonian-like tremors. His clinical status remained essentially unchanged in spite of aggressive medication treatment and several short psychiatric hospitalizations.

Following some investigations and consultations, I took an active role in promoting the idea of Electro-Convulsive Treatment (ECT) as an option worth trying for him, fearing from my own clinical experience that he may get stabilized at a compromised level of functioning, even if he responds to standard clinical treatment that is being provided. I was affected by a dramatic change in functioning in a man who led a very lively and active life (e.g., tennis all his adult life prior to this episode), who had no history of prior episode of mental illness or involvement in any treatment. I was greatly disturbed when I visited him in a geriatric inpatient setting; he was functioning at the lower end of functioning compared to other residents in this geriatric psychiatric unit.

Finally, without going into details of circumstances leading to it, he received a series of ECT in that inpatient facility, and later on continued to receive follow-up ECTs an outpatient basis, and his functioning began to improve dramatically over a one-year period. Soon thereafter, he decided to go against all medical advice to be completely without any psychiatric treatment, or be involved in any counseling, or follow-up psychiatric intervention. He soon resumed driving, his tremors cleared up completely (which was possibly related to side effects of one of anti-psychotic medications, rather than having any neurological basis, as diagnosed), resumed playing tennis, and joining in our monthly outings at the same Mexican restaurant.

At my suggestion, Ron Abramson invited him and his wife to present his recovery case, and I suggested that the focus of discussion should focus on his present life situations, in terms of what happened to him when he was experiencing the depressive episode, and how he came out of it, and his current status of recovery, not on any exploration of his past or any speculation of causative factors that may have contributed to his "episode." Knowing him well, I felt that such explorations may not be relevant to his wellbeing, as he may not be positively amenable to such probing of his past. This is also very typical of many Asian cultures, where adversities in life experience are common in many people's lives, and many of them are in the habit of compartmentalizing such experiences and leaving them behind, so to speak, for what they perceived as their current "survival" or "adaptation needs."

In other words, "unresolved feeling about perceived traumatic events" by cultural expectations and standards in some societies may not be encouraged to be actively explored, as many are used to accepting them as "fate of life events" from one's past, and the demands and expectations of the survival needs for the present occupy their minds. Only recently, I came to know from another relative of mine, an elderly person, who is a very successful professional in this country and a very caring family man, that he was sexually abused and "raped" as a boy by several adults, which he never divulged with anybody growing up through adulthood, until recently.

I am mentioning these two cases from cultural perspectives to highlight the view that not everyone who experienced childhood adversities develops "mental illness symptoms," or exploration of childhood "memories" is essential to the "recovery process." There are also many cases of very successful people in this country with experience of childhood traumas, including many survivors of holocaust. The Opinion piece, written in collaboration with Charles Boisvert in *American Psychologist* in 2006, titled *Using Positive Psychology with Special Mental Health Populations*, highlights this perspective.

I am in no way diminishing the importance of recognizing that many people do get affected from "adverse events" in their childhood, and many need mental health services to help them cope with or compensate for any "difficulties in life" that they may endure, and the importance of the need for actively preventing such episodes for other vulnerable members of our society, especially children. But it is also important to understand the varied nature of human resiliency and recognize that different people in different cultures deal with such events from their own past, and how they interpret the time flow arrow dimension in their lives, whereby from an existential perspective, past can never be recovered, it is the present momentary existence that we all have to deal with, thus highlighting

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the diversity of approaches for adaptations, with no value judgments implied. One theory does not fit all, given the human diversity.

Following my relative's case presentation at NE ISPS, who received ECT, and then chose not to follow any involvement in follow-up treatment upon recovery against medical advice, I started to write a collaborative article involving my relative's spouse (at his suggestion) and a couple of physicians who knew his case or provided some consultative support, and asked Harold Bursztajn to participate by reviewing and commenting on the initial draft. Harold helped me summarize the draft piece of the article, and many useful comments and suggestions for revision, and the article was published in the *Journal of Clinical Geriatrics and Gerontology* in 2014 titled, "Maintenance of recovery from severe psychotic depression following successful electroconvulsive therapy in an elderly patient with "natural support,"

I had another collaboratively written Opinion piece with Harold Bursztajn and Ron Abramson published in January of 2016, titled *Back to The Future*, in *Psychiatric Services*, the idea of which was developed in several exchanges we had following our various ISPS meetings. Please see also a Google+ video commentary giving more detailed to our thinking behind our writing piece. This article highlights the importance of focusing on understanding and managing the emotional status that is often associated with triggering "problematical atypical behavior symptoms" in clients with varied clinical diagnoses who may be exhibiting long-term and persistent psychological and behavior problems that appear not to be respond positively to "treatments" or "interventions" that are provided. The article questions the current traditional approach across disciplines in targeting long-standing and persistent "atypical behavior symptoms" as the primary focus for the "Individual Treatment Plans."

Prior to publication of this article, some years ago, I also published another collaborative article with three practicing psychiatrists, David Osser, Masood Islam, and Lawrence Albert, and with my long-term former collaborator in writings, Charles Boisvert, in the *Annals of Pharmacotherapy* in 2006, titled "*Rationale for Emphasis on Management Over Treatment of Schizophrenia in Clinical Practice*," which also expresses somewhat of a similar point of view.

It is worthwhile to make a comment here on the brief background to these articles and development of my thoughts on these issues. My years of work experience in a state psychiatric hospital and CMHCs in Rhode Island, and early years of working in a developmental disability inpatient facility, coupled with my training in learning theory approaches, stimulated my appreciation for both operant conditioning, which highlights behavior change by awareness of consequences, and classical conditioning, which highlights the importance of associative learned emotions, social and environmental cues in the production and maintenance of our behaviors, including "atypical behavior symptoms."

These concepts became more relevant through my work experience with people with persistent and long-term behavior issues who appear not to respond positively to any ongoing "treatment interventions" targeting their so-called "atypical behavior symptoms" in their "treatment plan" interventions. In my various multi-disciplinary work settings, I learned a great deal from the opportunity for collaborative dialogue and the importance of collaborative work with various other disciplines, social workers, psychiatrists, nurses, mental health workers, direct care personnel, clients, and family members. But the most important of all, for me, I believe, was my learning experience from years of supervising many Ph.D.- and Master's-level psychologists and mental health counseling students in their various internship and externship placements, which provided me with the incentive for undertaking research and evaluative studies, integrating clinical practice, and in the formulation of clinical models and in the completion of many of my publication efforts.

My latest publication is in the **December 2016** issue of *Adolescent Psychiatry*, entitled "Computer-facilitated Therapeutic Dialogue with Adolescents with Behavior Disorders." This article is based on my years of work using computer collaborative dialogue technique, and it was cited extensively in our collaboratively published book, *Mind Stimulation Therapy: Cognitive Intervention for Persons with Schizophrenia*, Routledge, 2013. See other articles on computer-facilitated therapy on my website: http://psychologymentalhealth.com/

This particular article highlights the use of MS Word Text Box format to engage in collaborative dialogues with clients in identifying personal goals, current functioning, perceived barriers to goals, and collaborative exploration by client and therapist of various potential steps to reach one's stated goals. The format described here can be used by medication prescribers as well as by other mental health professionals, and it has also potential for application in non-clinical situations involving conflict resolutions or mediation of conflicts or in supervisor-supervisee interactions or group problem solving scenarios.

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The technique of using visual modality accompanying routine auditory-based conversational dialogue not only promotes more effective communication, but also enhances the sense of ownership and active collaboration involving client sand clinicians.

CURRENT AND PROJECTED WRITINGS:

Below are some ideas for my future writing projects, mostly related to my work with diverse client populations using elements of Mind Stimulation Therapy across life spans.

In 2006 to 2013 (when I was 70-77 years old), I was working with young children at a CMHC program, dual diagnosed substance abuse clients, clients with diagnosis of "schizophrenia," and with psychiatric disabled adults in nursing homes. I am planning to undertake some publications focusing on the use of elements of Mind Stimulation Therapy model with these diverse client groups.

1. I just finished a draft article to submit to the *Journal of Psychiatric Mental Health Nursing* on my work experience with nursing home clients using elements of the mind stimulation therapy model and hoping to submit it by the end of next week.
2. In relation to one of my interests in working with the "elderly," I was just notified by the CEO of VNA (Visiting Nurse Association) of a local town in Massachusetts that a proposal for Senior Men's Support group that I submitted has been approved by the Town. I am scheduled to conduct a 4-session program, which is considered of Pilot study nature, with potential for longer-term commitment from this town, or expansion of the program into other surrounding towns, I have the opportunity to present the idea to other CEOs of VNAs of surrounding towns.

   Even though I am not actively involved in clinical practice, essentially retired, I am currently associated with Metis Psychological Associates, LLC with which another ISPS member, James Tyler Carpenter, is also associated. My clinical involvement has not taken off, due to my frequent visits out of State, and now with my upcoming extended visit to the Philippines. However, the CEO is banking on me to establish a satellite center of METIS in the same town where I would be working with the VNA to provide a men's support group, which hopefully will start in April, when we return from the Philippines.
3. I am also working on a draft based on a presentation that Charles Boisvert and I did at the 23rd and 26th at Cape Cod Symposium on Addictive Disorders on the use of Mind Stimulation Therapy (previous labeled: Multimodal Integrative Cognitive Stimulation Therapy-MICST) with **dual-diagnosed substance abuse populations**. Both presentations were based on my work with substance abuse groups in a CMHC, and a chapter was devoted to this work in our book: Mind Stimulation Therapy.
4. **Body-Movement-Relaxation**: I plan to use my collaborative work experience with a physical education teacher while working with special students (ages 10-14) in a CMHC-based alternative school program, integrating Body-Movement-Relaxation (BMR) exercise in counseling with children with special needs. This technique that was cited in our Mind Stimulation Therapy book with adults. For years I have used variations of this exercise with children in private practice and in behavior consultation and counseling intervention with special needs children in public schools. I also did collaborative play therapy with two mental health clinicians with younger children groups for a year and more; recently I was involved in doing a training session using body-movement-relaxation (BMR) technique for clinicians working with adolescents to address "boundary-violation" awareness, which is often a major issue in all kinds of "aggressive behaviors." Hopefully I will be able to integrate my work experience in formal writing involving the use of Body-Movement-Relaxation integrated in counseling and psychotherapy process, specifically in dealing with "boundary awareness and boundary violations"-related behavior issues, as I think the idea may considerable merit and application, as it draws from an existential awareness of movement and change in adaptive functioning to one's present social and physical environments.
5. I am also currently providing consultation to a Developmental Disability Agency program to review Individual Behavior Intervention Plans that typically use the Applied Behavior Analysis (ABA), and trying to highlight some of the limitations of operant conditioning philosophy that focuses on change of behavior by increasing awareness of consequences to one's behaviors, and not addressing the role of associatively learned cues, social milieu, and emotional agitation and arousal, and making

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the case for the need for use of positive redirection in the management of severe and persistent behavior disorders in developmental disabled adults. This is also another writing project for me at some point in collaboration with staff from this Agency.

6. I was also encouraged by the Editor of *Adolescent Psychiatry*, as well as by Robert Whitaker of MADD in private communications, to encourage me to write on Risk Management Consideration that often may be the underlying driving force for over-medication or other unnecessary "treatment" strategies targeting persistent atypical behaviors, and the importance of highlighting the role of emotional and associative cues in occurrence of such behavior episodes, or thinking through how best the risk management issue needs to be addressed in clinical service programs.
7. **Mentoring Program**: I am listed as available to provide mentoring to ISPS members, and had two active and productive contacts this past year. The program is in initial phase, and I am looking forward to my productive involvement in the future. The CEO of Metis is also working to establish a mentoring program for one or two post-doctoral and pre-licensure psychologist who may be interested in learning from my clinical experience and work history, and who may be interested in committing to join METIS.
8. Charles Boisvert and I are also working on a draft for **application of mind stimulation model for adaptive thinking, feeling, and behavior for general public**. An initial draft that we submitted to a publisher was not accepted, so we have to explore further and re-edit the draft. In view of my reasonable competence in developing PowerPoint slides with insertion of pictures, diagrams, and videos, I am toying with the idea of putting together a series of visual slides rather than text of our manuscript, so it can be published online without any publisher being involved.
9. I am considering writing an Opinion piece in a psychology journal such as *American Psychologist* on **over-emphasis on awareness of consequences for "behavior change" (à la operant conditioning principle**). Such an approach assumes that any insight and understanding achieved through weekly office-based clinical practice uniformly can be effective for behavior change for all clients by facilitation of "internalization of such experiences in ways that they can generalize to effecting behavior change from therapeutic settings to outside real life situations, with or without a "therapeutic supportive environment." This approach may not recognize the limits of "internalization" and "generalization" of experiences from therapy sessions to outside life situations, and the influence of associative learned cues and emotional agitation-arousal that may often influence production and maintenance of "clinical symptoms, which may not necessarily be amenable to change by just awareness of consequences to one's behaviors, as is evidenced by many exhibiting persistent and long-psychological problems. The preference for popularity of "operant principle for behavior change," I believe, is somewhat related to values that many hold relating to personal freedom and choice. There is also a negative connotation that emphasizing the influence of external factors or internal associative cues influencing our behaviors may in some ways take away from our sense of control and promote a social control philosophy, which many may come to abhor. Need to give some more thoughts for clarity of expression of this view.
10. **On psychosis and schizophrenia**: I have posted quite a few commentaries on ISPS Listserv on the topic, and I have been corresponding with some professional acquaintances on this topic. On ISPS Debategraph Forum, I posted the following classification of psychosis, consistent with some of my collaborative publications that I cited before. "Type 1 Psychosis may be conceptualized as "transient" psychotic states characterized by "atypical" thinking, feeling and behavior affecting one's everyday "functioning," which may "clear up" with or without any psychiatric intervention from Type 2 "persistent psychosis" that is often associated with many people with mental illness, who continue to present some levels of compromised functioning and "at risk status" in spite of any psychiatric support services they may be receiving." "Type 2 psychosis is characterized by "severe and persistent mental illness" associated with people being served through a variety of long-term facilities: inpatient, outpatient, jails, nursing homes, supported community residency programs (some may be homeless), who continue to present "atypical thinking, behavior, and mood symptoms" with compromised levels of functioning and "independence" with "at risk status" in spite of years of receiving psychiatric treatment and support services.

    Since I posted this, I came to know through my correspondence with Will Carpenter, Editor of the *Schizophrenia Bulletin*, referring me to a 1980 article by Crow in the *British Medical Journal*, where he proposed such a classification. But upon

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reading his article, what I understand is that Crow proposed a bio-genetic causality for the two differential categories of schizophrenia, whereby his Type 2 was more akin to the idea of Dementia Praecox à la Kraeplin (often classified as Disorganized [Hebephrenic] Schizophrenia), where loss of cognitive functioning show progressive irreversibility. In my conceptualization, I was merely emphasizing the difference in terms of management, and going forward, in enhancing adaptive functioning in one's current and unique present life situations. I need to formulate these concepts in updating a post on Debategraph to hopefully generate more discussion on the topic at some point in the future.

11. Blogs: Besides Google+ or Debategraphs, where I have not been as active as I should, I do maintain several other Blogs (one of which is devoted to publishing my various commentaries and response on ISPs Listserv or other Internet communications, without identifying any members or references of names of other people for confidentiality), and this and other Blogs are listed at the bottom of my website: Mind Stimulation Therapy and Reflections and Thoughts on Psychology and Mental Health Issues, https://existentialperspectives.wordpress.com
12. I am also currently associated with the Department of Counseling, School Psychology, and Educational Leadership at Rhode Island College, where I am supposed to teach a course in the Fall semester of 2017 on Mind Stimulation Therapy. Charles Boisvert, who is Professor there, collaborated with me many publications and co-leads a monthly support group for students on mind stimulation therapy application, which I also attend from time to time.

On a final note of my professional activities, if any of the ISPS members are interested in collaborating with me on any of the mental health issue-related writing projects that I cited, or desiring to follow up elements of the MST model in their practice or research, specifically on the use of computer-facilitated dialogue and body-movement-relaxation exercise, I will be very open to such overtures.

On other personal writings and blogging projects, I can also mention here that I maintain a South Asian Family blog where I posted my father's poems written in English at his 72 years of age, with messages of tolerance and acceptance of diversity in religious faiths, a much-needed message for the present world, our family genealogy with family history that I compiled, along with my Bangladesh travelogue, which may be of interest to some. I also wrote in Wikipedia on my maternal grandfather Azizul Haque's contribution to the development of finger print science. Only recent publications in the West and India, after the technique was introduced in late 1800s, finally credited him for his contribution to the Henry Classification System of Fingerprinting, which is still widely used in the world. Another Wikipedia article I wrote was on my eldest brother, AF Salahuddin Ahmed, National Professor of Bangladesh, who was a historian and very active professionally in his 90's. I also updated the writing on Motihari, the town in India, where the famous author George Orwell was born, as my brother was also born there. All of this may be of interest to some, as they are in the public domain.

As a final comment, I know the living experience is a mystery to all of us, and we are here and we are not here, a kind of momentary existential feeling is with us all the times of our conscious living existence, whereby the time flows only in one direction, towards one's physical and spiritual sense of "entropy." Independent of our diverse backgrounds and living existence, we are all faced with the Present Reality of Momentary Existence, needing to make the best of our life situations, in our own ways, reflecting on our own unique identities as living human beings. This existence feeling of time flow to "entropy," however one conceptualizes it, whether using one's understanding of natural science knowledge or the practice of spiritual and religious faiths, probably becomes more pronounced in our consciousness as we age. Somehow, in my 8th decade, I don't feel that way yet, at this moment of my writing, but I know it will come at any moment, anytime, anywhere. I surely then will feel differently! In the meantime, why not carry on, as if it will never come? I am grateful to my loving wife (48 plus years and going), for often putting into me a sense of reality and practicality, and who has endured years in dealing with all of my frailties in my personal life.

Education Committee report

By Ron Unger, LCSW

We hope to produce at least 6 webinars in 2017. You can view past webinars, such as our most recent "Compassion for Voices; Science and Application," at http://isps-us.org/webinars.php. We also started a YouTube channel for ISPS-US, and expect to be producing some interesting videos in 2017! View what's been posted so far at http://tinyurl.com/jqrs9dd; you can also subscribe and then receive notification when more become available. And please do let us know about your ideas for future webinars or video interviews, etc., or if you would like to help out with these or other educational projects! Contact Ron Unger: 4ronunger@gmail.com.

Announcing the Postpartum Psychosis Special Interest Group (SIG)

By Marie C. Hansen

Psychosis in the postpartum is a form of distress that is not often discussed in psychological terms. To date, there has been a significant over-reliance on genetic and hormonal theories of causation, with little exploration of the role of the environment. The leading treatments for postpartum psychosis are antipsychotic medications and electro-convulsive therapy (ECT), with the primary prevention strategy being lithium.

However, research shows there are many psychosocial factors involved in postpartum psychosis, including low social support, low socioeconomic status, and traumatic birth experiences, to name a few. These psychosocial factors are often neglected by both the popular media and postpartum advocacy organizations, and strikingly, there are currently no psychological therapies or guidelines for the treatment or prevention of postpartum psychosis. In addition, many women with postpartum psychosis later go on to be diagnosed with bipolar disorder, despite the fact that they did not have a prior mental health history.

At the ISPS-US meeting in October, I presented a paper questioning the lack of psychosocial approaches to postpartum psychosis (our own journal *Psychosis* has never had an article on postpartum psychosis). The paper prompted an audience discussion about finding ways for ISPS to promote more holistic ways of thinking about the experience. As a result, I started a special interest group for members of ISPS that would like to explore the topic further.

This November, a film titled "My Baby, Psychosis, & Me" won a VMG Mind Award in the U.K. The film promotes ECT as treatment of choice for postpartum psychosis and does not present a psychosocial or balanced perspective of what may be underlying this form of emotional distress. The film also has confusing messages about what is postpartum psychosis vs. postpartum depression. Many women who have experienced psychosis (postpartum or otherwise) have had negative reactions to the film.

Most enlightening are Nicky Hayward's analysis, "Baby, Me, Drugs, and ECT," in which she criticizes the film for its patriarchal angle (amongst other things), and Rai Waddingham's "A Lesson in How Not to Make a Film About Mental Health," which kindly supports the women in the film while challenging the film's predominantly biomedical narrative.

Given the recent media attention to postpartum psychosis, it feels highly important that ISPS help promote alternative narratives. I am writing this column to call on other ISPS members to join me in the Postpartum Psychosis SIG. You can join by emailing me: mariehansen@me.com. I have also created a discussion Google group with members of the Marcé Society to discuss psychological and social perspectives.

Together, we can change the script and better support mothers.

Links:

- Nicky Hayward: "Baby, me, drugs, and ECT"
- Rai Waddingham: "A Lesson in How Not to Make a Film About Mental Health"
- "My Baby, Psychosis, & Me" (available to watch for free)

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More details to follow. The Call for Papers will be posted on our website and mailed to our members. To join our mailing list, send your email and/or mailing address to contact@isps-us.org.

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Can a conference be a catalyst for change? It is exactly this wish that inspired the title and theme of the 2017 ISPS International Congress.

Sadly, this is a wish born out of frustration. Attitudes, practices, and services too often seem barely touched by the steadily developing understanding of psychological and social aspects of psychosis and of what is helpful for people who experience it. So we aim for this conference to be not only about the valuable sharing of new research, ideas, and developments, but also, as the title indicates, about making real change happen. The large number of organizations who have given their support to this conference can be seen here.

We are delighted to be meeting in the exciting city of Liverpool. Carl Jung saw it as “the pool of life,” and we hope its rich heritage (not just football and music!) will make it an energizing setting for a conference thinking about change. More information about the social program is available on our website.

Delegates at previous international conferences have often commented on how ISPS events stand out. They point to the unique mix of opportunities not only to learn from high-quality presentations, but also to join a rich dialogue between people with a wealth of experience and expertise, a fertile mix of professionals from a wide range of disciplines, and people whose experience and expertise comes through personal experience of psychosis.

ISPS conferences have also traditionally been warm and welcoming gatherings, where people go away feeling inspired and reinvigorated. We hope this one will be no exception, and look forward very much to welcoming you to Liverpool in August 2017.

Plenary speakers include: Jacqui Dillon, Jim van Os, Alison Brabban, Grainne Fadden, Rai Waddingham, Kwame McKenzie, Svein Friis, Anne Berit Eie Torbjørnsen and Jon Vidar Strømstad.

UPCOMING WEBINAR sponsored by Mad in America:

Open Dialogue: A Recovery-Oriented Approach to Early Episode Psychosis

About this Webinar

Six years ago, Dr. Chris Gordon, medical director of Advocates, Inc., a large community mental health organization in Massachusetts, set out to train in Open Dialogue practices. Open Dialogue is both a philosophy of care and a system of care, developed over the past 30 years in Tornio, Finland, which includes doctors, nurses, therapists, and other helpers who support families experiencing emotional or psychiatric turbulence.

The model is deeply humanistic, seeing crisis as a time of meaning and opportunity as well as possible danger. The team does not start from an assumption that a psychiatric or medical paradigm is necessarily the best way to approach the situation. This definition of the crisis, and almost everything else, is collaboratively understood in the network of support. The voice of the person at the center of concern is honored and amplified, and the path forward appreciates the strengths of the person and his or her social and familial networks. Outcomes in Tornio have been outstanding, with 80% of persons with early-episode psychosis working or in school at five years, and with a fraction of the use of antipsychotic medications compared to standard care.

Advocates developed the first pilot project in the country, which they called Collaborative Pathway, to adapt these methods in the United States. The Collaborative Pathway offers Open Dialogue services to young people and their families.

In this webinar, Dr. Gordon and Keegan Arcure, who is the director of the Collaborative Pathway Program at Advocates, will discuss the development of their program, how it operates, and their initial patient outcomes. They will share practical ideas for others hoping to adapt Open Dialogue to their setting. Those attending the webinar will have the opportunity to interact with the instructors

When

March 8th, at 3:30 p.m. Eastern Standard Time, 12:30 Pacific Standard Time. The webinar will last for approximately 90 minutes.

What you'll learn

You will learn about an emerging evidence-based practice for treating youth and families who are experiencing an early psychosis. Specifically, the course will provide an overview of the seven principles of the Finnish Open Dialogue model, the key elements of the family network meetings, key outcomes that can be expected, a description of the two programs at Advocates that apply Open Dialogue principles, preliminary findings, and lessons learned from the adaptation of Open Dialogue to an American urban setting.

Who should attend this webinar

This course is designed to educate mental health professionals (psychologists, social workers, licensed professional counselors, marriage and family therapists, nurses, psychiatrists, and peer service and support workers) as well as the general public. Licensed mental health professionals can earn **1.5 CEUs (though not CMEs)** (visit this page to verify your eligibility) and will learn about an innovative approach to treating early episode psychotic patients. If you have questions, please contact Bob Nikkel at bobnikkel@gmail.com.

NOTE: This webinar is SOLD OUT. However, a recorded version will be posted online after March 8th, and CEUs will still be available for psychologists, social workers, licensed marriage and family therapists, licensed counselors, and nurses.

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Announcing a psychoanalytic/ psychodynamic special interest group within ISPS.

Are you aware of the newly formed ISPS subgroup for those interested in psychoanalytic/psychodynamic contributions to understanding psychosis and to therapies that integrate that understanding?

If not, why not become linked in, whatever your level of knowledge and expertise?

Why the sub-group?

With the important breadth of interests within ISPS, we feel there is a need for those with specific interests to have a place to further those interests and to support and learn from one another. We are of the opinion that the ISPS journey will be strengthened by having both strong pillars and good arches.

How does it work?

- Mainly via email at present.
- We will have a special time to meet in the international conference in Liverpool in the summer.
- We want to develop special sections. For example, Michael Garrett from New York is gathering together those interested in promoting psychoanalytic thinking and practice within ***public services*** for those with psychosis.
- There is also interest in developing a group to share and promote research.
- We want to develop the information available in the psychodynamic section of the ISPS website learning tools.
- We will be communicating from time to time and hope other sub-groups will develop.

How to join?

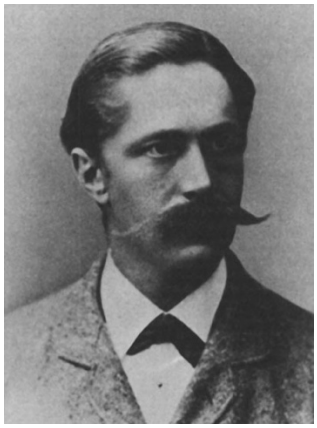
Simply send an email to Brian Martindale: bm@bmakm.plus.com

You will then be joined into the Google group.

Let Brian know of any special interest you have within the group, or wish to see the group develop in time. If your interest is public sector, you can also inform Michael Garrett at mgarrett50@aol.com

SAVE THE DATE:

Listening to Schreber's Voices: A Celebration of Daniel Paul Schreber's *Memoirs of My Nervous Illness.*



What: Written in the late 1800s, Daniel Paul Schreber's book *Memoirs of My Nervous Illness* is perhaps the most well-known first-person account of what is commonly termed "madness." **Listening to Schreber's Voices** is an immersive, multi-media, FREE, 2-hour event inspired by the book. Included will be readings of the book, poetry, dance, music, art, etc. inspired by the book by people with lived experience, voice-hearers, clinicians, theorists, family-members, friends, poets, writers, arts, musicians, dancers, videographers, and anyone else inspired by the memoir. We will be using all the rooms of the Jefferson Market Library, a repurposed 1800s courthouse. As Schreber's memoir was not only a memoir, but also a judicial document in support of his freedom from the asylum, we hope the environment will stimulate creative expression.

When: May 20th 2017, 6-8pm

Where: Jefferson Market Library
425 Ave of the Americas at 10th Street
New York City

Contact: Evan Malater: emalater@gmail.com

Marie Hansen: mariehansen188@gmail.com

This event is cosponsored by Das Unbehagen, the International Society for the Psychological & Social Approaches to Psychosis (ISPS-US), and Hearing Voices Network NYC.

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