ISPS - US Newsletter

United States Chapter of the
International Society for the Psychological treatments of the Schizophrenias and other psychoses
"...Innate among man's most powerful strivings toward his fellow men...is an essentially psychotherapeutic striving."
Harold F. Searles (1979)

Volume #4 Issue #1 Summer 2003

From the President

Ann-Louise S. Silver, MD

As we look back on 2002, we at ISPS-US are proud of our achievements and our evolving connections. We see 2003 as the year in which we "get real." The airlines advise passengers to put on their own oxygen masks before assisting those depending on them, and we have been doing this for the past three years. ISPS-US works well as a forum for its members and for colleagues who find their way to our local and national meetings and to our listserve. Now we will work more practically and directly with patients and with programs in our locales.

We have already become a significant voice in policymaking, through our impact on the revision of the PORT Report. This pilot effort has taught us that we are not just a cluster of clinicians and theoreticians, but an entity with real power. We will support the development of and the founding of treatment centers that include insight-fostering approaches in treating severe mental illnesses. We will advocate for a more individualized approach to medication, working against the current notion that medicated patients must never dare diminish or discontinue ingesting these agents. This is no easy task in a zeitgeist of the sick brain, of powerful pharmacological agents, and in a fragmented mental health field. "Managed care" has proven itself "mangling care." (A mangle is a machine developed in the late 1700s for laundering linen. An 1880s definition: "the process of mangling…consists in rolling the sheet tightly around a wooden mandril,...beating it meanwhile...with the plumber's mallet." A character in Charles Dickens' *Pickwick Papers*, says approximately, "Queer thing, to have my linens mangled when they are on me." (OED)) Professionally, all of us are enduring tight constriction and pummeling.

Our annual meeting in November, organized by ISPS-US-NYC, under Brian Koehler's leadership, was held at the William Alanson White Institute in New York City, historically just the right venue. Robert Whitaker galvanized the group in his opening keynote talk, and every one of the following speakers contributed to the intellectual and emotional vigor of the program. We honored Bert Karon: Bill Gottdiener reviewed Bert's contribution to our field and presented him with the annual ISPS-US award. Bert in turn complimented all of us. Stu Silver has produced a set of DVDs of the day's program, which you can order for $110 for the entire set of 11, or $10 per speaker. Contact Brian Koehler: make your check payable to ISPS-US. Any one of these talks would make great material for a local ISPS-US meeting, or as teaching material elsewhere.

ISPS-US has a membership of about 200, half of whom participate in our intellectually stimulating and sometimes fevered list-serve. I've never come across a more informative and scholarly list-serve, which really is an on-going meeting. We have now formed two specialized ISPS-US listserves, one for the ethics study group and the other for organizational administrative matters. Thanks to Joel Kanter both for his work as webmaster and for his valuable postings. Additionally, we have held two monthly board meetings, on the first Sunday of the month, using www.freeconference.com. Each participant is charged for an individual long distance call. It's working out very well, and would be a great way for study groups to meet.

At our business meeting following our annual meeting in New York, the ISPS-US Board unanimously adopted our by-laws. Again, we thank Stu for chairing the by-laws task force. We have made application for incorporation in the State of Maryland. Once approved, we will register with the federal government. Once assigned a number, we can apply for non-profit status as a 501(c)(3). This finally will allow us to fund-raise and to apply for grants. The Research Committee, chaired by Bill Gottdiener, is exploring launching a multi-centered "N of 1" protocol, as delineated by Julie Zito in her presentation at our

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recent annual meeting. This group will be using www.freeconference.com for their committee meetings.

Many of us have been together for these past four years, and are becoming really close friends. We now have our first ISPS-US marriage: I am enormously pleased to congratulate Brian Koehler, our ISPS-US Newsletter editor and Julie Kipp, our secretary on their marriage on December 24. They have been extremely generous to ISPS-US in countless ways. On behalf of all of us, I wish them the best over the coming decades.

On Friday evening, March 21, 7:30-9:30, Siobhan O'Connor, M.D. will be the Frieda Fromm-Reichmann Lecturer at the Washington School of Psychiatry, 5028 Wisconsin Avenue, Suite 400. O'Connor is an Irish psychoanalyst who recently relocated from Belfast to London, where she had received her psychoanalytic training. She is a wonderfully feisty and articulate theoretician and clinician who has worked for years in in-patient psychiatry. Preceding her talk, "Violence in Schizophrenia", ISPS-US-DC and the Washington School of Psychiatry will host a dinner at Maggiano's, a wonderful Italian restaurant within walking distance of the School. I hope many of you will attend, and we can say a toast to Brian and Julie.

We have our organizational victories to celebrate as well. The PORT Revision has not yet been released. However, the provisional draft, sent to 100 experts, which this time included me, did *not* include the onerous Recommendations 22 and 26, 22 recommending against psychodynamic therapy even in combination with medications, and 26 recommending against psychodynamic family therapy. The draft for the revised PORT still is almost entirely pharmacologically and biologically oriented. I wrote detailed suggestions for further revisions. We need to continue advocating for further changes in the next PORT revision. ISPS-US can be proud of its preliminary efforts: 1) our strong annual meeting which included PORT senior author Tony Lehman, 2) the ISPS-US panel at the American Academy of Psychoanalysis, which included PORT second author Donald Steinwachs, 3) our promoting the ISPS Task Force on the PORT, which includes U.S. members Bill Gottdiener and Colin Ross, and 4) the special issue, Spring, 2003, of the *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, "Treating the Schizophrenic Person: Finding a PORT in the Storm," which I co-edited with ISPS-PORT Task Force chair, T.K. Larsen, M.D. of Norway. While we can never know how our efforts influenced Lehman and Steinwachs, we can celebrate the revision, since the prior report was well on its way to setting a world standard for treating schizophrenia. ISPS has bought 1000 copies of this issue of the journal. Details will soon be available on how to order your copy. All the contributors are ISPS members, with the exceptions of Drs. Lehman and Steinwachs.

We need to grow and become a far more widely known entity and a resource for the mental health community. On February 26, I was given some time on NPR's Kojo Nnamdi show, where I said, "The purpose of ISPS is to promote a comprehensive and in-depth treatment of psychotic illness. We are trying to work towards promoting secure attachment – we are not advocating against meds certainly, but advocating for a place for the therapist in the picture on an ongoing basis. When your back is to the wall, it's good to have someone there with you. Psychotic illness brings with it just enormous, really unimaginable anxiety. When you think of everyday anxiety and neurotic anxiety, psychotic anxiety is exponentially higher. While the meds quell the anxiety, it's important to have someone there to help the patient sort out what they are so frightened about and to help patients regain their stability and confidence in themselves. As we have talked about schizophrenia as if we know that universally it's a brain disease, we have lost sight of the psychological aspects of this treatable illness, and the fact that very many people can recover from it."

We have a grand tradition to maintain and pass along to the next generation. Julie Wolter, as chair of membership recruitment placed ads in many professional newsletters. We are targeting the states in which we already have ISPS-US branches. We need everyone's help in publicizing our group. You have received a few copies of the ISPS-US trifold. Please give these to colleagues and other potential members. We still hope to reach a membership of 400, which would allow for launching of our journal, *Psychosis: Psychodynamic and Psychosocial Perspectives*.

We hope to have a strong representation at the ISPS meeting in September in Melbourne, Australia. Abstracts are due by April 15, and should be sent to isps@conferencestrategy.com.au.

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From the Editor:
But Is It Psychoanalysis?

Brian Koehler, PhD

The following thoughts were inspired by recent postings on our listserve as well as by an online discussion on schizophrenia & psychoanalysis sponsored by the *International Journal of Psychoanalysis* (Lucas 2003). I believe that Victoria Conn has proposed that we try to identify what unique contributions psychoanalysis has to offer clinicians in the treatment and understanding of severe mental illness. For this challenge, I am grateful. My own view is that psychoanalysts are in a good position, partly as a function of the psychoanalytic context (in regards to the amount of time spent with a particular patient, attention to forming a secure attachment, the focus on emotional processes, including unconscious processes such as dreams and various kinds of enactments, expression of emotional

experience in somatic language, careful and persistent attention to one's own emotional responses to the patient, etc.) to understand this group of illnesses from a phenomenological perspective (which must be the first step in approaching it from a neuro-science perspective--one should first have a good idea of what is awry prior to mapping out the neural regions/pathways involved--brief and sporadic contacts do not allow for the kind of immersion experience which is required in order for the patient to get in touch with her/himself and to be able to communicate this to another person--for a good phenomenological approach to schizophrenia I highly recommend Manfred Spitzer, Friedrich Uehlein, Michael Schwartz & Christoph Mundt (Eds.) (1992) *Phenomenology, Language & Schizophrenia* published by Springer-Verlag).

As I had noted in a previous ISPS-US listserve posting "Evolving Psychoanalysis," my understanding of psychoanalysis is that it is an intervention that focuses on the emotional processes that go on between persons (including dissociated, unconscious processes, which have been amply demonstrated in cognitive research), how past relationships have been structured in the individual's inner world, the anxieties that arise in close interpersonal contact, identity formation, and the vital emphasis on transference-countertransferential enactments, insight and containment. Psychoanalysis requires that the 'treater' study her or himself in the interaction so as not to collude in avoidance of emotional contact and resolution of conflicts (e.g., surrounding omnipotent destructiveness, separation, closeness, sexuality, envy, shame, guilt, etc.). Psychoanalysis reaches for emotional truths, identity formation, and integration of the personality. As Benedetti (Benedetti & Peciccia 1998) pointed out, we need a new language for psychoanalysis as we continue to help transform human suffering and assist persons in the integration of what he and his colleague Maurizio Peciccia have called the symbiotic and separate selves (relatedness & autonomy), to help these individuals cope with the alternating anxieties of separation (unrelatedness) and intrusion (feeling controlled, dominated, colonized, etc.).

Benedetti and Peciccia (1998) have identified pathological symbiosis (the fusion transference with the world evident in such symptoms as referential thinking and auditory hallucinations), splitting and autism as the basis of the ego structure of the person with schizophrenia. These clinicians have identified the psychotic structure to be the result of a lack of integration of the separate and symbiotic selves. Splitting causes the ideal Ego to be perceived as an alien voice or visual hallucination. With the narcissistic loss which brings about loss and fragmentation of the nascent self, the ego no longer understands itself, it is in shreds, swinging between an idealized, grandiose self-conception as a defense against organismic panic resulting in a pathological reorganization of self (Pao, 1979). In schizophrenia, the patient is both persecutor and persecuted. According to Benedetti (1990) because of splitting and the impaired ego structure of the schizophrenic patient, the psychoanalyst has a new task, unlike in the case of anaclitic depression in which the analyst must interpret the perverse relationship between the ego and ego-destructive superego (Bion's term) and the conscious impotence and unconscious omnipotence. Instead, the psychoanalyst "must first of all provide the Ego with that amount of narcissism it needs to integrate and understand itself...Psychotherapy is, first and foremost, a positivization of the patient as a person" (p. 11). Benedetti (Benedetti & Peciccia, 1998) remarked "The partial identification with the suffering of these patients encouraged me to dare seek out the places in our unconscious where human existence comes into contact with death" (p. 170). Benedetti also believed, and to this I can readily concur along with Searles and Herbert Rosenfeld, that deeper contact with psychotic patients, the kind of emotional contact upon which they depend for psychic survival, stirs up the psychoanalyst's own psychotic anxieties, but this loses power to be harmful because it is taken up into the "dialogic interweave" between patient and analyst and this duality becomes the symbol of the self and is therefore anti-psychotic in a non-psychopharmacological sense of the term. Benedetti presented another patient who painted her therapist as death (the patient's schizophrenia had commenced with a hallucination of a figure of death), as well as the savior who rescued her by carrying her in his arms from hell to heaven. Bertram Karon (personal communication) has noted the association between death and acute psychotic reactions, also noted by Bruno Bettleheim in the concentration camps of Nazi Germany.

Schizophrenic patients may consciously or unconsciously feel that they have no right to exist, as commented on by Swedish psychotherapist Barbro Sandin (Benedetti & Furlan, 1993), these patients express their being in terms of non-being. To exist may cause the destruction of the other, and at this level of mental representation, the self as well. A good deal of self-referential thinking, hallucinations and delusions seem to involve the patient's inability to be alone, to be separate, to feel ignored, or to experience others to be indifferent (Auchincloss & Weiss, 1994). One of my patients who I see five times a week, on his trip from upper Manhattan to lower Manhattan to come to his sessions, experiences the indifference of others on the subway or street as intensely persecutory and this moves quickly into somatic delusions and tactile hallucinations that others are robbing his body of its strength. Francis Tustin, in a talk in Paris before she died, pointed out that Bion suggested that absence becomes an inimical presence. This is a phenomenon that European psychiatry refers to as transitivism, i.e., others slip on and take on aspects of the patient's self, as opposed to appersonation, in which the patient takes on the characteristics of others. As an illustration of the latter, one of my patients, experiences what he calls a "branding", he feels and sees his mother's face with protruding and dangerous teeth taking the place of his own face.

Searles (1979) pointed out: "In general, and to a high degree, schizophrenic patients experience inner emotions not as such but rather as distorted perceptions of the outside world. All of outer reality becomes kaleidoscopically changed because of the impact upon it of the patient's unconscious feelings. That is,

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From the Editor, continued

what are essentially inner emotional changes are experienced as perceptual changes in the surrounding world" (p. 13). Benedetti (1992) noted the schizophrenic patient's difficulty in distinguishing self from non-self. The schizophrenic person lives in the unbearable paradox of needing to differentiate oneself from the colonizing influence of others in the merger experience, yet, to separate would mean loss of the self. The loss of one's own identity is always the basic danger. The abiding presence of severe annihilation and psychic-somatic death anxiety attests to this conundrum. Benedetti wisely notes that the patient's nascent self exists in the projections set before us, i.e., the hallucinations and delusions. In regard to the latter, Benedetti concluded:

"This negative kind of semiotics may be understood by us in the following way: the alienated Self, no longer having an unconscious image of its own identity, looks about in the surrounding world no longer for an image of the internal image--in other words a symbol--but for a substitute for it. This Self searches for something which refers continuously to itself, but does not lead back to itself because, sensorially speaking, it substitutes an absence. Without this external, hallucinatory substitute, the patient could not perceive himself; hence his resistance to abandoning it in a psychoanalysis which proposes to reduce it for him to a concept of Self. So our task is to look for the lost Self in the sensorial images which it sets before us, not by interpreting these images for him, but by enriching them with our presence to the point where we give them the consistency of new, positive symbols" (p.7).

Searles (1979) in his remarkable book on counter-transference, comments on the importance of the therapist's ability to not filter one's own experience of the patient, to the point of even becoming aware of one's own symbiotic needs for the patient, and experiencing the autistic patient as serving as a shield for one's own personality integration, which then allows the autistic patient to identify with the therapist and thus becoming able to do the same, i.e., to gradually exchange psychotic self-sufficiency and autistic defenses for deeper interpersonal relationships. In a discussion with a New York friend and colleague, Tom Federn, grandson of Paul Federn who was a close colleague of Freud's and one of the early psychoanalysts who treated psychotic patients, it was pointed out that Freud at one of the Wednesday evening psychoanalytic seminars held at his house in Vienna, suggested that the neurotic patient is persuaded to give up her or his resistances because of transference love for the doctor, that psychoanalysis is essentially a cure based on love. This, I believe, is recorded in the minutes of the Vienna Psychoanalytic Society. In a panel discussion on treating psychotic patients held at the 42nd Congress of the International Psychoanalytical Association held in Nice, France (Vermote 2002) one of the discussants concluded: "If the neurotic heals through transference love, the psychotic heals through countertransference love: holding, patience, tolerance, understanding. It is clear that interpretations are not the main therapeutic factor, but the therapeutic relationship" (p. 693). Benedetti (1987) held a similar position: "In almost every point of view considered until now, the underlying principle is therapeutic love. This feeling, otherwise well hidden in the folds of the psychoanalysis, must, in the experience with the psychotic patient, courageously bare itself in order to become, in the dialectic of its motivations and limits, an illumination of the human condition" (p. 135-136). Since Freud opposed hate to love in the dialectic of human existence, Benedetti has addressed the issue of countertransference hate in the psychotherapy with psychotic patients in, I believe, a particularly helpful way. Hate and aggression are mutually introjected and projected between patient and therapist. There seems to be, as revealed in the microanalysis of infant-mother interaction observed by such researcher-psychoanalysts as Beatrice Beebe and Louis Sander, an ongoing dialectic involving self- and other regulatory processes. This is particularly evident in the psychoanalytic observations and work of Harold Searles. As Freud pointed to the mutual sensitivity of the unconscious of each partner in the therapeutic dyad, Benedetti calls for "...the amenability of our unconscious to occupy a place in an existence that is important for the future of the patient" (p. 136). This structure attests to the intersubjective origins of the self, as noted and researched by, among others, Colwyn Trevarthen. According to Benedetti (1987), there is a triple function of countertransference hate/aggression. First, it is restricted by libidinal feelings towards the patient and bearing the suffering caused by the patient's omnipotence of the persecutor and powerlessness of the victim. Second, the therapist must engage in integrating one's own negative, 'bad' parts of the self, therefore the patient is not the only one in the room feeling the full weight of the negative self- and object representations. And thirdly, this internal containment, transformation and integration by the therapist is introjected by the patient. Benedetti, after noting that we do not know how this destructiveness originates, whether in the biology, individual, family or culture, described this deeper contact as follows:

"During the contact with the psychotic patient, his destructiveness is experienced in all of its manifestations--raving, hallucination, splitting. These are always the perpetuation of an original destructiveness, the roots of which, for me, are at the base of the very psychosis, whether schizophrenic or depressive. Now, in the psychotherapy, we interpret this destructiveness in all of its tragic interactions...But no interpretation, however careful and intelligent, would ever have the power to induce the patient to dislodge himself once and for all from that destructive iceberg, to disidentify himself from his impulses, if there were not something fundamental which permitted a new knowledge of it. We expose ourselves to this, we undergo the impact, we share it. We accept feeling the impossibility of the accusations, the autistic wall, the coldness of the psychosis, the horror of the delusion, the boredom and terror of the void, the barrenness and inanity of so many sittings with the patient; we even run the risk of his being physically violent. And what is more, by exposing ourselves to his direct assaults, fortunately mostly verbal, we tragically introject his aggressivity, developing counteraggressive impulses which are still useful, very, from a therapeutic

viewpoint, because they are bearers of a form of contact, because they are messengers of a dual reality...Well, in all of this, we have shared the seeds from which psychosis springs; and by not ceasing, in this state, to love our patient, we have proved to him the possibility of uniting and integrating good and bad objects, so that he may do this with us. That is to say, we have in a sense eliminated that frenzied terror of destructiveness that belongs to the realms of psychopathology and is a fount of its perpetuation...Aggressivity is transferred, above all, by our own internal transformation of it, not without a battle, and with the longing to be different. And the psychotic patient, in this light, becomes our teacher" (p. 138).

To the question is this psychoanalysis, my reply would be that it is. Psychoanalysis is always evolving and it is good to remind ourselves that two of the significant traditions of psychoanalysis, Interpersonal and Post-Kleinian, largely emerged from observations made in working with more disturbed patients.

For those interested in learning more about psychoanalysis and schizophrenia, I highly recommend the following volumes (most of whom were written and/or edited by ISPS members):

F. DeMasi's (Ed.) (2001) *Herbert Rosenfeld at Work: The Italian Seminars*. NY: Karnac.

D. Garfield (1995). *Unbearable Affect: A Guide to the Psychotherapy of Psychosis*. NY: John Wiley & Sons, Inc.

M. Jackson's (2001) *Weathering the Storms: Psychotherapy for Psychosis*. NY: Karnac.

B. Karon & G. Vandenbos (1981). *Psychotherapy of Schizophrenia: The Treatment of Choice*. Northvale, NJ: Jason Aronson Inc.

M. Robbins (1993). *Experiences of Schizophrenia: An Integration of the Personal, Scientific, and Therapeutic*. NY: The Guilford Press.

L. Sass (1994). *The Paradoxes of Delusion: Wittgenstein, Schreber, and the Schizophrenic ZMind*. NY: Cornell University Press.

A.-L. Silver (1989) (Ed.). *Psychoanalysis and Psychosis*. Madison, CT: International Universities Press, Inc.

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G. Benedetti (1987). Illuminations of the human condition in the encounter with the psychotic patient. In *Psychotherapy of Schizophrenia*, 129-138. NY: New York University Press.

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G. Benedetti (1992). The Psychotherapy of Psychotic and Schizophrenic Patients and Factors Facilitating This. USA-Europe Conference on Facilitating Climate for the Therapeutic Relation in Mental Health Services, Perugia, Italy.

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R. Lucas (2003). Psychoanalytic controversies: The Relationship between psychoanalysis and schizophrenia. *International Journal of Psychoanalysis*, 84, 3-15.

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B. Sandin (1993). When being is not to be. In G. Benedetti & P. M. Furlan (Eds.) *The Psychotherapy of Schizophrenia: Effective Clinical Approaches-Controversies, Critiques and Recommendations*, 23-27. Bern: Hogrefe & Uber Publishers.

H. Searles (1979). *Countertransference and Related Subjects: Selected papers*. NY: International Universities Press, Inc.

R. Vermote (2002). The nature of the problems of psychoanalysis with so-called 'difficult' patients. *The International Journal of Psychoanalysis*, 83, 689-694.

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From the Secretary

Julie Kipp, CSW

I wonder if ISPS-US members are aware of the challenges of building an organization like this from our grass roots up? I know that I have developed a new appreciation of all the mailings I get from organizations, and of the issues involved in keeping lists updated and members informed. At some point we will make the big developmental step of being able to have paid office staff, but right now anything we get done is done with volunteered time.

We have made an important step forward by instituting monthly conference calls, in which we can make organizational plans. We have been "meeting" monthly since February, and finding it very helpful in keeping our organization together. To give you a flavor, some of what we've discussed has included:

- the upcoming ISPS-US annual conference in November, this year in Philadelphia (call for papers posted elsewhere in this issue!),
- the progress of our not-for-profit application,
- the progress of mailings needing to go out,
- the progress of getting this Newsletter ready,
- relations with the International organization,
- research committee initiatives,
- recruitment initiatives,
- the wonderful new issue of the Academy written by ISPS-US members, and
- plans for an ISPS-US web site.

Somehow we all come away from each call with more work to do! But also we get the enjoyment of contributing to the growth of this organization committed to providing psychological and humane treatments to people with psychosis.

Lastly, I want to again thank the clients of Bronx REAL Continuing Day Treatment program who continue to stuff the envelopes, and paste on the stamps and labels for all our ISPS-US mailings.

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From the Treasurer

Barbara L. E. Cristy, LCSW-C

In 2002 a number of things were accomplished that affect the treasury of ISPS-US: the committee working on non-profit status will be ready to send IRS the application by the end of April. The committee working on this included Bill Gottdiener, Brian Koehler, Christine Lynn, Stuart Silver, Julie Wolter, and myself. However, it is Stuart Silver who did the lion's share of the work. Special thanks to Stu for accomplishing this monumental task.

This committee also worked on the by-laws and finished their job. The lion's share of this job was done by Ann-Louise and Stuart Silver. Again, special thanks go to them for another monumental task well done.

The by-laws change the annual dues year to correspond to the calendar year. This should make things a little easier and less confusing. The dues letter is going out the end of February-beginning of March for 2003. A dues letter will again be sent in November for the 2004 membership.

I want to welcome our new members: Daniel Bender, Paul Carroll, Gerrit Crouse, Christopher Ebbe, Patricia Gibbs, James Gottstein, Linda Jones, Robert Kay, Thomas Mallios, Pamela Saunders, Lois Schneider, Maurice Shilling, Susan Tephens, Neal Stolar, David Tansey, and Joseph Tarantolo.

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Outreach and Membership

Julie Wolter, Psy.D

Membership recruitment efforts have focused on trying to gain members in areas where there are local ISPS-US branches through advertisements in chapter newsletters for the National Association of Social Workers and APA Division 39 (Psychoanalysis). Personal recommendations to friends and colleagues remain the most effective means of recruiting members. We are also trying to obtain a list of the program directors at the National Association of State Mental Health to send a mass mailing to them. This would be an excellent opportunity to reach numerous individuals working in various capacities with patients. ISPS and ISPS-US newsletters and trifolds have been displayed at conferences wherever possible. If you know of an upcoming conference or meeting in which ISPS-US recruitment materials can be displayed, please e-mail Julie Wolter at jwolter@safeplace.net with details of the conference so arrangements can be made to forward the materials. As always, ideas for recruiting members and contacts with whom we can network are welcome and appreciated! E-mail them to Julie at the above address.

Julie Wolter, Psy.D
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ISPS-US Research Committee

Bill Gottdiener, PhD

The ISPS-US has launched a research committee with the goal of conducting original research on treatment interventions and outcomes for people diagnosed with psychotic disorders. A primary goal is to augment the existing evidence on what works and for whom with data on novel approaches to the study of commonly used treatments rendered in the usual practice setting with community-based populations. Additionally, methods will be emphasized which address gaps in the existing evidence base related to long-term management, adherence to recommended treatments, patient and therapist satisfaction with therapy, functional as well as symptom improvement, reasons for continuation and discontinuation of treatment, and adverse event monitoring. We are open to examining all forms of psychosocial treatments. Our focus is on the utility and effectiveness of various interventions and they will be considered from multiple theoretical and technical perspectives (i.e., psychodynamic, cognitive-behavioral, milieu, and psychopharmacological). The committee consists of an interdisciplinary group of experienced researchers and clinicians and they are: David Blakely, M.D., Victoria Conn, M.N., M.A., C.P.R.P., Bill Gottdiener, Ph.D., Courtenay M. Harding, Ph.D., Crystal Johnson, Ph.D., Eric M. Plakun, M.D., F.A.P.A., Colin Ross, M.D., and Julie Zito, Ph.D., R.Ph.

Please contact Bill Gottdiener, Ph.D., chair of the committee, at billgttdnr@cs.com for further information on the progress and activities.

Planned ISPS-US Web Site

Greg Rosen, MA, LCSW

Hi all,

I have agreed to function as "webmaster" for a new ISPS-US web site.

As my time and creative skills are limited, I am requesting help and the formation of a workgroup to assist with this project. More specifically, I need at least one or two graphically talented people who are willing to help set up layouts and designs for our pages based on the agreed upon content.

We could communicate through direct e-mail or phone conference if necessary. I have most of the software to put our creations on the web so basically I would need works submitted in Word or a graphics format which I could then transfer into a postable format.

Please contact me via e-mail at g.rosen@pipeline.com if you are interested. The actual content of the site has yet to be determined so I would love it if anyone sent ideas for what should be there. One of the great things about a website is that there is almost no limit in terms of size. Certainly it would be great to have some of the listserve highlights on the site--send me requests. Warren Schwartz so far has suggested a good link as well as having an online membership joining and paying service. Conference announcements seem another obvious use of the site. This is only the beginning.

Another nice thing about a having a website is the flexible publicity. Each site has invisible (to the surfer) keywords which are read by search engines. By updating or changing these keywords in response to new or changing content we can change our indexing on the search engines which will send visitors to our site. So, another thing to submit to me as suggestions are possible search terms you might use while searching the internet for an organization like ISPS.

Thanks much,

Greg Rosen

Trauma Perspective

Mara Conan, PhD

Introduction

In the field of psychiatry there is a growing awareness that traumatic circumstances can have a devastating effect on emotional well-being and a great deal has been written about the subject in recent years. However, in reading and comparing studies involving trauma, it is important to be aware that there is not one concise and widely accepted definition of trauma. In any particular discussion of trauma it is necessary to take note of the precise circumstances that are being considered.

General definitions of trauma fall into two major categories. The first group involve descriptions in which the objective factors inherent in a traumatic situation are summarized. An example is the definition given in the DSM-IV. A traumatic stressor is described as the "Direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's integrity: or witnessing an event that involves death, injury, or a threat to the physical integrity of another person or learning about the unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate".

Theorists and clinicians have pointed out, however, that similar traumatic stressors do not affect all individuals in the same way and that the impact of a traumatic event is often related to a variety of factors (e.g., age of victim, relationship of victim to perpetrator, the chronicity of the circumstances). Saakvitne, Gamble, Pearlman, and Lev (2000), for example, emphasize that in assessing for traumatic experiences, the subjective experience of the individual must be taken into account as well as the particulars of the stressful circumstances. Their definition of trauma exemplifies the second type of descriptions of trauma, that is, those that take into account subjective experience. They indicate that "A traumatic event or situation creates psychological trauma when it overwhelms the individual's perceived ability to cope, and leaves that person fearing death, annihilation, mutilation, or psychosis. The individual feels emotionally, cognitively, and physically overwhelmed"(p. 5).

Traditionally, the focus on the impact of traumatic circumstances on psychological stability most often occurred during war time when clinicians were confronted with the severe stress reactions of soldiers who had been in combat (Herman, 1992). Throughout the last two decades interest in trauma and its relationship to mental state has expanded to other domains. Herman suggests that with the legitimizing of the concept of post-traumatic stress disorder based on the experience of Vietnam veterans, there has been a gradual acceptance of the notion that the symptoms which develop following other traumatic experience (e.g., rape, incest and spousal abuse) involve similar psychological processes.

Interestingly, this renewed interest in trauma (and the way in which experience influences psychological disability) comes at a time in which there has been a wide acceptance of the belief that there is a biological basis for many psychiatric illnesses. Bessel van der Kolk and his colleagues have made clear how important the focus on traumatic circumstances has been in forcing people to consider a more balanced perspective. Van der Kolk and Mcfarlane (1996) indicate that "The development of posttraumatic stress disorder as a diagnosis has created an organized framework for understanding how people's biology, conceptions of the world and personalities are inextricably intertwined and shaped by experience. The PTSD diagnosis has reintroduced the notion that many "neurotic" symptoms are not the results of some mysterious, well-nigh inexplicable, genetically based irrationality, but of people's inability to come to terms with real experiences that have overwhelmed their capacity to cope" (p.4).

Trauma and Severe Mental Illness

Despite the increased attention the topic of trauma has received, there has been relatively limited interest in the role trauma plays in the disabilities of people who have been diagnosed as having severe mental illness. This has been the case, in spite of the fact that studies have suggested that childhood trauma (specifically sexual and physical abuse) is fairly common in this population. Herman (1992) indicates that "The mental health system is filled with survivors of prolonged, repeated childhood trauma. On careful questioning, 50-60 percent of psychiatric inpatients and 40-60 percent of outpatients report childhood histories of physical or sexual abuse or both" (p.122). In a study conducted in a New York State psychiatric outpatient clinic, Muenzenmaier, Meyer, Struening and Ferber (1993) found that 64% of the female clients at the clinic had histories of childhood abuse.

A major push for increased attention to the way in which trauma is related to symptoms of people who have been diagnosed with severe mental illness has come from consumer groups. For example, consumer advocacy has been influential in recent developments in New York State. New York State Office of Mental Health now has a mandate that their facilities provide both trauma assessment and treatment that takes into account trauma history. The Office of Mental Health's seriousness in this area is evidenced by the fact that there is currently ongoing training of New York State employees using a trauma based curriculum.

Symptomatology

The current trauma mandate marks a major change in perspective within both inpatient and outpatient psychiatric facilities. Working in a psychiatric setting in which clients have severe psychological problems (which include behavior that makes it very difficult to function in the community), there is an emphasis on psychotic symptomatology. Interventions are designed to quickly diminish such symptoms so that clients can return to the community. The underlying assumptions of the biological model of psychiatric illness certainly fosters this perspective. It is not typical for staff in psychiatric institutions to consider the way in which a client's history has influenced his symptom picture and what this means in terms of treatment needs. In addition, with increased influence of managed care there has been emphasis on what is believed to be cost effective treatment. The primary emphasis in treatment is on the use of

psychotropic medication to control psychotic symptomatology. There is a tendency to gloss over the fact that many patients are rehospitalized relatively quickly.

What is so significant about the trauma perspective in working with severely disturbed individuals is that it involves a real shift away from a focus simply on psychotic symptomatology. There is an awareness of the importance of trying to determine if the symptom pattern is more complex, and if patients show symptoms that are more typically associated with that of a posttraumatic stress reaction. Van der Kolk et al (1996), for example, have identified the following symptoms as suggestive of severe trauma: intrusive re-experiencing, autonomic hyperarousal, numbing of responsiveness, intense emotional reactions, learning difficulties, memory disturbances and dissociation, aggression against self and others, and psychosomatic reactions. Given a trauma perspective, for example, one might make an assessment as to whether flat affect (which suggests schizophrenic process) may be better understood as an emotional numbing based on a history of traumatic experience. Likewise, it is possible that auditory, visual, and/or tactile hallucinations actually involve intrusive re-experiencing.

The symptom which has received the most attention in the trauma literature is that of dissociation. Dissociation "manifests itself as the ability to disconnect from the present or some aspect of experience. Dissociation allows someone to distract himself or herself, or effectively to ignore aspects of one`s internal or external experience" (Saakvitne, et al., p. 25-26). It is a normal process and is active anytime we selectively attend to certain environmental stimuli and tune out others. However when it is used to cope with overwhelmingly distressful circumstances, there is consequence in terms of memory of these events. At such times there is "a separation of mental processes and contents. Thoughts, images, and sensations that would ordinarily be connected or integrated in one's mind are, in fact, stored (cognitively encoded) separately in fragmentary or compartmentalized forms" (Saakvite et al., 2000, p. 25). In this sense, dissociation is a psychological defense aimed at protection from overwhelming circumstances. It is because of dissociation that traumatic experiences are often not remembered.

Some Key Concepts in Trauma Theory

Along with a shift in the kinds of symptoms that are looked at, the trauma perspective provides a shift in the way symptoms themselves are conceived. Saakvitne and her colleagues, for example, talk about symptoms as coping strategies which individuals have developed in order to make it possible to sustain oneself through very traumatic circumstances. Such symptoms as substance abuse, hypervigilance, dissociation, and emotional numbness can be readily seen in this way. With this conceptual shift comes a transformation from a focus on pathology to that of adaptation and the ability to survive when faced with unbearably difficult situations. However, what is important for clients to come to understand is that while these strategies for coping may have been instrumental to survival in the past, they are currently preventing them from functioning effectively. For example, becoming emotionally non-responsive, may have been of major importance for a young child who is dealing with repeated sexual abuse. However, emotional numbing can be quite problematic in terms of establishing and maintaining relationships in adulthood. In part, psychotherapeutic work within a trauma framework involves developing new approaches to handle stressful situations. For example, one might focus on increasing awareness of emotional reactions and on methods of self-soothing that are not self defeating. The most important feature of the trauma perspective is a belief in the client's capabilities and ability to continue to change. "An adaptation model emphasizes resiliency in human responses to stress. It helps survivors recognize their own strengths and inner resources, instead of defining themselves by weakness and failure. It reduces shame. It engenders hope for clients and treaters alike" (Saakvitne et al., 2000, p. 12).

Another important emphasis within the trauma framework is on the role that past experiences play in current emotional reactivity. Specific environmental stimuli (which include social interaction) are seen as "triggering" emotional responses because they bear a resemblance to past traumatic circumstances. However, because the client is not aware of the connection, it seems as if things are happening randomly. Unable to account for feelings and concomitant cognitive and behavioral changes, the client is left feeling out of control. For example, for a survivor of childhood sexual abuse, being touched, smelling certain odors, or being talked to in a certain way may set off intense reactions. These reactions are confusing to clients, as well as to the people around them. The notion of triggering is particularly important in an inpatient psychiatric setting in which some of the techniques used to deal with problematic behavior (for example, being put in restraints) may be experienced by the client as similar to past abuse. In such a case, the intervention might lead to increased feelings of vulnerability and result in increased agitation.

Concluding Note

It is important to note that in the present discussion of a "trauma perspective", I have intentionally focused on only a small segment of the literature concerning the way in which traumatic events impact on mental health. One could certainly turn to theorists like Searles, Karon and Lidz for cogent insights in terms of severe mental illness and trauma. I must admit that my hope is that once clinicians are willing to look at childhood events and their relationship to psychosis, they will rediscover the relevancy and richness of this literature.

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Sullivan The Clinician

Kenneth L. Chatelaine, PhD

[Editor's Note: This is the third of a three-part series]

IV The Clinician at Work on the Ward (Selected Recorded Interview)

Throughout his practice Sullivan treated even the most severely schizophrenic patients as the "normal" human beings he perceived them to be. Although aware always of the individual's state of mind (alert, confused, angry, distorted, whatever), he still hammered away at each subject during the interview process in an effort to bring about an awareness of reality. Knowing how painful awareness could be for some, he nonetheless attempted to heighten each patient's ability to test and deal with the actual world. By causing the individual to face the facts about his life, he led both subject and interviewer to a perception of reality that would reduce the threatening level of anxiety within the patient.

The following interview between Sullivan and a patient at the Sheppard and Enoch-Pratt Hospital was recorded in or about the year 1927. The twenty-three year old male schizophrenic was interviewed during his fifth day of hospitalization. Confused and somewhat depressed, he seemed to require urging before he would do anything. He had quite strongly expressed the idea that anyone who came into contact with him would be poisoned. Eating only under supervision, he had to be tube-fed three times on the day the interview was conducted.

Sullivan: What is the situation? Why don't you talk? Do you mind telling me what it is all about? (Moves about in natural fashion and continues to gaze at recorder.) What is the idea?

Patient: Sir?

Sullivan: What is the idea?

Patient: The idea?

Sullivan: Why are you sitting there so silently? If you don't mind I should like to know why you act so odd. Do you think you know the gentleman, Peter, there? You are looking at him a great deal.

Patient: I know who you are, all right.

Sullivan: That is very fortunate. Tell me about it. Tell me about it. I don't think you know. I don't think you have the faintest idea who I am.

Patient: I know you are a policeman all right (grins).

Sullivan: And what makes you think I am a policeman?

Patient: Isn't that what you have been doing all the time—trying to get me in prison?

Sullivan: Who? Who has been trying that?

Patient: Everybody.

Sullivan: And why? Why has everybody been trying to get you in prison? Are you supposed to have done something that was wrong? Why has everybody been trying to get you in prison? Have you any idea? Would you mind telling me why you think everybody is trying to get you in prison?

Patient: Just because I said it, that's all.

Sullivan: Do you believe everything you say? Do you never make mistakes in what you say? Are you one of those people who is always right? Are you always right? (shakes head negatively.) I am glad you are not conceited. Now quite honestly, do you think I am a policeman?

Patient: Sure. I remember one of those from the times I have been to the city.

Sullivan: What makes you think I am a policeman? Because I have large feet? (grins) Or merely because you like to think I am a policeman? Well, whenever you feel like it, answer me. It doesn't cost any more than keeping quiet, you know. Did the police bring you to the hospital?

Patient: My mother brought me. Mother and brother.

Sullivan: Why should you connect me with the police? I should love to know. Isn't that a little bit cuckoo? (grins faintly) Isn't it a little bit weird to connect me with the police? Doesn't that require considerable imagination on your part? Or, maybe you have seen the blue cross on my car. Is that it?

Patient: I know your car – sure.

Sullivan: You know those blue crosses are physician's permits from the police. All the doctors who want them can get blue crosses from the police in Baltimore. The same as ambulances. Did you know that or didn't you? They are what are known as right-of-way signs. I put mine on the tail end because I want right-of-way over the speed cops. But the fact that I have a blue cross that says "Police Permit" doesn't make me a policeman. Mr. (patient's name) do you feel that everyone is against you—that you have no friends—that everybody has it in for you—is that the notion? (shakes head negatively.) Are you a stubborn person? Are you naturally stubborn?

Patient: No sir.

The transcript clearly shows that in 1927, Sullivan was already employing what is today called "reality testing." The many questions that Sullivan puts to the patient in rapid order is an attempt to force the patient to test reality. The goal of Sullivan's questioning is to force the patient to juxtapose his idea of reality against reality itself in order to disclose the patient's own idea of reality as distorted. By constantly drawing the patient to examine what is real, Sullivan wishes to display to the patient how his own idea of reality is deformed. The assumption is that when the patient understands this disparity he will start to correct his own distorted conceptions. Sullivan's creativity was demonstrated in the use he made of reality testing as early as 1927. Several decades before reality testing became

standard practice in clinical treatment, Sullivan was already making innovating advances in this form of psychiatric treatment.

Sullivan felt, and ensuing results showed, that good clinical work completed within a hospital unit should be extended into the post-institutional life of the convalescent patient. Unfortunately, however, such patients were all too often taken back into the unhealthy environment, which had precipitated the illness to begin with, long before enough insight had been consolidated to enable the patient to avoid immediate damage. The end result of such detrimental circumstance was often a recurrence of the illness.

Sullivan believed that, in order for the relapse situation to change for the better, much rethinking is needed in regard to the etiology and institutional care of schizophrenia. His clinical vision concerned the creation of convalescent communities in which the young schizophrenic patients could pause long enough after leaving the immediate care institution to become secure in meeting and solving future interpersonal problems.

Conclusion

Sullivan was one of the major American personality theorists of the 20th Century and contributed to the modification of Freudian psychoanalysis. Sullivan was a neo-Freudian (it is now called Interpersonal Psychoanalysis, although he rejected the term as applied to him), but it is important to stress the significant revision he introduced into Freudian theory. Whereas Freud believed in an intrapsychic model of personality, the idea that inner-psychological forces determined personality, Sullivan held to an interpersonal model of the self, the idea that this mental illness is a product of the mutual interaction between the human organism and the familial-social. While Freud emphasized libidinal forces as determinate of personality, with particular forces on the Oedipal complex. Sullivan shifted attention to the area of self-esteem and adjustment. Both Freud and Sullivan understood the adult personality as an arena upon which the unresolved conflicts of earlier life were played out and this idea of a past haunting a present was their common grounding in psychoanalysis. Freud, however, emphasized the Oedipal, the libidinal and the idea that personality was predominately shaped by the age of three. Sullivan saw life, not as a mere repetition of an Oedipal conflict, but as a process of continuous and progressive development until death. In a lasting reconstruction of psychoanalysis, he demonstrated how the distorted self (mental illness) is not only the produce of inner forces *but a result of the image of ourselves that society reflected back to us.*

Within American psychoanalysis, Sullivan was a primary force; along with William Alanson White and Adolf Meyer, in giving an added dimension to refocusing the center of psychoanalytic theory. Sullivan helped shift the center of gravity from neuropsychology to social psychology. Freud maintained that human personality was both intrapsychic and determined primarily by neurological drives. The libido was the primary physiological drive. Sullivan, by contrast, stressed the sociological and interpersonal shaping of personality rather than the neurological determinants. Twentieth Century philosophical developments emphasized the crucial role of society in the molding of human attitudes and character. Sullivan brought about a greater correspondence between psychoanalysis and the larger background of 20th Century sociological theory.

Author's Note

My first experience with Harry Stack Sullivan occurred in 1970, during the course of my research for the first major paper required of my doctoral program at the University Of Maryland. Entitling my paper "The Contributions of the NeoFreudians to the Social Definitions of the 1930's," I intended to address the works of Karen Horney, Erick Fromm, and Harry Stack Sullivan. The first two individuals I read and reported on with great ease; then I began to read what is considered to be Sullivan's greatest work, *The Interpersonal Theory of Psychiatry* (1953). I read the first chapter and understood nothing. I read it again and understood nothing. After a third try I gave up and left him out of my paper, hoping that my advisor would not notice. He did, and marked me down accordingly.

I did not read Sullivan again until I was asked to consider doing my doctoral dissertation on him. Needless to say, I had my doubts after my first experience, but my advisor suggested that I visit Dr. Edith Weigert at her home in Bethesda, Maryland. Dr. Weigert had known and worked with Sullivan for years. Between patients, this eighty-five year old woman psychoanalyst spoke of him for an hour in a soft voice. As I rose to leave she related one final incident. Out riding together one day, Sullivan put his hand on her shoulder and said, "Edith, you do not know how lonely I am." This was the great theorist on loneliness speaking, the one who had once defined the schizophrenic as "the loneliest of the lonely." And so my odyssey began.

"I probably shall not return, but remember this and do not forget it. I shall be controversial. There was no way to avoid it." (Sullivan's last words to his foster son, James Inscoe Sullivan, on January 2, 1949)

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Medication and Psychotherapy*

[Editor's Note: This is part 1 in a 2-part series.]

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*This paper is extracted from *Phenomenology and Lacan on Schizophrenia, after the Decade of the Brain* by Alphonse De Waelhens and Wilfried Ver Eecke. Leuven. Leuven University Press, 2001.

Medication is in many cases very helpful for the treatment of mental illness. Thus medication can be used with schizophrenics who are excited and otherwise would have to be controlled by two or three strong adults, and who would need to be tied in warm and cold towels so that the body of the excited schizophrenic would not get exhausted and possibly lead to death. Medication is also known to be very helpful for depressives. These are some examples that create a strong belief in the efficacy of medication. In this paper, I want, first, to report on some facts that should introduce some reservation about exaggerated hopes in what medication can achieve. Second, I want to develop an argument for a dual approach in the treatment of severe mental illness. Third, I want to present some scientific evidence for the importance of psychoanalysis or psychodynamic approaches with severe mental illnesses.

A. Limits to the use of medication with emphasis on schizophrenics.

First, nearly one third of schizophrenics remain psychotic even after an adequate trial of medication (Schulz, 991) and after analyzing sixty-eight follow-up studies of outcome in schizophrenia since the turn of the century, Richard Warner concludes that "recovery rates for patients admitted since the introduction of the anti-psychotic drugs are no better than for those admitted after the Second World War or during the first two decades of the century" (Warner, 79).

Second, the negative symptoms of schizophrenia, such as lack of affect, anhedonia, and amotivation are not so amenable to treatment by medication. Antipsychotic medication might result in either improvement or worsening of these symptoms (Ibid., 989).

Third, it is well known that there is a risk for a considerable range of side effects going from mild discomfort to permanent movement disorders (Ibid., 994), or to the sometimes lethal neuroleptic malignant syndrome (in 0.1 to 1% of patients treated with neuroleptics or according to some reports even in more cases) (Ibid., 995).

Fourth, medication of schizophrenics aims at symptom reduction. It sometimes omits looking at the quality of life of the treated patients (Awad). Two consequences have been related to an exclusive pharmacological approach to schizophrenics. Notwithstanding the serious side-effects, the belief in the efficacy of medication has led to a practice in the US in which the patients were given much higher doses than in other countries (Schultz, 990); they were even given more medication than needed to keep the symptoms under control (Ibid., 991). This defective approach now seems to be counteracted by the search for the lowest effective dose (Ibid., 990). The other consequence of failing to pay attention to the quality of life of schizophrenic patient is the high rate of suicide (10 to 17%) mainly attributed to their experiencing the hopelessness of their illness (Ibid., 989).

Fifth, schizophrenics treated by medication or by ECTC (electro-convulsive therapy) complain about their subjective experience (Awad 743; Kafka 25-6). For developing my philosophical argument I will rely upon Lauren Slater (1998), who describes herself in her book as a severely depressed person, with self-mutilation and suicide attempts leading to five hospitalizations. Her diagnosis was obsessive-compulsive disorder. The example works if one accepts either that there is a continuum among the severe mental illness forms or if one accepts that, in general, medication is not aiming at fine-tuning the subjective experience. By means of medication she improved so much that she obtained a doctorate, became a director of a clinic, published a book, and married all within 10 years. Ms. Slater complains that after a year she "cracked up" and had to increase her dosage without ever feeling as good as before. She complains about her loss of libido which leads her to worry that without her sexuality she is not in touch with her deeper self. She complains that she cannot get anything creative done. She feels pain at having lost her identity in which her illness was a crucial component. A common sense remark might be that one cannot have it both ways: being well and having nostalgia for one's past illness. Such a remark misses, however, something essential. The now improved person feels a need to make connections

between her psychic view of every detail of the world when she was ill and the psychic view of the world in her improved situation. Making the connections is a form of psychic work in which all crucial concepts, by which one organizes one's psychic world, must be changed and connected with the old ones. Whereas before she had to develop the courage to accept help and develop self-worth by relying on her trust of others, now she needs to care for others and develop self-worth by being active. Furthermore she needs to tell herself a story of how these two strategies are the strategies of one person. Making these psychic connections is psychotherapeutic work.

B. Dualist approach to treatment of severe mental illness.

Given the less than total satisfaction provided by a pharmacological approach, it might be useful to report on some forms of dual approach to the treatment of severely mentally ill persons.

A prime example of a dualist approach to the treatment of severe mental illness can be found in the proposal by Loeb and Loeb for the treatment of manic attacks. They hypothesize that "the primary and underlying …disturbance in manic-depressive illness is a biologically determined increase in phallic sexual instinctual drive... This biological determinant is counteracted by lithium therapy" (Loeb & Loeb, 891; also 892). The authors draw attention to the fact that the same dose of lithium taken by the patient does not produce a stable level of blood lithium. To maintain a stable therapeutic level of blood lithium, the lithium actually taken by the patient must be increased, sometimes dramatically, during manic episodes (Ibid., 881-83). The authors draw attention to another series of facts they observe: the manic phase was preceded by socially unacceptable aggressive sexual advances; those in turn were preceded by marked verbal sexual expressions. Loeb and Loeb postulate that the increase in phallic sexual thoughts was mainly unconscious. Psychoanalysis or psychoanalytically inspired therapy deals with the unconscious. With the help of such treatment the patients were able to become aware of their sexual thoughts and could even diagnose an undue increase in sexual thoughts and phantasies. The patients so treated were now able to inform their therapists about such phantasy changes in their lives. The therapist was then able to order a blood test and, when necessary, he could increase the lithium dose. That dose could then be diminished if a blood test, ordered after the patient reported diminished sexual phantasies, showed that the blood lithium level was rising above the therapeutic range (Ibid., 883). For Loeb and Loeb, psychoanalytic treatment is used as a tool that allows the patients to be accurate predictors of a coming manic attack. The prediction can then be verified by checking the blood lithium level. Loeb and Loeb thus provide an example where one approach (the biological one) is considered to be dealing with causes, whereas the second approach (the psychological one) is given an important function in that it allows the creation of a warning mechanism. The second approach is encouraged and applauded because it provides an additional diagnostic tool.

We find another example of a dualist approach in the recommendation of treatment of depression by Vergote. In this example, the relation between the two approaches (the biological and psychological) are the reverse from our first example. Vergote argues that the cause of at least some depressions is psychological and that treatment consists in doing psychic (psychoanalytic) work. Comparing depressives with melancholics, the author observes that melancholics accuse themselves whereas depressives complain about themselves. Since Freud, excessive self-accusation is attributed to a defect in the super-ego. Complaining about oneself, according to Vergote, indicates a defect in some other psychic entity than the super-ego. To complain is to express the feeling that one is less than what one wants to be. What one wants to be is defined by one's ideal-ego or ego-ideal. Vergote then concludes that the depressive whose main symptom is complaint about oneself is somebody who has been unable to mourn the loss of an impossible ideal. His recommendation is to help such patients to mourn such a loss. However, in order to be able to do the necessary psychic work patients must satisfy two conditions. They must be able to concentrate and pay attention. They also must have some narcissistic investment in their own psychic products (dreams, memories, feelings) in order to have the energy and interest to work with them. Medication might be mandated in order to provide enough sleep for the patient to be able to do the necessary psychic work demanded by psychoanalysis. Vergote explicitly criticizes those who would refuse to make use of medication as an instrument for psychoanalysis (Vergote 1993, 124-5). That same dualist approach of assigning medication a subsidiary role for psychotherapeutic treatment of schizophrenics is argued for by an experienced therapist of schizophrenics (Karon & VandenBos, 209-10, 436; Karon 1999, 5). Willy Apollon, the principal psychoanalytic therapist in a Montréal clinic for the treatment of severely mentally ill people, formulates the subsidiary role of medication as follows: medication should be used to prevent that the illness does damage to the organic body (e.g., by preventing sleep) (Apollon, 95).

However, some might argue that a successful dualist approach to other mental illnesses is not a valid argument for a dualist approach in the treatment of schizophrenia. One strong argument against a dualist approach and in favor of a pure medical treatment of schizophrenics is the study of May and associates at the Camarillo State Hospital in California. Five methods of treatment were compared. "1/psychotherapy without medication, 2/psychotherapy with medication, 3/medication alone, 4/ECT, 5/milieu therapy (Karon & VandenBos, 376). The study concludes "that medication was the treatment of choice, that improvement on their criteria up to day of discharge showed an advantage to patients receiving medication over those not receiving medication, and that all other differences were trivial" (Ibid., 377).

In their publication, Karon and VandenBos argue

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that the California study cannot be understood to be a proper comparison of good medication with good psychotherapy for the following reasons. First, each therapist had to do all five methods of therapy, including psychotherapy, even if they did not believe in the efficiency of a particular therapy. Belief in efficacy of psychotherapy by the therapist is essential for the success of the therapy whereas that is not so much the case for biological treatments (Ibid., 376). Second, most of the supervisors of psychotherapy described as experienced therapists had little experience with schizophrenics–-and some had none–-since their residency (Ibid., 376-7). Third, improvement was from the day of discharge, not at preset time intervals. Discharge meant interruption of psychotherapy, which is known to be anxiety producing. Furthermore, whereas follow-up psychotherapy was not routinely provided, medication was maintained after discharge (Ibid., 377, 463). Fourth, the study notes greater insight in patients who had received psychotherapy, but the study dismissed this observation as having minimal importance (Ibid., 377). Fifth, in a four year follow-up study less than half the sample is included so that differences in mean hospitalization of 200 versus 600 days become statistically insignificant even though the study started with a large sample of 288 patients (Ibid., 376-78). Sixth, the study eliminated the least and the most ill schizophrenics and kept the middle third. This led to a sample that was mainly lower middle class white, with above average intelligence. This is not representative of the known population of schizophrenics (Ibid., 376).

One can thus conclude that the California study ends up with statistical anomalies (reason 5 and 6), dismisses a benefit of psychotherapy (reason 4), makes a comparison at a time known to be negatively impacting patients receiving psychotherapy (reason 3), and standard medication was compared with psychotherapy done by inexperienced therapists some of whom lacked motivation and supervision was provided by therapists some of whom had no prior experience with schizophrenics. The comparison was therefore between good medication and bad psychotherapy (reason 1 and 2).

Column: Mind and Brain

The Schizophrenias: Neuropsychoanalytic Perspectives

(Part 1 in a continuing series on neuropsychoanalytic models of the schizophrenias)

Brian Koehler, PhD

The following is an initial speculative attempt, closely tied to replicable research findings, to arrive at what I would understand as a less reductionistic model of the schizophrenic disorders. It is grounded in neuroscience, phenomenology, epidemiology, attachment theory, and most importantly, psychoanalytic/ psychotherapeutic theory and experience. It holds as untenable the artificial separation of neural events from the autonomous and social selves of the experiencing individual as well as her/his socio-cultural contexts. As Hyman and Nestler (1993) pointed out in their volume "The Molecular Foundations of Psychiatry," it is simply in error to separate brain from mind and the social surround. They noted: "...even the most abstract environmental inputs such as spoken words--are mediated similarly [i.e., through signal transduction pathways and neuronal gene expression]; they likely activate specific neural circuits and the neurons within them. Synaptic events, in turn, influence intracellular second messenger and protein phosphorylation pathways, transcription factors, DNA regulatory elements, and, ultimately, the activation or repression of specific genes. The sum of such effects within large neuronal networks would then produce long-term changes in the overall functioning of the brain, and hence in the behavior of the individual as a whole" (p. 196). These authors privilege a molecular approach to psychiatric neuroscience. However, as pointed out by Leon Eisenberg (1995), the human brain is all biological and all social. It is untenable scientifically to sharply separate neurogenetics/neurobiology from psychosocial and environmental experience. I believe environmental and intrapsychic factors may play a much larger role in these disorders than our current zeitgeist allows for. That is, not only may environmental influences override the genotype (e.g., in Tienari's adoption study in Finland which demonstrated genetic control of sensitivity to the environment--Tienari et al 1993), but that there may be similar schizophrenic phenotypes without the genetic diathesis as primary. As Bolton and Hill (1996) noted in their scholarly volume "Mind, Meaning, and Mental Disorder: The Nature of Causal Explanation in Psychology and Psychiatry" published by Oxford University Press, intentionality pervades biological systems to the molecular level. They suggested: "An attempted elimination of the intentional account of DNA and protein synthesis would have to define in physico-chemical terms items such as triplet coding, the role of mRNA as a messenger, and the nature of correct functioning and mutations. Similarly, although the terms 'transcription' and 'translation' may seem to refer inappropriately to human language, in many respects the process more closely resembles that of human communication than it does physico-chemical processes" (p. 235). Because of our inability to understand meaning in psychotic speech and symptoms, we assume they are evidence of neurological dysfunction without for example any evolutionary value (Hundert 1992) or interpersonal survival value. Even negative symptomatology, in my experience, can often be better explained by such factors as learned helplessness, despair, interpersonal rejection and shame, unconscious guilt, social alienation/isolation, unintegrated traumatic experience and abysmally low self esteem, than attributing it to primarily genetically triggered aberrant prefrontal functioning. One possible explanation of the observed combination of hypoactivity in the prefrontal regions alongside of limbic hyperactivity, is to see the connection between increased arousal, e.g., anxiety and panic, and the paralyzing effects of

affective dysregulation on neurrocognitive functioning (for a view of the schizophrenias which underscores the role of affects and psychosocial processes in course and outcome see Luc Ciompi's "The Psyche and Schizophrenia: The Bond between Affect and Logic" published by Harvard University Press in 1988).

Berman and Weinberger (1999) in their review of neuroimaging studies in schizophrenia, noted that frontal lobe abnormalities (e.g., hypofrontality) during states of rest in patients with schizophrenia are observed only inconsistently, even in chronic patients with a high degree of negative symptomatology. It is during cognitive activation paradigms (e.g., working memory tasks) that these abnormalities are more present. However, researchers have speculated that these may be artifacts of performance variables (e.g., test anxiety, learned helplessness, etc.), motivation or even medication effects. Underactivation of the prefrontal cortex is the predominant finding. It should be noted that recently researchers (Wykes et al 2002) at the Institute of Psychiatry in London demonstrated psychological reversal of hypoactivity in neural regions associated with working memory, i.e., frontocortical areas. Significantly, along with this prefrontal underactivity is hyperfunction of hippocampal tissue (it is important to keep in mind that profound and chronic anxiety/stress activates a cascade of neural events culminating in cortisol-mediated atrophy of hippocampal tissue because the latter is rich in glucocorticoid receptors). Also significantly, hippocampal atrophy results in prefrontal hypoactivation. It is a known neuroscientific fact that psychogenic stress results in hippocampal atrophy, some of which clearly seems reversible. Increased medial temporal activity (mesolimbic pathways) may relate to productive (i.e., positive) symptomatology such as delusions and hallucinations. Increased postcentral blood flow, sometimes referred to as "hypergnostic" (see the work of Louis Sass on hyperreflexivity in certain patients with schizophrenia, in particular his "Madness and Modernism: Insanity in the Light of Modern Art, Literature, and Thought" published in 1992 by Harvard University Press), may reflect the significant role of the expression and defense against annihilation anxiety.

Berman and Weinberger (1999) noted that in their data from monozygotic twins discordant for schizophrenia, the affected twin had a reduced volume of the hippocampal formation and that this hippocampal tissue atrophy best predicted the degree of dorsolateral prefrontal activation during prefrontal cognitive activation tasks., i.e., the smaller the hippocampus, the less prefrontal activity observed. The authors focus on the regional interaction between prefrontal and medial temporal areas as key in the pathophysiology of schizophrenia. However, they do not raise the possibility that these findings may be related to the detrimental long-term impact of chronic anxiety/stress. An important question is whether the anxiety is secondary to the putative neurogenetic diathesis. This is a complex issue, but there is research noted by Walker, Baum & Diforio (1998) which demonstrates that the neurochemical indices of anxiety, e.g., cortisol in saliva and plasma, precedes the emergence of behavioral symptomatology.

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Book Review:

Hogarty's *Personal Therapy for Schizophrenia and Related Disorders*

Joel Kanter, MSW

Personal Therapy for Schizophrenia and Related Disorders (2002) by Gerard E. Hogarty, MSW, Guilford, 2002.

Gerard Hogarty's new volume, *Personal Therapy for Schizophrenia and Related Disorders,* is a groundbreaking work which presents an empirically-validated psychotherapeutic approach for schizophrenia based on a contemporary biopsychosocial understanding. Hogarty, a social worker who is a Professor of Psychiatry at the Western Psychiatric Institute and Clinic at the University of Pittsburgh Medical Center, has a long and distinguished career as a clinician/researcher with schizophrenia.

For over 30 years, Hogarty and his colleagues have developed a series of Psychosocial interventions (major role therapy, family psychoeducation, social skills training, personal therapy, and, most recently, cognitive enhancement therapy) and submitted each to rigorous empirical trials. After each trial, he carefully examines the data and formulates new approaches which incorporate his prior research findings and empirical data from other sources.

In the volume, Hogarty presents an approach to individual psychotherapy which he entitles "personal therapy" (PT). He describes his prior research efforts, most notably his two-year study of family psychoeducation (1, 2) which demonstrated a dramatic reduction in relapse in the first year of treatment, but a reduction in therapeutic efficacy as time passed. While observing that ameliorating family stressors reduced relapse, he also observed that family psychoeducation had no significant impact on the personal or social adjustment of schizophrenic patients.

Based on these prior experiences, PT uses a three-phase approach, the first focusing on clinical and environmental stabilization, the second on symptom management, and the third on developing new social and vocational initiatives. Throughout all phases, all patients were maintained on antipsychotic medications which were carefully titrated to minimize side effects. The progression of patients through these phases was determined by each patient's rate of progress, not by a prearranged protocol. Until the goals of one phase were accomplished, the goals of the next phase were not initiated. The research protocol followed patients for three years, an unprecedented duration for any intervention study in schizophrenia.

Before describing the three phases of PT, Hogarty devotes a chapter to outlining "essential prerequisites" for this intervention in considerable detail noting "that for decades are program has been guided by a silent mantra: *innovative psychosocial treatment is for naught unless the fundamentals of good care are firmly in place* (Hogarty's emphasis). His definition of "good care" includes psychological support (attentiveness, empathy, and encouragement), material support (financial support, stable housing, case management) and skillful medication management. Unique in the treatment literature, Hogarty addresses both the oft-ignored subject of obtaining government disability benefits **and** the intricacies of medication management. While the details of the former will be of little interest to most British readers, his attention to such seemingly mundane, yet essential, matters is impressive. (The clinic spent over $6000 annually for transportation subsidies when these costs were an impediment to clinic attendance.)

With these prerequisites in place, the first "basic" phase of treatment is initiated as a therapeutic team continues medications, "joins" with the patient and family, and educates patients about their illness using a stress-vulnerability model. In the second "intermediate" phase, patients examine their own illness is greater detail, exploring the precipitants of relapse, and finally coping strategies for symptom management are taught. Finally, in the third "advanced" phase, patients maintain stability and apply these coping strategies as they undertake new social and vocational initiatives.

Besides outlining the essential elements of PT, Hogarty describes the three-year controlled research protocol (3, 4) in considerable detail. In his discussion of the data, he carefully explores the considerable improvement of the control "supportive treatment" group, examining the therapeutic effects of "good care" and clinical management enjoyed by both experimental groups. However, while there was little significant difference between both treatment groups in both symptomatic presentation and functional adjustment at the one year mark (both groups improved significantly), the control group's progress leveled off while the PT group made impressive gains over the next two years.

However, examining patterns of relapse, Hogarty observed that a subgroup of PT patients who lived alone actually had a far higher rate of relapse than did patients who received "supportive treatment" only. He commented that "we wondered whether these historical negative effects of psychotherapy might have had less to do with the intervention per se and more with cognitively overwhelming life experiences" (p. 64). Not surprisingly, patients with strong family support had much better outcomes.

This sort of multidimensional data analysis is perhaps unprecedented in the field of schizophrenia research, whether involving biological or psychosocial interventions. Hogarty sifts through his research data with a refreshing deftness and honesty; when the data does not support the efficacy of his intervention model, he straightforwardly acknowledges this and attempts to learn from negative as well as positive findings. In doing so, he briefly notes his most recent attempts to enhance the cognitive functioning of schizophrenic patients (5, 6), an approach which is

yielding impressive results.

In spite of this impressive empirical data, many psychotherapists may reject Hogarty's embrace of biological psychiatry and his neglect of psychoanalytic conceptualizations. He has little patience with intriguing metaphors or sophisticated interpretations. Yet, among the impressive array of data, Hogarty writes with a passionate concern for the well-being of persons with schizophrenia that is so often overwhelmed by statistical analysis. Researchers of schizophrenia would do well to learn from his sophisticated, yet readable, analyses. At the same time, psychotherapists treating schizophrenic patients will emerge with a better appreciation of the interplay of the biological, psychological and environmental dimensions of this complex disorder.

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Book Review:
Paul Federn: *Another Way for the Theory of the Ego*, by Maria-Tarasa de Malo Carvalho

Translated by Tom Federn, CSW (grandson of Paul Federn)

Paul Federn, une autre voie pour la thaorie du Moi de Maria-Tarasa de Malo Carvalho (Paul Federn: Another Way for the Theory of the Ego, by Maria-Tarasa de Malo Carvalho). Reviewed by Monique Dechaud-Ferbus in Revue Francaise de Psychanalyse, 1/2001, published by **Presses Universitaires de France** (translation printed with permission)**.**

With this book, Maria-Tarasa de Malo Carvalho commits herself to establishing the foundation for an investigation of the concept of the ego. It is a doctoral thesis supervised by J. Laplanche [one of the most prominent French analysts, who probably is best known for the book he co-authored with J.-B. Pontalis, "Vocabulaire de la Psychanalyse," i.e., The Vocabulary of Psychoanalysis], which has as its goal to revisit the concept of the ego and to expand the originality of the thought of Paul Federn regarding this subject. With great urgency, the author examines the thought of Paul Federn, whose major point of reference is Freud.

Those among us who have read Federn in the collection of texts that one owes to Edoardo Weiss and which is published under the title "Ego Psychology and the Psychoses" sooner or later encountered difficulties in reading it. Paul Federn is one of the first psychoanalysts to have treated this very complicated theme, and Maria-Tarasa de Malo Carvalho uses to her advantage the perspective vis-a-vis this apoque and the contributions that psychoanalytic theory has been able to make since then to facilitate access to his ideas in a remarkable way.

Here she then leads us to a critical reading in which she puts in relief what has remained hidden in the work of Federn. This work, which permits us to better understand him also opens up new areas of investigation.

It is a solid theoretical work, which puts the descriptive approach often called phenomenological of Federn's work in perspective with the Freudian metapsychological point of view. For the author, if the elaborations of P. Federn do not constitute a perfected theory of the ego, it nevertheless contains elements fruitful for the development of the psychoanalytic conception of the ego. Many modern authors have been able to recognize the pertinence of the contributions of Federn, and, for example, Didier Anzieu [prominent French analyst who authored, among other works, a two volume study of Freud's self-analysis, L'auto-analyse de Freud] in the Skin-ego [le Moi-peau] gives him credit for being the precursor of this concept, so rich in content.

Maria-Tarasa de Malo Carvalho leads us to a better comprehension of the relationship of the ego and the body by making a detailed study of the elaborations of Federn with regard to the relationship of the ego to the body. Laplanche also cites Federn in Vie et mort en psychanalyse [Life and Death in Psychoanalysis], when he shows that the ego is constituted from

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Theory of the Ego, continued

perceptions taken up libidinally by it, a second time.

The book is divided into two parts. The first presents Federn as a figure of psychoanalytic history as well as his thought in the context of the history of the development of psychoanalytic concepts. This first part which I read with great pleasure shows Federn in his relations with his colleagues at the time of the meetings of the Vienna Psychoanalytic Society. He was among the first followers of Freud whom he joined in 1901. He is without doubt one of the most original thinkers and Freud, who had great confidence in him conferred upon him the leadership of the Vienna Psychoanalytic Society when Freud left Vienna.

I have read with interest the discussions about drives, narcissism and the ego, which preoccupied the conceptual investigation of this epoch. It is captivating to follow how the author establishes the connections between the meetings described in the Minutes of the Vienna Psychoanalytic Society and the writings of Freud, notably in what concerns narcissism, about which there is a constant dialogue between his own thought and those of his contemporaries.

The second part of the work presents the major themes, which constitute the contributions of Federn to the psychoanalytic theory of the ego.

This book has the immense merit of freeing Federn from the criticisms that his investigations are phenomenological theory, divergent from the Freudian conception or that they are precursors of the contemporary psychology of the self. The author shows us that Federn has never postulated nor accepted the distinction between the ego and the self. On the contrary, he has protected the ambiguity intrinsic to the ego, at one time subject of all perception and libidinal object. The ways taken by Federn are opposed to those of Hartmann: they have diverging theoretical options, and Federn never accepted the idea of a sphere free from conflicts in the ego. His hypothesis that the ego is constituted by the investment of libido places it entirely in the sphere of sexuality (one understands here the interest that Laplanche has had for this work, but contrary to Laplanche, the biological aspect of the social instinctual drive is preserved). Federn follows the elaborations of Freud, which establishes a relationship between the constitution of the ego and narcissistic investment and opposes the idea of the ego as an adaptive agency. This notion, although appearing in The Ego and the Id, was never accepted as valid by Freud, but it is upon this conception of the ego that Hartmann based the development of his theory.

First, based on descriptive observations, Federn is interested in experiences, which would be able to clarify certain very particular manifestations of the ego, both pathological and normal. He has described a "sentiment of the ego" narrowly linked to the variations of its frontiers. It is a wholly particular and paradoxical property that the ego does not share with any other psychic agency; "It is a concrete entity in relation with the continuity of the person with regard to time, space and causality...it is the totality of the feeling that one has of his own living person."

One sees here that for Federn the ego is indeed an agency as Freud called it, but that it is also an experienced entity, an experience. It is the simplest psychic state, which accounts for the ego as body ego and psychic ego.

Maria-Tarasa de Malo Carvalho proceeds to study in the greatest detail what Federn elaborates regarding the constitution of the ego and its frontiers.

The familiarity of Federn with individuals suffering from psychosis and his interest in psychotic processes have turned his investigations in the direction of the ego and narcissism ... Determined to successfully treat psychotic patients, he had to think about modifying certain elements of what defined the framework of the treatment of those persons who suffer from neurosis. But to do this, it was necessary to increase the understanding of psychotic phenomena. It was in this spirit that his investigation of the ego proceeded. For him, the ego originates in the establishment of libidinally invested frontiers, and it is the existence of frontiers, which assure the evidence of the perceptions. He writes, "We have arrived at the firm conviction that the evidence of the frontiers of the ego ought to be protected in order that the exterior world would be able to remain evident...we are able to say that the ego (in the psychosis) is absent from the function of perception, which comes into play without the libidinal contribution coming from the ego, that is to say without the support of sexuality in its linked and linking form." He proceeds to reevaluate estrangement, depersonalization and delirium in the light of this conception.

I also have appreciated the finesse of Maria-Tarasa de Malo Carvalho's analysis of Federn's conception of an "actual neurosis," a notion that we owe to him. He describes the feeling of estrangement (called "being estranged" in the text of Maria-Tarasa de Malo Carvalho) as the most frequent transitory narcissistic actual psychosis. He takes the phenomena of estrangement as examples of the libidinal nature of the ego.

Maria-Tarasa de Malo Carvalho proceeds to show why Federn is opposed to the idea of a loss of reality as the initial stage in the formation of a psychotic symptom and why, on the contrary, he postulates "a gain of reality." For Federn, it is the loss of ego, which would characterize the beginning of a psychosis with the result that this no longer would be capable of assuring the inhibition of the unconscious investment. It is in this way that unconscious contents can gain the character of reality, when they become conscious without being linked to the unity of the ego.

Federn's position is based on the desire to demonstrate that there is a sentiment of reality, which to a great degree

depends on the investment effectuated by the ego at its borders. The ego only owes its coherence and its efficiency to some energetic investments, which come from the amalgamation of two instinctual currents: libido and mortido (the term that he utilizes for the death drive).

Maria-Tarasa de Malo Carvalho shows us that Federn was totally preoccupied by the economic point of view to the detriment of the dynamic point of view concerning identifications, a point of view that he hardly developed. However, his contribution regarding the comprehension of the psychoses is emphasized by Racamier [prominent French psychoanalyst] has fundamental and it would be a mistake to neglect him, in as much as Maria-Tarasa de Malo Carvalho makes understanding him considerably easier.

Federn remains an important author, whom it is important to read or reread as Maria-Tarasa de Malo Carvalho invites us to do. It was above all his attention to psychotic phenomena, which allowed him to propose the most stimulating formulations in the domain of the theory of the ego. He has opened the way to a comprehension of the "illnesses of the ego" in relating them to a failure of narcissism, correlative to a failure of repression.

Federn, Maria-Tarasa de Malo Carvalho informs us, is preoccupied with the structure of the ego, with his description of it as reservoir of libido and the fluctuations of narcissistic investment. Although she reports about Federn's familiarity with psychotic processes, she does not make this work a specialized study of psychosis. Among the elaborations of Federn about the ego, Maria-Tarasa de Malo Carvalho considers those which characterize this concept from a metapsychological point of view as worthy of interest. It is a study attentive to the inner development of this concept, which reveals the importance attributed by Federn to the hypothesis of Freud regarding the constitution of the ego as an object of libidinal investment.

I have only rendered an imperfect accounting of the richness of this work and the erudition of its author. We are only able to enrich ourselves by this work of great exactitude, which permits one to discover Federn and to undertake a way of psychoanalytically investigating the ego. It is a work solidly based just as much for the history of psychoanalytic concepts as for the clinical researches, which flow from it.

Books of Interest to ISPS-US

The following books were sent by the authors for ISPS-US to review in future issues of our newsletter. On cursory examination they seem to be quite relevant and interesting:

John Appel (2000). *Who's in Charge? Autonomy & Mental Disorder*. Danbury, CT: Rutledge Books, Inc.

Alex Sabo & Leston Havens (2000). *The Real World Guide to Psychotherapy Practice*. Cambridge, MA: Harvard University Press.

News from Local Chapters of ISPS-US

Berkeley/San Francisco

Sue von Baeyer, PhD

We have been relatively inactive here--the last two meetings we had were last year--David Rosenfeld from Buenos Aires gave a talk at Boyer House (BHF) on the Death Instinct a year ago February, and Philip Alex gave a talk on a sweltering June day last year on Delusions--a wonderful presentation. Since then we are fallow. I hope to take it up again when the weather cools--it is too hot to hold anything at BHF in the summer--BHF being our location and our benefactor for mailing the announcements.

Editor's note: Interested persons in the Berkeley/San Francisco area can contact Dr. von Baeyer at siouxcvb@aol.com for information on this local chapter of ISPS-US.

Chicago

David Garfield, MD

The Chicago chapter of ISPS-US had its second anniversary this spring and celebrated with dinner at Chicago's Italian Village Restaurant on March 22, 2003. Many attended and much fun was had by all. Our chapter has held steady in terms of numbers over the last year with a very solid core group of about 20 and many others weaving in and out. We have spent the last year getting to know each other and planning our educational activities. We have an active community liaison committee, spearheaded by Jill and Garry Prouty and contacts have been established with dozens of local community agencies. We plan to do educational programs for many of them but manpower is limited at this time so we will be brainstorming the best ways to reach out. The Institute for Psychoanalysis, Chicago, has been a gracious and lovely home base for us. Gertrude Pollit and Peter Giovachinni from the Center for Psychoanalytic Study continue to be available to present and

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News From Local Chapters (Chicago), continued
discuss as do many of our other fine and seasoned clinicians and theoreticians. We have students attend from the Illinois School for Professional Psychology, The Chicago Medical School and from a variety of other schools in town. We lost Dr. David Downing as he moved to Indianapolis but he stays in touch. Presentations this past year have included some by Frank Summers, Garry Prouty, David Garfield, Charles Turk and Gertrude Pollit. With her increasing responsibilities for US-ISPS, Julie Wolter has handed over the secretarial duties to Dorothy Mead who has been doing a terrific job. Oltea Schwartzenberg has also stepped up to help out with many of our organizational tasks.

Our goals are to sustain and enhance our own membership with meaningful study, presentations and guest speakers. To expand awareness of ISPS and its many activities to those in the Chicago area who work with psychotic patients and invite them to join us. To provide education on the psychological treatments of psychosis to mental health organizations and professionals.

The Chicago Chapter has been addressing all three goals in an ongoing fashion and looks forward to a third year of growth and prosperity.

Respectfully submitted,
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New York

Brian Koehler, PhD

The New York Chapter of ISPS-US first convened about 7 years ago and has been been meeting continuously on a monthly basis since 1997. In November 2002 our chapter sponsored the Fourth Annual ISPS-US conference, "Beyond the Wall: Contemporary Psychoanalytic and Psychosocial Perspectives on Psychosis," at the William Alanson White Institute. We started a visiting speaker series, which in the past has included David Feinsilver, M. Gerard Fromm, Leston Havens, Bert Karon, Loren Mosher, Michael Robbins, Louis Sass (discussion by James Ogilvie), Ann-Louise Silver, Wilfried Ver Eecke, Vamik Volkan and others. This past academic year we heard presentations by Marvin Hurvich on annihilation anxiety in borderline and psychotic states; Michael Robbins on therapeutic action (using process material from audiotaped sessions); Tom Federn on Benedetti, Freud, and Paul Federn (his grandfather); Scott Gremmel on schizoanalysis and integral depth psychology; Maurice Shilling on the interplay of countertransference and resistance; and Sharon Farber on religious issues in self-harming patients. The last two presentations of this year will be by Brian Koehler on neuropsychoanalytic perspectives in the schizophrenias in June and Julie Kipp will present in July on the community as therapist in severe mental illness. Michael Eigen and Anni Bergman will be presenting sometime in the Fall 2003.

For information on the NY Chapter of ISPS-US please contact Brian Koehler at (212) 533-5687 or brian_koehler@psychoanalysis.net.

Philadelphia

Harold R. Stern, PhD

The impetus for founding an ISPS chapter in Philadelphia stemmed from the appearance of Nobel Laureate John Nash at the Philadelphia Free Library in the Fall of 2002. ISPS-US manned a booth at this popular event with a sign-up sheet for persons interested in forming a local chapter, and the rest is history.

Bertran Karon, Ph.D., co-author of *Psychotherapy of Schizophrenia: The Treatment of Choice*, addressed our first meeting, held November 7, 2002, at the home of Harold Stern. An audience that included psychologists, psychiatrists, social workers, nurses, graduate students and family caregivers of persons with schizophrenia joined in the discussion of the theory and techniques of treatment. Because the topic could not be covered in one session, the group decided to continue the discussion in a series of monthly meetings in private homes.

Subsequent meetings included one in which Victoria Conn summarized the highlights of the ISPS national conference in NYC (Beyond the Wall: Contemporary Psychoanalytic and Psychosocial Perspectives on Psychosis); and in the next month one in which Harold Stern detailed his approach to treatment and cited case studies of recovered patients; and following that, a meeting in which David Wilson discussed the modifications needed in the treatment of patients dually diagnosed with schizophrenia or bipolar disorder and substance abuse. In March, Dr. Paul Fink, an academic psychiatrist who is a past president of the American Psychiatric Association, and former Chairman of the Thomas Jefferson Medical University Department of Psychiatry spoke about the current status of training programs for psychiatric residents, in which there is a "dearth of training in doing psychotherapy" in contrast to an emphasis on training in psychopharmacology. Next, our April meeting will feature Leigh Whitaker, Ph.D., reviewing Robert Whitakers' book, "Mad In America" and presenting his own research on treatment outcomes using psychological approaches. Dr. Whitaker, who developed the Whitaker Index of Schizophrenic Thinking (WIST) is currently Adjunct Clinical Professor at the Institute for Graduate Clinical Psychology at Widener University.

Although the Philadelphia meetings are open to all interested persons, membership in the chapter is contingent on joining ISPS-US. For further information, contact Harold Stern <hsternmail2.gis.net> or (610) 949-9339).

Washington, D.C.

Ann-Louise Silver, MD

The Washington branch of ISPS has held only one meeting this year, in conjunction with the Washington School of Psychiatry's Frieda Fromm-Reichmann Lecture. On March 23, 2003, Siobhan O'Connor, M.D. spoke on the topic, "Addressing violence in schizophrenia." She is a lively and engaging speaker who thinks very clearly on clinical issues. I imagined Fromm-Reichmann attending in spirit, and being especially pleased to make her acquaintance. These two women share the strong commonalities of warmth, clinical acumen and forthrightness.

Dr. O'Connor delineated the regressive processes of schizophrenia in the inpatient setting. We studied the therapeutic effect of traditional multidisciplinary roles and how clear structure in the team can provide containment for the disintegrated object relationships of the patient. She stressed the discomfort of containing the bad object and the impact that this has had is general psychiatry for those who want to be perceived as good objects for their patients. These remarks left me sad that David Feinsilver was not there to hear her, and to agree enthusiastically.

Dr. Siobhan O'Connor completed her training as a Psychoanalyst with the British Society while working as a Consultant Psychiatrist in Northern Ireland. Attracted to working with the more severely disturbed patients, she took responsibility for a locked ward, applying psychoanalytic ideas to the practice of general psychiatry. Her experience of rehabilitation of many patients who had been seen as resistant to treatment led to the development of a more active Inpatient Unit and her interest in writing about the problems of acute psychiatry. She has recently moved to London for the opportunity to develop her work in psychoanalysis, but continues her work as a general psychiatrist in the public sector. She believes this gives her the opportunity to provide a more therapeutic approach in acute psychiatry than she might have given in the specialized role of Consultant Psychotherapist. She now is an active member of ISPS-UK. Hopefully, she will address us at some future ISPS-US meeting.

We look forward to regularly scheduled meetings next year, perhaps in conjunction with the Columbia Academy of Psychodynamics which meets monthly in Columbia, MD.

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CALL FOR PAPERS

5th ANNUAL CONFERENCE of ISPS-US

United States Chapter of the International Society for the Psychological treatments of the Schizophrenias and other Psychoses

PHILADELPHIA, PA

SATURDAY-SUNDAY, NOVEMBER 8-9, 2003

THOMAS JEFFERSON MEDICAL UNIVERSITY

The Solis-Cohen Auditorium, 1020 Locust Street, Philadelphia, PA 19107

The Mind Behind the Brain

Co-chairs: Harold R. Stern, Ph.D. and Brenda Byrne, Ph.D.

In our era, we hear and read forcefully repeated pronouncements on advances in psychopharmacology. At the same time, funding for direct patient care is slipping away, as hospitals and community programs continue to shrink or close. Some even claim that psychotherapy is dangerous for those struggling with psychotic illness. Mental illness is manifested as a disorder of the mind involving chaos in thinking and feeling, and a loss of trust in the self and in others. ISPS-US is working toward more balanced and humane approaches that promote secure attachments and better mental health. We emphasize sorting things out by talking. It helps to talk with someone who can understand and integrate what was seemingly chaotic and help create balance and order.

We invite submissions of 30-minute papers for our fifth annual meeting. Clinical reports, theoretical papers from a wide variety of orientations, public policy papers, historical studies, and personal accounts are welcomed. Please send an abstract (100-200 words) along with your proposed title by August 20th (so we can put our brochure together) and an objectives statement to:

Harold R. Stern, Ph.D., 354 Winding Way, Merion Station, PA 19066-1500
(610) 949-9339, hstern@mail2.gis.net

Fee: Early registration for members $100; Non-members $140; Students $50

After August 15: Members $120; Non-members $150; Students $65

(Note – People who sign up to become members may pay $140 and simultaneously have membership in ISPS-US.)

To Register: Please fill out as below and return with check (payable to ISPS-US) to:

Harold R. Stern, Ph.D., 354 Winding Way, Merion Station, PA 19066-1500

Name_____ E-mail Address_____
Street_____ Apt._____
City _____ State____ Zip_____
Payment Enclosed_____
Request Hotel Reservations_____ Institutional Affiliation:_____

We anticipate providing CE credits for psychologists, social workers, and nurses and will provide more precise information in our forthcoming flyer.

Articles, commentaries, vignettes, poems,
book reviews, movie reviews???

Contribute your piece to the next issue of the ISPS-US Newsletter

Deadline: October 31, 2003

Newsletter Editor - Brian Koehler
brian_koehler@psychoanalysis.net 212-533-5687

(All contributions should submitted by e-mail or on diskette)

Check out the ISPS Website: www.isps.org

Coming Soon: The ISPS-*US* Website
Contact Greg Rosen for more information:
g.rosen@pipeline.com

Combined ISPS and ISPS-US Membership Application

(Please note: Local branches may assess additional dues.)

Name:_____

Address:_____

_____

City:_____State:___ Zip:_____

Institutional affiliation:_____

_____

Home phone*_____

Work phone*_____

Fax:_____

E-mail:_____

Join listserve: Yes_____ No_____

List in directory: Yes_____ No_____

Specific interests:_____

_____

*Please indicate preferred number

Yearly Dues:
Mental health professionals - $40.00
All others - $20.00

Checks payable to ISPS-US

Send to Barbara Cristy, LCSW-C
Treasurer, ISPS-US
1015 Spring Street #201
Silver Spring, MD 20910

14TH ISPS CONFERENCE

Reconciliation, reform, and recovery: Creating a future for psychological interventions in psychosis

September 22 - 25, 2003
Melbourne Convention Centre
Melbourne, Australia

For further information, contact Marg Scarlett, ISPS Secretariat,
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