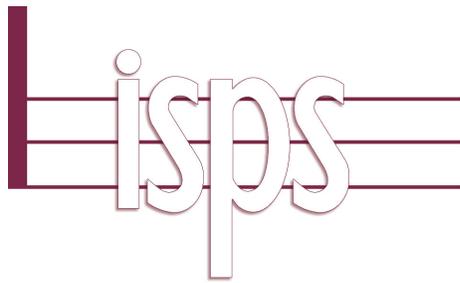


ISPS-US
P.O. Box 491
Narberth, PA 19072
contact@isps-us.org
www.isps-us.org
(610) 308-4744



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

President's Report

Brian Koehler PhD
New York University

For all that has been — Thanks. For all that shall be — Yes.
Dag Hammarskjold

Recently, the Executive Board of ISPS-US met at New York University for our annual working retreat. The following persons participated in our retreat: Ron Abramson, Jessica Arenella, Marty Cosgro, Susan Dansker, Lori Kalman-McCartney, Julie Kipp, Brian Koehler, K. Lowenthal, Alice Maher, Ann-Louise Silver, Karen Stern and Ross Tappen. Prior to our retreat, I surveyed our members on our listserv as to their concerns, suggestions, etc., on all aspects of our functioning. I also posted our agenda and our proceedings after the retreat was over. The board members discussed a wide range of subjects, including, but not limited to, our website, annual meetings, the formation and support of local branches, course offerings, newsletter and listserv, our monthly teleconference calls to address issues (e. g., planning for our annual meetings), our relationship with the international group, etc. We are continuing to advance psychosocial treatments and interventions for persons diagnosed with a severe mental disorder and to do outreach to various populations of clinicians, clients and their loved ones, students and trainees, researchers, academics, etc. Our website has been newly designed and organized by Susan Dansker who is helping to take us into the 21st century in terms of electronic communications and exchange. We now have a blog embedded within the website moderated by Jessica Arenella and a Facebook page and blog organized by Alice Maher. Please check out our new website, Blog and Facebook page if you have not already done so. Please feel free to contact me should you wish further details on our recent retreat.

In the service of making my president's column more than just a report of our proceedings, I would like to continue to share part of my vision for ISPS-US, in particular, concerning the advancement of psychosocial treatments, e.g., CBT and psychodynamic psychotherapies, intensive case management, psychoeducation, cognitive remediation, supported housing and employment,

family interventions, use of self-help interventions such as the establishment of the hearing voices networks, etc., as well as the transformation of our existing mental health delivery systems which are not ade-

Treasurer's Report

K. Lowenthal

For the last two and one half years I have had the honor and the pleasure of being the Treasurer of ISPS-US. During this time our organization has been financially solvent and we have been able to hold successful and profitable meetings in New York City (2008) and Rockville, Maryland (2009). Our solvent position has enabled us to plan more meetings, improve our website, promote the book series, and have a general sense of optimism about the future.

On a personal level, I have really enjoyed working with the members of the executive committee. Although not myself a clinician, I have enjoyed following the listserv. I look forward to continuing to be of service to the organization.

“Innate among man's most powerful strivings toward his fellow men... is an essentially therapeutic striving.”

Harold F. Searles (1979)

Continued on page 2

Continued from page 1

quately serving our clients/patients/ therapeutic partners. I would also like to briefly mention the proposed new diagnosis for DSM-V, the “developmental trauma disorder” and its potential relevance to ISPS.

I would like to refer to some significant comments of our current Director of NIMH, Thomas Insel MD. These comments are from his article “Notes from translating scientific opportunity into public health impact: a strategic plan for research on mental illness” published in the Archives of General Psychiatry, 2009; 66 (2): 128-133.

Insel (2009) soberly noted:

“For the past decade, researchers have been anticipating how the power of genomics and imaging will yield biomarkers and new treatments for mental disorders. Despite high expectations, neither genomics nor imaging has yet impacted the diagnosis or treatment of the 45 million Americans with serious or moderate mental illness each year. While we have seen profound progress in research (with molecular, cellular, and systems neuroscience revealing new, unexpected insights about the brain), the gap between the surge in basic biological knowledge and the state of mental health care in this country has not narrowed and may be getting wider” (p. 128).

He also noted:

“In contrast to the steadily decreasing mortality rates of cardiovascular disease, stroke, and cancer, there is no evidence for reduced morbidity or mortality from any mental illness. A recent analysis of mortality in 8 states reported that individuals with serious mental illness die 13 to 32 years earlier than those without mental illness. Rates of suicide have remained constant, resulting in more than 30,000 deaths per year in the United States...Premature deaths related to mental illness were more often due to medical comorbidity, especially cardiovascular and pulmonary disease, rather than suicide” (p. 129)

Insel reported further statistics on disability from mental disorders:

“The World Health Organization Global Burden of Disease study listed mental illnesses as the leading source of disability in Americans and Canadians aged 15 to 44 years, accounting for nearly 40% of all medical disability in this age group. The National Comorbidity Survey (1992) and National Comorbidity Survey replication (2002) used face-to-face surveys to compare disability from mental disorders in nearly 10,000 households. The results demonstrate no change in the prevalence of mental illness between 1992 and 2002, but increased rates of treatment. For all classes of mental illness, rates of treatment increased from 20% to 33% during this 10-year period. Curiously, despite increased treatment, there was no evidence for decreased disability. Indeed, the more recent cohort shows a loss of income that is considerably greater than all previous reports. While more people are receiving treatment, fewer than half of those treated receive treatments for which there is any evidence base” (p. 129).

After reviewing the disappointing results from the three major NIMH- sponsored psychopharmacological studies, i. e., CATIE for schizophrenia, STEP- BD for Bipolar Disorder and STAR*D for Depression, Insel noted: “While psychosocial interventions have received much less marketing attention than pharmacological treatments, the results are arguably more encouraging. For people with schizophrenia, assertive community treatment, family psychoeducation, and supported employment have substantial effects on functional recovery and relapse rates. Many studies have found cognitive behavior therapy to be an effective treatment for mood and anxiety disorders [and for schizophrenia as well]. However, few patients actually receive evidence-based psychosocial treatments” (p. 129).

Continued on page 3

Table of Contents

Special Features:

<i>President’s Report:</i>	1-5
<i>Treasurer’s Report:</i>	1
<i>Vice President & Web Editor’s Report:</i>	6
<i>ISPS-US Board Condemns Arizona SB 1070:</i>	7
<i>Where is Your Face?:</i>	8-9
<i>Recovery: Why is it being redefined to mean “doing better but still mentally ill”?:</i>	10-14

I firmly believe that ISPS-US and ISPS are at the forefront of the advancement of a diversity of psychosocial treatments for persons diagnosed with a severe mental disorder, many of which are evidenced-based. I am still in the process of collecting articles demonstrating the efficacy of various kinds of psychosocial treatments for our data base. The latter will be made available to our members, clients and family members, researchers, students, clinicians, academics, as well as the interested general public. Please consider sending me any references that you feel are relevant (my email address is bk64@nyu.edu).

I would like to mention a fairly new volume on the subject of transforming our current mental health system, which many people in the field believe is in urgent need of significant improvement. The volume is "Healing the Broken Mind: Transforming America's Failed Mental Health System" by Timothy Kelly (2009), published by New York University Press. Kelly is the Director of the DePree Center Public Policy Institute and is the former Commissioner of Virginia's Department of Mental Health. Kelly quotes the relevant statistics which signify the need for a transformation of our existing systems:

- in any given year 26.2 percent of America's adult population (57.7 million people) meet the criteria for a diagnosable mental disorder.
- in 2003, 340,000 Americans visited emergency rooms as a result of suicide attempts and 30,000 of those who attempted suicide died.
- ten years ago, the surgeon general found that over \$69 billion dollars was being spent annually in direct costs for mental health services, yet often without benefit to service recipients.

I could add many other statistics to this edited list, but the fact of reduced longevity of our therapeutic partners is very alarming. Also, in 2007, epidemiologists and psychiatrists at Columbia University observed that the number of children and adolescents treated for bipolar disorder, had skyrocketed, rising forty-fold (8,000 percent) from 1994 to 2003.

Kelly lamented the restriction of patients with severe mental disorders to state hospitals only to ignore their pressing need for effective treatments. He quoted from the President's New Freedom Commission on Mental Health issued in 2003: "America's mental health service system is in shambles...[and] needs dramatic reform" (p. 5). We know that many such individuals have suffered various kinds of traumas that are not being effectively addressed with current treatments. We in ISPS should promote psychosocial interventions which assist individuals in recovering from the effects of such traumatic experiences as well as the social isolation and social defeat which is often intrinsic to their standing in society. We need to emphasize the importance of continuity of care and the for-

Continued on page 4

17th International Symposium of ISPS Dubrovnik, Croatia 2011

ISPS is now holding its international conferences **every two years** and the next conference will be in the beautiful old Croatian City of Dubrovnik on the Adriatic Coast

The dates are May 31st (for workshops) - June 1st - 4th (conference), 2011

The title will be: **PSYCHOLOGICAL THERAPIES FOR PSYCHOSES IN THE 21ST CENTURY -
influencing brain, mind and society**

www.isps2011.org

Continued from page 3

mation of secure, safe attachments with the individuals we serve. There is so much more to address on this issue, but in the interest of space requirements, I will move onto to my last point, the importance of the diagnosis of developmental trauma disorder and its potential relevance to our patients.

The introduction of PTSD in the DSM-III made it possible for many Vietnam veterans to be recognized and treated for their trauma symptoms. The number of US children reported to be victims of childhood maltreatment (abuse, neglect, etc.) is 10 times greater than the prevalence of PTSD in combat soldiers. The symptoms of PTSD do not adequately reflect the symptoms and experiences of traumatized children. When such trauma takes place within the context of what is to be a safe/secure caregiving/attachment environment, the trauma takes on a profoundly different shape. We know from the neurobiological research of many developmental traumatologists, e.g., Martin Teicher, that brain development is profoundly affected in these children. Early interpersonal trauma derails development in multiple domains.

These changes can have a significant effect on the developing self, interfering with its coherence and cohesiveness. Abused and neglected children, instead, often receive diagnoses related to anxiety, mood, attention, etc., which become the focus of treatment at the expense of addressing the shame, fear, terror and rage consequent to threats to psychic or physical survival.

In response to this nation's significant public health threat, the National Child Traumatic Stress Network's DSM-V Task Force has proposed a new clinical syndrome: Developmental Trauma Disorder. This diagnosis describes five clusters of symptoms observed in many children who have suffered repeated trauma in an interpersonal context:

- 1) affect and impulse dysregulation
- 2) disturbances of attention, cognition and consciousness
- 3) distortions in self-perception and systems of meaning
- 4) interpersonal difficulties
- 5) somatization and biological dysregulation

Continued on page 5

**ISPS-US would like to thank the following people for their generous donations
(beyond dues) through May to September 2010:**

Julie Kipp, PhD, LCSW

Faye Margolis, PhD

Brian Koehler, PhD

Gertrude Pollitt DPsa

Effie Kokkinos, PhD *in memory of Irene Kokkinos*

Clint C. Stankiewicz, PsyD

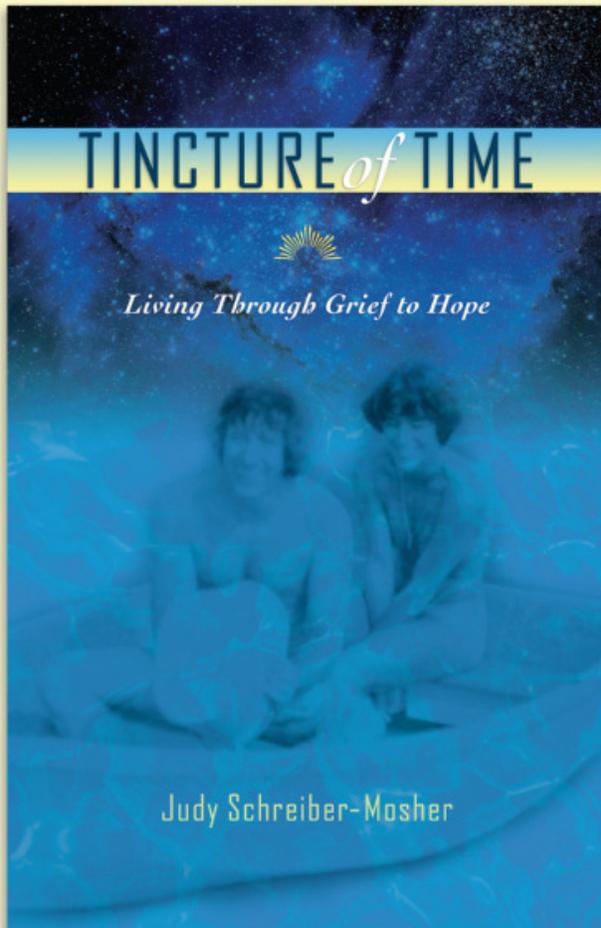
Thanks so much for your generosity. We count on your donations! To make a tax-deductible contribution to ISPS-US, please use the membership form in this issue or click the donation button on our website, www.isps-us.org. One area in which donations are especially needed is the fund to allow low-income people to attend the annual meeting.

Note: If you made a donation but your name is not included, it's because you did not give us permission to print your name. Please let us know if we may thank you publicly!

ISPS-US is a 501(c)(3) nonprofit organization.

Continued from page 4

I believe that incorporation of this diagnosis into the DSM-V would be an achievement for those of us who have been studying the effects of fear/trauma/ neglect /social isolation and defeat on the brain and self of the child (adolescent and adult). Personally, I would like to see the term “with or without psychotic features” added to this diagnosis. We know from research that many persons who experience chronic hallucinations have suffered childhood maltreatment (including neglect). This is only one aspect of this complex situation. Perhaps, many persons can be spared a diagnosis of “schizophrenia” should this diagnosis with a “psychosis” specifier be incorporated into DSM-V. It would also bring much needed attention to the role of the social environment, especially trauma and social isolation (profound loneliness), in the severe mental disorders. In addition, the current work on epigenetics (factors influencing DNA readout) and the social- psychological impact on gene expression in mental disorders may get further needed research dollars.



*Tincture of Time,
Living Through Grief to Hope*

WRITTEN BY JUDY SCHREIBER-MOSHER ABOUT
THE DEATH OF HER LATE HUSBAND AND
PROMINENT PSYCHIATRIST, LOREN MOSHER.

From her husband’s “death sentence” through her first three years of widowhood, Judy Schreiber-Mosher’s *Tincture of Time* blends passion and sadness with magical moments of the past and present until she eventually emerges with the sense of a future.

Available through Amazon and on the Soteria Press website, www.soteriapress.com, \$14.00

ALSO AVAILABLE FROM SOTERIA PRESS:

Remembrance Calendar, Stars Who Brighten the Face of Heaven, \$9.95 and *How to Cope with the Death of a Partner, Strategies for Surviving the Difficult Times Ahead and Maintaining your Emotional Health*, \$7.50

Soteria Press

Vice President's Report

Marty Cosgro, Ph.D.

The executive committee had another productive retreat this July in New York City, and laid the foundation for tele-seminars to be offered in the future. Members will be able to get further specialized training in psychotherapy with psychosis, without the confines of a specific location. The initial seminar is likely to be focused on the work of Harry S. Sullivan, and other relevant seminar topics were discussed. It's exciting to see how our mission is being further implemented with the development of the new tele-seminars. More information will be made available as the details of the seminar take shape.

The responses to our slogan contest have been wonderful and all reflect the passion members have for this meaningful work. It will be a challenge for the executive committee to choose a winner before the conference in November. There is still time left to submit entries to MCosgro@charter.net. Entries should be succinct so they can be printed on any number of advertising items we may use in our efforts to reach out to the broader community who may not know of us or the work we do. The winning slogan will be printed on a T-shirt for the winner (and likely available for others to purchase as well).

Our website, newly re-designed by Susan Dansker, continues to provide important information to people throughout the world. In 2010, we have averaged over 1900 new visitors per month, and recent data tells us we're being visited by people from 24 different countries. There are more renovations planned, with a focus on becoming more personal, while providing still more resources to clinicians, students, service users and family members. Anyone with an interest in helping to develop the website into a more resourceful place should contact Marty Cosgro (see above). No technical skills are required, just an interest in helping us provide more useful information to our audience around the globe.

Join Us in the Berkshires!

For the ISPS-US 11th Annual Meeting
Psychosis, Trauma, and Human Connections: Building Community

November 5-7, 2010
 The Austen Riggs Center, Stockbridge, Massachusetts

Keynote Speaker
Joanne Greenberg, DLH Author: *I Never Promised You a Rose Garden*

Honorees - Featured Speakers
Françoise Davoine, PhD & Jean-Max Gaudillière, PhD
 Authors: *History Beyond Trauma*

Hosted by ISPS-US Berkshires
 Jointly sponsored by The Lifespan Learning Institute
 CEU/CME credits will be offered.

See www.isps-us.org for more details.
 To request a brochure, e-mail Karen Stern at
contact@isps-us.org or call 610-308-4744.

ISPS-US Board Condemns Arizona SB 1070

STATEMENT BY HEALTH CARE PROVIDERS IN RESPONSE TO ARIZONA'S NEW IMMIGRATION LAW

May, 2010

As health care providers committed to human rights and health justice, we strongly condemn Arizona SB 1070, which was signed into law on April 23, 2010 by Governor Jan Brewer. This unprecedented law requires law enforcement officials to detain anyone suspected of being in the country illegally to confirm their immigration or citizenship status. It also criminalizes the failure to carry identity documents that legitimize a person's presence in America.

This law will promote racial profiling, discrimination, and intimidation by law enforcement officials, who are routinely present in emergency rooms and other health care settings. The law will create new obstacles to obtaining needed health care. It is an affront to human rights and a devastating step backwards for the health and well being of the entire nation.

American Academy of Family Physicians Asian Health Services Community Health Center Association of Clinicians for the Underserved National Physicians Alliance Committee of Interns and Residents/SEIU Healthcare Doctors for Global Health, Board of Directors Physicians for Human Rights United States Chapter of the International Society for the Psychological treatments of the Schizophrenias and other Psychoses (ISPS-US)

Contact:

*Jean Silver-Isenstadt, MD, PhD
Executive Director National Physicians Alliance
888 16th St. NW, Suite 800
Washington DC 20006
Tel: 202.420.7896
Fax: 202.747.2969
E-mail: npa@npalliance.org*

If you would like to share your thoughts in our next newsletter issue about the Board's decision to express a perspective on this law or about your own perspective on the law, please email Warren Schwartz at wrrnschwrt@aol.com.

Where is Your Face?

Michael Eigen

“Did you see the photo of the woman’s face torn off by a pet chimpanzee?”

I nodded but Garren didn’t wait for my nod. He was already high speed.

“My face has not been the same. It’s gone. Torn off. I look in the mirror and don’t see it. I see a mess of flesh, bones, nerves. There is nothing to me but gross, yucky horror.”

He paused and I had a sense he was waiting for me to confirm his description of what he looked like. I thought of accounts I read about face disfiguration and operations to “correct” it. I knew from my own experience how distorted I can look or feel I look.

I know that the face is the soul, What one says of the face one says of the soul.

But this is not always so. When I was growing up, I would hear that how one looks is not the true measure of who one is. In high school, the adage applied to homely people who had good souls, although Shakespeare linked deformity of soul with body.

Now in my seventies I have a hard time with such binaries. I gravitate to faces that are well used, textured with experience. When patients speak of envied beauty, I often feel out of it. Popular stars they mention don’t do much for me. The face in front of me is usually good enough for me.

I wonder what I must look like to Garren. Torn face, torn soul. I look for signs of horror but find his lips downturned in something like disgust. Hard to tell the difference between disgust and gritting lips in tension.

“Are you pressing me out of you?” I ask. “Keeping me at arm’s length?”

“Do you see you in me, me in you?” he countered.

I remember a similar look I had when I was younger. It was more a way I felt inside than looked outside. Holding myself tight, becoming a shield. Not only afraid of letting in toxins but fighting against toxins long entrenched. Disgust with --- God only knows. I picture a baby tightening, fighting, going dead. He dreams of toxic waters and he is a fish unable to survive. Soon he will die or be crippled.

Disgust shuts out the bad taste of life. It keeps a lot of good taste out too.

“I ripped a photo of our cat when I was a kid,” said Garren. “Torn to pieces. I was a kind of chimpanzee then. Jealous maybe? But it was more. I was trying to rip a feeling out of me, a caring feeling. I loved the cat. How do

Continued on page 9

Continued from page 8

you explain ripping a photo of what you love? Ripping love out of you. I know the black rule, you do to others what was done to you. But I did not entirely have all the love ripped out of me. Some survived. Feeling survived in a crippled kind of way. I didn't kill the cat. I once cut the heads off a row of roses and my father said, "What are you doing?" I didn't know. I froze. That's a part of it, always frozen. Something's frozen."

What I took as disgust was something frozen? Is chronic disgust a chronic freeze? But I may be seeing my face in Garren and he was moving with his own trajectory. He ripped a photo, not a cat. He ripped his feelings. His feelings ripped him. When we are wounded inside we often rip at the wound, trying to scratch it out. We try to get rid of pain by ripping at it. We have something inside that rips at ourselves, rips our insides out.

"How much would I have to rip out before I could rest? No wonder the chimp blew me up. Being torn apart happened to me. I know that. You know that. We know I was torn to pieces. But what gets to me now is sighting a chimp *in me* tearing *me* to pieces. A chimp I loved, felt close to – a me-feeling, warm, intimate. And a me ripping the hell out of it. What am I tearing at? I don't want to be a pet chimp, a pet cat, a pet anything! I don't want to be a pet! I'm trying to tear the pet-me out of me!"

He looks at me, I at him. I wonder what we are seeing. We're both so aware of expressions. He smiles a little and sighs, "There's got to be a better way."

The look I called disgust disappeared for the moment and a whole other face appeared, Not torn or disfigured. An intriguing face, a bit bemused, sophisticated and sincere. I felt my own gripping thing loosen, that gripping thing that stops feelings from breathing.

I rip him, he rips me. Life rips us. Then a moment of rest, a pause. A rest between seizures. A face one can say yes to.

ISPS-US Executive Council

Officers

President: Brian Koehler, PhD
President@isps-us.org
Vice-President: Martin Cosgro, PhD
VP@isps-us.org
Secretary: Lori Kalman, MSN, APRN, BC
Secretary@isps-us.org
Treasurer: Kay Ellen Lowenthal, Esq
Treasurer@isps-us.org
Newsletter Editors: Warren Schwartz, PsyD,
Peter Austin
Newsletter@isps-us.org
Listserv Moderator: Matthew Morrissey, MA, MFT
List@isps-us.org
Website Editor: Martin Cosgro, PhD
Webeditor@isps-us.org
Research Chairs: Courtenay Harding, PhD, Brian
Koehler, PhD, and Yulia Landa, PsyD
Research@isps-us.org
Membership Chair: Jessica Arenella, PhD
Member@isps-us.org

Book Series Editor: Ann-Louise S. Silver, MD
Book@isps-us.org

Founding President: Ann-Louise S. Silver, MD

U.S. Members, ISPS Executive Committee:
Brian Koehler, PhD and Martin Cosgro, PhD

Honorary Members

George Atwood, PhD
Gaetano Benedetti, MD
Anni Bergman, PhD
Maurice Green, MD
Joanne Greenberg, DHIL
Leston Havens, MD
Bertram P. Karon, PhD
Dori Laub, MD
Harold F. Searles, MD
John Strauss, MD

Heads of Local Branches

Baltimore-DC: Ann-Louise S. Silver, MD
DC@isps-us.org
Berkshires: Marilyn Charles, PhD, ABPP
Berkshires@isps-us.org
Boston Area: Ronald Abramson, MD
Boston@isps-us.org
Central California: Martin Cosgro, PhD
CentralCal@isps-us.org
Northern California: Matthew Morrissey, MA, MFT
NoCal@isps-us.org
Southern California: Mary Madrigal, PhD
SoCal@isps-us.org
Chicago: Sheila Curren, PhD, LCSW
Chicago@isps-us.org
Michigan: Patricia L. Gibbs, PhD
Michigan@isps-us.org
New Jersey: Jessica Arenella, PhD
Ross Tappen, MA
NJ@isps-us.org
New York City: Brian Koehler, PhD
NYC@isps-us.org

Recovery: Why is it being redefined to mean “doing better but still mentally ill”?

Ron Unger

A lot of efforts to transform an often oppressive mental health have focused on “recovery” and making the mental health system more “recovery focused.” Many agencies have integrated the notion of recovery into their practice, and if the use of this word were a measure of progress, we would be well on our way to system transformation! Unfortunately, what seems to be happening is that as the word “recovery” is used more and more, it seems to mean less and less. I know someone for example who is on heavy doses of an antipsychotic as well as other medications, lives in a foster care home, and spends most of his daytime hours in a mental health day treatment program, yet is assured by his case managers that he is “recovered.”

I believe that recovery remains a useful concept, but also that it will only give us leverage to change the system if we give it a clear and powerful definition, and resist efforts to water down that definition.

I would like to propose the following definition: **Recovery means having regained a meaningful life, no longer having a mental health disability, and no longer being in need of any sort of mental health treatment.** It does not mean that the person for certain will never need mental health treatment again in the future – the person might – but this is also a possibility for people who have never been diagnosed. It also does not mean that achieving a full recovery is the only way to have a meaningful life; instead, it is important to note that a person may find a meaningful life all the way along the journey to full recovery, whether or not that full recovery is ever accomplished.

(Recovery as defined above is a real possibility for people diagnosed with mental disorders. “Schizophrenia” is the diagnosis with the worst outcomes on average, yet when Harding did a long term outcome study of people who had been hospitalized for years with this diagnosis, she found that a third or so met this kind of criteria for recovery. It is unclear how many more might make such recoveries if we geared our mental health system toward helping people accomplish them.)

When we recover from a broken bone, we don’t still need a cast. We can eventually use the body part containing the formerly broken bone and it can eventually become as strong as it was before. When we recover from a cold, we eventually transition from “recovering” to “have recovered” at which point the cold is history. That’s a common sense understanding of the term “recovery.” But somehow when people talk about recovery from a mental condition, this common sense understanding goes out the window. Instead, there may be talk about people being “recovered” even though they still seem to require professional treatment such as medications, or there is talk about how one should expect to “always be in recovery.” What’s going on with that?

A number of things, it turns out. Pressure to define mental health “recovery” as something other than true and full recovery comes from a number of quarters, with a variety of different motivations. In what follows, I will attempt to outline most of these motivations and then show why each one leads to problems.

Historical connections with the physical disability movement

Some people see “mental disability” as similar to physical disability, and so seek to use the word “recovery” in a way similar to that used in the physical disability movement. In the case of physical disability, it is often clearly known that full physical ability cannot be expected to be regained. To inspire hope in such cases, it was found helpful to refocus on fully recovering a meaningful life, which could be done despite the fact that the physical ability was not going to be regained. In such cases, redefining “recovery” to mean regaining a meaningful life made a lot of sense, because that helped people focus on functioning at the peak of their potential, within the limits of whatever physical disability existed.

However, mental health “disabilities” are different from many physical disabilities, in that as far as we know, it is always possible for the person with the mental health disability to regain their full ability to be mentally healthy, while for many physical disabilities, this is not true. In the case of someone with a physical problem where recovery from the problem itself is possible, it clearly would be wrong to define “recovery” as meaning just regaining a

Continued on page 11

Continued from page 10

meaningful life, while neglecting the possibility of recovering from the physical problem itself. For example, a woman with a physical injury that impairs her ability to walk may be able to regain a meaningful life by using a wheelchair, but if she might actually regain her ability to walk as well if given directed effort and therapy, then we would also want her to know that and to be given support toward the physical recovery. Similarly, the person with a mental health problem from which the person might recover deserves to know of the possibility, so that effort and assistance might be offered toward this accomplishment.

Efforts to focus directly on reducing mental health symptoms are often unhelpful

Changing focus is a key part of recovery: to recover from a “symptom” it is often necessary to quit focusing on trying to get rid of the symptom, at least in any direct way! The problem is that the things people do to control the “symptom” in the short run usually make both the “symptom” and the person’s life worse in the long run.

Let’s look at “anxiety” as one example. A man may perceive himself as having “too much” anxiety. In response, he avoids doing or thinking anything that creates more anxiety. As a result, he fails to learn that he could actually survive doing or thinking those things, and as a result of avoidance and hiding, he feels smaller and weaker and of course, more anxious. Also, because he is focused on reducing anxiety rather than getting on with his life, he becomes hypervigilant for more signs of anxiety, so he notices anxiety more often and it seems to get worse, etc. He may even take pills to avoid feeling the anxiety: this may work briefly, but when the pills wear off anxiety is even higher, plus as a result of using pills to manage the anxiety, he feels even less competent to manage the anxiety without the pills.

Problems with “hearing voices” involve the same dynamics. A woman for example who identifies hearing voices as a problem may become willing to do almost anything to “make the voices go away.” This might mean overuse of distraction to avoid noticing the voice, or when that fails to work or causes too many concentration problems, she might at times go the other way, and obey voice commands as a way to quiet the voice for a bit. Both avoiding the voice, and giving in to its commands, makes her feel weaker than the voice, and unable to face it. And since the voice is what is believed to be the problem, she becomes hypervigilant so as to notice when it might be present, which of course increases the frequency with which she hears it. She might also take pills to weaken the voice, but these may result in voices that are even worse when she quits the pills, and in any case reinforce her sense she is not strong enough to face the voice.

So what might work better? In all these cases, the solution is to quit seeing the “symptom” as the primary problem, and instead focus on making wise choices in life. In other words, just accept that the “symptom” exists, and focus on creating a meaningful life.

So the anxiety is no longer the problem, instead the focus is on making wise choices when feeling anxiety – continuing to go forward without avoidance if the anxiety upon examination appears unwarranted, or changing course in appropriate ways if a realistic hazard exists that needs to be taken into account.

The “voices” are no longer the problem, instead the focus is on making wise choices regardless of what the voices say. So the emphasis is on making good and thoughtful decisions, and opinions expressed by voices can even be considered in such decision making, though not allowed to dominate. With the emphasis on wise decisions, there is no need to either “get rid of” or “distract from” or to “give in to” the voices.

The mental health system traditionally focused on getting rid of people’s “symptoms” without noticing that focusing on getting rid of symptoms could make them worse. So one way of pushing against that has been to ask the system to focus on recovery instead, and to define recovery as meaning having a meaningful life despite the presence of mental health symptoms which might continue indefinitely.

However well intentioned this may have been however, it creates the impression that full recovery cannot be expected, and that one will always be a person with mental health problems, relying on often toxic mental health treatments, struggling to find a meaningful life in competition with people who do not have mental health problems. Such an impression can create unnecessary hopelessness. A better approach might be to recognize the im-

Continued on page 12

Continued from page 11

portance of accepting current mental health problems and refocusing on achieving a meaningful life, but also recognizing that in doing so one may possibly shrink one's mental health problems to the point they are no greater than the problems in mental and emotional regulation experienced by all human beings.

Wanting to reduce stigma by allowing more people to feel they have overcome their “mental illness”

When recovery is defined in a common sense sort of way, as true and full recovery, then only those who have really overcome their mental health disorder related disability and need for treatment can define themselves as “recovered.” This means that all those who have not yet accomplished those objectives may be defined as “not yet fully recovered” and so may feel more vulnerable to stigma, or the sense they are “less than,” due to the absence of full recovery. So one approach has been to attempt to remedy this problem by defining recovery very broadly, so that as many people as possible can identify as having “recovered” rather than being “still mentally ill.”

Unfortunately, this approach creates more serious problems than it solves. By redefining “recovery” as less than full elimination of the mental health problem, it creates the impression that full elimination of the problem is impossible, and so reduces hope and efforts toward real recovery. Further, once mental health workers and others learn that “recovery” means “still having the disorder but just functioning a bit better” then “being recovered” comes to mean “still mentally ill” and stigma continues anyway.

A better approach would be to work on reducing stigma as a whole, for everyone who has been diagnosed with a problem. One way to do this would be to encourage less focus on and less use of labels and more attention to the specific problems, and the specific abilities, of given individuals. With this approach, people can be dealt with respectfully in a way that matches where they are at all the way along the journey to recovery. And the message that a full recovery is possible can again be offered to provide hope to those on that journey.

Concern that a belief in full recovery will lead to the taking of inappropriate risks

When the criteria for full recovery includes “no longer needing treatment” there is then the concern that some people will be encouraged to abandon treatment too soon, while such treatment would actually still be beneficial for them. But if recovery is defined just based on functioning in the world, despite the presence of continued illness or disability, then this temptation is removed. With such a redefinition, it becomes possible that a person still depending on medications or other treatment, yet functioning well in the world, can be defined as fully recovered.

But defining a person as “fully recovered” while that person still needs treatment creates the impression that no further recovery is possible, which reduces hope that the treatment will eventually become unnecessary. If a person still needing a brace or crutch after a physical injury was told he or she was “fully recovered” the natural implication would be to believe that efforts for further recovery, resulting in eventual elimination of the need for the brace, could not be expected to be successful. When the treatment a person is depending on is potentially quite toxic, such as the antipsychotic medications, then defining a person as “fully recovered” who still depends on such medications will naturally result in the impression that further recovery is impossible, which in turn may result in unnecessary damage or even death as the person fails to even attempt further recovery that might eliminate the need for the medication. And just as dependence on a brace or crutch might limit physical performance, there is the danger for example that depending on medications such as the antipsychotics may unnecessarily limit mental and emotional functioning.

A better approach is to address the risk of treatment being abandoned too soon, not by redefining recovery, but simply by addressing this risk directly. It can be pointed out that abandoning a necessary form of treatment too soon might actually increase impairment and slow recovery. At the same time, the need to take some risks by experimenting with gradually withdrawing various treatments, at appropriate times, can be acknowledged to be a natural part of the recovery journey. Consumers can then be encouraged to make thoughtful decisions about when to continue and when to experiment with discontinuing treatments, using collaborative discussions with mental health professionals to think through relevant issues.

Continued on page 13

Continued from page 12

“You will always be recovering” – concern about underlying vulnerability

Another risk is that a person may see themselves as “recovered” and yet still have an underlying vulnerability to a recurrence of the disorder, resulting in relapse when the person fails to attend to the vulnerability. One way to defend against this possibility is to convince the person that he or she should forget about becoming “recovered” and accept instead an identity as “always recovering” which includes continued vigilance for the possibility of relapse. This form of thinking is common in the substance abuse field; once people stop using the substance, they are trained to always see themselves as more vulnerable than others to falling back into addiction, and so to see themselves as “always recovering” rather than “recovered.”

It is important to note that there is no clear objective criteria for how to distinguish a person’s precise level of vulnerability to either substance abuse or to mental and emotional problems, so there is no objective way to distinguish a person who might better think of herself as still “recovering” and another person who could safely think of herself as “recovered” and now no more vulnerable than the average person.

In the substance abuse field, the thinking is that it is usually better to be safe than sorry; since the treatment methods themselves tend to be non-toxic, if a person ends up feeling they are “still recovering” unnecessarily, the costs are likely to be minimal, compared to the risk of slipping back into addiction. Also, as long as one is doing well on the objective measure of how well one has escaped the active addiction – years of sobriety – there is comparatively little stigma attached to being defined as in some sense “still recovering.”

In the mental health field however, the notion that one can at best be expected to be “always recovering” is much more hazardous, and creates a murkiness that allows much of the real hope for recovery to be obscured. For one thing, if the expectation is simply that the person will be “always recovering” then the notion that psychiatric medications may have to be part of that effort at recovery is easy to introduce, and a person’s hope to ever be off dangerous medications may be dimmed. Also, the notion that one is “still recovering” from a mental illness implies that one is to some extent still mentally ill, a notion that can be used to justify lowered expectations for the person so identified.

It is true that if a person who in the past has had a mental health problem ceases to care for his or her mental health, there is a good chance that this person will experience a recurrence of the mental health problem. But a person who has recovered to the point where that he or she does not require treatment, may only need to do the same sorts of things to sustain mental health that other people, never diagnosed, also need to do to sustain their mental health. So rather than insist that people who have previously been diagnosed see themselves as “always recovering,” it is possible instead to notice how healthy mental habits are important to everyone. Early in recovery, developing healthy habits may take extensive conscious effort and support, but eventually such habits may be as strong (or even possibly stronger) than they are for healthy people who never experienced a breakdown. Framing this possibility is important, because it nurtures belief in the realistic possibility that a previously diagnosed person might eventually compete in various arenas where mental health is important, on equal footing with people who never have had a mental health diagnosis.

Concern for profit

When a full recovery is seen as a possible and desirable goal, then a shift to the elimination of the need for mental health treatment in a person’s life is also seen as a desirable goal. But such shifts reduce the chance for profits in the mental health industry, which does best when people become “consumers for life.” Pharmaceutical companies, organized solely around the goal of profits, naturally oppose any message implying that the need for their product might be eliminated.

It is critical though that the mental health system be readjusted to focus on the wellbeing of the people it treats, and that perverse incentives of various kinds be removed. In particular, research and education needs to be taken out of the hands of the pharmaceutical companies, so that the focus goes back to what is good for people instead of profit.

Continued on page 14

Continued from page 13

Worry of professionals that they will be seen as incompetent

When crisis occurs and emotional arousal is high in all parties, there is considerable pressure to have the “right” solution. In our society, this is expected to be provided by trained professionals who have many years of college education which is supposed to train them in precisely what to do in such a situation. This puts extreme pressure on mental health professionals who respond to a mental health crisis and to all of the confusion around it. The mental health professional may not be able to understand what is going on in the mind of the person at the center of the crisis, what caused it, or how to really help the person. One way for the professional to handle the pressure on him or her is just to reduce expectations, and a key way of doing that is to define the person at the center of the crisis as having a “biological illness” that results in thinking and behavior that is “not understandable” and from whom the best that can be expected is the modest improvement that is likely from the treatment the professional knows how to provide, psychiatric medications. Full recovery can be defined as impossible, and recovery can be redefined as adjusting to and getting support in “living with the illness.”

All this leaves the professional defined as quite competent, and no longer in crisis due to not knowing what to do. The problem is that the person at the center of the crisis, the diagnosed person, is now likely to be in a state of hopelessness, defined as biologically ill, not understandable, and with no hope of a full recovery.

What would work better? First, it would help if mental health professionals had more competent training, so they were more capable of understanding people in the middle of a crisis, (for example people experiencing “psychosis”), and able to provide assistance other than medications. (Those not motivated or inclined to develop such increased understanding might better be encouraged to seek other occupations.) The hiring of more “peer professionals” would also be helpful, as these are often people with naturally higher levels of understanding due to their own experience.

But even with the best training we might provide, and selection of the most competent and caring individuals we might hire, there would still be much happening in many a mental health crisis that would go beyond the ability of the professional to quickly understand or resolve. What is critical at such a points is for the professional to be able to admit his or her uncertainty about what is going on and about how to resolve it, without pretending to know that there is no way the consumer could be understood, and without pretending to know that recovery is impossible. This means that the professional must lower expectations about him or herself, stepping out of the role of someone who “really knows what is going on” and adopting the lesser role of “someone who has some training that might help some, but only to a point.” Here it is the professional’s willingness to be seen as less competent than others might expect, that creates the space for hope that the diagnosed person may have more possibility for improvement, including hope for full recovery. The fact that the diagnosed person has not recovered at any given point may for example be due to not having yet received the sort of help which might be effective, rather than due to that person’s intrinsic hopelessness.

So what we need are professionals who have hope that their clients can be understood and helped to fully recover, and who are willing to and capable of thinking deeply about how to assist with that. Further, these professionals must be able to accept the moments when they don’t know what to do to make such a recovery happen, without attempting to resolve that uncertainty by redefining full recovery as impossible.

Conclusion:

There are no good reasons to allow mental health recovery to be redefined as in effect “doing a bit better but still mentally ill.” Nor are there good reasons to define it as a goal that can be approached but never reached, as in notions about a person “always recovering.” Instead, we need to insist that real and full mental health recovery be understood to the best of our knowledge to be possible for everyone. Further, we need to insist that all mental health treatment be geared to support progress toward such a recovery, rather than geared to maintain people as lifetime consumers of mental health services.

Combined ISPS and ISPS-US Membership Application

Join / Renew your membership / Copy this for a colleague / Have your institution join

(Please note: local branches may assess additional dues)

Name, degree(s) (as should appear in listing): _____

Address: _____

City: _____ State: _____ Zip: _____ Country (if not U.S.): _____

Preferred phone number: _____ work / home / cell Fax: _____

E-mail address: _____ Web address: _____

Institutional affiliation(s): _____

Professional interests: _____

Do you wish to join our e-mail discussion list? Yes / No

Do you wish to be listed in our member directory? Yes / No

Do you wish to be listed in our public web directory? Yes / No

Annual Dues:

Note: includes ISPS journal subscription

All professionals: \$100

Institutional (Please include contact name and a 100-word description of organization): \$150

All others (including full-time students): \$55

Lifetime individual membership: \$1,000

Additional tax-deductible contribution:

\$10 / \$25 / \$50 / \$100 / \$250 / \$500 / \$1,000 / Other: \$ _____

On behalf of / in memory of: _____

May we thank you for your contribution in our publications? Yes / No

(Optional) I'd like to earmark my donation for:

A scholarship for consumers, students and mental health workers to attend our meetings

Sponsorship for a low-income member

Upgrade our website to include video clips

Launching ISPS-US into self-publishing

Other: _____

Total amount enclosed: \$ _____

Please make check payable to ISPS-US.

Send to: ISPS-US
P.O. Box 491
Narberth, PA 19072

Or join / donate on the Web at www.isps-us.org
E-mail: contact@isps-us.org
Voicemail: 610-308-4744

ISPS-US is a 501(c)(3) nonprofit organization.

ISPS-US
P.O. Box 491
Narberth, PA 19072

NONPROFIT ORG
U.S. POSTAGE
PAID
WAYNE, PA
PERMIT NO. 725

Place Your Ad in the ISPS-US Newsletter

Advertise your organization, private practice, conference,
book or journal in the quarterly ISPS-US Newsletter

Your ad will reach 300+ like-minded colleagues
for one year (four issues)

Rates: \$250 (full page), \$150 (half page horizontal),
\$100 (two-column), \$60 (business card size)

Deadline: Rolling

When your ad and payment are received,
your ad will be placed in the subsequent four issues
of the ISPS-US Newsletter

For advertising rates and specifications, please e-mail Karen Stern