

ISPS - US Newsletter

United States Chapter of the
International Society for the Psychological treatment of Schizophrenia and other psychoses

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

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From the Editor

Brian Koehler PhD

David Feinsilver MD, a past president of ISPS and psychiatrist-psychoanalyst at Chestnut Lodge Hospital in Rockville, Maryland, was interviewed by me on 4/22/95 and several years later on 2/6/99 when David was seriously ill and fighting heroically against colon cancer. David's accomplishments and publications have been detailed previously in this newsletter (Summer, 1999) in an obituary beautifully written by Ann-Louise Silver MD.

David had graciously accepted my interviewing him as part of his presentation to a clinical seminar I have been teaching since 1994 on the psychoanalytic therapy of schizophrenic patients. I invited David as one of the visiting speakers to our group because of his significant contributions to the field and his attempts to formulate a more comprehensive treatment approach to the schizophrenias. I had previously spoken to him of my work on integrating neurobiological and psychoanalytic perspectives on schizophrenia coalescing around the concept of the self. I believe David resonated to this effort at bridging psyche and soma and integrating the splits that have been dividing our field into advocates of mind (functional) vs. brain (organic) diseases, a fallacy laid to rest by such disciplines as developmental psychobiology and molecular biopsychiatry which have non-reductionistically and amply demonstrated the profound impact of experience on neural structure and function.

The seminar and private interview with David took place at my office in Manhattan. David shared with the seminar participants his insights and experience working psychoanalytically with schizophrenic persons. His theoretical approach coalesced around his "Feinsilver maxim #?": "containment of the bad object experience has been, and will continue to be the focus of the therapeutic work." David clarified his dialectical mode of therapeutic action: at one pole the therapist provides supportive-containing interventions addressing the patient's areas of deficit on all bio-psycho-social levels, and at the other pole, confrontational limit-setting interventions directed at areas of emotional conflict. Both poles were important to address in the comprehensive psychoanalytic treatment of chronic schizophrenic patients. At one pole, the analyst provides direct, more concrete care, e.g., use of antipsychotic agents to address the disorganizing effects of the patients bad object experience emerging in the transference relatedness with the analyst, the "broken self" of the patient; at the other pole, the analyst utilizes psychoanalytic interpretations to address the core aspects of the "vulnerable self" of the patient, e.g., interpreting the kill-or-be-

killed atmosphere holding sway in the unfolding transference-countertransference experience.

David spoke of his more sparing use of a technique he developed at Chestnut Lodge for engaging more out-of-contact regressed patients: transitional play. This technique is based on the Winnicottian concepts of transitional objects, playing and potential space, as well as Arnold Modell's views on transitional relatedness with more disturbed patients. David preferred to actively address the healthier parts of the patient, as well as making therapeutic contact with the more ill regressed parts. He saw the road to recovery in the patient to be in the symbiotic joining and at the same time, helping the patient to come out of it. There's not enough space here to include an old Hasidic tale which David loved to use as an illustration of schizophrenic breakdown (see "Transitional Play with Regressed Schizophrenic Patients" 1989); but this tale contains the reparative elements that David discovered was necessary in helping the regressed patient resolve her/his organismic panic and pathological reorganization of self (Pao,1979).

David emphasized a treatment model that is reality oriented and one in which the analyst assumes the responsibility for care of the patient on all bio-psycho-social levels. He named this function, the therapist as "mentsh". In his mentsh model, the key to the cure, is the therapist's ability to make a "counteridentification" with the patient's split-off, bad object experience that keeps doing the patient in. The therapist, through a

continued on page 2

Table of contents

| | <u>Page</u> |
|--|-------------|
| From the Editor..... | 1 |
| From the Secretary-Treasurer..... | 2 |
| Interpersonal Psychiatry and Schizophrenia..... | 3 |
| ISPS-US Conference.. | 4 |
| Introduction to Boyer House..... | 5 |
| Self Psychology and the Psychoses.. | 6 |
| Column: Expressive Arts..... | 6 |
| Column: Mind and Brain | 7 |
| Review: Garfield's <i>Unbearable Affect</i> .. | 8 |
| Excerpt: Dorman & Penney..... | |
| Letter to the Editor..... | 10 |
| Poetry..... | 10-11 |
| Excerpt: Karon..... | 10 |

From the Editor, continued

kind of inner self-containment in the countertransference, assists the patient to rise above, contain and integrate the bad object experience within her- or himself.

David spoke on a more personal level during the interview. He spoke of his family and his analytic influences that led to his concept of the therapist as *mentsh*. He agreed with my suggestion that this concept be extended to the patient as well. Dan Schwartz MD (Austen Riggs), David's attending psychiatrist during his residency at Yale Psychiatric Institute, and Harold Searles MD (David's supervisor at Chestnut Lodge), were two individuals David noted as having an impact on him. He noted that Dan Schwartz was "the embodiment of the kind of therapist I wanted to be." He believed that Harold Searles made profound observations of the transference-countertransference relatedness with schizophrenic patients. In regard to the issue of medications, an issue that is still controversial for many psychoanalysts, David was more favorable towards using antipsychotic agents than Searles. Perhaps with the synthesis of agents with less harmful side effects and greater efficaciousness, this issue may become less problematic for many analysts. David believed that the value of medications were that they decreased anxiety enough for the patient to become more organized and therefore have a clearer and more workable bad object experience in the therapy without being overwhelmed by it. This seems related to Ping-Nie Pao's (1979) position on medications: they were often useful as an adjunct to the psychotherapy but should not take its place nor be the sole treatment effort.

As a post-Kleinian psychoanalyst, I was very interested in what David meant by his phrase "bad object experience," i.e., how was it similar and/or different from the traditional Kleinian view of split-off rage directed at the primary object based on the interaction of genetic and experiential factors. David gave his definition as follows: "The more people find themselves with overwhelming conflicts, things that have frustrated them in their lives, were thwarted and immobilized [by] them, made them sick, then you will encounter clinically massive efforts to split off this bad object experience, this is where deficits in functioning will be."

Towards the end of our talk together, David spoke of our need to nurture and help ISPS grow, particularly in this country. As usual, in a style that has further endeared him to me and added to my respect and admiration for him and his integrity, David called for inclusivity of membership. He called for an inclusion of clinicians and individuals who may have "way-out" views, views that are "far from what you think are right" for "they probably have some way of looking at things the same way you are."

Part 2 of my interviews with David Feinsilver MD will be published in the winter issue of this newsletter. Prior to his untimely death, David set up a scholarship fund to subsidize someone in financial need, who submits a worthy paper to be given at the ISPS conference to take place in June, 2000 in Stavanger, Norway entitled "Schizophrenia and other psychoses: Different stages-differ-

ent treatment?" See the box following this article for details.

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CFNR - Feinsilver Fund

Established to fund a scholarship to the International Symposium (next will be June 5 - 9, 2000 in Stavanger, Norway) for the best paper on research on the psychotherapeutic treatment of the severely disturbed, for those who would not otherwise afford to attend. Submit papers to both:

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From the Secretary-Treasurer

Julie Kipp CSW



The ISPS-US organization is continuing to grow. Everytime we put information out into the ethers - with the Newsletter, with our recent first annual Conference - I hear from more professionals who have been wishing for just such an organization as this. There is a great need for information and support for psychotherapeutic and psychosocial work with seriously mentally ill people. It seems to me that in today's increasingly bureaucratic and narrowly biological climate, both experienced and less experienced clinicians have need of ISPS-US. The esteemed and renowned clinicians of an older generation appreciate having an organization in which to pass on their years of experience, while workers newer to the field are hungry for more humane and in-depth approaches to their patients. If our first year is any indication, it seems that there

continued on page 3

Interpersonal Psychiatry and Schizophrenia

Ann-Louise Silver MD

As I study the history of the psychotherapy of schizophrenia, I become increasingly impressed with the impact of interpersonal psychiatry in the United States. The teachings of Harry Stack Sullivan and Frieda Fromm-Reichmann profoundly influenced the next generation of mental health professionals. Many of these students, now our senior faculty, are still teaching and practicing throughout the United States. Helen Swick Perry's biography of Sullivan, which was a runner-up for a Pulitzer Prize in biography in 1982, was titled "Psychiatrist of America." She commented that his theories were as influenced by his Chenango County in New York State as were Freud's by his Vienna. He was influenced by George Herbert Mead and William James. His friend and colleague Frieda Fromm-Reichmann brought her orientation, strongly influenced by Sandor Ferenczi and Georg Groddeck, to Chestnut Lodge. Together, they taught at Chestnut Lodge and the Washington School of Psychiatry. Later, Fromm-Reichmann was among the founders of the Washington Psychoanalytic Institute's New York branch, which has flourished as The William Alanson White Institute. Harold Searles built a magnificent structure of works, on the foundations constructed by these two psychoanalysts. Otto Will transmitted their orientation to The Austen Riggs Center, Will having been analyzed by both Sullivan and Fromm-Reichmann. Leston Havens has made Sullivan's philosophy readily accessible.

Summarizing the essence of their teachings, I focus on these giants' tough and stern attitude toward the illness, and on their respect for their patients. They emphasized that all patients have within them healthy and creative aspects. We must work to

Secretary-Treasurer, continued

is a lot of room for further growth in numbers of ISPS-US members.

I want to thank Allen Kirk for his kind gift of money towards a scanner which I am using in my role as assistant editor of the Newsletter. With the scanner we are hoping to develop a more attractive, visually inviting Newsletter. Allen's gift allowed us to get the next-step-up scanner, rather than the cheapest model. Thanks, Allen!

At our recent meeting of the Board of Directors, it was decided that dues will cover the calendar year, from January to December. Recent dues payments will go towards the year 2000, but if you haven't sent dues in since late 1998 (charter members!) or early 1999, please send in your 2000 dues. (See membership form on page 11.) Also please continue to tell interested colleagues about ISPS-US. An upcoming project when we are able to increase membership will be an ISPS-US journal.

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find our way to these areas, to support them, and to be patient as a trusting therapeutic alliance gradually forms. Schizophrenia is an illness of profound anxiety, an adaptation in the aftermath of catastrophic disorganization. The adaptation is unique to each sufferer, but universally involves profound loneliness and isolation, along with brittle grandiosity. The sufferer enormously magnifies a sense of personal destructive potential. The therapist's task is to stay with the patient, thus demonstrating that the sufferer is still simply human.

In the interpersonal approach, therapists actively use their personalities, hoping to develop a comfortable working relationship with each patient. We follow each patient's lead, sharing activities in which the patient feels relatively calm, while listening for transference themes, and being alert to shifts in countertransference. We see shared playfulness as intrinsic to mental health. We monitor body language, our patients' and our own. We don't mask our reactions with blank expressions. Our patients know where we stand. The therapist bears continuing responsibility to keep the work moving forward. We do not leave it to the patient to do essentially all the verbal work in a free-associative mode. We work at putting ourselves in the patient's place. To help patients conquer their anxiety, we must understand our own. And we must monitor our narcissistic needs, and not require our patients to supply us with success. Stubbornly persistent work with patients who do not necessarily improve is humanistically important, but more vitally, it keeps us in touch with our own primitivity - our psychotic and tumultuous aspects.

I urge all the readers of this article to read Fromm-Reichmann's *Principles of Intensive Psychotherapy*. It has been in print continually since 1959, published by The Chicago University Press, and available in paperback for just \$13. Sullivan's *The Interpersonal Theory of Psychiatry*, *The Psychiatric Interview* and *Clinical Studies in Psychiatry* are also in paperback, at about the same price. Leston Havens' *Participant Observation: The Psychotherapy Schools in Action* is in paperback for \$30, and his *Approaches to the Mind* is still in print, and probably available on the net and through used book sellers as well. Harold Searles' *Countertransference and Related Subjects* is in paperback for \$40 (I got this information from Amazon.com). I include this reading list with a forceful plea to young mental health professionals and others to read these books. They are inspirational and accessible, providing an extremely strengthening clinical orientation. They set you on firm ground. If you are apprehensive and confused about what to say to your patients or clients, your own anxiety works against the possibility of a therapeutic alliance. They delineate the philosophy of the founders of ISPS, and now, of ISPS-US.

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ISPS - US Holds First Annual Conference

Paul Carroll PhD

The first annual ISPS-US meeting was held on October 2, 1999 at the Washington School of Psychiatry on the topic of "Creating Space for the Unaccommodated Self in Psychotic States." The meeting was co-chaired by Christine Lynn, MSW and Allen Kirk, MD. It was opened by ISPS-US President Ann-Louise Silver, MD, who dedicated the meeting to the memory of Dr. Jack Love, of Chestnut Lodge. Dr. Brian Koehler announced the honoring of Dr. Harold Searles by ISPS-US for his profound contribution to the understanding of persons with schizophrenic and borderline disorder. Dr. Searles, who is living in Davis, CA, was not able to attend but sent word that he wished very much that he could have been at the meeting. A certificate was created and will be sent to him along with a videotape of the meeting. Dr. Koehler spoke about the honoree's work, highlighting the view of the innate therapeutic striving in all human beings, the vicissitudes to which this striving is subject in schizophrenia, and the channel of contact that is opened through awareness of countertransference in the symbiotic therapeutic relationship, in particular, the communication of the impact and meaning of the patient's existence for our own as a curative factor in the treatment of schizophrenia.

Julie Kipp, CSW, presented on "The Chestnut Lodge tradition: The concept of regression and implications for today's treatment settings." She reviewed points of view held by prominent clinicians at the Lodge - Fromm-Reichmann, Pao, Searles along with Winnicott's ideas on regression. She contrasted the work of these analysts with the world in which we now find ourselves, where we are overly concerned with the suppression of symptoms. In a prior era, one could consider the degree to which a person in psychosis could utilize regression in treatment to reach underlying conflicts. The hospital could provide a place for the patient to be as sick as need be, to regress, but not forever, just for episodes, from which there would be contact with the debilitated, dependent parts of the person. Ms. Kipp gave examples of her work at the R.E.A.L., a continuing day treatment program in the Bronx, NY, of tailoring the tolerance of regressive behaviors to the particular person and particular stage of treatment they are in, combining speaking to the adult and making room for the child. Dr. Silver recalled that the work on the units at Chestnut Lodge was extremely analytic, the chief attending and nursing staff tended to create their own particular style of milieu, and she recalled "stepping into the warm bath of psychosis" on Main Two where Jack Love had been an administrator for many years. This came from an attunement of all the staff to dynamic processes, including the nursing staff who themselves were in analysis provided by the hospital. Dr. Silver went on to describe how Fromm-Reichmann drew a staff of analysts to the Lodge and organized the training of therapists in the particular type of milieu that was created by the psychoanalyst-administrator. Dr. Sidney

Blatt added that the presence of an idealized fantasy in the inner world of schizophrenia that is the kind of regression that must be engaged and brought into reality contact and adaptive functioning.

Christine Lynn, MSW gave a paper titled "Into the light of day: Recovering parts of the self from somatization in the wake of early trauma." She described the treatment of a man who had schizophrenia and who went through a major trauma - the amputation of his legs and some fingers, due to frost-bite, having lain in the snow for a long time. Utilizing a Jungian and Bionian perspective, she came to understand her own dreams and physically painful experiences while working with him in his acute medical crisis as the vehicle for bringing symbolic meaning to the condition of his catastrophic change. It allowed for the entering of the area of death, the underworld, and the functioning of the therapist as a self-object. Going through the catastrophic loss together leads therapist and patient to make contact and work through the type of terror that characterizes schizophrenia. It was the process of reaching to the depths of such a traumatic experience that lead to language that could give meaning to the terror of schizophrenia.

Virginia Hendrickson, MSW gave a paper on "Understanding and working with the traumatic origins of psychosis: Restoring alpha function to the terrorized self." She described her work with a psychotic patient who was traumatized by premature birth, medical procedures, repeated separations from mother and sexual molestations. She used the poetry of Rilke to evoke for the audience the nameless dread, the terror of psychosis. She articulated a therapeutic stance which integrated Bion, Grotstein, Lacan and Winnicott in a way that allowed for the containment of beta elements and the creation of a contact barrier for the patient, and a way that the therapist can experience the evacuated elements, go through it with the patient

Marvin Skolnick, MD. was the final speaker. He described his experience of working with a Bionian perspective in a day treatment setting. While he acknowledged the collapse of the transitional space that would allow for such a process, he shared with the audience a rich vision of the conditions that could allow for healing of schizophrenia in a group oriented setting. To paraphrase Hilary Clinton, it takes a village to raise a schizophrenic; the question is, how do we create a village that can heal a schizophrenic? A community must be able to metabolize what is split off without romanticizing the serious human suffering involved. He finally returned to Searles' view that one does not go unscathed in this work. Some of the deepest anxieties are stirred in the therapists and these are at times defended against by projective identification, demonizing and rejecting both patients and therapeutic staff themselves.

Editorial Comment:

This was the first annual conference of ISPS-US. We

continued on page 5

An Introduction to the Boyer House Foundation

Crystal Johnson, PhD
Executive Director, Boyer House Foundation

The Boyer House Foundation is a private, nonprofit organization providing intensive, long-term, psychoanalytically-informed treatment to adults with severe psychiatric disorders.

At Boyer House, we work with patients who have experienced significant problems in their lives due to mental illness. They range in age from mid 20s to 50s. Typical DSM-IV diagnoses include Schizophrenia, Schizoaffective Disorder and Bipolar Disorder, as well as the Axis II severe personality disorders. Typically, patients have been unsuccessful in a series of prior treatments, and they are often deeply estranged from their family of origin and other support systems.

In our approach to treatment, we attend to multiple levels of the work: namely, the direct clinical contact, the work of the clinical team, and the organization itself.

Direct Clinical Contact

Each client has a treatment program that includes 12-14 hours per week of direct clinical contact. Clients live together in households of 3 to 4 persons in the community. Each client works with a treatment team composed of an individual psychotherapist, a milieu therapist, group therapists, the family therapist and the psychiatrist. In our treatment, we combine intensive psychoanalytically-informed individual psychotherapy with intensive milieu work and psychopharmacology. We view each treatment modality as an important aspect of coming to understand our patients and working to address the problems that trouble them.

The Work of the Clinical Team

The members of the treatment team meet regularly to discuss client progress and to fine tune the treatment. By actively combining the perspectives of all clinicians working with the client, we develop an in-depth understanding of, and approach to, each client's unique struggles and goals. This dynamic interplay among the different professional disciplines is a key component of our clinical philosophy. Our treatment approach relies on the unique qualities of our team, wherein a diverse group of clinicians actively works together to address complex client problems in a way not possible for clinicians working in isolation. Successful treatment requires not only the direct work of each clinician with the client, but also the productive interaction and engagement among team members.

In addition to weekly staff meetings, case conference and clinical discussions, each clinician also makes use of external clinical consultation. In this way, our work is supported by experienced clinicians who are outside the immediate sphere of influence of patient projections and organizational dynamics.

The Organization

Finally, an absolutely critical aspect of our work is our view, and use, of the entire organization as the treating entity. The functioning of the organization itself, at many levels, has an enormous impact on the ability of patients to make changes in their lives. The vulnerabilities and dysfunctions of the organization parallel the vulnerabilities and dysfunctions of our treatment system, and, by extension, our patients. By addressing the functioning of the organization, we are addressing the functioning of the clinical team and the client treatments.

For example, at a very basic level, we must maintain an adequate relationship to reality (e.g., pay our bills, obey the law) in order to facilitate our clients' ability to do the same in both a psychological and concrete sense. At another level, our ability to maintain reasonable, well-defined and flexible boundaries between the various functions of the organization facilitates the patient's ability to develop and maintain the analogous intrapsychic and interpersonal boundaries. Similarly, an effective and generative authority structure helps to provide an optimal environment for patients who are struggling with the intrapsychic analogues of these difficulties. Finally, a robust, flexible and creative organization is a powerful facilitating force for patients' treatments.

We find this to be an exciting treatment format and would welcome your comments and ideas. We are also interested in hearing from other organizations doing similar work (e-mail at boyerhf@jps.net). For more information, please see our website at boyerhouse.org.

ISPS-US Conference, continued

convened at a comfortable meeting space, the Washington School of Psychiatry, with about 40 participants in attendance. All the papers stimulated thoughtful comments from the audience.

The administrative board of ISPS-US met at the lunch hour to discuss a variety of subjects, including a change of name of our organization back to something more like the previous, less unwieldy title. The primary topic, however, was the question of ISPS membership. In particular, should we have one category of membership for all, including mental health professionals, patients, family members, and all interested others; or professional membership differentiated from non-professional membership. The board was primarily in favor of the former, but thoughtful arguments were put forth to support the latter position. We hope to present representations of both points of view in the Winter edition of the Newsletter, and welcome input from members on this issue.

Self Psychology and The Psychoses

David Garfield MD

Having been in Chicago for twelve years now, I have become progressively impressed with the potential value of self psychology with regard to the treatment of psychosis. This conviction rests on three premises. First, the psychology of the self posits narcissism, the narcissistic transferences (now selfobject transferences) and empathy as superordinate processes in pathology and treatment. Almost all authors and clinicians who address psychotic processes will testify to the "narcissistic gap" (Benedetti's term) that is central to the condition of psychosis. Furthermore, Freud's well founded observation, that patients with the more serious narcissistic neuroses (the psychoses) do not form the kind of transferences that hysterics and obsessives do, points to the fact that another kind of transference experience is necessary. This is where attention to archaic idealizing or merging/mirroring selfobject experiences can help stabilize and reverse the fragmenting of subjectivity which we see in our psychotic patients. Finally, a continual empathic immersion in the patient's experience not only provides data on what is going on inside, but as Kohut (How Does Analysis Cure--1984) points out, this kind of depth understanding is part and parcel of the healing process.

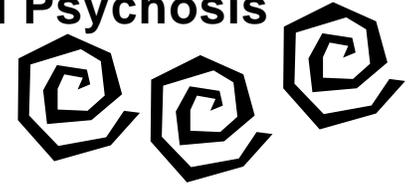
If you don't own Kohut's first book "Analysis of The Self" (1971) then go out and buy it if for no other reason than page 8. There is a chart that illustrates the breakdown products of the two types of selfobject transferences--the mirroring transference of the grandiose self and the idealizing transference of the idealized parent imago self. What is most striking about this chart is Kohut's intuitive grasp of the kind of transformation that takes place in psychosis. In the breakdown of the idealizing transference--one sees the mechanical, emotionless, paranoid configuration as characterized by Tausk's "influencing machine." On the other pole, the transformation into psychosis includes hypochondriacal preoccupations followed by body breakdown experiences such as hallucinations and other odd sensory/motor phenomena.

What is most important to take away from this explication is Kohut's understanding that normality and pathology exist on a continuum -- from an intact self in contact with enhancing selfobjects to a fragmented, inchoate self struggling to attain cohesion at any cost. Rather than our patients with psychosis as being cut from a different cloth, the psychology of the self sees our patients as suffering from deep rends in the fabric. Several authors such as Stolorow, Brandschaft and Atwood have begun to look at ways in which the self psychological treatment of psychosis can mend these conditions. I am optimistic that more insights into the psychotherapy and psychoanalysis of psychotic patients will emerge from the views of self psychology.

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Column: Expressive Arts Therapy and Psychosis

Tina Olsen CSW



Music reaches inside every human being. It crosses national, cultural and racial boundaries. Music can be a powerful tool to pull people out of their self-imposed shells. For the past eleven years, folk singing and a guitar have been my primary tools in working on the in-patient units at South Beach Psychiatric Center, Staten Island NY. This series recounts 'Eureka' days.

The units in the hospital are racially and ethnically balanced similarly to various neighborhoods in New York City. The patients are assigned to the unit where they came from so they would feel less isolated. There is a unit of the typical Bensenhurst, Brooklyn population (Russian, Jewish Orthodox, Spanish, African, and mostly others of mixed European decent). In the past, the few Asians did not participate in any activities for lack of translators. Two years ago, the hospital concentrated the many new Asian admissions from all around the city into this unit. A generally Asian staff, speaking the native languages (Cantonese and Mandarin) oversees the treatment and is always available. This unit is now about half Asian and the scene of the following events.

A small, nineteen-year-old Asian patient greets me with great joy when I arrive. At an earlier session, she had attempted to join in the singing group. That was her *first* group participation. At all other times this girl threw herself about making whining noises. She speaks no English, but her body language is eloquent. Today, it is clear to me she not only wants to join, but to lead the group. She begins to sing a beautiful song in Cantonese (later the staff translates it as a love song). As she sings, the unit becomes very quiet. Everyone listens attentively. Her physical presence changes - becomes more dignified. Her singing is lyrical and on key. It is as if the space electrically transforms from one of chaos to calm. Everyone, from every culture, is transfixed.

She receives resounding applause from the other patients and staff. Then an orthodox Jewish woman sings a grace in Hebrew. The atmosphere is the same -- quiet and attentive by all present. Another patient sings a solo from Chinese opera. This too is about love. While singing her expression is joyous, where previously it was despairing. Then the group sings together a simple repetitive gospel song, "This Little Light of Mine." Everyone is clapping together. With each verse a different patient is "lit" by having their name featured. The song continues for ten minutes and the mood becomes harmonious. One patient begins to dance to the song; others join in and still others shake hands. Their repressed desires to be joyous, to feel love and express it, are given freedom.

continued on page 7

Expressive Arts, continued

This day reminds me that the desire for peace and love is strong in everyone. In the most tormented person it may lie very deeply buried, but it is there. The music permits these desires to be expressed. Leading them, I feel like a midwife to the voice of the human spirit. Even people gripped by the severest of fears still have basic human needs to be expressed. With music we, staff and patients alike, are all equal: just human beings. While singing together, sharing hopes, dreams and fears, the patients are sane. And, that sanity is built on the bedrock of compassion.

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Column: Mind and Brain

Brian Koehler, PhD

The mind-brain relationship, as it specifically applies to the field of psychiatry and medicine, has been explored by a Harvard social psychiatrist, Leon Eisenberg (1986, 1995). Eisenberg (1986) suggested that psychiatrists should not focus exclusively or reductionistically on the brain as an organ and thereby overlook the experience of the patient as a person. He cautioned: "We may trade the one-sidedness of the brainless psychiatry of the past for that of a mindless psychiatry of the future". Using Bohr's "complementarity principle," Eisenberg noted: "The demonstrable pathology of disease does not suffice to explain the considerable variance in the illness experience which accompanies apparently identical lesions. The quality and duration of the illness experience are shaped by the sick role constructed out of cultural beliefs, by the patient's niche in family and social structure, and out of psychological traits idiosyncratic to the patient, no less than by organ pathology." Mind and meaning cannot be discovered in the neural machinery, it presupposes the latter but are properties that emerge only within a human social context. Eisenberg indicated that bodily dysfunction can cause problems in living, yet symptoms can be the somatic embodiment of problems in living and rarely are they simply one or the other. According to Eisenberg: "Neither brainlessness nor mindlessness can be tolerated in psychiatry or medicine. The unique role of psychiatry...will be found in the extent to which it contributes to the understanding of psychosomatic and somatopsychic integration, i.e., to the ways in which the mind is embodied and the body literally mindful."

More recently, Eisenberg (1995) concluded that the human brain is constructed socially. He noted that the "cytoarchitectonics of the cerebral cortex are sculpted by input from the social environment because socialization shapes the essential human attributes of our species." Eisenberg pointed out that although major brain pathways are specified in the genome, neural connections are formed by, and consequently reflect, socially mediated experiences. According to this view, psychiatry is

"all biological and all social." Mental function requires both brain and a social context. Eisenberg concluded, "To ask how much of mind is biological and how much social is as meaningless as to ask how much of the area of a rectangle is due to its width and how much to its height or how much of the phenotype is due to genes (nature) and how much to environment (nurture)."

According to Alanen (1994) neural and psychological processes should not be separated too sharply from each other. He noted: "An important starting point for all integrated psychobiological psychiatry is the insight that interactionality with other people is part of human biology. Interactional relationships play a crucial role in the growth of human personality and in the underlying development of our cerebral functions." This latter viewpoint was also proposed by the great Russian scientists Luria and Vygotsky. Alanen, as did Schefflen (1981) and Robbins (1993), hypothesized that interactional relationships with others participate in the pathogenesis of the schizophrenias at both psychological and biological levels.

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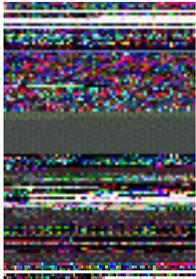
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Book Review: Garfield's *Unbearable Affect*

Brian Koehler PhD



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

Leston Havens in his forward to David Garfield's book *Unbearable Affect* stated, "This welcome, enticing, in many ways extraordinary book approaches the most difficult mental states in both usefully theoretical and practical human terms. It makes intelligible

what is often dismissed as bizarre or unintelligible and what may be most important, illustrates how these states can be managed and improved. It is a book of deep understanding and wise advice, moving, accurate, and useful." Havens pointed out the need for psychotherapeutic treatment in addition to and because of the support psychopharmacology has provided to our more ill patients.

Garfield, in understanding the role of affect in mental life in general, and in psychotic illness in particular, has substantial backing both within the history of psychiatry and psychoanalysis, and in current neurobiological theory. Eugen Bleuler, Carl Jung, Elvin Semrad, Luc Ciompi* and many other prominent psychiatrists have pointed to the crucial role affectivity plays in the origin and course of mental illness. Within neurobiology, LeDoux (1996), Cytowic (1996) and Damasio (1994, 1999) have emphasized the significant role emotion plays in neural functioning, psychopathology and reason itself.

Garfield's approach to psychotherapeutic praxis with psychotic patients is summarized by him as follows: "When affect is used as a guide to psychotherapeutic work with patients in psychosis, the ordinary can emerge out of the extraordinary. Amidst the bizarre, the alien, and the unintelligible communications, the natural element of emotion provides the tool to guide both doctor and patient. By seeking out, harnessing, and rechanneling affect, the storms of psychosis can be successfully navigated."

Garfield, as does Luc Ciompi in his theory of schizophrenia called Affect-Logic, understands psychosis, schizophrenia in particular, as primarily an affective disease which impacts negatively on neurocognitive functioning. His goal is not just to assist the patient in locating and bearing intolerable affects, but also to channel affect into more adaptive and creative forms of expression.

This book, which is written from the perspective of Dr. Tony Potter, a young psychiatric resident, revolves around treatment cases which come to life thanks to Garfield's humanistic and jargon-free approach. The book is broadly divided into three sections: "Affect Diagnosis," "Affect Therapeutics" and "Staying out of Psychosis." Affect diagnosis outlines the role of affect and primary process in

the pathogenesis and course of psychosis. Affect therapeutics, to me the most interesting and compelling section, presents the crucial role of the countertransference in working with more seriously ill patients as well as "forms and transformations of affect" in psychosis. In this section, Garfield outlines the psychotherapeutic approach of Elvin Semrad MD: the importance of acknowledging, bearing and putting into perspective "the intolerable affects that have driven the patient into psychosis." In regard to the therapist's helping the patient tolerate, contain and bear the overwhelming affect, Garfield makes the important point that in this phase of treatment, the therapist must serve in Kohut's language, as a selfobject, i.e., becoming an extension and living part of the patient's experience. Garfield noted that Semrad called for placing the unbearable affect into a new perspective and context; as the affect is better tolerated in the psyche-soma it can now be anchored to the rational mind. Additional chapters in this section cover the role of shame, self-esteem and narcissism in paranoid psychosis. "Staying out of Psychosis," the final section of this book, explores the psychoanalytic theories of such diverse clinicians as Binswanger, Sullivan, Benedetti, Arlow and Brenner, Mahler and Wolf in accounting for therapeutic change in psychotic patients.

Dr. Garfield's "Unbearable Affect", although theoretically and clinically unique unto itself, is situated in a very fine tradition of psychoanalytic treatment of psychosis dating from Carl Jung and extending to such theoretically varied clinicians as Luc Ciompi (1988) and Ruth Riesenber-Malcolm (1999).

* Luc Ciompi, a prominent Swiss psychiatrist and schizophrenia researcher, developed the concept of Affect-Logic and applied it to the understanding and treatment of schizophrenia. This is an understanding of the psyche as a complex hierarchy of affective-cognitive systems of reference generated through action. Relevant past experiences are stored within these affective-cognitive systems, which are viewed as vulnerable and unstable in schizophrenic individuals. Ciompi emphasized the emotional side of all therapeutic settings, calling attention to the necessity of maintaining the patient's sense of safety.

Ciompi, L. (1988). *The Psyche and Schizophrenia: The Bond between Affect and Logic*. Cambridge, MA: Harvard University Press.

Cytowic, R.E. (1996). *The Neurological Side of Neuropsychology*. Cambridge, MA: The MIT Press.

Damasio, A.R. (1994). *Descartes' Error: Emotion, Reason, and the Human Brain*. NY: Avon Books.

Damasio, A. R. (1999). *The Feeling of What Happens: Body and Emotion in the Making of Consciousness*. NY: Harcourt Brace & Company.

LeDoux, J. (1996). *The Emotional Brain: The Mysterious Underpinnings of Emotional Life*. NY: Simon & Schuster.

Riesenber-Malcolm, R. (1999). *On Bearing Unbearable States of Mind*. NY: Routledge.

Excerpts from:

“Being together in the therapeutic relationship in schizophrenia”

Daniel Dorman & Catherine Penney (1999)

International Journal of Psychotherapy, Vol. 4, No. 1

Introduction

This dialogue was presented at the Congress for the International Society for the Psychological Treatments of Schizophrenia and other Psychoses (ISPS) in October 1997.

The Dialogue

Dr. Dorman: I am Daniel Dorman. I am an analyst and psychiatrist and I practice in California. Miss Catherine Penney is my ex-patient. What we want to do today is to give you an idea of what transpired, the essential elements of what went on in a psychotherapist relationship in the treatment of Miss Penney who was profoundly schizophrenic when we met. She was in treatment for 9 years. The treatment was entirely psychotherapeutic; no psychotropic drugs were used. I will give you some background so that you get a picture of the stage and Miss Penney will fill in what was essential to her recovery... Her schizophrenia actually began probably by age 8, I think, at which time she heard what she later knew were voices...About as early as age 11 members of her family felt she walked in a rather strange and withdrawn way. She developed almost no social relationships at all. By the time she was 16 or 17 she developed rather bizarre behavior which included mumbling to herself, and building a small altar in her room. She developed rather complicated rituals around food which involved how, where, when and what to eat. She began losing weight which ultimately took her down to 80 lbs. She was, when I first saw her, 19 years of age...She heard voices in her head, which were of a murderous sort. The treatment was such that I would see her for individual psychotherapy which was a 50 minute/hour, 6 days a week...From the time she was discharged [from hospital] to the end of treatment which was about 9 years after we met, I saw her in out-patient therapy in my office in Beverly Hills for, I guess it was originally, five times a week and then we decreased it after several years to three times and then once a week. At the very end of treatment, Catherine made a decision that she wanted to move to Hawaii. I was encouraging but as part of separation from me and from her schizophrenia, meaning that she was taking up her life...Now I think what I will do is to turn the talk over to Catherine herself because we want to give you an idea of what went on between us that resulted in her leaving her schizophrenia.

Miss Penney: I would like to say that besides being a patient advocate, I am also a RN case manager and some of my duties include social work - finding affordable housing for clients, getting them set up with food distribution, and I am involved with crisis intervention and nursing education, teaching coping skills to help people maintain being stable so they don't have relapses and go back into the hospital..As a field nurse I have a lot more autonomy and I can really feel I am doing something for the client...

...I'd say the most important thing that I feel about the therapeutic process is that Dr. Dorman always conveyed to me that I was a whole person, that I was not a label or a diagnosis...I still carry the growth that developed from this interaction and from this investment in my wellness...This was a man or a physician whose vision of me wasn't about a pathological thing, it was a human being suffering from something - maybe a disorder, an illness, but I was not the illness. He was seeing beneath the symptoms. He was addressing the person underneath the symptom, underneath the behavior...And I can tell you that as a person in the middle of psychosis, I was overwhelmed with feelings of badness to begin with and when you are told "Catherine you are manipulating" it's like you are being punished instead of sitting down and talking about why, what's going on. It's like you're manipulating and that just makes you go deep under more. It makes you want to go down even deeper. Does it mean that you accept behavior that is inappropriate? No, you don't do that, but you can still address the human being whilst setting limits on behavior and as a nurse I now see that that is not done very much. I think there is a real need to focus on that

Part 2 of this dialogue will be published in our Winter 2000 issue.

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Letter to the Editor

This past week (August 4th - 8th) yet another blow was struck against real help for persons with schizophrenia. Governor Pataki signed a bill that would give courts the authority to force patients to take psychotropic drugs or face hospitalization. This new law was inspired by the patient, Andrew Goldstein, who caused the death of Kendra Webdale; and Julio Perez, who caused Edgar Rivera to lose his legs.

Ironically, the Times admits that this bill would not have prevented either of these incidents, since Mr. Goldstein begged for treatment and couldn't get it, and Mr. Perez had been allowed to leave the emergency room hours before the crime. Worse yet, this bill will cost \$40 million dollars a year. Although the Democrats wanted the state to pay for counseling and other treatment that patients need to avoid being involuntarily hospitalized, the governor opposed that approach, saying the purpose was not to provide additional services to mental patients.

Continued on page 10

Letter to the Editor, continued

On the following Sunday, the Times published a long article about Susan Fuchs, a mental patient who was murdered in Central Park. She had been ill for almost 20 years. She had constantly resisted drugs saying "I am a vegetable on medication. I can't enjoy anything...I can't live without my mind.," before she leaped into the Hudson in a suicide attempt. That time, someone pulled her out of the water.

We all know patients who resist medication. We know they constitute a large percentage of the population of the mentally ill. It would seem to me, that regardless of our individual views on when and how much medication patients should receive, we are the group of people most able to let the public know, that resistance to medication is *not* the result of mental illness, but is caused by the feeling that drugs make patients feel worse than their mental illness.

I have no suggestions as to how to implement such education, since I lack talent in that area, but it seems to me that there must be practitioners in our organization who have that ability. The governor's action and the story of Susan Fuchs dramatically inform us that even more patients will be vulnerable to steps taken by ignorant lay people. I feel even more impelled than before these two events occurred, to advise lay people that psychotherapy for schizophrenic individuals is available and helpful and it is my hope that our members will do the same.

Revella Levin, PhD
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Editorial Comment:

The viewpoints expressed in this section are not necessarily that of the editor. The issue of medication and involuntary treatment of the seriously mentally ill patient is a highly complex one that requires thoughtful study and dialogue between patients, family members, providers, politicians, researchers, and the public. Please send your views on this significant issue to the editor so that we can initiate an ongoing dialogue between our members.

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next triennial ISPS international meeting:
June 5 - 8, 2000
Stavanger, Norway
deadline for abstracts - December 31, 1999
Stavanger Forum
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telephone: +47 51 59 8100
fax: +47 51 55 10 15
e-mail: isps2000@stavanger-forum.no
(or contact ISPS-US for copy of submission materials)

Poetry

Untitled

Kathy Belarge

I was there and I wasn't
I raced and raced
Ahead of myself
I couldn't keep up
My life was passing
I was grown
I was here and they were there
The faster I went, the farther away they were
I couldn't get there
They were in another world
Not meant for me.

(Please send your poems for possible inclusion in the
ISPS-US Newsletter to:

Brian Koehler PhD
80 East 11th St. #339
New York, NY 10003
(212)533-5687
e-mail: bkoehler7@compuserve.com)

Excerpt from:

"Internalizing the tolerant, kind,
confused, and stubborn therapist
and insight"

Bertram P. Karon (1998)

Psychotherapy in Private Practice, Vol. 17(4).

"Insight creates change. It is not accurate empathy, but the therapist's attempt at empathy (whether or not successful) that produces change in patients. It is absolutely necessary for a competent therapist to tolerate being confused. Patients internalize the therapist into their superegos, replacing the internalized, punitive parents. They also internalize the therapist as a model for the ego and the relationship with the therapist as a model of a human relationship. Consequently, the therapist must be tolerant and kind, must create hope, and be stubborn in not accepting therapeutic failure."

§

The Turning of the Tide

Steve Vernon

for two decades
i have let confusion
choose my course

rushing like a swollen river
it capsized everything
in its way

it seduced my sister Sanity
and robbed me of my
brother Clarity

i would sit still
in periods of twilight
afraid of the impending dark

quietly yearning for
lucidity with the next light

during one bleak black moon
when psychic pain shot deep
to the core of my being

i must have said
a prayer
a fervent prayer for balance

it seems that this particular prayer
convinced the relentless tide to turn

so that confusion rushed head on and spent itself
once and forever
in a sea of calm

The Life of a Dead Man

Reiko John Imazaki

I was on the path to death
My addiction put me in the tomb
It wasn't till my calling was yelled out to me
It was clear as a shout
But quiet as a whisper
But still I struggled
With the rags of the dead
Wrapped around me
I had to work hard
To get untangled from my bondage
For I thought my death would never come
For I believed I had been through all life had to offer
But I hadn't experienced a life of light
This was a light which I felt was turned off in the process
I came to realize the light was always shining inside of me
Deep down in the depths of my soul
It was so dim
Everything seemed grey
No happiness; No pain
Nothing to worry about, right? Wrong
I lost my identity
Forgot Where I came from
I just didn't care
Now I have been found
By the light which I thought was gone
The old me is no more
But the new is alive and full of life
I am free
And dwell In a kingdom of love
I remember where I am from
And know where I am going
Thanks to the Almighty God
Who created the Heavens and Earth

8/3/98

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Please include dues for yearly membership in both ISPS and ISPS-US chapter
Mental health professionals - \$40.00 All others - \$20.00

Send to: Julie Kipp, CSW
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