

## Reports from meetings held by local ISPS groups and chapters

The ISPS UK reports from a successful meeting with the therapeutic relationship as theme.

The ISPS US reports from their third annual meeting, which had a rich clinical focus, but which also was influenced by reflections on the terror a few weeks earlier.

In several other countries there are ongoing work to establish local groups as a part of the ISPS network.



*From the ISPS UK meeting: Sarah Davenport, conference chair, Jan Olav Johanssen, Chair of ISPS and Brian Martindale, Chair ISPS UK*

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## On this newsletter

You may have noticed a small change in the physical format of the newsletter, compared with earlier issues. By cutting the height with 2 cm (from A4 to the American format), we help the chapters in the USA save money on distribution of the newsletter to their members. But we are not cutting the content!

As a matter of fact, this issue of the ISPS newsletter is the largest one so far in terms of number of pages, which means that the members are submitting more material for mutual inspiration and enrichment.

We thank Brian Koehler, Johan Cullberg and John Read for their major contributions to this newsletter, - three valuable papers that supplement each other both in content and in form. They are helping us to learn from experiences in the past to use that in our efforts to give a better future for persons suffering from psychosis.

An increasing number of local groups or chapters of ISPS is being formed in different countries, and we are also thankful that these groups take the extra work to share with us a taste of their work and discussions in their meeting.

All these signs of a growing and creative ISPS network, - also reflected in the newsletter and on the ISPS website, - is an inspiration to us all !

*Torleif Ruud, Editor*

## Objectives of ISPS

- promote the appropriate use of psychotherapy and psychological treatments for persons with schizophrenias and other psychoses
- promote the integration of psychological treatments in treatment plans and comprehensive treatment for all persons with schizophrenias and other psychoses
- promote the appropriate use of psychological understanding and psychotherapeutic approaches in all phases of the disorders including both early in the onset and in longer lasting disorders
- promote research into individual, family, group psychological therapies, preventive measures and other psychosocial programmes for those with psychotic disorders
- support treatments that include individual, family, group and network approaches and treatment methods that are derived from psychoanalysis, cognitive-behavioural, systemic and psycho-educational approaches
- advance education, training and knowledge of mental health professionals in the psychological therapies

### The ISPS executive committee

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Brian Martindale, UK  
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## ISPS secretariat

The ISPS secretariat is a link between members and the executive committee, updates the website, prints and distributes the newsletter, keeps a database of ISPS members and local networks, and helps the society and the members with information and other services. Mail to the ISPS and the executive committee may be sent to the secretariat, who will forward it to the right persons.

The secretariat is hosted by Centre for Psychotherapy and Psychosocial Rehabilitation of Psychoses SEPREP, which is a non-commercial foundation and a network of clinicians and researchers promoting psychological treatment of psychoses in Norway.

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### ISPS honorary life time members

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## From the chairman

Dear friends

### What are the most important goals for the ISPS?

I think we all agree that our main objective is to secure a room for the humanistic values in contemporary and future psychiatry. In the western world the pressure in the economy is towards more and more so-called "effective" treatment strategies; that is, treatments of short duration and especially with emphasis on short in-patient treatment. Of course, in itself this is not a wrong development, given that it produces the right results.

However, these strategies as well as others, require that we know what we are talking about; that we do not simply lean ourselves on pure beliefs of what treatment really works. The great problem for the psychological interventions often is that the result of the treatment first shows after a longer period of treatment.

In modern health care system, we have imported quality measures, effectiveness measures, from the industrial world. We count length of stay, number of admissions and so on and uncritically see those measures as measures of an efficient health care system. It is my opinion that we need to challenge these rather primitive means of measuring the outcome and cost/effectiveness of our health care delivery systems.

Efficiency and productivity expressed by length of hospitalisation, number of admissions, treated patients per time unit, and cost in Euro, Dollar or Pounds are incomplete measures for quality in a medical context. The measures should be supplemented by measures of results based on the course of illness for specific diagnostic categories.

The quality of our health services can be defined along three dimensions:

- Patients perceived quality. That is, do the patient get what he/she wants?
- Professional quality. Do the professional use and provide the methods necessary for treating the patient according to professional standards?
- Administrative quality. This level will be about cost/benefit within the resources available.

The real results of our psychiatric treatments very often will not be apparent before many years after the treatment commenced. For psychiatry, that is an enormous challenge and especially for the psychological treatments provided for years. The ISPS should try to make recommendations for outcome measures that are not limited to such simple means as listed above, but measures that can be practical tools for us to demonstrate the overall effectiveness of our treatment; that is, what results we achieve. Such measures can a brutal measure as survival rates, which, I am sorry to say, is used in some countries already. A better and more

optimistic measure

is relapse rates measured by readmission, remission rates, time to remission, symptom level, social functioning and so on.

If we are to justify the place and role of psychological treatments we must attend to these questions. The board of ISPS will encourage all members to give their contributions to this important discussion.

*Jan Olav Johannessen*  
Chair, ISPS

### Scholarship from the David Feinsilver Fund for presentation at the ISPS 2003 symposium in Melbourne

David Feinsilver was a well known psychiatrist and psychotherapist at Chestnut Lodge Hospital, organiser of the ISPS Symposium 1994 in Washington DC and member of the ISPS board.

He established a fund which would grant a scholarship to fund the travel expenses to the upcoming ISPS meeting for the best research or clinical paper on the psychotherapeutic treatment of the severely disturbed.

The applicants will be those who would not otherwise be able to fund their transportation and accommodations. Those submitting abstracts to the ISPS-Melbourne meeting should indicate on their submission that they wish to be considered for the award.

They should also send their abstracts and papers by e-mail no later than August 1, 2003 to Ann-Louise S. Silver, M.D. (asilver@psychoanalysis.net) and Brian Koehler, Ph.D. (bkoehler7@compuserve.com)

## Interview with Gaetano Benedetti, MD, Co-Founder of ISPS in 1956

**Brian Koehler, PhD, USA**

While in Stavanger, Norway attending the 13th International Symposium for the Psychological Treatments of the Schizophrenias and Other Psychoses, June 5 - 8, 2000, I had the honor to spend time with Gaetano Benedetti, MD and his younger colleague in the field of schizophrenia, Maurizio Peciccia, MD. For six months prior to my encounter with Professor Benedetti, I had been meeting with several colleagues on a biweekly basis to discuss the clinical theories of Drs. Benedetti and Peciccia and to compare these with the work of Harold Searles, MD. I would like to thank those colleagues and friends who participated in that seminar: Paul Carroll, Joyce Epstein, Larry Freeman, Julie Kipp, Christine Miller, James Ogilvie, and Janet Ottmann.

In this column, I will present excerpts from an interview I did with Drs. Benedetti and Peciccia on the morning of Professor Benedetti's address to the congress and a panel discussion in which Dr. Benedetti's work figured prominently. This panel consisted of myself, and Drs. Peciccia and Gary Bruno Schmid, all of whom including my New York colleague, Julie Kipp CSW, participated in the interview. Dr. Schmid assisted Professor Benedetti in translating German into English. Although the interview was primarily with Gaetano Benedetti, his responses seem to be also the product of a fruitful collaboration with his colleague, Maurizio Peciccia. The fuller transcript of this interview is being prepared for publication in a psychoanalytic journal.

Before presenting some biographical details of Gaetano Benedetti, I would like to inform our members that in future issues of this newsletter, I plan to report on an interview with Joanne Greenberg, noted author of «I Never Promised You a Rose Garden» and patient depicted in that story with Freida Fromm-Reichmann as her therapist, as well as interviews with other significant contributors to our field, such as Martti Siirala, MD. I would also like to address from a theoretical and clinical perspective, the psychotherapeutic needs of persons with a bipolar disorder.

Gaetano Benedetti joined the psychiatric staff at the Zurich University Clinic Burghölzli in Switzerland in 1947 (two years prior to Harold Searles' joining the staff at Chestnut Lodge). It was at the Burghölzli Clinic that Eugen Bleuler (1857-1939) created the term «schizophrenia» and studied the psychodynamic life of schizophrenic patients in close cooperation with Carl Gustav Jung, and also Sigmund Freud. Manfred Bleuler, the son and successor of Eugen Bleuler as director of the Burghölzli, described Benedetti as a «highly valued member of our staff» and that the staff «were increasingly touched by his devotion to schizophrenic patients and by

his ability to understand their psychodynamic life». Bleuler noted that Benedetti's empathy for his patients was similar to that of his father's. As the era of psychopharmacology began, reserpine from India came into use at the Burghölzli in the 1950's, Benedetti increasingly focused his work on the psychoanalytic psychotherapy of psychotic patients. He worked closely with Gustav Bally, Medard Boss, Marguerite Sechehaye, and Christian Müller (with whom he founded the International Symposium for the Psychotherapy of schizophrenia in 1956 at the psychiatric clinic at the University of Lausanne). In 1956, Benedetti was appointed professor of psychotherapy at the University of Basel. He continued his work with schizophrenic patients until he retired in 1985. Benedetti has remained active until the present in his teaching and supervision of clinicians involved in the psychotherapy of schizophrenia. Bleuler noted that «Benedetti discovered again and again that, behind his psychopathology, a schizophrenic person has an intellectual and emotional life as do normal people... It is a great task to break through the isolation of the schizophrenic, whether permanently or only for a brief time. This great experience plays an important role in Benedetti's therapy and teaching». Benedetti, later in his career, regarded his work with schizophrenic patients to be devoted not so much to the transmission of insight, but to «transitional subjects, of therapeutic dreams which straighten out the negative images of psychosis, of mirror phenomena arising from the creation of symbols of progressive psychopathology of therapist-patient symmetries, of transforming images». Benedetti calls for an integration of our «wandering with the patient in the desert of his psychosis with the growing concerns of social psychiatry».

**BK:** Dr. Benedetti, how would you define the basic problem in schizophrenia from a psychological perspective?

**GB:** In schizophrenia, the transference and countertransference affect has devastating effects, because the peripheral part of the self seems to be missing, that part which has developed through object relations [Ed. note: similar to Peter Fonagy's dialectical model of self development] and which can be metaphorically represented as the protective membrane of the cell which has differentiated itself so as to absorb the impact with the outside world. Our impression is that the protective membrane of the self is composed of a mirror image of the self which is formed approximately during the phase of Lacan's (1966) mirror, and which develops until it becomes the symbol of the self. Just as, upon interaction with the environment, the membrane changes in order to preserve the inner part of the cell, so the symbol of the self is transformed upon contact with the world in order to preserve the central nucleus of the self, protected, unchanged, always the same as it was.

The basic biological conflict of all living beings -

how to modify themselves upon contact with the surrounding environment and, at the same time, maintain unaltered their own structure - is exacerbated and becomes dramatic in psychosis. Here, the lack of membrane - of symbols of the self exposes the inside of the cell - the center of the self - directly, and without any mediation, to the impact of the world. The center of the self thus pours out and spreads itself projectively outside. The central nucleus of the self, when it is faced with and directly modified by the emotions of interpersonal relationships, loses its function as an organizer and structurilizer of world experience within those space-time coordinates which give us the sense of our existential continuity, the sense of always being ourselves, whatever the situation.

BK: How do you understand such symptoms as auditory hallucinations and delusions, as well as more «negative» symptoms, such as alogia, anergia, etc?

GB: Negative symptoms like anergia, apathy, etc., express the breakdown of the exhausted psychotic ego, the loss of its resources, and the widening of the chronic schizophrenic existence. Their psychotherapy needs the mild and slow stimulation of the still present resources as well as the possibility of nourishing the patient's ego by means of a constant, reliable, but not too active countertransference. Negative symptoms may also be defenses against every form of activity by severely injured patients.

So called «positive symptoms» indicate the impact of split - off parts of the patient's Self, which cannot be repressed by the weak psychotic ego into the Unconscious and which appears therefore to the patient as events of the outer world, as the activity of persecutors, etc. It is possible that the therapist introjects the split - off feelings and drives of the patient in order to transform them into positive symbols, to humanize them and to give them back to the patient in a new form.

BK: How do you define «Therapeutic Symbiosis» and is it a necessary part of the work?

GB: Therapeutic symbiosis can be considered as the therapeutic sublimation of that pathological symbiosis, which lies at the very core of schizophrenia and which Eugen Bleuler termed «transitivism» and «appersonation», where the patient, because of his symbiotic need and the disorder of his «ego boundaries» (Federn), confuses himself with the world, with the objects, upon which he projects the bad parts of his Self. The sublimation of this process in therapy is possible in so far as the therapist projects back to his patient the positive mirror-image of himself. The identification of the patient's ego with the object upon which he had projected the bad side of himself, in order to get rid of it, fragments the ego, while the therapist tries continuously to nourish the patient's ego.

BK: How do you define «Therapeutic Images», «Transitional Subject», and the use of dreams in therapy?

GB: In my efforts to focus the concept, I have decided to make use of the metaphor «transforming images». I would like to start off by saying that, at any point of our psychological efforts, whether in individual, family or group therapy, it is the germination within the therapist of transforming images which shifts the sad, oppressive, delirious, anxiety-provoking images by the patient. And it is by taking notice of these negative images, not by contradicting them, but by extending them towards new horizons, that a common thread can be woven in the psychotherapy, a push towards the «positivisation» of the psychotic experience; towards the «progression» of the psychopathology, the creation of «transitional subjects» between us and the patient.

Therapeutic transforming images, as I see them, derive from our ability to identify ourselves with the catastrophes occurring within the patient, to «live» them as if they were, in a way, our own - perhaps even dreaming about them at times; they derive from our ability to absorb the patient into ourselves, to the point that our latent psychotic nuclei are mobilized to some extent. These nuclei then lose all their power to harm us, precisely because they are now part of the dialogic interweave.

This is how the patient enriches our minds with symbolic images, while he thinks he is exhausting our energies, and how we can restore to him what he has awakened in our unconscious. Our «absorbing» of the sick person, which must precede the transformation process, amounts to the act of internalizing the split, cut - off and negativized parts of him. This absorption, which may manifest itself (at certain stages of the therapy) in the therapist's dreams about death, enables the patient to gain a therapeutic awareness of the positive parts of himself, which would otherwise be completely buried by the negative aspects. It is from these parts that the therapist forms a virtual image of the oneness of the patient, which is then continuously projected onto him, as a transforming image. There is perhaps nothing so stubborn as the resistance the schizophrenic puts up against therapeutic positivization. It is as if the persecutor within him would not permit it at any price; and indeed, at times it is possible to positivize the patient only through the time and space we share with him. The positivizing image cannot, therefore, reach the patient unless we provide the vehicle for it, by concentrating on it in his presence.

As for «Transitional Subjects», let us think of a voice, hallucinated by the schizophrenic patient, which however tells the patient how to overcome his fears, or which gives good interpretations of his symptoms. In a case where the patient was afraid even of singing birds (they knew him, they persecuted him), the voice said: «go into the garden and listen there to the voice of God». This hallucination was still, as such, a psychotic symptom; but, as I used to say, a «progressive one», a psychotic symptom

. . . . continues on page 9

## August Strindberg's mid-life crisis – a case of self-cure of psychosis

Johan Cullberg MD, PhD, Stockholm, Sweden

August Strindberg is one of Sweden's internationally most well-known novelists and dramatists. During the last decade of the 19<sup>th</sup> century he experienced a deep life crisis, which developed into paranoid psychotic delusions. I shall here describe the background to the crisis, and the recovery process that led him back into full creative productivity. Many psychiatrists and psychoanalysts have studied his case and he has been attributed diagnoses such as chronic schizophrenia, borderline personality, early brain damage, epilepsy, bipolar disorder, paranoid psychosis, absinthe delirium, alcoholism. The problem is that practically all these psychobiographies have been performed with a heavy reliance upon not Strindberg's own "autobiographic" writing and with little effort to make an analysis of the reliability of the sources. Literary research has, however, shown that much of Strindberg's so called autobiographic writing is quite subjective and often to be regarded as novelistic reinterpretation and reinventing of real events.

In sketching Strindberg's mid-life crisis, I have tried to separate the mythology of his life (including his own) from what we know really happened. Besides much of his huge literary production, I have studied his letters, the "*Secret diary*" as well as many eyewitness stories. There is also an abundant scientific literature about his mid-life crisis, the so-called "Inferno period". Thus it has been possible to follow him continuously, almost day by day, not unlike a psychoanalytic encounter. However, I realise that the encounter is rather one-sided, even if now and then it has appeared to me that I have heard Strindberg's voice harshly criticising my writing!

### Early life

Born 1849 as the 4<sup>th</sup> of 11 children, he experienced his mother's death in tuberculosis at the age of 13. Four of his brothers and sisters died early, and Strindberg describes his early years as a state of constant emotional hunger. The father remarried soon after the death of his wife. August never accepted this "betrayal" of his mother. His young adult years were stormy. Strindberg's debut as a playwright, came quite early and his fame as a novelist was also soon established. His output was prolific with novels such as *The Red Room*, *The Son of a Servant*, and plays such as *Miss Juliet*, *The Father*, *Creditors*, etc. were soon playing on many stages in Europe. Strindberg's views on his marital problems could be witnessed by his many readers in Northern Europe in the novel *A madman's diary*.

After having separated from his first wife, Siri von Essen, in 1889 he lost the custody of his three children –

he was in his beginning forties at the time. He was also threatened with a court case on morality charges due to his blasphemous writings. In this period he experienced a reduced creativity as a writer. He wrote to his publisher, "my big poet's udder is drying up". This made him start a new, and at the time, less successful career as a painter. (Recently, however, one of his paintings was sold at auction for over a million pounds). He felt increasingly alienated in Sweden and in 1893 he finally left for Berlin.

There he met a young and bright Austrian journalist, Frieda Uhl. The couple married and moved to Austria where their daughter Kerstin was born. Soon the new marriage was creaking and Strindberg left his family. In August 1894 he went to Paris to start a new life. In a letter he wrote "...I am restless like a crayfish which is changing it's shell". He also stated that he would become world famous by revolutionising the natural sciences through alchemy. This period marks the beginning of the so-called "Inferno period", which continued until 1898 when he "regained the grace to write for the stage".

### The "Inferno period" – 1894-1898

In Paris Strindberg lived alone in a cheap rented flat with his microscope, chemical reagents, test tubes, retorts, and Bunsen burners. Several of his plays were staged in Paris at the time but Strindberg was already too engrossed in his alchemy to really bother about them. His scientific reading was impressive, as was later his spiritual reading.

Strindberg's inner struggle with his deep ambivalence towards women, and his lonely sexuality in connection with a growing mystical need, is witnessed in several letters. By this time his teeth had begun to fall out and he complained of weariness. Still he lived and worked very regularly. His alcohol consumption was sometimes high but there were never any signs of alcoholic dependency. His intake of absinthe was also well controlled.

The alchemy project was partly concerned with inventing new ways to make gold. No less important was the mystic religious aspect of alchemy as an act of mental purification, in preparation for the descent into the inner, mystical world. Initially Strindberg sounds triumphant about the possibilities of making gold. He has a large correspondence but meanwhile is rather isolated, and apparently sees no women. Sometimes he describes a vague feeling of external threat. In his letters he reveals his wishes to work a miracle, that he is walking in the desert, and he wants to celebrate Easter with his "disciples". Even if we must not regard this as a hundred percent serious wish, it indicates a grandiose identification with Christ. When the alchemy successes did not come, depressive states were more frequent. His great expectations became increasingly mixed with apprehension and anxiety. In a letter to a friend, one month before his mental break down, Strindberg

desperately discusses how he is to tell whether he is a paranoiac or whether he is being driven into paranoia by all negative circumstances. The letter ends: "I beg you: Every bit of information about me from here must be received with great caution".

### The psychosis

The novel *Inferno*, which Strindberg wrote a year later, is a dramatised autobiographical version of his spiritual experiences during this period. Here both visual and auditive hallucinations are described. However, even if he suffered from illusions, no hallucination has been verified in Strindberg's real life. He was, however, a keen reader of modern psychiatric literature, for instance Henry Maudsley's psychiatric textbook from 1879. But we know that he suffered from increasing panic anxiety attacks during 1896, and delusions about having his life threatened by various groups such as art and gold dealers are described in his letters and in his diary. He also feared that his earlier friend, the famous Polish intellectual Stanislaw Przybyzowski had come to Paris to kill him. And in a postcard to the artist Edward Munch, who also lived in Paris at the time, he wrote: "the last time I saw you, you looked like a murderer – or at least a henchman." One week later, during the last days of July 1896, Strindberg left Paris in full panic, and travelled via Norwegian friends in Dieppe to Lund in southern Sweden. These friends later testified to his poor mental condition. He thrusted with a pole in the room's walls to investigate hidden electric circuits etc. In Lund he lived in the house of an old friend, a physician. Here he experienced "electrical assaults", jumped out of the window and left the house never to return.

A month later, however, he reports that he now begins to understand his situation in a new and spiritual context, that he had been forced to leave Paris because of the command of "superior powers". During the autumn his condition fluctuates. According to his diary he was often delusional and the Danish professor of Literature Georg Brandes whom he met in Copenhagen in November 1896 perceived him as "a broken down intelligence".

During the spring of 1897 his religious seeking intensified and he gradually began to regain his mental health. His studies of the Swedish mystic Emanuel Swedenborg's (1688-1772) work from the middle of the eighteenth century made a profound influence on his thinking. Here Strindberg learned that God had sent his "Educational and Disciplinary Spirits" from Jupiter to Earth to save those sinners who experienced guilt feelings. The others' souls were lost. Strindberg now understood that his sufferings had been an expression of God's love and His wanting to save him – they were not just the effects of persecution of evil humans. This new understanding rendered all his earlier experiences comprehensible: he had not been mad. It was God, his severe but divine Father, who had embraced him.

### The recovery

Strindberg's capacity for work returned. During the late spring of 1897 he completed *Inferno*, describing his mystical journey. However, its reception later that year was characterised by rage and disappointment from the literary Sweden. At the beginning of 1898 Strindberg made comeback to theatre with the drama *To Damascus*. His religious conversion back to his parents' Christian faith, which he had fought vigorously earlier in life, was a fact. This faith was to deepen through the years to come. He regained his intense productivity – around five dramas per year during the first five years - though his writing style was much changed.

Like many other great artists, having gone through a psychosis, he no longer worked naturalistically but the style became "expressionistic". Strindberg also used his psychotic experiences in the dream techniques, which were to have a great influence on European theatre. This is most clearly visible in *A dream play* from 1901. A tragic and existential preoccupation was added to his writing. His psychosis never returned – at least not to the same degree as during the *Inferno* period. However, there were traces of it in ten years later when Strindberg, several years after having divorced his third wife, finally had to realise that she was engaged to marry another man. In 1912 Strindberg died from a cancer in the stomach.

### Strindberg's mental state according to the experts

There are quite a few analyses of Strindberg's psychiatric and psychological problems. The first and most magisterial analysis is Karl Jaspers' book *Strindberg and van Gogh*<sup>2</sup> from 1921. Jaspers simply states that "Strindberg was schizophrenic". He promotes the view that Strindberg's intellect broke down during these last years of the century and that he never regained his mental health. According to Jaspers most of Strindberg's post-*Inferno* writing bears witness to his defective mind. (However, I believe that Jaspers like several other psychiatrist writers mistook expressionism for insanity!). I will not here discuss all the speculative analyses, which have been published during the years. In 1971 the British psychiatrist E W Anderson<sup>3</sup> claims that the diagnosis was a benign paranoid non-schizophrenic reaction with a possible reinforcement through an absinthe or alcohol intoxication.

One should also not forget a genetic vulnerability: both a sister and his daughter Kerstin ended up in mental hospitals with schizophrenia-like psychoses. I agree with Anderson in his diagnosis that Strindberg suffered a delusional disorder with reactive traits. There is, however, no real evidence for attributing clinical significance to the moderate use of absinthe. Today we know that the visual hallucinations described by Strindberg were literary fantasies.

Several literary critics during the 1980s, among them Evert Sprinchorn<sup>4</sup> in USA, have argued for not believing

in Strindberg's psychotic experiences at all. Instead they are looked upon as dramatisations of his need to get a mental kick in a period during which he was actually to some extent burned-out. In my opinion such a view is not less reductionistic than the claims that Strindberg was schizophrenically demented. In 1898 his younger sister Elisabeth was admitted to a mental hospital because of a psychotic disorder. She was never released. She wrote a letter to his brother asking for help. In response he wrote a letter filled with insight and compassion: "Your beliefs about being persecuted are similar to my experiences when I was ill; they are groundless; though not quite, since one is said to persecute one self. If you have read my book *Inferno* you can find the causes of my persecutory belief, as mainly depending upon self-accusations. And you also find the road I was seeking to find resignation".

### **Psychological aspects of Strindberg's personality and recovery**

My interpretation of Strindberg's impressive and durable personality change is the following. During the entire adult life he experienced an extraordinarily intense narcissistic conflict. Strindberg's self-image was deeply split, the one side being strong, masculine, free, grandiose, and the other weak, feminine, subhuman, parasitic. The grandiose part of the self covered his self-hatred, and as long as the conscious self-love was active and nourished by successes of different kinds, the strong feelings of greed and insufficiency could be denied or split off. These feelings are also an often-underlying content in his dramatic work.

Such a narcissistic dilemma is a common feature in artists and other persons living on their creativity. Narcissistic traits are often seen to grow increasingly dominant during a successful career. They also create relational conflicts. The grandiose part of the personality will crave more and more reinforcement in order to fulfil its task of covering the negative and split off part of the personality, to make it non-existent. Such reinforcement is accomplished by consuming important people's appreciation and love. Enjoying never ending successes, conquering the opposite sex, becoming the adored centre of other people's interest becomes an obsession. When somebody loses attraction and is less rewarding as an extended "self-object", he or she is thrown away as useless and exchanged for a new object. At the same time it creates an intense tendency towards affective shifts. Depressive spells and loneliness become natural companions not least during the latter part of these people's lives. Such an intense narcissistic dilemma is easily observable in Strindberg's life.

During the early 1890s Strindberg's narcissistic supplies were exhausted. He had experienced a series of important losses and humiliations, and his literary capacity was significantly diminished. He desperately tried to avoid the threatening collapse of his grandiosity, which

would reveal his deep wounds. The efforts to create a new family were unsuccessful, and his fantastic reparative idea of creating a new natural science implied leaving his family and old life behind. As could be expected this turned out to be a complete failure.

At such a point in one's life, and having invested the whole personality, one may accept one's failure after a reparative period, lick the wounds and return to life, perhaps a little wiser. One may alternatively feel that it is impossible to return, because shame and self-hatred is too strong; suicide may then be the only way out. The third, less common alternative is to deny reality and enter psychosis. This was the case with Strindberg.

The spontaneous prognosis is good in this kind of psychosis. The way out of psychosis and the return to society is perhaps the most trying part of the psychotic process; it is provoking to the self-image to deal with the experience of having been mad. Strindberg was aided in this through his religious studies. Having been an outspoken atheist during the eighties his religious seeking became nourished during the *Inferno* period. Emanuel Swedenborg became appointed as his Vergile, guiding him in interpreting the *Inferno* experiences. How this was made possible is more understandable when learning that Strindberg fifteen years earlier had completely cut off the bonds to his father and also to his childhood's religious faith. He had denied and repressed his ambivalent love for his father and he never went to his funeral. The competitive oedipal struggle with his father is very evident as revealed in the autobiographical novel *The Son of a Servant*, published in 1885?. Such a denial of the masculine dependency, accomplished through a grandiose self-sufficiency, and ever increasing "neurotic" reparative efforts, will sooner or later become dangerous to any man's mental health - even if it may be sublimated through creative activities. Because of this denial of the good inner father image, Strindberg's genuine masculine self-feeling was weak and had to be overcompensated. Of course the conflict became more intense because of Strindberg's problematic idealised inner image of his dead mother. (The split-off part of this idealised mother image can be frequently witnessed in his many dramatisations of evil woman personalities. Strindberg was also known as a "woman-hater").

The reading of Swedenborg had revealed that the persecutory experiences he had gone through depended on the fact that the mighty God in heaven was not only interested in, but also loved, August. If Strindberg were not able to accept his earthly father, he would surrender to this divine Father. His dangerously collapsed self-feeling was filled by the incorporation of the Father's strength and love. In his later years Strindberg took much care in his religious life not to lose his new-won spiritual Father.

This transformation from psychotic delusions to religious revelation is an impressive act of creativity since it allowed Strindberg both to disregard the alchemist

failure and the humiliating fact of having been mad. In his new-won religious faith he was able to regain his denied Father image. This possibly gave him a deeper masculine self-feeling. Strindberg's life and creative production is clearly divided into a pre- and post-Inferno period. The analysis of the vicissitudes of his narcissistic dilemma shows that the same personality traits may continue in the transformation of middle life, although in a new and less vulnerable setting.

**1) Paper presented at the Royal College of Psychiatrists Annual meeting in London July 10, 2001**

- 2) Jaspers K. Strindberg und van Gogh. Versuch einer topographische Analyse. Bern 1922
- 3) Anderson EW. Strindbergs illness
- 4) Sprinchorn E. Strindberg as a dramatist. New Haven 1981

*. . . continues from page 5 (interview with Benedetti)*

with a communicative, antipsychotic intention. The voice was, as the patient soon said, also a personification of the therapist, it was his presence in him. This transitional subject was a hallucination of the patient (a dissociated part of the self), as well as the presence of the therapist in his unconscious; it was both, the patient and the therapist.

BK: How do you understand the countertransference and its' place in the therapy process?

GB: The positive countertransference is the very motor and source of the therapeutic process. Within the countertransference can be distinguished the awareness of the therapist's conflicts, which have been mastered by the therapist and can therefore increase his sensitivity for symmetric conflicts of the patients', from what, I would call simply the human relatedness to a tragic and dying existence. [Ed. note: Drs. Benedetti and Peciccia's comments on hate in the countertransference are extensive and will be published in the fuller transcript of the interview].

BK: How do you define psychosynthesis and how does this differ from psychoanalysis?

GB: Psychoanalysis is the uncovering of the unconscious layers and backgrounds of the psychotic symptoms (like hatred, narcissistic wounds, rage, delusions, hallucinations, etc.). It helps to discover at their origins, dangerous life experiences. Psychosynthesis is the patient - therapist common building of a new self - identity, out of the experience of the therapeutic relationship.

BK: Have you had the experience of seeing patients recover?

GB: Yes, this is a great and moving experience. As well as in the treatment of an acute psychosis, where «suddenly», even during a therapeutic session, the psychotic self - identity changes, as in the slow development of chronic schizophrenics, where creative possibilities of the patients' lie not side by side with their psychotic symptoms, but are extracted from the very core of the symptoms themselves as the patients recover [Ed. note: Here Dr. Benedetti's theory is different from a Bionian and Post - Kleinian understanding of the psychotic and non - psychotic personalities as co - existing, for Benedetti, from the dialogic interweave a psychotic core can be therapeutically transmuted]. See also the enclosed follow - up of 10 patients recently treated by Dr. Peciccia [Ed. note: See M. Peciccia & G. Benedetti, 1998, «The integration of sensorial channels through progressive mirror drawing in the psychotherapy of schizophrenic patients with disturbances in verbal language», in The Journal of the American Academy of Psychoanalysis, 26 (1), 109 - 122].



## News from the ISPS networks

*This column is for report on activities in the ISPS groups and networks throughout the world. We encourage members to share events and developments for mutual inspiration, - for networking between networks.*

### The New York Chapter of ISPS-US

The New York Chapter of ISPS-US first convened in 1996 and has been meeting regularly on a monthly basis since 1997. We had been meeting primarily at Paul Carroll's apartment until our membership grew from about 18 to close to 100 members. Each meeting is attended by anywhere from about 15 to 25 persons. We now have an institutional sponsor, New York University, in downtown Manhattan.

In the past year we have participated in case presentations by Leston Havens, Vamik Volkan, Joyce Aronson and Kerstin Kupfermann. We have heard papers on a personal history in psychiatry and psychoanalysis by Maurice Green, annihilation anxiety by Marvin Hurvich, phenomenology and schizophrenia

by Louis Sass and James Ogilvie, and bipolar disorders by Brian Koehler. We have watched videotapes featuring Harold Searles and R. D. Laing, Bertram Karon, and Joanne Greenberg on her therapy with Freida Fromm-Reichmann. Presenters for the coming academic year include Anni Bergman, James McCarthy, Andrew Lotterman and others. Revella Levin suggested that we devote time to discussing countertransference anxieties in the psychoanalytic therapy of psychotic patients.

If you are interested in participating in our monthly meetings, please contact Brian Koehler at (212)533-5687 or [bkoehler7@compuserve.com](mailto:bkoehler7@compuserve.com)

### Dutch IPSP group

Since "ISPS-London" in 1997 a group of dutch therapists is meeting each other for a couple of times a year. After the symposium in Stavanger last year there have been several meetings in the Netherlands in which we have specially focused at settling an ISPS-group for the Netherlands as well as for Flanders: "ISPS-Nederland/Vlaanderen". We have decided to do so by founding a society according to the dutch law. We will use the possibility to link the membership of this society to ISPS.

A preliminary executive committee has been formed, of which the members are Margreet de Pater-Zijlstra, Jos de Kroon, Tom Kuipers and myself, all psychiatrists. We have met some flamish therapists who have interest in joining us and making our activities known in Flandres. Also we are making contact to the society for psychiatric nurses in the Netherlands.

We are planning an Invitational Conference about

## ISPS 2003 in Melbourne, Australia, 22-25 September 2003

**14th International Symposium  
for the Psychological Treatment of  
Schizophrenia and Other Psychoses**

**Reconciliation,  
Reform and  
Recovery:  
Creating a future for  
psychological treatments  
in psychosis**

For more information, send your name, mailing address, telephone, fax and e-mail address to:

ISPS 2003  
Locked bag 10  
Parkville, VIC 3052  
Australia

You may state your interest in presenting a poster, paper, workshop or symposium. You will then receive further information as soon as it is available. You may also ask for additional copies of information to distribute to colleagues.

Please also find updated information on the ISPS web site [www.isps.org](http://www.isps.org)

psychological treatments for psychoses with the aim of broadening our network. It will be held probably in May 2002 in Eindhoven. We hope 50-60 persons to take part. If possible we will launch ISPS-Nederland/Vlaanderen at that occasion.

After that we will eventually organise a congress at which all professionals and others interested in our countries will be invited.

*Jan Leijten*

### Third annual meeting of ISPS US

ISPS-US held its third annual meeting on October 6, again at the Washington School of Psychiatry. We honored Maurice Green, M.D. a long-standing contributor to the psychological treatment of the psychoses and its research. His wisdom and warmth set a healing tone for us, as we struggle through the aftermath of the September 11 terroristic attacks in New York City and Washington. Our theme, "Celebrating Our Dialogue" acknowledged our growing cohesiveness through our listserve, which has now joined with the ISPS-UK listserve — essentially coincidental with the joining of military forces of the US and UK in Afghanistan.

Harold Stern, Ph.D., recently returned from Russia where he teaches on psychoanalysis, is now launching the ISPS-US-Philadelphia branch. He presented a series of clinical vignettes to illustrate his intuitive treatment methods, crediting his mentor, Hyman Spotnitz. Andrew Martin, who recently obtained his Psy.D. presented work with a chronically psychotic man. Clare Mundell, Ph.D. gave an eloquent discussion, bringing together aspects of her work at Chestnut Lodge, her thoughts on our current national grieving Her remarks coincidentally dovetailed with Michael Robbins' keynote address, "The Language of Schizophrenia and the World of Delusion." He used his work with a woman who has profited enormously from treatment, to illustrate his understanding of "schizophrenese." Philip Alex, Ph.D., from The Boyer House in San Francisco presented on "The Therapist's Post-Session Drawings, Presaging Trends and Issues." He integrated this with his supervisory sessions with Sue Von Baeyer, Ph.D. Sue did not make the trans-continental flight from San Francisco to Washington, choosing to stay with her daughter, given our current state of war.

This year's meeting was more consistently clinically focused than last year's, when we debated on Recommendation 22 of the PORT Report. Meanwhile, we are increasing our research agendas, and are grateful to Julie Zito, Ph.D. psychopharmico-epidemiologist from the University of Maryland, and Anne Riley, Ph.D., MSW of NIMH for their collaborative suggestions.

At our business meeting, our new Membership

Recruitment Committee Chair, Julie Wolter, Psy.D. from Chicago reported on the high level of interest in psychological treatments of severe mental illness among current trainees in psychology, and suggested we launch a chat-room. Additionally, she will increase our web-linkages. The group also voted to support our web-master, Joel Kanter, LCSW-C in his proposal that we allow prospective members of ISPS-US to get a chance to see what we are like, by having access to our list-serve for some limited period of time so they can then decide whether to join officially or not. We hope to make significant contributions toward the success of our next ISPS meeting in Melbourne, Australia.

*Ann-Louise S. Silver, M.D.*

*ASILVER@psychoanalysis.net*

### Conference Report from ISPS UK

#### 'The therapeutic relationship in individuals and families affected by psychosis'

ISPS has carried a torch for working meaningfully with people suffering from psychosis, and kept it alight for nearly 50 years. Following the London conference 4 years ago, which attracted 800 delegates from 28 countries, there has been a gathering energy and vision to establish national groups. The second meeting of the UK chapter occurred between 13<sup>th</sup> and 14<sup>th</sup> of September, when 200 professionals, service users and carers gathered at the University of Reading, and participated in 50 presentations, seminars and workshops. Jaspers observed that in extreme psychotic states we meet all the philosophical and religious concerns common to man, and ISPS UK has created a hospitable and broad church for those drawn into seeking to understand the mystery of psychotic experience and how to relieve the associated complex sufferings.

It has been spoken of as a family – and we were told of a colleague in the States who, following September 11<sup>th</sup>, called to let us know that he is still here – at a conference which emphasised the primacy of therapeutic relationships, as the foundation, the vehicle and often the content of our treatment, the message, 'I'm just calling to let you know that I am still here', seems particularly important.

For me, and perhaps others too, this was much more than just another conference. In some ways it was a gathering constituency, an alliance of people from diverse backgrounds who are, at least in part, like minded.

#### An antipsychotic gathering

Schizophrenia is a condition characterised by destructive fragmentations, intrusions and blurrings. These occur at every level – and many commented on the difficulty of finding the time or the opportunity in day-to-

day practice for thinking about experience, both for ourselves and with our patients. The conference provided just this, time for talking with one another, time to compare experiences and think. As such, it was both a model and method, and for this brief time we were able to practice what we preach, and effectively engage in an antipsychotic experience.

We began by acknowledging that 'treatment as usual' in the UK is in a poor state. Our colleagues and co-workers struggle to provide for people's needs and so often are in an analogous position to the old woman who lived in a shoe and had so many children that she didn't know what to do. We also gave thought to the interesting tension between a therapeutic relationship and a relationship with a therapist and noted the comments from a service user perspective, that falling in love may still be a preferred alternative!

### **Recovery and hard won trust**

Cliff Prior, from the National Schizophrenia Fellowship invited us to look beyond the therapeutic relationship to the emerging recovery ethos, and a redefinition of professionals as guides, navigators, and cartographers, working with those who are experts by experience. The constituents of a therapeutic relationship are increasingly clear, in particular that it is sufficiently stable and enduring to win trust. Service users were described as valuing time, space and sensitivity and I took it as an indictment of my own profession that they so seldom seem to find this with their psychiatrist. One tentative but crucial issue was the possibility of there being enough trust to have genuine debate between service users, carers and professionals, concerning discerning between what arises from illness and what services are appropriately held responsible for. This pointed towards re-owning of projections and openness about both our limitations, and inadequate provision.

### **Hard core psychiatry**

The concept of 'hard-core psychiatry' emerged at the beginning and rumbled on throughout our proceedings. It seemed to be a way of expressing concern about the very severely ill, the homeless, the dangerously self-neglectful, or those unreachably lost in their madness. I found myself sitting with two associations with 'hard core', these being pornography, and the compacted course rubble that is laid underground to give a solid base for foundations. Were these of any use? I thought they might be, for at the deep end of mental health practice one meets the exploited, the overwhelming, the overexposed and the perverse, and the ambition of constructive engagement in all this involves breaking it up into manageable pieces, prepare the ground, put it in the right place and compact it so that it provides a secure foundation for whatever may then be built above it.

The hard core also contains a sense of protest. One of

our respondents commented, 'where I work we are overwhelmed'. This raised the issue of how to reconcile ourselves with images of services in Stavanger when the reality for some working in the NHS is of wards described as 170% full, and where there are 14% vacant consultant posts. We had many different reactions, frustration, defeat, disbelief and envy, but Brian Martindale also spoke of being humbled by these achievements, for here was a demonstration of what has been possible somewhere in the world, and which can raise a vision for the rest of us. I think some of us also wondered fleetingly how difficult it might be to learn Norwegian, so as to be able to generously say to our patients 'we are here if you need us, please come earlier than you usually do, that is good for you and good for us also.' Jan Olav also drew a round of applause for simply reminding us that we need to preserve a sense of humour, and that we can find humour in the most unlikely places if we look out for them.

### **SOME POINTERS TO THE FUTURE:**

#### **The need to explore our terms of engagement**

The conference gave a resounding endorsement to the

#### **Soundbites: voices at the conference:**

'State mental health services are designed to keep a lid on madness'

'I was afraid of the depths of his neediness and the possibility of getting sucked into his madness'

'Manualised therapy can be like the walls of the asylum protecting us from intimacy and relationship, an attempt to turn everything into medication'

'we may have a preference for anxiety reducing approaches rather than engagement and thinking.'

'I try not to get too tribal – I prefer to get on and say 'lets talk about a patient''

'Being there in a warm way ... doing things in a calm way'

'Sometimes good medicine tastes bad'

'Standing up to destructive psychotic states'

'The importance of research goes beyond insight and can influence culture'

'Conventional psychiatrists say, 'patients are not supposed to feel better after talking to us.''

'The world always looks better on overheads than it is in reality'

'Analytic models are based on the breast, whereas cognitive ones use the bottle'

primacy of the therapeutic relationship and the need to frequently reflect on what gets in the way of making and sustaining relationships with our patients. Some see diagnosis as just such an obstacle, especially where this is simplistically seen as 'labelling'. This could usefully be debated in depth. We are caught between a social constructionist critique of diagnosis and the need to give names to experiences that are meaningful and helpful. We appear muddled, ambivalent and embarrassed with the term 'schizophrenia' with all its stigmatising associations, and dependency on hospitals and medicines. I felt that Jan Olav was the least embarrassed amongst us, but wondered if this was linked to him having a secure sense of what he now has to offer those he gives this diagnoses.

### **Revaluing the authority of personal experience**

At present our professional journals seldom carry recognisable accounts of personal experience, apart from those of dead colleagues in the obituary columns. It seems that a combination of respect for confidentiality, and pursuit of a form of Evidence Based Medicine which overvalues quantitative and undervalues qualitative evidence, has denuded our professional literature of its humanity. This is in stark contrast with user-based journals like *Open Mind*, which carry provocative and evocative accounts, witnessing to the complexities of illness and recovery. In rethinking recovery we have much to learn from our patients.

### **Reintegration of the arts**

Salvador Dali once famously asserted that 'the only difference between Dali and a madman, is that Dali is not mad' – now there much that could be made of this statement, but for me it stands as some kind of affirmation that the arts can offer a great deal more than insight, illustration and expression, but an opportunity to find and redefine identity, facilitate exploration, and access creativity, imagination and play, as powerful restorative forces, whether or not they are accompanied by a reduction in 'symptoms'

The Royal College of Psychiatrists have called this year's annual campaign – '2001 a mind odyssey – a celebration of arts psychiatry and the mind', and the Annual General Meeting saw a flowering of poetry and film, drama, visual arts, dance, and perhaps symbolically the President gave a recital. Many are hoping that this will be a permanent change, and there is currently a move to establish a special interest group on Psychiatry and the Arts, within the Royal College of Psychiatrists.

### **Shifting the balance of power**

At our business meeting we debated and agreed an interim constitution, which, amongst other principles, upheld a wish to promote the integration of psychological treatments and arts therapies in treatment plans, and

included a public health perspective by supporting the comprehensive treatment of all persons with schizophrenia(s), and other psychoses.

In the UK we now work in a climate where the National Service Framework requires the development of a psychologically sophisticated, committed and comprehensive service for people experiencing their first episode of psychosis in every district in the country. This is a tremendous opportunity, and there is a need to get involved and influence service development.

However there are some doubts and concerns whether patients will genuinely be on the brink of a re-centring of service provision or whether they will be disenfranchised by a society moving steadily away from socialism towards individualism, in which the have-not status of those experiencing psychotic disorders will only deepen.

We have also heard of the risks service users can be exposed to through being individually over-involved in our processes – and there is a particular sadness in the stresses of representation and involvement leading to relapse. It questions what user involvement really means, and how that can be best supported.

### **Moving from compliance to cooperative alliance**

Our logo, two hands touching, building bridges, stands as an icon of connection. To act as a positive force for healing and recovery we need to constitute ourselves as a community of therapists and a therapeutic community, tolerant and understanding of our differences and inevitable conflicts (picture 4), but held together by some higher good than merely conducting our own therapy or asserting the claims of our preferred theory. We have had the opportunity to reflect on the primacy of relationship as the prerequisite for everything else. The most obvious centre for us to gather around is the patient, his family and their experience in the move from compliance to seeking genuine ways of working in cooperative and creative alliance.

*Glenn Roberts,  
MBChB, FRCPsych, MD  
Consultant in Rehabilitation Psychiatry,  
North Devon District Hospital,  
Barnstaple, Devon EX31 4JB*

See report in the next newsletter from:  
**ISPS symposium on: Psychological treatment of psychoses - What is good practice?**

The symposium is in Stavanger, Norway, February 7-8, 2002, in connection with a meeting of the task force on documenting effect of psychological treatment of psychosis. The members of the task force give presentations, and the 150 participants come from Norway and other Nordic countries.

## Guidelines for the formation of national / regional / local ISPS networks

As an international society, ISPS makes membership available through national, regional and local networks (groups).

ISPS encourages and supports formation of such groups and networks and will keep the organisation of networks as bureaucratically light as possible.

Each group or network may decide its geographical and/or professional boundary (see note at the bottom of this page).

ISPS networks contribute 20 % of their annual total dues to ISPS, with the minimum amount of £2 per member of the network.

Contact ISPS secretariat if you have any questions concerning forming a local group or network. An information package is available for those who want to form local groups or networks, and the ISPS secretariat may give you information on local groups and members in your area.

### The conditions of being a member network of ISPS

1. **The primary aim of the network** must be the promotion/development of psychological therapies for persons vulnerable to psychotic disorders.
2. **The network pays the ISPS network fees.** Membership of the international ISPS and its benefits will only be available through networks that pay the expected contribution to ISPS for its members. These network fees to ISPS will be kept to the absolute minimum to allow for a maximum growth potential of local networks.
3. **The network keeps a reliable, up to date membership list and sends this to ISPS.** For communication and ratification of membership purposes, it is required that each network has a reliable and regularly updated list of members with each member's address, telephone, fax and as far as possible e-mail address. A named person in each network must have the responsibility for the membership address list and for regularly sending updates of this list to the ISPS secretariat (with an easy way of notifying the secretariat of additions and deletions). The ISPS secretariat will make available different formats of data files as a common way of recording and submitting this information.
4. **The constitution of the ISPS is accepted.** The constitution is available from the ISPS secretariat and on the ISPS web site.

#### Members of local/national ISPS groups or networks will

- receive the ISPS newsletters through the network twice a year
- be entitled to reduced fees at ISPS international conferences
- be able to be involved in other activities of the ISPS as these develop

Organisations other than ISPS networks are welcome to affiliate to ISPS for an affiliate fee of £100 per year or £250 for three years. The organisation will receive ten copies of the newsletters and is encouraged to make ISPS events known to their members. Please contact the ISPS secretariat for further information.

In addition to ISPS membership through such national/regional/local networks, there is also individual membership available in the international society (see the last page of the newsletter).

**Notes:** *In some areas it might make sense to have a national network or a network covering several small nations or those with a common language if meetings or other forms of dialogue were realistically able to happen. Large networks might have local subgroups. In other areas, a city or county or region within a country may want to form its own network with direct membership of ISPS.*

*Some networks form to promote skills or knowledge etc in one particular therapeutic modality eg cognitive therapy, the application of psychoanalytic understandings to psychosis, family interventions, arts therapies. Networks of users (clients, patients, consumers) and family members may wish to join. Other networks may want to aim to bring together different therapeutic modalities - as well as user movements and administrators.*

**START UP MONEY FOR ISPS NETWORKS**

\$

**Start up grants** The ISPS is offering grants to help in the setting up of local ISPS groups according to the ISPS guidelines (see page to the left)

**How much?** \$12,000 is available worldwide up to April 2002. It is hoped that further amounts will be available to other networks in following years.

**How much for your proposed network?** In the first year we intend to make grants of between \$500 and \$1000 dollars each to an area within a country or a national group.

**How to apply:** Application for funding should be brief but convincing, they must...

- a) Contain a simple development plan for an ISPS network that is signed by at least ten persons involved in the psychological treatment of psychosis
- b) State why the money is needed in the coming months
- c) Give an agreement to produce simple evidence in April 2002 as to how it has been spent
- d) Provide a named person responsible for administering the money and the bank account details to which the money will be paid (preferably a local ISPS account)
- e) Future: a plan is needed how the network would finance itself without such a grant in the future
- f) A very brief annual report on the progress in developing the network (this could serve as a source of help and ideas to inform others via the newsletter etc)
- g) Preference will be given to developing countries.
- h) Applications for smaller amounts of money extended over a longer time will be considered e.g. for X hours of admin time / month over 2-3 years

**Applications** should be typed and sent by post, fax or email in the first instance to:

Brian Martindale and Courtenay Harding  
 ISPS C/O SEPREP, Jerbanetorget 4A, N-0154 Oslo, Norway.  
 Fax + 47 2310 3779  
 E-mail isps@isps.org

**www.isps.org - the ISPS website**

ISPS	- constitution of ISPS, objectives of ISPS , addresses to the executive committee
Newsletter	- read, download and print the ISPS newsletters using Adobe Acrobat Reader
Local groups	- information on local ISPS chapters and groups, local newsletters, meetings or events
News and events	- news and information on ISPS congresses and other events
Literature	- book reviews, new books and articles recommended by ISPS members
Research	- information on research and present studies
Discussion groups	- discussion groups for ISPS members
Membership	- information on membership, and membership form to fill in and submit
Other websites	- links to other useful sites related to the objectives of ISPS

**Submit information or comments e-mail to isps@isps.org or on a diskett to ISPS**

## The need for evidence-based destigmatization programmes

**John Read, New Zealand**

### Attitudes Towards “Mental Patients”

Prejudice against people diagnosed schizophrenic and those with other mental health difficulties has been extensively documented [1]. The findings are remarkably consistent over place and time, with dangerousness and unpredictability among the most often reported perceptions [2,3]. Nunnally found that the US public experienced ‘mentally ill’ people not only as more dangerous and unpredictable than other people but also more worthless, dirty, cold and insincere [4]. In New Zealand, most of those attitudes have been replicated, in addition to delicate, slow, tense, weak and foolish [2].

Such attitudes are readily expressed in actual behaviour [1]. Discrimination in the workplace, when seeking housing, or when applying for loans or insurance [1,5,6] and rejection by friends and families [1,6-8] have been well documented.

Professionals are not exempt. Health professionals have worse attitudes towards the ‘mentally ill’ than the public [9]. Many mental health professionals [10] and GPs [11] prefer not to work with the severely disturbed. Although there is good reason for mental health professionals’ blaming the media for the promulgation of the violent ‘madman’ stereotype [12], many such professionals hold similar attitudes to those of journalists [13].

### Destigmatisation Campaigns

For decades attempts to rectify this alarming situation have been predominantly based on the belief that the best approach is to ‘educate’ the public to adopt the dominant biological paradigm. Despite debate about the relative contributions of psychosocial and biological factors to schizophrenia [14-16], destigmatisation programmes, enthusiastically assisted by the drug industry, have sought to persuade the public that people with psychological difficulties are ‘ill’ in the same sense as people with medical conditions [17-19]. As early as 1961 this approach was deemed a failure, by the US Joint Commission on Mental Illness and Health: “The principle of sameness as applied to mentally sick versus the physically sick .... has become a cardinal tenet of mental health education. ... Psychiatry has tried diligently to make society see the mentally ill in its way and has railed at the public’s antipathy or indifference” [20, p.59]. Then, as now, the failure was located in the ignorance of the public rather than in the validity of the principle.

The public does tend to reject bio- genetic causal beliefs. Sarbin and Mancuso [21] found that the US public uses the ‘mental illness’ metaphor less readily than mental health professionals, preferring explanations involving environmental stressors. Wahl [19] has

replicated this finding in the US, as have Angermeyer and Matschinger in Austria and Germany [22]. (The latter study found an exception to the public’s psychosocial perspective, in that the relatives of schizophrenics held more “biological/constitutional” beliefs, because of “greater exposure to the knowledge of psychiatric experts and their having to deal with their own feelings of guilt”.) A recent survey of over 2000 Australians found, in relation to schizophrenia, explanations focused on “day-to-day problems and traumatic or childhood events” rather than “inherited or genetic” factors [9]. However both Wahl [6,19] and Jorm [9,17], like many others, conclude that the answer is to redouble efforts to persuade the public they are wrong.

### The Relationship of Causal Beliefs to Attitudes

That such efforts have failed seems evident from research, spanning four decades, of consistently negative attitudes, including studies of specific populations showing no improvement in attitudes over time [2,23]. Some evidence suggests that attitudes are actually worsening [1]. One study found that as “knowledge” based on the traditional “mental illness” perspective increased attitudes became increasingly negative [24]. Therefore, the assumption on which destigmatisation programmes have been based requires careful examination.

Numerous studies show that rather than biological and genetic causal beliefs being related to positive attitudes to ‘mental patients’, the opposite is the case. Sarbin and Mancuso [21] found that on the rare occasions that the public does employ the ‘illness’ metaphor they tend to reject the person concerned. Golding et al. [25] confirmed that people espousing medical explanations were more reluctant to become friends with ‘mental patients.’ Schwartz and Schwartz [18] reported that such views are related to experiencing ‘mental patients’ as not accountable for their behaviour, a key component of the unpredictable aspect of the stereotype. In 1980 a National Institute of Mental Health report confirmed that nonresponsibility, unpredictability and dangerousness form the core of the stereotype, and found that being treated by medical professionals or modalities, or in medical settings, is more stigmatising than alternative approaches [26]. Mehta and Farina [27] reviewed studies demonstrating that “the disease view engenders a less favorable estimation of the mentally disordered than the psychosocial view.” Their own study found that participants in a learning task increased the intensity of electric shocks more quickly if they understood their partner’s mental health problems in disease terms than if they believed they were a result of childhood events.

A study of 469 young New Zealand adults confirmed that the greater the belief in bio-genetic causes the more negative the attitude towards ‘mental patients’ [28]. Another New Zealand study also found that those with bio-genetic causal beliefs experience ‘mental patients’ as

more dangerous and unpredictable, and are more likely to avoid contact with them than were those with psycho-social causal beliefs [29]. This study also found that presenting information about psycho-social causes, and critiquing biological theories, significantly improved attitudes, particularly perceptions of unpredictability and dangerousness.

Mental health professionals with a biological perspective are less inclined to involve patients in the management of mental health services [30] and assess videotaped 'patients' as more disturbed than professionals with a psychosocial perspective [31].

'Psychiatric patients' tend to have more positive attitudes than the general population [32] and to reject medical model explanations [33]. (When 'patients' don't accept that they have an illness this is often dismissed as a 'lack of insight' and viewed as evidence that they are still 'sick.' This use of the term 'insight' is the opposite of its original psychodynamic meaning - the ability to relate current difficulties to past life events.) Organisations of 'psychiatric patients' have long railed against the effects of a 'medical model' perspective on their self-esteem, accusing it of increasing stigma while minimising the complexity of their lives and their capacity for recovery [34,35]. Of 74 members of such organizations in New Zealand 44% experienced their receiving a psychiatric diagnosis as leading to lower self confidence, 53% to social rejection and 62% to difficulty gaining employment [36].

Presenting a social learning orientation to clients leads to more efforts to change than presenting a disease explanation, with the latter group more often using alcohol and drugs to relieve their distress [37]. Birchwood et al. [38, p. 387] found that "patients who accepted their diagnosis reported a lower perceived control over illness," and that depression in psychotic patients is "linked to patients' perception of controllability of their illness and absorption of cultural stereotypes of mental illness."

Hill and Bale [39] showed that individuals with medical causal beliefs adopt a passive role with mental health professionals. Having reviewed the data on this issue they concluded:

Not only has the attempt to have the public view deviant behaviour as symptomatic of illness failed, but the premise that such a view would increase public acceptance of persons engaging in such behavior seems to have been a dubious one to begin with. . . . The notion that psychological problems are similar to physical ailments creates the image of some phenomenon over which afflicted individuals have no control and thereby renders their behavior apparently unpredictable. Such a viewpoint makes the "mentally ill" seem just as alien to today's "normal" populace as the witches seemed to fifteenth century Europeans. (pp. 289,290)

### How does the medical model produce such negative attitudes?

The biological model replaced the moral depravity model of medieval origin. It was hoped that the 'bad to mad' transition would produce less punitive attitudes by bestowing the dignity of the sickness role and its attendant non-responsibility component. It seems, however, that "illness has lost much of its power to mitigate and excuse, so that 'sickos' are treated as if they were some strange minority or political sect" [40, p.475].

Mehta & Farina [27] suggest three reasons. The first is that viewing distressed people as sick, while discouraging blame, produces a patronizing attitude in which they " ... like children, must be treated firmly. They must be shown how to do things and where they have erred. Hence the harsher treatment." The second is that believing in "biochemical aberrations" renders them "almost another species," an explanation reminiscent of Hill and Bale's previously cited conclusion. The third is that an illness framework makes us feel vulnerable because the disease might strike us too, whereas psychosocial explanations suggest that their "exceptional circumstances" won't happen to us. "And these feelings of vulnerability may give way to harsher treatment."

Another factor may be the need to deny our own fears of 'going crazy' and to project those fears onto others. A set of causal beliefs that not only creates the illusion of a categorically separate group (rather than acknowledging the dimensionality of emotional distress), but also creates or exaggerates the difference between the two categories by supposing biochemical or genetic aberrations, seems likely to fuel the reciprocal processes of distancing, fear, projection and scapegoating. When the type of differences promulgated imply faulty brain functioning so severe that a person is denied responsibility for their actions, then our fear may be compounded by the notion that this person could lose control at any moment and by the belief that this unpredictability, which may express itself in a violent manner, needs to be severely, even harshly, controlled. This hypothesis draws support from the finding that the less we hold 'mental patients' responsible for their behaviour the more harshly we treat them, and the less aware we are of the harshness of that treatment [27].

Factors which reduce perceived differences, however, seem likely to break this circle of fear, projection, distancing and rejection. Two such factors are establishing contact with users of mental health services [23,28,29,41] and, in the process, portraying their difficulties in terms of their life histories and circumstances rather than portraying them as suffering from illnesses. Future destigmatisation programmes must choose between approaches that have been demonstrated to be effective and those that have been repeatedly demonstrated to increase fear and prejudice.

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... continues on page 22

## ISPS and the WPA (World Psychiatric Association)

The ISPS is applying for affiliate membership of the WPA. This is part of a concerted effort by ISPS to bring to greater awareness of other professionals, ideals, knowledge and skills etc contained within the ISPS membership. We hope to know that our application has been successful at the next WPA General Assembly. This will be during the

### **WPA World Congress August 2002 in Yokohama, Japan**

This event will be an excellent opportunity for our members to organise:

- Symposia, Workshops or Courses (deadline for submission is July 1, 2001)
- Papers, Lectures and Posters (deadline for abstracts is December 1, 2001)

The WPA web site is <http://www.wpanet.org>

The WPA Japan congress web site is: <http://wpa2002yokohama.org>

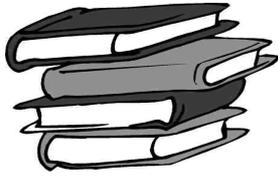
The WPA organises a great number of other conferences in conjunction with local member organisations and others. We would like to encourage you all to make submissions, and to draw up symposia on behalf of the ISPS and taking appropriate promotional material with you (we intend to soon have a information flier that can be downloaded from the web site).

An excellent start has already been made. During the WPA Regional meeting with the Royal College of Psychiatrists in London in July this year, there will be ISPS member presenting on Early Detection and Early



**We do research in Schizophrenia**

## Book reviews



### Book Review

**Professor Marius Romme and Sandra Escher: Making Sense of Voices. A guide for mental health professions working with voice-hearers. London, 2000.**

Mind publications, Granta House  
15-19 Broadway,  
London E15 4BQ  
ISBN 1-874690-86-3

“Hearing voices is an intense, intrusive experience. The voices have no apparent outside source, but feel as if they are coming from someone or something else. Psychiatrists describe them as auditory hallucinations, and often pay little attention to what the voices actually say. It’s even suggested that listening to the content increases the hearer’s undesirable fixation on this ‘unreal’ world”.

The authors professor Marius Romme and Sandra Escher introduces their book about ‘Making sense of Voices’ with these words. They point out various reasons for suggesting a change of approach towards voice-hearers. Primarily it stems from the voice-hearers’ need to achieve acceptance of their experience. Next comes the importance of approving the competence and knowledge of persons who are living successfully with their voices. Romme and Escher’s own research and that of others also urges a new approach, with specific attention to the relationship between the voices, life-story and what it says. Other reasons arise from the different capacity people have to cope with voices, and from doubts about the scientific validity of calling voice-hearing an illness. Finally, the

authors mentions problems concerning the efficacy and side-effects of current treatment with neuroleptic medication which further argue the case.

Marius Romme and Sandra Escher have demonstrated that there are many ways of understanding and approaching experiences and problems associated with hearing voices. Through more than thirteen years of clinical, self-help and research work they have made important contributions to the mental health field which have been both inspiring and challenging.

*Inspiring* to many professionals and users because Romme and Escher represent an open-mindedness towards life and human experiences and at the same time a clear ideological perspective about phenomena called “mental illness” and “auditory hallucinations”. Their introduction of concrete ways of analysing and dealing with voices have also been very important.

*Inspiring* to voice-hearers because their experiences can be talked about and dealt with in very concrete ways without being identified as a imminent symptom upon serious mental illness.

*Challenging* because Romme and Escher’s perspectives and approaches can be seen as “on the fringes” in many psychiatric communities and helping systems. A voice is just a voice as an experiential fact and not primarily denominated as a hallucination. It can be approached and explored as any other kind of human experience with its different qualities, meanings and associations.

The book is divided into three sections. In the first part, called “*Why we need a new approach to hearing voices*” the authors go through reasons for this, discuss research results in the field and also look into the important relationship between the voices and the individual’s life history. Of particular interest are studies of voicehearing in the general population, and the findings that there are people hearing voices with the characteristics of auditory hallucinations who do not show further psychopathology. This urges to caution about diagnosing mental disorder on the basis of hearing

voices alone.

The second section of the book called “*Analysing the voices*” represent in many ways a manual for just analysing the voices together with the person. A semi-structured interview is published together with the book. It has been developed by the authors and revised several times through the work with voicehearers. The interview situation gives the individual an opportunity to talk about the voices in an open and concrete way. Interviewing skills and explanations to each part of the interview are described thoroughly. A topic we would have liked included and discussed in this section is the qualifications of the interviewer. What is the experience of the authors in this aspect?

The next step of analysing the relationship between voices and hearer is comprising a well constructed report. The idea is to organise the material in order to get as clear a picture as possible of the situation and the problems the voices represent. The authors guide us through the steps of making the report and the final construct, where the main purpose is to try to get an answer to two questions: Whom do the voices represent? What problems do the voices represent?

In the third section of the book “*Interventions*” Escher and Romme underline that learning to deal with the voices is a process for the person. Through their work with voice-hearers they have seen three distinct phases: the starting phase, the organisational phase and the stabilisation phase.

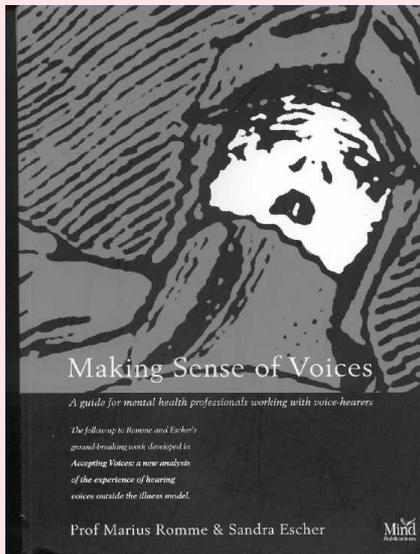
According to our experiences with long term psychotherapeutic treatment with patients who are hearing voices, these guidelines appear as very fruitful. First of all, it is very important to give professionals tools they can use in approaching the not understandable and bizarre. Helpless helpers often act helplessly and in a way that can severely reject the patient as a subjective self. Secondly, the authors convey a

psychotherapeutic attitude: hearing voices has its meaning for the individual which is of vital importance. Finally, problems related to hearing voices can be solved over time. Some may learn to accept their experiences as a way of being. One patient gave the following analysis of her long lasting voices: "Earlier my voices were not coming from me. Over years I have realised that I always have this echo from my own unconscious when being awake. The transition between sleep and being awake is for me only gradual. I have learned that my voices can help me keep in touch with reactions and feelings which I otherwise would not have recognised".

The book represents an important contribution to the knowledge about the users experience- based knowledge. This knowledge should be given higher priority than knowledge based upon observations by professionals. In other words, knowledge based upon the latter is only valid when the users knowledge is recognisable in it.

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## **Psychosis (Madness)**

**Ed. By Paul Williams**

**Book Review by Franz Resch Heidelberg**

There is growing empirical evidence that psychotherapeutic measures do have a positive impact on psychosis. Relief from acute symptomatology and especially improvement in drug resistant patients have been documented. As different approaches like cognitive, behavioral and enriched supportive counseling strategies present with similar effects in the long run, it is stated, that the establishment of a therapeutic relationship may

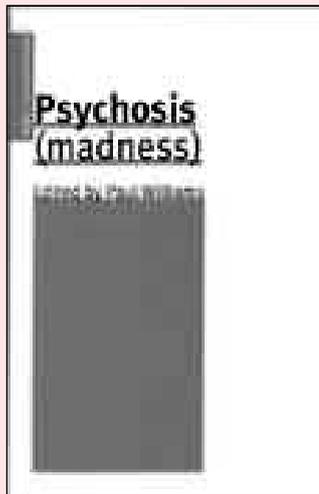
constitute the basis of various efforts to help the patients. This "old" finding draws new attention towards psychodynamic approaches to the field.

The book by Paul Williams on Psychosis tries to line out different trajectories of subjective realities in psychotic persons, empathically emphasising the "tremendous suffering" (P.Williams) of inflicted individuals. The basic idea of the book is not a narrow minded abandonment of modern neurobiology and genetics but the critical notion, that "genes affect how sensitive one is to the environment, and the environment affects how relevant one's genetic differences may be" (Lewontin1993, cited by P.Williams,p8). Psychoanalysis may offer a "source of knowledge" for the understanding and treatment of psychosis, in that it helps to give "coherent meaning to confusing or bizarre communications", psychodynamic concepts may additionally help to formulate and implement adequate treatment plans including a variety of different treatment modalities. In this respect different procedures may be appropriately applied according to a patients subjective needs and objective capacities at a given point in treatment.

Psychoanalysis of whatever school is not "pertinent" in extreme settings (M Conran, p27) as a method of direct approach to the patient, because of immediate and concrete relationships of the patient with doctors and nurses. But naturally the formation of transferences occurs in a similar intense and archaic way evoking "counter-transferences of a corresponding nature"(M Conran)- which influence the concrete relationships on the ward. Conran's important statement has to be cited: "...yet there is, in my view, no other way to make sense of the relationships in which the schizophrenic engages than by analysis of the transference, and that its value to the patient lies, in the first instance, not through interpretation made to him, but by interpretation to the doctor and nurse so as to enable constructive relationships to continue.."(p29).

With a plenty of clinical material, case histories and the adoption of a developmental perspective on psychosis presented by distinguished authors –most of them consultant psychiatrists and all of them members of the British Psychoanalytic Society- the book provides new fascinating insights into psychotic reasoning and leads up to basic and practically useful recommendations for clinical work and the therapeutic approach to the patient. P Williams gives an introduction to the field, L Sohn addresses the problem of psychosis and violence, M Conran's contribution deals with sorrow, vulnerability and madness, M Sinason asks questions about different co-existing selves in psychotic patients and how these may be integrated in the therapeutic process. T Freeman reminds us of the fact that delusions in schizophrenia not seldomly resemble

childhood phantasies and may result from the emergence of a childhood mode of mental activity. R Lucas gives a report on how to manage psychotic patients in a day hospital setting. Last not least D Bell provides us with new insights in destructive narcissistic features of patients.



The book on psychosis is published in 1999 by the institute of psychoanalysis in London and should not be omitted by any therapist interested in the treatment of psychotic patients because it contains very interesting clinical material and carefully lines out different pathways to the subjective worlds created by the psychotic process.

Heidelberg, 28.10.01  
Franz Resch

## Book reviews to come . . .

In the next newsletter we bring review of the book «A Language for psychosis. Psychoanalysis of Psychotic States, edited by Paul Williams.

As a member of ISPS you should tell book publishers to send relevant books to ISPS for review in the ISPS newsletter.

. . . . continues from page 19 (J Read on attitudes)

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## Psychosis: Psychological Approaches and their Effectiveness Putting Psychotherapies at the Centre of Treatment

Edited by Brian Martindale, Anthony Bateman, Michael Crowe & Frank Margison

This is a most timely book as there is increasing recognition by both professionals and users (and also service planners) that psychological approaches for people with psychotic conditions can be effective, and indeed, are often much sought after by users and their families. However, these were rarely considered and often disparaged in the ascendancy of the 'decade of the brain'. The book updates psychiatrists, psychologists and nurses in a range of psychological therapies that should be available in every modern mental health service. It both outlines the approaches and provides or reviews evidence for their effectiveness.

The authors are selected expert clinicians and researchers from around the globe who describe in clear language the differing contexts, aims and methods of the psychological treatment interventions and evidence for their effectiveness.

**Gaskell, London 2000, Paperback, £25.00, ISBN 1 901242 49 8**

### Foreword John Cox Preface

**1 Introduction** Brian V. Martindale, Frank Margison, Anthony Bateman and Michael Crowe

### Cognitive approaches

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*Philippa A. Garety, David Fowler and Elizabeth Kuipers*

3. Compliance therapy: a collaborative approach to psychiatric medication  
*Peter Hayward, Roisin Kemp and Anthony David*

### Family, group & psychosocial approaches

4 Psychoeducational multi-family groups: adaptations and outcomes  
*William R. McFarlane*

5 Bringing into clinical practice skills shown to be effective in research settings: a follow-up of the 'Thorn' training in psychosocial family interventions for psychosis  
*Ian Baguley, Anthony Butterworth, Kieran Fahy, Gillian Haddock, Stuart Lancashire and Nick Tarrier*

6 Group therapy and schizophrenia: an integrative model  
*Nick Kanas*

7 Preventing relapse and re-admission in psychosis: using patients' subjective experience in designing clinical interventions  
*Larry Davidson, David A. Stayner, Matthew J. Chinman, Stacey Lambert and William H. Sledge*

8 Crisis residential care for patients with serious mental illness  
*Wayne S. Fenton and Loren R. Mosher*

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### Individual psychoanalytic psychotherapy

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*Roberta Siani and Orazio Siciliani*

### Early interventions using need-adapted psychological treatment models

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#### Finland

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**What is your contribution to the next newsletter?**

- your local ISPS group and its activities ?
- meetings, congresses or workshops ?
- new approaches in psychological treatments of psychoses ?
- research that you are involved in ?
- questions that you would like to discuss ?

Please send material to ISPS within April 20, 2002

**How to become a ISPS member and enjoy membership rights**

**Different ways to become a member of ISPS**

You may become a member of ISPS as a member of a local or national ISPS group or network. Members of such groups will receive the ISPS newsletter through their group and have reduced fees on ISPS congresses. ISPS encourage and support members to form local groups (see page 9).

You may also join ISPS as an individual member using the form to the left. The fee is NOK 250 (appr. £20) per year or NOK 625 (appr. £50) for three years. As a member you will receive the ISPS newsletter and have reduced fees on international ISPS congresses.

Application form for individual membership in ISPS	
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