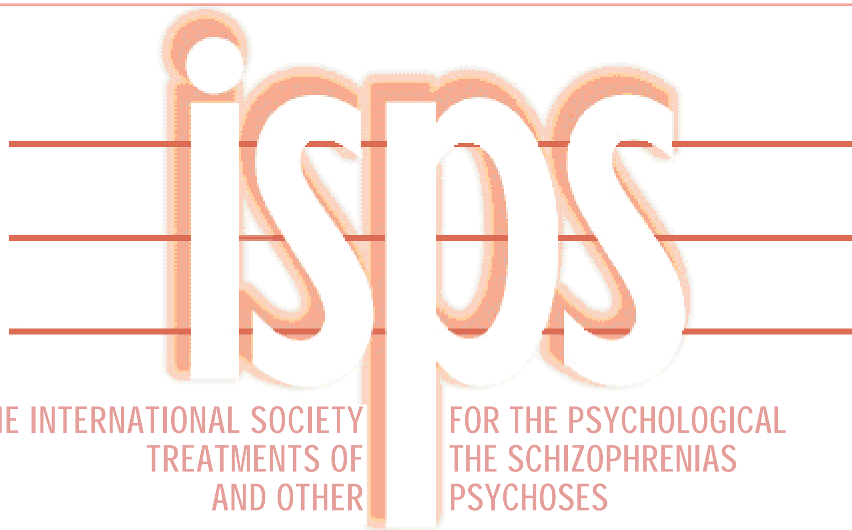


UK Newsletter
June 2007

Contents

- 1 From the Editor
- 2 Letter from the Chair
- 4-9 Bath Conference Reviews
- 10-13 The Name Change - Going Forward
- 14-20 Book Reviews
- 21-22 Local Networks, Announcements and Contacts
- 23 ISPS UK Committee
- 24 Forthcoming Events and Contact Us

DEADLINE FOR NEXT NEWSLETTER : 15th SEPTEMBER!

From the Editor

I would like to welcome everybody to a very exciting issue of the ISPSUK Newsletter. It is the first that is printed to a redesigned layout which allows the use of photos. This will improve the reading experience so I hope you will find it pleasant and feel free to send your comments on our new design.

I will be very brief in introducing the contents since the high quality of articles is requiring our attention. The compilation of articles in this issue includes vibrant reviews of the March ISPS conference that took place in Bath. The discussions on the name continue and three thoughtful contributions from ISPS committee members help explore the issues involved. The reverberations of the email list discussions can be felt in the articles.

Further into the issue you will find reviews of two books from the ISPS series. Firstly 'Family and Multi-family work with Psychosis', and secondly 'Evolving Psychosis: Different Stages, Different Treatments'. Both are stimulating reads the first focused on the pragmatism of working with families and the second very skillfully reviewing 'good practice' work with people that experience psychosis.

Local networks are expanding and one can see why in a report of a dynamic presentation that took place in one of the Northern Network's meetings. With the above you can find the usual news items and announcements. Happy reading and I am looking forward to receiving your contributions and ideas for future issues.

Vasilli Magalios

Letter from the Chair

Conferences are something ISPS UK tends to do well. Around 200 people made it to our two-day residential in Bath at the end of March, and were rewarded with a vibrant mix of contributions from artists and academics, service users, carers and professionals. I hope the experiences for those who were there have stayed with them- those who weren't can get a sense of them from the reports in this issue - but inevitably new priorities take centre stage in our minds and conversations. Let's take stock of a few key lines of development, inside and outside ISPS.

The update of the NICE Guideline on Schizophrenia

The two Davids (Orton and Kennard) met with representatives of a number of fellow stakeholders at a meeting convened at CHT by Beatriz Sanchez, to share and co-ordinate our comments on the scope of the Guideline update. David O subsequently performed the Herculean job of pulling together the suggestions from ISPS members into a coherent and incisive response. At the time of writing it appears that at least three of our members have been invited onto the Guideline Development Group, which is where all the comments on the scope will be reviewed: Doug Turkington, Janey Antoniou and Anna Maratos. [We await a formal announcement of the group's full membership.] While it's important that the GDG members approach their task objectively, it is excellent that the ISPS perspective will be strongly present in the update.

The Mental Health Bill

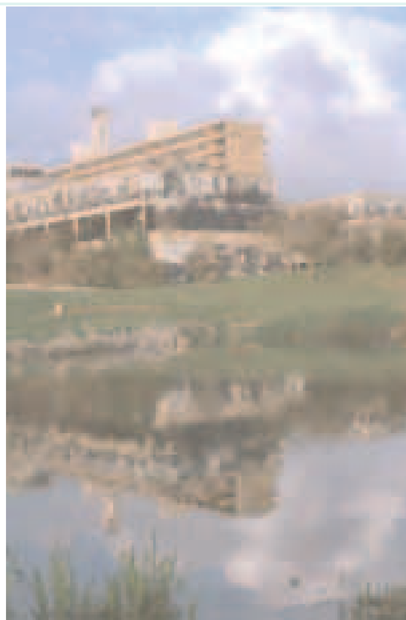
There has been a vigorous discussion on the ISPS UK email list, facilitated by Chris Burford, on the debate in progress in Parliament about the new Mental Health Bill (May has seen the largest number of postings in the history of the email list.) In particular this has been around the question of whether the power to decide if someone should continue to be detained, or required to accept treatment in the community, should be extended to several disciplines in the mental health team. The question for ISPS is whether such an extension would on balance lead to more and better psychological treatment for people experiencing psychosis. It is perhaps a pity that the current debate is clouded by anxieties associated with legal responsibility – which clearly nobody wants to have. The broader issue of the emancipation of the mental health professions envisaged in New Ways of Working can surely be only to the good.

Mental Health Bill 2006-07
Government Bill - Introduced by Lord Warner
Progress of Bill including links to debates

The opportunity for ISPS may come as these changes are rolled out and those affected look for information, ideas, dialogue and support.

Changing the name of ISPS

At the AGM in Bath members took a decisive step towards ceasing to use the term schizophrenia in the full name of our organization. This step can be seen as part of an evolutionary process. When ISPS was founded in 1956 the initials stood for the International Symposium for the Psychotherapy of Schizophrenia. Since then Symposium has become Society, Psychotherapy has become Psychological Treatments (reflecting the broad range of approaches by practitioners who do not all see themselves as psychotherapists), and Schizophrenia has become Schizophrenia and other Psychoses. Removing the term Schizophrenia altogether, although evolutionary, is a big step, and comes after heartfelt debate. Articles in this Newsletter help to unpack the issues involved.



Bath University, location of the 2007 ISPS AGM

Benefits of membership

This has been a source of some recent debate in the context of the suggestion that joining the ISPS UK yahoo group email list should be made available to interested non-members. It is argued that this would enhance the influence of the list in promoting the cause of ISPS. Against this is that it would deter people from joining and detract from the benefits of membership. Which are? I hear you ask. I suggest these fall under the headings of tangible and intangible. Tangible: reduced conference fees, hard copies of the Newsletter, and now 20% off books in the ISPS series. Intangible: being part of and supporting a national and international movement to promote the psychological needs of people experiencing psychosis and their families; joining local member networks and support groups. Speaking of which, there is news of two more embryonic local networks, in the South West and in East Anglia. If you live or work in either of these regions do respond to the invitation to get involved.

New Committee

The AGM saw the election of five new members, bringing the elected committee strength to 15. The full list is in this issue. I'm very pleased that we now have carers as well as service users represented on the committee. The first meeting of the new committee looked at a number of ideas for future conferences, which will be firmed up over the next few months, and at developing the UK section of the ISPS website.

I am sorry this has been a longer letter than usual. There's a lot going on.

Best wishes to all

David Kennard

CONFERENCE REVIEWS

ISPS UK Residential Conference:
Psychosis, Experiencing, Understanding and Recovering.
26-27 March 2007, Bath

Judith Varley, Carer:
I arrived on the Sunday afternoon to bleak, empty wind-swept walk-ways and did not see any direction notices. Eventually, I found help in the library and in due course was directed to a standard student bedroom. I missed a welcoming reception desk, delegates list and a designated common-room type venue where I could meet other participants informally that first evening and on the Monday after the Roman Baths event. I was even denied the names of others with whom I shared a common front-door in my quarters on the grounds of 'confidentiality' (such a familiar barrier), and in fact I never met these people.

It was a lost social opportunity and frustrating to know there were new contacts all around the campus as well as people I knew already. That's the gripe.

Paul Farmer, Chief Executive of MIND, addresses a plenary session

The conference itself was crammed with goodies, informative and entertaining, sometimes very moving particularly when participants contributed from their most personal experiences. The first day was of presentations in the lecture theatre, and the second offered a wide range of varied papers and workshops with the usual frustrations of having to choose just one for each session when so many appealed.

The varied artistic experiences displayed over the 2 days were by turns, arresting, insightful, intriguing, provoking, moving, amusing and fleeting. Many came and went too quickly for me (at least) to catch more than a glimpse, when a more extended consideration was appropriate to the image or comment, space for digestion, but that's the way with conferences. So much information concisely packed, and with a range inaccessible in as short a time away from the Conference situation.

I especially enjoyed Peter Chadwick's humourous early paper, especially his DSM V 'Categories for the Bland'. It was good to share a laugh, and he provided many but illumined with so much substance too. As the Conference had an artistic emphasis, there were many times when I knew that artistic creativity allowed ways of expressing the

inaccessible and the intolerable. So many of us rely on words as our main or only exercised communication, so, paintings, poetry, dance and music add substantial dimensions on a different level of understanding. In these two days, meaningful descriptions, experiences and patterns of psychosis were teased from the blanket term 'schizophrenia' and various routes to recovery explored. Humour, collaboration, problem solving techniques, finding meaningful purpose, ways of managing symptoms and drugs, building social supports and a sense of community, alongside decent food, housing and clothing are all important, as they are in 'normal' life. However, they have a particular poignancy from the perspective of mental health distress when they are frequently marginalised or denied.

An apt image I noted was that the organisation ISPS provides overlapping rings rather than boxes, and that applied equally to the presentations, and the whole meeting too.

Fortunately, the evening at the Roman Baths was as one mis-placed from Summer, calm and warm, a magical setting as the daylight faded and was replaced by the drama of flickering flares, their reflections and the background illumination of the Abbey. This was followed by the poetry readings in a room overlooking the water and David Kennard's adaptation (and rendering) of the YMCA song which were all much appreciated.

I propose the latter as a new tradition for the social evening of future conferences.

I do not know if the abstracts are published in a professional journal currently, but it would be beneficial to share this richness from gifted and learned speakers, provide good publicity and a source of new recruits for ISPS too.

Keynote Speaker service user Peter Chadwick

Janey Antoniou, Service User:
ISPS is significantly different from any other group I belong to in that it contains people with many diverse and robust views. Therefore when I go to the conference I always expect to be challenged and to disagree with as much as I agree with. In that way the Bath conference didn't disappoint – I came away feeling suitably battered!

I liked the format with a day of large lectures and then a day to choose more defined subjects and workshops. I thought the campus was beautiful and the rooms comfortable. The best bit for me was Peter Chadwick's talk and

the workshop sessions. I especially enjoyed the session I chaired (which I would not have otherwise gone to), talks by Nick Moore and Gary Winship. This tells me that I should have adventures sometimes and not just go to talks I think will be useful!

If there was a downside, it was that there was no where on the campus that people could go to socialise. I went to the social at the Baths and then just went back to my room. The idea of having the social at the Roman baths was inspired but I found the poetry too raw and had to leave. There should have been some thought about whether it was appropriate to have poetry (which was admittedly very good) that was therapeutic for the writer rather than entertaining for the listener.

All-in-all I enjoyed myself, talked to a lot of people, put faces to names on the email group and learned a lot. I think this is what a conference should be about.

Joaquin Ponte, Clinical Psychologist: The Quest for Recovery

I came from Spain to the ISPS meeting in Bath. I arrived late but the waitresses were so kind as to reheat the dinner for me. Then I talked a while with a group sharing a bottle of wine and some jokes; later, quiet rooms, simple and comfortable.

Next day the quest for recovery began. John Lennon would be very pleased to hear from you. There are still some people that IMAGINE that a different mental health approach is possible. They stand up for hope and good practices. They work hard because ANOTHER (mental health) WORLD IS POSSIBLE.

I will play, if you kindly allow me some humour, with J.R. Tolkien's fellowship of the ring to tell you about our characters. Our first speaker Peter Chadwick (Frodo) spoke from his heart. Peter was not proud or arrogant; he tried to share his lifetime experience and knowledge. Peter spoke to us about stress, about personal transformation and suffering. He recognized the role of medication in achieving recovery.

He shared his feelings about rejection and stigma. Peter also explained his understanding of psychoses being the concatenation of normal processes that become toxic. This is a Copernican shift from many traditional psychopathological theories. It is a jump from distinct categories of illnesses to a continuous dimensional thinking of disorders. I have to think about it, because I must confess I feel my clients do think and feel in a different way from me. Frodo Chadwick made a deep impression in everyone's heart and gave us laughter with his DSM5 of everyday common pathologies.

The Studio Upstairs talk, Douglas Gill with his divergent thinking presentation dissociated us into a dichotic state of mind. Maybe he was one of the Black Riders undercover. We heard some ideas and watched others unrelated at the same time. Rich but confusing I dare to say; many theories but I could not see how it would relate to my practice.

Glyn Harrison's (Legolas) exposition on the myths on schizophrenia's epidemiology was clear

Brian Martindale and Gráinne Fadden enjoying a break in the sunshine

and well built. His clear arrows of data defeated the trolls of biological myths. Now I understand why I see more men than women in my unit. It had a risk though, to shift the emphasis from biology and genetics to environment completely. Still like the diathesis-stress model of multifactor aetiology for psychoses.

Douglas Turkington's (Gimli) exposition was again informative and to the point. His classification of schizophrenia was suggestive and provocative, may be as a dwarf gem. I am not so sure about the traumatic psychoses hypothesis. I have to read it properly, but I think that we remake our memoirs of the past from the viewpoint of present. How can we know if those reports are true? What about projection, limits between reality and fantasy," false" (Screen) recollections? Otherwise, to put the main emphasis in trauma may be excessive. We should explore these aspects no doubt about that, but we very careful. Remember Freud's theory of seduction.

Cullberg´s (Gandalf) speech was full of wise ideas and interesting data; powerful and peaceful figure as a magician. His integration of theories and practices was superb.

The social evening at Bath was joyful with the wine and little (for Spanish standards) but very tasty food. Good time to make new friends and discuss the day's ideas.

The poetry reading was varied. The best aspect of it was how proud and happy the poets-clients felt showing their creations to the professionals. This symbolic act of recognition and praise was expressive of ISPS position towards therapeutic work.

Next day was for workshops. The gentle American Lady Courtenay Harding (Elves queen) explained her twenty questions for a sound clinical practice. We also watched the dance (Louise Pembroke) of the girl against/together, with her hands (voices). Tamsin Knight (Aragorn's finance, the elf that becomes human) surprised us with her all accepting "not so common" ideas groups. The groups of listeners to the workshop participated lively. The "conversing with voices" by Mark Hayward (Tom Bobadill) was rather revolutionary in his approach. The basic stance being not to make the symptoms disappear but to value, understand and control then. It reminded me of Jung's acceptation of the Shadow side of our personality.

The weather was so fine. The food was rich. Talks were soft and suggestive. The lake was full of pretty ducks; company was sweet, landscape open and green. We came home to the elves again with Courtenay

Harding and her long term studies that gave us doses of hope and courage. Said goodbye to friends and prepare to go back to start with renewed energies our quest for recovery. Thank you, fellowship of the ring. The dark lord of Psychoses has its days numbered. Remember keep going for Utopia and the Horizon so we will keep moving forward.

Helen Spencer, Assistant Psychologist: Diary of an Assistant Psychologist

Sunday 25th March
On board the BRS573 from Newcastle to Bristol, having been unable to locate Brian in the departure lounge I suddenly found myself announcing to the air stewards in a dramatic-type, fashion: 'Is there a Dr by the name of Martindale on board?'- But alas, it seemed our ISPS guide and guru had missed his flight! For a psychologist (in the making), having not quite mastered the art of challenging my own catastrophic thoughts, I perceived Brian's DNA to be a sure sign of misfortune, as we headed off down the runway without him. Luckily, I was accompanied by my colleague Becci Hall, an

Recover – Recovery – Recovered

This poem, by Hazel Hammond was read by the author as part of the presentation by the Studio Upstairs Writers Workshop at the Bath Conference and is reproduced by kind permission.

My life has been recovered
Its true suicide holds little temptation now
And I have talked myself out of it
Night by night – the deep splash and the 'never....'

My life has been recovered like an old chair
A new surface in the way I am with others
Being seen through a different prism
There's single, pensioner, artist, madwoman…

My life has been recovered
Layers of the new experience, of pleasure, of research
Ensured by saying yes – not looking back
And savouring 'I don't have to never... never…'

My life has been recovered – like archaeology of the mind
After twenty seven years of poor partnership
It comes out from under duty
Some of the artefacts still clogged with the past.

My life has been recovered like earth on an exhumation
Some of the sad parts, psychotic parts, patter down
Of the new stability – memories clear
Like a wax pattern painted over with water colour…

Occupational Therapist. True to her profession, she produced a 'meaningful activity' out of her bag – a women's magazine (thank God it wasn't finger paints this time).

Forty minutes and four celebrity gossip pages later, a phone call from Brain confirmed he had managed to book himself onto an evening flight- things were looking up.

Monday 26th March
This was my first visit to Bath, and my first attendance at an ISPS conference. I was amazed by the international gathering of such a wide range of professionals, including: art therapists, music therapists, drama therapists, psychotherapists, psychiatrists, occupational therapists, psychologists, researchers and assistants. Indeed, I felt very privileged to have been attending such a prestigious event. Our first keynote speaker Psychologist Peter Chadwick gave an inspirational talk entitled 'Psychosis from the Inside: Demystifying Madness and Mystifying Insanity'. His underlying theme: to explore the madness of sane people and the sanity of psychosis. Chadwick explained the need to understand the deeper meaning behind the psychotic experience, in order to understand that people's thoughts are not as crazy as once seen. He went on to highlight elements of sanity, imbedded within the insane experience, by giving a very personal and emotive account of his own episode of paranoid illness. A key point that stuck in my mind, was Chadwick's suggestion that modern day society is pathologising everyday life in a reductionist way. In a sense, giving people 'labels' and 'diagnosing normalities'. This I could relate to, having just read in the women's magazine about how to: 'Cure Yourself of Shopaholic Spending' (or something similarly ludicrous). Indeed, Chadwick truly set the scene for the highest of standards, which were to remain throughout the conference.

Tuesday 27th March
With an early morning start on the second day, I was looking forward to Consultant Psychiatrist Dr. David Ward's workshop on: 'Early Intervention in Psychosis (EIP) and Child and Adolescent Mental Health Services (CAMHS)'. This was of particular interest to me, as David shares links with our neighbouring Early Intervention Service, in the North East of England. David gave a very thoughtful and in-depth workshop which was centred on the implications of 'diagnosing' and 'medicating' young children and adolescents. Clear parallels seemed be arising with this sense of 'un-labelling' or 're-labelling', which became a predominant theme throughout the conference; including Professor Douglas Turkington's 'subgroups', and the majority vote to abolish the term 'schizophrenia' from the name of the society.

Overall, the conference turned out to be even better than my expectations, and my brief 'dairy accounts' just don't do it justice! I came back from the conference with a buzz and a sense of excitement. Being around optimistic, likeminded people had re-energized my passion for Psychology. The conference had instilled within me, hope and enthusiasm for my work once again. Thanks to all who contributed to making it such an enjoyable experience.

THE NAME CHANGE: GOING FORWARD

Chair's note: At the AGM on 27 March two proposals were voted on. The votes cast for each proposal were as follows:

That the ISPS UK supports in principle the removal of the word "schizophrenia" from the full name of ISPS and will work towards this for the 2009 conference.

For 17, Against 0, Abstentions 4

That the ISPS UK change its full name to 'The UK Network of the International Society for the Psychological Treatments of Psychoses (including "schizophrenia")', to take effect in 2009.

For 8, Against 15 Abstentions 0

In this article **Dan Pearson** sets out some of the background issue to the AGM vote. It may be helpful to note that the decision at our AGM does not prescribe what the full name should be. The international board has undertaken to make a decision on the full name in 2009, so we have till then to make suggestions. Whatever the full name, it is intended to continue to use the initials ISPS.

Dan Pearson – Consultant Therapist , P.I.E.R. Early Psychosis Service – Leicester City, Leicestershire and Rutland: Those of you who attended the residential conference in Bath, who are inclined to read each newsletter in depth or have kept up-to-date with recent discussions on the e-mail list will be aware that the society; or at least the UK branch, is currently exploring the possibility of a small, but significant name-change.

The full title at present; as I'm sure you will all know; is:-

"The International Society for the Psychological Treatments of the SCHIZOPHRENIA and Other Psychoses".

Discussions regarding the possibility of a change have been on-going within the committee and elsewhere since the proposal was first mooted in the lead-up to the residential conference in Manchester in 2005. Two different proposals were voted on at the AGM this year with the majority vote supporting the following statement:-

"That the ISPS UK supports in principle the removal of the word 'Schizophrenia' from the full name of ISPS and will work towards this for the 2009 conference".

Whilst many, if not most, of those reading this will have some personal or professional appreciation of the reasons behind the challenge to the use of the word "SCHIZOPHRENIA" the committee thought that it might be useful to draw-

out aspects of that debate through the pages of this newsletter.

The concept of Schizophrenia has been contentious for several decades, if not from its very inception, with challenges arising from a variety of directions. Those challenges might be broadly classified as either scientific or ethical in nature.

Scientific challenges question the concept of "Schizophrenia" in relation to its validity or its utility. Validity arguments have most often concerned questions of aetiological certainty and of the appropriateness of employing disease or illness conceptualisations – in other words, whether "conditions of the mind" should be subject to diagnosis and classification in the same way as "illnesses or diseases of the body". Utility arguments, on the other hand, have questioned whether the "diagnosis" is of value in making predictions about prognosis, or in identifying and coordinating "effective" treatment and care.

Ethical challenges have been more concerned with the implications of the use of the term; in particular, its consequences in relation to stigma and labelling – the continuing negative public attitude towards the term, the significant misinformation and misunderstandings associated with its place in societal consciousness; promoted by various media; and the very unpleasant ways that shortened versions – for instance, "schizo" – are used as insults.

On the other hand, it does have acceptance within the dominant systems of diagnostic classification in most Western countries – DSM IV and ICD 10; it is supported by detailed legislative guidelines for service delivery and by a significant percentage, if not the majority, of diagnosing clinicians; and, most importantly, has real meaning in the lives of an enormous number of service users and their families / carers.

In the past many of the challenges to the concept of Schizophrenia have been associated with those promoting psychological, social and environmental models for the explanation of mental illness and, of course, the core identity of the ISPS involves the promotion of psychological interventions in the treatment of those with such diagnoses. It would be very easy for the society to take a narrow or simplistic position in further challenging the use of the term generally and, more specifically, in relation to our own name. It is, also, however, a core feature of the ISPS identity that we are interested in the voices of all of our members, including, in particular, when those voices reflect differing experiences, understandings, attitudes and needs.

In order to help us to determine how best to proceed with the decision of the AGM as noted above, we would like to encourage members of ISPS to share their voices with us Presented below are some observations from two of the committee.

We have included these thoughts here, in the first instance, to keep you informed of what is happening. We hope that you have found it helpful. If you have views on this matter and would like to share them please feel free to contact us either through this newsletter, or the e-mail discussion list – the details of which you will find on the back page.

Response: A historical note

Brian Martindale

Bleuler coined the term schizophrenia and used the term group of SCHIZOPHRENIA - to describe the divisions in the mind that he observed clinically and I think the ' double book keeping ' so commonly seen. A future ISPS book will describe how Bleuler was very aware of the many different forms and presentations of psychosis and introduced psychotherapies into the Burgholzi.

Bleuler's first psychoanalytic work 'Freudian mechanisms in the symptomatology of the psychoses' appeared in 1906 and was the first psychiatry professor in the world to support Freud's psychoanalysis openly and to try, together with his colleagues, to put it into practice in his clinic.

It is interesting how history distorts the discoveries of our forefathers especially how schizophrenia became regarded as a distinct almost biological entity and lost is dynamic connotation in terms of the splitting processes.

Although I think that in the circumstances of 2007 with all the negative baggage now attached to it, there is some sense to make moves to dispense with the term, clinically I think it is important to keep talking about why we need some kind of words such as psychosis. (It seems crazy to me to believe that by changing the word we are going to reduce stigma for more than a brief period of time – this needs other approaches).

For me it is important to have a clinical word to describe an alteration in the person's relationship to reality. The beauty of the original intended use of the word schizophrenia - especially with its connotation of divided mind - is that it so beautifully captured the kind of doubleness of clinical phenomena such as

described in the following frequently quoted anecdote:

The old lady who complained that all her possessions were being stolen by people who got into her flat through the pipes and cracks in the floorboards. However she went to the mental hospital to complain rather than the police station.

Or the patient who was overheard being friendly to the hospital porter asking him questions about his interests and other seemingly innocent and appropriate social questions. The porter then reciprocated also in a friendly way and said something like "how about you" - to which the patient said suddenly and very aggressively "mind your own bloody business".

Many trusts are beginning to organise themselves into psychosis and non-psychosis services and I forecast problems if psychosis services are not well equipped to help many people who have had a psychosis but now suffer mainly from non-psychosis problems.

Response: Schizophrenia – What's in a Name?
Janey Antoniou
Service User

The mental health service user position on the word 'schizophrenia' is neither uniform nor clear. And since most of us are not mental health professionals it is not going to mean what it does to someone who has had formal training in the art (science?) of diagnosis. Few have heard of Kraepelin and Bleuler. For users, their understanding of the word will be a mixture of what has been learned or explained by mental health professionals, what is on the Internet, what they see in the media and what comes from family, friends, peer-group and culture.

Some users feel that having been given a schizophrenia label has made their lives a lot harder. Others (including me) accept that the label can cause problems but try to show people that despite the diagnosis we are still valid and 'normal' human beings. When people have run away from me in the past, it's my behaviour they have found alarming, not what it was called.

I accept that ISPSUK has voted to work towards removing 'schizophrenia' from the full name of ISPS but feel I must point out that the word psychosis, though seemingly more acceptable to professionals is also a stigmatised and mis-understood word in the wider world. Is it better to be a 'psycho' than a 'schizo'? Also, in a society with members who can't tell the difference between paedophile and paediatrician, what chance is there of them knowing the difference between psychotic and psychopathic?

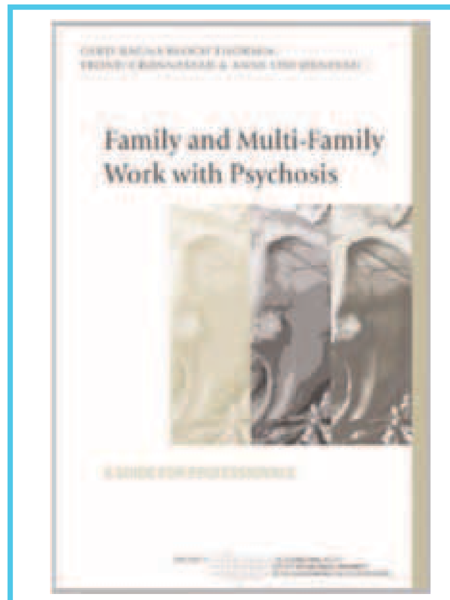
If we are to lose the schizophrenia part of our name, I personally would be in favour of losing the psychoses part too, though I have not thought of any alternatives yet.

BOOK REVIEWS

Gerd-Ragna Bloch Thorsen, Trond Gronnestad, Anne Lise Oxnevad (eds) *Family and Multi-Family Work with Psychosis*, Hove: Routledge, 2000, pp.152, £18.99 paperback (ISPS Members £15.50)

Reviewed by Eve Thompson, BFT worker and working with families

This book is an account of a family group psycho education service that has been running for ten years in Stavanger, Norway, in conjunction with an early detection and intervention project for people with schizophrenia. It is based on a model developed by William Mcfarlane, MD Director, Centre for Psychiatric Research, Maine Medical Centre Portland Maine, USA. The Clinicians who developed this service give a detailed description of a thorough belt-and-braces project to educate and support families. The Stavenger service concentrates on the families of people with psychosis but the authors emphasise that the model can be applied to other disorders such as Anorexia and dual diagnosis. There is a chapter on drug abuse and psychosis by Christine Barraclough, which describes in detail a method of working with families of people suffering from psychosis and substance misuse.



In the first chapter an 'Introduction to Family work' the concept of 'Expressed Emotion' is thoroughly explored. The stress/vulnerability model for serious mental illness and the part the family can play is also explained. It is made plain, however, that there should be no blame attached to carers who express critical comments or hostility to the patient or become emotionally over-involved. The severe strain families experience is emphasised and the following excerpt encapsulates the refreshing and heartening attitude which underlines the Stavanger family work model.

If we do not see the family's pain and its right to get support for itself then it is not just the family that we let down but the patient as well. The family is often the patient's important resource. If it does not receive appropriate help then it may become overwhelmed in its task of supporting the patient. If we fail to help the family we deny the patient access to this important source of support.

Chapter 2, Methods, describes how the Stavanger model operates and makes plain that considerable commitment is required from families participating in the service. The multi family group which will consist of four to six families plus two leaders, who will be experienced clinicians preferably from different disciplines, will meet every second week for two years. This can seem daunting to relatives and patients and so an introductory meeting is held with each family

where the group leaders can fully explain how the process will work and how they can benefit from the knowledge, advice and support they can gain from the group. Before this meeting the patient will have agreed to the family group being formed and that he/she will take part.

Before the multi- family groups begin at least three meetings will be held with each family. The first meeting/s are called 'crisis conversations' and give individual family members the opportunity to work through their own reaction to their relative's breakdown. The authors point out that the support and information the families receive from health services will determine how well they handle the initial crisis. They refer to the anger and frustration many relatives feel when trying to talk to hospital staff, and the sense of being rejected and ignored. If these feelings and events are not adequately worked through they may appear at a number of points in the multifamily group.

The next step is unusual and intriguing. The family is invited, with the group leaders, to draw up a family tree or Genogram. This helps the family to understand its internal relationships and provides insight into their significant life events. It is also an effective way of revealing any hereditary traits. House moves, planned abortions, miscarriages, a family member' problems with drugs or alcohol and other events which may have proved stressful can be recorded and discussed and the quality of relationships examined. The genogram should cover two or more generations.

The third meeting is about early warning signs and is covered in depth. The patient attends and participates if well enough. He/she will also have separate meetings with a group leader. The aim is to establish positive relations and to see the leader as a sympathetic person who is there to help. Sometimes patients from the families taking part can come together for a joint meeting before the multi-family group starts. There may also be a get-together with refreshments, or a social activity such as a bowling evening which can give patients the opportunity of forming a common network inside and outside the family group.

After the introductory meetings have taken place a full day education seminar is arranged for all the families. The purpose of the seminar is to provide information about psychosis its treatment and management. The patients do not attend as it is felt that it may prove difficult for them to stay concentrated for a whole day at this stage in the treatment course. It has also been found that families need the freedom to express their own worries and anxieties. The group leaders conduct the seminar but may invite colleagues to present individual topics. The authors give an example of a seminar programme. At the end of the group's first year a second seminar concentrating on recovery will be held which both patients and families attend.

About two weeks after the educational seminar the first meeting of the multi-family group will take place at a time convenient for the families. The patients will be part of the group. The group leader will explain that in this meeting family members will be able to share accounts of their lives, their hobbies and likes and dislikes. There will then be a follow-up meeting where they can talk about the illness and its impact. Moreover, discussions should include problem solving sessions, relapse issues, and exploration of feelings with an emphasis to reformulate family problems in a positive way.

The group leaders will then take five minutes to choose a problem to discuss, they will talk aloud so that group members can hear what they are saying. Families whose problem has not

been chosen this time will find taking part in the problem solving process useful since they may have or have had similar problems.

The problem solving method used by the group is very similar to the one practised by Meriden. The book concentrates on the 'mismatch' category of problems [i.e. Mismatch between the desired state and reality. For instance where the patient cannot handle a given task (e.g. to go to school)] and the point is made that a problem should be chosen that presents a reasonable chance of success before the group goes on to tackle more difficult and complex situations. Each part of problem solving is then described in detail.

Many verbatim examples of actual conversation in the groups provide a vivid and effective illustration of how a group functions. Work with individual families can also occur during the two year period. Help to work out crisis intervention plans is offered which can be made by the patient together with his/her family and the group leader.

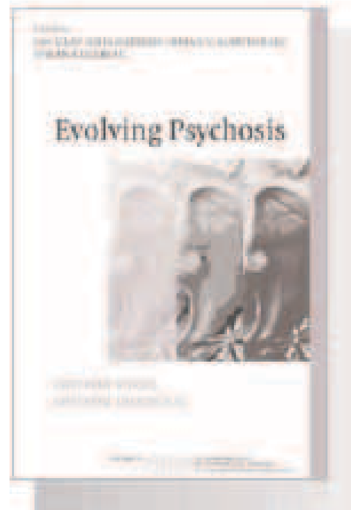
Some families will also need help with communication skills which can be practised with the group leader using similar modules to Meriden.

In Chapter 3 Experiences there is a section focussing on differences between the single family group (SFG) and the multi-family group (MFG). The advantages of each model are compared and discussed. It appears that working with families in a similar situation in a MFG provides a secure framework of mutual support to tackle problems and change their situations. As described above both types of group can be used in the Stavanger model.

This book is described as a guide for professionals and reviewing it as a carer I am impressed by the authors' empathy with families and the vast amount of practical knowledge of the problems they face My only reservation about the Stavanger model is the two year commitment required, particularly in the early stages after diagnosis. However, the importance that the model attaches to family involvement in recovery and the respect and confidence it shows in the ability of the family to rise to this challenge is both heartening and impressive. In Norway the multi-family groups are well attended and there is a moving account by a carer as to the support and benefits they can bring. It would be interesting to see if carers would respond to attending a pilot group here, perhaps using a combination of BFT and the carers education and support packages that are increasingly offered to families in this country.

Evolving Psychosis: Different Stages, Different Treatments edited by Jan Olav Johannessen, Brian Martindale and Johan Cullberg. Published for the International Society for the Psychological Treatments of the SCHIZOPHRENIA and Other Psychoses (ISPS) by Routledge, Hove, 2006; 298 pp; £19.99 paperback (ISPS Members £16.00)

This review by Chris Brogan of the Regional Department of Psychotherapy, Newcastle upon Tyne was commissioned by and first published in the British Journal of Psychotherapy, March 2007



Edited by three leading authorities in the psychological treatment of psychosis, this is the latest publication from the International Society for the Psychological Treatments of the SCHIZOPHRENIA and Other Psychoses book series (ISPS), and it is clearly aimed at a wide range of health professionals interested in psychological treatments. I think that those working in early intervention services might find this book utterly fascinating, challenging, at times controversial and compelling. The collection of articles encompasses richly diverse psychological and psychosocial models drawing ideas from North America, the Antipodes, Scandinavia, Germany and the UK.

The editors set out to focus on 'the need for individually tailored treatment programmes in psychosis, the effectiveness of a broad spectrum of psychological treatments, the need for early intervention, the need for the development of better integration between some of the important psychological treatments, such as psychodynamic and cognitive behavioural therapies and the need for new and better diagnostic categories' (Preface). Central to this book is the idea that psychosis is an evolving process requiring different interventions at different phases and that there is a person behind the psychosis, often terrified, with whom it is imperative to engage before it is too late.

When I went into psychiatry from general practice, I was quite perturbed and puzzled that, apart from a few notable exceptions, psychiatrists on my training scheme were obsessed with the genetics and fine-tuning of chemicals. Their humanity was in fact very evident with the patients with psychosis and their families but, publicly, they were apologetic about this as if it was somehow shameful. It was as if they too were operating under a psychotic split, perhaps in response to an adolescent identity crisis in psychiatry over where it belongs in the realm of medicine.There are hopeful signs that psychiatry can recover from being obsessed with biology, at the expense of the psychological and social, and this book has robust examples of the radically different ways in which patients with psychosis are conceptualized and treated.

The book is divided into four parts: the nature of psychosis, early intervention in psychosis, phase specific treatment of

psychosis, and the need for integration. The introduction gives an informative historical account of the idea that psychosis is an evolving process with different stages needing different approaches and briefly outlines Alanen's need adapted model. I was rather hoping that a whole chapter could be devoted to Alanen's work, but his work is published in other ISPS books. The introduction concludes with the view that psychodynamic ideas are very relevant in the crucial business of establishing a relationship with the patient which forms the bedrock of treatment for the ensuing years.

The opening chapter by McGorry thunders in like a powerful Beethoven first movement. The argument for early intervention as soon as possible in the critical period of the first few years is irrefutable, to avoid the alienating treatment strategies which can arise from behavioural crises, and which result in poor continuity of care and poor engagement where the patient only accesses the service when absolutely desperate and suicidal. This amounts to an indictment of many mental health services. As a start he recommends separating the organizing of first episode and recent onset psychosis services from services for those with more chronic illness whose needs are different. McGorry goes on to summarize the evidence for pre-psychotic intervention of combination CBT and low dose neuroleptics directed at an ultra high risk subgroup with subthreshold symptoms, which might reduce the transition to full-blown psychosis. This is very much in the research stages with large ethical issues. Lastly, he reiterates the need to reduce the duration of untreated psychosis to a minimum, thereby enhancing the quality of treatment, shortening the course of the illness, adapting the treatment to match the different stages of illness and recent research that suggests that it is important to go on using intensive treatment for five years in the critical period when the patient is most vulnerable and needs most help. This chapter lays the pitch for the rest of the book and the rest of the section on the nature of psychosis.

Two of the three remaining chapters in this section major on the psychodynamics of psychosis.The other chapter gives a very useful summary of the research into the relationship of personality and psychosis, with a reminder that there can be a 'normal' personality underneath, similar to the psychoanalytic idea of a psychotic and non-psychotic part of the personality. Antisocial, schizotypal and schizoid features maybe associated with disorganized, positive and negative symptoms respectively and carry a worse prognosis. Simonsen, the Danish author of the chapter, advocates a dimensional

view of the heterogeneous presentations of what is called schizophrenia. This links with the contribution of two other Danish authors, Thorgaard and Rosenbaum, who attempt to reclassify schizophrenia into overlapping dynamic categories, one of which may be more prevalent at different stages in the illness. They are a separation attachment disorder, a distrust/loss of trust disorder, a relation disorder, an identity disorder, a paroxysmal and relapse disorder (fear of uncertainty of the next breakdown), control and loss of control disorder and a self care failing/ care failing disorder. The authors aim is to help therapists maximize empathy with the patient and, to my mind, they succeed in conveying their humaneness and warmth. The other psychodynamic paper is a rather dryer, metapsychological post-Lacanian look at psychosis which on the second reading was fascinating, but rather spoilt at the

beginning by several references to the schizophrenogenic mother and a tone of blaming mothers, and I'm not just being PC! If I have understood, there has not only been the failure of the Symbolic as represented by the Name of the Father which is not respected by the mother or is absent, but patients with psychosis have experienced a preceding failure of what is called the Imaginary system created by the mother which helps the infant create a body image separate from the mother which acts as a container. Failure of the Symbolic order and of the Imaginary in a child facing real trauma leads to psychotic breakdown amply illustrated in two examples.

One of the remarkable features of this book is the juxtaposition of highly scientific research papers with practical this-is-how-I-manage patients with psychosis chapters, and the next section on early intervention is no exception. One research paper on identifying symptom clusters, which accurately predict first onset psychosis in a cohort of patients followed up over eight years, is followed by a chapter on phase specific group treatment of patients with early psychosis. A psycho-educational group is offered first, followed by a group promoting recovery, decreasing shame, isolation and relapse prevention for those showing signs of remission. Interpersonal skills groups and groups targeted at those suffering from co-morbid conditions such as substance abuse form a comprehensive service tailored to different stages. The other chapters in this section include the value of behavioural analysis in predicting relapse using examples of clinical cases and a psychosocial intervention programme adapted to different stages, which dovetails into the next section on phase-specific treatment.

For a psychodynamically minded clinician, Cullberg's and Sue Hingley's contributions were the most rewarding. Cullberg's interest in psychoanalytic classical formulations of psychosis has waned as his optimism for a psychodynamic search for meaning of the psychotic state has grown. He thinks that the 'heroic' cases of cure (which have fascinated me) are rather unusual and such cases need to be selected very carefully for intensive psychoanalytic work which otherwise could be harmful. Any psychodynamic work has to be embedded in a psychiatric organization which is adapted to the patients needs. This is a chapter full of humility and humanity illustrated by an example of working alongside a very paranoid patient who had been traumatized by poor care when hospitalized. Engaging her rational mind in a cognitive way and then moving on to more interpersonal areas of her marriage enabled her to recover and to go into long-term psychotherapy, demonstrating beautifully the need for different approaches at different stages. His other examples illustrate the value of flexibly combining cognitive and dynamic ideas. His optimism extends to patients with chronic psychosis with personality changes where there is a disorder of self who respond to good rehabilitation informed by dynamic understanding – which is where Hingley takes her case example. This is an example of work in a rehabilitation setting with a man who had been institutionalized for 10 years.

She describes the various phases of treatment first aimed at maximizing the therapeutic alliance through empathy, understanding that having an identity was very threatening for him, followed by work in a depressive phase triggered by the insight that the hallucinations and delusions protected him from reality, to the next phase of allowing himself

to express feelings, a phase of a developing sense of self, tolerating love and hate, exploration of fantasy and reality and finally thinking about his various identifications. He was able to move to a rehabilitation hostel and sustain better interpersonal relations. Like Cullberg she emphasizes the value of integrating dynamic and cognitive models.The other two chapters in this section describe a cognitive analytic approach again with a good example and a very interesting paper on improving the cognitive skills of patients with cognitive defects estimated to be present in 60%–70% of patients with schizophrenia.

The last section entitled 'Integration' contains two chapters with a more political dimension, both exploring the role of trauma in psychosis.The first by Ross discusses the relationship between dissociation identity disorder, suggesting that there is a subcategory of patients with schizophrenia who have the hallmarks of dissociation identity disorder, who are more likely to have suffered from trauma and have a better prognosis. Ross thinks that the climate in his native USA is not conducive to further research in this area, because of the overemphasis on biological causation. Read and Hammersley take this further by looking at the factors that influence which research attracts more publicity. They cite two large-scale studies on the relation between child sexual abuse and schizophrenia which come to different conclusions.

They suggest that the one showing no significant association is methodologically flawed and draws unjustifiable conclusions ignoring a wealth of data supporting an association. Like Ross they think that biological and genetic factors are promulgated relegating psychological and social factors to the periphery, not least because it profits the pharmaceutical industry. Heady stuff! However, they recognize that there has been a recent surge of interest in the role of trauma.These two chapters sandwich a mindbending reworking of Roy Schafer's four categories of reality – the comic, the romantic, the tragic and the ironic – into the different stages of treatment in patients with schizophrenia, into the developmental stages that therapists undergo themselves and into the history of psychotherapeutic work in asylums, all peppered with wise quotes from Searles and Fromm-Reichmann. Silver, the author who worked at Chestnut Lodge, uses several cases to exemplify the different categories including treatment with a patient who committed suicide. She examines unflinchingly the reasons why we become therapists and concludes that the younger generations who want to slay dragons and those who are in a more ironic and depressed parental position can mutually help each other, but points out that psychoanalytic work in schizophrenia is becoming increasingly rare.

I think this book has managed successfully to combine a great spectrum of different thinking without it becoming a hotchpotch or diluting differences. The editors have achieved this by setting out clear foci and structuring the book accordingly. My only criticism is that family therapy or systemic ideas hardly featured. I thoroughly recommend it as inspiring optimism in a climate increasingly dominated by short-term or reductionist treatments.

LOCAL NETWORKS, ANNOUNCEMENTS and CONTACTS

Northern Network

Presentation by Christine Castles, RN, MPH, CHES, at the May 2007 Northern Network meeting held at The Retreat at York

A 40-Year Journey Through the Mental Health System - the presenter's reflections

First, I would like to thank David Kennard, Chair, ISPS-UK who so graciously extended the invitation for me to speak And, the meeting would not have been possible without Jen Kilyon who was instrumental in organizing this event and Susan Mitchell whose continued interest and contribution makes it happen.

My involvement with the International Society of Schizophrenia and Other Psychoses (ISPS) began in November 2004 while aboard a plane to the Carter Center, Atlanta, Georgia to attend the annual Rosalynn Carter Mental Health Symposium on mental health policy. In mid-air, I learned from another passenger, who happened to be a social worker, about ISPS and its world-wide network of caring health care providers, clients, families, and others who share in common their desire and commitment to promote humane, psychological treatments for people with mental illness. This relatively brief conversation started me on a new career path where my degrees in nursing, sociology, and public health combined with invaluable personal life experience all converged to open new doors. Little did I know the places I'd go.

From Boston to Madrid, New York and Los Angeles, I have presented (either alone or with Dr. Johnson) “A 40 Year Journey through the Mental Health System.” Most recently, I was honoured to present at ISPS-UK Northern Network in May 2007. The invitation, not only to speak at ISPS-UK, but the venue itself, the Retreat at York, was particularly meaningful to me, as this seems to be the birth place of mental health reform: the dignified treatment of people experiencing mental illness. It is symbolic of the freedom and compassion that allows one to have a quality life; to be and become that person of one's own choosing.

However, in spite of the venue of the actual presentation, the overall audience response has been overwhelmingly consistent. Across the continents, any specific cultural differences seemed to be mitigated by the message, which I am finding to be much more powerful than I ever imagined. To me, this is quite remarkable, and points to the very human experience of mental suffering that transcends race, religion, creed, nationality, education, economics, and social status. Sadly, I find that wherever I go, pain and suffering seem to be the greatest equalizers of all people, and the quest for comfort is the common denominator. But cultural differences are significant when it comes to the alleviation of pain and discomfort. Because of its international presence and due diligence, I feel that ISPS is uniquely positioned to make significant inroads in all psychological aspects of mental health: treatment, research, education, advocacy, policy for individuals, families and communities at large.

The overall goal of my presentation was to increase the awareness of

the role of trauma in severe and persistent mental illness. The data for this case presentation was gleaned from medical records, which underwent additional authentication by expert review. Verbal feedback combined with a preliminary review of the evaluations reveal that the wide variation and discrepancy in the diagnoses and treatments of the case I presented elicited many feelings from the audience including shock, horror and distress for some, while others, especially service users, could identify with the seemingly endless labelling, stating such things as "I've been there."

The trauma narrative, too, evokes many responses including sadness, anger, and awe, although many know intuitively (or from research) the clear relationship between trauma and symptoms. One participant commented in response to a learning objective "that [there is an] intuitive place/effect of trauma on all of us, and this has relevance as [trauma] theory is now developing."

Health care workers, if not doing so already, often express their desire to learn more, reassess their clients from another perspective, and listen more carefully, and to encourage actions in the self and others that will further promote recovery efforts. As one attendee said "This reminds me that we need to give more time to service users. Some staff need to change their attitude towards service users." But most fruitfully, the presentation appeared to give many a renewed sense of hope for recovery. One participant stated, "It made me realize that I am not alone." Another commented, "I feel we are all brothers and sisters. Mental illness is in every walk of life."

To date, I am delighted to say that I continue to receive feedback from many individuals in the UK about how they have been inspired by the presentation, and how empowered they feel to continue to make a difference in either their own lives, or that of others in the collective struggle for mental wellness.

The flight back from the UK proved to be another opportunity. Coincidentally, I again sat next to a social worker, and we shared our own personal stories, in which mental health concerns were central. With our new-found connection, I shared the mission of ISPS, most reminiscent of the conversation I had with the other social worker I met on the plane just a few years ago, who lead me to ISPS and to great new heights.

Christine Castles may be contacted at: cacastles@yahoo.com

The next meeting of the northern network will take place at The Retreat, York, on Tuesday 18th September 2007. For further information on the topic and speaker please contact Garry Brownbridge (gbrownbridge@retreat-hospital.org) or Jen Kilyon (kilyon@blueyonder.co.uk), and watch for an announcement on the email list.

East Anglia

Calling East Anglian members, specifically Norfolk and Suffolk If you are interested in the formation of a local member's network with the possibility of arranging a local meeting, please contact mary_rose_roe@hotmail.com

SOUTH WEST

Following the taking of soundings at the Bath Conference, there is sufficient interest in a South West network. Work is under way to prepare the ground, and full contact information will be published in the October issue of this newsletter.

east MIDLANDS

Contact Tim Calton, tim.calton@nottingham.ac.uk

west MIDLANDS

Contact Gráinne Fadden, grainne.fadden@bsmht.nhs.uk

north east Psycho-Dynamic and Psychosis Interest Group

Contact Richard Duggins
richard.duggins@nmht.nhs.uk

specIal Interests:

FAMILIES

Dan Pearson
daniel.j.pearson@talk21.com

Social Work

Trish Barry
trishbarry515@hotmail.com

Nurses

Keith Coupland
keith@furlong.demon.co.uk
or
Mark Hardcastle
Mark.Hardcastle@wshsc.nhs.uk

Arts Therapies

Sheila Grandison
sheila.grandison@elcmht.nhs.uk

General Psychiatry

Chris Burford:
cburford@gn.apc.org

ISPS UK Committee and Associate Committee Members

Elected members:
David Kennard (Chair), dkennard@ntlworld.com; **Psychology and Groups**
John Gale, (Hon. Treasurer) jg@cht.org.uk; **Corporate Member**
Janey Antoniou, janey.antoniou@ukonline.co.uk; **Service User and Trainer**
Trish Barry, trishbarry515@hotmail.com; **Social Work**
Chris Burford, cburford@gn.apc.org; **General Psychiatry and e-mail list**
Gráinne Fadden, grainne.fadden@bsmht.nhs.uk, **Psychology and Family**
Alf Gillham, alf.gillham@ggc.scot.nhs.uk **Clinical Psychology and Assertive Outreach**
Sheila Grandison sheila@barendt74.fsnet.co.uk; **Arts Therapies**
Jen Kilyon, jen@empathywithcarers.co.uk **Carer**
Vasilli Magalios, v_magalios@yahoo.co.uk **ISPSUK Newsletter**
Brian Martindale, Brian.Martindale@stw.nhs.uk; **Psychiatry**
Dan Pearson, daniel.j.pearson@talk21.com; **Families**
Alex Reed, alex.reed@ntw.nhs.uk **Nursing and Family Therapy**
Steve Trenchard, strenchard@retreat-hospital.org **Nursing and Workforce Development**
Judith Varley, juv@liverpool.ac.uk **Carer**

ISPS UK Associates:
Group Work and Psychology
Kathy Taylor, ktaylor_psy@yahoo.co.uk
Garry Brownbridge, gbrownbridge@retreat-hospital.org
Alison Brabban, abrabban@btopenworld.com,

Arts Therapies
Katie Clayton, Katie64@aol.com

Users and Families
Peter Ruane, ruane.p@blueyonder.co.uk

Social Work
Pat Land, nolandpat@hotmail.com

forthcoming events

Date: 27th June 2007
Event: "Why Choice"
Organisers: NIMHE (National Institute for Mental Health in England); Matrix Research and Consultancy; and Astra Zeneca.
Location: London, UK

Date: 16th - 17th July 2007
Event: National Mental Health Nursing - Transforming practice ideas into reality
Organisers: MHNA, Unison, Royal College of Nursing
www.jillrogersassociates.co.uk
Location: Cambridge, UK

Date: 12th - 14th September
Event: Annual Conference '07
Organisers: British Association for Behavioural and Cognitive Psychotherapies
Location: Brighton, UK

Date: 21st September 2007 (3 - 4.30 pm)
Event: Presentation by Mandy McCoull, Art Therapist
Location: Claremont House, Newcastle upon Tyne, UK

Date:1st February 2008
Event: Conference on Working together with Families in treating Psychosis
Organisers: ISPS UK
Location: Newcastle upon Tyne, UK

Date:15th -19th June 2009
Event: ISPS International Congress
Organisers: ISPS International
www.isps.org
Location: Copenhagen, Denmark

Networking

ISPS UK email group

Don't forget that you do not need to wait until the next Newsletter if you have something to say or want to hear what others have on their minds! The ISPS UK email discussion group is alive and lively - and for all members with email access. If you are not signed on contact Chris Burford: cburford@gn.apc.org or Denise Rolland (see below).

ISPS UK contact details:

Denise Rolland, UK Administrator can be reached by email on admin@isps.org.uk . Should you feel that an event that you are involved in would be of interest to our members please contact Denise for further details on advertising in our Newsletter.

The ISPS UK website is at www.isps.org/uk

One of the strengths of ISPS UK is the bringing together of a wide range of views, however the views expressed by authors in this newsletter are not necessarily shared by ISPS UK as a whole.

DEADLINE FOR NEXT NEWSLETTER : 15th SEPTEMBER!