THE INTERNATIONAL SOCIETY FOR THE PSYCHOLOGICAL TREATMENTS OF THE SCHIZOPHRENIAS AND OTHER PSYCHOSES

newsletter

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News from the chairman and the ISPS executive committee

Dear friends and colleagues,

It is a pleasure to inform you all that time and place for ISPS 2003 in Melbourne, Australia, has now been decided: the venue will be the Melbourne Convention Centre, and the dates are 22nd- 25th September 2003. The title is " Reconciliation, Reform and Recovery: Creating a future for Psychological Treatments in Psychosis ". So, we must all now start making plans for our visit to Australia, and also start marketing this major event in our own professional milieus.

The board has had several telephone meetings since the last issue of the newsletter. We continue to concentrate on making a good foundation for establishing regional and local chapters. I refer here to an outline of possible economic support for new local chapters, reffered elsewhere in this issue by Brian Martndale. It is the board`s impression that there is a growing activity "around the world", with regional meetings coming up in the UK, US, New Zealand, Scandinavia etc.

The board has now also sent a formal application for affiliation with the World Psychiatric Association (WPA). The ISPS will be represented with symposia at the regional WPA/Royal college of Psyciatrists meeting in London July 12th -15th this summer. At the same time we will have a board meeting in London, and all members who want to address the board are heartily welcome to do so. The WPA World congress in Yokohama, Japan, will take place August 2002. The board will encourage the members of ISPS to submit symposia, workshops etc, focusing on the importance of psychological interventions.

The "PORT- task force" is continuing it`s important work, and all members are encouraged to support their work by sending them significant references and points of view.

Finally, it is a pleasure also to report that the economy of ISS now is safe and sound, after what was a good economic result of our 2000 conference in Stavanger. Together with the enthusiasm of our members, this makes a solid foundation for further progress for the important work carried out by all of you.

On behalf of the board, I wish you all a nice summer (that is, those of you who find themselves on the northern hemisphere, for our members on the southern hemisphere I guess we wish you a nice winter?).

Jan Olav Johannessen
Chair, ISPS

On this newsletter

The theme and dates for the ISPS 2003 in Melbourne is presented in this issue, you will find the address for getting more information and make sure you are on the mailing list for the second announcement with a preliminary program and deadlines for presentations.

Even if there are few local news this time, there are important news about startup money available for local ISPS groups.

In this issue we bring comments on the paper «Quo vadis, ISPS?» by Professor Yrjö Alanen in the last newsletter. We still welcome more comments as a part of an important discussion for the ISPS as a society.

This time we are also print two papers from studies in Germany, and we thank the authors for sharing their work with other ISPS members in this way. By submitting their papers they challenge other members to share their experiences with the international ISPS community by submitting other clinical or scientific papers. Franz Resch also reports from the work to establish a local ISPS group in Germany.

You may help us identify new books as early as possible so that we can bring reviews of them, and you are welcome to submit book reviews yourself. We also welcome your list of articles from international journals that you would recommend as core readings on psychological treatments of psychoses.

We will also remind you of the ISPS website. Due to larger capacity and frequent updating, the website contains information that we cannot include in the newsletter, and some information will be available on the website before it may be distributed in the newsletter. We encourage you all to use the website actively to spread news on meetings and other events, as well as on developments in treatments and research that you are involved in.

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

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 the 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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Commentaries on Prof. Yrjö Alanen's paper "Quo vadis, ISPS?" (last issue)

Commentary on Quo vadis, ISPS
By Colin A. Ross, M.D.

I am grateful for this opportunity to add some thoughts To Dr. Alanen's. I did my psychiatry residency in Canada from 1981 to 1985, and have been practicing in the United States since 1991. I run three Trauma Programs at hospitals in Dallas, Los Angeles, and Grand Rapids, Michigan. The patients are 90% female, 65% meet DSM-IV criteria for borderline personality disorder, 65% meet criteria for substance abuse, 80% for posttraumatic stress disorder and 100% for a dissociative disorder.

On the Structured Clinical Interview for DSM-III-R (SCID), two thirds meet criteria for schizoaffective disorder or schizophrenia. The patients have higher scores than the norms for schizophrenia on the positive symptom scale of the Positive and Negative Syndrome Scale (PANSS). The average patient experiences more than five of the eleven Schneiderian first rank symptoms.

Only a small minority of the patients receive antipsychotic medication. Published prospective outcome data and clinical experience demonstrate that many of our patients experience sustained remission of their psychotic symptoms in response to intensive psychotherapy. Their average length of stay in our inpatient program is twelve days. The bulk of the therapy work is done on an outpatient basis. The therapy is a mixture of cognitive-behavioral, psychodynamic and systems principles and techniques.

Demonstrating the efficacy of psychotherapy for schizoaffective disorder and schizophrenia is actually a simple scientific problem, if we compare it to the experiments conducted in physics and molecular biology. All that we lack is research funding, time, effort, and organization. I already know how to treat chronic psychotic symptoms to stable resolution with psychotherapy, including auditory hallucinations. I know the assessment measures, treatment outcome measures, and method of therapy, which is well described in my books (Ross, 1994; 1995; 1997; 2000). I need to develop a treatment manual and a reliable measure of the fact that therapists under study are delivering the treatment package. Neither of these projects requires more than sufficient time and energy; the creative, clinical, and scientific thinking has been done and published.

The assessment tools are standard structured interviews used in the field, such as the SCID. The treatment outcome measures include widely used self-report measures such as the SCL-90, Beck Depression Inventory and Dissociative Experiences Scale. There is nothing mysterious or complicated about any of this. All that is required is the standard machinery of psychometrics and treatment outcome studies.

I learned all of this from the study of multiple personality disorder, which was renamed dissociative identity disorder in DSM-IV in 1994. I would say that at least one third if not half the patients described in presentations at the 2000 ISPS Meeting in Stavanger are the same patients that I see in my Trauma Programs. The same is true of the artwork that was on display.

Psychotherapy for chronic psychosis is highly effective in a subgroup of patients. Part of the research effort must be to identify the subgroup so that it can be triaged to psychotherapy. The measures employed in treatment outcome studies can be analyzed to yield predictor variables. I already know what these are clinically. Patients I have treated to stable remission of their psychotic symptoms are like good therapy candidates in general. They have relatively few negative symptoms of schizophrenia; they have many positive symptoms but no formal thought disorder; they are motivated, psychologically-minded, and hard-working; they have histories of serious psychological trauma; they have extensive comorbidity; and their voices can be engaged in rational conversation. Additionally, they have high scores on the Dissociative Experiences Scale and meet criteria for a dissociative disorder on the Dissociative Disorders Interview Schedule, the text of which is posted at www.rossinst.com. Prospective research data for the psychotherapeutic treatment of chronic psychotic symptoms are included in the Results section of a paper which is posted on the same web page (Ellason and Ross, 1997).

Admission criteria to the psychotherapy study could include: meets DSM-IV criteria for at least three of posttraumatic stress disorder, borderline personality disorder, major depressive disorder, substance abuse, and a dissociative disorder; scores above the fiftieth percentile for schizophrenia for positive symptoms on the PANSS; scores above 30 on the Dissociative Experiences Scale; scores below the twenty-fifth percentile for negative symptoms for schizophrenia on the PANSS; and meets DSM-IV criteria for schizophrenia or schizoaffective disorder.

With sufficient funding, time, effort and energy, the efficacy of psychotherapy for chronic psychosis could be demonstrated in less than ten years for less than fifty million dollars. But serious funding is required in the tens of millions of dollars. Such funding is not available for political and ideological reasons. From scientific and public health points of view, investment of tens of millions of dollars in such studies is realistic and sensible.

To me, the problems are all political. Psychiatry is dominated by pseudoscientific biomedical reductionism. For instance, although widely accepted as conclusive, the Danish adoption studies in fact provide zero scientific evidence for a genetic basis to schizophrenia, as argued irrefutably in my book *Pseudoscience in Biological Psychiatry* (Ross and Pam, 1985). Overall, concordance for schizophrenia in monozygotic twins is about 40% - 45%. These data are consistent, clear and replicated. The predominantly genetic basis of schizophrenia is a

marketing ploy for bioreductionist psychiatry, not a scientific fact. It is not supported by the data.

Various bioreductionist hypotheses about partial penetrance and multiple loci are simply attempts to preserve the bioreductionist viewpoint in the face of data which refute it. Such mechanisms explain nothing, cannot be refuted and are not supported by any specific findings at the DNA level. How many billions of dollars is the taxpayer going to spend on futile bioreductionist research before making a serious, but comparatively small investment in psychotherapy for chronic psychosis? There is no sign of the tide turning in academic psychiatry in North America. That is why the ISPS is an important organization.

The primary public policy tool of the ISPS should be research data. We have to have data and we have to be scientific. The efficacy of the psychotherapy of chronic psychosis can be demonstrated as conclusively as the efficacy of cognitive therapy for depression. This is a simple scientific task. It needs to be demystified and formulated as what it is; a straight-forward problem that can be tested and solved with known, well-established methods and measures. The problems are logistical, financial, organizational and political, not conceptual or scientific.

Unfortunately, although the science is simple, the political problem is monumental. We are talking about a paradigm shift in psychiatry, which is a big job. Big, but not impossible. Such are my thoughts.

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Commentary on «Quo vadis, ISPS?»
By Kim T. Mueser, Ph.D.

I applaud Professor Alanen's thoughtful and provocative paper on the current state of psychotherapy for schizophrenia and future directions for the field. In his paper Professor Alanen has raised many critical issues, and provided a spirited challenge to the widely held assumption that schizophrenia is an organic illness, and that psychoanalytic approaches hold little promise for this population. Perhaps most importantly, he expresses justified concern for an overly restrictive approach to both understanding the etiology of schizophrenia, and recommending which interventions, including psychotherapy, are of greatest benefit.

Dr. Alanen makes an important point in questioning the belief that schizophrenia is an organic disorder. This challenge is based on the fact that no biological parameters have been shown to consistently discriminate patients with schizophrenia from other psychiatric disorders or the general population, and the fact that there is evidence that environmental factors play a role in etiology of schizophrenia (Tienari et al., 1993). The first point, that there are no biological differences that reliably distinguish schizophrenia, is accurate, and suggests the contention that schizophrenia is an organic disorder must be regarded as a hypothesis at this time, and not an established fact.

The study by Tienari et al. (1993) does suggest that the environment may play a role in the development of schizophrenia. However, it should be noted that the findings from this study have yet to be replicated, in contrast to the numerous studies showing that genetic factors contribute to increased vulnerability to schizophrenia. The notion that the environment is involved in the development of schizophrenia is not inconsistent with the stress-vulnerability model, which posits that biological vulnerability and environmental stress interact in determining the onset and course of the disorder. Based on this model, it may be speculated that individuals with moderate amounts of biological vulnerability may be susceptible to developing schizophrenia only if they are exposed to sufficiently high levels of stress and/or if they have insufficient opportunities to develop effective coping skills or social supports. Thus, the symptoms of schizophrenia may be biological in nature, yet interact with the environment. Explaining this model to patients and families does not seem tantamount to "psychological castration," as it avoids blame for causing schizophrenia while providing hope, optimism, and guidance for improving its outcome.

I agree with Professor Alanan that a restrictive approach to treatment recommendations for persons with schizophrenia is problematic, and is predicated on the assumption that we know more about how to treat the disorder than we truly do. Indeed, I believe that it is important to keep an open mind about theories and interventions that may improve the outcome of this devastating illness. At the same time, it is also critical to be mindful that the shared goal of professionals, patients,

and their families is to improve the functioning of persons with schizophrenia, and that hard evidence, in the form of controlled, objective, and replicated research studies, provides substantial guidance in identifying such interventions. Specifically, there is abundant evidence documenting that supported employment, long-term family intervention, assertive community treatment, skills training and illness self-management, cognitive-behavior therapy for psychosis, and integrated treatment of mental illness and substance abuse problems improve the functioning of persons with schizophrenia (Mueser et al., 2001). Patients have a right to these interventions, some of which involve psychotherapy and others which do not, and the availability of such treatments should form the core of any competent treatment system for schizophrenia.

So what is the role for psychotherapy in schizophrenia, and in particular, psychoanalytic approaches? A clear role has not yet been established, but controlled research, such as that conducted by Professor Alanen (Alanen et al., 2000), is beginning to suggest benefits, and to indicate which patients are most appropriate for such treatment. Psychotherapy for schizophrenia needs to be placed in the context of comprehensive mental health treatment, which includes access to demonstrated interventions such as those listed above, and recommended based on the individual needs of patients. As research on the treatment schizophrenia provides more tools to clinicians, the importance of individualizing treatment grows, as does the prospect for a positive outcome.

In order to move into the future and to continue to expand our armamentarium of treatment methods for schizophrenia, as Professor Alanen asserts, it is crucial that we do not operate with “blinders” to the work of others, and endorse an overly restrictive view of effective treatments for schizophrenia. Indeed, the greatest obstacle to improving our knowledge about the treatment of this disorder may be the erroneous belief that we already know well enough how to treat it effectively. If we humbly accept the limits of our knowledge, and remain open to different treatment approaches, we will be able to work collaboratively and effectively towards the mutual goal of improving the functioning and outcome of schizophrenia.

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Book review

Colin A. Ross: The Trauma Model A Solution To The Problem Of Comorbidity In Psychiatry.

Manitou Communications, Inc.
1701 Gateway, Suite 349
Richardson, TX 75080
ISBN 0-9704525-0-0
404 pages

”The polydiagnostic patient with extensive comorbidity is the major recipient of inpatient psychiatric treatment. In managed care terms this is the high cost, high utilization, high recidivism patient. There is no scientific model in psychiatry, which accounts for this patient, even though he or she is the major consumer of psychiatric services. The dominant model in contemporary psychiatry is the single gene - single disease model.”

In his introduction the author states that the origins of the trauma model are in his work with comorbid patients over the last twenty-one years.

He addresses the problem of comorbidity, and through concrete examples in his introductory chapter he exemplifies nicely that we very seldom meet the “one true diagnoses” patient. As in his earlier works he challenges the conviction that the genetic bases of schizophrenia is scientifically validated. He claims that this conviction among his teachers has been based on ideology, not science. As a consequence a number of clinical myths has followed from the belief that schizophrenia is a genetically – caused medical brain disease.

As in his earlier writings, Doctor Ross draws upon a thorough review of the literature. He states that “the worlds literature on the efficacy of antidepressants is based on physically healthy individuals with simple, clean psychiatric profiles who are not acutely suicidal”. He also states that “there are no scientific drug studies for polypharmacy regimens in polydiagnostic patients”. In an interesting calculation he shows that the direct effect of all drugs is equal the placebo response rate.

He will tell you that the drug literature shows what to describe for depression, obsessive compulsive disorder, bipolar mode disorder, panic disorder, schizophrenia, etc. But, what about the patient who meets criteria for five or six different axis one disorders?

Through examples he illustrates that there is a tendency to neglect the patient’s trauma history, and to concentrate on making the correct diagnoses. He tells the story of his patient Albert: “Albert had been seeing psychiatrists for twenty years, since he was a teenager. His current diagnoses was bipolar mode disorder. He was taking lithium, amytriptylin, haloperidol, cogentine, methotrimetrazin, and flurazepam. He smoked marijuana regularly and may have been knocked unconscious in a car accident as a teenager”. For him and other patients, the details of the trauma history varied. The “clinical material “ he worked with was a veritable tidal wave of trauma. Yet trauma was basically ignored as a theme, factor or cause of the patients problem. And he continues: “Not a single professor was trying to treat serious mental illness with any form of psychotherapy”.

The author draws a line to the somatic crises, a hospital emergency department. Who asks a person with hypovolemic shock about a gene for chemical imbalance? He claims that the same logic will be applied to the rape victim. To consider a search for the gene controlling her trauma response makes no biological sense. There cannot be a single gene for this complex set of symptoms that span most of the DSM IV TR, or even a definable finite set of genes or gene regions”.

Back to comorbidity. Doctor Ross states that “studies consistently find that rates of mood disorder and schizophrenia are equally elevated in the relatives of both clinical groups, and higher in the relatives of both clinical groups than among realities of controls”. Only a tiny minority of affected individuals have the disorder and pure form, with no diagnosable comorbidity. For instance among 379 patients with borderline personality disorder, there was a comorbidity of for example anxiety of 88%, substance abuse 64% and eating disturbances 53%.

The author also offers some observations that up to this point has not been referred in any scientific journal: In his chapter on nature versus nurture he states that “the biorreductionist might object that there is a gene or genes for obesity. This theory can be disproven by taking an airplane from Dallas to Amsterdam. Why should a gene for obesity be present at a higher frequency in the Caucasian population of Dallas than in the capitals of Europe? The higher rate of obesity in Dallas than in Amsterdam is obvious from a few minutes observation of both populations”.

Although advocating a distinct trauma model, he also admits that the trauma model cannot account for all mental illness. In psychiatry, the negative symptoms of schizophrenia may be caused by the disease process of schizophrenia, concurrent depression, side effects of medications or chronic institutionalisation. None of the major symptoms in psychiatry have any diagnostic specificity. There are only so many ways the brain can react to external trauma or endogenous disease; sadness, anxiety, thought disorder, dementia, dissociation, addictive craving, and so on are part of a limited collection of psychiatric symptoms generated by the brain. And, when the psychotic symptoms arise from the trauma pathway to positive symptoms of schizophrenia, their temporal overlap or independence from periods of depression does not affect the conceptualisation or treatment plan. The melancholic features of depression could be no more than severe by criteria in

which case they would occur in both severe atraumataic depression, and severe trauma depression.

Doctor Ross claims that "within the trauma model, both schizophrenia itself and psychotic symptoms in general are highly trauma driven". He examines the phenomenon of auditory hallucinations in detail, and also pays a visit to the sampling effect in relation to studies of heterogenous groups of schizophrenia. In his analysis of voices and other auditory hallucinations, we miss a review of the rich psychodynamic litterature on this subject, and would suggest that the trauma model could draw upon a lot of the work done within that tradition. As he says "within the trauma model voices may be the patient to, in some but not all cases", I am sure that most of us with psychodynamic background would agree to that, and also be willing to reinforce that statement. In his concept of "dissociative subtypes of schizophrenia" the author could be in danger of going into the same trap regarding so called " non-dissociative subtypes of schizophrenia" as the bioreductionists already are caught within when it comes to understanding serious psychiatric disorders.

In his chapter on twin and adoption studies we miss an updated overview, Kringlen and co-workers has for example shown that concordance rates for schizophrenia and monozygotic twins gradually has been reduced so that it is now 30% and not 40 – 45%. And, we also miss Tienarii's adoption studies.

In chapters on therapy he advocates psychotherapeutic techniques, with special emphasis on the locus of control shift. These are exciting proposals, which connect very well to the interpersonal psychotherapeutic tradition as developed by Sullivan, Fromm-Reichman and others. Although there are some maybe provocative statements in Colin Rosses book it ads very nicely to his previously works, for example "the pseudoscience of biological psychiatry" issued on Wiley in 1995. And for us situated in Europe it is also a clear demonstration that the humanistic approaches have a broader place in European psychiatry than what it at present have in the US.

And that of cause is a challenge of the ISPS.

Jan Olav Johannessen

Other books by Colin A. Ross

Multiple Personality Disorder: Diagnosis, Clinical Features, And Treatment (1989)

The Osiris Complex: Case Studies In Multiple Personality Disorder (1994)

Satanic Ritual Abuse: Principles Of Treatment (1995)

Pseudoscience In Biological Psychiatry (1995)

Dissociative Identity Disorder: Diagnosis, Clinical Features, And Treatment Of Multiple Personality, Second Edition (1997)

BLUEBIRD: Deliberate Creation Of Multiple Personality By Psychiatrist (2000)

Original papers

Dyadic Affect Regulation in Interactions of Schizophrenic Adolescents and their Parents

Barbara Haack-Dees

The study was carried out by the author within the framework of the Graduiertenkolleg “Klinische Emotionsforschung”, which was sponsored by the Deutsche Forschungsgemeinschaft (DFG). It was supervised by Prof. Dr. Rainer Krause (University of the Saarland, department of Clinical Psychology) and Prof. Dr. Franz Resch (University of Heidelberg, department of Child Psychiatry).

The aim of the study was to look for specific markers in the nonverbal-affective behaviour of schizophrenic adolescents and their parents and to explore, whether there is a specific relationship between facial expression and the level of expressed emotion. Special attention was paid to the identification of protective affect regulation patterns in contrast to maladaptive patterns.

For this purpose, 10-minutes-discussions between schizophrenic adolescents and their parents and discussions of a healthy control group were videotaped. The expressed-emotion-index of each of the parents was assessed by using the five-minutes-speech-sample (Magana et al., 1986). The facial-affective behaviour was coded using EMFACS (Friesen & Ekman 1984). As context information, visual contact and paraverbal behaviour was assessed.

On the basis of a detailed analysis of the facial behaviour, specific styles of dyadic affect regulation were found for the different groups. Both the schizophrenic patients and their parents differ from the control group concerning their facial-affective behaviour. A striking result is, that the parents of the schizophrenic patients differ more clearly from the matched controls than their sons and daughters do from the healthy adolescents.

In the discussions of schizophrenic adolescents and their parents a facial-affective style could be observed, that seems suitable to produce more interactive distance than in the discussions of healthy adolescents and their parents. Both the schizophrenic adolescents and their parents show a reduction in the overall frequency of facial activity and in the frequency of facial affects. Especially the facial expression of positive affects (smiling and laughing) is strongly reduced. Additionally, the facial activity of the schizophrenic adolescents is dominated by negative affects whereas in the healthy adolescents‘ faces there is a balanced relation between positive and negative affects.

Concerning the interaction of facial behaviour, paraverbal behaviour and visual contact, in the group of schizophrenic patients and their parents a distance-maximizing style could be observed as well. A comparatively small amount of facial-affective synchronization reactions indicates a small degree of affect attunement.

The facial activity of high-EE-parents of schizophrenic adolescents is less variable and vivid compared to low-EE-parents. Additionally, high-EE-parents of schizophrenic adolescents express less negative affects than low EE-parents.

In dyads of high-EE-overinvolved and high-EE-critical parents of schizophrenic adolescents specific patterns in the paraverbal and gazing behaviour and in the facial synchronization behaviour were found. These patterns indicate a fundamental deficit in the expression of negative affects in dyads with high-EE-overinvolved parents and a deficit in the expression of positive affects in dyads with high-EE-critical parents.

The results show that on the one hand there is a fundamental difference in the affective communication of schizophrenic adolescents and their parents compared to healthy adolescents. On the other hand, the dyadic affect regulation pattern also varies with the EE-index of the parents. In each group a different arrangement of protective and maladaptive communication behaviour could be observed.

These findings suggest that different kinds of communication training must be applied depending on the EE-level of the parents: Whereas in families with emotionally overinvolved parents the overt expression of negative emotions should be practised, in families with critical and hostile relatives it is more important to establish a positive relationship by fostering the expression of positive affects. In this sense, the results support and supplement the findings of the expressed-emotion-research and can make a contribution to the prevention of relapse in schizophrenic patients.

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Brief scientific communication

The concept of Expressed Emotion (EE) in schizophrenic adolescents and key relatives interaction considering emotional aspects of verbal behaviour and head positions

Brigitte Ramsauer, Peter Parzer, Franz Resch

Indroduction

Concerning the role of the family in relapse of schizophrenia, more than 40 years of empirical expressed emotion (in short EE) research highly supports the relevance and usefulness of relatives' emotional attitude (EE) as an influencing factor on the course of schizophrenic disorders. Usually, relatives' EE attitude was assessed by a semi-structured interview (Camberwell Family Interview, *CFI*; Vaughn & Leff, 1976) within the first three weeks after a patient's acute admission. The patient is not present during the interview. Statements of criticism, hostility or emotional overinvolvement with reference to the patient constitute relatives' level of expressed emotion as high in EE (critical or emotionally overinvolved or both) or low in EE. Today, three meta-analyses exist, integrating numerous studies of different cultures. They consistently confirm the predictive validity of relatives' EE attitude as the best and robust predictor on the course of schizophrenia nine or twelve months after discharge from psychiatric hospital. The risk of symptomatic relapse and hospitalisation increases two times if patients return to a high-EE household (50%) compared to patients returning to a low-EE family environment (21%), independent of the factors medication and duration of illness (Kavanagh, 1992; Bebbington & Kuipers, 1994; Butzlaff & Hooley, 1998). Additionaly, intensive face to face contact (more than 35 hours per week; Brown et al., 1972) to high-EE relatives has a worsening effect on outcome whereas intensive face to face contact with low-EE relatives reduces relapse rates tendentiously (Bebbington & Kuipers, 1994). Within a vulnerability-stress framework (Nuechterlein & Dawson, 1984), results of EE interaction research clearly emphasize different communication and problem solving styles depending on relative's EE attitude (Hahlweg et al., 1989; Wuerker, 1996). However, EE researchers failed to investigate the role of emotion and affect as central features of relative's EE level and of interpersonal communication in a more precise way. Especially the expression of emotion and affect in verbal and non-verbal behaviour warrants further investigations. People express and communicate mutually their emotions so that they serve as information signals how to organise and regulate the self and the social interaction (Frijda, 1986; Johnson, 1998). In addition, deviations in regulating intimacy or distance are discussed as one important risk factor in the family environment of schizophrenics (Resch, 1994; Steimer-Krause, 1996). Thus, an individual with a diathesis for schizophrenia - for example a specific 'affective vulnerability' concerning the interpersonal dynamic of intimacy or distance - who is exposed to a high-EE family environment, may modify, reduce or interrupt his emotional communication in a way, thereby the threshold of the development of a new psychotic episode decreases.

Therefore the present study was designed to extend the EE outcome and interaction research with regard to the following aspects. For the first time, the influence of EE attitude of key relatives of schizophrenic adolescents on patients' and relatives' verbal behaviour and head positions compared to dyads of non-schizophrenic adolescents' and on key relatives' verbal behaviour and head positions in interaction were examined simultanously. The concept of EE was specified by psychological theories of emotion and affect (Frijda, 1986; 1989). Relative's EE and it's constituent scales of verbal behaviour and head positions were understood as action tendencies of approach or avoidance respectively rejection. It was hypothesised that adolescent's and relative's behaviour differ as a function of adolescent's mental health status (schizophrenic or mental healthy) and relative's EE level (low-EE or high-EE).

Methodology

The empirical investigation, including a 5-minute speech-sample and a direct interaction task (discussion about adolescent's futur educational or professionals plans), took place at the time of patients' discharge from psychiatric hospital.

15 dyades of schizophrenic (12) and schizo-affective (3) adolescents at the age of 14 to 21 years (mean = 17,6 years) with one key relative (13 mothers, one father and one grandmother) participated in this study. Eight patients (53,3%) had their first, four patients (26,7%) their second, two patients (13,3%) their third and one patient (6,7%) his forth admission to psychiatric hospital (For more details, see Ramsauer, Parzer & Resch, 2001, *in preparation*). The control group consisted of 17 dyades of age- and sex-matched mental healthy adolescents according to their Youth Self Report ratings (*YSR*, Achenbach, 1991) and one key relative.

To assess relatives EE level, the method of Five-Minute-Speech-Sample (*FMSS*, Magana et al., 1986) was used. Verbal behaviour was coded by using the Rating Scales for Verbal Behaviour in Family Interaction (*RFI*, Hahlweg, Dürr & Müller, 1995). The *RFI* scales *acceptance* and *theme-orientation* as 'positive' affect codes as well as *criticsm and devaluation* and *influencing and reading s.o.'s mind* as 'negative' affect codes were scored according to a 5-point Likert scale (1=not at all, 2=low, 3=medium, 4 =high, 5=very high) The corresponding head positions of approach and avoidance or rejection were transcribed by the Berner System for Nonverbal Behaviour in Interaction (Frey, S. & Cranach, M., 1973).

Preliminary Results

According to *FMSS* ratings, 7 (46,7%) relatives of schizophrenic adolescents were classified as low-EE and 8 (53,3%) as high-EE. In the control group, 13 (76,5%) relatives of mental health adolescents were equally rated as low-EE and 4 (23,5%) as high-EE.

Significant differences were found in the verbal- and head positions-data, depending either on relatives' EE-level or adolescents' mental health status or both. Thus, schizophrenic adolescents failed to be constantly theme-oriented. By turning the head away, schizophrenic adolescents exhibited the highest rejective behaviour towards high-EE relatives whereas schizophrenic adolescents towards low-EE relatives and normal adolescents at least partially tried to regulate the intensity of negative affects in interaction on a tolerable level without loosing sight of relative. Schizophrenic adolescents in interaction with high-EE relatives failed to do so and interrupted face-to-face contact for self regulation.

Relatives of schizophrenic adolescents tried to influence their adolescent schizophrenic family member by ignoring his autonomy. High-EE relatives were more critical than low-EE relatives. Low-EE relatives of normal adolescents were most acceptant. Specifically, low-EE relatives reduced the intensity of face to face contact with their schizophrenic family member. They turned the head to the patient, but by bending the head, they avoided to face their counterpart.

Conclusions

These findings show, that the integration of clinical research on emotion and EE research is a successful approach, by focusing on the course of schizophrenic disorders in adolescence. A model about the significance of EE, familiar emotional communication and the course of schizophrenic disorders in adolescence needs a developmental perspective. EE may, to some extent, be a reaction of relatives to the functioning and social skill deficits of the schizophrenic adolescent family member, which were described as essentially mediators of a high-EE attitude and of schizophrenic relapse (Hooley & Hiller, 1998). The additional finding of this study, that 6 out of 8 adolescent patients with relatives' classified as high-EE at the time of discharge had two or more admissions to psychiatric hospital, supports the reaction hypotheses above. Additional studies are needed to promote further understanding of psychosocial and psychotherapeutic approaches in schizophrenia in adolescence.

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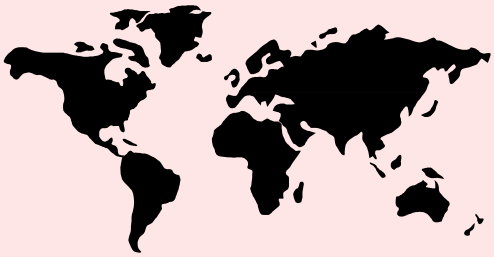

News from the ISPS networks

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.

Foundation of a local group of German psychotherapists on the topic : "Psychological Interventions in Schizophrenia"

On March 14th 2001, a workshop on the psychotherapy of psychoses was held in Munich during the Congress of the World Association for Dynamic Psychiatry. The topic of premorbid personality development and it's impact on the initiation of psychosis was discussed by M.Ammon and F.Resch with about 30 participants. After the workshop, 16 interested persons took part in the first meeting of a local group of psychotherapists aiming at the foundation of a German ISPS network.

The participants were psychologists and doctors from all over Germany and Austria. All were interested in widening the vision on schizophrenia: not only to look at biological and cognitive deficits, but also to take into account emotional aspects of stress regulation and communication. Many of the new members are therapists working in the field of psychosis. We made an address list, planned to keep in touch by email and post , inform each other about meetings and congresses on the topic of psychotherapy of psychoses. Finally and importantly we decided to meet for a second time this year during the congress in connection with the opening of the "Prinzhorn Exhibition" in Heidelberg, September, 16th 2001.

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Comments by Brian Martindale

Professor Resch describes an important development. Germany is a very big country and there are also other groups who have been meeting in some regions of Germany, (some for many years), who are sympathetic to the work of ISPS, and who have members who have been involved in ISPS congresses. We hope to have some information about them in future Newsletters and some ideas as to how the different groups might link with one another and with the central ISPS. If you work in Europe please contact Brian Martindale with any ideas you have about developing ISPS networks in your city or region or country. I think most countries have an expression something like –'from little acorns, big oak trees grow'.
drbmartindale@cableinet.co.uk

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 furhter information as soon as it is available. You may also ask for additional copies of information to distribute to colleages.

Please also find updated information on the ISPS web site www.isps.org

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 Treatment and an ISPS workshop on case formulation according to the Need Adapted Model.

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.

There is a wide-ranging introduction then a section based on cognitive approaches, then another on family, group and psychosocial approaches, followed by a psychoanalytic approach. The penultimate section describes the integration of a range of these approaches used in early interventions, designed to improve the chances of full recovery in the community and minimise chronic disability. The authors of this section are Scandinavian where these approaches are increasingly widely practiced. Finally, there is a comprehensive overview from Australia that gives an encouraging vision of modern mental health services for those vulnerable to severe mental disturbance and also valuable pointers to further research likely to be fruitful.

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

To order copies, return the form below (with payment) to: Book Sales, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG, United Kingdom. Telephone +44 (0) 20 7235 2351, extension 146. Fax +44 (0) 20 7245 1231. Credit card orders can be taken over the telephone.

Please send me ____ copies of Psychosis: Psychological Approaches and their Effectiveness , at £ 25.00 each. Total £ _____	Name
	Address
	VISA card ( ) Mastercard ( )
Postage and packing free in the UK and for surface mail to overseas destinations.	Card. No
( ) I require air mail delivery at the additional cost of £ 4.	Expiry date
Cheques (sterling only) should be made payable to the Royal College of Psychiatrists	Date and signature

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 it's geographical and/or professional boundary (se 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 of 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 develops

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

The first allocation decisions will be made towards the end of July 2001.

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

What is your contribution to the next newsletter?

- your local ISPS group and its activites ?
- 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 October 10, 2001

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

Send or fax to: ISPS c/o SEPREP, Jernbanetorget 4A, N-0154 Oslo, Norway — Fax no. +47 2310 3779

Name	Membership: ❑ New ❑ Renewal
Street/address	Title: ❑ Mr ❑ Dr (med) ❑ Prof ❑ Ms ❑ Dr (PhD)
City/town	Profession: ❑ Medical doctor ❑ Psychitarist ❑ Psychologist ❑ Nurse ❑ Social worker ❑ Arts therapist ❑ Student in: ❑ Member of user org.: ❑ Other:
Postal code	
Country	
Telephone	Are you a psychotherapist in your country? ❑ Yes ❑ No
Fax	If yes, please tick up to three orientations: ❑ Psychoanalytic ❑ Systemtic ❑ Cognitive ❑ Group ❑ Integrative ❑ Family ❑ Milieu ❑ Other:
E-mail	
Payment by credit card: ❑ VISA ❑ Am. Express ❑ Master Card ❑ Dibers Club Card no: Exp /	Place of work: ❑ Private practive only ❑ Institution / organisation: ❑ Retired from: ❑ Other:
❑ Payment by enclosed check	Membership for: ❑ One year (NOK 250) ❑ Three years (NOK 625)
Date (dd/mm/yy): Signature:	