ISPS Newsletter

Volume 3 #1 **January, 2014**

In This Issue

Prof. Dr.med.
Gaetano Benedetti

Co-founders of ISPS

Professor Benedetti
with Christian Müller
in central Europe, 1950s

ISPS Journal now 4 issues per annum!

Prof. Dr.med. Gaetano Benedetti (1920-2013) Co-Founder of ISPS

ISPS members will be fully aware that our co-founder passed away on December 2nd, 2013 at the age of 93. A funeral and memorial service was held at Riehen, close to Basel in Switzerland on December 13th and a good number of members of ISPS were able to join his family, friends and other colleagues.

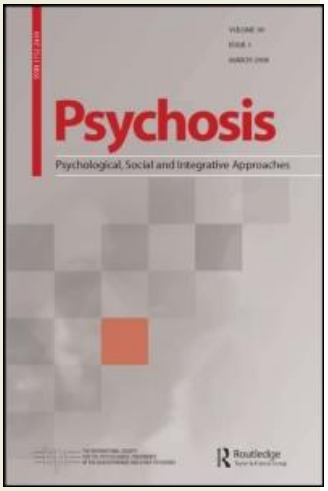
Benedetti made outstanding contributions to understanding the inner world of persons with psychosis and he gave a great deal of thought to the kind of empathic humane interventions that could be psychotherapeutic and of assistance in the rebuilding of shattered inner worlds. His works has been especially widely appreciated in the German and Italian languages and to some extent French. Problems of translating the subtlety of language have hampered wider disemination of his work in the English language. His ideas continue to stimulate clinical and research work and especially notable for this is the Benedetti Institute in Perugia, Italy, headed by Maurizio Peciccia of ISPS Italy. A number of the ISPS participants at the funeral had been frequent long distance travellers to learn from Benedetti,sometimes for many years.

As well as founding the ISPS in 1956 with his Swiss colleague Professor Christian Müller (who died earlier in 2013), Benedetti attended and played an active part in most ISPS International conferences until 1991. He was proud to witness the growth of networks and the host of ISPS conferences that take place around the world each year. Following the ISPS Warsaw conference, Maurizio Peciccia was able to present Benedetti with a plaque from ISPS that Brian Koehler had organised. It was clear that this touched him.

A full obituary will appear in the next edition of Psychosis and the executive will be considering other ways in which his creative life and work can best be honoured, protected and further developed.

Brian Martindale
ISPS Chair

Message from the Chair of ISPS



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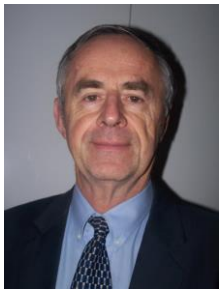

I thought it would be useful for all members to have a communication from myself as Chair of the EC as we start a new year.

I believe the ISPS is at an important time of transition. This is not only because in the last year we have had to face the loss of our esteemed founders of the organisation. This difficult time coincides with the further positive consolidation of our regional networks and this brings into focus the question of whether ISPS can really be a significant organisation at regional and international level that can play a major part in making real changes in our field.

Whether it does or not depends considerably on our own organisational capacities to mobilise our human resources with our combination of passion and knowledge.
To this extent, the executive has made a number of decisions that we think will assist you in your further regional development.

At our executive meetings in Warsaw, we made a renewed commitment that the focus of our energies will be 'Outreach'. What does this mean in practice?

a) **We agreed we need to develop our communications with our ISPS regional networks.** Therefore there are now regular email exchanges with two leaders from each network and of course these can be further circulated as appropriate. The hope is that these exchanges will support the further development of the networks. Already the idea of collating a) research b) training being carried out by ISPS member has been agreed and I hope you will see the fruits of this before long.

b) **We are putting more energy into making a broad range of learning tools available on our website.** This will develop step by step in the coming year and we will welcome ideas and information about useful resources

c) **We have agreed to build up active cooperative relationships with international organisations with overlapping goals** and executive members are taking the lead in this. We hope that at regional level similar activities will occur with national and regional organisations as we will not be effective if we are a series of islands.

d) **Some years ago ISPS UK's Charter of Good Practice was brought to the attention of the International ISPS community** but has slipped out of focus. It was developed by ISPS UK as a result of me having been inspired by the Charter for patients I had

Fees vary across regional groups

TO JOIN US NOW

contact Antonia Svensson

isps@isps.org

seen being used in Stavanger, Norway, as a result of work by Jan Olav Johannessen and his colleagues. We are recommending that all regional networks adopt this or their own version and use it regularly to promote thought and reflection and comparison with what is available. It is important to have ideals to aim for and I think you will agree that these serve as very concrete goals.

The ISPS Charter of Good Practice is available here

e) **Our journal PSYCHOSIS and our ISPS books series are important vehicles for promoting the ISPS focus.** The journal is expanding in 2014 to four productions each year to cope with the quantity of quality submissions and our book series has a pair of fresh and talented series editors.

f) **We welcome comments and suggestions on any of these areas.** They should be sent to isps@isps.org or they can be debated by our members on our international discussion list, which you can also join by contacting isps@isps.org .

Brian Martindale
ISPS Chair

ISPS Supports the 'Melbourne Hearing Voices Declaration'

The Melbourne Hearing Voices Declaration has been developed by people with lived experience of hearing voices from Australia, UK and Europe. The aim is to build support within the mental health system for the work in which they are leading in the hearing voices space.

It was launched at the World Hearing Voices Congress, held at the Melbourne Convention and Exhibition Centre on 20-22 November 2013. The Congress was organised and led by experts by experience, with 600 delegates attending from all around the world including consumers, carers, health professionals, policy makers and researchers.

By publicly supporting the "Melbourne Hearing Voices Declaration" ISPS is demonstrating its support for:

* The consumer leadership movement
* The importance of engaging in a productive way with the experience of hearing voices
* Commitment to building some action in this space into your planning processes over the coming period

By being a part of this Declaration there is the opportunity for us to collectively build support in our organisations and across the mental health system for the work that the

Congress embodies.

link to **The Melbourne Hearing Voices Declaration**

NZ court rules that abuse can cause schizophrenia

From: Read, John [mailto:J.Read@liverpool.ac.uk]
Sent: 03 December 2013 08:58
Subject: major victory!! A rather wonderful thing has just happened in NZ

A District Court judge has upheld an appeal by a sexual abuse survivor against a decision (in relation to a claim for financial compensation) that sexual abuse can not cause 'schizophrenia'.

The opinion of two psychiatrists that there is no evidence of a causal link was overturned when a third psychiatrist (David Codyre - a good friend and colleague) presented what the research actually says (including some of our papers Richard). The psychiatrists maintained their denial even after being presented with David's summary of the research!

But the judge overturned the decision, citing some of our work and a previous UK judge's similar deicsion. This is a major breakthrough which we should publicise far and wide. Please send it on to all your contacts and to any journalists you know. I am doing an internview tonight for NZ's leading Sunday paper.

I have attached the full ruling - it is wonderful reading !!

www.nzlii.org/nz/cases/NZACC/2013/385.html

John

From (NZ) SUNDAY STAR-TIMES
8th December 2013
ACC to rethink abuse link
SARAH HARVEY

A judge has ruled in favour of an ACC claimant in a case expected to have "enormous" ramifications for the way mental health patients are treated. In the decision, released recently, Judge Grant Powell in the Wellington District Court agreed with a psychiatrist who said a man's

schizophrenia had been caused by trauma from sexual abuse in childhood. Two ACC-employed psychiatrists had earlier said there was no evidence schizophrenia was anything other than a biological condition passed down through families and so the man's abuse had nothing to do with his condition. However, the judge agreed with a growing body of research that says traumatic events can cause psychosis.

The research includes the work of clinical psychologist John Read, who has been at the forefront of research to show a relationship between childhood sexual and physical abuse and psychotic symptoms, including schizophrenia. Read said the ramifications of the decision were "enormous". "It is gratifying that years of research on this issue is impacting the judicial system. These rulings will also make it harder for psychiatrists to ignore disclosures of sexual abuse by severely disturbed patients, or to dismiss them as either irrelevant or imagined. "This is a significant victory for all those patients and researchers who have been saying for many years that the experiences which biological psychiatry believes are symptoms of a brain disease called schizophrenia are best understood as responses to adverse life events. "Very often the voices abused people hear are the actual voices of the perpetrator of the abuse." Read said it was "alarming" that the two ACC psychiatrists "either knew nothing about the many studies documenting the relationship between child abuse and psychosis or were trying to mislead the judge". The man referred to in the finding had been covered by ACC for his history of sexual abuse but it was schizophrenia that had stopped him from working. He had sought to gain an independence allowance from ACC in December 2010. An independence allowance covers people who are permanently impaired as a result of an injury. The maximum weekly allowance is $84.97. In 2011, ACC decided it would not cover the allowance because it said his schizophrenia was not linked to his covered injury - a significant history of sexual abuse between five and 13. He was assessed by a psychiatrist who prepared three reports but concluded sexual abuse "is not likely to be the material cause of the current condition. There is no evidence of sexual abuse as an etiological factor [cause] in schizophrenia." His claim was declined and despite an appeal and subsequent reviews it was again found his incapacity related to his schizophrenia, which ACC said was a health issue unrelated to the sexual abuse.

After another appeal, psychiatrist David Codyre provided a report that completely disagreed with the previous psychiatrists. "With due respect to my colleagues who undertook the prior psychiatric reports . . . their opinion that sexual abuse is not causally related to schizophrenia is not evidence based." Judge Powell said ultimately he found Codyre's analysis "a more compelling and inherently more credible cause of the appellant's schizophrenia". Read said the finding would reduce the frequency with which psychiatrists dismissed abuse

disclosures as irrelevant or imagined and increased the probability of people being offered trauma-based psychological therapy instead of anti-psychotic medication.

New Zealand Association of Psychotherapists public issues spokesman Kyle MacDonald said the judgement was encouraging and could mean entitlements for many other people. "The reality is there a lot of people who would be in the mental health system who would have a diagnosis of a psychotic disorder who may now be entitled to access some treatment under the ACC. "For a long time there has been a mindset of how schizophrenia and psychotic disorders are treated, which is that it is a biological disorder which needs to be medicated and managed. "The reality is that actually these people are underserviced in terms of therapy and psychological intervention. This is a way to get people more therapy and more psychological help." ACC said it would consider whether this decision "has any wider impact" but took the view it would have "limited" value as a precedent and it would "continue to carefully consider each person's unique situation and circumstances".

- © Fairfax NZ News

Link to judge's full decision http://www.nzlii.org/cgi-bin/sinodisp/nz/cases/NZACC/2013/385.html?query=schizophrenia

Research Abstracts

By Brian Koehler
New York University

I was very glad to see the following research update by researchers from The Netherlands on the construct of social defeat and psychosis published in the most recent issue of Schizophrenia Bulletin. Seventeen years ago, in what I had hoped to be truly an integrative paper (given at ISPS London 1997), I had presented my observations on the large overlap between the neuroscience findings of chronic stress and social isolation (a form of social defeat and social exclusion) and the neuroscience of "schizophrenia." My thinking at that time, and still today, is that the social high risk factors such as immigration, racism, relative poverty, high expressed emotion, urban birth/living, etc., could possibly be mediated by of a deeper terror of loss of relatedness leading to a loss of self value, cohesion and continuity.

The Social Defeat Hypothesis of Schizophrenia: An Update.
Jean-Paul Selten, Elsje van der Ven, Bart P. F. Rutten and Elizabeth Cantor-Graae.
Schizophrenia Bulletin, Volume 39 (6): 1180-1186.

Abstract
According to the social defeat (SD) hypothesis, published in 2005, long-term exposure to the experience of SD may lead to sensitization of the mesolimbic dopamine (DA) system and thereby increase the risk for schizophrenia. The hypothesis posits that SD (ie, the negative experience of being excluded from the majority group) is the common denominator of 5 major schizophrenia risk factors: urban upbringing, migration, childhood trauma, low intelligence, and drug abuse. The purpose of this update of the literature since 2005 is to answer 2 questions: (1) What is the evidence that SD explains the association between schizophrenia and these risk factors? (2) What is the evidence that SD leads to sensitization of the mesolimbic DA system? The evidence for SD as the mechanism underlying the increased risk was found to be strongest for migration and childhood trauma, while the evidence for urban upbringing, low intelligence, and drug abuse is suggestive, but insufficient. Some other findings that may support the hypothesis are the association between risk for schizophrenia and African American ethnicity, unemployment, single status, hearing impairment, autism, illiteracy, short stature, Klinefelter syndrome, and, possibly, sexual minority status. While the evidence that SD in humans leads to sensitization of the mesolimbic DA system is not sufficient, due to lack of studies, the evidence for this in animals is strong. The authors argue that the SD hypothesis provides a parsimonious and plausible explanation for a number of epidemiological findings that cannot be explained solely by genetic confounding.

I thought many people in our ISPS community would be interested in this recently published article (Schizophrenia Bulletin) by Dan Freeman and colleagues on cognitive-affective biases in paranoid, delusional thinking. It is congruent with psychodynamic approaches which have always underscored the role of intolerable affects, self-esteem, sense of self, the role of subjective meanings, relatedness, personal and cultural history, etc. However, the question of causality vs correlation is still in need of intensive study, e.g., could the affective parameters and concomitant paranoid thinking/delusions be downstream to a multiplicity of factors involving certain polymorphisms, copy number variations, attachment patterns, early life stress and trauma, developmental traumas, psychological agency, sociocultural high risk factors (social isolation and defeat), lack of social understanding and support (which are neurprotective), etc.

Current Paranoid Thinking in Patients With Delusions: The Presence of Cognitive-Affective

Biases.
Daniel Freeman, Graham Dunn, David Fowler, Paul Bebbington, Elizabeth Kuipers, Richard Emsley, Suzanne Jolley and Philippa Garety.
Schizophrenia Bulletin, 2013, 39 (6): 1281-1287.

Abstract
Background: There has been renewed interest in the influence of affect on psychosis. Psychological research on persecutory delusions ascribes a prominent role to cognitive processes related to negative affect: anxiety leads to the anticipation of threat within paranoia; depressive negative ideas about the self create a sense of vulnerability in which paranoid thoughts flourish; and self-consciousness enhances feelings of the self as a target. The objective of this study was to examine such affective processes in relation to state paranoia in patients with delusions. Methods: 130 patients with delusions in the context of a nonaffective psychosis diagnosis (predominately schizophrenia) were assessed for contemporaneous levels of persecutory ideation on 5 visual analog scales. Measures were taken of anxiety, depression, threat anticipation, interpretation of ambiguity, self-focus, and negative ideas about the self. Results: Of the patients, 85% report paranoid thinking at testing. Symptoms of anxiety and depression were highly prevalent. Current paranoid thinking was associated with anxiety, depression, greater anticipation of threat events, negative interpretations of ambiguous events, a self-focused cognitive style, and negative ideas about the self. Conclusions: The study provides a clear demonstration that a range of emotion-related cognitive biases, each of which could plausibly maintain delusions, are associated with current paranoid thinking in patients with psychosis. We identified biases both in the contents of cognition and in the processing of information. Links between affect and psychosis are central to the understanding of schizophrenia. We conclude that treatment of emotional dysfunction should lead to reductions in current psychotic experiences.

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Members voices

Thoughts on the role of family in ISPS
By Pat Wright, ISPS-US

For every person experiencing psychosis there are several family members who may be affected to various degrees by their experience. Historically the role of the family -in many cultures has been ignored. (Why this is so would be an interesting discussion at another time).

I would like to see more "family voices" represented by ISPS, hence this article. At the Chicago conference in Fall 2012 we had an informal lunch workshop for family members. One of the members was in the process of creating a website in New York for "loved ones" as well as anyone interested in resources related to someone who may have experienced "extreme states".

My involvement with ISPS began a few years ago while looking for information to help my now 24yr old son who has been hospitalized several times the past 4 years with the diagnosis of psychosis. I didn't trust the medical system and the "take your pills for the rest of your life and you'll be fine" philosophy. We did have a "carers" subgroup on-line for a while bringing up many issues e.g. what do we even call ourselves?

Since I work as a Parent Educator it's been natural to explore research, attend many conferences and read many books on the subject of psychosis, attempting to understand what my son was going through and maybe find a way to be helpful. I was part of the beginning of a "First Episode Psychosis" family education group at the hospital where my son had been admitted. Several parents still stay in touch desperately trying to do right by our young adults who are rebuilding their lives. We share with each other without a roadmap of what's ahead which can be frightening at times.

Fortunately my son and I have always been close so we've shared about our different lessons over the years traversing the path of "extreme experiences" together when possible. I have gained skills in understanding, advocating and knowing when to step back, but it's not comfortable and maybe it never will, the best I can hope for is? I don't even know how to finish that sentence.

At the Alternatives Conference in Texas this December (sponsored by the US Dept of Human Services) I heard a long time member of the "Psychrights" movement talk about the power of the family in advocating for the rights of their loved ones especially in the midst of a crisis rather than be left alone in the "system".

We each have our own ideas, opinions, and feelings on the "role of family" and my invitation is to open the topic for further discussion within ISPS newsletters and conferences.

Pat Wright, ISPS-US
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My experience of the International ISPS Conference in Warsaw
By Sacha Lawrence, ISPS-UK

I booked myself onto an ISPS Conference rather intuitively

and without knowing much about the organisation. My choice was informed by my interest in perspectives laid outside the UK mainstream paradigm which seem to me have been dominated by CBT approach for Psychosis. For a Counselling Psychologist who strives to understand and integrate a variety of philosophical ideas, that seem rather restrictive, so I chose to go to Warsaw to learn more.

The Conference lived up to my expectations and offered a good range of theoretical perspectives which were well integrated into open discussions, reflections and open supervision sessions. It was refreshing to see so many like-minded people in one place and be amongst professionals who recognise the value of analytic ideas in a complex world of postmodern psychotherapy.

Observing so many Psychiatrists and Psychologists amongst the ISPS delegates was very encouraging. I also wondered why an interdisciplinary dialogue had a natural flow at the ISPS, and why it is often different in my day-to-day experience of interprofessional communication.

I chose to start from within, by reflecting on my own route into the profession. It started in orthodox medical training in the 90s in Russia, which took me later to holistic therapies and eventually found its logical place in Counselling Psychology in the UK. I reflected on the difference between me 'then' at the beginning of my path vs. me 'now'. I remember my initial enthusiasm with cognitive models at the beginning of my psychology training. In fact, CBT at that time was the model I could relate most to, perhaps due to its similarities with a medical model and symptom focused formulations. I moved later to existential, dynamic and phenomenological ideas. I learned to appreciate deeper meanings of 'what does it mean' for the client; what is 'really going on' and 'what belongs to whom'.

The most valuable point in my personal experience and professional growth started with the beginning of my personal therapy. That allowed me to move from a 'nothing wrong with me' attitude to recognition of my own defences and denials.

I then realised what was missing in the puzzle: sadly, neither mainstream Psychiatry, nor Clinical Psychology (at least in the UK) include personal therapy as a core element of their university curriculum. I see such an educational approach as rather odd, if not assumptive, taking into account a variety of reasons why many people choose a Mental Health career in the first instance. This is without mentioning the fact that the most prominent and influential psychiatric thought of the past has been initiated by the likes of Freud, Jung, Lacan or Green, all of whom were in analysis.

This has been addressed in post-modern world by putting a greater emphasis on scientific research. Unfortunately,

the latter has been predominantly delivered by the use of nomothetic measures in order to advocate external validity of the findings and therefore to produce 'evidence' for optimal therapeutic intervention. Needless to say that a mere definition of "evidence" of effective practice in Mental Health is open for interpretations and we all are familiar with a negative impact of such findings on availability of a range of psychotherapeutic interventions on offer.

I would like to finish with a quote from Nancy Williams' presentation, which to me catches the essence of my reflection:
"It is falsely reductionist and naively Cartesian to assume that psychologically based problems require psychological solutions, whereas biologically based problems require biological ones. Biological events affect psychological experience, and psychological experience affects biology. Pharmaceutical intervention can reduce psychotic misery, and psychotherapy can change the brain".

I forgot to mention that many people I met at the Conference were in analysis themselves and perhaps this is what created a unique environment of a shared forum and an in depth understanding of a client experience.

Reference
Williams, N. (2013, August). More Simply Human: On the Universality of Madness". Plenary Lecture, the 18th ISPS Congress, Warsaw.

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Power to Communities: Healing through Social Justice

(INTAR [1] 2014, Liverpool,UK)

Although service user / survivor-led research suggests that a minority of people find biomedical diagnoses and drug treatment helpful, many do not. They, their families, friends, advocates and supporters, find that a range of different forms of help and support are valuable in helping them move towards self-defined recovery. These include peer support, engagement in voluntary work, creative activities such as writing, dance and poetry, spiritual support, and political activism. Other systems of support that focus on meaning and recovery rather than drugs and case management, such as Open Dialogue, the Need Adapted Treatment approach, and Soteria, have been desired alternatives by many, but are hardly availably outside of a small set of locales.

The availability of choices is of the essence here, and for the past 10 years the International Network Towards Alternatives and Recovery (INTAR) has brought together survivors and service users, family members, professionals and advocates from around the world to promote a much broader range of help for people who experience distress and psychosis. INTAR associates believe that mental health services fail to offer genuine choices and are instead reliant on drug treatment, coercion and hospital care. Thereby they deprive the person in crisis of their dignity, autonomy and real opportunity for re/discovery.

INTAR's first meeting took place in 2004 in Sheffield, Massachusetts. It brought together over thirty people with many years of experiences in alternative services/supports, who shared personal stories of recovery, family struggles, community activism, clinical experience and research to launch the Network. It was a happy and inspiring event, but also marked with deep sadness at the passing of Loren Mosher, founder of the first Soteria House, who was a key member of the founding group that brought us all together. Subsequent INTAR meetings took place in Killarney (Ireland, 2005), Gabriola Island (BC, Canada) 2007, Toronto (2008), New York (2009), and Toronto (2011). We are delighted to announce that the first INTAR event to be held in the UK will take place in Liverpool from the 25th - 27th June 2014.

The five conference themes are (1) social justice and mental health, (2) securing human rights in psychiatric care (3) cultural diversity and mental health, and (4) creating and developing healing communities. The fifth, arts and madness, threads across the three days. These themes concern the different contexts in which individual experiences of madness and distress occur and that are key to understanding and responding to these experiences. We have been fortunate to attract a number of internationally distinguished speakers who will deliver plenary talks on these themes.These include Peter Beresford, Isaac Prilleltensky, Kate Pickett and Marianne Schulz (day one), Bhagarvi Davar, Rameri Moukam and William Sax (day two), and Jacqui Dillon, Alison Gilchrist and Brendan Stone (day three). We also intend to make space for performances of dance, poetry, plays, films and reading, including some surprises and appearances by well-known supporters.

Plans are already well advanced, and we are fortunate indeed to have received enthusiastic support and help from friends, colleagues and organisations in the Liverpool area and the UK. The international organising committee for INTAR is working closely with a local organising group. This would not be possible without the support of a number of individuals and groups. The Liverpool Mental Health Consortium (http://www.liverpoolmentalhealth.org), which was set up

in 1995 with the purpose of improving the local mental health services is an umbrella organisation that gives voice to service users / survivors, families and community groups in the City. Through the Consortium, service users, survivors, families and community groups are closely involved in planning the conference, and deciding which workshop submissions will be accepted. The Liverpool Clinical Commissioning Group (http://www.liverpoolccg.nhs.uk) has provided much-needed financial support to help get the conference up and running. This has made it possible to appoint a part-time administrator for the conference, Jackie Patiniotis. Liverpool John Moores University has also pledged some financial assistance, and the event will take place with the support of the University of Liverpool, in its new conference and accommodation centre.

There are plenty of opportunities for workshops, presentation and performances, and you will find instructions on this webpage for submitting proposals (deadline 31st December 2013). The local organising committee will be arranging training and support for service users / survivors who want to be involved in the selection of submissions. This will ensure that the conference will reflect INTAR's values as well as the concerns of a broad range of stakeholders. More details are now available at http://intar.org/2013/11/818/ where you can follow the link to register, and you can submit proposals for workshops, presentations, readings and performances viahttp://intar.org/2013/09/intar-conference-liverpool-2014-call-for-contributions-3/. Past INTAR conferences have been inspirational, life-changing events. Don't miss out. See you there!

Peter Stastny
Philip Thomas

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[1] The International Network towards Alternatives and Recovery, www.intar.org

Forthcoming ISPS events

2014 ISPS Australia Open Dialogue Approach National Tour
Monday, 17 February 2014 - Friday, 28 February 2014
Featuring Jaako Seikkula and Markku Sutela from Finland.
There are talks being held all over Australia between the 17 -28 Feb 2014.
Open Dialogue seminars
Contact: ispsaus@gmail.com

ISPS-SE annual meeting
Friday, 14 March 2014 - Friday, 14 March 2014
Gothenburg, Sweden
"WHEN EVIL EXPERIENCES RULE - the development

of, among other things, auditory hallucinations"
Speakers/discussants: Professionals and clients.
Contact: kent.e.nilsson@hotmail.com

ISPS UK one day conference
Thursday, 27 March 2014
London, UK
Psychosis and the arts: Optimism and evidence for recovery
Contact: sheila.grandison@eastlondon.nhs.uk

ISPS Croatia 2014: School of psychotherapy of psychoses
Croatia
Wednesday, 14 May 2014 - Saturday, 17 May 2014
Inter-University Centre in Dubrovnik, Croatia
"Personality, Personality Disorders, Psychoses"
Keynote speakers to be announced soon
Contact: ivan.urlic2@gmail.com

4th DDPP Congress
Berlin, Germany
Friday, 16 May 2014 - Sunday, 18 May 2014
Psychotherapy and medication in the treatment of people with psychosis (conference in German)
Speakers include: Volkmar Aderhold, Jürgen Gallinat, Stefan Klingberg, Ute Merkel and Gwen Schulz
DDPP stands for "Dachverband deutschsprachiger Psychosen Psychotherapie" = umbrella organization for German speaking psychotherapy of psychosis.
ISPS-DDPP is seeking representation by and cooperation with ISPS-Germany.
congress program www.ddpp.eu/terminansicht/ddpp-kongress-2014.html
further information www.ddpp.eu

7th annual conference of ISPS Hellas
Saturday, 17 May 2014 - Sunday, 18 May 2014
Athens, Greece
"Preventing Psychosis in Groups and Families"
Greek and Foreign invited speakers
contact: Dr Anastassios Koukis info@ispshellas.gr , a_koukis@otenet.gr
www.ispshellas.gr

43rd congress of ISPS Germany
Thursday, 19 June 2014 - Saturday, 21 June 2014
Bochum, Germany
Psychotherapy of Psychoses, Social Therapies of Psychoses, Group Psychotherapy, Psychodynamic Approaches, Therapeutic Relationship, Early Prevention of Psychoses
Speakers: Klaus Hoffmann, Tilman Kluttig, Georg Juckel, Ute Naumann, Seza Krüger-Özgürdal,Nicolas Nowack
www.zsp-salzwedel.de/isps-germany
Contact ISPS-Germany@gemeinde-psychiatrie.de

8th annual congress of ISPS-CH

Friday, 20 June 2014
Lausanne, Switzerland (Psychiatric Hospital of Cery - University of Lausanne)
"Insight et psychose: regards croisés"
Key speakers, in French: Philippe Conus (Lausanne), M. Debbané (Geneva), Jean-Nicolas Despland (Lausanne) and English speaker - Paul Lysaker (Indianapolis).
contact: alessandra.solida@chuv.ch

ISPS UK 2014 Residential Conference
Wednesday, 17 September 2014 - Thursday, 18 September 2014
University of Leicester, UK
From Diagnosis to Dialogue
Speakers include: Lucy Johnstone, John Read, Marius Romme, Jaakko Seikkula and Rachel Waddingham
Call for papers: deadline 31st January 2014
Contact: alison@ispsuk.org

2nd ISPS Italy conference
Bergamo, Italy
11 September 2014 - 12 September 2014
Title and keynote speakers to be announced soon.
Contact: matteomazzariol@yahoo.it

Schizophrenia Days Conference 2014
Stavanger, Norway
Monday, 03 November 2014 - Friday, 07 November 2014
The largest interdisciplinary mental health conference in Europe
"Evident or Evidence-based? Mental health services under the magnifying glass."
About Schizofrenidagene www.schizofrenidagene.no

See you in New York!

ISPS NY 2015
Wednesday, 18 March - Sunday, 22 March 2015
New York, USA
The 19th International Congress of ISPS will take place in New York City
From DNA to Neighborhood: Experience and Relationship in Psychosis - An International Dialogue
Continuing Education and Continuing Medical Education offered by the Institute for the Advancement of Human Behavior (IAHB)
Contact: isps@isps.org
www.isps2015nyc.org

ISPS THE INTERNATIONAL SOCIETY FOR PSYCHOLOGICAL AND SOCIAL APPROACHES TO PSYCHOSIS
Formerly the International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses

Publication information

Editors: Klaus Lehtinen and Antonia Svensson, ISPS International Organiser

Published quarterly. For submission deadlines see below:
April 2014 issue - 15th March
July 2014 issue - 15th June
October 2013 issue - 15th September
January 2015 issue - 15th December

Submit material for consideration or suggestions to Antonia Svensson at isps@isps.org . Submissions should be in Arial 12 font without special formatting such as boldface, italic, color other than black, or capitalization of entire words. Items submitted in other ways may be returned.

The deadline to submit material for the next ISPS newsletter issue is
15th March 2014

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