

**Eighth Annual Meeting: Trauma and Psychosis**  
**October 6-8, 2006 ~ Santa Monica, California**

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**Presentation Abstracts**

You may contact the presenters who have e-mail links for more information about their presentations.

**SATURDAY, OCTOBER 7**

**Case Presentation: Progressing in Our Journey: A Medication-Free Therapy of Schizophrenia**  
**Daniel Mackler, LCSW**  
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*Note: this presenter does not wish this abstract to be published on the Web because of confidentiality concerns.*

**Dori Laub, MD, DFAPA (Keynote Speaker)**  
**Traumatic Psychosis-Narrative Forms of the Muted Witness**  
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This paper postulates that at the center of the traumatic psychosis there is a deficit- an absence of the very history of the experience of trauma, which originated the psychotic process. The finding that a disproportionately very high number of long term chronically hospitalized patients in psychiatric institutions in Israel, were Holocaust Survivors, most of them whom carried the diagnosis of schizophrenia, and that very little of their persecution history could be found in their medical charts, led to the above mentioned assumption. A videotestimony study was conducted with 26 members of this group who received extensive psychological testing before and five months after the study. Robust improvement in PTSD symptoms (particularly in the withdrawal cluster) was found in the post study tests.

A preliminary analysis of the content of these testimonies demonstrates not only the paucity of persecution related memories- the deficit postulated above- but also the various strategies employed to deal with this deficit, such as - claiming total forgetfulness, insisting on the irrelevance of these memories or an ambiguity on complete equanimity, creating screen memories that replace them, etc. An attempt is made to psychoanalytically formulate these "voids of memory" and their fragmenting impact on life and examine whether a co construction of a trauma narrative can have an ameliorating effect.

**Heather I. Milliken, MDCM, FRCPC, CSPQ and Lyn Williams-Keeler, MA, BCETS, FAAETS**  
**The Trauma of First Episode Psychosis: The Etiology; The Association with Insight; The Treatment**  
**(Cancelled)**

The onset of a first episode of psychosis is undeniably a traumatic experience for both the young person affected and for their family.

This paper will initially describe the etiology, nature and severity of the trauma associated with first episode psychosis. Next, this paper will discuss the complex relationship between insight and first episode psychosis with insight being both a potential contributor to the traumatic experience ("too much...too soon") but also an essential goal of treatment in order to achieve symptomatic, emotional, psychological and functional recovery.

We will then discuss how an understanding of the traumatic experience of first episode psychosis is incorporated into the development of an individualized psycho-bio-social treatment plan for both the

incorporated into the development of an individualized psycho-bio-social treatment plan for both the affected individual and their family with an emphasis on the importance of developing a therapeutic alliance (therapeutic attachment).

This paper will describe a range of possible individualized therapeutic interventions including supportive psychotherapy, individual and family psychoeducation, CBT (cognitive behavioral therapy), CPT (cognitive processing therapy), DBT (dialectical behavioural therapy) and EFT (emotionally focused therapy). Using examples from the Nova Scotia Early Psychosis Program, including research data and a video presentation, the importance of tailoring the psychotherapeutic intervention to the recovery needs of the individual will be demonstrated.

A major focus of psychotherapy is the integration of the traumatic experience of psychosis with the overall experience not just of illness but of a valuable life. "Finally ... a dimension is added to my life...that you dare to handle and which can be useful in the end.".(Romme 1989)

**Yulia Landa, PsyD**

**Traumatic Paranoia: Cognitive Assessment and Treatment**

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This paper reviews theory and research on the relationship between traumatic experiences and paranoia. The following types of such relationship are discussed: (1) paranoia is caused by traumatic experience, (2) PTSD is secondary to paranoia, (3) paranoia and PTSD are parallel responses to a traumatic event. Accordingly, the variations of the cognitive behavioral treatment models that combine cognitive behavioral interventions for paranoia and for PTSD are considered. Both group and individual treatment models for traumatic paranoia are described, and preliminary research findings presented. The implications for training and service development are discussed.

**Sue von Baeyer, PhD**

**Contagion of Trauma in Psychosis**

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This paper is a discussion of a fifteen-year treatment of a patient with intermittent psychotic episodes and a history of trauma. The paper focuses on how several audiences reacted to the analyst presenting this particular case in which the patient's history included multiple traumas and psychosis. As the analyst presented to various case conferences, she began to notice the disruptive effect the presentation of this patient had on the participants. The question then arose: was the unsettling effect that the participants experienced in listening to the presentation a result of:

- (a) contagion of trauma due to the patient's history and current behaviors vis a vis the analyst (intrusions into the analyst's private life and threatening behavior);
- (b) the analyst evacuating the patient's split off affect and psychotic thinking into the participants as a way for the analyst to continue the treatment unimpeded and not confused;
- (c) the analyst's unmetabolized counter transference reactions to the traumatized patient being transferred into the participants.

**Brian Koehler, PhD**

**The Neurobiological and Psychological Effects of Trauma and its Impact on and Transformation in the Psychotherapeutic Relationship**

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DeBellis (2004) defines maltreatment during childhood as neglect, physical, sexual and emotional abuse which constitutes a chronic and profound degree of stress. He pointed out that recent neuroimaging studies in adult PTSD and other anxiety disorders provide evidence for medial prefrontal and anterior cingulate dysfunction. Results from pediatric studies suggest that maltreated children have excessive cortisol secretion. DeBellis (2004) noted that elevated levels of catecholamines and cortisol may lead to adverse neural development through the loss of neurons, delays in myelination, abnormalities in developmentally appropriate pruning, or the inhibition of neurogenesis and decreases in the expression of brain-derived

appropriate pruning, or the inhibition of neurogenesis and decreases in the expression of brain-derived neurotrophic factor (BDNF). The neurotoxic effects of childhood trauma will be described as well as their potential impact on later relationships, including the psychotherapeutic relationship. The psychological effects of trauma have been well documented, ranging from a sense of a wounded self (Cyrulnik 2005) to pervasive dissociation (Howell 2005). Psychoanalysts have long studied the impact of trauma on interpersonal and self-relationships. This paper will describe some of the impact of trauma in persons with psychosis on interpersonal relationships, particularly, the psychotherapeutic relationship, e.g., impasse, negative therapeutic reactions, negative transference/ countertransference enactments, etc., and their therapeutic containment, understanding and transformation.

**Philip M. Alex, PhD**

**The Paradoxical Ordeal of Delusions: Emergency Strategy, Metaphoric Communication and the Precarious Places In-Between**

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The coexistence of the delusion's defensive and expressive functions presents a paradox and an ordeal to the therapist and delusional patient alike: the delusion speaks to the therapist – and to all who would listen carefully to it – about the nature, injury, and potential restoration of the self, yet tends to prevent the delusional person from thinking meaningfully or transformatively about its implications. To the therapist, a delusion can seem deeply metaphoric and symbolically laden in nature; for the delusional patient, it concretely replaces symbolic thought and attempts to attenuate unbearable emotional experience. This paper describes and illustrates the precarious but necessary therapeutic endeavor to create conditions under which the delusion's metaphoric communications about the injured self can become accessible to the patient and eventually outweigh its concretizing defensive function.

Theoretical considerations are illustrated by three clinical examples: one from work with a delusionally encapsulated patient who could not be reached, and two from work with patients whose delusional systems yielded over time to allow their metaphoric, symbolic and communicative functions to reach the patients' conscious understanding and produce generative change in their internal and objective lives. Emphasis is placed on listening to the delusion and to the patients' experience of it as organized symbolically, while striving to maintain a difficult-to-achieve balance between over-immersion in the delusional material and risking premature interpretation. The case material brings to life patients' subjective encounters with both terrifying and grandiosely gratifying delusional experiences and the differing transference-countertransference relationships that developed within each delusional situation.

**Ronald Abramson, MD**

**Psychotherapy of Psychoses in the "Real World"**

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Many patients who have psychotic mental illnesses experience improvement and even recovery from intensive psychoanalytic psychotherapy. But it is not realistic to expect that in every location there will always be enough adequately skillful therapists or adequate financial support to sustain the therapy. One answer to this mismatch between resources and need is to see patients less intensively.

This is a clinical report describing three patients with Paranoid Schizophrenia who have been seen in an outpatient private practice for several years. They have experienced substantial improvement with intermittent visits utilizing psychoanalytic psychotherapy and psychopharmacology. This experience will be contrasted with two other patients with whom the therapy failed.

Patient characteristics that have facilitated successful psychotherapy have been the presence of a logical observing ego when not psychotic, significant areas of successful adaptive functioning, and little need for external structure. Characteristics of successful intermittent psychotherapy for these patients are validating the patients' experience, conveying respect, and appropriately sharing the therapist's thoughts in an intersubjective manner.

This clinical material suggests that many patients with psychotic illnesses may benefit from this approach.

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**Christine A. Castles, RN, MPH and David Read Johnson, PhD**  
**Traumatic Etiology of Psychosis**

This collaborative presentation will examine the traumatic etiology of the client's psychotic episodes which were diagnosed as schizophrenia and led to long-term inpatient hospitalizations. The presenters have collected the actual medical records from these hospitalizations, which spanned many years, and have examined them in relation to documented traumatic experiences in childhood and adulthood. Traumatic triggers of these episodes can be clearly seen, though for the most part, the medical professionals involved failed to identify the traumatic events, integrate a trauma perspective in their treatment of the client, and accurately diagnose the disorder. The presenters will discuss, from both the perspective of the client and a mental health provider, the reasons for the mental health field's seeming ignorance of the role of trauma in the etiology of psychosis, specifically the lack of a coherent theory, barriers to investigating or believing client reports of abuse, and lack of available methods of treatment. Given the significant advances that have been made in the past two decades on the study of posttraumatic stress disorder, surely there is now an excellent opportunity to apply this new knowledge to the field of the psychoses.

**SUNDAY, OCTOBER 8**

**Françoise Davoine, PhD (Invited Speaker)**  
**Wit, Witness, Wisdom : Exploring the Common Field of Psychosis and Trauma**  
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In my experience, psychotic episodes usually investigate traumatic unexplored events, which occurred in a time out of joints. In the transference, they have to be approached *hic et nunc*, in the present tense of the session, although they may have happened long ago.

Through clinical cases, I will present three tools we use together with the patient, in this research facing the Uncanny:

- 1-- the use of coincidences, chance, dreams and outlandish impressions of the analyst, building a witness for the patient's surrealistic experiences.
- 2—the emergence of wit when patient and analyst are at wit's end.
- 3—the help of works of wisdom of authors and researchers on war traumas, such as Homer, Cervantes, and Laurence Sterne, for instance.

**Jean-Max Gaudillière, PhD (Invited Speaker)**  
**Even in America, there is no Self Mad Man.**  
[Jean-Max Gaudillière gaudilliere1@hotmail.com](mailto:gaudilliere1@hotmail.com)

Through a clinical vignette, I intend to define some cognitive distortions which a traumatized person (or his/her descendants) is facing in the social link, concerning also the reality and authenticity of the trauma. They happen in the transference, and can be used in the therapy.

At a certain point, madness as a way of research challenges blindness as a way to reestablish a community, after social, political and historical catastrophes. Activated by these paradoxical fields, the analyst is obliged to reconsider permanently his/her own relationship with complicated times.

**Clancy D. McKenzie, MD**  
**Does Schizophrenia Meet DSM-IV-TR Criteria for Delayed Posttraumatic Stress Disorder?**  
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The author illustrates an exact parallel between development of schizophrenia and development of delayed PTSD from war. This includes the initial trauma, how it grows like an abscess of the mind through recurrent flashbacks, nightmares and intrusive thoughts, and how, through the process of repression, this isolated

flashbacks, nightmares and intrusive thoughts, and how, through the process of repression, this isolated core nucleus of consciousness is walled off in the unconscious mind – only to be activated 10-20-30 years later by a second trauma which is sufficiently intense and similar to the first to awaken it and all that it has become in the unconscious mind. The massive repression of years of flashbacks, nightmares and intrusive thoughts, constitutes the precursors and the negative symptoms of delayed PTSD, and the explosive eruption of the repressed material represents the appearance of positive symptoms.

Charles Figley, founding editor-in-chief of the *Journal of Traumatic Stress*, wrote that this “fits like a glove with what is known about traumatic stress.”

Sarnoff Mednick of USC wrote: “I was very skeptical about Dr. McKenzie’s findings, but the Finnish database on 6,000 schizophrenic patients revealed a very high level of statistical significance.

O. Spurgeon English, wrote: “the findings are based on sound psychodynamic principles supported by findings in the literature,” and Paul MacLean concurred with where and how the schizophrenic process was taking place in the brain.

Schizophrenia is shown to meet every DSM criteria for delayed PTSD. This new understanding broadens treatment possibilities and allows for three levels of prevention. Diagnoses/symptoms vary month by month according to age-of-origin specific feelings/ behavior/reality.

**Oliver Mason, D. Phil., D.Clin.Psy**  
**Childhood Abuse and Delusional Content**  
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Childhood abuse is increasingly seen as associated with psychotic symptoms in adulthood and recent case studies have suggested there may be links between the content of psychotic symptoms and the nature of childhood abuse. However evidence has usually been anecdotal or formed on a case formulation basis. This study aimed to systematically investigate relationships between experiences of childhood abuse, later maladaptive schemas and the content of delusions in adulthood. Thirty-nine participants with a history of delusional beliefs as part of a diagnosed psychotic disorder completed Bernstein’s Childhood Trauma Questionnaire. Participants were categorised into those with ‘mixed abusive experiences’ (n=18), ‘emotional abuse alone’ (n=9) and ‘no abusive experiences in childhood’ (n=12). Maladaptive schemas were investigated using Young’s Schema Questionnaire (YSQ). The content of delusions and the nature of other anomalous experiences were assessed using the Schedule for Clinical Assessment in Neuropsychiatry (SCAN). A thematic analysis was carried out of the content of delusions producing a range of themes for comparison between the groups. Thematic analysis revealed eight major themes in the delusional beliefs: seeing self as bad; others see as bad; defective body; spirituality/entities; loss of control; surveillance/conspiracy; other threat harm; special abilities. Overall, greater abuse was related to a greater number of maladaptive schema. Small but relevant differences emerged between the groups in respect of associations between abuse, schemas and themes that highlight potentially meaningful but non-linear relationships. These are tentatively interpreted as evidence for the compensatory nature of delusional content in the context of life histories of abuse.

**James E. Gorney, Ph.D. ([jegorney@comcast.net](mailto:jegorney@comcast.net) ) and Beverly C. Gibbons, PhD**  
**([bevgibbons@comcast.net](mailto:bevgibbons@comcast.net))**  
**Human Relatedness, Psychosis and Trauma: The Legacy of Otto Will**

#### Symposium Overview

This symposium will memorialize and transmit the legacy of Otto Will, one of the most creative and influential psychotherapists of the twentieth century. During his career at Chestnut Lodge and the Austen Riggs Center, Dr. Will taught by example, inspiring colleagues and students to engage in long-term psychoanalytic relationships with psychotic and schizophrenic patients. Drawing inspiration from his two analysts, Sullivan and Fromm-Reichmann, Dr. Will emphasized the healing power of human attachment and relatedness. Although he contributed significantly to the psychoanalytic literature, Dr. Will’s enduring legacy reside most vividly among his former patients, supervisees, students and colleagues.

legacy reside most vividly among his former patients, supervisees, students and colleagues.

Consequently, this symposium will not only review Dr. Will's publications and research upon the psychotherapy of schizophrenia, it will also provide first hand accounts of his exemplary clinical practice and inspired teaching. The presenters will demonstrate how Dr. Will's creative and innovative praxis introduced both attachment theory and a relational perspective into psychoanalytic technique, thirty years prior to their respective contemporary elaboration.

Here will be marked the journey of a true visionary, humanist and prophet. With all of his mind and heart, this was a clinician who worked fearlessly on the edge. Dr. Will's life and clinical practice can provide courage and inspiration for those today who continue to explore psychotic and traumatic experience.

Paper Number One

Otto Will: More Simply Human Than Otherwise  
James E. Gorney, Ph.D.

Otto Will, M.D. was a brilliant psychoanalytic psychotherapist, an inspiring teacher, and a flawed, yet generous, larger-than-life human being. It will be my purpose here to transmit some of Dr. Will's legacy, as one who was privileged to have been a supervisee, student, and colleague of his for ten years, while he was Medical Director at The Austen Riggs Center.

Otto Will was deeply influenced by his two analysts, Harry Stack Sullivan and Frieda Fromm Reichmann. Their emphasis upon the critical importance of human relatedness spoke to Otto, as he himself struggled throughout his life with loneliness, attachment hunger, and separation anxiety. It was Sullivan's famous point of view that "schizophrenics are more simply human than otherwise," which came to inform Otto's premise that the building of a successful human relationship was the essential task of psychotherapy.

Otto unapologetically presented himself in all of his flawed humanity, never hiding behind the power of his role or position. He always admitted mistakes, acknowledged his limitations, and readily shared personally painful experiences and memories. This human responsiveness on his part invited and engendered similarly human responses in the other.

Dr. Will was a visionary and prophet. He wrote and spoke of the history within psychiatry of biologizing severe psychopathology, and thereby advocating exclusively biological therapies. For Dr. Will, such a point of view denied and avoided the most salient dimension of severe psychopathological states; namely, that they are disorders of human relatedness and require a human relationship within which to grow and transform. Dr. Will predicted that all new developments in neurophysiology and psychopharmacology, will tempt clinicians to flee from the difficult task of trying to establish human relationships with those who are psychotic, withdrawn, or otherwise unrelated.

Contemporary efforts on the part of pharmaceutical companies, managed care, and insurance cartels have now succeeded in withdrawing virtually all third party support for long-term dynamic psychotherapy. It is in this context that the life and work of Dr. Will is an inspiration to continue providing a humane, long-term psychoanalytic relationship to individuals across the entire range of human suffering. His particular clinical genius illuminates the ways in which psychosis and trauma become manifested within disordered patterns of human attachment and relatedness.

Paper Number Two

Otto Will: The Written Legacy  
Beverly D. Gibbons, Ph.D.

From the vicissitudes of his own experience with attachment, separateness and disruption, Otto Will developed both a method of working with profoundly troubled people and a philosophy of being human that informs this work. As Dr. Gorney asserts, this method and philosophy were most vividly transmitted orally, experientially, in live action during his work with patients and colleagues. Yet an important body of written work also exists comprising 62 pieces and spanning almost four decades. This presentation will examine selected papers from Dr. Will's written legacy explicating his theory and praxis, and elucidating his ferocious commitment to human connectedness as well as his uncompromising respect for the dignity and

ferocious commitment to human connectedness as well as his uncompromising respect for the dignity and distinct separateness of each individual, regardless of their psychiatric status.

Dr. Will wrote eloquently of the long history within psychiatry of biologizing severe psychopathology, and thereby advocating exclusively biological therapies. For Dr. Will, such a point of view catastrophically denied and voided the most salient dimension of severe psychopathological states: namely, that they are disorders of human relatedness and require a human relationship within which to grow and become transformed. This paper shall thereby chart Dr. Will's profound written investigation of the relational field and, ultimately, it will focus upon the connection between trauma and psychosis, which forms the core of his scholarly work.

**Norman Jay Gersabeck, MD**

**"Substance Dependency-Induced Psychosis": A New Diagnosis with Strong "Antibiological Implications"**

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My lecture is about the proposed diagnosis of Substance Dependency-Induced Psychosis (SDIP). There is very impressive support for its validity. It would have long ago been officially established, if it weren't for its political incorrectness -- for not agreeing with "biological ideology." It is an important diagnosis -- because it's almost as common as schizophrenia. Its correct diagnosis leads to a largely psychotherapeutic treatment -- that has led to a complete remission in one third of cases. Official establishment of the diagnosis would go a long ways to countering the predominant, current "pill and an appointment" approach to psychiatric practice. The role of trauma in functional psychoses is rather clear and common in SDIPs -- though the main trauma is in the development of the substance dependency itself. In addition to the trauma that is secondary to the practice of the dependency itself -- is the trauma to the narcissistic part of self (NPOS) -- for the addict even contemplating cutting back, or stopping the substance use. These traumas have much to do with the initial onset of the psychosis, and their later relapses. One fairly extensive SDIP case history is included -- which well illustrates the value of a psychoanalytic understanding in its treatment. In addition to the clinical similarities between SDIPs and schizophrenia, I discuss the important active placebo functions that addictive substances and antipsychotic drugs have, for both disorders. They have a positive (pro-narcissistic) nature for the former -- and a negative (anti-narcissistic) nature for the latter.

**Richard M. Waugaman, MD**

**Therapeutic Work with a Patient with Post-Traumatic Psychosis**

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I will present intensive individual psychotherapeutic work with a patient to illustrate various aspects of the treatment of post-traumatic psychosis. Depending on your interests, I am prepared to present either a patient with Dissociative Identity Disorder with psychotic symptoms, or a patient with schizophrenia. In either case, how I worked with their histories of trauma will be a central focus. I can present a patient I treated at Chestnut Lodge with either of those conditions. If I present a patient with D.I.D., I will focus on the therapeutic benefits of working directly in psychotherapy with the patient's alters.

**Lawrence E. Hedges, PhD, ABPP**

**Achieving Optimal Responsiveness in Transference Psychosis**

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In the early 1980's a group of California therapists began reporting on "organizing" transferences that could be studied in the context of well developed personalities during major psychotherapeutic regressions (Hedges 1983,2003). Organizing transferences are formulated as the earliest structures in personality that memorialize fetal and neonatal experiences of organizing physical and mental channels to the maternal body and to parental minds. Early impingements into the organizing processes range from environmental under-stimulation that causes forming channels to wither and withdraw, to environmental over-stimulation that causes the nascent channels to constrict and block. Intermediate forms of impingement can serve to create anomalies in cognitive and affective processing of psychotic proportions that have been reported in

create anomalies in cognitive and affective processing of psychotic proportions that have been reported in extensive case studies (Hedges 1994a,b,c; Hedges 2000a,b). Traumatic interruptions of organizing channels that might otherwise come to serve developmental processes of intersubjective connection such as nurturance, soothing, regulation, and evacuation, become inscribed in psyche as, "never reach in that way again." Clinical research demonstrates that these records can be revived as organizing transferences and worked with during psychotherapeutic regressions that have often been characterized as transference psychosis. Whether the organizing pockets are large (i.e., pervasively affect functioning) or small, they can be engaged by the alert psychotherapist as the human desire to connect is activated in the therapeutic relationship and as the characteristic withering and/or constricting patterns re-assert themselves as transference and resistance structures that can be known and worked with intersubjectively. The theory of the organizing transference and its implications for the psychological treatment of more dramatic schizophrenic, psychotic, dissociative, autistic, and schizoid states is presented along with case illustrations.

**Daniel Paul, PhD and E. Lisa Pomeroy, PhD**  
**Symposium Title: Depression, Psychosis And Traumatic Loss**

Freud, in "Mourning and Melancholia", asserts that depressed personalities have a pathological disposition to succumb to depression in the face of loss 1) because their relationships are characterized by greater ambivalence than normal people; they are guilty about their hatred of their loved one and 2) because there is a predominance of the narcissistic type of object choice. Consequently, there is a readiness to regress to an identification with the lost object to replace an object cathexis, turn the aggression toward themselves, and truncate mourning. Freud advises helping the person mourn and be less guilty about his/her hatred.

Freud does not develop his insight that it is the depressed personality's penchant for establishing relationships on a narcissistic basis that makes it difficult for them to see the other as a separate person. This insight has implications for the understanding of the pre-morbid personality and for treatment. The panel applies these new ideas to psychotic and borderline patients who succumb to depression in the face of traumatic loss.

**The Role Of Narcissistic Object Choice In The Understanding And Treatment Of Depression**

In "Mourning and Melancholia", Freud asserts that depressed personalities have a pathological disposition to succumb to depression in the face of loss 1) because their relationships are characterized by greater ambivalence than normal people; they are guilty about their hatred of their loved one and 2) because there is a predominance of the narcissistic type of object choice in depressed personalities. Consequently, there is a readiness to regress to an identification with the lost object to replace an object cathexis. Treatment involves facilitating mourning and helping the person be less guilty about his/her hatred. Strachey observes that Freud's paper "Mourning and Melancholia" is an extension of his paper on "Narcissism" written a year earlier. Yet, Freud uses the insights advanced in the paper on "Narcissism" only to account for the acute phase of the depressive illness.

This paper asserts that the depressed person's pre-morbid personality develops relationships according to the narcissistic type. They have difficulty tolerating separateness and see the other as embodying aspects of themselves. There is an absence of analytic type relationships where the other is loved for qualities that they possess and seen as people in their own right. This new view of depression emphasizes that in addition to helping the patient with guilt over hostility; it is essential to help the patient see the other as a separate person. Developing the capacity to see others as separate people makes the patient less vulnerable to depression in the face of future losses. These ideas are illustrated in the treatments of a psychotic and a borderline patient who succumbed to depression in the face of traumatic loss.

**Traumatic Loss: Healing The Agony**

Patients lacking a separate sense of self typically did not receive early relational support in order to develop self-esteem. Early narcissistic defenses develop. If severe trauma interrupts the narcissistic structure, a psychotic illness or other primitive mental disorder may occur. Dr. Daniel Paul's view of depression as related to the pre-morbid narcissistic personality will be explored in this clinical paper. A psychoanalytic treatment case will be presented as an example of this dynamic.

### The Case of Jessica

This middle aged extremely bright female came to treatment with a history of being a second generation Nazi Holocaust survivor. It was disclosed that at age three there was a traumatic death of the patient's grandfather. He had been her major source of support for self-esteem, relationship, inner stability, secure attachment and healthy development.

The grandfather, one day, walked out of the house alone instead of his normal routine of taking a daily walk with his granddaughter. The grandfather suffered a heart attack and died. Jessica believed the death was her fault. As a result of internal attacks upon her mind, she regressed to a narcissistic position. Jessica developed a "false self" without empathy; she demonstrated poor reality testing.

After a period of hospitalization as an adult, the patient's awareness deepened and eventually included an experiential awareness of her primitive internal world. Jessica expressed sadness at lacking attachment and having no awareness of being a "separate self." The underlying fantasy was a fusion state with her dead grandfather which avoided the impact of the holocaust and her grief.

Jessica's narcissistic disorder was over-determined, including transgenerational trauma from the Nazi decimation of her family.

### **Ira Steinman, MD**

#### **Intensive Psychotherapy of Schizophrenia: When Schizophrenia was Known as Mother-God.**

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Judith was viewed as a biologically impaired schizophrenic, through a year of hospitalizations, ECT, high dose phenothiazines and five times per week supportive psychotherapy and years of day care and group therapy; her diagnosis was confirmed on two separate psychological testings.

Luckily, she stumbled into an emergency room I was working in just after residency finished. She was bleeding profusely from self inflicted wounds. After taking appropriate medical action, I began to inquire as to why she had cut herself. Such an approach was so different from her previous five years of supportive care that she and her family consulted me and decided that an intensive psychotherapy with me might help.

Numerous delusions and hallucinations were evident and became clearer as we went deeper into her history and perceptions. Gradually, as her antipsychotic medications were titrated down and stopped, she uncovered not just the contents of a pervasive thought disorder, but a severe two year long period of sexual abuse by an older relative. As she integrated these traumatic phenomena and her attempt to avoid them by fleeing into psychosis, she cleared and healed; she had worked through her distortions and extreme transference feelings in the container of an intensive psychotherapy.

Instead of schizophrenia on an organic basis, Judith had been schizophrenic as a result of intolerable trauma. For the last thirty years, this previously untreatable schizophrenic has been off all antipsychotics, and has worked and enjoyed a number of relationships for the last twenty five years.

### **Dawn Brett, PhD, BCETS, FAAETS**

#### **Annihilation Anxiety**

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Psychodynamic theory provides the foundation for understanding some of the similarities between the effects of Trauma and Psychosis. Though developed for different reasons, Annihilation Anxiety is experienced in Psychosis as well as Trauma sequelae and obliterates feelings of safety and trust. Annihilation Anxiety affects certain ways of thinking, feeling, behaving, and relating to oneself, others, the world, and the future. Except if experiencing suicidal ideation, there is strong motivation to avoid annihilation, and symptoms that developed due to Annihilation Anxiety are very resistant to modification. Ways to effectively work with Annihilation Anxiety in Trauma psychotherapy and the importance of understanding Trauma-specific and personalized Counter Transference will be discussed.

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