ISEPP Bulletin

International Society for Ethical Psychology and Psychiatry, Inc.

ISEPP Conference, Nov 13-15, 2014" *2014 - Number 3*

What's Inside:

The Bad News, the Good News, And the *Better* News!

First, the bad news. Brian Kean, our reluctant Executive Director (*his* words, not ours), resigned his position due to the work load and personal demands. But he also stepped down because he's a responsible person; it proved difficult to keep up with things in the United States from his native Australia, so he made the tough choice. The good news, though, is that Brian remains as Editor-in-Chief of our journal, Ethical Human Psychology and Psychiatry. Good news, indeed.

Thank you, Brian. Thank you for stepping into such a demanding role when we needed you, and we're grateful you remain with EHPP. Your voice is too important for us to lose.

The better news is that Brian's decision was promptly addressed as the ISEPP Board of Directors unanimously elected Dominick Riccio, Ph.D. to return to the position he held for some seven years, at least until the conference Board meeting in November, 2014. Dr. Riccio also serves on the conference committee and on the executive committee, so he is already up to date on matters, and has participated in the negotiations Brian started with UCLA, our partner in this conference.

But the *best* news is that conference planning has progressed quite well in the hands of Michael Gilbert, David Cohen, Joe Tarantolo, Jeff Lacasse and Dominick Riccio, who form your conference committee. Indeed David Cohen has organized an outstanding group of plenary presenters from all over the world, many of whom will be with us for the first time. Finally, Michael Gilbert has issued the ISEPP call for papers: this year all breakout groups of 1 hour each will be in the same style of the plenary speakers except twice the time. If you are a paid member by August 15, 2014 please sign up ASAP because there are only 12-20 spots available for the breakout sessions scheduled for Thursday November 13, 2014. The call for papers is also included here, along with the registration form, so please check these out.

So register today to join us. See you in L.A., everyone.

International Society for Ethical Psychology and Psychiatry, Inc.

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email: psychintegrity@gmail.com
website: www.psychintegrity.org.

About the International Society for Ethical Psychology and Psychiatry: The International Society for Ethical Psychology and Psychiatry (ISEPP) is a nonprofit, 501C research and educational network of professionals and lay persons who are concerned with the impact of mental health theory and practice upon individuals well-being, personal freedom, families, and communities. For over three decades ISEPP has been informing the professionals, the media, and the public, about the potential dangers of drugs, electroshock, psychosurgery, and the biological theories of psychiatry.

ISEPP is supported by donations and contributions. Officers receive no salary or other remuneration.

Help us continue our work by sending a donation to ISEPP today.

ISEPP Bulletin Submission Policies

We want the Bulletin to reflect and serve our varied membership and much of what appears in our pages is from the membership. Some items are from outside, however, because we're interested in anything that might interest our readers. Our submission policies therefore are quite simple.

Authors may submit work to the Bulletin while simultaneously submitting to other publications or forums if they choose. Where this is the case, we ask that authors inform Bulletin staff so that our readers may be advised accordingly.

Authors retain full rights to and ownership of their work once it is submitted to, or published in, the Bulletin. Authors may subsequently submit or distribute their work to other publications or forums, where appropriate, without the expressed consent of ISEPP or the Bulletin.

We ask that authors specify in any subsequent publication or distribution that the work was originally published in the ISEPP Bulletin, noting the relevant issue number.

A Cautionary Note

Given that you are reading this newsletter, you are at least acquainted with psychotropic drugs, the risks they pose, and the potential hazards of discontinuing their use. All psychotropic drugs produce adverse effects, can be addictive, and can lead to physically and emotionally distressing withdrawal reactions when modified or discontinued.

Consistent with ISEPP's mission, the information in this newsletter is meant to inform and educate. It is not intended as a substitute for proper individualized psychological or psychiatric care. Nothing in this newsletter is intended to be taken as medical advice.

If you, or someone you know, are taking any psychotropic drug and are considering stopping, you are encouraged to do so gradually and under the supervision of a knowledgeable and responsible professional.

This is the safest and healthiest way to proceed. It is also the most likely to be successful.

ISEPP
International Society for Ethical Psychology & Psychiatry

ISEPP Annual Conference

TRANSFORMING MAD SCIENCE AND REIMAGINING MENTAL HEALTH CARE

A Joint Conference with UCLA Luskin

November 13-15 2014

DoubleTree by Hilton (LA Westside) – Culver City LA

www.psychintegrity.org

REGISTRATION FEES:	***Full Conference*** (11/13-11/15)	***Thursday-Friday*** (11/13-11/14)	***Friday-Saturday*** (11/14-11/15)	***Thursday Only*** (11/13)	***Friday Only*** (11/14)	***Saturday Only*** (11/15)
Advanced (by 8/31)						
Individual	$250	$135	$235	$40	$110	$135
ISEPP Paid Member	$225	$120	$210	$35	$100	$120
Registration (after 9/1)						
Individual	$300	$175	$275	$60	$135	$170
ISEPP Paid Member	$265	$150	$245	$50	$120	$150

OPTIONAL OTHER FEES: Awards Dinner Friday 11/14 $60 CEU Certificate $25

Name: _____ E-Mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ - _____ Organization/School: _____

REGISTRATION AMOUNT ENCLOSED: $ _____

Please send completed form and registration fee made payable to ISEPP to:

Michael Gilbert 100 Bradford Heights Road Syracuse, NY 13224

ISEPP/UCLA Conference
Transforming Mad Science and Reimagining Mental Health Care
Culver City, CA
November 13-15, 2014
PLENARY SPEAKER INFORMATION
David Cohen, Ph.D.
Conference co-organizer

BRIEF LIST OF PLENARY TALKS/SPEAKERS

CONFIRMED:

Grounded "Eutopianism"—Piecing/Peace-ing our Way Together: Toward a World with Commons and without Psychiatry
BONNIE BURSTOW, Ph.D., Faculty member, Department of Leadership, Higher, and Adult Education, Ontario Institute for Studies in Education, University of Toronto, Canada, author, *Psychiatry Disrupted: Theorizing Resistance and Crafting the (R)evolution* (2014), and the forthcoming *Psychiatry and the Business of Madness*.

Reclaiming Humanity: Building a Post-Psychiatry World through Inner-Exploration, Mutual Support, and Community Building
LAURA DELANO, Psychiatric liberation activist, writer, and community organizer, Boston, USA

Moral Competence and the Decline of "Health"
BOB FANCHER, Ph.D., Psychotherapist, Life Therapy Counseling Services, Portland, Oregon, USA, author, *Cultures of Healing* (1996).

Where Ethics Meets Practice In Psychiatric Diagnosis And Treatment
ALLEN FRANCES, M.D., Emeritus Professor of Psychiatry, Duke University, NC, USA, former DSM-IV Task Force Chair and author, *Saving Normal* (2013) and *Essentials of Psychiatric Diagnosis* (rev ed, 2013).

Toward a De-medicalized Non-coercive Educational Approach for Mental Health: Its Possible Model and Funding
TOMI GOMORY, Ph.D., Associate Professor of Social Work, Florida State University, USA, co-author of *Mad Science: Psychiatric Coercion, Diagnosis, and Drugs*

We Need a Revolution in Mental Health
PETER GØTZSCHE, M.D., Director, Nordic Cochrane Center, Denmark, author, *Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Health Care* (2013).

The Neuroscience Discourse Actually Supports Withdrawing Alleged Psychiatric Diseases from Medicine
FRANÇOIS GONON, Ph.D., Institute of Degenerative Disease, Université de Bordeaux, France, neurobiologist, specialist in dopaminergic neurotransmission and in science communication.

We Have a Dream. (Getting Engaged to a Doctor.)
DAVID HEALY, M.D., Professor of Psychiatry, Hergest Unit, Bangor, Wales, UK

Consumer reporting of the psychotropic drug experience: Toward an integrated knowledge base
SHANNON HUGHES, Assistant Professor of Social Work, Colorado State University, Fort Collins, USA

The misunderstanding between patient and healer drives mental health research. How might we progress in caring for psychologically distressed people? The situation in France.
PASCAL-HENRI KELLER, Ph.D., Professor of Psychology, Université de Poitiers, and psychoanalyst, France, author, *Open Letter to the Depressed* (2012) and *The Dialogue of Body and Mind* (2010).

The Problem of Medical Journals, And What To Do About It
JEFFREY R. LACASSE, Ph.D., Assistant Professor of Social Work, Florida State University, Tallahassee, FL, USA, and **JONATHAN LEO, Ph.D.,** Professor of Anatomy, Lincoln Memorial University, Harrowgate, TN, USA

Creating Evidence Based, Effective and Humane Mental Health Services: Overcoming Barriers to a Paradigm Shift
JOHN READ, Ph.D., Professor of Psychology, University of Liverpool, UK, co-author, *Models of Madness: Psychological, Social and Biological Approaches to Psychosis* (2nd ed., 2013), and *Experiencing Psychosis: Personal and Professional Perspectives* (2012).

The Barrier to Rethinking Psychiatry: The Guild Interests of the American Psychiatric Association
ROBERT WHITAKER, Journalist, editor and lecturer, USA, author of *Mad in America* (2002) and *Anatomy of an Epidemic* (2010).

Demedicalizing Memory Dysfunction and Neutralizing Neuromania
PETER WHITEHOUSE, M.D., Ph.D., Professor of Neurology, Case Western Reserve University, Cleveland, OH, USA, author of *The Myth of Alzheimer's Disease* (2007) and co-founder, The Intergenerational School.

TO BE CONFIRMED (POSSIBLE):

KEITH HOELLER, Ph.D., Seattle, WA, USA
NICHOLAS LANGLITZ, PHD, New School, NY, USA
JOANNA MONCRIEFF, M.D., University College, London, UK
BRIAN KEAN, PhD, and NIALL McLAREN, Australia
JAMES B. GOTTSTEIN, PsychRights, Alaska, USA

ISEPP Conference Hotel Information

Doubletree by Hilton – Los Angeles Westside

6161 W. Centinela Ave., Culver City, CA 90230

Special Hotel Rate of $109/night (until October 14 2014)

Reservations Number #1-800-222-8733

Group Code is ISE to book online at Doubletree by Hilton

Group Name: ISEPP Conference

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CALL FOR PAPERS

The International Society for Ethical Psychology & Psychiatry, Inc. is accepting proposals for presentations related to alternative approaches and perspectives in mental health care in order to move reform forward (e.g., future visions of "mental health" field). There will be a limited number of breakout sessions on Thursday November 13th due to format of this year's conference. All presentations will be 1 hour in duration and must adhere to the following format (5-10 minutes on current problem, 25-35 minutes on potential solution, and 15-30 minutes discussion).

PROPOSAL FOR BREAKOUT SESSION*

(Information as it would appear in conference program)

Name of Presenter(s) and Credentials:

Title of Presentation:

Brief Summary of Presentation (200 words or less):

Learning Objectives:

Short Biography (200 words or less) of Presenter(s):

A/V or other items needed (e.g., projector/screen, flipchart/markers, etc.):

Note: LCD Projectors, Screens, and power cords will be provided. Presenters are expected to bring their own laptop as well as any necessary adaptors (e.g., for Apple products).

*Presenters are expected to register for and attend conference.

DEADLINE FOR SUBMISSION: AUGUST 23 2013
EMAIL INFORMATION TO MGILBERT@IACAF.ORG

SMOKE AND MIRRORS

Chuck Ruby, Ph.D.

In our attempt to spread ISEPP's message, one of our biggest challenges is to confront the linguistic smoke and mirrors of conventional psychiatry and psychology. Just like the magician uses visual sleight of hand to create illusions, linguistic smoke and mirrors refers to the use of language that tricks people into believing something that isn't quite true. It's like in the Wizard of Oz; we need to clear away the smoke and mirrors in order to see what's really going on behind the curtain.

The stage is set with the very term "mental illness". The thing we call "mental illness" has nothing to do with illness. An examination of the DSM demonstrates this fact. Despite giving the impression of a scientific medical tome, none of the diagnostic criteria mention anything about real illness. Consider the difference in meaning between these two statements:

1. "John has a bipolar illness."
2. "John's difficulty in managing how he feels is causing him a lot of serious problems."

Even though both are describing the exact same problem, the first statement implies there is an inner malfunction that John cannot correct without medical care. The second statement naturalizes and humanizes the problem, thus implying hope.

Piggybacking on the term "mental illness", many other terms are liberally used to imply disease, dyscontrol, and despair. It is quite common to see such language in brain imaging research. For example, the phrase,

"…dopamine levels are lower and the basal ganglia are smaller in people with ADHD…"

gives the impression that a deficiency of dopamine causes ADHD. But the phrase could be restated as,

"…people who have demonstrated chronic inattentiveness have smaller basal ganglia because inattentiveness reduces the production of dopamine."

This latter interpretation is similar to how one would say, people who demonstrate chronic physical inactivity have smaller and less active muscles."

Even single words can have the same effect of implying disease. It is very commonplace to see terms like "dysfunctional", "underactive", and "abnormal" used to describe brain regions of people labeled with mental illness. But smoke and mirrors hide the fact that the noted brain regions are merely different, not diseased. Moreover, terms such as "healthy controls" and "normals" are typically used to describe those not afflicted with the purported disease.

Using language like this to create a screen of smoke and mirrors can insidiously fool both laypersons and professionals alike. Here are a few of the very common misunderstandings that result.

1. "Your disbelief in mental illness is dangerous since it would leave millions of people without the help of mental health treatment."

At the heart of ISEPP's message is the rejection of mental health and mental illness as matters of literal health and illness. But that rejection does not preclude us from helping people. It just points out the absurd proposition that anything mental can literally be ill or healthy. This foundation, therefore, argues against the use of drugs as an alleged treatment of the alleged illnesses. It also argues against the arrogant and authoritarian attitude taken by many of today's mental health professionals who think they know what's best for you.

2. "Your disbelief in mental illness is ludicrous. Just look around and you'll see countless people who are obviously mentally ill."

Mental illness exists! But to repeat, the thing we call mental illness exists. The problem is that smoke and mirrors have created an illusion that the thing has something to do with health and illness, when in fact it has to do with personal, moral, spiritual, economic, and political problems. I suspect some professionals knowingly go along with this charade in order

to feel better about their vocation by portraying themselves as some type of medical professional. But I think most merely get swept up into the profession's culture and belief system, just as I did when I started out. I accepted the proposition that the mind can be ill without questioning if the emperor of mental illness was actually wearing any clothes.

3. "There is increasing evidence that mental illnesses are biologically based. This shows they are real illnesses"

The things we refer to as mental illnesses do have a biological basis. But this statement is both exceedingly obvious and irrelevant. Of course the thing we call mental illness has a biological basis. Everything you can experience or do is possible because of the biological structure and functioning of the brain. Realizing this truism only points out that we are biological organisms that remain alive and function through our body's ongoing biological processes.

4. "Research has shown mental illness has a genetic component. This is evidence that it is a real illness."

This misunderstanding is related to the previous one. It is recognized that the thing we call mental illness may have a genetic component, even though there is controversy over just how much is genetically determined. This does not mean, however, that there is a schizophrenia or bipolar gene, or that the conditions are caused by damaged or mutated genes. Besides, there are a number of genetically determined human characteristics that are not considered illnesses.

5. "The fact that symptoms are successfully reduced with psychiatric drugs is evidence that mental illnesses are real diseases caused by chemical defects of the brain."

True, there are isolated anecdotal cases where these drugs seem to work. But these drugs do nothing more than suppress or excite emotions, thoughts, and behaviors. So if the symptoms are defined as emotions, thoughts, and behaviors (which they are), then by definition the drugs reduce the symptoms. But this is meaningless in terms of curing true illness. Further, the placebo effect has been shown to have a much greater effect on one's sense of wellbeing than the chemical property of the drugs.

The mental illness industry was built without a firm foundation. The only thing that gives it the impression of a real medical science is the smoke and mirrors of language. It is our job to point out this deception and bring humanity back to human living.

a certain slant of light

makes brightness and shadow

throughout all of one's life.

how to grieve for yourself

each person must ask him/herself

and mix the ingredients and seasonings very carefully.

Robert Sliclen

Editors note: The following article was included in the previous issue but incorrectly attributed to Chuck Ruby. We are reprinting in this issue with the correct author; Joe Tarantolo, with our sincere apologies.

Primum Non Nocere

THE MIND IS A TERRIBLE THING TO WASTE

Joseph Tarantolo, M.D.

Confusion!
Unfortunate setback!

I am referring to the presidential edict known as the Decade of the Brain, signed by President George H.W. Bush in 1990. It was supposed to celebrate our great scientific/ neurological knowledge and promote research that was destined to bring quick relief to mental woes through biological and physiological manipulation. It hasn't! Instead, as a result of this scientific-political juggernaut, the coffers of the pharmaceutical industry have been filled and we now have a culture of foolish scientism entrapping millions of children and 10's of millions of adults on the pharmaceutical carousel for their problems of living.

I use the term "entrap" advisedly. Is that fair? Let me explain. I have assisted 100s of patients with being weaned off of psychotropic drugs. By the time they get to me they have begun to suspect that drugging themselves out of their problems is ill advised. I always ask: "Well, you know you had problems that had to be dealt with, so why did you fall for it, why did you take drug after drug, one on top of the other?" (Most are stuck on 4-5 drugs.) The answer usually has the following components: (a) An expert told me to do it, experts should know the right thing to do; (b) I liked the idea of simply fixing myself; (c) I was insecure; (4) I thought there was something wrong with my brain! These components create a potent situation for entrapment; as my colleague Grace Jackson says, " A Perfect Crime."

Central to this sad state of affairs is the confusion between "Brain" and "Mind". It is easy to define and characterize the brain, a corporeal substance: It weighs 2 ½- 3 lbs, it is organized around distinct areas such as Parietal, Frontal, Temporal cortices; it is made up of a panoply of fatty substances; there are pathways and neurotransmitters and we can even watch-grossly-how it operates with such primitive tools as functional MRIs. Ahhh, but the Mind -- that's a different story.

Marilynne Robinson, a world class novelist (see her award winning "Gilead" and "Home") and student of philosophy and religion, in her turgid dissertation, " Absence of Mind" speaks out against "the polemic against the Mind" (p. 74). She is a critic of the rationalists and materialists such as Freud who make no room for metaphysics and religious faith. Another brilliant critic, Hannah Arendt, supports Robinson's view. Arendt was the controversial author of "The Banality of Evil" about the trial of Holocaust organizer, Rudolf Eichman. She labels two functions of the mind. The first is, of course, to comprehend. Even our biologist brothers would agree with that. But the second is more mysterious: to wonder. That is the miracle of the mind. And it is the importance of this capacity to wonder that gets lost in the unenlightened view of biological determinism. An example: Rita Carter, a medical journalist clearly in the camp of unenlightened biological psychiatry, states in her mixed up titled book "Mapping of the Mind" that "emotions are generated in the limbic system"(p 15). Really? What a peculiar observation! So the weeping at a friend's funeral or the anger of an adoles-

cent who becomes violent after a childhood of deprivation and neglect, these emotions were generated by the limbic system? A truly funny way to understand life. Wouldn't it make more sense to say that what "generated" the emotions was grieving and longing for help and sustenance? Indeed things do happen in our limbic system (and our cardiovascular system, and our gastrointestinal system, etc.) when life happens. It is life that "generates" and we react to what gets generated. As the late Thomas Szasz said: "Machines function, animals behave, humans act." (I recently told a therapy group in my practice that they were " high functioning" and that was not a compliment.) Szasz simplified the notion of mind: it is our internal conversation. I call it our interior dialog. In mental illness it is this dialog that gets damaged early in life and then re-damaged later in life; it is this damaged mind that wreaks havoc on our interpersonal life.

With the help of my colleague Ann Louise Silver, a psychiatrist and psychoanalyst who eschews the out-of-control use of psychotropics by our profession, I recently started a discussion group at the Washington School of Psychiatry (WSP) entitled: "Treating Psychosis Without Neuroleptics." Harry Stack Sullivan founded the WSP in 1939 to escape the New York/European orthodoxy of psychoanalysis and to establish a school that welcomed the input of all the social sciences. This school was the first of its kind, promoting the idea of Interpersonal Psychiatry, exploring all social forces that damage or support it.

One of the readings suggested by Ann Louise was a 1959 article out of the now defunct Chestnut Lodge in Maryland published in "Psychiatry, Journal for the Study of Interpersonal Processes." The title is "Loneliness" written by the brilliant Frieda Fromm Reichman. (The psychiatrist in "I Never Promised You a Rose Garden" was modeled after her.) Her dissertation using both literary and scientific writing touched me, both personally and clinically.

We humans all spend our lives contending with our need for connection. In Sullivanian terms, we do this to maintain "self-worth." Sensory deprivation, isolation, poverty, ostracism, social and familial disdain all set the stage for the derailment of basic cognitive functioning. This derailment leads to a profound collapse of emotional well being. Language for seeking succor is lost in convoluted-bizarre-disjointed-metaphorical speech. The schizophrenic loses his ability to wonder. It should be no surprise that in the psychotic state death and emotional isolation become virtually synonymous. "I am not going to let any one kill you, I will not abandon you, I am here for you." These are all necessary interventions with the mad patient. Remember, as Sullivan often reminds, the mentally ill person, the schizophrenic, the mad man is merely human. So the therapist must connect with his own terror of loneliness. And this is not a "Brain" problem but a human struggle.

THE MEMORY BOX

I still use
that deep blue
business card box.
The one you made
with the Venetian
hand dyed paper.

Nameless names
countless numbers
passed through
these odd years;
only you remain
constant and indelible
in my memory.

Remember
riding Big Sky
you, on gusty Bianca
I, on Rusty the nag?

Fishing for trout,
On shrinking sand bars,
Where the ancient Atlantic
sipped newly flowed streams.

Periwinkled shores
in Newfoundland--
giggles and guffaws
as fires sparked
warm moments
in the dark

I remember;
I remember you,
kimono clad,
in Kyoto.
you learned how
to use chopsticks
as an August Moon rose
to its magnificent fullness.

Dominick Riccio

ALL IN THE FAMILY

Lloyd Ross, Ph.D.

Lt. Col. Chuck Ruby, Ph.D., newly elected ISEPP Board Chairman, has been an active and dedicated member of ISEPP. Here is his story.

He was raised in the 1960s and 1970s in rural, blue collar western Pennsylvania. While going to school he worked pitching hay and as a truck driver. In May, 1978, Chuck received his college degree from Indiana University of Pennsylvania, majoring in criminology and psychology. He then decided to join the U.S. Air Force and started a career as an Air Force Officer. He served in the Philippines, Panama, and the U.S.

Chuck received a Master of Arts degree in Latin-American Studies at the University of Alabama in 1986 and a Master of Science degree in psychology at Florida State University in 1993. He completed his education in 1995 by receiving his Ph.D. in psychology from Florida State University.

During his stay in Florida, Chuck also worked at the Florida State University Psychology Clinic in Tallahassee as a trainee, conducting inpatient psychological assessments. Later, he did a residence in Clinical Psychology at Malcolm Grow USAF Medical Center on Andrews Air Force Base. There he provided psychological testing and psychotherapy to military members and their dependents, while receiving additional training in substance abuse, neuropsychology, and forensics, spending a year as chief resident.

Chuck later became an instructor at the USAF Special Investigator's Academy, at Andrews Air Force Base, Maryland. And was also part of the faculty of Malcolm Grow Medical Center Clinical Psychology Residency Program. He became a Clinical Professor for the Uniformed Services University of the Health Sciences, Department of Medical and Clinical Psychology, in Bethesda, Maryland.

Colonel Ruby worked at the Air Force Office of Special Investigations, providing command level psychological consultation in support of Air Force criminal, fraud, and counterintelligence investigations worldwide. He conducted fitness for duty and pre-employment evaluations of investigators. The Air Force Office of Special Investigations is the Air Force equivalent of NCIS, made popular by the TV show bearing its name. But please don't call Chuck "Gibbs." He's hears enough of that over the years and he is the real deal.

Chuck retired from the Air Force as a Lt. Colonel in 1999 after 20 years of service. He retired with three Meritorious Service Medals, three Air Force Commendation Medals, and both an Air Force Achievement Medal and the National Defense Medal.

Dr. Ruby was licensed as a psychologist in Maryland since 1997. In 1998, he began working as a psychologist, providing psychotherapy and other psychological services for residents of the surrounding community at the Pinnacle Center for Mental Health and Human Relations in Waldorf, Maryland. He is currently the Director and General Manager of the Pinnacle Center, where he provides expertise and clinical management for a moderate sized group practice. He also worked for Psychology Consultants Associated in Tuckerville, Maryland, conducting fitness for duty examinations for the Maryland State Police and Department of Juvenile Justice employees. He has worked for the Center For Children in LaPlata, Maryland, conducting evaluations of juveniles charged with criminal offenses who were referred by the Department of Juvenile Justice.

Chuck is a Fellow in the Maryland Psychological Association and also a member of the Society For Humanistic Psychology (Division 32 of the APA.) He has consistently protested the APA's refusal to enforce the prohibition of its member's participation, under the Department of Defense, in torture. In fact, in 2012, Chuck resigned from the APA in protest of this issue. He is also a member of Psychologists For Social Responsibility.

Chuck started "Operation Speak Up" which, through his efforts, has

become an integral part of the ISEPP agenda. Operation Speak Up has fought against psychologist involvement in military interrogations. We have allied ourselves with The Coalition For an Ethical Psychology on this issue. Operation Speak Up has been instrumental in informing the nation and the media as well as Congress on the relationship between psychiatric drugs and soldier suicide. This movement has been led by Chuck with support from the rest of us.

Chuck and his wife Debbie live in Welcome, Maryland where he is an avid Boater. He has 6 adult children and 8 grandchildren as well as 3 dogs. How his boat got her name is both a funny story and a good representation of who this man is. When he and his wife Debbie first acquired the vessel in 2009, she was named "Venture One," which held no particular meaning for them. Everyone told them to just be patient and eventually she would earn a new name --- something would come to them. They were correct!

One afternoon they were coming into the marina after a day on the Potomac with their kids and grandkids and Chuck had his granddaughter next to him while piloting the boat back in. He brought the boat down off plane too late coming in, which basically causes an enormous wake as it displaces the water under the front 2/3 of the 42' boat! The boats on the docks were bouncing up and down with the waves and they damaged 3 swim platforms on large boats at one dock in particular! People were yelling at them from the docks. After he secured their boat in their slip, Chuck hurried to the dock where the boats were damaged and apologized profusely; assuring everyone that he would make sure any and all damages were repaired. He and another boater on the "waked" dock assessed the boat damage so Chuck could contact his boater's insurance to start the repair process. Chuck was so upset with what had happened that evening that he talked about selling the boat and leaving the marina in shame. Everyone felt so sad for him because he had grown to love boating so much!

Apparently the story spread all over the marina within hours! The next day, people in the marina whom they did not previously know, were coming up to Debbie telling her how "wonderful" her husband was and how "gracious" he was in his response to the damaged boats, along with "honest," and "a great guy with impeccable character". Another comment I heard many times from fellow boaters was "Anyone can make a mistake, it is how you handle it that counts!" (Chuck and Debbie were stunned that anyone would behave any differently when damaging someone else's property, but it appears that they do.) So, what Chuck thought would be a disaster and make everyone at the marina despise him, actually made him a local hero!

The damaged boats were quickly repaired by their insurance company and all was well. The following spring they had a boat naming ceremony (OK, a party) on the dock where the damage took place and appropriately named their boat "Wake Whisperer." She had found her name and Chuck found fame at the marina, not infamy!

Debbie went on to say that they have wonderful friends at the marina and in their boating life, and many of those friendships began with that incident!

Wake Whisperer is up for sale (interested?) right now, as they purchased another boat this year and named her FriendShip!

Our future as an organization depends upon the work and idealism of members like Chuck Ruby. This young man and others like him are vital to ISEPPs growth and development as an organization that makes a difference. We at ISEPP salute you Chuck and you also have out trust.

Primum Non Nocere

On & Off the Medication Carousel

Joseph Tarantolo, M.D.

The Power of Unwanted Drugging -- Is There Any Room for Compromise with Biological Psychiatry?

Biological psychiatry's certainty has been with us a long time. Some illustrations:

1 - "Mental illnesses are brain diseases." Thus proclaimed Willhelm Griesinger in 1845. Griesinger was a physician and humanistic reformer of the European asylum system.

2 - Eugen P. Bleuler, who in 1911 coined the term schizophrenia, told the Massachusetts Psychiatric Society at its 1929 meeting: "… the schizophrenic thinking seems to be of direct physical origins…"

3 - "Patients are victims of their brain rather than their mind," a view held by the psychiatry historians Richard Hunter and Ida Macalpine, 1974.

4 - Thomas Insel, the current director of the NIMH: "We can think of mental disorders not just as brain disorders but as disorders of brain circuits," and (paraphrase) the NIMH will spend billions of dollars to find out the causes of broken circuits in schizophrenia and other serious mental illnesses.

5 - E. Fuller Torrey in his 2013 screed against those of us concerned about forced drugging, "American Psychosis": " The freedom to be insane is a cruel hoax perpetrated on those who can't think clearly [whom we label schizophrenic] by those who refuse to think clearly [e.g., Dr. Tarantolo]"

The pharmaceutical industry has escalated this broad assault on the brains of the severely (and not so severely) mentally/emotionally/psychologically disturbed by promoting billions of dollars of drugs to activate, subdue, inactivate, deaden, and otherwise distort the normal brains of those with peculiar and disturbing mindsets and behavior.

Those of us who want to reform modern day psychiatry (Note: I am a reformer not an abolitionist such as Thomas Szasz. I am also a psychiatrist and although I am often embarrassed by the frequent inanities of my profession, I still believe there is potential for much good in the profession.) might try being kind and compassionate to the biological ringleaders. Dr. Torrey, for example, had to watch his schizophrenic sister slowly degenerate in institutions over some 50 years, a case evidently fitting Kraeplin's category of Dementia Praecox, i.e., those who never get well.

Dangerous patients shall not be discharged until they can demonstrate reasonable behavior without drugs.

We reformers, I think, can join the biological psychiatrists, join them in how we too do not know what "causes" schizophrenia. It will be a difficult club to maintain with both us interpersonalists led by the teachings of Harry Stack Sullivan and the neurobiologists led by Eugen Bleuer claiming to own the truth. For many of us perpetrators of the psychogenic view, we are not comfortable with the lectionary of psychiatric diagnoses. Our mantra is that madness has always been with us and we categorize it at risk of sounding stupid. But as I peruse the history of "madness" what strikes me over and over again, both in my clinical work and the descriptions of madness throughout the ages is that madnesses seem always to have one characteristic in common: rebellion!

The mad use language every which way disobeying laws of syntax and usual usage. They lie and otherwise corrupt the truth. They dismiss the practices of social discourse and cause others to suffer their gross hygiene. Their delusions are an assault on reason. They treat the usual probity of scheduling with disdain missing appointments at will, arriving when there are no appointments, demanding time that is not available. They are a mess and they create a mess.

Harold Searles in his mammoth analytic text, " Countertransference," slips in a profound snippet among his extensive philosophical, scientific, and psychological observations. The patient himself, he says, takes an <u>active</u> part in denying "reality." There is an exercise of Will there; it is not all predetermined. It is not enough to have a so-called schizophrenogenic mother, or abuse, or a family life filled with rage and incoherency. So many of us may have had these various familial constellations without coming unglued, sliding totally into a delusional life. As one of my "word salad" patients said in a moment of lucidity: " I don't want to grow up!" That's his choice!

Torrey mocks the placebo effect, " Do you really think persuasion is going to cure a brain disease?!" he taunts. Here he is picking a fight with the psychoanalytic industry that believes that "

the truth will set you free," the truth being the unconscious. Without making a case for psychoanalytic therapy or the various "supportive" therapies that indeed use much persuasion, I wish only to point out that Dr. Kraeplin was not correct. There are delusional people, the "mad", usually young ones, who get better. I'll site an older study examining the role of neuroleptics in the treatment of schizophrenia for some hints about this issue.

R. F. Prien, et al., published a very ambitious study in 1969 involving 7 different psychiatric hospitals (Brit J Psychiatry, vol 115:679-686 "Relapse in Chronic Schizophrenia following Abrupt Withdrawal of Tranquilizing Medication.") Note: Neuroleptics were often referred to as Major Tranquilizers or ataractics. In the 60's there was still a modicum of scientific curiosity about what to do with these dangerous drugs. In the introduction the authors acknowledged the dangers of prolonged use. Little did they know that soon "Atypicals" would usher in even worse life-endangering practices. Their review of the impact of "drug withdrawal" indicated that, well, the impact of drug withdrawal was all over the map. Relapse was cited anywhere from 13% to 74%. No one knew what the optimal dosage was. We still don't. No one understood the profound withdrawal phenomenon. We still don't. No one knew how to determine who should be off or on the drugs. The American Psychiatric Association had not yet published their Task Force concerning the dangers of Tardive Dyskinesia.

Into this fray the researchers got over 800 patients from 7 different psychiatric hospitals, mean age 41, length of hospitalization ranged from 2 to 34 years with a mean length of hospitalization of 14.5 years, who were randomly assigned to one of 4 groups: (1) high dose 2,000 mg chlorpromazine, (2) low dose 300 mg chlorpromazine (3) placebo and (4) physician's choice. The study lasted 24 weeks.
The results, again, were all over the map. At one hospital, (they did not identify the hospitals in that Table even though they named them in the Methods section) hospital G, 72% of participants did not relapse off the drug, while at hospital A, only 12% did not deteriorate off the drug. Overall, combining the data from the 7 hospitals, 40% of the placebo group relapsed, 13% of the low dosage group relapsed, and 6% of the high dosage group. No statistical difference between high and low dosage. There was a significant difference between placebo and both drug groups. There was another group of 18 patients who were not medicated at the start of the study. Only 1 of them relapsed.

Some observations: First, one criterion for entry into the study was "No evidence of organic brain disease…" Now biological psychiatrists believe that schizophrenia is a brain disease. So, by their reckoning schizophrenics cannot be included in their own study. Second, 60% of the drugged patients, at least for 24 weeks, did not relapse. And this was with abrupt withdrawal. And who knows what the milieu was like in each of these hospitals. This is important because so many people are told they must take their drug for the rest of their life. Third, these were chronic patients, with at least 2 years of hospitalization. I would bet even a larger percentage of newly diagnosed madness would not relapse without being drugged. Fourth, we are not told any details about the 18 who were not drugged at the beginning of the study. Did they refuse medication? Did they have enlightened doctors? Fifth, to their credit, the authors conclude "… a large proportion of patients receiving tranquilizing medication at low relapse hospitals were really in no need of ataractic [i.e., neuroleptic] drugs.'

Even though I would prefer to rid us of neuroleptic drugs completely, I would like to consider some compromises with my drugging biological psychiatrists:

A. No one with the diagnosis of schizophrenia be given neuroleptic drugs against their will. Forced drugging creates a hostile environment that potentially scares off those needing help and wanting help.

B. For the 1st psychotic event, the 1st hospitalization, a period of up to a year be given for the patient to reconstitute in a safe, supportive milieu. A year represents one full cycle of life, enough time, hopefully, for the patient to come to grips with his rebellion. If there is no substantial improvement, a neuroleptic drug may be offered. If the patient improves on the drug, dosage be monitored with attempts to lower dosage or discontinue the drug every 6 months. By the way, the last statement is actually the APA "standard of care," so often ignored by institutional psychiatrists.

C. For those who are hospitalized by the court because of dangerous, threatening behavior, and are drugged: they will not be discharged until they can demonstrate reasonable, rational, non-dangerous behavior without drugs. I think this is the most controversial of my suggestions. But public safety is important. It is foolhardy to depend on drugs with idiosyncratic effects which most people find unpleasant. Finally, if it were up to me, I would eliminate the broad category of "not guilty by reason of insanity." People who break the law and are convicted should be held accountable. Having said that, compassion and treatment should be made available for convicted felons who are mad as a matter of moral obligation.

Some reading:

Harold Searles, Countertransference.

H. S. Sullivan, 1927-28, Amer. J. Psychiatry, 84:105, "The Onset of Schizophrenia"

Eugene P. Bleuler, 1930 Amer. - Psychiatry, Vol X p203-211

Roy Porter, Madness: A Brief History.

Gary Greenberg, Book of Woe, 2013

C.B. Dunlap, 1924 in Amer. J. Psychiatry, Vol 3, p403-421. "Dementia Praecox. Some preliminary Observations on Brains from Carefully Selected Cases and A Consideration of Certain Sources of Error."(Note: The author found "no gross [or histologic] changes of pathological significance in the dementia praecox group which could be considered as proof of the organic nature of the disease." SULLIVAN CITED THIS STUDY. BLEULER IGNORED IT!)

Task Force Report 18, Tardive Dyskinesia, Amer. Psychiatric Association, 1979

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THE CONCEPT OF MENTAL ILLNESS

WHY I DON'T BELIEVE THEY ARE BRAIN DISEASES AND WHY PSYCHIATRISTS DO

Ron Leifer, M.D.

This essay is repetitious, but repetition is necessary in order to "get it".

The concept of mental illness is a logical, social and economic disaster that is costing the American people millions of dollars a year in a futile search for the causes of it in the brain. Philosophers could do a great, practical service, saving us millions of dollars a year, by deconstructing this concept.

In his now infamous but classic book, The Myth of Mental Illness, Thomas Szasz tried to do this. After Szasz died, Charles Krauthammer, the Fox commentator, called Szasz "an author that everyone knows but no one has read." Perhaps it is time to consider Szasz' s ideas again. I knew Szasz well - we were friends for more than fifty years. By "myth" Szasz meant what Gilbert Ryle meant in The Concept of Mind, namely that a myth is not a fairy tale, it is a category error. It is a metaphor, like "spring fever" and "heartbreak" that use words that belong to the category of body to refer to a mental state. In The Concept of Mind, Ryle criticizes Descartes for asserting that reason and emotion are always separate. That reason and emotion can occur together is confirmed by ordinary language where we can ask "What is your anxiety about?" or "Why are you depressed?" but it makes no sense to ask " What is your diabetes about?" or "What is your cancer about?" He also criticizes Descartes' notion of "res cogitans" on the grounds that while we can directly observe or introspect our own minds, we cannot directly observe the minds of others and have no solid ground that they have minds like we do. Rather, he says, we make inferences about the minds of others based on their words and actions. Therefore, res cogitans is a category error because it uses mind to refer to speech and action. Ryle gives an example of a category error: a man comes asking to see the university. So I show him the classrooms, the administration buildings, the library and the sports fields and he says "Thank you very much but where is the university?" He didn't realize that university is a class name for what he has seen and not another member of the class.

An important comparison to psychiatry is when a young doctor comes to me asking to see schizophrenia. So, with proper permission I introduce him to a man who speaks in word salad, claims to be speaking to god, and suddenly takes off his clothes. I ask him "Why are you doing that?" He answers " God told me to." The young doctor says " Thank you very much but where is the schizophrenia?" and goes off to join a team researching the brain for the cause of schizophrenia, not realizing that schizophrenia is the class name for what he has seen and not another symptom of it and certainly not the cause of it. Indeed, where is the schizophrenia that psychiatrists have been looking for for decades without success? Psychiatrists commit a category error by assuming that schizophrenia is a process in the brain that causes those symptoms rather than the class name for them. They waste millions of dollars looking for the cause of a class name in the brain. How smart is that?

Despite its logical flaws, the concept of mental illness is socially useful. Sociologists of knowledge, such as Karl Mannheim, realize that knowledge and concepts are like commodities. Concepts that support powerful social interests are promoted and concepts that threaten or oppose those interests are repressed and censored. What social interests does the concept of mental illness support? First of all and obviously, it supports the definition of psychiatry as a medical specialty. In the 1960's many people questioned whether psychiatry is a medical discipline. All the other medical specialties focused on a part of the body: nephrology on the kidneys, cardiology on the heart, etc. The concept of mental illness creates the impression that the mind is the special organ of psychiatry. That the mind is a function of the brain is commonly assumed, so psychiatrists research the brain, seeking the causes of mental illness. This puts psychiatry in conflict with neurology and some have suggested that the two should be merged into a single discipline: neuropsychiatry. This creates a category error, however, since psychiatry is not about either the mind or the brain. It is about speech and behavior.

The second important institution that supports the concept of mental illness is the pharmaceutical industry. If mental illnesses are biochemical imbalances in the brain, it is believed that they can be "treated" with drugs. Abilify and Risperdal are two of the most commonly prescribed drugs and make the pharmaceutical industry millions of dollars in profit and a very powerful social interest group.

The third social interest group that supports the concept of mental illness is the most powerful of all and buttresses the other two. The third interest group is the general public. To understand this and how it came to be, it is necessary to make a diversion to the history of the rule of law. The rule of

law was instituted in the latter eighteenth century in the French and American revolutions. These were revolutions against the absolute power of the tyrant kings who could resist the attempts of any one to deviate from their royal edicts by simple writ of capture (letters de cachet). The rule of law provided that before a person could be deprived of life or liberty it must be proven in a court of law governed by rules of evidence that the accused had violated the law. The problem with the rule of law is that it does not offer sufficient protection from persons who deviate from common rules of conduct and speech. It does not protect people who talk in word salad or who believe they are receiving orders from God. Since psychiatry deals with speech and conduct, it is the perfect agency to provide a supplementary and covert form of social control disguised as medical diagnosis and treatment, including involuntary confinement. The general public now relies on psychiatry for protection against mass murderers and suicidal terrorists. Some have suggested that vulnerable populations should be subjected to preventive screening, which reintroduces the evils *that* rule of law was designed to eliminate, namely, writs of capture, now called warrants for psychiatric commitment. What should be done to correct this situation? I do not advocate the abolition of involuntary commitment. The public demand for it is too great to resist. I advocate that, if my reasoning is accepted, psychiatric diagnosis and involuntary commitment should be recognized as social control rather than medical procedures so that more protections against abuse can be implemented and our false image of ourselves as a society ruled by law can be corrected.

We should remember that years ago, slaves who tried to escape were diagnosed as suffering from a mental illness called "drapetomania". When the Soviet Union existed people who criticized it were diagnosed with "sluggish schizophrenia" on the grounds that anyone who opposed such a perfect utopia must be mentally ill. Psychiatric confinement was also used in this country to control people who protested for civil rights. Some have called communism " the slowest path to capitalism". By the same token, coercive psychiatry may be the slowest path to totalitarianism. .For example, explaining why a man crossed the street by saying he was hungry is meaningless because being hungry, by itself, is not an intelligible reason for crossing the street. Saying he was hungry and was headed for the restaurant across the street is explanatory and intelligible. By the same reasoning, to say that the Newton School shooter's actions were caused by mental illness or psychiatric drugs is meaningless, but to explain it as possibly motivated by the desire for revenge or the desire to feel his power over others is culturally intelligible.

A. R. Louch maintains, with careful and close reasoning, that scientific explanation of human action are untenable. Biological psychiatry's attempts to explain behavior they name and classify as mental disease as caused by brain processes is meaningless. The term "mental illness" is meaningful only in terms of the purposes for which it is used. The term "mental illness " is a performatory act that justifies drugging people and depriving them of freedom or excusing them of responsibility for a criminal act (the insanity defense). As postmodern critical theory alleges, the use of causal explanations for human action disguises and justifies psychiatric oppression. C. S. Lewis said “Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive.”

Explaining human behavior as caused by the brain negates moral explanations and judgments of human action since an action can only be judged as criminal if there is *mens rea*, that is, criminal intent. Where there is no intent, there is no responsibility. If an act was caused it cannot have been intended. From the foregoing, it follows that the rebirth of mind in psychiatry and psychology is not so much a matter of abandoning neuroscience as it is of switching the official language from cause and effect to meaning and purpose; that is, switching explanatory language from cause and effect to meaningful motive and purpose. The language of mind is meaning and purpose not cause and effect. This means that psychiatry must stop diagnosing people and looking for causes in the brain and start to try to understand them. To claim that an act was caused by mental illness does not explain it; it just changes the identity of the actor for social purposes

The explanations we choose to explain human behavior will determine where we look. If we choose the language of cause and effect, it will lead us to look at the brain. If we choose the language of cause and effect because it seems more scientific because it resembles the physical sciences, mind disappears. If we choose the language of purpose and meaning, mind is reborn and the humanities become relevant. Who controls the use of language in psychiatry will determine whether mind and the humanities are relevant or irrelevant.

The question is not “Which language is correct?” The question is the social and political question “Who controls the language?” The answer to this question cannot be understood in the language of cause and effect, but only in the language of social purpose and meaning. Psychiatrists choose the language of cause and effect because it makes them look like scientists and medical doctors and it disguises their social function as agents of social control..

Nursery Rhymes, Fairy Tales, & Psychiatric Research

Lloyd Ross, Ph.D.

This is a new column that is being introduced to the ISEPP Bulletin directed at the children of the world in order to help them to truly understand the fundamentals of modern psychiatric research. The first is the classic piece which explains the very beginnings of psychiatric research. The names have been modified significantly to prevent cursing and swearing as well as to protect the guilty. Any names similar to those of anyone, living or dead is purely coincidental and unintended. After all, this is intended to be a teaching aid for children.

THE FROG AT THE FOUNDATION OF BIOPSYCHIATRIC RESEARCH:

AN HISTORICALLY VERIFIED ACCOUNT

Once upon a time, it was a purely coincidental event, … some might call it fate, that during the second quarter of the 20th century 9 young boys and one young girl all were growing up on the same block in the same city very near the sacred halls of Pupa University Psychiatric Institute. Their names were Edgar Sourette, Peter Krapp, Alan Zorba, Stanley Krapola, Pedro Jerkson, Xavier Crotch, B.J. Barfly, James Swisher, and Marvin Flunk, and the one young girl, Judith Rat.. The kids were all friends and so were their families. Their fathers all shared a common goal of making sure that their children had a scientifically oriented thought process.

One summer day, the fathers of these young children devised a way to interest them in learning about the scientific method. They presented the children with a large bull frog and told them to do a scientific study with it and record the results. This was very exciting to the children who never did something like this in so independent a manner. The kids got together and planned an experiment carefully. They drew a starting line in the back yard and placed the bull frog on the line. Little Alan and little Peter Krapp then poked it with a stick and yelled as loudly as they could: "Jump!"

The frog leaped in the air and landed and the children measured the distance from the starting line. It was exactly 11 feet, 3 ½ inches. The children carefully recorded their results in a notebook. Little Edgar had volunteered to do the amputations along with Max, and little Judy Rat kept the notes. Stanley and young B.J. Barfly were responsible for the measurements.

For the second part of the experiment, Marvin and Edgar cut one front leg off the frog and repeated their first trial. They placed the frog on the starting line and Pedro poked it with a stick and loudly yelled: "Jump!" The frog leaped into the air but this time only jumped 9 feet, 10 ¼ inches from the starting line. Again, they carefully recorded all the data in a notebook.

Now they cut the other front leg off the frog, placed him on the starting line, poked it with the stick, and loudly yelled: "Jump!" The frog jumped into the air and landed exactly 7 feet, 5 ¾ inches from the starting line. This measurement also, Judy duly recorded in their

notebook. Young Edgar and Marvin, who seemed to enjoy the experiment the most, now cut one of the rear legs from the frog. They placed the frog on the starting line and little Xavier poked the bull frog with the stick, with all of them loudly yelling: "Jump!" This time, with three legs missing, the bull frog only jumped 1 foot and 1 inch. The kids duly recorded the measurement and little Judy wrote it into the notebook.

Finally, Edgar and Marvin joyfully cut the last leg off the bull frog. They placed the frog on the starting line, Stanley and James poked it with a stick, and loudly yelled: "Jump!" This time nothing happened. The bull frog did not move. Again, this information was duly recorded in the notebook by little Judy.

The children now went into the house, sat around the dining room table and studied and debated their findings for hours. Finally, they reached a consensus conclusion:

"WHEN YOU CUT THE LEGS OFF A BULL FROG IT GOES DEAF"

And that, children, was the very beginnings of bio-psychiatric research.

I hope that you children enjoyed the story. I have one additional thought, however. Successful scientists must survive the experience of rejection if they are eventually to be successful. Very few successful people start out successful. Theodore Geisel (Dr. Seuss) took his first book to 20 publishers before the 21st accepted it. Inventor Thomas Edison often made as many as 50,000 trials before coming up with a workable product. 50 gazillion, is about how many trials the drug companies have to do when testing new psychiatric drugs, before being able to achieve three successful trials, enough for the Food & Drug Administration to approve the drug for marketing to the public.

I hope you enjoyed this historically accurate children's story. We will be back in the next edition of the Bulletin with another chapter of "NURSERY RHYMES, FAIRY TALES, & PSYCHIATRIC RESEARCH."

P.S. If any of you out there have an interesting story for this column, please submit it to me, Lloyd Ross, at dr.lloydross@gmail.com. We reserve the right to edit what you write to camouflage the guilty parties so that they don't sue us.

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