

ICSPP Newsletter

International Center for the Study of Psychiatry and Psychology, Inc.

"The Conscience of Psychiatry"

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In This Issue:

Conference Debrief
ICSPP and Universal Screening
Psychiatric Rights on Trial
An Early Intervention Saga
Kevin McCready Memorial
Research Grant
Truth on the Air
Freedom Center-Massachusetts
ADHD in Mexico
"My Big Fat Drug Rep Dinner"
Frankly Quoting

And, Since Nobody Complained,
More *Northeast Times*

**Also Read the ICSPP
Journal: *Ethical Human
Psychology and Psychiatry***

**Editor:
Andrew Crosby, MA**

Ninth Annual ICSPP Conference Scores High From the Editor

By all accounts, the ninth annual ICSPP conference, held this past October in Bethesda, Maryland, was a success. Many thanks have already circulated, so let it simply be said that the co-chairs, presenters, conference committee, and attendees all cooperated to make the event informative, inspirational, and memorable.

We can all take a bow.

There are many reasons Bethesda 2006 was a hit. Delores Jankovich provides a thorough summary, along with her take on the experience, inside. I'll mention but a few representative items here.

The Law was on Our Side

The Legal Plenary Panel, chaired by Peter Breggin, gave tremendous behind-the-scenes examples of what drug companies do, conceal, and how they operate until and when they are formally challenged. We learned of the legal machinations of discovery, preemption, and the dirty tricks played with research methodology, data collection and interpretation. And we learned what happens when unfavorable, even tragic, results occur.

We have read about all this, in Peter's books and other sources. But having a string of trial lawyers, many of whom Peter has worked with, tell their stories and express their amazement and disgust provided depth.

The incidental banter between Peter and the panel members between presentations also provided a sense of

continuity and community. Yes, ladies and gentlemen, it turns out we associate with trial lawyers. They are hard-working and passionate, just like us. They're even funny sometimes.

Stefan Kruszewski's account of his experiences at Pennsylvania's Department of Public Welfare was also touching and disturbing. A psychiatrist, Kruszewski's role was to investigate child deaths in state facilities.

Lloyd Ross appropriately invoked Dante for Kruszewski's introduction. Dante's warning about what awaits those who fail to act when action is paramount is well heeded. Kruszewski acted. And so must we.

Then there was Karen Effrem's detailing of the insidious development and evolution of child mental health screening and Joseph Glenmullen's discussion of the politics of SSRI adverse effects and the FDA. Did I mention Grace Jackson? She informed us how little the courts know while being forced to render decisions even so.

I could go on, but Delores already did. Please read what she has to say.

ICSPP Finds a Theme

Perhaps most crucial, ICSPP found a theme at this conference. We've always had a theme, of course, but it has been broad and difficult to act upon as a group. Matters were refined at this year's Board of Directors meeting, however.

Thanks largely to the influence and

(Continued on page 3)

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About the International Center for the Study of Psychiatry and Psychology: The International Center for the Study of Psychiatry and Psychology (ICSPP) 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 ICSPP has been informing the professionals, the media, and the public, about the potential dangers of drugs, electroshock, psychosurgery, and the biological theories of psychiatry.

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

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

Updates from Newsletter Headquarters

Many thanks to all who have offered kind words about the newsletter since my tenure began. Your feedback suggests the newsletter is accomplishing it's goals. I won't bore you with discussion of these; suffice to say that we are on the right track. That's good news for ICSPP.

You may have noticed some refinements with this issue. For these we thank the good people at **Leesburg Printing** of Leesburg, Florida. They have generously provided us with a new publishing program, hence our latest face-lift. Pleasure doing business with you, Leesburg.

Finally, on behalf of the entire staff at Newsletter Headquarters I am pleased to announce that we have an addition: **Delores Jankovich, MA, MSW**. Delores is a long time Advisory Board member, regular conference participant, and contributor to this issue. With this development, our "entire staff" doubles.

Welcome, Delores. We are happy to have you aboard and will promptly put you to work on the next issue.

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 ICSPP'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.

(Continued from Page 1)

efforts of Dr. Effrem, ICSPP is devoting the year between Bethesda 2006 and DC Area 2007 to educating and informing the public about Universal Child Mental Health Screening. ICSPP will act on this throughout the year (we've already started) and next year's conference will be devoted to this cause.

This theme was hardly picked out of a hat. It was chosen because Universal Screening, in all its varied forms, is the greatest threat facing our children and their miss- or uninformed families.

Think this is abstract? Think again. It's real and it's happening. Lloyd Ross, National Executive Director, gives us the details inside and calls on us to (sound familiar?) act. Lloyd tells us as to how to proceed. So, let's proceed. Let's act.

If Lloyd's work doesn't grab you, consider the story of the Gamondes family. They share an adventure with their local Early Intervention Program that illustrates one way universal screening has snuck up on us. You'll find it starting on page 27, after Dr. Effrem's lead-in article.

Please trust that neither this family's story nor ICSPP's new theme is an indictment of Early Intervention or any sincere attempt to help children or families where real challenges exist.

Rather they are calls for ethical practice, informed consent, and respect for the rights of families and individuals to exercise self-determination.

Now, that's a theme.

Heck of a year coming up, ladies and gentlemen.

A Note From the Membership Director

Robert Sliclen, Ph.D.

As part of our upcoming membership renewal campaign, I'd like to ask all of our members to consider whom they know who might be interested in supporting the work of ICSPP. The person can be a personal friend or a professional colleague. Please email their name and address to me and we'll send out the next one or two newsletters to them to make them aware of our organization and to whet their appetite to join. Please email the person's information to sliclen@optonline.net.

[Editor's Note: Robert is also our photographer. Most of the time. While unable to wield his camera for the photos in this issue, he did do touch ups so his amateur stand-in would suffer minimal embarrassment. Thanks as always, Robert]

IMPORTANT HIGHLIGHTS OF THE 2006 ICSPP CONFERENCE

By Delores Jankovich, MA, MSW

Every year I think "This is the best conference yet." And then it does seem to get better! It was particularly helpful and inspiring to focus on both the law and mental health. As we all know, if we are to end coercive mental health treatment, it will have to be through the collaborative effort of both the law and mental health. I have a favorite quote on my wall regarding social justice, and I am sorry but I cannot provide the source of the quote. However, I thought it appropriate to include the quote since it applies to how I have begun to think in regard to social justice:

"The greatest threat to civilization is not poverty or ignorance. It is injustice. That's what denies basic humanity the most. That's the first thing a civilized society needs to spend its energies on fighting injustice. Everything else falls into place when that's taken care of."

It was celebratory to hear about **Jim Gottstein** winning in the Myers case in Alaska. It is my understanding then that currently the courts cannot do a legal commitment if there is a less restrictive alternative available regardless of whether there is funding for the alternative. Jim mentioned "three synergies for change:" Public attitudes, alternatives and honoring legal rights.

As a factual matter, it cannot be shown that these drugs are in the person's best interest, and coercion impedes alternatives. Less than ten percent of involuntary commitments meet legal standards. Psych Rights will focus on providing effective public legal representation in order to further eliminate coercive treatment. Jim is moving forward with his commitment to justice with Psych Rights, Soteria-Alaska and Choices, Inc. The reference provided for Choices, Inc., was Chapter 9 in Loren Mosher's book.

Jim noted that public education has moved forward with Robert Whitaker's work, "Mad in America," and Michael Perlin's work in international human rights and disability law. We need to continue to move this forward also at the community and individual level.

Robert Dinerstein's presentation on Human Rights and People with Mental Health Disabilities and the Issue of Capacity emphasized the broad understanding of choice for an individual with a disability. The old concept of a guardian as someone who manages one's life is hopefully beginning to disappear. The guardian or power of attorney acts in the person's best interests and KNOWS and FOLLOWS the person's values. Each person needs to have an advanced directive, and there needs to be a shift in assisting others, to interdependence and support for the individual. When someone can no longer make definitive choices in his or her life then he or she needs to be able to choose who will make those choices for him or her.

Graham Duke's presentation on The Law and Psychiatric Drugs was an inspiring talk regarding his remarkable career ad-

dressings international and drug policies.

Stefan Kruszewski spoke of his work in the Department of Public Welfare, Bureau of Program Integrity, Commonwealth of Pennsylvania where he worked as a psychiatric consultant. He made the courageous decision to become a whistleblower after discovering numerous abuses and deaths of both adults and children. He now has his own private practice. Dr Kruszewski's presentation was filled with important subject matter, however, three salient points need to be consistently recalled: 1) Pharmaceuticals have been misrepresented; 2) Misrepresentation of psychotropics have resulted in tremendous abuse and mortality; 3) People who have misrepresented drugs need to be taken to task.

Michael Perlin spoke on International Human Rights and Disability Law and the Universal Factors. It is important to note that he is the creator of the Online Mental Disability Law Program and the Director of the International Mental Disability Law Reform Project, Justice Action Center. He has written a casebook on American and International Disability Law. Mental Disability Law tracks incarceration of mental health patients. All states use appointed counsel as even non-profit attorneys will not take such cases. Michael has worked in 13 nations and overall the violations world-wide are reflective of the conditions in the hospitals of the '70's. He reports that there is corruption of "sanism" in every country. He remarked that a holocaust survivor called on American hospital "Dachau without an oven." Ongoing suffering is apparent from the individual through the community, state, national, and international level!

Dr. Karen Effrem gave a comprehensive and sobering presentation regarding the Origin and Dangers of Child Mental Health Screening. Her research has confirmed the fact that this screening is universal involving all state and federal agencies. Further, those agencies that have conducted current screenings have resulted in very high false positives with many more being referred for treatment than are in need of treatment. Most agencies are assuming passive parental consent unless the parents object. Dr. Effrem reported the fact that two million children are now on antipsychotic drugs. She further emphasized the need for ICSP members to actively intervene in stopping this screening process.

Susan Stefan presented on the Evolving Legal Views of Psychiatric Evidence. She confirmed that expert testimony that is helpful for psychiatric disabilities is now being excluded. The following are some of the points of particular note: 1) The time is right to challenge prediction of dangerousness. 2) Unstructured interviews that predict dangerousness should not be permitted. 3) Structured interviews and statistical proof should be utilized in addressing dangerousness. One important reference she mentioned was the book, "Proving the Unprovable" by Crystal Logan.

Chair **Peter Breggin** and the Legal Panel of **Andy Vickery, Don Farber, Michael Mosher, and Derek Bratslow** reported on the ground breaking work they are doing in both civil and criminal liability cases involving prescription drugs. Dr Breggin spoke of his plan to write up 35 cases in his

new book which will address the spellbinding theory of psychiatric medication. This theory addresses the phenomenon of intoxicative anosognosia. It was inspiring and reassuring that there are such individuals as Dr. Breggin and this Panel, who are addressing the issues of harm to individuals and families which can evolve from prescription drug use.

Grace Jackson warned us to Beware the Dangers of the Incompetent State. The state is ignorant of the crises in risk assessment and there are systematic errors in how risk assessment is done. The illusion of safety of psychotropic drugs is due to manipulation and concealment of data. The concealment of data involves non disclosure, ghost writing and bad bias (including or excluding certain information). The FDA never investigates neurotoxicity. The state does not understand why drugs are toxic and is ignorant of the crisis in risk assessment. It is also ignorant of many lines of evidence demonstrating drug-related harm. The state needs to: 1) evidence a choice - understand that there is a right to refuse treatment 2) understand the diagnosis and treatment 3) rationally evaluate information, and appreciate the facts of a particular situation - insight into risks and benefits. The state is not competent in assessing competency of patients.

Peter Breggin spoke on Medication Spellbinding which is the basic underlying response to brain damage. It is psychological and organic. All psychoactive drugs mask the adverse effects. If the patient sees a change in him/herself he or she does not relate it to the drug. Very often people on drugs think they are doing better than ever, and they attribute it to the drugs. Physicians should be concerned if someone thinks he or she is doing well on a drug. Addiction and mania are phenomena of spellbinding. It is a myth that "all medications are poison - the idea is to balance poisons." This concept applies only to physical disease. Dr. Breggin noted that, "The capacity to love is the first thing to go when on neuroleptics."

Dr. Joseph Glenmullen presented on "SSRIs, Akathisia, and Suicidality: The History of the FDA's 2005 Black Box Warning on Antidepressant-Induced Suicidality." He noted that there was more publicity in 1990 about aggressive actions or suicidality/homicidality than in 2004. One of the core statements made by Dr. Glenmullen was the fact akathisia rather than depression is causing suicidality in patients.

Dr. Thomas Bratter discussed: When Psychotherapy Becomes a War: Working with Gifted, Alienated, Angry Adolescents Who Engage in Self Destructive and Dangerous Behavior. Dr. Bratter gave a stimulating talk about his school which treats and teaches troubled young people from approximately age 20. Most of the students are successful, many going on to ivy league colleges. Dr. Bratter mentioned Patch Adams as one of his inspirations for teaching. Emphasis on psychotherapy is minimal, however, though the importance of relationships is emphasized.

Plenary discussion ended with **Dr. Grace Jackson's** breakout group which was filled with significant data that she provided regarding brain damage and neurotoxicity as a result of psychotropic drug use. It was very thought provoking and rewarding, providing information for us to consider as we go forward in our work.

I attended the paper presentation by **Lloyd Ross, Ph.D., Jeffrey Danco, Psy.D.,** and **Robert Slicen, Ph.D.** and found it very helpful in learning ways to protect the privacy of clients who want to receive psychotherapy without the use of drugs. The importance of this information cannot be overemphasized.

Susan Stefan's breakout session provided me with valuable information about how to confront local courts regarding ending outpatient commitment procedures. **Karl Humiston, M.D.** and **Michael Humiston, J.D.** presented insightful information regarding hidden agendas in governmental programs. Michael made the important remark, "All programs provided by the government are a type of policing." It is important that clients know the facts as, "what you don't believe you can't understand."

Last but not least, I would like to comment on **Dr. John Currie's** presentation on effective interventions for prepubescent boys labeled ADHD, ODD and/or Conduct Disorder. I found his comments on sensory stimulation of these children to be particularly interesting and hope to look further into sensory research. Dr. Currie provided a comprehensive bibliography which will prove helpful.

Due to my work in institutions and my experience with a family member receiving psychotropics, and my observations of the very severe adverse effects of the drugs, I continue to find exciting interest in the work of Peter Breggin, Grace Jackson, and Jim Gottstein. However, all the presentations met my needs, both personally and professionally.

I was particularly happy to see psychiatric survivors and consumers as well as some family members present at the conference. It was great to see survivors presenting and my hope is that we will continue to include the law and to include survivors and family members as presenters. It was very inspiring to see the courage of **Mathy Downing** who had lost her child to suicide, and the film director **Robert Manciero**, as they presented the film "Prescription: Suicide?" Also of special note is something to look forward to in **Dr. Toby Watson's** plans to open a group home for individuals who desire drug free treatment.

Words cannot fully express the appreciation I feel for all who put together and presented this conference. It was an invaluable learning experience in a setting filled with community.

IMPORTANT NOTIFICATION TO ICSPP MEMBERS

ICSPP is mobilizing a program throughout the United States to inform the public about Teen Screen and Universal Mental Health Screening, a NON-SCIENTIFIC screening that is NOW being implemented in at least 40 of the States.

The program is a blatant attempt by the pharmaceutical industry to multiply their markets for psychiatric drugs ten-fold over the next several years. It is also an organized attack upon privacy rights of families and a total wiping out of any informed consent.

We are asking ICSPP members throughout the country to volunteer to speak at their State Education Association Meetings, at State Parents-Teacher's Association meetings, at local Parents-Teachers groups, at Local Libraries, at Board of Education Meetings, and at other resources where the public can be informed. If you volunteer to help us organize this effort, we will supply written materials to you along with video's such as Dr. Karen Effrem's video to play for both small and large groups. These efforts by all of you throughout the country are vital if we are to make any impact at all upon what is about to take place, a virtual drugging of the population under the guise of preventing psychiatric illnesses in the future, even though these same drugs are both ineffective in curing anything, and cause extremely damaging and permanent side effects.

The therapists among this group will have an added bonus by becoming active in this program. I personally have found that whenever I speak before a group about this, I wind up generating referrals for myself. Hopefully, this will not be your sole purpose in joining us, but self-support is a reasonable bonus.

Please respond to this by sending me , at the email address below, your Name, Address, Phone number, and State or area you will attempt to cover. Either I, Dr. Riccio, Dr. Slicen, or another committee member will be in touch with you to help you to facilitate the campaign.

Remember, the Teen Screen program is already underway, is funded heavily by the federal government, and if we do nothing it will be in the schools in YOUR town shortly.

To all of you, thank you in advance for your help in this program.

Warmly,

Lloyd Ross
North American Director
ICSPP
LloydRoss1@worldnet.att.net

PARENTAL INFORMED CONSENT NOTIFICATION
(Produced by The International Center For The Study of Psychiatry & Psychology www.ICSP.org)

Date: _____

Dr./Mr./Ms. _____, Superintendent of Schools

Address: _____

City, State, Zip _____

RE: _____
(student Name)

Dear _____:

This is to inform you that under no circumstances is the school district, any school within the school district, or through any other means, to administer to my child _____ any survey, analysis, or evaluation for mental or psychological problems, pursuant to the 1998 Protection of Pupil Rights Amendment (PPRA), as amended by the 2003 No Child Left Behind Act (42 US 1232h(b)(2)), which specifically prohibits any such survey, analysis, or evaluation without my/our permission. In accordance with State statutes relating to parental involvement and consent, this letter serves to require prior written notification from the school as well as my written consent concerning any intent to provide mental health screening, social screening or counseling to my child. This restriction applies as well to all EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) services, which are typically provided via state funds. Compliance with this federal law is mandatory and expected.

I appreciate the school's position in these matters and it is regrettable that a notice of this nature is necessary. I /we thank you in advance for your cooperation and compliance with this lawful directive. For our mutual protection, a copy of this letter is on file with my attorney.

Sincerely,

(parent's signature)

(parent's signature)

(date)

cc:

(State Commissioner of Education)

(School Principal)

TEENSCREEN & UNIVERSAL MENTAL HEALTH SCREENING: ICSPP TASK FORCE TALKING POINTS (SUMMARIZED)

By Lloyd Ross, Ph.D., FACAPP., P.A.

What is TeenScreen?

TeenScreen is a 52 question computerized self-administered questionnaire that takes 10 minutes to complete and was developed by Columbia University Children's Psychiatric Center. It can also be completed with paper and pencil. The test supposedly identifies the warning signs of "mental illness" through the answers on these multiple choice questions. The questions are a checklist specifically geared to match criteria from the American Psychiatric Association's (APA) DSM IV. It supposedly identifies at least 6 mental disorders: Social Phobia; Panic Disorder; General Anxiety Disorder; Major Depression; Alcohol and Drug Abuse; and Suicidality. The questions on the test are "loaded." They are designed to plant the seeds of mental illness criteria and make an adolescent feel that normal, everyday feelings and thoughts are abnormal. For example: "In the past year, has there been any time when you weren't interested or involved with anything?"* (How many of you were interested for 365 days in a row?) "In the last year, has there been any situation when you had less energy than usual?" (Who can honestly answer no to that?) (The above questions are not taken from the TeenScreen test but are similar in nature so that copyright laws are not violated.)

How did TeenScreen develop?

President Bush established the **New Freedom Commission on Mental Health (NFC)** in April, 2002 to study and make recommendations regarding the mental health delivery system in the U.S. Many of the commission members were highly connected to the nation's largest drug companies. On July 26, 2004, he announced that the NFC recommended mental health screening of **every** American from "birth to old age" with particular emphasis upon children, adolescents, and school personnel. In other words, "**Universal Mental Health Screenings.**" These screenings would serve to identify people with symptoms and connect them to treatment programs. The NFC went on to recommend the **Texas Medication Algorithm Project (TMAP)** as the model for treatment. He also instructed more than 25 federal agencies to develop an implementation plan based upon those recommendations. TMAP is a pharmaceutical Industry driven treatment plan that **mandates** the use of specific brand name drugs, and since its

inception, has almost bankrupted the State of Texas and has eaten up both the Medicaid and Medicare budgets in that State.

When tested in controlled trials, these drugs were found not to work. Neither anti-depressants nor stimulants are effective in children. More than 2/3 of the studies of anti-depressants given to children showed that the medications were no more effective than a placebo (sugar pill.) Most of the positive results came from drug company sponsored trials. Psychostimulants have not produced long term changes in either social skills, academic skills, peer relationships, or school achievement levels. There is a vast body of studies that show the dangerous and deadly side effects of these biochemical interventions in **children** who do have emotional problems. In addition, due to very rapid developmental changes, it is difficult if not impossible to diagnose young children accurately. Often, signs and symptoms of mental disorders in adults are the characteristics of normal development in children and adolescents.

Does TeenScreen work?

The Center For The Prevention Of Suicide, Rochester, New York, released a study completed in 2006. They concluded that "Given the lack of an adequate evidence base regarding either the use of or the utility of screening programs for preventing suicides, suicide attempts, or factors associated with suicide risk, efforts to use such programs should be regarded as *investigational in nature*," (their emphasis). The U.S. Preventative Services Taskforce (USPSTF) states: "We found no evidence that screening for suicide risk reduces suicide attempts or mortality." The USPSTF found in a study that: "there is insufficient evidence that treatment of those at high risk reduces suicide attempts or mortality." In addition, in nearly every school shooting incident in the United States in the past 15 years, the children involved were already taking one or more psychiatric drugs, had the dose increased, or had just stopped them abruptly. The question now becomes: **Are these drugs creating cases of extreme violence and suicide?**

Is TeenScreen scientifically validated & effective at preventing suicide? (How effective is it as a diagnostic tool?)

TeenScreen's extremely high false positive rates makes the

test virtually useless as a diagnostic instrument. One study, completed by the creators of the test themselves, found an **82% false positive** rate, meaning that if 100 adolescents scored in the diagnosable range, 82 of them would be flagged as having some mental illness without having any real problems. A weegie board would only produce a 50% false positive result. Dr. David Shaffer, Chairman of Child & Adolescent Psychiatry at Columbia University, the man who developed TeenScreen, found in one study that of 1,729 New York City high school students who were screened, 475 students tested positive for depression and suicide. 262 of the 475 students who tested positive agreed to a follow-up. Of those, 203 had no evidence of depression and suicidality at follow-up, (77%).

Shafer also found that when students were retested, the positive predictive value of TeenScreen was 16%. That means that 84% of those designated by the test as mentally ill and were not would have been referred for treatment for every 16 suicidal youths correctly identified. This makes TeenScreen invalid for screening anything.

The test has no more scientific validity or ethical legitimacy than the mass screening for “mental defectives” during the eugenics movement 2 centuries ago in the U.S. That screening resulted in the sterilization of 72,000 Americans, among them children as young as 10 years old.

Is informed parental consent a component of the TeenScreen program?

The President’s Freedom Commission on Mental Health concocted a way around telling parents what they wanted to do with your child, probably because they knew that parents would object. So they created the concept of “**passive parental consent.**” In other words, if the parent is uninformed and does not send in an “opt-out” letter to the school, the school can assume that the parent “passively” gave consent for the screening.

The 1998 Protection of Pupil Rights Amendment (PPRA) as amended by the 2003 No Child Left Behind Act, states: “No student shall be required as part of any applicable program, to submit to a survey, analysis, or evaluation that reveals information concerning...mental or psychological problems of the student or the student’s family...without the **prior** consent of the student (if the student is an adult or emancipated minor,) or in the case of a non-emancipated minor, without the **prior** written consent of the parent.” Parents, therefore, have the right to refuse this test if any federal funds are involved, and they are.

The program tried to slip by with the passive consent scheme at first. However, after a lawsuit, they modified this stance and started to request active parental consent. However, this can change again at any time which is why ICSP is distributing “Parent **opt-out forms.**”

How extensive is TeenScreen? How many States are involved?

According to the Suicide Prevention Resource Center (SPRC), 41 states have plans in place and 35 of them will be using TeenScreen type surveys thus far. New York, Florida, Nebraska, New Mexico, Oregon, and Vermont are specifying TeenScreen by name. Within the year, all 50 states should have plans in place.

What other screening programs are in use?

Screening for Mental Health, Inc., has put out The Signs of Suicide Prevention Kit, (SOS), which first provides students with a video that details the warning signs of suicide. Students are then given a 7 question survey with yes or no answers regarding suicidality. If a school official feels a student is at substantial risk for suicide, they can arrange for an emergency hospitalization **without parental consent.**

The Massachusetts Department of Education distributed anonymous voluntary mental health screening called “The Youth Risk Behavioral Survey” to select schools. The reports of the 2001 and 2003 testing indicates a reduced amount of suicidal, aggressive, and dangerous behaviors, whatever that result means. Other similar tests are also being published.

What is the underlying motivation for TeenScreen?

The New Freedom Commission, TMAP, and TeenScreen appears to be a blatant political/pharmaceutical company alliance that promotes medication, and more precisely, the newer, more expensive antidepressants and antipsychotics which are at best, of questionable benefit and come with deadly side effects. These programs appear designed to simply recruit customers for pharmaceutical companies by channeling children to “treatment,” especially where TMAP is used. (Ohio’s version is OMAP).

By creating the NFC, the pharmaceutical industry has taken over control of U.S. public health policy, representing one of the biggest hijackings of public tax dollars in history. Individuals are unable to pay for these high priced psychiatric drugs; Insurance companies are unwilling to pay for high priced psychoactive drugs. Through the NFC recommendations of mental health screenings of all Americans, followed by a TMAP type treatment program, the pharmaceutical industry has arranged that the state and federal governments

will pay for their psychiatric drugs in an ever expanding market. Hence, the purpose of all this is **“market expansion.”** Putting the pharmaceutical industry in charge of the mental health of our children is like putting the fast food industry in charge of our diet.

Do political “contributions” have anything to do with these programs?

The pharmaceutical industry has spent more than \$800 Million in federal lobbying and campaign contributions at both state and federal levels. In the past seven years, more than with any other industry, the money has swayed public policy and has rendered the FDA totally ineffective as a regulatory agency.

What are the real costs of Teen Screen?

In a study by TeenScreen’s developers, it was concluded that the screening cost is \$37.00 per child and \$250.00 per child who is referred, which would be approximately 1/3 of all children tested. Additional costs were not calculated. However, if only 10 million children are tested, the testing cost alone would amount to \$370 million dollars and referral costs would be over \$1.2 billion dollars. This does not even take into account follow-up and medication costs which could produce ongoing costs of over \$90 billion dollars per year. That is only 10 million children. TeenScreen and the NFC want to screen “all” children.

What are some of the political ties in Teen-Screen?

The majority of personnel working on the development and implementation of TeenScreen have close money ties to the major pharmaceutical companies who are pushing this program and who have contributed to its advances. In addition, a high number of NAMI officials are also involved with this project. The American Psychiatric Association states unabashedly in the organizations *Advocacy News*, that they worked to successfully suppress the story of mental health screening from being reported by the mainstream media.

Have psychiatric drugs in any way been implicated in suicides and death?

Both the anti-depressants and stimulants have been shown to cause akathisia, which often results in suicidal ideation and sometimes in suicidal actions.

Robert Whitaker, journalist and author of the best selling book “Mad In America,” recently published evidence that the death rate of patients on the newer, more expensive TMAP drugs, the “atypical” antipsychotics such as Risperdal, Zyprexa, Seroquel, etc., is 2 times that of patients taking the older, much cheaper, typical antipsychotics such as Haldol and Thorazine.** Even though this has been verified in multiple studies, these drugs have not been taken off the market and continue to be the drugs of choice in the TMAP program and its clones.

In another study, David Healy, M.D., the British psychiatrist whose research was responsible for the British banning antidepressants for children and the United States placing Black Box warnings on them, found that the suicide rate for “treated” schizophrenics has increased 20 fold since the introduction of psychotropic drugs. He also found major increases in diabetes.***

** Whitaker, R. “Anatomy of an epidemic: Psychiatric drugs and the astonishing rise of mental illness in America.” Ethical Human Psychology and Psychiatry, Vol. 7, 1, Spring, 2005.

***Healy, D. et al., “Lifetime suicide rates in treated Schizophrenia: 1875-1924 and 1994-1999 – cohorts.” British Journal of Psychiatry, 2006, 118: 223-228.

What is the position of The International Center For The Study Of Psychiatry & Psychology, (ICSPP), in terms of TeenScreen?

ICSPP opposes psychiatric screening of any kind, as well as the use of unproven psychiatric medications whose benefit/risk ratio is negative. ICSPP also opposes any intrusion into the privacy of the family without full prior disclosure and active, informed parental consent.

Kevin McCready Memorial Research Grant Offers First Award

By Andrew Crosby, MA
And Toby T. Watson, Psy.D.

Michael Gilbert, Psy.D., was the recipient of the first award from the Kevin McCready Memorial Research Grant. He is receiving \$1,875.00 from the ICSPP fund to conduct a study on the education of parents regarding ADHD and medication.

The study, which is underway in New York City, has two components. First is a survey exploring the education parents receive regarding ADHD and available treatments, including medications. The second component consists of individual and group meetings with parents during which they are trained about the facts of ADHD and in the medication-free approach designed by Dr. David Stein, the Caregivers Skills Program.

The grant money is going towards materials, paying for group meeting space, and for providing a stipend to a few professionals who are conducting the parent training sessions. Advertising, copying and postage are also expenses paid for by the grant proceeds.

Dr. Gilbert anticipates that parents are often misled and misinformed about childhood disorders and psychotropic drugs, and that what they are told is inadequate to permit informed decision-making. He believes he will find that Dr. Stein's medication-free approach will yield greater short-term and long-term symptom reduction.

In a recent update, Dr. Gilbert reported that the study is proceeding well after a delayed start. Thirty families are participating in the study, about half of which have begun the Caregiver Skills Program. Comparisons between these groups will be made. The study is scheduled to be completed by Summer 2007, and Dr. Gilbert will be presenting his data at next year's ICSPP conference. Dr. Gilbert also plans to compile five-year follow-up results.

The grant was named after Dr. Kevin

McCready, a psychologist who founded San Joaquin Psychotherapy Center in Fresno, California, one of the only non-medication Day Treatment Facilities in the United States. Dr. McCready, while he was with us, and his staff still today, help people every day taper off psychotropic medications and find meaningful ways to recover from a variety of conditions and challenges. We lost Dr. McCready far too soon in December of 2004.

Running the center was a challenge in itself, and Dr. McCready fought to keep the program alive under adversity from those opposed its non-drug, informed consent, and empowering model approach. Dr. McCready was tenacious, and instead of backing down, he was able to use his quick humor and ironies to drive points home.

Dr. McCready was also one of ICSPP's most inspirational presenters. Among his many passions was a love of philosophy and classic literature. He was fond of quoting some of the greatest thinkers to put a pen to paper.

One of my favorite McCready quotes: "If you make people think a little, they'll like you. If you make them think a lot, they'll hate you." A lesson well heeded.

Dr. Toby T. Watson, member of ICSPP's Board of Directors, is the Founder and Chairperson of the Kevin McCready Memorial Research Grant, and has made a commitment to continuing and funding the grant. This fund is important for many reasons; most importantly, it provides researchers with data to support providing ethical and humane treatment, something that has somehow been lost in today's research "marketplace."

Dr. Watson is requesting we all help by donating \$25 or \$50 for next year's awardees. Donations can be sent to the ICSPP-Memorial Grant at the information on the opposite page. Please donate. When you do, you will support ethical research that will influence practitioners and students.

You will also contribute to confronting the prevailing belief system. That will help all of us.

Kevin McCready Memorial Research Grant **up to \$4,000 !**

The International Center for the Study of Psychology and Psychiatry (ICSPP) co-sponsors an annual competition for research funding to the Kevin McCready Memorial Research Grant.

Eligibility:

1. All individuals with graduate level research training are welcome to apply once per year.
2. All individuals will be automatically become ICSPP members for one year upon grant award, and winners must present their findings or proposal at the following ICSPP conference (if research is not yet completed, a discussion of research and proposal can be presented.) Partial funding will be reserved until research is completed and presented. Past conferences have been held in New York, Los Angeles and Chicago. This year's conference will be held in Washington D.C.-Bethesda, MD. (See www.icspp.org).

Award and Proposal Requirements:

Up to \$4,000 shall be awarded to one or two applicants each year that meet the following proposal requirements (Please Note: if the research-dissertation is already completed, the applicant need only submit the completed paper or article.)

1. The purpose of the research award grant is to financially and professionally assist *any* individual or group who intends to study or present the effects of psycho-social, psychotropic medication-free psychological treatment.
2. The proposal must be no longer than two type written pages.
3. The proposal must include a vitae-resume or brief biographical history.
4. The proposal must include: title, nature of study, hypothesis, research location, potential for completion, approximate time for completion and a *detailed method of data collection*.
5. The proposal must include briefly how the funds are to be used (if not already completed.)

Yearly Deadlines:

January 31st for application.

Process:

First, use above criteria for making an application. Send to the address below.

1. Upon receipt of your application, two ICSPP Board members will review the applications and will notify applicants by Feb. 15st via telephone and in writing of their award success.
2. An ICSPP membership application and "Memorial Award Acceptance Contract" will be mailed to applicants. The Contract will indicate the applicants willingness to conduct the study- research (if applicable) and present their finished research at the annual Fall ICSPP conference.
3. Upon return of the application and Contract, three fourths of the total awarded amount will be mailed to the applicant, less the ICSPP membership fee, if not already paid.
4. When the ICSPP conference date is confirmed, the applicant will be notified of the conference and will be required to present at the conference.
5. Upon completion of the research presentation at the ICSPP conference, a ceremonial plaque will be presented with a check for the remaining proceeds.

Address:

ICSPP- C/O Dr. Toby Watson
2808 Kohler Memorial Drive, Suite 1
Sheboygan, WI 53081

Questions:

For questions please contact Dr. Watson @ tobytylerwatson@charter.net or at 920-457-9192.

Truth Hits the Airwaves

By Andrew Crosby, MA

In the last issue, we learned about MindFreedom International's internet radio show, The MindFreedom News Hour. Host David Oaks referred to the medium of voice as particularly well-suited to getting the word out - both to reach others, and so that others may reach you.

He's not the only one who feels that way.

Two of ICSPP's stalwarts, Dominick Riccio, International Executive Director, and Laurence Simon, co-editor of *Ethical Human Psychology and Psychiatry*, recently hit the internet 'airwaves' as well. Their venture, Psychtruth.org, LLC, debuted this past August and features, among other material, nanocasts (also called podcasts) with information and interviews. Listeners can check in and listen on the spot, or download the 15-minute segments onto their computers or iPods for later use.

The Back Story

Larry Simon traces Psych Truth's origin to a previous effort he and Riccio made to reach out: a local cable access television show they did some time back. This yielded little exposure, but they learned a few things. And they set out for a better way to connect.

Through exploring several options, Riccio stumbled onto Errol Smith, founder of Affiliated Nanocasting Network (ANN). ANN develops, produces, manages, and markets radio podcasting programs. Smith boasts a portfolio of some 300 shows covering topics as diverse as HIV/AIDS, nutrition, publishing, and safe shopping (how to avoid scams and rip-offs).

Smith was looking for "experts with marketable, specialized knowledge," for ANN. He didn't want just anybody doing anything, rather he sought people with a real mission, and a real service to promote. Hooking up with Smith was as eye-opening as it was advantageous. According to Riccio and Simon, Smith is a luminary with regard to the future of media. Smith believes the internet is expanding, and he is dedicated to anticipating it's possibilities. This raises an important question:

What the Heck is a *Nanocast*?

For the small number of you who know less than I do about technology and what the rest of the world is doing, think of nanocasting as the opposite of broadcasting. It is the process of producing and recording radio or other digital media and posting it on the internet via a server. People searching the web for a topic of interest to *them* will find the topic that is of such interest to *you* that you recorded and

posted nanocasts. These are available 24 hours a day, 7 days a week, ready to be found as people search.

And search we do. Excerpts from *Radio Ink*, an industry trade magazine, posted on the ANN website, report that there is a steady replacement of the 'mass' market by a growing number of 'micro' markets "that cater to the needs of specific groups or individuals." Surveys demonstrating a significant decline in reliance on print media as people are increasingly on-line are also cited. Print medium, particularly for advertising, is fading.

A USA Today.com post from February 2005 describes podcasting as "recording what amounts to your audio blog." As indicated, one advantage is that those who are unable to afford breaking into conventional media outlets now have options. This is a relatively inexpensive way to reach others, *and for others to reach you*. When people turn on the computer, they often seek something specific. For those who seek the truth about psychiatry or psychiatric drugs, Psych Truth is an easy destination.

Hyperbole? Don't bet on it.

Back to the Truth

Psych Truth has exceeded expectations during its brief existence. Simon and Riccio credit Errol Smith for arranging an easy link on Yahoo News. Establishing relationships and sharing links with other organizations and their sites is also helping matters.

Simon enthusiastically reports he is "impressed with the power of the web" which has yielded their site 30,000 hits to date, with up to 1,228 visits per day. Simon quotes Smith as stating "the average retailer or pastor would die for an audience like that."

What does this audience listen to? Psych Truth Radio presently features eleven segments, most of which are fifteen minutes in length. More have been recorded and will be available by the time you read this. Two of the segments consist of discussion between Riccio and Simon, and serve as an introduction and a wrap up.

In between there are interviews with Peter Breggin, David Cohen, Grace Jackson, David Stein, Bertam Karon, *Mad in America* author Robert Whittaker, and several others. Topics include "What Causes Schizophrenia?" "Can You Trust the Drugs You've Been Prescribed?" and "The Successes and Failures in Mental Health Treatments."

Yes, familiar names and topics to many of us.

But not to many of the listeners who have logged on to

Psych Truth. To them, this is fresh. They were just clicking, maybe looking for the truth about psychiatry, maybe just looking. And they found Riccio and Simon. They found something else, too.

Just Say “Know”

Timed with ICSP’s October conference, Riccio and Simon launched Psych Truth’s *Just Say “Know” to Drugs* campaign. This was an effort to get one million people to go to their doctors and pharmacists with a form, downloaded from any of several websites. The form has areas to list medications with their benefits, risks, and alternatives. People were asked to fill out this form with their providers, and to have their provider sign it once completed.

The point was to encourage us to think and learn about what we are putting into our bodies, and to do something even more rare - open a dialogue with our healthcare professionals instead of just nodding and walking out with our prescriptions. The underlying theme is a little something called *informed consent*, a central issue for ICSP and like-minded organizations.

Altogether, ten organizations, advocates, and healthcare professionals joined Psych Truth in the *Just Say “Know”* effort, including The Law Project for Psychiatric Rights (PsychRights, of Jim Gottstein fame), *Natural Bodybuilding and Fitness* magazine, The James Naylor Foundation, and, of course, ICSP.

How did the campaign go? Simon reports that about 400 people downloaded the forms. While this is shy of the one million mark, he adds, “there is no way of knowing how many people carried out a search of the side effects of the drugs without downloading the form. This number could have run into the thousands.” One aim was to get exposure, though, and that seems to have worked. Not only did it lead to discussion with other organizations about cooperating in the endeavor, but a free lance writer caught on and plans to write an article on Psych Truth for *Health* magazine.

Incidentally – *Health* magazine has six million readers. I’m guessing *Just Say “Know” Take 2* will get a touch closer to the million mark.

The Future of Psych Truth

Funny thing: I asked Larry Simon what he planned for Psych Truth in the future and the phone line went quiet. I had to wonder if he and Dom had considered this. This is a guess, but perhaps they haven’t.

These guys are bright, motivated, and accomplished. But they are neither flashy, nor especially technically inclined. When Dom told us a while back he was doing podcasts, it was all I could do to keep from asking, “You *know* about that stuff?” Up until a short time ago, though,

he didn’t. He learned. Like I said, these guys are motivated.

***“In the meantime,
they are reaching people.
And, more and more,
people are reaching
them.”***

They seem to be feeling their way into this before making any quantum leaps. The next steps they envision include upgrades in technology. Their shows are recorded over phone lines, and the sound is typical phone line quality, a bit tinny and grainy. This is on the mend. They also want to add content – more shows, a book shop, a more advanced forum – and continue to link up with like-minded organizations and their sites. This is all in progress, and things will move along.

A quantum leap can’t be far off, even if Dom and Larry can’t see it yet. In the meantime, they are reaching people. And, more and more, people are reaching them.

Which brings us to you.

If you are one of those who can’t attend our conferences or regional meetings, and who connect with ICSP mainly through the newsletter ... get to a computer and search for Psychtruth.org. You will hear our International Executive Director and journal co-editor. You will hear our brightest and bravest practitioners and conference presenters. Even if you are not technically inclined, get online and come along with ICSP and Psych Truth into the 21st Century.

But, *please* don’t stop reading the newsletter. This talk about the demise of print media has us worried.

[Editor’s Note: Shortly before going to press, Dominick Riccio reported that a follow-up to the *Just Say Know to Drugs* campaign is planned for the near future. The working title is *Just Say Know, Then Say No to Drugs*.]

Psychiatric Rights on Trial: Faith Myers and Jim Gottstein Win One for Us

By Andrew Crosby, MA

It began with a collision of circumstances in late February, 2003. It ended with an important legal decision just months ago: on June 30, 2006, the Alaska Supreme Court rendered a decision in favor of Faith Myers and against the Alaska Psychiatric Institute (API). The decision also favored the constitution while going against some of organized psychiatry's central principles.

Put simply, at issue was the conditions under which the government may forcibly drug someone deemed mentally ill. The attorney in the matter was James B. Gottstein, Esq. Jim is founder of Alaska's Law Project for Psychiatric Rights (PsychRights), president of the National Association for Rights Protection and Advocacy (NARPA), and serves on the ICSPP Board of Directors.

The Case:

Myers v. Alaska Psychiatric Institute

On February 21, 2003, Faith Myers, 51-year-old mother of two, was hospitalized at Alaska Psychiatric Institute, a state facility. Her son and daughter had signed a petition for her hospitalization because Faith was reportedly behaving strangely and leaving threatening notes to others in her apartment complex. She faced possible eviction. When her children confronted her or tried to help, Faith reportedly became angry. One news account states this was shortly after Faith lost her father.

Faith had a history of over twenty years of psychiatric diagnoses (including Post Traumatic Stress Disorder, and, more recently, Paranoid Schizophrenia) and hospitalizations at API. She had voluntarily taken psychotropic drugs most of that time, mostly the older generation neuroleptic, Navane, on which she was able to work and raise her two children as a single mother. In 1997, this was switched to Risperdal, which was later supplemented with Paxil and Navane again. Later still, Faith was prescribed Zyprexa. On these drugs, however, Faith experienced serious psychotic symptoms for the first time, and when she protested, they were forced on her.

***“And a process that would
routinely take ten minutes
became a four-month
all out legal battle.”***

When state troopers forced their way into her apartment and removed her in handcuffs on February 21, 2003, Faith Myers had been off of psychiatric drugs for up to two years due to the adverse effects of the Risperdal and Zyprexa, which made her hear voices, among causing other difficulties. So, when advised she would be prescribed Zyprexa upon this admission, Faith declined.

And API filed a petition.

And Faith called Jim.

And a process that would routinely take ten minutes became a four month all out legal battle.

According to Jim, Alaska Statutes allow everyone the right to decline drugs *unless they lack the capacity to make the decision*. If deemed incompetent to decide for themselves, the hospital can do whatever it wants. Specifically, the statute states, “If the court determines that the patient is not competent to provide informed consent and, by clear and convincing evidence, was not competent to provide informed consent at the time of previously expressed wishes ... the court shall approve the facility's proposed use of psychotropic medication.”

So, on March 5th, 2003, Faith and Jim entered the court room. They argued that under the constitution, the state cannot force someone to take psychotropic drugs unless it can be proved that it is in the person's best interest and that there are no less intrusive alternatives. They further argued that since the state was stepping in and making the decision the court had decided Faith was incapable of making, the court needed to decide what decision Faith would have made had she been competent.

The Defense ... A Unique Approach

A number of things were new in *Myers v. API*. One has already been mentioned: a hearing which is routinely handled in ten to fifteen minutes, stretched out for months. “There were three separate petitions/hearings which took the four months,” Jim recalls. “The hearing for the forced drugging order which was appealed and resulted in the *Myers* decision took about 4 hours, I think. What then ensued was the four month legal battle until she was finally released just before the 4th of July weekend, a side story in itself.”

Another key element was the deposition Jim took with API psychiatrist Dr. Robert Hanowell just days after Faith was hospitalized. Jim challenged Hanowell (and psychiatric practice in general) regarding informed consent, available alternatives to medications, the determination that Myers was incapable of giving informed consent, and his knowledge base and understanding regarding the efficacy of psychiatric drugs and the biological / chemical imbalance theories of mental illness.

Hanowell's answers reflect the woeful state of affairs psychiatry faces when confronted with these matters and practices. While Faith Myers may have been acting strangely in February, 2003, Hanowell gives no indication that thoughtful decision-making had taken place at API to assess and help her.

While unable to cite any literature on etiology of mental illness or drug efficacy, however, Hanowell did graciously agree to read materials Jim offered. He had plenty on hand.

Another unique feature of *Myers v. API* was testimony, via telephone, from Drs. Loren Mosher and Grace Jackson. Dr. Mosher testified about the research pertaining to the biological

and chemical imbalance theories of schizophrenia, while Dr. Jackson's testimony centered on risks and poor efficacy of Zyprexa, based on the drug company's own research.

Jim notes one more element, perhaps not unique, but crucial nonetheless: the testimony of Faith Myers. Jim states, "Faith had completely cogent and well thought out reasons for not taking the medications and yet the court still ruled she was incompetent to decide." She "was completely logical."

The Trial Court Rules ... In Favor of API

The superior court ruled in favor of API. Jim notes the judge, most likely, wished not be blamed should there be problems upon Faith Myers's release. In the decision, however, the trial court noted that "a valid debate exists in the medical / psychiatric community as to the safety and effectiveness of the proposed treatment plan, it is troubling that the statutory scheme apparently does not provide a mechanism for presenting scientific evidence challenging the proposed treatment plan."

It was further stated that psychotropic drugs, "affect the mind, behavior, intellectual functions, perception, moods, and emotions and are known to cause a number of potentially devastating side effects." API never disputed this.

Jim notes that it would seem that Drs. Mosher and Jackson had some effect here. Nonetheless, the superior court held that the above issues were irrelevant because Faith Myers had been deemed incompetent. Thus, as the statutes allow, the hospital could do what it pleased.

The Supreme Court Decides Otherwise; And, Yes, There are Implications

"The (Alaska) Supreme Court didn't buy that," Jim says of the trial court's reasoning. As quoted from the press release PsychRights distributed on the date of the decision, "The (Supreme) court found Alaska's forced drugging regime to be unconstitutional when the state forces someone to take psychiatric medications without proving it to be in their best interests or when there are less restrictive alternatives."

Good thing they appealed. Jim reports, "since PsychRights is working to change the system, we look forward to any and all of our cases being appealed because that is a key place to make changes." Indeed, Jim addresses this up front with his clients, and if they are unwilling to appeal, he is unlikely to accept the case.

Jim and Faith had agreed to appeal if needed. Faith Myers, like Jim, is devoted to changing the system. She and Jim met "a year or two" prior to the start of this drama when Faith gave public comment to the Alaska Mental Health Board. Jim promptly got her onto the board of directors of the Alaska Mental Health Consumer Web, a survivor-run drop in center.

As for what this decision means, Jim says, "By requiring the least intrusive alternative to forced psychiatric drugging, this decision has the potential to change the face of current psychiatric practice, dramatically improving the lives

of people who now find themselves at the wrong end of a hypodermic needle."

***"Representation is so
important, because
that's where the system
is broken."***

Acknowledging that some people choose to take psychiatric drugs, Jim emphasizes the issue is just that, choice. "For people who want to try non-drug approaches, the research is very clear that many will have much better long-term outcomes, including complete recovery after being diagnosed with serious mental illness. This decision restores the rights of those people to pursue that potential."

That is the broad picture, of course, and results will be gradual. There have been significant local consequences to the decision, however, which were practically immediate. In his recent presentation at the ICSPP conference this past October, Jim noted, "The Myers case was a four-month all-out legal battle the likes of which they have never seen before. The hospital didn't like it, *and I've gotten people out with an email since then.*"

Why the abrupt change? Jim noted that with 10 to 20 hearings per week, the commitment proceedings are noted for following the "path of least resistance. It's so easy ... (psychiatrists) fill out a form, testify for a few minutes, and they get their orders. But, if they are forced to do a half-day hearing, or a full day, or two day hearing, just to get someone committed, *they will look for something else.*"

One account entails a patient contacting Jim the day before his commitment hearing was to be held. Jim told the hospital, "If you file, I'll represent him." Jim then proceeded to the hospital, but was unable to meet with his client. He'd been released.

Representation is so important, because, Jim says, "that's where the system is broken." In fact, that's the focus of another case about which Jim is awaiting a Supreme Court decision. In that case, *Wetherhorn*, Jim is arguing that "people are entitled to lawyers who actually work for them."

A Word on Alternatives ... And a Word of Thanks

As a lawyer, Jim is a talker. But that's just the start. Jim is a serious advocate and activist; when he suggests alternatives are needed, he is instrumental in putting them in place. For example, Jim is president of Soteria - Alaska, a program in the works based on the work of Dr. Loren Mosher. In the 1970s, Mosher demonstrated that a non-medical, non-forced drug environment was helpful to people diagnosed with schizophrenia. So helpful, in fact, that long-term outcomes were far superior to those of the traditional hospital setting.

A similar idea in the works is CHOICES, Inc. (Consumers Having Ownership In Creating Effective Services). Another Mosher / Soteria inspired concept, CHOICES, Inc. is what a mental health system should be like. People will have several treatment options to choose from, as opposed to the present options which, as Jim clarifies, all involve drugs.

The idea with these, as Jim describes it, is to “*be with* people, rather than *do to* them.”

Thanks to Jim’s extraordinary efforts, it is becoming easier for all of us to *be with* and not *do to*. We must also thank Dr. Grace Jackson for her integral role, and Dr. Loren Mosher, who passed away not long after offering his testimony in *Myers*. Despite his passing, Dr. Mosher’s work continues to inspire us in our work.

Most importantly, thanks to Faith Myers for playing a crucial dual role. With *Myers v. API*, Faith represents the people we are all devoted to helping, and the survivors / advocates who are a crucial part of ICSP and all similarly committed organizations.

Editor’s Notes:

This article has many sources. These include the court’s decision, the transcript from the trial court proceedings, and the deposition of Dr. Robert Hanowell. These are available from the PsychRights website (psychrights.org). The Hanowell deposition is especially interesting, and recommended.

News reports from the *Anchorage Daily News* were also used, and there are links to these on the PsychRights website as well.

Jim Gottstein’s quotes were taken partly from email correspondence, but largely from his recent conference presentation. Check out the DVDs listed on pages 36 – 40. There is much to be learned there. You’ll be surprised.]

Finally - Jim Gottstein’s other efforts and contributions mentioned here, Soteria-Alaska, the Wetherhorn case, and CHOICES, Inc., will be covered in upcoming newsletters.

MY BIG FAT DRUG REP DINNER

By Steven E. Rubin, MD

The dinner reception at the rather posh restaurant began at 6:30. We kicked off with cocktails, wine and hors d’oeuvres. The amicable pharmaceutical product detail representative, A.K.A., the ‘drug rep,’ introduced himself and welcomed us, one and all. At 7:00 PM he introduced the evening’s guest speaker; a psychiatric physician who endorsed, unequivocally, the efficacy of the night’s featured psychotropic medication and the disorders it is prescribed for.

Local speakers are paid around one thousand dollars. Practitioners who travel or have published research papers sponsored by pharmaceutical companies often receive higher fees. Many doctors work the circuit and speak for competing companies and their respective medications.

As the group of psychiatrists and physicians-in-training gathered around the dinner table, the formal presentation was launched. Appetizers and more wine were served.

The talk was visually enhanced by PowerPoint slides prepared by the company and distributed to the speaker by the drug representative. The information is determined by the pharmaceutical company. Most of the data is generated by physicians who were paid to qualify, monitor or disqualify patients who did or did not meet the company’s criteria for “scientific research.” Speakers are mandated to use these slides. More wine was served and the waiters took our orders for dinner.

We sat and we listened. While sipping and chewing, colleagues nodded their heads in confirmation and collaboration. Suddenly, we weren’t just psychiatrists. We were chemists, physicists and philosophers. We were dealing with facts.

Dinner was served, the food and propaganda readily digested. A roundtable discussion of clinical experiences was started. Medical identities were mutually validated and the group reassured itself that psychiatrists are doctors too.

Dessert was served, and the comradeship flowed along with the after-dinner liquors. Finally, our pharmaceutical representative host thanked us and we applauded ourselves. Silently we were being tagged as to whose offices would soon be visited so free medication samples could be dispensed.

The evening’s tab would amount to a few thousand dollars, a commendable investment pittance in exchange for the millions of dollars that will be generated by prescribing physicians.

I would like to be able to say that I went out to the street curb and threw up afterwards, but I didn’t.

The Brain God Gave Us Cannot Be Improved by Drugs - Infant & Child Psychiatry Examined

Address by

Fred A. Baughman Jr., MD

(Author: The ADHD Fraud: How Psychiatry Makes
“Patients” of Normal Children, Publisher:
www.Trafford.com)

to:

The 6th Annual Encuentro Internacional De Educacion In-
fancia Y Preescolar
Mayo 24-25-26-27, 2006
Sede Teatro Nova
San Nicolas de los Garza, N.L., Mexico

Mexican psychiatrists, psychologists and educators are im-
porting a plan for the mental health of your nation and your
children from the US. This plan is called “biological” psy-
chiatry and insists that every human failure and frailty is a
brain disease—a “chemical imbalance” of the brain needing
a chemical balancer—a pill. How convenient for the Big
Pharma—the world-wide pharmaceutical industry-- that
owns and operates psychiatry today. How convenient for
psychiatrists and physicians without enough patients: every
child a “patient.” Before you take another step you should
look very closely at what is happening in the US in the
name of “mental health.”

I have been a physician for 46 years, let me share some of
my insights. I am sure you want what is best for your chil-
dren. I applaud your protection of family, your maternal-
ism, your mothers.

The #1 duty of the medical profession--of all physicians-- is
to determine whether or not an abnormality is present. A
disease *is* an abnormality; abnormality = disease.

Abnormalities are gross (visible to the naked eye), micro-
scopic, or chemical. *Just as abnormality = disease; no
abnormality = normal = disease-free.*

In polio/infantile paralysis, muscle wasting/atrophy of the
limbs is evident to the naked eye--a macroscopic abnormal-
ity—a disease! In cancer of the cervix in women a “Pap”
smear shows cancer cells under the microscope—a disease!
In diabetes the blood sugar is elevated—a disease! In
phenylketonuria—PKU, tested for in newborns, the
phenylalanine level is increased, a true chemical imbal-
ance /abnormality—a true disease!

The other thing about medicine is that every treatment—
medication or surgery targets an abnormality and makes it
normal or more nearly normal.

You will learn about psychiatry, unlike the rest of medicine, that it
diagnoses no actual abnormalities/diseases, that all of it's disorders =
chemical imbalances = diseases are made-up, invented, contrived,
illusions and that its treatments—drugs, ECT, and psychosurgery
make no brain or body abnormalities normal or more nearly normal,
rather, they—the psychiatric treatments--cause abnormalities, the
first and only abnormalities.

The main problem with ADHD drugs is that they are given to ADHD
children—who are normal children [1].

Once Ritalin, or any psychiatric drug, courses through their brain and
body, they are, *for the first time*, intoxicated/abnormal/diseased [2].
When they gain two, three, or more psychiatric diagnoses, psychiatry
speaks of these added diagnoses or labels as “co-morbid” and as jus-
tification for prescribing two, three or more psychiatric drugs—none
of them targeting an actual disease, only a school-child who was
physically-medically normal before the first drug—usually for
ADHD—was ingested. At 3 ½ years of age Macauley Showalter of
Minneapolis, was diagnosed ADHD and begun on Ritalin. Days
short of his 8th birthday, he crawled up on his grandmother's sofa,
went to sleep, and died. In the interim, he had been diagnosed with 5
psychiatric disorders—none evident at autopsy--and poisoned with 5
psychiatric drugs all of them present in every body fluid.

Psychiatric drugs appeared in the 1950's. Psychiatry and the al-
mighty, obscenely wealthy, pharmaceutical industry married and
gave birth to the “chemical imbalance” market strategy. They would
call all emotional pains and all troubled, troublesome behaviors
“chemical imbalances” of the brain needing “chemical balancers” –
pills.

Thirty-six years ago, Congressman Cornelius E. Gallagher opened
the September 29, 1970, hearing on *Federal Involvement in the Use
of Behavior Modification Drugs on Grammar School Children*, say-
ing: “I want to welcome you here today to our hearing into Federal
responsibility in promoting the use of amphetamines to modify the
behavior of grammar school children.”... “From the time of puberty
onward, each and every child is told that “speed kills” and that am-
phetamines are to be avoided. Yet this same child has learned that
Ritalin, for example, is the only thing which makes him a function-
ing member of the school environment and both his family and his
doctor have urged the pills on him.”

Pushing the “disease” model, Dr. Ronald Lipman of the FDA, an
agent of government, testified: “hyperkinesis is something that
brings the child into conflict with his parents, peers, and teachers,
and the teacher observes behavior and has a referral role to play...
hyperkinesis is a medical syndrome. It should be properly diagnosed
by a medical doctor.” Here we have federal government, with no
scientific proof whatsoever declaring that overly active children have
a brain disease, and that teachers have a role in its diagnosis.

In 1948, 'neuropsychiatry' was divided into 'neurology,' my spe-
cialty, dealing with organic diseases of the brain, and 'psychiatry,'
dealing—not with diseases at all, but with the normal, if trouble-
some, emotions and behaviors of all human beings [3].

In 1980, the APA changed MBD to ADD. In 1987 they changed
ADD to ADHD. In 1994 they added behaviors to the 1987, ADHD

checklist to capture more “patients.” In psychiatry there is no discovery of diseases as throughout medicine, rather they are voted into existence after consultation with Big Pharma and their advertising firms.

In 1969, I discovered the “glioma-polyposis” syndrome, clearly a disease, clearly genetically caused.

In 1972 I discovered CHANDS, clearly a disease, clearly genetically caused.

From the 1950s, when psychiatry began its claims of “chemical imbalances” to the present time, psychiatry has discovered and validated not a single real disease.

In 1994, Paul Leber of the FDA, wrote me about ADHD: “no distinctive pathophysiology ...has been delineated.”

In 1998, F. Xavier Castellanos of the NIMH wrote to me: “... we have not ... met the burden of demonstrating the specific pathophysiology...”

At the November 16-18 1998, National Institutes of Health, Consensus Conference, William B. Carey [1] concluded: “The ADHD behaviors are assumed to be largely or entirely due to abnormal brain function. The DSM-IV does not say so but textbooks and journals do.” “What is now most often described as ADHD... appears to be a set of normal behavioral variations...” Here was Carey, the only teller of truth, standing up to psychiatry and the pharmaceutical industry asserting the children were normal, there was no reason to drug them.

But Carey was followed by James M. Swanson and Castellanos [4] who reviewed the structural-MRI research and insisted: “... ADHD subjects have on-average 10% brain atrophy,” it is a brain disease. From a floor microphone I asked: “Dr. Swanson, why didn’t you mention that virtually all of the ADHD subjects...were on ...stimulant therapy and that this is the likely cause of their brain atrophy?” Swanson, stammering, replied: “I am planning...to investigate that.”

The articles reviewed [5-18] their titles, abstracts, conclusions and press releases spoke of the drug-induced brain atrophy as if it was due to the never-proved disease—ADHD.

Caught in the “disease” lie, the Consensus Conference Panel confessed: “...we do not have an independent, valid test for ADHD...there are no data to indicate that ADHD is due to a brain malfunction.” The ADHD epidemic, nationwide stood at 4 million.

Palco of NPR observed: “ADHD is like the Supreme Court’s definition of pornography: ‘You know it when you see it.’”

My testimony: “ADHD is a total, 100% fraud,” was confirmed.

In 2000, Castellanos [19], admitted: “Incontrovertible evidence is still lacking...”

In 2002, Castellanos, et al [20], published the one-and-only MRI study of ADHD-untreated patients. Inexplicably, their ADHD-untreated subjects were 2.2 years younger and smaller than the normal controls, voiding the study, letting stand the overwhelming likelihood that the ADHD drugs were the cause of the brain atrophy.

In 2002, Weinberger [21] of the NIMH, claimed “major psychiatric diseases”...are associated with “subtle but objectively characterizable changes” in brain structure and function. However, he was unable to reference proof for a single one.

In 2002, the Advertisement Code Commission of Holland [22] determined that Brain Foundation Netherland’s claims that ADHD is an inborn brain dysfunction “...gives a wrong and misleading representation of the facts and enjoined them to stop. This appears to have been the first determination by a national government concerning the fraudulent representation of a psychiatric diagnosis as a disease.

In 2003, Ireland prohibited GlaxoSmithKline (GSK) from claiming on it’s paroxetine leaflet: “works by bringing serotonin levels back to normal.” Officials stated: “...claiming that a particular... product works by bringing serotonin levels back to normal is not accurate.”

While Goodman [23], of the FDA, acknowledged that claims that SSRIs correct a serotonin imbalance go “too far,” he next had the temerity to suggest: “I think that is reasonable shorthand for expressing that this is a chemically or brain-based problem and that the medications are normalizing function.”

At the March 23, 2006, hearing of the Psychopharmacological Drugs Advisory Committee of the FDA, chaired by Goodman, Baughman [24], testified: ‘Saying any psychiatric diagnosis “... is a brain-based problem and that the medications are normalizing function,” is an anti-scientific, pro-drug, lie. Yet this has become standard practice throughout US medicine and at the APA [25], AMA [2], AACAP, AAP, CNS, AAFP [26], FDA [23] and virtually all government health care agencies.’

Journal articles [1], press releases, ads, inserts and informed consent documents for psychiatric research communicate the lie that psychological diagnoses are abnormalities/diseases.

All patients and research subjects with psychological problems are led to believe they have an abnormality/disease, biasing them in favor of medical interventions, and against non-medical interventions--love, will-power, spirituality, talk therapy, etc., which presume, as is the fact of the matter, that the individual is physically/medically normal and without need or justification for a medical/pharmaceutical intervention.

The FDA is the agency most responsible for conveying the facts needed by the public to make risk vs. benefit/informed consent decisions. Instead—colluding with industry, deceiving and preying upon the public--the FDA spreads the psychiatric “disease”/“chemical imbalance” lie.

Both the US and Mexico are democracies. The right to informed consent--universally violated by such "chemical imbalance"/ "disease" lies must be restored throughout the practice of medicine—including psychiatry, as long as they insist on going to medical school and calling themselves physicians.

If you have a troubled, troublesome student—and you will have many—think of your own child, nephew or grandchild and remember that when they act out it is because they are human and because they are in pain and are struggling and need all of the understanding and help they can get both at home and in school. The last thing they need is a drug. Do not be seduced by psychiatry and the pharmaceutical industry that would recruit you to be a "pusher" of drugs. With no diseases to treat, that is exactly what they have allowed themselves to become--pushers of drugs.

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POOR LEONARD'S ALMANACK

Leonard Roy Frank

September 2006

ON PERSONAL AND SOCIAL CHANGE

1. Change is most successful when those who are affected are involved in the planning.

WARREN BENNIS (management and leadership theorist), *Why Leaders Can't Lead: The Unconscious Conspiracy Continues*, 1989

2. When the hour... has come, the infection flashes like an electric spark over hundreds of miles....

The message goes through the air, and, in the one thing that counts all men are suddenly of one mind even if only in a blind conviction: *Things must change*.

JACOB BURCKHARDT (Swiss historian), "The Crises of History," 1869, *Force and Freedom: An Interpretation of History*, edited by James H. Nichols, 1943

3. As you come to know the seriousness of our situation — the war, the racism, the poverty in the world — you come to realize it is not going to be changed just by words or demonstrations. It's a question of living your life in a drastically different way.

DOROTHY DAY (human rights activist, 1897-1980), quoted in *Catholic Worker*, June-July 1990

4. The human species is forever in a state of change, forever becoming.

SIMONE de BEAUVOIR (French philosopher), *The Second Sex*, 1950, translated by H. M. Parshley, 1952

5. Is there a spiritual reality, inconceivable to us today, which corresponds in history to the physical reality which Einstein discovered and which led to the atomic bomb? Einstein discovered a law of physical change: the way to convert a single particle of matter into enormous physical energy. Might there not also be, as Gandhi suggested, an equally incredible and [as yet] undiscovered law of spiritual change, whereby a single person or small community of persons could be converted into an enormous spiritual energy capable of transforming a society and a world?

JAMES W. DOUGLASS (human rights activist), *Lightning East to West*, 1980

6. Discontent is the first necessity of progress.

THOMAS ALVA EDISON (inventor, 1847-1931), *The Diary and Sundry Observations of Thomas Alva Edison*, edited by Dagobert D. Runes, 1948

7. When I see changed men, I shall look for a changed world.

RALPH WALDO EMERSON (philosopher), journal, London, April 1848

8. How lovely to think that no one need wait a moment, we can start now, start slowly changing the world!

ANNE FRANK (Jewish diarist and Nazi death-camp victim), 1944, *Anne Frank's Tales from the Secret Annex*, translated by Ralph Manheim and Michel Mok, 1984

9. All progress lay through opposites to their reconciliation.

FRIEDRICH FROEBEL (German educator, 1782-1852), quoted in Robert Hebert Quick, *Essays on Educational Reformers*, 1897

10. The human condition is something at once horrible and marvelous. *Estamos muy mal hechos, pero no estamos terminados*. We are very badly made, but we are not finished.

EDUARDO GALEANO ([Uruguayan journalist](#) and social critic), closing sentences, David Barsamian interview, *Progressive*, July 1999
(Continued on Page 24)

Survivors Present in Bethesda: Freedom Center of Massachusetts Takes Top Honors

By Andrew Crosby, MA

Not all of this year's presenters were brilliant researchers, clinicians, or lawyers. Some were brilliant survivors and advocates. We had an impressive cast: Tina Minkowitz, J.D., Clover Smith, Eric Fabris, Nathaniel Lehrman, M.D., and Anne Marsden.. Also with us were Will Hall and Aby Adams of Massachusetts's Freedom Center.

All presentations were well organized and important, as was the work they represented. Following debate by the judges, Aby Adams and Will Hall of Freedom Center took the prize, a \$500.00 award offered by PsychRights. Their presentation was entitled, "Regulation Enforcement Deficit Disorder (R.E.D.D.): The Failure of Mental Health Legal Protections in Massachusetts, A Diagnosis, Etiology, and Treatment Plan for One of the "Best" States in the U.S."

Aby and Will described their work at Freedom Center, which largely involves helping the people who contact them for urgent support because the official supports are, well, unsupportive. Though Massachusetts has among the most progressive mental health legal systems in the country, laws and regulations are routinely disregarded; the watchdogs don't watch much. People get caught up, and need a voice. Aby, Will, and the rest at Freedom Center, are often that voice.

They can't help everybody, however. Visibly frustrated at times, Aby and Will discussed the overwhelming requests for their volunteer help from people in hospitals and in the community whose rights have been violated or whose needs go unmet. Most times, what is needed is someone with knowledge and courage to stand up and speak up. Freedom Center does both. They can't be everywhere, but manage to make a difference even so.

Freedom Center – What You Should Know

"*You are not alone*," is the first thing one learns upon checking out the group's general brochure on their website. It's true. Run by and for survivors, Freedom Center of Northampton, Massachusetts has been offering a variety of supports since 2001. Founded by Will Hall and Oryx Cohen, Freedom Center was the first consumer run advocacy and support organization in their area.

Freedom Center offers weekly support groups where people share stories and resources, and plan edu-

cational and advocacy campaigns. They run weekly yoga, acupuncture, and writing classes. Like PsychTruth (page 12) and MindFreedom (last issue), Freedom Center also runs their own weekly radio show.

They are activists. Broadly, they are alerting the community to forced drugging, they intervened at a run-down mental health residency program, and initiated a reform campaign against policies at ServiceNet, a large local mental health service provider. Individually, they attend treatment team meetings with clients and speak up. Because who else will?

Freedom Center has held events with such notable guests as "Mad in America" author Robert Whitaker and former head of schizophrenia research for the National Institute of Mental Health (from the good old days, as it were) Dr. Loren Mosher.

Freedom Center has achieved some notoriety as well. They've received awards from the Smith College of Social Work class of 2003 and the psychology students association at Mt. Holyoke College. They've scored two rush-hour interviews on their area's NPR affiliate radio network, have spoken to high school and college classes, to the press, and recently presented at the annual conference for the National Association for Rights Protection and Advocacy (NARPA) in Baltimore, Maryland.

Will and Oryx also presented recently at the Alternatives conference in Portland, Oregon where more than 600 survivors were on hand for a series of workshops. Oryx also presented at a Trauma Healing Conference in San Diego this past September. And Will Hall talked to the *New York Times* where he was quoted in an article about the tragic September 3, 2006 murder of psychiatrist Wayne Fenton by one of his patients.

These people talk a lot. Good thing. They believe as we believe: forced drugging is coercive, but people should have the right to choose among many options, including drugs if they like; truly informed consent is vital to a helping relationship; communities, not bureaucracies, need empowering.

And Finally ...

Despite the frustrations, Freedom Center is doing its part and then some. Aby, who is Freedom Center's Legal Team Coordinator, was recently asked to join the mental health advisory panel of the Disability Law Center. That's progress. She'll get to do some more talking, no doubt.

Check out Freedom Center's website. It features tons of information with relevant articles and recordings of recent presentations. (Their ICSP presentation is in the works.) There is also an impressive array of links to related sites. And don't forget their radio show.

Keep talking, Freedom Center. We hope you talk with us again soon.

Ninth Annual ICSPP Conference

Bethesda, Maryland

7, 8, & 9 October 2006



Two of our conference co-chairs, Dominick Riccio, Ph.D. (left) and Jim Gottstein, J.D..



ICSPP Founder and Director Emeritus, Peter Breggin, MD. Peter chaired the legal plenary panel and presented on Intoxication Anosognosia (medication spell-binding). (Photo: Kermit Cole.)



Joseph Glenmullen, MD and Karen Effrem, MD take in the presentations on day three of the conference.



Robert Manciero, director of the documentary, "Prescription: Suicide?" with Mathy Downing, whose family was featured in the film. Here, they address the group at the 2006 gala.



Dream Team Plus; the members of the legal plenary panel with other notable attendees. Left to right: Michael Mosher, JD, Graham Dukes, MD, Andrew Vickery, JD, Jim Gottstein, JD, Peter Breggin, MD, Derek Braslow, JD, Don Farber, JD, Jake Johnson, Ph.D., and Dominick Riccio, Ph.D. Jim, Jake, and Dom were conference co-chairs. Mosher, Vickery, Braslow, and Farber impressed attendees speaking of their litigation against drug companies and physicians for harm caused by SSRIs and other psychotropic drugs.



Robert Dinerstein, J.D. was our first presenter. He spoke on “Human Rights and People with Mental Health Disabilities: The Issue of Capacity.” (Photo: Kermit Cole.)



Michael Perlin, J.D. spoke on the first morning. His presentation was entitled, “International Human Rights and Civil Liability Cases.”

11. No good comes fully fashioned, out of God's hand, but has to be carved out through repeated experiments and repeated failures by ourselves. This is the law of individual growth. The same law controls social and political evolution also. The right to err, which means the freedom to try experiments, is the universal condition of all progress.

MOHANDAS K. GANDHI (Indian spiritual and political leader), *M. K. Gandhi: Speeches and Writings*, 1918

12. An epoch will come when people will disclaim kinship with us as we disclaim kinship with the monkeys.

KAHLIL GIBRAN (Lebanese poet, 1883-1931), "Sayings," *Spiritual Sayings of Kahlil Gibran*, translated by Anthony R. Ferris, 1962

13. The predicament of contemporary man is grave. We seem to be destined either for a new mutation or for destruction.

ABRAHAM JOSHUA HESCHEL (Polish-born U.S. theologian, 1907-1972), *A Passion for Truth*, 1973

14. Up to now, whenever a society turned a new leaf, it had the devil at its elbow.

ERIC HOFFER (San Franciscan longshoreman and philosopher), *Reflections on the Human Condition*, 1973

15. I think it not improbable that man, like the grub that prepares a chamber for the winged thing it never has seen but is to be — that man may have cosmic destinies that he does not understand. And so beyond the vision of battling races and an impoverished earth, I catch a dreaming glimpse of peace.

OLIVER WENDELL HOLMES JR. (Supreme Court chief justice), "Law and the Court," speech at a dinner of the Harvard Law School Association of New York, 15 February 1913

16. The process of evolution can only be described as the gradual insertion of more and more freedom into matter.

T. E. HULME (English philosopher, 1883-1917), "The Philosophy of Intensive Manifolds," *Speculations: Essays on Humanism and the Philosophy of Art*, 1924

17. It is as if man had been suddenly appointed managing director of the biggest business of all, the business of evolution — appointed without being asked if he wanted it, and without proper warning and preparation. What is more, he can't refuse the job. Whether he wants to or not, whether he is conscious of what he is doing or not, he is in point of fact determining the future direction of evolution on this earth. That is his inescapable destiny, and the sooner he realizes it and starts believing in it, the better for all concerned.

JULIAN HUXLEY (English biologist), "Transhumanism," *New Bottles for New Wine*, 1957

18. Every great advance in natural knowledge has involved the absolute rejection of authority, the cherishing of the keenest skepticism, the annihilation of the spirit of blind faith.

T. H. HUXLEY (English biologist), "On the Advisableness of Improving Natural Knowledge," 1866, *Lay Sermons, Addresses and Reviews*, 1870

19. Man as we know him is a poor creature; but he is halfway between an ape and a god, and he is traveling in the right direction.

DEAN WILLIAM RALPH INGE (English prelate), "Confessio Fidei," *Outspoken Essays: Second Series*, 1922

20. Nothing... is unchangeable but the inherent and inalienable rights of man.

THOMAS JEFFERSON, letter to Maj. John Cartwright, 5 June 1824

21. Our goal is to create a beloved community, and this will require a qualitative change in our souls as well as a quantitative change in our lives.

MARTIN LUTHER KING JR., "Nonviolence: The Only Road to Freedom," *Ebony*, October 1966

The Dangers of Infant and Toddler Mental Health and Early Intervention Programs

Karen R. Effrem, MD
ICSPP Board of Directors

The traumatic experience that Mrs. Gamondes and her family underwent is a perfect example of government/corporate expansion of biopsychiatric control of even our youngest children [Ed. Note: see following story]. Did you know that there is a crisis in infant and early childhood mental health? According to the academic elites, bureaucrats, and front groups for the pharmaceutical industry, as well as their willing accomplices in the media, mental illness is rampant even in our youngest children. They are promoting a cradle-to-grave mental health screening, labeling and intervention system.

For instance, the Florida Strategic Plan for Infant Mental Health says, “Even before their first birthday, babies can suffer from clinical depression, traumatic stress disorder, and a variety of other mental health problems.”

A study from Yale University tells us, “Pre-K students are expelled at a rate more than three times that of children in grades K-12, according to a primary study by researchers at Yale on the rate of expulsion in pre-kindergarten programs serving 3- and 4-year-olds.”

Because this purported problem is so severe, these same elites have many suggestions to deal with it.

The report of the President’s New Freedom Commission on Mental Health (NFC) says, “Since children develop rapidly, delivering mental health services and supports early and swiftly is necessary to avoid permanent consequences and to ensure that children are ready for school.” Their goal to deal with this crisis is to make sure that, “Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.” Within that goal, the report lists the following recommendation: “Promote the mental health of young children.”

The NFC report recommended a model program for dealing with this infant mental health crisis called the Nurse Family Partnership. The program is described as follows: “A nurse visits the homes of high-risk women when pregnancy begins and continues for the first year of the child’s life. The nurse adheres to visit-by-visit protocols to help women adopt healthy behaviors and to responsibly care for their children.” Do Americans really want to establish government as arbiters of what is “healthy behavior” and how mothers, even dysfunctional ones, “responsibly care for their children”? These programs are being pushed in Congress as not only a solution for “at risk” families, however arbitrarily that is defined, but for ALL families.

The Federal Mental Health Action Agenda (FMHAA) is the implementation plan for the New Freedom Commission report, and it has many concerning recommendations and plans. For instance, one of the grant programs being pro-

moted by the FMHAA is called the State Early Childhood Comprehensive System. Forty-eight states and several territories have received federal funds to implement these grants. The Minnesota program is described as a “federally-funded grant project to coordinate and integrate early childhood screening systems to assure that all children ages birth to five are screened early and continuously for the presence of health, socioemotional or developmental needs. Children and their families should then be linked to mental health services, early care and education, ... so that all eligible children ... enter school ready to learn.” (Emphasis added.) A mission statement from South Dakota for this type of program said, “All Children in South Dakota, are supported by the community through a comprehensive system of care that meets their social, emotional, physical, and spiritual needs.” (Emphasis added)

One federal program that already includes both the screening and home visiting components of the FMHAA infant mental health system that will no doubt be expanded is the early intervention system for infants and toddlers that is part of the Individuals with Disabilities Education Act (IDEA). Passed by Congress in 1976, this federal law began as a way to provide equal access to education for children that had physical disabilities, such as cerebral palsy, blindness, deafness, and orthopedic problems. It was expanded in 1991 to include emotional disturbances and learning disabilities. After 1991, the law has expanded again to include infants, toddlers, and preschoolers, and the now epidemic rates of the diagnosis of autism and autism spectrum disorders. IDEA was last reauthorized in 2004.

The definition of emotional disturbance in federal regulations is “disturbingly” vague and subjective and includes the following components:

- “Inappropriate types of behavior or feelings under normal circumstances”
- “Pervasive mood of unhappiness or depression”
- “Inability to build or maintain satisfactory interpersonal relationships with peers and teachers”

Many expert sources admit the lack of scientific validity behind psychiatric diagnostic criteria, especially for young children:

- “The science is challenging because of the ongoing process of development. The normally developing child hardly stays the same long enough to make stable measurements. Adult criteria for illness can be difficult to apply to children and adolescents, when the signs and symptoms of mental disorders are often also the characteristics of normal development.” (Surgeon General 1999)
- “Childhood and adolescence being developmental phases, it is difficult to draw clear boundaries between phenomena that are part of normal development and others that are abnormal.” (World Health Organization, World Health

Report, 2001)

- Dr. Benedetto Vitiello, director of Child and Adolescent Treatment and Preventive Interventions Research Branch for the National Institutes of Mental Health, acknowledged (2001) “the diagnostic uncertainty surrounding most manifestations of psychopathology in early childhood.”
- A 2005 National Center for Infant and Early Childhood Health Policy report on infant mental health admitted that “the diagnostic classifications for infancy are still being developed and validated...”

Not only does the law cover young children with known and diagnosed disabilities, including the much more vague and subjective emotional disturbances and autism. The law goes a step further with infants and toddlers when it defines these children “at risk” for a disability as “individual[s] under 3 years of age who would be at risk of experiencing a substantial developmental delay if early intervention services were not provided to the individual[s].” Those areas of developmental delay include “social and emotional development.” The types of services included for infants and toddlers encompass:

- “Early identification, screening, and assessment services”
- “Psychological services”
- “Family training, counseling, and home visits”
- “Social work services”

The Gamondes family experienced all of the above services, and as one can tell from the account in this issue of the newsletter, those experiences were far from positive. In addition, to the grave intrusions into family autonomy and parental authority, which will be discussed below, there is little scientific evidence to justify these interventions. For example:

- The 2005 National Center for Infant and Early Childhood Health Policy report cited above also admitted:
 - “Lack of longitudinal outcome studies”
 - “There is neither a systematic data base, clear criteria for [medication] treatment or dosage recommendations that have been identified or standardized for pediatric use (Greenhill et al. 2003).”
 - “Broad parameters for determining socioemotional outcomes are not clearly defined”
- Dr. Vitiello of NIMH, in the same paper cited above, also stated, “Little research has been conducted to study the effectiveness of psychosocial interventions in young children, and the long-term risk-benefit ratio of psychosocial and pharmacologic treatments is basically unknown.”
- With regard to home visiting programs specifically, the longitudinal studies of the most famous “controlled” trial program, the Nurse Family Partnership admit in their studies that they have had no effect whatsoever on the mental health or behavioral issues of “at risk” children:
 - “It is important to note, however, that the reduction in total behavioral problems on the CBCL [Child Behavior Checklist completed by the mothers] was not corroborated by teachers' reports of

child behavior.” (Olds and Kitzman, 2004).

- “There were no program effects on...mental development, or behavioral problems...” (Kitzman and Olds, 1997).
- “There were no statistically significant program effects for the nurses on...their children's temperament or behavior problems.” (Olds and Robinson, 2002).
- “There were no statistically significant nurse effects on sensitive-responsive mother-child interaction, children's emotional regulation, or externalizing behavior problems [nurse visited].” (Olds and Robinson, 2004)

An integral part of the Gamondes' experience was the hypervigilance on the part of the home visitors for autism. Government concern for this particular issue is quite justified, given that the incidence of full-blown autism has skyrocketed from one in ten thousand children in the 1960's and 1970's to one in 166 children today. Tragically, however, the most likely cause of this phenomenon is the huge expansion of use of vaccines preserved with the mercury containing substance thimerosal during the 1980's and 1990's until 2003. Mercury is a known neurotoxin whose vapor release from broken thermometers or laboratory accidents results in environmental emergencies. Yet, mercury was injected into the developing nervous and immune systems of infants at levels hundreds of times greater than the EPA considered safe. Although except for the influenza vaccine, thimerosal has been removed from vaccines given to children, it is still given to pregnant women in certain products and vaccines. The federal government and the pharmaceutical industry absolutely refuse to acknowledge the role of thimerosal in the autism epidemic.

Therefore, the early intervention programs and home visitation, even if they correctly identify autism, which they did not do at all in the Gamondes' case, are completely unable to offer the kind of help necessary to help mercury poisoned children deal with this devastating neurological condition, such as chelation to remove the heavy metals from their system and nutritional support to overcome the neurological damage. (For more information on the controversy, cover-up and scientific evidence, see David Kirby's excellent book *Evidence of Harm*; also the paper on the decline in California autism rates after the removal of thimerosal from vaccines at <http://www.JpandS.org/vol11no1/geier.pdf>; and the information on the International Medical Veritas and Autism Research Institute websites at www.imva.info and <http://www.autismwebsite.com/ari/index.htm>, respectively)

With regard to family autonomy and the scope of government, and in light of the Gamondes experience, of particular concern is the federal government promoting through taxpayer funds and even enforcing via potential child abuse and neglect reporting mechanisms, one particular view and philosophy of parenting and norms for socioemotional health. This infant mental health screening, home visiting, and early intervention system demotes parents to mere partners with government in the raising, education, and medical care of children when settled case law such as the Supreme Court cases, *Pierce vs. Society of Sisters* (1925), *Meyers vs. Nebraska* (1923), *Wisconsin vs. Yoder* (1972) and *Troxel vs. Granville* (2000), as well as hundreds of years of history and legal tradition have clearly delineated the parents alone

as the sole determiner of these decisions and philosophies.

What should then be done? We should oppose actual programs and their funding for home visits and infant mental health screening. If children need specific services, they should be obtained from private providers. We need to demand that the CDC and FDA remove thimerosal from all vaccines. Most importantly, we need to make sure our children are viewed not as bags of chemicals out of balance or individuals with disabilities, but instead as unique individuals as the Declaration Of Independence describes "endowed by their Creator with certain unalienable rights including life, liberty, and the pursuit of happiness." free from government interference in their emotional and family lives.

EARLY INTERVENTION AND THE 'AUTISM DRAGNET' by Adriana Gamondes

As the parents of two late-talking children, my husband and I were suddenly made aware that there's a kind of "dragnet" to seek out Autistic children in American communities, using "Early Intervention", an arm of the Department of Health, which exists to provide government-funded therapeutic services to preschool children. "The Autism Dragnet" is the title of an article by Thomas Sowell describing something similar to what our family experienced (Jewish World Review, 8/16/01).

When our twins- a boy and a girl- turned eighteen months old, we began to notice that their speech was lagging behind that of other children the same age. Though they had spoken a few single words before nine months, seemed precocious, alert, engaged and affectionate, played imaginatively and did not appear to be "losing skills," they were not acquiring speech very rapidly. By the time they were two, we contacted Early Intervention (EI) in the hopes of getting speech therapy for both children.

We were jokingly warned about EI by neighbors who said that "every child they see is Autistic." We heard from the families of three normal formerly late-talking children who'd been grossly mislabeled as autistic by EI therapists, which seemed to be a very high rate of misdiagnoses for a town with less than 800 children under the age of eighteen. This was especially interesting because Early Intervention is legally barred from making diagnoses. We kept this in mind as we scheduled weekly early intervention therapy sessions for the twins. But as a backup, we put the twins on a waiting list to be evaluated at Children's Hospital Boston for "real" diagnoses which could trump any illicit labeling by Early Intervention,

should that occur.

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In any case, we believed we had a likely explanation for the twins' late speech: heredity. Approximately half of my mother's closest relatives were late-talkers and all turned out fine, even extraordinary. Because of this family history and maybe because most pop theories on late-talking make dire speculations on slim evidence, family members were against getting social services for the twins, but we didn't want to be complacent.

As it happened, speech therapy for the twins was a wash. Our daughter would only speak outside of therapy, and only if I followed her lead and used methods that the EI speech therapists refused to try. Our son only began talking the week after speech therapy was cancelled. But this was the least of our complaints about our experience with EI.

From the first interview, aside from being leery of all the intrusive "socio-emotional family screening" questions asked of us, we were curious about why EI staff weren't interested in the children's diet (all organic) except in documenting that the children looked generally "well fed." When we asked about any possible subtle nutritional deficiencies or toxic exposures which might contribute to speech delay, an intake person at EI said, "Don't beat yourself up." I had to wonder - when did trying to take responsibility for one's children become a form of *masochism*? Was this in the DSM?

Then, early on in speech therapy sessions, we found the therapists meddlesome in family matters which had nothing to do with speech development, but had to do with- of all things- attachment-style parenting. We were surprised. Because an aversion to physical closeness and affection is said to be a hallmark of Autism (not to mention the studies of post-institutional or "sensory deprivation" Autism among Romanian orphans, Federici and Associates, 1998), we would have thought that EI staff would be happy to hear that we weren't discouraging the twins' barnacle-like need for affection. But the offer of "help" in getting the twins to "self comfort" was repeated and pressure was applied to place the children in daycare. One of the therapists even implied that "some studies," if they "didn't show correlation," did show that attachment parenting and speech delay "coincided." She never managed to come up with a citation for any study which concluded that attempting to meet all of an infant or toddler's needs for comforting and refusing to force a child to cry alone in a crib in order to "train" them to sleep leads to impairment.

Initially I chalked this pressure up to Dr. Phil's recent televangelical "nanny" segments promoting the popular "Ferberizing" technique of "sleep training." Interesting that Dr. Richard Ferber had recanted his "cry it out" method just that year (*To Cry, or Not To Cry: 'Ferberizing' Clarified*, ABC News Special Report. November 16th, 2005). But maybe it was more than that. The fact that these therapists didn't welcome news of the children's need for closeness could have been the first hint of institutional railroading. In retrospect, it could appear that the children's affectionate natures were causing a hitch in the therapists' program, possibly making it harder to affix a certain "shadow" or "threshold" trait which could act as a foot in the door to forming a diagnosis of Autism Spectrum Disorder. We can't be sure of their motives, but the "shadow trait" that kept coming up during therapy was "Sensory Integration Disorder".

We didn't complain of "sensory issues" at the intake, yet "sensory therapies"- many of them goofy, pointless exercises- began to take up a large part of sessions in place of speech development work. We could understand the value of relaxing the children through silly fun, but the twins didn't always like these exercises or the pressure to perform them. At the same time, the therapists were not taking the children's cues to romp in other ways, so relaxing the twins in order to induce speech didn't appear to be the goal. I never could understand what was meant by "sensory integration" anyway, or how it applied to our children. If the slide at the playground was hot, neither twin would slide on it. If they didn't like a food, they spit it out. They laughed when being tickled, shivered when cold, and danced to music. What sense wasn't being integrated?

We also hadn't complained of pre-existing discipline problems, yet therapy was too often aimed at disciplining the twins, as if they were being prepared for a classroom setting. Since we'd never intended to send the children to daycare, we don't worry about daycare-friendly conformities like sitting in a circle. At barely two years of age, the twins were relatively cooperative, had not been violent to other children and stayed out of the road on walks. We felt we had a few bases covered. And besides being safe and secure, the children were happy. We didn't want outsiders pushing the discipline envelope and risking that happiness.

Nevertheless, the therapists were relentless in foisting some sort of "boundary" training or behavioral "prompting." Since these therapists were creating many of the discipline problems which would need to be fixed, they found opportunity. For no cultural reason that I could see, both therapists insisted on wearing large, dangling earrings to sessions, for example. I felt this was an "attractive nuisance." I had asked them not to wear these things and was pointedly ignored. When I pressed the subject, I was told that "In the real world", the twins would have to learn to resist temptation. Well, I thought, this was why we didn't invite people to set up meth labs or shave with straight edge razors in the playroom. We weren't letting the "real world" in just yet.

My son in particular can hardly contain himself at the sight of jewelry and would try to climb on the laps of the therapists to (gently) play with their earrings. He was rebuffed repeatedly each week. He took this as complete rejection. At the very least, it seemed kind of counterproductive to use unpleasant object lessons as a way to teach him to talk ("Noooo, these earrings are *miinee*."). And talk, he did not.

The sudden changes that occurred in my son's behavior as a result of being reprimanded and rejected were not noted by the speech therapists as "changes" but were assumed- in spite of all my reports to the contrary- to be his normal self. My son went from joyful to listless during the course of each session. He began to habitually bang his back against the safety gate. He found that pelted the therapists with Fisher Price dolls was very entertaining. More discipline problems resulting from discipline.

I felt like the Cat in the Hat had come to our house with the pink spot that spreads and spreads. If the therapists had started out overly-eager to apply preconceived labels, then you could say that the experiment of imposing structure (which Autistic children are said to thrive on) backfired. But it wasn't a total loss: quite conveniently, the children's response to arbitrarily imposed structure triggered some previously nonexistent behavior which could be found on any checklist for Autism Spectrum Disorder (STAT, CARS, CHAT, etc.). And if certain of the children's reactions to discipline couldn't be categorized as Autistic-like, then, again, it still wasn't a total loss: those behaviors could be dressed up as improvement from some invented starting point and the unstated ASD label could be resurrected all over again.

When my son became more clingy in general at this time and I reported it, one therapist remarked on this as *positive change*. I was flabbergasted. If my son was any closer to me than he had been before therapy began, he'd be a tattoo. Had they conveniently forgotten his affectionate behavior (which they'd offered to help modify) and replaced it with an "aversion to touch" which was "improving due to therapy" to suit criterion and flatter themselves on reports?

When only one therapist came for a particular session and set down to work with his sister instead of him, my son attacked his sister for the first time in his life. I didn't feel believed when I told the therapist that this was the first time I'd ever seen my son behave this way. The therapist documented my son's outburst and the monumental tantrum that my daughter threw in response. I assume now that she recorded these things as, of course, "red flags" for autism.

What's more, the therapists asked me to hide the toys my son prefers in order to "expand his play." When my son began to appear aimless and at loose ends during therapy sessions, it was up to me to engage him somehow, because the therapists wouldn't. His punishment ("prompting"?) for the times when he snubbed their color-matching puzzles and ugly plastic dolls was to be ignored.

Worse than this, when my daughter would perform cute antics, the therapists would chuckle and make approving remarks between themselves. When my son would perform cute antics and I laughed, I sensed that the therapists were modeling to me that I

should not laugh. They responded lugubriously, as though I should also find his behavior a little “sad” or maybe “worrisome”. If my son brushed his teeth by himself, it was because he “needed something to chew.” He didn’t have fun, he had “impulses.” He didn’t have a sense of humor, he had “tics.” He didn’t have interests, he had “compulsions.” He didn’t explore or show affection, he satisfied “sensory issues.” I’ve heard animal trainers assign more human emotions to dogs.

I thought these insinuations and unspoken judgments amounted to a kind of gesture warfare on the part of the therapists, aimed at altering my perspective of my children, which the children may well have sensed. As an adult I found the experience crushing and confusing and, since I couldn’t follow my impulses to pelt the therapists with Fisher Price dolls, grab the kids and run away, I found myself stuck in some hypothermic gap between fight or flight. Paralyzed with indecision or not, I still wouldn’t let the way I saw my children be changed. Instead, since I held to my perspective, I had the sickening “research” opportunity of witnessing how symptoms of ASD could not only be invented, they could even be *induced*. If the twins were both behaving in increasingly negative ways, the therapists did not believe that this could be a response to adult behavior. The therapists certainly weren’t beating themselves up about it.

Though the therapists seemed affectionate towards my daughter in the way that people at horse races display affection for the horse they’re betting on, this didn’t mean that, to them, she wasn’t autistic. They just seemed to think she was less Autistic than her brother. It became apparent that my daughter’s skills were not being regarded as skills but as “fixations.” For example, my daughter would joyfully enumerate objects to over one hundred by thirty months of age and spontaneously began reading some time before this. In an engaging way, she insisted that we write out and illustrate words on her drawing pad at each meal and bedtime, which is how she chose to learn to talk, and it was working. When I asked why the therapists didn’t attempt to use my daughter’s love of numbers and letters to reinforce speech, I was told that the exercise would be too “academic.” They didn’t ask if she comprehended the words she was reading or the numeric values of what she was counting, which she clearly did.. It then dawned on me that the therapists had most likely refused to reinforce my daughter’s ability to read and count because they had labeled her as having “hyperlexia”, which I understood to be, in part, an obsession with numbers and/or letters without comprehension. To the EI therapists, she was Rainman.

But even the threshold disorders of “Pervasive Developmental Disorder- Not Otherwise Specified” and “Atypical Autism” require various traits of rigidity, perseveration, social avoidance and ritualistic play which could not be applied to these affectionate novelty buffs. No mention was ever made of alternate explanations for late-talking by the therapists. No mention of Specific Language Impairment or Asynchronous Development, which bear traits overlapping with Autism - nothing. No matter how many times I read

and re-read every checklist for Autism I could find, I never did come across “loves surprises” or “laughs at fart jokes” among the markers.

For all that was just plain wrong about it, I was still reluctant to cancel speech therapy because we’d been confused by some of the misinformation given to us by EI staff. They’d led us to believe that the age of three is some kind of radical cut-off point, beyond which the development of language suddenly becomes much harder. We were frequently reminded, in tones of alarm, that we didn’t have time to wait for our number to come up for the evaluation by specialists at Children’s Hospital and needed to think about what was “best for the children” immediately, even if that meant accepting labels, which were coming hard and fast but never in clear terms. The therapists would mention a DSM diagnostic label or criteria but would use the loophole of simply exchanging the word “disorder” for the less official sounding word, “issues.” I was told, of course, that my children had “sensory integration issues.” My husband and I waited for the moment when we would be told that our children had “Autism issues” or “PDD issues.”

Several months into therapy, I called Early Intervention’s headquarters to make a complaint about the illicit labeling and asked that one of the therapists be changed. This therapist had raised her voice at me while sitting right next to my children, barking that maybe I “needed therapy” after I contradicted some of her diagnostic hinting. In the following weeks, the offending therapist wasn’t changed. Little changed, so it was clear that many of the things we didn’t like about the program were part of a trickle-down, so to speak. The problems must be coming from above.

And soon came the confrontation we’d been anticipating. No-one called us to schedule this important meeting. As a result, my husband was not forewarned and wasn’t there to participate or-maybe more importantly- to act as corroborating witness. The program director showed up wearing very long, ornately-beaded earrings and had the two therapists in tow. In front of the children, using the scheduled time for speech therapy, the director tried to make a case for sending the children to a local program for Autism and Pervasive Developmental Disorder. The program director said that they’d “seen red flags.” She gave me a pamphlet with a smiling, mentally handicapped child on the cover. I just kept shaking my head and saying something brilliant like, “Uh, I think we’ll pass.” At some point, the program director smiled wanly and told me, “Even if your children remain the way they are forever, they’ll still be interesting people!” I wondered how it was loving or showing “interest” in children to go against instincts and better judgement to force them into treatment they may not need.

I was too stunned to see the effect that witnessing this conflict was having on the twins and deeply regretted allowing the meeting to continue. I regretted allowing any of it to happen. In the next few weeks, I called Early Intervention and cancelled services, saying that we were “leaving the country indefinitely.” It’s the kind of excuse you give to a stalker or a cult recruiter, to echo the sentiments written by another early intervention escapee.

To further the cult analogy, the receptionist who took the call became unhinged when I announced our withdrawal. I had to

hold the phone away from my ear as she shouted that we would “*have to* allow a final visit” in order to provide “closure for the therapists and the children,” and that we’d “have to fill out some paperwork” saying why we were ending therapy. I asked if they had legal recourse to make us do these things. There was a pause and the woman said, “I don’t know.”

After this phone conversation, we received a number of calls from the program director, which we ignored. She came by the house very early one morning, clearly in the hopes of cornering us. Then the campaign petered out and we sighed with relief. What was disconcerting is that Early Intervention staff seemed to wish that they did have legal recourse. It’s certainly not hard to imagine how anyone might feel seeing all that momentum and effort wasted. But who *asked* them? As the parents of genuinely Autistic children had assured me, if the twins were, in fact, suffering from the disorder, we’d be begging for help instead of being forced to chase it away with “rusty meat hooks.”

There were other things said and done in the course of the final meeting which are worth mentioning for the shock value. For example, the program director told me- in case shining a ray of optimism might motivate my husband and I to place the twins in the PDD program- “Some children enter the program and later have the Dx removed”. Yes, she pronounced it “dee ex.” Maybe she thought it would sound less like “diagnosis” that way. Saying “diagnosis” outright could lead to uncomfortable questions about who was making the diagnoses which were “removed,” since EI is not a certified authority. And if the “dee ex” could be removed, then why was it made to begin with? Is Autism like a cold or a flu? Or were they claiming to be able to cure it?

What’s more, this program director (unprompted) dismissed some possible causes of Autism which, if I had mistaken her for an expert and if my children had been truly in danger as she said, could potentially have cut us off from alternative forms of help or prevention. She said, “Thimerosal (in vaccines) is no longer believed to cause Autism.” Furthermore, she explained that the Autism epidemic had been discounted. She said that the symptoms are just better recognized.

To me, these statements wipe out any benefit of the doubt over why EI staff would err on the side of zealousness in searching for autism. In at least the case of our local branch, this couldn’t be because of reports of epidemics or because of growing suspicions about thimerosal or other immune-depleting environmental toxins. They didn’t believe in these things.

What did they believe in? When I described the behaviors of the therapists towards the twins and the twins’ responses in an email to Professor Stephen Camarata, a speech pathologist and head of Vanderbilt University’s speech development center, he explained that the “withholding,” pointed “ignoring,” the “set-up” of wearing tempting jewelry, the lack of attention to the twins’ cues to play and general focus on behavioral modification were all categorically “aversive prompting”, consistent with “discrete trials training” and part of the con-

***“We never understood why
Early Intervention staff
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Disorder.”***

troversial ABA-Lovaas method of applied behavioral analysis designed for Autistic children. He sent me the titles of two studies showing that the use of applied behavioral techniques by Early Intervention, which involve excessive prompting and which ignore children’s play initiatives, could cause - *tada* - an increase in the disruptive behaviors associated with autism. Koegel, Dunlap and Koegel, 1988, showed this result for Autistic children and Haley and Camarata, 1994, showed this result for non-Autistic children.

In the *Journal of Early and Intensive Behavioral Intervention (JEI)*, Volume No. 3, Issue No. 2, I found reference to the use of aversives in forcing Autistic children to manage their own pain, which may have been one of the “studies” to which the EI therapist referred in pressuring us to cease attachment parenting.

I pondered if, like psychotherapists, Early Intervention Therapists were required to undergo the very therapy they applied. I thought this might explain the multiple incidents of disruptive behavior we’d endured from them. And furthermore, couldn’t their perseveration and lack of sensitivity to social cues land them squarely on the “spectrum?”

So many questions. If Early Intervention’s goal was simply to help our twins, I’m not sure why they told lies, manipulated, used intimidation and showed discouragement of and disinterest towards the measures we took to seek alternative or medical explanations for speech delay. We never understood why Early Intervention staff seemed to *need* the twins to suffer from autism spectrum disorder and not something else while they were at it. Was it a sort of turf war to get government grants per head of ASD child?

This is not to say that individual therapists are in on any conscious conspiracy, though. I think institutions can count on certain personalities to aggressively fetch the stick for the pat on the head, which anyone plagued by telemarketers can attest. But what force was advocating this policy of aggression at early intervention?

Last year, my bright, well-behaved, formerly late-talking eleven year-old nephew was threatened with Ritalin by a Montessori school principle in Florida. My formerly late-talking sister was told that her son would be removed from mainstream classes if he was not started on medication. She refused and withdrew her son. The same thing had happened to me when I was five years old, and my parents had also refused to drug me

for “daydreaming.” In looking for something which could explain our experience with EI, I thought I’d start with that old family friend, the pharmaceutical agenda. If a mollusk dies in South Carolina, pharma was there, so why not this?

For one thing, we were curious to know if there were dangerous psychiatric drugs waiting for us at the end of the Early Intervention rainbow. We didn’t stick around to find out personally. I imagine there’s reports of “disruption” from preschool therapists which lead to *referrals*, but I don’t know how that works. All the same, it was much too easy to find drugs at the *beginning* of the rainbow.

I struck paydirt within minutes of turning on the computer. In the NIMH website, I learned about the mega-million dollar Congressional funding of an Autism “dragnet” to “seek out and treat” ASD children via the Children’s Health Act of 2000, which saw to the creation of the Interagency Autism Coordinating Committee (IACC) and the Studies to Advance Autism Research and Treatment (STAART) Network, which will focus on clinical trials. Because of the overwhelming focus on biomedical research which overshadows any reference to more legitimate proposed studies, these programs appear somehow “genetically linked” to the T-MAP program. All of this seemed to be merely gestation for the Orwellian-sounding New Freedom Initiative launched in 2002, which itself is breeding little monsters like H.B. 470. Terms like “mandatory mental health screening for preschool children” and “forced drugging” really grabbed my attention when reading about these legislations.

It’s all so hard for a layperson to keep track of, but I understood intuitively that the macro-to-micro effect in the realm of bad mental healthcare policy proposals might be likened to leaving the lid off some federal garbage can of human nature. You soon find your own backyard besieged with emboldened therapeutic raccoons who no longer run away when you pitch rocks at them.

To risk being diagnosed with Autism for even noting this fact, on the NIMH website section devoted to autism spectrum disorder, 100 more words are used to promote drug therapies than are used to describe behavior modification in treating autism. 103 more words, to be exact. The behavioral therapy loosely described in the NIMH site sounded so gruelingly intense (up to 40 hours a week of ABA) that I suspect our own children could not be forced to endure this kind of treatment, much less the separation from their parents that it would require. Unless they were drugged, which could only happen if we were tied down and drugged as well.

The NIMH website does not specify which of the myriad of ABA applications are being referred to. It seems too preposterous to even imagine that the NIMH-preferred types of behavioral therapies might turn out to be those most likely to cause distress, trauma, depression, humiliation and rage in young children in order to ensure parental and public consent to medicate. But I tend to believe that the NIMH website was not referring to the possibly kinder-gentler ABA applications such as Greenspan’s “Floortime” and the like. As it stands, an interview with Gary Mesibov of the likewise kinder-

gentler TEACCH method revealed that the NIMH funding for the Koegel Autism Center had been cut in 2001 in preference for funding biomedical drug therapies for autism. (<http://lookingupautism.org/Articles/GaryMesibov.html>) I know that funding comes and goes, but I imagine that some therapeutic organizations might find theirs “going” more often than others. I have a quirky, not very serious superstition that if I name a fear out loud, it will be less likely to come to pass. For the sake of appropriately and inappropriately labeled ASD children everywhere, cross fingers that it works this time.

I too easily came across the NIMH’s calls for drug-test subjects (drugtrials.com!) among children with Autism Spectrum Disorder. The drugs slated for testing are neuroleptics and SSRI’s, among others. No mention of the risks associated with this drugs appears anywhere on the site. The NIMH website also advocates the use of Ritalin and other stimulant drugs for children with ASD, claiming that “brain chemistry” studies show that many of these children suffer from an overlap of ADHD symptoms, a view that’s echoed throughout the Autism “advocacy” community. On the web, it was no trouble to find many accounts of parents medicating children under the ages of three who’d been diagnosed with “mild ASD”, using drugs like Zyprexa, Seroquel, Ritalin, Luvox, Paxil and Prozac.

It’s horrifying to think that some children with specific language impairment (late-talking with no pervasive cognitive problems, if I understand correctly) or phonological problems may speak as late as three, four or five years of age. It doesn’t seem impossible that children with these lesser-touted issues who, after being mislabeled as ASD and treated with psychotropics, could end up so damaged by the drugs (or psychosurgery, which is currently being “investigated” by the NIMH) that their language impairment, behavioral quirks or social differences- which may have otherwise resolved naturally- could become permanent or worsen, making ASD a self-fulfilling diagnosis.

As far as weighing the effects of these drug treatments and intensive therapies on appropriately diagnosed autistic children, I respectfully leave this to the horses’ mouths: organizations like Autistic People Against Neuroleptic Abuse (apana.org) and eloquent Autistic adult activists like Michelle Dawson of No Autistics Allowed (http://www.sentex.net/~nexus23/naa_sen.html) have much to say on these matters.

It also seems all too easy to misdiagnose ASD if one uses the NIMH-recommended checklists or if one believes the prevalence reported on their site. The list of “traits of Autism” on the NIMH’s website had been expanded beyond the DSM definition to include things which seem like normal childhood eccentricities to anyone with common sense. The rate of occurrence of Autism in the general population had also been expanded, according to the addendum in the NIMH site, from the older, more conservative rough estimate of 1/1000 to the new figure of 1/166. Supposing that our children turn out to be officially cleared of all charges, 1/166 would be almost the precise rate of *misdiagnoses* of Autism in our small New England town. Aside from invoking the word “quota,” this made me wonder whether any parent of a genuinely autistic child would be happy to hear that resources- which could have been aimed towards therapeutic improvements and the search for a cause- could be systemati-

cally wasted on children mislabeled with the disorder.

Just as the program director for early intervention had announced, the NIMH website refers to studies which conclude that thimerosal in vaccines does not cause autism. The site states that thimerosal is no longer in childhood vaccines, but it does not address the fact that thimerosal can be found in some flu vaccines given to children as young as six months of age. There is (of course) no mention of the “rider” on the Homeland Defense bill protecting drug companies like Eli Lilly from thimerosal-related lawsuits (<http://www.vaccinationnews.com/DailyNews/2003/January/CongressGives20.htm>).

By the numbers of parents on the web who’ve accepted the label of “mild ASD” and are sending their children to early intervention, while simultaneously and conversely sending their children’s hair samples to special laboratories to be tested for heavy metals (“chelation scams” are said to be abounding because of these growing fears), EI and the NIMH seem to have found a use for our generation’s thimerosal fears without the inconvenience of having to address the controversy.

Two pediatricians who’ve seen the twins’ full range of development claimed they could find nothing wrong with them. When asked about Early Intervention’s tendency to mislabel more than one of his patients with ASD, one of these pediatricians recalled the first thing he’d learned in medical school: “When you hear the sound of hooves, you’re supposed to think horses, not zebras.”

But it doesn’t seem like horses would bring in government grants or even billions of dollars in drug sales. Unless you slap paint on them and call them zebras. Welcome to Africa.

We don’t know yet how this story turns out for the twins. We’re still seeing some of the effects therapy had on them, though they get along well again, as they always have. Almost all of the so-called “red flags” in the twins’ behavior were never seen again after sessions were terminated. They’ve always seemed bright and lively to us and the words are coming. In trying to stay off our state’s “mental health radar” for the time being, our choice of speech enrichment resources have been limited.

After seeing his published research on bright, late-talking children in Thomas Sowell’s *The Einstein Syndrome: Bright Children Who Talk Late*, we scheduled an evaluation with Professor Stephen Camarata, PhD, of Vanderbilt University. He himself was a late-talker and has been openly critical of some of early intervention’s practices as well as the expansion of the traits of Autism. We feel confident that, at the very least, this speech pathologist won’t force fashionable diagnoses. Even if it turns out that our children need some form of cognitive support, we don’t believe that the early intervention therapists we’ve encountered are fit to make that determination and will not let their kind near our children ever again.

That is, if we can help letting these people near our children. As if the EI faction is some kind of omniscient glut of missionaries, haunting places where children under three might frequent, foisting free referrals, breaching privacy and spreading the word, we were actually solicited by a staff member on a very crowded public playground recently. I’d seen her lurking about with a cold, appraising eye and no child of her own to justify her presence. The big earrings should have tipped me off.

My son apparently got this EI person’s attention when he found a broken slat on a tall wooden play-structure. As he sat there demonstrating the loose slat and giving me his report on it in his typical jargon, what I saw was the world’s shortest and cutest safety inspector. What this EI staff member saw was a toddler who couldn’t speak fluently and who was irrationally banging a piece of wood. Fair enough, except it wasn’t any of her business. Our Lady of Early Intervention sidled up to me, introduced herself by name and rank and said, “I noticed that your little guy doesn’t say much. Have you been told about early intervention services?” Then she added, “I don’t mean to pry. We’re in the phonebook”.

She did so mean to pry. All the clever things I could have said but never do in these situations. It’s my own personal speech delay, which people like this EI staffer should be grateful for. When I later found myself reflecting that it may have been a good thing that I hadn’t shot back at the EI therapist, I realized that something about this situation was really frightening me. Again, it was as if I feared these people might have recourse. That night I had a terrible dream about a tough-talking woman who had kidnapped the twins and was trying to take custody of them in court. I woke up feeling shattered. Note to self: no more History Channel series on the Third Reich for a while.

None of this was sitting well with my husband either, who doesn’t need dreams or TV to illustrate precedent. When he was a child, his family had been forced to escape Argentina at the time of the military hunta in the 1970’s, when over thirty-thousand government critics, mainstream intellectuals and pacifists were executed and their children stolen to be raised with “proper values” by members of the military elite. Nevertheless, my husband wasn’t getting too worked up about the intrusiveness of a little government agency in our case. He explained that if things went downhill in this country and that, somehow, these helpful types got the power and “new freedom” they seemed to long for, we could always use our dual passports.

To most of us sheltered Americans, it seems crazy (sceen-ably so) to think it could go that far. Still, I find that there’s alarmingly little need to hyperbolize or make hysterical parallels in order to portray the present situation as a little chilling. All we need are the facts, Ma’am.

Northeast Times Highlights

Chronicling the Fictional Lives of the Northeast Membership

Northeast Times is a parody of the Newsletter presented in its entirety only to Northeast Group members. By popular demand, cleaned up excerpts are included here for everyone's enjoyment. These pages are just for fun and this stuff is entirely made up. Hence our motto ... *If it never happened, you'll read it here first!*"

Surgeon General's Warning:

This is a parody of the ICSPP Newsletter. The focus is on ICSPP Northeast members and any resemblance to anyone *outside* the Northeast Group is entirely coincidental.

This is especially true where FDA and drug company officials are concerned. They would never do stuff like this.

Really. I wouldn't kid about something like that.

In This Issue:

Director Dom Cut Loose!

FDA's Hotel Hassles

Northeast Group's Vagus
Nerve Implant Research

Northeast Member
Biography: Phil Tenaglia

Neuroleptic Crossword
Puzzle!

Editor and Creator:
Andrew Crosby, MA

Riccio Beats the Rap!

"I'm Innocent, so (to Heck with) You Guys!"

Dominick Riccio, International Executive Director, was acquitted and freed yesterday when a grand jury failed to indict him on charges of conspiracy and fraud.

"I have been rightly declared innocent," Riccio proclaimed at his press conference. "In fact, I am vindicated, the truth has been revealed, and all you people who thought I was guilty are a bunch of booger heads!"

A brilliant psychoanalyst, speed reader, and gourmet cook, Riccio is also an accomplished poet. He displayed his prowess by reciting his statement to the press in iambic pentameter, leading Northeast Group compatriot Phil Tenaglia to weep openly upon hearing his words.

"Lovely," Tenaglia declared, sobbing into his sweatshirt sleeve. "Simply lovely. Equal parts Elizabeth Barrett Browning and 'Beowulf'." Tenaglia then blew his nose into a sweat sock causing many near him to recoil in disgust. He was wearing the sock at the time.

Attorney William "Slick Willy" Dumassky, beaming with pride beside Riccio, credited *Northeast Times* and ICSPP Newsletter investigative reporters for his client's vindication. "If it weren't for Andrew Crosby, Riccio would have gone down in flames and rotted in the decrepit dungeon that is our federal penal system."

This prompted Lloyd Ross, National Executive Director, to snicker and mumble to nobody in particular.

Shaking visibly from heavy Sno Cap ingestion, Dumassky favorably compared *Northeast Times* editor, An-

drew Crosby, to *New Yorker* investigative journalist, Seymour Hersh: "Hersh isn't fit to wipe the goose poop off Crosby's roller blades," Dumassky stated.

Crosby disagreed, finding the hyperbolic comment unnecessarily crass. "Sy Hersh does a great job at skate maintenance," Crosby said of his long-time equipment manager. "I thought Bob Woodward was a natural until Sy came along."

Investigative Journalism Prevails

Riccio faced fraud and conspiracy charges at the indictment proceedings. Federal authorities alleged that Riccio had set up numerous phony consulting positions for pharmaceutical companies which he used to glean "gobs of money" from companies and from the FDA. But, as Andrew Crosby had predicted, the prosecution's case came down "like a house of cards."

Also as Crosby predicted, when the jury rendered its decision, Dominick Riccio did "freaking back flips."

The case was cracked when Crosby uncovered documents proving that Riccio's sudden spike in "income not necessarily declared, kind of," was actually the result of gambling winnings. Riccio is a well known poker aficionado, Crosby explained, and "recently hit a lucky streak" while on a whirlwind European gambling excursion.

Additional findings presented at the indictment proved that the real culprit of the phony consultation positions was none other than biopsychiatrist D. Bummer Goofy.

Goofy could not be reached for comment. Having had his appearance surgically altered, he's skipped the country. Credit

card and cell phone records, obtained by *Northeast Times*, suggest he is in Buenos Aires. According to Crosby, "We have an investigative team chasing down his (fanny) as we speak. Goofy's going to get it this time."

*"That would
explain my desire
to kill him,"
Crosby said.*

FBI authorities confirmed Crosby's assertions and are also pursuing Goofy. "Goofy will be brought to justice," said Special Agent Barney Crudfoot. "He absconded with tens of millions of dollars of tax payer money – almost as much as Riccio took in from gambling this year – and he framed Riccio. That fink's gonna get it, all right."

Other Interesting Implications

Robert Sliclen, Membership Director, offered his unique perspective on an aspect of the story no else has thus far considered.

"The theme of this story deals with Riccio being attacked, persecuted ... all but destroyed," Sliclen said. "Finally, he is rescued, as it were, by the very author of the story."

Sliclen described this as a "text book example" of the author playing out his Oedipal fantasies toward Riccio, leader and symbolic "father" of the group. Crosby is clearly acting out a transference reaction toward Riccio, Sliclen asserted.

"That would explain my desire to kill him," Crosby said of the Freudian interpretation. The Oedipal Conflict is a well-known psychodynamic concept which describes Sigmund Freud's unconscious wish to kill William Shakespeare.

Despite the apparent threat, Riccio is in no danger according to Sliclen. "Crosby is too freaking busy with the newsletter and conference work to act on any impulses. He doesn't have the time."

"That's true," agreed Lloyd Ross. "Andy's infatuation with the newsletter and related efforts sure is good news for Dom." Ross elaborated that Crosby's involvement with such activities demonstrates he is finally progressing into the latency stage of psychosexual development.

In Eriksonian terms, Ross said, Crosby is progressing from "Inferiority vs. Mastery" to "Industry vs. Roller Blading all Day."

Riccio's Future Plans

His release and vindication complete, Riccio plans to return to his practice, his cooking, and his poker playing. "Oh, yeah," Riccio said, "And I'll get to some of those meetings at Lloyd's place, too." Thus, Riccio's position as International Executive Director is secure.

"We're glad he got sprung," said Crisilda Rucci, Conference Concierge Extraordinaire. "Nobody else can focus the Northeast Group like our Dominick."

While all in the Northeast group are happy about Riccio's release, some disagreement about Riccio's leadership abilities exists. "I wouldn't call it 'focus,' exactly," said Geraldine Lewis. "That's probably too much to expect from us."

FDA Hearings Snarled By Hotel SNAFU

The Food and Drug Administration (FDA) struggled this week to conduct hearings regarding the approval of new uses for two common psychiatric drugs. Two specially appointed Special Appointment Approval Committees were to hear testimony from pharmaceutical researchers as a preliminary measure to unquestioned acceptance of these proposals.

According to the FDA's uncritically accepted press release, at issue was the approval of the *not-even-close-to-typical* neuroleptic, Risperdoink, for use as a treatment for irritable bowel syndrome, and for the *nothing-even-remotely-approximating-a-stimulant*, Strattivo, as a treatment for falling asleep at FDA hearings.

The hearings were snarled, however, due to botched accommodations at the venue where the proceedings were to be held, Bethesda's Triple Threat hotel.

"Cripes," said Wally Nomind of the FDA. "The Triple Threat blew it, big time. This was worse than a foot cramp."

The trouble commenced when the hotel, which was scheduled for renovation, was imploded as the participants entered the building. The group barely managed to outrun the expanding cloud of dust and debris.

"They should have heeded the 'Do Not Cross' barricades and yellow tape that cordoned off the blast zone," said Bethesda Police Chief Harvey Shootfirst. "Jeesh, the place was closed for, like, a ten block radius. These people are scientists or something?"

"We thought that was to keep out protesters and, you know, the public and stuff," said Nomind while coughing and wiping grime from his glasses.

"It is disturbing that Triple Threat management knew about this and didn't tell us," said Angelina Ran-

dom, FDA Chief Administrator for Chief Administrative Damage Control, of the snag. “What a bunch of bone heads.”

Triple Threat management could not be reached for comment as their premises, including their telephones, had been loaded onto dump trucks bound for New Jersey.

All was not lost, however. A fleet of vans were on hand to ferry attendees from the debris pile to an alternate venue, The Remeron Inn.

“Sure! That Was a Big Help!”

FDA and pharmaceutical company officials were unimpressed with the shuttle arrangements. While some managed to arrive at their new destination, many were scattered across the region.

The Risperdoink Committee was dropped off at Baltimore-Washington International Airport (BWI). Before this error could be discovered, they had set up their tables and PowerPoint equipment and presented their research findings on Risperdoink’s success in treating irritable bowel syndrome.

“Problem was,” said Goober Rotsnocket, chief Risperdoink researcher, “that we presented our findings not to the FDA, but to a bunch of podiatrists from Iowa. They looked like FDA types, but were just on a layover.”

Dr. Boris Guacamole of the Iowa Society for the Preservation of Podiatrics and Stuff Like That was pleased with what he heard at BWI.

“It was cool,” said Guacamole. “We are proud to be included with pediatricians, neurologists, and general practitioners in the *way-the-hell-off-label* psychiatric drug prescription craze. Talk about your expanded income!”

“Neither irritable bowel syndrome nor toenail fungus are confirmed brain diseases.”

As a result of the glitch, Risperdoink gained approval as a treatment for toenail fungus, but only as an adjunct to talk therapy. “Sure,” said Guacamole while reaching for his script pad. “Like *that’s* going to happen.”

Guacamole then caught his connecting flight to Arkansas.

And It Got Worse From There

Another challenge for the FDA was competition from The Northeast Group. A nonprofit educational network of mental health professionals and advocates, The

Northeast Group held its press conference without a hitch in the new venue.

“The van ride was great,” said Membership Director Robert Sliclen. Sliclen held his head out the window during the trip according to group members, “just like his Golden Retriever, Cody, when they drive up to the Adirondacks. He had that big doggy smile and his ears were flopping all over.”

At the press conference, Dominick Riccio, International Executive Director, poked more holes in the drug company research than a vice president on a bird hunting expedition.

According to Riccio and the Northeast Group, “Neither irritable bowel syndrome nor toenail fungus are brain diseases any more than depression or schizophrenia.”

“Of course they are,” countered the FDA’s Random. “Didn’t you uncritically accept our press release and addendum?”

Riccio and Lloyd Ross, National Executive Director, presented drug company research that showed “ridiculously flawed methodology” and “totally wacked conclusions” based on “pathetic results.”

Even a child could see the researchers had manipulated their studies. For example, Geraldine Lewis pointed out that all of the “favorable” results were accounted for in a group of subjects the drug company called the “Made Up Group.” “They always pull that one,” Lewis said, “It’s their only shot.”

So, What Happened Here?

The FDA approved Risperdoink as a treatment for both toenail fungus and irritable bowel syndrome. They also approved Strattivo for falling asleep at FDA hearings “and for just plain falling asleep.”

“Finally,” declared researchers, “Mankind will be saved from the scourge of sleep after, like, millions of years. Are we great, or what?”

When asked about the Northeast Group’s abject failure to exert any influence, the group members were unaffected. They seem unflappable. “Nothing flaps us,” Riccio said, “This happens all the time. Anybody hungry?”

“It’s the way things are today,” shrugged Phil Tenaglia. “We speak the truth, a handful of people listen, then the ones in power do whatever they want. Our primary aim is to not uncritically accept what authorities offer.”

“The Northeast Group does not uncritically accept much of anything,” confirmed Crisilda Rucci, “but we can’t control what the rest of society will do. They don’t seem ready to question authority yet. Perhaps their courage needs more time, and more efforts like ours.” Rucci then added, “How about Tai food?”

Sliclen, a big fan of Tai food, surprisingly failed to respond. “Hey, everybody,” he called. “The van’s coming! *I call a window seat!*”

ICSPP Conference DVDs – Check Them Out

ICSPP conferences are unique. We share and acquire information that can be gleaned from nowhere else, and, perhaps because of this, we share a strong sense of community.

Viewing the DVDs is an excellent way to experience these events if you've been unable to attend, and to re-experience the inspiration you felt if you'd made the trip. They also offer a valuable way of introducing ICSPP's ideals to others. Sharing conference experiences by viewing the DVDs with colleagues is an excellent way of spreading the word and supporting your views.

The order form, with prices, is on page 40. Purchase what you can, or what you find most interesting. You'll be surprised at what you've missed ... even if you were there.

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Peter R. Breggin, M.D. David Cohen, Ph.D.	Your Psychiatric Drug May Be Your Problem
Peter R. Breggin, M.D. Pam Clay, J.D. Donald Farber, J.D. Danny McGlynn, J.D. Michael Mosher, J.D.	Psychiatry, Malpractice, & Product Liability Issues
Peter R. Breggin, M.D. Kevin McCready, Ph.D. Loren Mosher, M.D. Tony Stanton, M.D.	The Treatment of Deeply Disturbed Children & Adults Without Resort to Psychiatric Drugs
Peter Breggin, M.D. Ron Hopson, Ph.D.	Children In Distress: ADHD & Other Diagnoses
Tony Stanton, M.D.	Working With Very Disturbed & Traumatized Children
Paula Caplan, Ph.D.	What is Wrong With Psychiatric Diagnoses? : Biopsychiatry and the DSM
David Cohen, Ph.D.	Drugs In Psychiatry As A Socio-Cultural Phenomenon
Gerald Coles, Ph.D. David Keirse, Ph.D.	Why We Shouldn't Label Our Children ADHD or Learning Disabled
William Glasser, M.D.	Psychotherapy Vs. Drug Therapy With Children
Hon. Marion Crecco	New Legislation, Children, and Medication Abuses
Louise Armstrong, Ph.D.	And They Call It Help: How Psychiatry Has Failed Our Children
Peter R. Breggin, M.D. Jake Johnson, Ed.D.	Reclaiming Our Children

2003 - Treating the Difficult Child: ADHD, Bipolar, and Other Diagnoses: Challenging the Status Quo with Solution Based Therapy

Peter Breggin, M.D.	The Biological Basis of Childhood Disorders: The Scientific Facts
David Cohen, Ph.D.	New Research on the ADHD Drugs: A Comparative Study of Stimulants
Brian Kean, M.A.	The Dangers of Diagnosing Children: Results of the Multi-Modal Treatment Approach Study
Robert Foltz, Ph.D.	Bipolar, ADHD and Conduct Disorder: The Diagnostic Dilemma.
Bruce Levine, Ph.D.	Common-Sense Solutions for Disruptive Children Without Drugs or Behavioral Manipulation
Dominick Riccio, Ph.D.	Family Therapy: The Treatment of Choice for Working with Difficult Children
Kevin McCready, Ph.D.	Psychodynamic Therapy with Children and Families
David Stein, Ph.D.	A Drug-Free Practical Program for Children Diagnosed with ADHD and Most Other Behavioral Disorders

2004 - Critiquing Disease Models of Psychosocial Distress and Implementing Psychosocial Theories and Interventions

Vera Sharav	Screening for Mental Illness: The Merger of Eugenics and the Drug Industry
David Healy, M.D.	Manufacturing Consensus in Psychopharmacology: The End of Psychiatry as a Science?
Peter Breggin, M.D.	Violence Induced by Psychiatric Medications: Cases, Questions, and Contradictions
Brian Kean, Ph.D.	The Risk Society and Attention Deficit Hyperactivity Critical Social Analysis Concerning the Development and Social Impact of the ADHD Diagnosis
Pam Oatis, M.D.	A Pediatric Practice Using no Psychotropic Drugs, and Teaching Peers and Residents to Treat Difficult Children by Asking How and Why
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George W. Albee, Ph.D.	A Radical View of the Causes, Prevention, and Treatment of Mental Disorders

(2004 Continued)

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Celia Brown and David Oaks	The Continuum of Support: Real Alternatives and Self-Help Approaches
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Raymond DiGuiseppe, Ph.D.	Is Anger Adequately Represented in the DSM?

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OVER THREE DECADES OF ICSPP ACCOMPLISHMENTS

- Stopping the worldwide resurgence of lobotomy and psychosurgery on adults and children, and all psychosurgery in federal and state institutions.
- The creation of a federal Psychosurgery Commission by Congress (1970's)
- Alerting professionals to the dangers of tardive dyskinesia in children (1983). Tardive dyskinesia is a potentially devastating neurological disorder caused by neuroleptic or antipsychotic drugs.
- Alerting professionals to the dangers of dementia produced by long-term neuroleptic drug use (1983).
- Motivating the FDA to force the drug companies to put a new class warning of tardive dyskinesia on their labels for neuroleptic drugs (1985).
- The withdrawal of a large multi-agency federal program to perform dangerous invasive experiments in inner-city kids in search of supposed genetic and biochemical causes of violence (the violence initiative) (early 1990's).
- The initial cancellation and later modification of a potentially racist federally sponsored conference on the genetics of violence (early 1990's).
- Alerting the profession to danger of down-regulation and dangerous withdrawal reactions from the new SSRI antidepressants such as Prozac, Zoloft, and Paxil (1992-4).
- Monitoring, and at times modifying or stopping unethical, hazardous experimental research on children (1973-present).
- Encouraging that NIH Consensus Development Conference on Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder to raise serious concerns about "ADHD" and stimulants for children.

While each of these critiques and reform projects was initially considered highly controversial, and while each was frequently opposed by organized psychiatry, most are now widely accepted as rational, ethical, and scientific. For example, Psychosurgery is no longer widely practiced and not at all in state or federal institutions or on children in the United States; the multi-agency federal program aimed at using invasive biological procedures on inner-city children has been disbanded; the conference on the genetics of violence was delayed and then vastly modified; all experts now recognize the dangers of tardive dyskinesia in children; many researchers have confirmed that the neuroleptic drugs produce dementia, and experienced doctors now recognize the potential for dangerous withdrawal effects from the SSRIs.

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