

ICSPP Bulletin

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

"The Conscience of Psychiatry"

2009 – Number 3

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Bulletin Staff:

Andrew Crosby, MA
Editor

Delores Jankovich, MA,
LMSW
Co-editor

Syracuse Conference Close At Hand Register Now and Join Us !

Have you been looking for information to use for debunking genetic theories of ADHD and Bipolar Disorder? Have you been hoping for some strategies to reduce the widespread use of medications in children? Want to know more about how consumers are misled about drugs or about financial conflicts of interest that infest medical research?

Jay Joseph, Matt Irwin, Allison Bass, and Jeff LaCasse will be speaking about those topics in Syracuse at the 12th Annual ICSPP Conference in Syracuse, New York. Register online at icspp.org, or use the registration form (which has all the hotel information as well) on page 21 inside.

We'll also have EHPP Managing

Editor Robert Folz, Psy.D. and editor Brian Kean, as well as David Stein and DuBose Ravenel. The schedule, with all the presentation titles, is on pages 18 to 20. Check it out - you'll be impressed as always.

We'll also have special entertainment at the Gala - someone you may have caught on You Tube - social worker and recording artist Dan Mackler who will perform "Little Bottles" and much more. Lloyd Ross tells us about Dan inside on page 5.

We'll be at the Renaissance Syracuse Hotel on Friday and Saturday, October 9th and 10th. Call and book your room today ... and be part of yet another ICSPP conference experience.



Left to Right: Howard Glasser, Al Galves, Bruce and Bonnie Levine. Glasser and Bruce Levine will be presenting in Syracuse. (Photo: A. Crosby)

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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.

**ICSPP Newsletter
Submission Policies**

Authors may submit work to the newsletter while simultaneously submitting or distributing to other publications or forums if they choose. Where this is the case, we ask that authors inform newsletter staff so that our readers may be advised accordingly. Other publications will have their own guidelines, however, of which authors should be aware.

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

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

Authors are responsible for the content and accuracy of any statements made in their contributions.

Submissions or inquiries may be sent to the editor or co-editor at the email addresses on the inside back page of this issue. We look forward to hearing from you.

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.

The ICSPP Journal is Now Online

Subscribe Today - You Haven't Missed a Thing!

Springer Publishing Company is now providing online subscriptions to all who subscribe to *Ethical Human Psychology and Psychiatry*. That means subscribers can view current and back issues - even way back to when the journal was called *Ethical Human Sciences and Services* - in their entirety. All you have to do is keep current with your dues to maintain access.

If you already subscribe to EHPP you either recently received or soon will receive an email notification from Springer Publishing

Company. This will contain your user name (your email address) and password for the system. It will also contain the link you'll need: www.springerjournals.com. You are then ready to log in and get reading. (Note that EHPP and EHSS are under two different links: www.ingentaconnect/content/springer/ehpp and www.ingentaconnect/content/springer/ehss.)

If you've deleted that email or forgotten your password, use the "Forgot Password" function at

springerjournals.com to receive a quick reminder.

If you *don't* already subscribe, now is a great time to start. Just complete the membership form (the 'Subscription' line) on the ICSPP website or on page 30 of this issue, and Springer will reach out to you shortly.

All those issues are just sitting there waiting for you. Again, you haven't missed a thing.

Subscribe now. Here are just some of the great articles from great authors who, like you, belong to ICSPP:

The Genetic Theory of Schizophrenia: A Critical Overview Jay Joseph

Psychostimulants in the Treatment of Children Diagnosed with ADHD: Acute Risks and Psychological Effects (Parts 1 & 2) Peter Breggin

What is Really Known About Psychological Alterations Produced by Psychiatric Drugs David Jacobs, David Cohen

The Psychiatric Drugging of Toddlers Peter Breggin

Current Trends: Are Newer Antipsychotics Better? Doug Smith

Better Never Than Late: Peer Review and the Preservation of Perspective Peter Schonemann

A Critical Look at Some Assumptions of Biopsychiatry Glenn Shean

Schizophrenia: Medical Students are Taught it's all in the Genes Jay Joseph, Jonathan Leo

Pharmaceutical Agenda Setting in Mental Health Policies Richard Gosden, Sharon Bader

The Rhetoric of Evidence - Based Practice Craig Newnes

The Science of Psychopharmacology? Victor Sanua

Reversal of Schizophrenia Without Neuroleptics Matt Irwin

Abnormal Psychology Textbooks: Valid Science or Political Propaganda? Laurence Simon

The Mistreatment of Mood Disorders in Youth Robert Folz

The ADHD Epidemic in America J.M. Stolzer

Why Psychiatric Drugs "Work" Jeffrey Danco

Psychiatry's "Chemical Imbalance" Fraud Fred Bauman



Two EHPP editors, Brian Kean, Ph.D. (left) and James Tucker, Ph.D.

Not pictured are Leighton Whitaker, Ph.D. and Managing Editor Robert Folz, Psy.D.

(Photo: A. Crosby)

ICSPP Marks Two Passings

Remembering Victor Sinua

Victor Sanua, Ph.D., was a long-time advisory council member of ICSPP. He was a smart, kindly man who advocated strongly for children, especially those diagnosed with autism, and who was a staunch supporter of ICSPP principles. Year after year Dr. Sanua made the trip from New York City to Bethesda, Maryland to participate in the annual ICSPP meetings and conferences. He at all times put the real needs of children ahead of professional advancement or reputation and stood almost alone in the field of autism as a proponent of caring, non-drug approaches for children. He will be missed.

Peter and Ginger Breggin

In Admiration of Al Siebert

Can you remember anyone's biography that opened, "From beginning to end, his life was easy"? Can you seen an autobiography that concluded, "And so I had a lot of lucky breaks and life turned out well for me every step of the way"?

In reality, life is not easy for any human being. Certainly, some people have it worse than others. They are afflicted with illnesses, losses, misfortunes and injustices that seem beyond the usual spectrum of human misery. But neither misery nor misfortune identifies a human being as unique or worthy of admiration.

What matters is how we respond to whatever what life gives us. Sometimes we are given much and seem to waste it. Sometimes we are given little and make the most of it. Al Siebert knew this better than most. He knew that we are here to do our best to benefit from and to master whatever life gives us. He not only offered us a personal example of how to triumph over misfortune, he told us how to go about doing it. Al will always remain a shining example to all of us about how to make the most of our lives.

Peter and Ginger Breggin

MEANINGFUL ENTERTAINMENT AT THE OCTOBER ICSPP CONFERENCE

By Lloyd Ross, Ph.D., FACAPP., P.A.
North American Director

We have invited Daniel Mackler, a psychotherapist in Greenwich Village, New York City to sing and play his guitar at our awards dinner at our conference in Syracuse, New York. Dan has produced and published the powerful DVD "Take These Broken Wings" In it, he interviews Peter Breggin, Bert Karon, and allows the real person who was the patient in the book "I Never Promised You A Rose Garden" to discuss her very successful recovery without medication and what she is doing now. Dan's DVD as well as several of his folk song CD's will be for sale at the conference, and he will sing the great anti-psychiatric medication song "Little Bottles" along with some of his other fine works. (Note: Dan's words in the song "Little Bottles" are set to Malvina Reynolds' classic folk song, "Little Boxes.")

Let me describe to you in Dan's words who he is.

"I am a psychotherapist in Greenwich Village (in New York City). My expertise lies in helping people remove the blocks that prevent them from connecting with their true selves.

People connected with their true selves live productive, purposeful, and fulfilling lives. All people deserve this, and I offer my experience, insight, and compassion to help them achieve it.

I have worked with hundreds of clients in a variety of settings. I have helped people overcome depression, anxiety, substance abuse, relationship conflict, daily life stressors, eating disorders, recent and past trauma, sexual problems, social isolation, phobias, sexual abuse issues, and family-related problems.

There are many ways, and it can be different for each person. Different types of talk therapy can be very useful to different people, including studying why a person has the hallucinations and delusions in the first place. Some people heal without therapy at all, though. A gentle supportive environment helps---low pressure environment. Good friends can help. Support groups. Good diet and nutrition. Mild exercise can help. A sense of purpose. Journaling. Also, many people have found that taking distance from their family of origin can be very useful. Getting decent housing helps. Living in a safe, secure place. Talking to other people who have recovered helps.

Some of this may be very difficult to achieve in the USA (and western world), where it's MEDS MEDS MEDS and MEDS are all that count, but still, achieving some of these things has helped many people recover. and meds usually prolong the problem significantly, and make recovery harder. True, the American pharmaceutical industry knows it too---but it's not to their advantage to share it, so they hide it by every "scientific" means possible. Such a terrible misuse of science."

This is how Dan describes his philosophy as a therapist:

"My philosophy as a psychotherapist is one of respect. I have the greatest respect for human individuality and uniqueness – and for the healing capacity of each person. I have witnessed amazing transformations in people, and the hope I see translates into my work with each new client.

Therapy is a two-way process, and I am a highly interactive therapist. I have studied many schools of therapeutic thought and have taken the best from them. Likewise, I have a great respect and even love for various parts of the ma-

jor world religions – and I draw on their truths.

I believe in the value of searching for and integrating the truth of one's own unique childhood story. This is not easy, but I have found again and again that the answers to so many of life's deepest questions lie there – at the root of who we are as people.

I believe the goal of therapy is to become conscious and free – and I believe we are all capable of this."

Below are some of Dan's CDs.

Prophet for a Dying Planet

All songs written and performed by
Daniel Mackler
Length: 70:54

Prophet for a Dying Planet, released January, 2009, is an album of psychological protest music—against abusive families, inappropriate parenting, and the destruction of our planet. These 22 songs, each focusing on the struggle to become real, are musical versions of this website's message. Many of these songs are directly autobiographical as well.

Lullabies for the Inner Journey

All songs written and performed by
Daniel Mackler
Length: 71:10

Lullabies for the Inner Journey, also released January, 2009, is an album to inspire the inner journey toward enlightenment—and protest the stagnation of the norm. These 22 songs promote healing, courage, honesty, and ad-

venture on life's path.

COMING SOON: I will be releasing another CD of original music (*The Holy Man Blues*) in the next few months (probably around the summer of 2009). It's going to be my most radical music yet – fierce, blunt, unadulterated, and autobiographical.

Oh, and if you're curious, I created a music video for *Little Bottles*, one of two anti-psych med songs I wrote. Both songs appear as music videos on the

bonus features of my [Take These Broken Wings](#) DVD, but I put this one on YouTube as well.

(Note: My words are set to [Malvina Reynolds'](#) classic folk song, [Little Boxes](#).)

Dan Mackler's review of the DVD take these Broken Wings can be accessed on Youtube at <http://www.youtube.com/watch?v=INlyDZqibQQ>

Join us at the ICSPP Conference in Syracuse for our Awards Dinner and some great music.

Warmly,

Lloyd

A Very Grand Opening: Soteria-Alaska Starts Operations

By Andrew Crosby, MA

Newsletter readers with good memories might recall Delores Jankovich's article "Soteria-Alaska: Recovery Through Relationship" from our 2007 #1 issue. Delores described the ongoing efforts of Alaska attorney and valued ICSPP member Jim Gottstein who, along with Alma Menn, ACSW, Dr. Aron Wolf, and Susan Musante, MS, were putting together a unique setting to help some of their community's most vulnerable citizens.

Well, Jim has recently, happily, and quite proudly announced the long awaited opening of Soteria-Alaska. Presently the opening is on a partial basis, with only two residents, as licensure matters are still being ironed out. Jim referred to this moment as "a milestone six years in the making," as the complex work, largely involving obtaining fund-

ing, began in 2003. Jim was at the helm of the project at the time, but has since stepped aside from the lead role. He credits the project's successful opening to "God-send" Susan Musante, Soteria-Alaska's project manager, and to Dr. Wolf, a psychiatrist who early in his career worked at Chestnut Lodge. Jim is quick to point out that house manager Bill Miller and Alma Menn were also invaluable. Menn, for



Jim Gottstein, left, chatting with Brian Kean at the conclusion of the 2008 conference in Tampa, Florida.
(Photo: Andrew Crosby)

one thing, had been the administrator of the original Soteria House, which operated in California from 1971 to 1983.

The Original Soteria – A True Therapeutic Community

Decidedly unlike conventional institutions, Soteria House opened in San Jose, California in 1971. It was headed by Dr. Loren Mosher, psychiatrist and then Chief of the Center for Studies of Schizophrenia for the National Institute of Mental Health. The concept was as simple as it was unique: Provide a non-medical, non-hospital setting for people newly diagnosed with psychosis; apply moral treatment principles; keep track of what happens; compare that to what happens to comparable people treated in hospitals.

The idea was that a safe, tolerant, unhurried environment and sincere human involvement would make Soteria (from the Greek, salvation or deliverance) a place to heal. Why might such a setting be more conducive to healing than a hospital? One reason had to do with the theoretical model. While hospitals may mix in other approaches, the primary approach is, of course, medical; doctors and nurses have the authority, psychiatric drugs are the standard, and troubled people are seen as having a disease to be treated.

Soteria's approach, by contrast, was phenomenological. Instead of attempting to treat or cure, the aim was to understand a psychotic person's experience free of judging, labeling, or invalidating it, and to help him or her understand it. This work was carried out largely by non professionals in a concerted effort to avoid reliance on preconceived models or expectations. Drugs were used minimally, only when deemed necessary, and for short duration.

Another matter pertains to size of the setting. Hospital wards are large, with perhaps 40 to 60 people present, including patients and staff. That necessitates elaborate structure, which leads to inflexibility, reliance on authority, and institutionalization of roles – all matters that do little to help a frightened, disorganized person reintegrate and heal.

Mosher believed that severely disorganized people were unable to get to know and trust such an environment, and were unable to find a surrogate family within. A small setting avoided

that fundamental complication and negated the need for elaborate structure.

The results were good for Soteria, demonstrating that people could effectively – and *cost-effectively* – be helped in such settings. But Soteria closed in 1983 when funding dried up, and no significant efforts to use such an approach were made again. Why not? The medical / biological model was achieving prominence, and the National Institute for Mental Health had little interest in other approaches. Mosher and his colleagues believed that psychiatry was resistant to acknowledge that people experiencing schizophrenia – the field's primary domain – could be successfully managed by non-medical people in a non medical setting. What would that say about their disease model and their status as a medical specialty?

Back To Alaska

Soteria-Alaska will rely on the same basic principles as the original, as set forth by Loren Mosher and Luc Ciompi. The setting will be small and unhurried. The emphasis will be on relationships – *being with*, as opposed to *doing to*. Staff will uphold the expectation that everybody who comes to them for help can heal, become stronger, and remain a valuable citizen. Personal

autonomy will be respected. No formal therapy will be conducted, rather all interactions will be regarded as therapeutic, with the goal of understanding precipitating events. And of healing.

Once completely up and running, the home will provide for up to eight residents at a time who will be referred by local emergency rooms or the state hospital. Residents can also be self-referred or referred by families. Two full-time staff will typically be on hand at any given time, working eight to twelve hour shifts.

The prevailing view is that psychosis is a brain diseases which only science and medicines can treat. So Jim, Alma Menn, Susan Musante, Dr. Wolf, and many others have made a huge effort – *six years* in the making – to get Soteria-Alaska off the ground and into their community to again challenge that doctrine.

We wish them and their residents the best of luck. And we'll check in with them for some details on their progress for our next issue. In the meantime, please check out soteria-alaska.com and psychrights.org to read more the home and its philosophy.

A Few Words about Dr. Loren Mosher

Loren Mosher's death in 2004 at age 71 was a terrible loss for the reform movement. David Oaks of Mindfreedom International, remarked, "One of our Schindlers has died," a poignant reference to Oskar Schindler, who saved over 1,100 people slated for extermination.

While Dr. Mosher is well known for his work on Soteria, he also made headlines in 1998 for his dramatic resignation from American Psychiatric Association. His widely published letter of resignation was passionate, well-reasoned, and scathing. It's easily found online; following are some excerpts.

"The major reason for this action is my belief that I am actually resigning from the American Psychopharmacological Association."

"No longer do we seek to understand whole persons in their social contexts - rather we are there to realign our patients' neurotransmitters. The problem is that it is very difficult to have a relationship with a neurotransmitter, whatever its configuration."

"The fact that there is no evidence of confirming the brain disease attribution is, at this point, irrelevant. What we are dealing with here is fashion, politics and money."

"I always remember Manfred Bleuler's wisdom: 'Loren, you must never forget that you are your patient's employee.' In the end, they determine whether or not psychiatry survives."

Jim Gottstein and The Zyprexa Papers Scandal

A Bulletin Retrospective and Update

By Andrew Crosby, MA

It occurs to me that ICSPP has quite a few members who've joined during the past year or so who may be unaware of Jim Gottstein's role in what he's called The Zyprexa Papers Scandal. Jim is more than an "Alaska attorney and valued member of ICSPP" (and several other organizations) as you've just read, he is also a tireless advocate. That's a good thing because The Zyprexa Papers Scandal is a legal battle that now spans more than two-and-a-half years of wrangling between Jim and drug manufacturing giant, Eli Lilly and Co. Many ICSPP members may have forgotten, or be unaware of, Jim's heroic achievement – and of the costs he's born as a result. So let's recap from the Newsletter's detailed account of this matter (in the 2007 #1 issue) and get an update.

The Backstory

In December of 2006, Jim subpoenaed an extensive set of what had previously been internal documents from drug manufacturer Eli Lilly and Co. The documents pertained to Lilly's most profitable product, the atypical neuroleptic Zyprexa, and some of the documents dated back to 1995 – the period when Zyprexa was still in development.

In addition to using the documents for a case, Jim posted them on his PsychRights website and disseminated them to several parties. These included Peter Breggin, David Oaks of Mindfreedom International and Will Hall of Freedom Center, as well as Vera Sharav of the Alliance for Human Research Protection (AHRP), most of whom posted the documents on their websites. Jim also sent the documents to "Mad in America" author Robert Whitaker, and a guy by the name of Alex Berensen. No small thing, Beren-

sen was a reporter for the *New York Times*.

How significant was the material in the Zyprexa Papers? Well, on December 17, 2006, the *Times* ran the first in a series of articles on their contents. This first article, like many that followed, ran on page one – above the fold. That's how significant the material was.

Specifics on the Content "Viva Zyprexa"

Berensen's articles for the *Times*, (which can still be read at PsychRights.org – and I suggest you check them out at the "Zyprexa Papers Scandal" link) are detailed, unequivocal, and straight to the point. The Zyprexa papers contained reports and internal communications that show Lilly knew early

on that as much as 30% of people taking Zyprexa would experience significant weight gain and increased blood sugar levels, both risk factors for diabetes. Indeed, Lilly's own marketing research "found that psychiatrists were consistently saying that many more of their patients developed high blood sugar and diabetes while taking Zyprexa than other antipsychotic drugs."

The documents clearly delineate Lilly's concerns about this – not about the health problems or suffering the drug caused, but about how word of these problems would harm the sales of the blockbuster product.

The documents convey the company's plans to address this dilemma, and indeed show that Lilly "engaged in a decade-long effort to play down the health risks of Zyprexa, its best-selling



Jim on the set of Fox news channel's "Your Turn" where he appeared with fellow ICSPP members Peter Breggin, Bruce Levine, and Dominick Riccio in October, 2008. (Photo courtesy of Larry Towe)

medication for schizophrenia.” This included an extensive campaign with specific directives from management for sales reps to avoid discussion of Zyprexa’s health risks with doctors when possible, and to minimize these risks if the topic came up. Lilly executives advised their sales reps to encourage doctors to continue prescribing the drug extensively, even for off-label uses (uses for which a drug is not approved), such as for dementia in older people.

That’s illegal, by the way; while doctors are permitted to prescribe off label in accordance with their judgment, drug manufacturers are not allowed to encourage this practice. Lilly not only did so, but did so openly, about it, entitling their 2000 marketing campaign Viva Zyprexa.

In an editorial, the *Times* called for congressional hearings addressing what was in those documents.

Where Did the Zyprexa Papers Come From?

The documents had been released by Lilly to interested parties, including professional witnesses, during the course of a class action lawsuit involving some 8,000 patients who reportedly developed diabetes or related health problems from taking Zyprexa. This case reached a settlement in 2004 with Lilly agreeing to pay \$750 million to plaintiffs.

In November 2006, Jim was contacted by one of the professional witnesses for the plaintiffs in that case, Dr. David Egilman, who suggested that the documents (still in his possession) could be helpful to Jim’s legal and mental health advocacy work. The documents, however, and the specific conditions under which they may be shared or disclosed to others, were protected by a court order to which Egilman needed to adhere.

Well, Jim subpoenaed the documents and Egilman released them in accordance with the stipulations of the protective order.

Lilly didn’t see it that way, however. They promptly hauled Jim and anyone else they could get into court. They contended the documents were private and contained trade secrets, and that Jim had not properly subpoenaed

them.

The Legal Fall Out for Jim

Eli Lilly and Co. filed suit against Jim, and against the parties to whom Jim had disseminated the documents, which included hearings at United States District Court in Brooklyn, New York, in January of 2007. In addition to Jim having to respond to questions regarding who said what to whom – and when and why these discussions occurred – there was some impassioned and compelling testimony. Vera Sharav, for example, responded to a question about how Jim had obtained the documents thusly:

It was validated in my mind when they appeared on Sunday in *The New York Times* front page, then again on Monday on the front page. Then, of course, the editorial calling for congressional hearings ... My interest is in the content because the documents (show) that Eli Lilly knew ...that Zyprexa causes diabetes. They knew it from a group of doctors that they hired who told them “You better come clean.”

Little children are being given this drug. Little children are being exposed to horrific diseases (that shorten their lives) ... Now, I consider that a major crime. And to continue to conceal these facts from the public is ... not in the public interest.

And therein lies the crux of the issue. To Jim, Vera Sharav, and everybody else on this side of the matter, the central concern was *the public’s right to know* as opposed to Eli Lilly’s right to privacy regarding their emails and marketing training manuals.

Judge Weinstein disagreed. In his February 13, 2007 decision he held that Jim had acted improperly. He referred to Jim, Egilman, and Berensen of the *Times* as “conspirators” and called their actions “irresponsible.” He added that

Eli Lilly had been irreparably harmed by their actions. (Actually the judge may have been on to something about that last point. We’ll get to that soon.)

Upon receiving that February 13, 2007 decision, Jim issued a statement that can be summed up thusly: “I vigorously dispute this.” He set about the appeal process, and here we are two-and-a-half years down the tortuous legal road.

In July of this year Jim and his attorneys filed a detailed brief specifying in precise terms how he had acted properly in every regard, and as to how the decisions of the District Court in Brooklyn “are untenable, and its opinion of Gottstein should be reversed.”

The Legal Fall Out for Lilly

Remember that *New York Times* editorial calling for congressional hearings about what was in those documents? Well, a bunch of attorneys general agreed, and Lilly was called in to court and asked who said what to whom. Jim’s attorney’s referred to this matter at length in their recently filed brief, to wit:

On January 15, 2009, the Justice Department announced that Lilly was pleading guilty to promoting Zyprexa for ‘off-label’ uses not approved by the FDA, causing false claims to be submitted to federal programs such as Medicaid, and conducting an illegal marketing campaign to primary care physicians knowing that there were virtually no approved uses of Zyprexa in that market.

In addition to pleading guilty to this criminal charge, Lilly agreed to pay \$1.415 billion, consisting of a criminal fine of \$515 million, asset forfeitures of \$100 million, and civil settlements up to \$800 million. RA–249-51. The Justice Department stated that this was ‘the largest criminal fine for an individual corporation ever imposed in a United States criminal prosecution of any kind.’

Jim noted recently that the criminal

suit against Eli Lilly was initiated *after* Judge Weinstein's 2007 decision wherein, in addition to calling Jim a conspirator, he ruled that there was "no sign of potential criminal liability" regarding what was in the Zyprexa Papers.

Conclusion

There *is* no conclusion yet. Not for Jim, anyway. I would love to say David has beaten Goliath, but let's not overstate matters. For one thing, while Jim's appeal holds promise it is still very much a work in progress - despite that powerfully worded brief - and he continues to accrue enormous legal expenses. Even if Eli Lilly folds its hand, issues an apology, and sends Jim roses, he will be paying for years to come.

Also bear in mind that while Lilly has paid out huge settlements they also sold \$4.8 billion worth of Zyprexa *in 2007 alone*. Even though prescriptions waned during that year, price increases still made Zyprexa profitable - and it's only one of many products Lilly sells.

But while Jim hasn't beaten the pharmaceutical Goliath, he has certainly chipped away at him. In doing so he has also chipped away at the psychopharmaceutical complex. He may just have brought matters a step or two closer to a tipping point, perhaps not unlike that which befell the



The "Your Turn" Panel: Jim on the right with Bruce Levine and host, Kathy Fountain. (Photo courtesy of Larry Towe.)

tobacco industry.

True, tobacco is still much in use and there are still profits to be made. But no longer does the industry tout the wonders and benefits of its product. And, most importantly, no longer does the public regard tobacco as safe. The belief system changed ... because a tipping point was reached. Thanks to Jim - and his fellow "conspirators" - biopsychiatry is on slightly shakier ground than it was not long ago.

Check out Jim's website, psy-

chrights.org. Under the "Zyprexa Papers Scandal" link Jim has posted all the relevant newspaper articles *and* all of the legal documents, including transcripts.

Jim has achieved much. We can help, and be part of this important struggle. Please send a tax deductible donation to his legal defense fund at the address given below.

The Jim Gottstein Legal Defense Fund

ICSPP board member Jim Gottstein is in a legal battle with Eli Lilly over the exposing of Zyprexa documents. He is being legally bullied by the powerful corporation and needs our support in raising money for his legal defense which will be very costly. If we want people like Jim (who, by the way does all his legal work for psychiatric survivors on a pro bono basis) to be able to stand up to the psychpharma power bloc, we need to help him to weather this storm financially.

Please send as much money as you can, whether it be \$1 or \$1000 as soon as possible to:

Jim Gottstein Legal Defense Fund
c/o Dominick Riccio, Ph.D.
1036 Park Avenue, Suite 1B
New York, NY 10028

BULLETIN BOOK REVIEW

Drug Induced Dementia: A Perfect Crime

Grace E. Jackson, Bloomington, IN. AuthorHouse, 2009
440 pp., \$29.95.

Reviewed by Delores Jankovich, MA, LMSW

Grace Jackson provides detailed substantiation of the chemical injury that is occurring in all ages of people from the use of prescription drugs. Indeed, this is a 21st century crime of unprecedented dimensions and one that is growing every day. The focus of this book is on psychiatric drugs as a cause of iatrogenic damage to the brain and the body. This is a book that must be read by all physicians, students and practitioners in the mental health professions as well as by the public. Dr. Jackson has painstakingly written this book in such a way that many consumers can understand the risks of developing dementia from psychiatric drugs even though parts of the book are very difficult to understand. Everyone who sees patients should place this book in their waiting room and discuss it in their practice. "Drug Induced Dementia: A Perfect Crime" should be a part of the curriculum of every medical school. We are in urgent need of identifying and addressing this tragedy locally and internationally.

The way I approach this information is "a spoonful at a time." I'll admit this is pretty hefty reading for my bedside table. This is clearly writing that evokes painful feelings and a struggle to come to terms with "how we have arrived at such a juncture." We are dealing with a crime of huge dimensions. Grace Jackson has faced this dilemma with courage and perseverance, bringing us a work of great scholarly magnitude. This accomplishment has required her to lead in uncharted territory and to identify the problem, describe the findings of damage and propose what we can do about it.

She is ingenious in the metaphor she has chosen to introduce us to the workings of the brain. Dr. Jackson uses the familiar American treat, the Tootsie Pop.: "Candy coating = cortex; tootsie roll center = subcortex; and lollipop

stick = brainstem." She further invites us to explore popular movies that depict murder mysteries showing the difficulty of identifying causation and responsibility when there are multiple murder suspects, some of which may be hidden --- as is the case in injury or death due to treatment with psychiatric drugs.

Psychiatry has escaped the role of perpetrator of the perfect crime since,

effects upon the brain and the entire soma are not known, not recognized or denied. The cause of damage or death is thought to be an accident or due to the "underlying illness."

There is no clear definition of dementia. Dr. Jackson states that dementia is a term that refers to cognitive symptoms that are serious enough to interrupt social, occupational and inde-



Dr. Grace Jackson, also the author of "Rethinking Psychiatric Drugs: A Guide to Informed Consent," presents at ICSPP's 2005 conference in Queens, New York. (Photo: Robert Sliclen)

with current research and clinical practice, it is extremely difficult to identify the source of harm. Drugs are used to target diseases of specific organs. When someone dies from a common disease process such as heart disease, it is unlikely that the treating physician considers prescription drugs (from past or present treatment) as a possible cause. Often psychiatric patients are receiving more than one psychiatric drug. The

pendent function. She shared that Dr. Perminder Sachdev has suggested that the term dementia no longer be used due to semantic ambiguity, clinical harm and stigma. However, not only is the term dementia still used, it has inspired new practices and new drugs, all of which are of questionable value.

The origin of dementia is primary (within the brain) or secondary (within the body - also called soma). Psychiat-

ric drugs cause both primary and secondary injury. As Grace emphasizes, we must understand: "Psychiatric drugs are a common but frequently unrecognized source of primary and secondary dementias."

The desire for power rather than truth, termed "performativity" by the late philosopher, Jean Francois-Lyotard, has led to a focus on symptoms and pathology rather than on causation. Identification, prevention and mitigation of dementia is not the concern of the medical profession. The medical profession, and all who collude with them, continue to support a structure of power and domination which leads to further diseasing of the brain and body. Dr. Jackson gives us the truth. To further quote Dr. Jackson: "The chronic use of medication as promoted and often mandated in the United States today, results in adaptive changes in the brain which oppose the intended and immediate drug effects."

To continue to drive home the adverse effects of care intended to help, note the following: "Drug-induced disruptions in brain processes have been demonstrated in the context of chronic treatment of all psychiatric drugs."

When tracking the course of dementia in patients with a history of psychiatric treatment, the tragic fact is that many people do not live long enough to identify and track dementia as those receiving psychiatric drugs die 13 to 30 years earlier than those who do not take psychiatric drugs. Dr. Jackson mentioned that Emil Kraepelin coined the term *dementia praecox* during the 19th century to describe a syndrome we now call schizophrenia. This led people to believe that dementia was inherently present in psychotic experiences. Indeed, as recent as 2002 I was told by a young psychiatrist that "schizophrenia also known as dementia praecox means the presence of dementia and indicates there will be a persistent decline of functioning in the individual, regardless of treatment." Thus the way "psychiatric illnesses" are conceptualized needs to be addressed.

Dr. Jackson clearly indicates that "lethality of neuroleptics cannot be overstated" and she calls for urgent attention to "drug-induced dementia, particularly, as it occurs prematurely and even among the very young."

There is a very clear association

between psychiatric drug use, dementia and mortality, regardless of the drug class. Detailed descriptions of investigative research into antidepressants, antipsychotics, anxiolytics (anti-anxiety drugs), mood stabilizers and stimulants are included as separate chapters in this volume of work. This is a tremendous service for all practitioners, consumers, ex-consumers, survivors and family members of those who are suffering emotionally. The very large body of fine references further provides the links necessary for those who need and/or desire to pursue additional information.

The concluding sections of this book offer information on identifying the problem of damage from psychiatric drugs and how to respond to the problem both on a personal and/or systemic level. Dr. Jackson lists the variables that need to be considered by individuals and clinicians when drug therapy is being addressed. She discusses the faulty research designs utilized in evaluating drug efficacy and safety. The sobering fact is that drug regulatory agencies continue to ignore faulty research thereby contributing to the injury and death of many individuals.

On a systemic level, many of Dr. Jackson's recommendations call for the dismantling of Group Think practices and non-reimbursement for poor or essentially harmful medical care. She asks for protection for those physicians who practice critical thinking and excellence in care and for whistle blowers who call attention to medical care that is a part of accepted practice but is neglectful or harmful.

Dr. Jackson notes that the majority who are iatrogenically damaged took the drugs without informed consent and/or were coerced through the State to take harmful drugs. She gives proposals for compensation and rehabilitation of the iatrogenically injured.

Physicians must have the right to challenge Medical Consensus (Group Think) and to choose those practices that promote health and safety for their patients. The following quotes say it all in terms of the respect for human life that need to be put in place:

"On a systemic scale, the best thing that could happen in any democratic society would be the eradication of

unwarranted, coercive therapies. Only within psychiatry is the fundamental right of patient autonomy, and the fundamental duty of physician non-maleficence, routinely trampled. Preferably, law schools and medical schools would prioritize the creation of an entire network of professionals (such as Jim Gottstein, Esq., and the Law Project for Psychiatric Rights) who would be dedicated to the task of preventing psychiatric assault."

This book should lead people to question whether they should ever consider taking psychiatric drugs. Even when people are not forced but are suffering and drugs are recommended to them, they are usually unaware of the "gentle coercion" present when drugs are presented as best practice. Perhaps the question needs to be, "Why would anyone be encouraged to take drugs that we now know are ultimately damaging?" Is it not a moral consideration that when one person is harmed, so are others, in particular those who love them and may have to shoulder the burden of caring for someone who is chemically injured? Also, deprived if not harmed, are those that have been or would be the recipients of this person's creativity and resourcefulness.

Dr. Jackson's book is dedicated to Jim Gottstein, Esq. of Alaska and his astounding work in defending the legal rights of those diagnosed with a mental illness. She is also inspired by the excellence of drug-free care and education being provided by Dr. Toby Watson in his home town of Sheboygan, Wisconsin. Dr. Jackson's goal is to open a Clinic for the Chemically Injured in her home area of North Carolina and she will also be seeking neurologists of conscience to join with her in this endeavor. She believes that it is time for all of us in ICSPP to move forward in our own way and commit to this worthy cause of addressing chemical injury due to psychiatric drugs..

In reading Dr. Jackson's work I am reminded of a quote by George Orwell, "In a time of universal deceit, telling the truth becomes a revolutionary act."

Thank you, Grace Jackson, for a book presenting the truth about psychiatric drugs in unprecedented form and scholarship.

Clinical psychology and Attention Deficit Hyperactivity Disorder

Craig Newnes

Craig Newnes is a dad, gardener and Director of Psychological Therapies for Shropshire County PCT. He completed his clinical psychology training in 1981 and later trained at the Institute of Group Analysis and with the Boston Psychoanalytic Institute.

He is editor of the *Journal of Critical Psychology, Counseling and Psychotherapy* and commissioning editor for the Critical Division of PCCS Books. His latest book is *Making and Breaking Children's Lives*. Until 2006 he was editor of *Clinical Psychology Forum*, the house journal of the British Psychological Society's Division of Clinical Psychology and Past-Chair of the BPS Psychotherapy Section. Nowadays he tires easily.

Clinical psychology makes bold claims to be a scientist practitioner profession. It finds itself in the invidious position of also claiming expertise in human relationships whilst psychologists are not being noticeably better at human relationships than members of other professions. We are not alone in this paradox: builders and plumbers are notorious for rarely working on their own homes, general practitioners are not particularly healthy and many child experts have no children. The particular combination of wanting to appear as scientists and experts in people makes the profession vulnerable to criticism concerning both aspirations. British applied psychology's lead professional body, the Division of Clinical Psychology of the British Psychological Society,

has embraced much of the rhetoric typical of professions (the need to "protect the public", for "accountability", etc.). In doing so, the Division has failed to examine scientifically whether this rhetoric translates into reality.

In the UK, the profession of clinical psychology has become adept at jumping on bandwagons. The profession assumes ownership of a variety of practices as they become fashionable and develop potential for paying our salaries. From psychometric assessment and psychotherapy to cognitive therapy and consultancy the profession has embraced different practices while claiming a scientific basis for its position of power. The enthusiasm with which the profession approaches powers under the new Capacity Act and a potential role in the Attention Deficit Hyperactivity Disorder (ADHD) explosion give cause for concern that, as a scientific discipline, clinical psychology has gone off the rails. As one more branch of the 'psy-complex' (Nicolas Rose's term for the group of professional vested interests in the psychology and psychiatry industries), however, its financial future is assured.

"There is broad support for the current medical definition of ADHD among the general medical community.' But what is meant by 'broad support'?"

Before 1990 there were barely 5000 children in the UK diagnosed with ADHD. There are now over 200,000 (Wright, 2003). Ritalin, a potentially

brain disabling drug, remains the commonest treatment. There are increasing claims that children who are difficult to manage have a neuro-developmental disorder. The phrase "neuro-developmental disorder" is one aspect of a lexicon designed to simultaneously obscure meaning and give power to 'those that know' – in this case so-called child experts.

In fact we have no idea how any given individual is meant to develop neurologically, nor can we know that a person is neurologically disordered from behavioural observation. Yet ADHD is solely diagnosed through such observation (of perfectly normal conduct – see, for example, Timimi and Radcliffe, 2005) and clinical psychologists then *infer* a neurological problem. This is perfectly in step with child psychiatrists who then prescribe drugs such as Ritalin in order to suppress the conduct. There are numerous examples of such practice amongst clinical psychologists.

Medicalizing conduct

Authoritative assertions abound from clinical psychologists. These are, of course, merely part of the rhetoric of professions which allows statements to appear true, when they can only ever be opinion. Murray, McKenzie, Brackenridge and Glen (2006), for example, state, "There is broad support for the current medical definition of ADHD, and its sub-types among the general medical community." They cite Goldman et al (1998) and Taylor et al (1996) in support of their statement. But what is meant by "broad support"? Worse, in what sense is work cited from 1998 and 1996 current? Let us assume that some medical and related professions support a medical definition. It is tempting to conclude, "They would, wouldn't they?" The authors continue, "ADHD can be debilitating, impacting negatively on educational achievement, social behaviour, and family life." There is no acknowledgement of the circularity of their position – we diagnose ADHD by observing behaviour and then claim that behaviour is *caused* by ADHD. This is an example of a category error common in main-

stream psychiatry. A condition – depression, schizophrenia, Asperger’s syndrome – is *inferred* from someone’s conduct and then that same conduct is seen as arising from the inferred condition. It is like saying that chairs and tables (specific examples of a category) are furniture (the category) but also, somehow, *caused* by furniture. For categories such as ADHD, depression and so on, any meaning of the observable conduct is obscured by a nonsensical confusion of category and cause. Such statements, by repetition, soon become the mainstay of professional writings and it can be difficult to enter the arena without participating in the rhetoric – an argument frequently used by authors to justify their use of diagnostic terminology. Such terminology can be promoted as a kind of ‘short-hand’, as if other professionals will immediately know what is meant. But if an expression is, by definition, meaningless, it will mean only what the reader thinks it does. Your ‘depression’ is not mine, one person’s understanding of ‘ADHD’ is rarely another’s. If the reader or recipient of the diagnosis is unfamiliar with such terminology, then such medicalized statements boil down to, “trust me, I’m a professional.”

Murray et al’s paper is ostensibly about General Practitioners’ knowledge of ADHD. The results of their survey of 40 GPs bear brief examination. Taking it as read that ADHD is a sensible way of labeling individuals, they asked GPs about diagnostic features, causes, effective treatment and the range of professionals to be involved. Only nine GPs were aware of all three diagnostic criteria (attention deficits, hyperactivity and impulsivity). Such knowledge tended to be voiced by more recently qualified practitioners. Murray and his colleagues reasonably suggest that such GPs have been more recently exposed to the growing literature on ADHD. Like any advertising campaign, such exposure is likely to lead to more so-called knowledge. Critically, the more the construct ADHD is used in medical literature, the more GPs are likely to accept it as an entity; the value of simple repetition has not been lost on those with a vested interest in promoting ADHD.

Unsurprisingly, 16 respondents identified genetic/biological origins of diagnosed conduct. Over half the GPs said they did not know the cause. Again, the proliferation of studies and journal articles on the theme of ADHD creates a context in which it is very difficult for GPs to question core constructs in their work – diagnosis being key. The older GPs are likely to have seen much of this before – in relation to so-called breakthroughs for a host of real (cancer, cystic fibrosis) and imagined (depression, schizophrenia) conditions. They may be used to the rhetoric and less swayed by the promotion of newer disorders, only to have their wisdom dismissed as a need for ‘education’. Even the way the researchers frame the questions gives little room for maneuver on the part of their respondents. They ask about the cause of ADHD. They don’t suggest that GPs might like to consider whether ADHD as a construct has validity.

***“Clinical psychologists
find themselves ignored
by colleagues for
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any practice.”***

Clinical Psychology Forum (CPF) is not typical of the literature scientist practitioners are exposed to. As a newsletter it publishes a high percentage of submissions. These are unconstrained by the conventions demanded of submissions to journals such as the British Journal of Clinical Psychology. As such, CPF can reveal a great deal more about the profession in the UK than other British journals. Authors can produce polemical, political and reflective pieces in addition to local studies. These can reflect the dominant discourse of scientism (where no statement can be made without recourse to a numbing range of studies) or can be reports of work that attempts to go against the mainstream. Such work tends to draw on theories and practice outside the dominant medical paradigm, notably social science, philoso-

phy and political action. Papers of this type remain in the minority in *Clinical Psychology Forum*. Nonetheless, some examples are outlined below to show that there remain islands of practice in clinical psychology that continues to challenge the dominant discourse around ADHD.

Beyond the mainstream

The willingness to report work that goes beyond the parameters of accepted practice in the context of a medicalized National Health Service should not be undervalued. Clinical psychologists and other professionals find themselves ignored and insulted by colleagues on a regular basis for questioning virtually any practice (diagnosis, the use of medication and other physical interventions) that conforms to Foucault’s conception of ‘the Gaze.’

The clearest exposition of practice beyond mainstream psychological work with children is to be found in a special issue of *Clinical Psychology* edited by Nick Radcliffe, Scott Sinclair and myself (2004). This special issue morphed into the book *Making and Breaking Children’s Lives* (Newnes and Radcliffe, 2005). It includes papers examining ADHD as a construct (e.g., Brown, 2004, Spellman, 2004), different ideas about the kind of lives that might lead to children receiving the diagnosis (Verere, 2004) and attempts to influence family life that do not frame conduct in diagnostic terms. Cobner (2004) describes a clinical psychology service which deliberately maintains separation from the psychiatric arm of the Gwent Child and Adolescent Mental Health Service (CAMHS). Cobner and her colleagues offer telephone consultation to potential referrers which clarify the service philosophy – ‘the creation of alternative narratives.’ Referrers preferring a diagnostic frame can be redirected to psychiatrists. Conversations with families then follow a three stage model – in Cobner’s terms ‘deconstructing ADHD, exploring alternative narratives and thinking about the usefulness of diagnosis.’ This last is considered from psychological (the usefulness of diagnosis in reducing uncertainty) and practical (the possibility that a diagnosis will lead to much-needed financial benefit via Dis-

ability Living Allowance) perspectives. Myatt, Rostill and Wheeldon (2004) use the concept of functionality (so called problem behaviour maintains the status quo in any system) to re-direct parents' attention away from the conduct labeled as ADHD: "If we were not talking about John's ADHD, what would we be talking about instead?" (p.36) Myatt and her colleagues remind us the "For professionals, an ADHD description may render them powerless if they are non-prescribing." (p 36) Their paper calls to professionals to move beyond diagnosis and maintain a position of curiosity shared with the parents. In the same special issue Woodhouse (2004) describes the work of the Cactus Clinic, founded by Steve Baldwin and committed to offering alternatives to medication for families with an ADHD diagnosis. In its assessment of a referred family the clinic considers a wide range of possibilities that might account for conduct deemed problematic. These include nutritional deficiency, metal intoxication, hormonal and metabolic disorders and genuine neurological conditions. Considerable information is offered concerning the adverse effects of drugs like Ritalin before children start on a drug withdrawal programme. This is followed by a caregivers' programme and a nutritional protocol. The clinic recognizes the modernist need for 'evidence' and researches and revises all its methods in a continuous programme. Outcomes are consistently excellent.

Southall (2006) begins her paper "Children do not develop in a vacuum." (p. 33). Her critique of the diagnostic tendency focuses on ADHD and challenges clinical psychologists to rediscover environment and context as key to understanding any conduct. Ayling (2006) goes further and invokes the UN Convention on the Rights of the Child to protect the right of young people to independently access services when they feel unsafe in the family system in which they have become identified as 'the problem child'. It would be interesting to see the same Convention used to challenge the use of the ADHD diagnosis.

Analysing micro-neighbourhood referral patterns

Working in Birmingham, Carl Harris (Harris, 2005) takes context, particularly physical context, very seriously indeed. Alongside specialist community development workers and a small group of residents, he has drawn up a new map of the locality. This map groups sections of local housing estates into 'micro-neighbourhoods.' Fifty-seven micro-neighbourhoods of varying shapes and sizes were constructed. Some are long and narrow, stretching along a road; others are compact, incorporating a number of defined 'closes' or 'groves'; others group together rows of high and low rise blocks of flats. On average there are around 200 people in each micro-neighbourhood.

Five (out of the 57) micro-neighbourhoods accounted for 29, or half, of referrals to a clinical psychologist. Two micro-neighbourhoods accounted for over a quarter of the referrals over an 18 month period.

"Engels would have been unsurprised at this treatment of the working classes 150 years after his study."

These results fitted with information gathered from a health visitor who had been working in this area for 10 years. She was asked to put crosses on a map to indicate which parts of the patch she felt were most in need of support. She put five crosses on the map of the whole area, two of which were in the two already identified micro-neighbourhoods.

Bernardo Jiminez, Professor of Community Psychology from Mexico visited the project and was shown the data. He was then taken on a drive around the estates and shown the houses

in question. He provided a commentary on the houses in the context of their landscape and the houses' relationship to each other in their respective formations.

In the most modern estate, only separated from the area of high referral by a single-carriageway road, houses are grouped in horse-shoe clusters frequently facing in towards a central (sometimes green) area. They appear to have a shared identity.

In the areas with the high referral rate the houses are arranged in a Radburn formation - in straight rows with the front doors of one row facing the back gardens of the next row or 'grove'. Inside, bedrooms, garages and front door are all at street level, while the living rooms and kitchen are on the first floor. Engels would have been unsurprised at this treatment of the working classes 150 years after his study of Manchester in post-industrial Britain.

The micro-neighbourhood analysis has an effect on the way we might understand the pattern of referrals to the community psychologist. The information was taken to a Neighbourhood Management meeting within the NDC organisation. This team is a group of theme coordinators, each having a strategic responsibility for a different part of the programme - health, housing, education, employment, etc. At the meeting the data were presented and a discussion followed concerning:

- the hard to let nature of the housing,
- the consequent desperation of those who were likely to accept it,
- the difficult histories which some people may bring to the location,
- the reputation attached to the location,
- failure of services to deliver to those living there,
- the unorthodox, 'difficult' layout of the houses themselves,
- the environment surrounding the houses (which is an expanse of grass with no 'cues', e.g., paths or benches, as to how it should be used),
- the 'unsupervised' or 'un-

overlooked' nature of a significant section of the rows of Radburn houses (which may then become a locus of behaviour which is difficult to manage),

- the absence of play facilities for young people,
- the 'barrack-like' nature of the housing layout which may not promote the development of a sense of community,
- the low levels of 'resources' of those living there, which will make it unlikely that they will be in a position to provide support to each other.

Implications for practice

Given the above it must be asked whether clinical psychologists can side with children and families.

I have focussed on Harris's work because it illustrates a position rarely taken by professional psychologists – that of a genuinely curious outsider who acknowledges families and other local people, both professionals and neighbours, are likely to know what contributes to distress in their communities. The position places us as, simultaneously, part of 'the Gaze' and critical of it. As public employees such a position is likely to be both tenuous and short-lived. If psychologists can provide additional impetus for creating more healthful environments, then that is good enough. Harris, before qualifying as a clinical psychologist, studied the wider social sciences and philosophy. That back-ground plus parenthood should, perhaps, be obligatory for those clinical psychologists who work in child services.

My analysis is likely to be seen as unbalanced. This is intentional. The dominant psychological and pseudo-medical discourse requires a balancing rather than balanced response. It would appear that many clinical psychologists, both in the Academy and clinical practice, tend toward a conservative maintenance of the status quo (crucially in the maintenance of their own status as experts) in relation to diagnosis of conduct they, like many psychiatrists, see as "conditions" or "syndromes." Their vested interest as paid professionals

makes it extremely difficult to seriously challenge this dominant discourse relating to child-hood (indeed, to living). There are, however, examples of practice which step beyond the confines of diagnosis and dust-bin terms like "disorder." This practice draws on a rich history, both philosophical and sociological, which emphasises the need for professional classes to take a humble and collaborative stance alongside that majority of citizens oppressed by a rich, frequently professional minority. Clinical psychologists can, and do, use their position of power and authority to draw attention to what millions already know – that society is organized to keep certain people in charge. Eschewing diagnosis and the possibility of "treatment" for ordinary behaviour are but two small changes that clinical psychologists might make in their practice. They are likely to find allies in such an endeavour both within and beyond the usual confines of professional groups. It might be too much to ask that they have families of their own before they invade and observe the lives of others less privileged than themselves.

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What's in a Name?

The Newsletter Upgrades its Image

As you've probably noticed, we've upgraded our moniker; the ICSPP Newsletter is now the ICSPP Bulletin. Nothing else has changed – we've just gone with a label better suited to what we've been producing.

The credit for this goes to Burt Seitler, Northeast Group member and frequent newsletter – excuse me, *Bulletin* – contributor. A few of us New Jersey people were talking over lunch one day, the newsletter came up, and Burt said, "You ought to change the name of that thing. Call it 'the Bulletin,' or something. Calling it a 'newsletter' is just ..." He left the sentence dangling, but his expression sug-

gested his spinach pie had been left out too long. I got the message immediately.

I of course promptly cracked a joke, saying I'd already decided to change the name – to *The New Yorker*. Burt then turned to Lloyd Ross and asked, "Why do I even bother talking to this guy?"

But there was a reason I went for a joke to derail the discussion: The discussion was over. Burt was right, I knew it, and he'd given us the new name. Pass the ketchup, please.

But, as indicated, nothing else has changed. The Bulletin's goal is the same as the Newslet-

ter's always was. We seek to inform, interest, engage, and inspire you, the varied ICSPP membership. Four times a year we want to put together something that gives you a feel for what ICSPP stands for and what its members are doing. We hope that this publication, by whatever name, will foster a sense of community, of belonging to something special. The Bulletin will continue to feature material *about* you, *for* you, and *from* you.

So please keep in touch. Our contact info is on the inside of the back page.



Burt Seitler, who recently renamed the Newsletter over a Greek salad, with Geraldine Lewis at the 2008 conference. (Photo: Andrew Crosby)



The staff of the ICSPP Bulletin, Delores Jankovich, MA, LMSW and Andrew Crosby, MA at the 2007 conference. (Photo: Robert Slicen)

ICSPP 2009 Presentation Schedule

Friday, October 9, 2009

TIME	ROOM	PRESENTERS and TOPICS
8:15-8:30	LAFAYETTE	Toby Watson Ph.D. & Michael Gilbert Psy.D. - "Opening Remarks" (No CE)
8:30-9:45	LAFAYETTE	Plenary 1 - David Stein Ph.D. – "Parenting without Drugs: The Caregivers' Skills Program"
9:45-11:00	LAFAYETTE	Plenary 2 - Howard Glasser M.A. – "What Are We Doing in the Meantime?"
11:00-12:15		Plenary 3 - DuBose Ravenel M.D. – "Training for Self-Control: An Evidence Based, Common Sense Solution"
12:15-1:00	SKANEATELES	LUNCH - ICSPP Buffet Lunch \$10, Purchase Tickets at Registration Table
1:00-1:45	LAFAYETTE	Panel 1 - Stein, Glasser, Ravenel, Mercogliano, Kean, Guest
1:45-2:30	LAFAYETTE	Plenary 4 - Martin Irwin, M.D. – "Strategies to Reduce the Overuse of Psychiatric Medications in Children"
2:35-3:20		BREAKOUT SESSIONS 1-5
	LAFAYETTE	Breakout 1 - Elisabeth Helsing, Ph.D. & Graham Dukes M.D., J.D. – "Breast Feeding & Child Mental Health"
	POMPEY	Breakout 2 - Norman Hoffman M.D. – "The End of Childhood: The Effect of Inappropriate Diagnoses and Use of Medication on Adolescent Identity Formation"
	FAYETTEVILLE	Breakout 3 - Fred Moss M.D. – "Psychiatric Medication: Beneficial or Dangerous"
	DEWITT	Breakout 4 - Tom Bratter, E.d.D. & Lisa Sinsheimer, M.D. "The Nine Guiding Principles of the John Dewey Academy."
	MANLIUS	Breakout 5 - Jock McLaren M.D. – "A Molecular Resolution of the Mind-Body Problem"
3:20-3:30		BREAK
3:30-4:30		BREAKOUT SESSIONS 6-10
	LAFAYETTE	Breakout 6 - Brian Kean Ph.D. – "Inclusive Early Childhood Education: Preventive Measures for Achieving Social and Emotional Well-Being in Early Childhood"
	POMPEY	Breakout 7 - Jeanne Stolzer Ph.D. – "The Drugging of Motherhood: A Biocultural Prenatal and Postnatal Analysis"
	FAYETTEVILLE	Breakout 8 - Chris Mercogliano M.SW. "In Defense of Childhood"
	DEWITT	Breakout 9 - Ray LeMay M.Sc. – "Social Role Valorization Inspired Intervention as a Tonic for Psychotropic Medication: New Intervention Strategies for Children and Youth in Residential Care"
	MANLIUS	Breakout 10 - Madhu Sameer M.SW. – "Flight to Health: A Case Study"
4:30-5:15	LAFAYETTE	Panel 2 - MD - Breggin, Kohl, Hoffman, Ravenel, Moss, Guest
5:15-5:45	LAFAYETTE	Plenary 5 - Peter Breggin M.D. – "Why ICSPP Matters So Much, What It's Accomplished and Where Is It Heading?"

6:30-8:30 Special Evening Session Open to the Public featuring Peter Breggin M.D., Howard Glasser M.A., David Stein Ph.D., DuBose Ravenel M.D.
 Brief presentations with Q&A (No CE)

Saturday, October 10, 2009

TIME	ROOM	PRESENTERS
8:15-8:25	LAFAYETTE	Toby Watson Ph.D. & Michael Gilbert Psy.D. (No CE)
8:25-9:10	LAFAYETTE	Plenary 6 - Allison Bass M.A. – “The Story of How American Consumers are Routinely Mis- led about the Safety and Effectiveness of New Drugs and Treatments”
9:15-10:15		BREAKOUT SESSIONS 11-15
	LAFAYETTE	Breakout 11 - Jeff LaCasse Ph.D. & Jonathan Leo Ph.D. – “Non-disclosure of Financial Con- flicts of Interest in Medical Research”
	POMPEY	Breakout 12 - Sarah Edmonds Ph.D. – “Non-Violent Communication: An Alternative to Drugging Children”
	FAYETTEVILLE	Breakout 13 - Gary Kohls M.D. – “What Holistic Mental Health Caregivers Should Know about Managing Psychotropic Drug Withdrawal”
	DEWITT	Breakout 14 - Linda Andre BFA – “Doctors of Deception: The Untold History of Electro- shock Therapy”
	MANLIUS	Breakout 15 - Faye Karpouzis B.Sc. – “Short-Term Results of the Neuro-Emotional Tech- niques (NET) on a Cohort of Children with Medically Diagnosed ADHD”
10:20-11:20		BREAKOUT SESSIONS 16-20
	LAFAYETTE	Breakout 16 - James Gottstein J.D. – “Litigating Against the Psychiatric Drugging of Children & Youth”
	POMPEY	Breakout 17 - Burton Seitler Ph.D. – “Psychoanalytic Treatment of a 3 ½ Year Old Autistic Girl”
	FAYETTEVILLE	Breakout 18 - David Stein Ph.D. – “Controlling the Difficult Adolescent using the Real Econ- omy System for Teens (REST) Program: Theoretical Orientation Does Not Matter”
	DEWITT	Breakout 19 - Elisabeth Szlec M.A. – “Virtue Therapy: A New Approach to Difficult Chil- dren and Families”
	MANLIUS	Breakout 20 - Jay Joseph Psy.D. – “Genetic Theories of ADHD, Autism, Bipolar Disorder: A Critical Evaluation”
11:25-12:25	LAFAYETTE	LUNCH - ICSPP Buffet Lunch \$10
	LAFAYETTE	Kevin Miller, B.A. FILM- (Director) "GENERATION RX" (No CE)
12:25-1:10	LAFAYETTE	Plenary 7 - Toni Heineman Ph.D. – “A Broken Heart is not a Mental Illness: Diagnosis and Treatment of Children and Youth in Foster Care”
1:15-2:10		BREAKOUT SESSIONS 21-25
	LAFAYETTE	Breakout 21 - Robert Foltz Psy.D. – “Current Trends and Challenges in the Treatment of Mood Disorders: The Possible Impact of Prescription Privileges for Psychologists”
	POMPEY	Breakout 22 - Tom Bratter Ed.D. & Lisa Sinsheimer M.D. – “Experiences Before, With, and After Psychotropic Medication”
	FAYETTEVILLE	Breakout 23 - Toni Heineman Ph.D. – “A Home Within: One Child, One Therapist, for as Long as it Takes”
	DEWITT	Breakout 24 - John Benda M.S.W. – “Family Therapy as an Alternative to Medication: A Symbolic-Experiential Approach to Working with Painfully Complex Children, Adolescents, and Families”

	MANLIUS	Breakout 25 - Sal Pizzuro Ed.D. – “Postsecondary Education Patterns of Enrollment, Support, and Accommodations Among Students with Disabilities: A State-Wide Survey”
2:15-3:15		BREAKOUT SESSIONS 25-30
	LAFAYETTE	Breakout 26 - Sharna Olfman Ph.D. – “The Building Blocks of Children’s Mental Health: Care and Community”
	POMPEY	Breakout 27 - Matthew Israel Ph.D. - “Positive Behavior Modifications with Optional, Supplementary Aversives if Required: An Effective, Harmless, Alternative to Psychotropic Medication”
	FAYETTEVILLE	Breakout 28 - Gary Kohls, M.D.- “What Mental Health Caregivers Need to Know about the Neuroscience and Nutritional Science of the Brain”
	DEWITT	Breakout 29 - Stephen Sheller J.D. – (tentative) “Side Effects of Risperdol and Zyprexa”
	MANLIUS	Breakout 30 - Noelene Weatherby-Fell M.A. – “Taking the Time to Talk”
3:15-3:25		BREAK
3:25-4:25		BREAKOUT SESSIONS 31-35
	LAFAYETTE	Breakout 31 - Evelyn Pringle – “Yellow Brick Road of Child Psychopharmacology: Nursery School to Teen Screen”
	POMPEY	Breakout 32 - Grace Jackson, M.D.-(Tentative)
	FAYETTEVILLE	Breakout 33 - Burton Seidler Ph.D. – “Hey! Are You Talking About Me Buddy? The Non-Medication Treatment of a Young Man Exhibiting Paranoid Symptomatology”
	DEWITT	Breakout 34 - Alexandra Adame (Ph.D. Cand.) & Larry Leitner Ph.D. – “What it Means to Identify as a Psychiatric Survivor and Mental Health Professional”
	MANLIUS	Breakout 35 - Elizabeth Root M.SW. – “What to Do About Nature Deficit Disorder?”
4:30-5:30	LAFAYETTE	Plenary 8 - Peter Breggin, M.D. Harmful Effects of Psychiatric Medications and Alternatives for Children.
5:30-5:40	LAFAYETTE	Toby Watson Ph.D. – “Closing Remarks” (No CE)

6:30:-8:30

GALA Awards Dinner (No CE)

Sunday October 11, 2009

8:30-10 am

ICSPP Board Meeting (No CE)

Difficult Children and Families

Understanding Instead of Diagnosing:
Evidence-Based Interventions & Support Instead of Just Medications

Conference Objectives:

Compare the most effective child and parent therapeutic approaches
Explain why current interventions and plans may not be working
Discuss what long term outcomes occur with and without drug -treated children
Explain why children of different race and income receive different interventions
Compare and contrast the following approaches: Magic 1-2-3, Caregiver's Skills Program (CSP), Nurtured Heart Approach (NHA),
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Conference Purpose: To educate and inform professionals in the helping disciplines (including, but not limited to, psychologists, social workers, psychiatrists, counselors, educators, nurses, and physicians) as well as psychiatric survivors and interested lay persons regarding a variety of interventions and supports which have been demonstrated as effective in helping challenged and challenging youth and their families. The emphasis will be on detailed psychological approaches. Scientific and clinical findings will be discussed and explored regarding differing psychological programs, methods, and interventions.

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The order form, with prices, is on page 28. 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. 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
Toby Tyler Watson, Psy.D.	The Four False Pillars of Biopsychiatry: Examining the Scientific Facts about the Underlying Assumptions of Biopsychiatry - Chemical Imbalances, Inheritance, Genetics, and Adoption Studies
Laurence Simon, Ph.D.	Therapy as Civics: The Patient and Therapist as Citizens
David B. Stein, Ph.D.	Parenting and Treating Difficult Teens Without Drugs or Make Believe Disease
Dominick Riccio, Ph.D.	The Role of Therapeutic Function of the Father in the Treatment of Difficult and Acting Out Children
Matt Irwin, M.D.	Treatment and Reversal of Schizophrenia Without Neuroleptics
George W. Albee, Ph.D.	A Radical View of the Causes, Prevention, and Treatment of Mental Disorders

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Nadine Lambert, Ph.D.	The Contribution of Childhood ADHD, Psychostimulant Exposure, and Problem Behavior to Adolescent and Adult Substance Abuse
Celia Brown and David Oaks	The Continuum of Support: Real Alternatives and Self-Help Approaches
Robert Whitaker	Anatomy of an Epidemic: The Astonishing Rise of Mental Illness in America
James B. Gottstein, J.D.	Psych Rights Legal Campaign Against Forced Drugging and How You Can Participate
Raymond DiGuiseppe, Ph.D.	Is Anger Adequately Represented in the DSM?

2005 - Schizophrenia and Bipolar Disorder: Scientific Facts or Scientific Delusions Implications for Theory and Practice

Brian Kohler, MD	The Schizophrenias: Brain, Mind, and Culture
Elliot Valenstein, Ph.D.	Biochemical Theories of Mental Illness: Some Hard Facts About Soft Science
Laurence Simon, Ph.D.	Abnormal Psychology Textbooks: Valid Science or Oppressive Propaganda
Clarence McKenzie, MD	Delayed Posttraumatic Stress Disorder from Infancy and the Two Trauma Mechanism
William Glasser, Ph.D.	Defining Mental Health as a Public Health Problem
Peter Breggin, MD	Current Trends in Treating Bipolar Disorder in Children and Adults
Dominick Riccio, Ph.D.	Why Mental Health Professionals Fail in their Treatment of “Schizophrenic” and “Bipolar” Diagnosed Clients
Bertram Karon, Ph.D.	Treating the Severely Disturbed Without the Luxury of Long-Term Hospitalization
Ann Louise Silver, MD	Keeping the Spirit and Philosophy of Chestnut Lodge Alive
Grace Jackson, MD	Allostatic Loads: Exploring the Long-Term Consequences of Psychiatric Drugs
Daniel Dorman, MD	Psychosis as a Fact of the Human Condition
Joseph Glenmullen, MD	Misdiagnosing Antidepressant-Induced Decompensation as “Bipolar Disorder”

2006 – Mental Health and the Law

Robert Dinerstein, J.D.	Human Rights and People with Mental Health Disabilities: The Issue of Capacity
Graham Dukes, MD	The Law and Psychiatric Drugs: Strengths, Weaknesses, and Experience
Stefan Kruszewski, MD	What Happens When the 1 st Amendment Butts Heads with Special Interests
Michael Perlin, J.D.	International Human Rights and Civil Disability Cases
Karen Effrem, MD	The Origins and Dangers of Child Mental Health Screening
Susan Stefan, J.D.	Evolving Views of Psychiatric Evidence
James Gottstein, J.D.	A Coordinated Campaign to Successfully Change the Mental Health System
Plenary Legal Panel Andy Vickery, J.D. Don Farber, J.D. Michael Mosher, J.D. Derek Braslow, J.D.	Prescription Drugs: Civil and Criminal Liability Cases and Concepts
Grace Jackson, MD	Parens Patriae, Parens Inscius: Beware the Dangers of the Incompetent State
Peter Breggin, MD	Medication Spellbinding (Iatrogenic Anosognosia): A New Concept
Joseph Glenmullen, MD	SSRIs, Akathisia, and Suicidality: The History of the FDA's 2005 Black Box Warning on Antidepressant-Induced Suicidality
Thomas Bratter, Ed.D.	When Psychotherapy Becomes a War: Working with Gifted, Alienated, Angry Adolescents Who Engage in Self-Destructive and Dangerous Behavior
Tina Minkowitz, J.D.	Remaking Human Rights: Advocacy by Users and Survivors of Psychiatry
Anne Marsden	You Decide Who Decides – Yeah Right!

2007 – Universal Mental Health Screening And Drugging of our Children

Fred Baughman, MD	Who Killed Rebecca Riley?
Grace Jackson, MD	Chemo Brain – A Psychiatric Drug Phenomenon
Karen Effrem, MD	Universal Mental Health Screening: The Facts
Robert Folz, Ph.D	Treating Mood Disorders in Youth: Understanding the Evidence
Peter Breggin, MD	The Truth about Bipolar Disorder
David Oaks	I was a College Student Mental Patient: How Psychiatric Survivors and Mental Health Professionals can Unite for a Nonviolent Revolution in Youth Mental Health Care.
Vera Sharav	America's Children Need a Child Rescue Operation
Jeffrey Lacasse, MSW and Jonathan Leo, Ph.D.	Consumer Advertising of Psychiatric Medications: Lessons Learned and Future Challenges
Joanna Moncrieff, MD	Deconstructing the Chemical Imbalance and Justifications for Drug Treatment
Maurine Kelly, Ph.D.	The Trials (and Tribulations) of One Therapist's Struggles to Provide Effective Psychotherapy to Children on Psychotropic Medications
Johanna Tabin, Ph.D.	Psychoanalytic Understanding of Why ADHD Behavior Occurs
Debose Ravenel, MD	Common Behavioral and Learning Problems in Children -An Alternative Approach: A Pediatrician's Perspective
James Gottstein, J.D.	The Psychiatric Drugging of America's Children: Legal Rights of Children and Parents
David Stein, Ph.D.	Weaknesses in Psychologist Training: Why Low Treatment Efficacies and Invalid Tests
Michael Valentine, Ph.D.	Analysis of Actual Adult-Child Interaction and Communication Patterns that are a Drug Free Alternative to the Medical Model's View of ADHD
Dominick Riccio, Ph.D.	Common Sense and Integrity in Psychotherapy when Working with Children and Families
David Keirse, Ph.D.	How to Help Troubled and Troublesome Kids in School and How to Stop the Criminal Behavior of 21 st Century Psychiatrists
Plenary Panel: Brian Kean, Ph.D. James Tucker, Ph.D. Noelene Weatherby-Fell Thomas Cushman, Ph.D. Dorothy Cassidy, M.Ed.	Whose Disorder is it? Protecting Normal Children: Preventing Bullying and Creating Effective Learning Environments Without the use of Psychiatric Diagnoses and Drugs

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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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2009

ICSPP is a nonprofit 501 (c)(3) organization. We are a volunteer organization with no officers receiving salaries or other financial benefits. **All annual memberships in ICSPP** includes our ***ICSPP Newsletter***, and other mailings, and helps us to continue to respond to the hundreds of information queries we receive from the public, the media, and concerned professionals. All members have the satisfaction of supporting our mental health reform efforts as described in our Mission Statement. Our journal, **Ethical Human Psychology & Psychiatry**, is vital to those who seek to read, write, and publish on issues critical to institutional psychiatry as well as to the life of **ICSPP** as a scientific and educational institution.

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