

ICSPP Bulletin

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

"The Conscience of Psychiatry"

2009 – Number 4 (Sorry We're So Late!) Issue

What's Inside:

2009 Conference:

A Photographic Look Back

Updates:

New Website Coordinator
Bulletin Coming Online

A Mother's Proclamation

Interview: Krista MacKinnon
of FOR

Articles:

Drugs are No Solution
and
Depression is Valuable

Film Review:

Mackler's "Broken Wings"

Poetry:

Kenn's 'Letter To Ange

Bulletin Staff:

Andrew Crosby, MA
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Delores Jankovich, MA,
LMSW
Co-editor

Syracuse 2009 Was a Hit Glad You Could Join Us

Our 2009 conference was a fine show, thanks to organizers Toby Tyler Watson and Michael Gilbert, seen below. Also hard at work were Burton Seitler and Jake Johnson, who took presentation proposals, and Susan Parry, who booked some of the speakers.

We had plenty of familiar faces, and new ones, too, both at the podium and in the crowd.

We're glad so many of you could make it, and we sure hope to see you next year when we will be back in Syracuse again.

We'll have more to say about our 2010 conference - topics, speakers, and all that fun stuff - in the next Bulletin. Until then, enjoy the photos and highlights, and everything else we've put together for you, in the following pages.



Dr. Toby Tyler Watson, ICSPP International Director, and Dr. Michael Gilbert at the Syracuse conference. They were the primary conference organizers for 2009. Michael will be doing it again in 2010.
Photo: Andrew 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.

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**ICSPP Bulletin
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.

ICSPP Welcomes New Website Coordinator

After more than six years of handling the ICSPP website and related duties, Andrew Levine has stepped aside. As we thank Andrew for his time and service, we also welcome his successor, Maria Mangicaro. Below, Maria tells us about herself.

I have 15 years in the graphic arts industry, a Bachelor's Degree in Legal Studies from the University at Buffalo, a paralegal certificate from Syracuse University and experience as a legal blogger.

To help promote the 2009 conference I created a blog on a free website to compile videos and information on the presenters and other

related topics, I also posted information on event sites, press releases and helped create a facebook cause. I did the same type of internet connecting for an event Michael Gilbert hosted and for seminars given by Dr. Charles Gant. As a courtesy and to help strengthen connections, I would be happy to do that for any ICSPP member hosting events they would like promoted. If any ICSPP members would like to contribute information for the ICSPP blog I would be happy to post it.

I am also a psychiatric survivor. Long term chemical exposure working in the pre-press department of a printing company cause an

acute manic episode from toxic encephalopathy. I was misdiagnosed for two years as having bipolar disorder. Testing Dr. Charles Gant ran indicated past exposure to lead and other toxins. A series of intravenous chelation treatments and other detoxing therapies helped to reverse symptoms.

On my own I accumulated enough information to initiate a worker's compensation claim that eventually gained support from an occupational doctor and a neurologist to the dx of toxic encephalopathy. My case is an example of the need to take an effective occupational work history in a psychiatric evaluation, as well as the need to recognize the effects of past exposure to lead and other heavy metals.

ICSPP Bulletin To Join the 21st Century

We here at Bulletin Headquarters have many gifts. We are knowledgeable, idealistic, and concerned with our members' interests. We are dedicated to our craft, and willing to work long hours for no money, although, yeah, we occasionally whine about the money part.

We are, however, technically challenged and slow to change. For example, over the years we have made several attempts to get the newsletters onto the ICSPP website, but with money issues, technical complications, and time pressures, we've just let that slip.

But that is soon to change, and we think you'll like what's coming.

Long story short, I had once asked a guy who's helped me with some computer stuff about how to get the newsletters onto our website and, at the time, he had little to say. Well, I recently got in touch with

him about some upgrades I'm ready for, and he asked about the newsletter. It turns out he's learned a few things since we last spoke, and he was full of ideas about how we can go high tech.

He explained it all to me on the phone. Here's the ten percent I understand: We will still be producing the Bulletin with our standard technology, using Word Publisher. (That's my favorite part.) We will still be printing and mailing the newsletter, at least to everybody who still wants to receive a hard copy. (We are also happy with *that*, since some members, like me, don't like change.) But the Bulletin will also be posted online, *including back issues*, available for full viewing to all members, and maybe even the general public.

We'd hoped to get this all in place for *this* issue, but with the

work load, the Holidays, and some unexpected dental work, we need to ask you be patient for just a bit longer. Again, we think you'll like what's coming. And the best part is that this will help us get word of our contributions out to more people. That's always a good thing.

Actually, the best part is probably that I'll no longer get those strange looks when I tell people we have no way to view our newsletters online. That's become embarrassing in an age when everybody – even boring people – are on My Space.

We expect this to happen by our next issue, so hang in there with us just a bit longer. We'll keep you posted about what's happening, and how to check in with the Bulletin online.

A Mother's Proclamation

Teri Braegelmann

On June 1, 2007, my 22 year old son, Joshua, committed suicide by shooting himself in the head. This was an irrational, impulsive act which may have been prevented, had we received better information and warning about the anti-depressive effects of his prescribed medications common among young adults. Sadly, the information existed. We simply did not know about it. I'm seeking to ensure that medications with BLACK BOX WARNINGS, like those being taken by my son, are visibly identified on the prescription bottle given to a patient from a pharmacist, thereby warning a patient and/or his/her caregiver of the special attention that should be given to these important FDA warnings.

Joshua took prescribed anti-depressants for approximately nine weeks prior to his suicide. My son's bottle of medication simply said "take with food or milk" and "may cause dizziness." It made no mention of the BLACK BOX WARNING, and nor did any of the other materials given to him by the pharmacist. In the weeks after my son's death, I became concerned about the medication (which was the same as Joshua's) I was taking for my own depression. I started researching possible side effects. I found a patient medication guide for the medication.

Upon reading the patient medication guide, I discovered the BLACK BOX WARNING, which is directed by the FDA to be inserted at the very beginning of the prescription package insert. A copy of that warning is attached. The BLACK BOX WARNING contains critically necessary information, a review of warns of potential serious adverse side effects and what behaviors or symptoms to watch out for. This information appears essential to informed patient decision-making and drug effectiveness. I was shocked to find such serious risk vs. benefit information, especially pertaining to young adults under the age of 25 years, tucked away in a box and probably never received by most patients. Amazingly, there was no directive to this vital information on my son's bottle of medication.

I equate the BLACK BOX WARN-

ING to the critical information found by FAA inspectors after a plane crashes. Unfortunately, the plane crashed for our family and I'm sure many others, given the statistics I have found. My son was never given the patient medication guide containing the BLACK BOX WARNING. Because of the lack of this vital information, we, the family never knew what to look for or even the potential risk involved in taking the prescribed medicine until months after Joshua's death. Joshua exhibited all of the side effects listed in the BLACK BOX WARNING for clinical worsening, however, the information came too late to assess or monitor him properly. It is hard to put into words the impact of the loss of my son. Joshua was an identical twin and left behind his bother, Aaron, who was and continues to be impacted in his own unique way. Losing Joshua continues to haunt every second of every day of our lives.

In closing, I would like to speak not only as parent but also as a consumer when I say that more than ever before in our country consumers are becoming proactive in their own health care

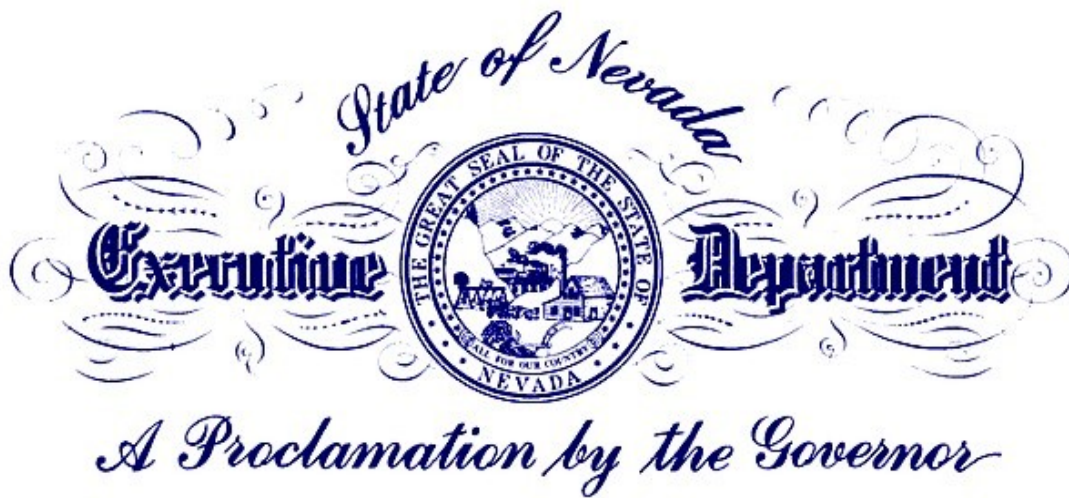
choices. Simply put, we have an expectation to be informed about our choices. This is evident for every age group. Further, we have a duty when we entrust our lives to those in the medical and pharmacology professions to give our input and insight related to our experiences, especially when other lives may be at risk. I have great concern for our many veterans returning from war, as a vast majority fall into the 18-24 age group and many may be prescribed these anti-depressive medications. If they may be at risk, they have a right to know what those risks may be and what to be on the lookout for. We have a duty to ensure that we give them our best, as they have sacrificed so much already. Sharing my tragedy is not an easy endeavor for me. Losing my son is the most difficult thing I imagine I will ever endure. It is my hope that others properly receive the tools necessary to make an informed decision regarding their medication.

Sincerely,

Teri Braegelmann (Joshua's mom)



Joshua and Teri Braegelmann at Mount Charleston, Las Vegas, Nevada, February 2007.
(Photo courtesy of Teri Braegelmann)



WHEREAS, in 2007 the U. S. Food and Drug Administration (FDA) required that makers of all antidepressant medications update the existing warnings on their products' labels; and

WHEREAS, these warnings must include an advisory of the increased risks of suicidal thinking and behavior, known as suicidality, in young adults ages 18 to 24 during initial treatment; and

WHEREAS, the FDA recognizes that suicidality is a growing concern, especially among the increasing number of young Americans who are prescribed antidepressant drugs; and

WHEREAS, education and awareness are essential tools for informed decision making; and

WHEREAS, communication between a patient, the caregiver, and the health care provider is vital to assuring a successful treatment plan and to providing hope for an individual who is struggling to overcome depression; and

WHEREAS, patients and their families should always be informed of all of the possible side-effects and life threatening adverse events of their medications and be warned of the danger of mixing medications with over the counter drugs or alcohol; and

WHEREAS, patients, care-givers, and health care professionals must work together to understand all of the ramifications of prescribed medications and should be aware of, and discuss immediately, any clinical worsening, suicidal tendencies, or unusual changes in behavior, especially during the initial few months of a course of drug therapy as stated in the "Black Box Warning"; and

WHEREAS, suicide hotline volunteers, triage professionals, public awareness and ongoing communication about this important issue are essential to preventing a heartbreaking and tragic loss;

NOW, THEREFORE, I, JIM GIBBONS, GOVERNOR OF THE STATE OF NEVADA, do hereby declare November, 2009

ANTIDEPRESSANT DRUG AWARENESS MONTH

Interview: Krista MacKinnon of Family Outreach Response

by Delores Jankovich

Krista, you are the Early Psychosis and Recovery Family Coordinator at The Family Outreach Response (FOR) center in Toronto, Canada. I understand that FOR is a one-of-a-kind organization that provides supportive services for family members and/or their loved ones whom are experiencing extreme emotional distress.

Tell me about your role at FOR and how you became interested in doing this work.

I am a family support worker and mental health recovery educator at FOR. I offer counseling, education, advocacy, and support to people struggling with mental health distress and to those who care about someone who is struggling emotionally. My role is to focus specifically on families that are experiencing something of this nature for the first time. Sometimes my role involves helping with system navigation and connecting people to the psychiatric system, and sometimes my role involves providing support and education to families who's loved ones are not choosing to use the formal mental health system as a tool in recovery. I do this wherever the support is needed, sometimes in hospitals, in family homes, sometimes in libraries, coffee shops or restaurants.

I became interested in doing this work because I myself went through what gets labeled "first episode of psychosis" at sixteen years old, and was given an unhelpful diagnosis of bipolar disorder. My family at the time became an ally to the medical system and the illness concept instead of becoming an ally to me in my recovery because they were not given thoughtful family support and education to understand what was happening for me at the time. It was clear to me then, and clear to me now that families need

to be educated not just by nurses and professionals in the medical system but that families actually need to have a wide variety of materials and sources of knowledge to make informed choices on what kind of support they want to offer to the people they love during extreme emotional times.

What prompted the founding of the Family Outreach Response as an organization?

In 1992 part of the Centre For Addiction and Mental Health set up a task force of families and staff members to look at the needs of psychiatric survivors and their families. In the meetings the need for family outreach was expressed loudly. A Family Council was created and was given space and support as a result. Limitations of time, energy, funding and expertise were encountered and a few years later FOR applied to the Ontario government for Community Investment Fund help. A portion of this \$20-million fund had been earmarked for family and consumer/survivor mental health initiatives. A wonderful coincidence: the FOR initiative and CIF funding appeared at the same time. Since, FOR has expanded significantly with two offices and ten staff, five full-time and five part-time.

FOR was not given funding to specifically be an alternative family program or even a recovery oriented support service for families. The funding was simply to provide support. It is through the proven success of the recovery oriented family program that FOR has been able to grow and get more funding and resources to be where we are now. We are very grateful to be able to do the cutting edge work we do while still having Ministry of Health funding.

If you would, briefly outline the principles that make the difference

between FOR and other family support organizations for those diagnosed as mentally ill such as The National Association for the Mentally Ill (NAMI, the major family support organization in the U.S.).

For one, NAMI is heavily funded by the pharmaceutical industry and FOR has a policy to never accept funding from the pharmaceutical industry. In fact, FOR will not even participate in conferences that have pharmaceutical industry sponsorship. Secondly, philosophically we are very different. The education work FOR does is largely around educating families about the recovery model rather than the biological mental illness framework of understanding. For example, in the educational groups we run for families we do not teach from the perspective of the diagnostic statistical manual and the symptoms accompanied with given diagnoses but rather we focus on communication, relationship, and critically analyzing what is happening in the given situation, including deconstructing the illness system itself. We often have survivors come and tell their stories of recovery and talk about what they found most helpful from their loved ones in their most difficult times. We also focus on ways families can manage their own "dark emotions" and learn how to offer support while also letting go of things beyond their control.

What organizations or resources were helpful in forming the philosophy and programming that FOR chose when establishing their services?

The survivor movement and the recovery movement and all the related literature and research were extremely helpful in creating programming and establishing the principles and values of the services offered at FOR. We are also lucky that The Centre For Addiction and Mental Health graciously provides us

with office space and another organization called Community Resources Connections Of Toronto provides us with some back end administrative support. We've also been heavily influenced and learned volumes through our involvement with the International Network Towards Alternatives in Recovery (www.intar.org) who are an international summit of world-renowned survivor leaders, psychiatrists, psychologists, family members, and other mental health professionals who meet annually to promote alternatives to the harm of diagnosis, medication, hospitalization, coercion and force.

How does what you provide in services for a person experiencing his or her first psychosis differ from what you would provide for someone who has had an experience of more than one psychosis?

It is important to address internal and external oppression and discrimination in both cases, but sometimes the iatrogenic harm and learned helplessness that can occur from unhelpful system supports for those who have been in distress for longer periods of time are quite great. I'd say 60 percent of what I provide in services for someone who has had more than one experience of psychosis is often around directly facing and overcoming some of that damage. In first episode psychosis family work, sometimes it is the family who is in crisis while the person who experienced psychosis has already started to move on and heal. In both cases there are parallel healing journeys happening and the family support offered at FOR honours both those tracks and their respective choices and options for managing healing. Sometimes the family work is about being the bridge between the two journeys. Also, in first episode psychosis, the work is about connecting people to services and supports and community that are

meaningful and helpful. A first break of psychosis can be a real biographical disruption for people that can shake their identities to the core, so we spend time and energy focusing on making sense of the experience and inviting people to take authorship over what is happening for them.

Through a recent communication with me, you shared that you had attended the 2009 Conference of The International Network Toward Alternatives and Recovery in New York. What was the high point of that conference for you?



Krista at the FOR office in Toronto.
(Photo courtesy of Krista MacKinnon.)

There were many high points for me. Sometimes promoting recovery in a system that is so inherently illness-based can feel isolating and lonely, so to talk and work with a room full of survivors, professionals and families who wholeheartedly believe that we can do things differently and need to be doing things differently in mental health service delivery, is very affirming and energizing. Will Hall did a fabulous keynote that really highlighted how damaging the system can be and how viable alternatives are, that was touching and beautifully delivered. Another great

moment was when Thomas Bock, a Professor of clinical psychology and social psychiatry at the University Clinic of Hamburg looked up first break in his German-English dictionary and discovered the English translation to be "first chance." I found that to be quite fitting.

What would you say is the most important quality that a parent or other concerned person can have in relating to his or her loved one when the loved one is in extreme distress?

It's imperative that concerned people know their limits of involvement and understand their role in supporting someone. Sometimes this means accepting that even in when extreme-distress their relative is entitled the right to risk, the dignity to fail and the opportunity to learn from their life path. As a support person you are there to inspire, love, support and care, not to control or "save" someone. This is a difficult thing for many people to embrace when they can see someone they love really struggling and making what they deem "poor choices" but is a highly important skill for the relationship and for healing.

How do you provide education and support to family members when they face conflict or opposition when presenting an alternative view of recovery, while interfacing with individuals who utilize the disease model in addressing extreme states of distress?

That is the most challenging part of our job. When families are educated about recovery and alternatives they rightfully become quite frustrated with the status quo. We provide resources and information for families to keep them inspired and impassioned about recovery, as well as providing advocacy and emotional support. We host a social justice and recovery group that families can become involved in if they are wanting

to take action and to promote different frameworks of understanding and different ways of offering support.

Does the social justice and recovery group provide connection with recovery-informed legal help, or does it primarily provide emotional support for the process?

The social justice and recovery group is a new group. This group was formed in order to provide a way to utilize and channel the anger and frustration experienced when individuals realize the oppression and pain they experienced in the disease model of mental health. What action and focus the group will take specifically is yet to be determined and will come directly from the will of the group.

In your experience, what do consumers, ex-users and survivors most want in their ongoing relationships with family members and/or friends?

Consumers, ex-users and survivors want the same things that everyone wants in their relationships. We are not different. We want patience, acceptance, compassion, empathy, hope, and kindness, a non-judgmental attitude. We want to have the right to run our own lives and make choices that we feel make sense for our individual life paths.

Certainly, FOR is a model of support and care that is greatly needed in other loca, especially here in the U.S., as well as in other countries. What is the first task necessary in order to create a like-minded group to accomplish what FOR is accomplishing?

It might be helpful to align with other interested established groups. The Center to Study Recovery in Social Contexts was a sponsor of the last INTAR conference, I wonder if there are any individuals there who are interested in supporting some development with regard to family recovery work? Part of what makes FOR work so well is that everyone who works here is a professional but is also someone who has been personally affected by mental health distress and the psy-

chiatric system either as a family member, or as a survivor. To establish a program like FOR in other communities it would be helpful to start with a group of impassioned psychiatric survivors and family members who are wanting to see families being supported and educated differently. There may even be some pockets of NAMI that are more open to collaborating with survivors and developing more recovery oriented family supports. Also, the director of the program, Karyn Baker, and I are always happy to travel and share our materials and do training with new family organizations wanting to offer this type of service.

What is the most satisfying element of this work for you?

The most satisfying element of this work for me is when I see families go from being completely in distress to being calm and empowered even in crisis. Families really learn to survive and thrive even amidst incredibly difficult situations. It is very satisfying to see healing happen not just individually with people in recovery but relationally within the family. The resilience I see in the families I work with is beautiful and makes me proud to be part of the human race.

Would you share some of the interests and practices that help you unwind and provide enjoyment for you?

I am a mom of two amazing little boys who provide me with endless giggles, challenges, snuggles, and lessons. I am a long-time yogi and Buddhist spiritual practitioner. My interests lie in personal development and growth and in the potential for connection and intimacy between people. I think we've only scratched the surface of the power of love and healing through relationship. In my personal time I engage in all sorts of wonders to keep me engaged and happy in the world from building websites to chanting with my shruti box to writing and creating art. I like to always try new things and find different ways of being in my body, from yoga to Parkour, to gymnastics to running to hip hop dancing. Lately I've been all about the hip hop dancing and have been having a blast with that.

For those who want to learn more about your organization, how do they go about contacting FOR?

Well, a useful source of information is our website of course <http://www.familymentalhealthrecovery.org/> but also people can contact me directly at 416-535-8501 ext 1935.

Is there anything else that you would like to add in regard to your work or of specific note about FOR?

I would like to add that Karyn Baker and I are doing recovery education for mental health professionals. We offer this in a variety of ways, but often we do this in a six week training course. Many professionals were coming to our family recovery education groups to learn about recovery so the next logical leap was for us to officially offer training to professionals. We feel very lucky to do this work and spread the lessons of the recovery model to interested professionals.

It is great to know that you are bringing awareness and education that, hopefully, will inspire conventional workers to pursue alternatives in working with those who are going through painful emotinoal experiences.

I appreciate the generous time you have given to sharing this information. The ground-breaking work that you and your organization are doing is giving new hope for those who experience extreme emotional states as well as for their family members and friends.

Your interview gives ICSPP the opportunity to begin circulating awareness of The Family Outreach Response to those who are in need of alternatives in their recovery. We commend you for the work you do. Thank you, Krista MacKinnon.

Imbalance or No Imbalance: Drugs are Not the Solution

By Charles Greenstein

We need to be more careful in our handling of the chemical imbalance issue. This seems to be the easiest target when we, those who strive to reform the field of mental health, seek to dismantle the medicating brigade of our opponents. It truly is the most ridiculous-sounding aspect of their theories. But while I doubt there ever will be scientifically reliable proof of such a neurochemical imbalance, I can't say that I would be completely shocked if it were true. I can't say that it's *impossible*. Thus I think it may be helpful for us to perhaps not place so much emphasis on the 'chemical imbalance,' which I believe isn't so much the heart of our problem.

I bring up this issue because it seems like tons of things are happening in the field of neuroscience: we are studying those who meditate, and indeed finding brain changes that occur during these states. Many other experiments on the brain are being conducted with what appears to be reliability. And while I take most of these reports with a grain of salt (hinged on what every foremost brain scientist seems to report: that we don't know *squat* about the brain – even with all our fancy experiments), may it one day be possible to show chemical changes in one who is very depressed? Sure. I'm not sure what significance it would have; a difference in brain chemistry could not in itself be called an *imbalance* – that part is simply subjective and cultural. But nevertheless, our critique of psychiatry and psychoactive medicating cannot be dependent merely on the denial of changes in neurochemical alterations.

In addition, judging on my experience with psychiatry, both personally and within our culture, the chemical imbalance theory does not mark a central part of their regime. This is indeed hypocritical and deceptive, as the field often reveals itself to be. The chemical imbalance theory, I think, is

there just kind of on the back burner. It's there just in case anyone asks any questions. Instead, it is more often the greed, anxiety, and fearfulness that take over both the psychiatrist and the patient. "I'm going to write you a prescription to help deal with your depression," a doctor might say. "Sure! Great! Sounds wonderful!" the likely response goes, echoing a suffering, desperate patient who will try anything to alleviate his or her problems. It is almost like the case of a drug addict who, upon hearing that a certain substance will make him feel good, leaps up at the opportunity, with no questions asked. Our whole society is caught up in this delusion – the delusion of a substance-addicted junkie.

I myself an example of one who came to a psychiatrist with such desperation. Being only fifteen at the time, when even our internet-savvy-ness was barely underway (this was in 20001), I had little knowledge of emotional healing, psychiatry, drugs, or much of the informational world for that matter. I was thrown into a psychiatrist's office unsuspectingly, indeed hoping for some magical fix to my depressive and obsessive mind states. With a grinning smile on her face, as if to enhance the gratification of my fantasy, this doctor told me I could start feeling better "*today*" – following a visit to my local pharmacy. Boy did that sound good. Yet I was, in fact, not *completely* ignorant to what was going on. The idea of a chemical cause came up in our discussion and I inquired, "So where can I get my chemicals tested? I want to know how badly I have the disorder." To this she responded, in the most deceptive and dishonest words I'll never forget, "Well it's very hard to get a test done. It takes a lot of high-tech equipment. You'd probably have to travel really far." And so I left it at that, walking away in blind belief that there was something wrong with my genetic makeup.

Thus while the 'chemical imbalance' does have its place in the armor of

psychiatry and the pharmaceutical industries, I've found that this isn't really an issue to many people. Many people just want "help," and if there's a drug that can be claimed to help, great. No further questions asked. For indeed, if one were to question far enough, they would find themselves in a dead end. There *is* no big testing lab somewhere out West where we can measure our depression levels, as I was so criminally misled to believe. And additionally, the notion of such an imbalance seems to crumble apart within any visit to a psychiatrist. The logic seems to work as follows: "You were abused as a child, and now you're going through a rough divorce. Here's some medication to help with your chemical imbalance." So if we can retranslate that: "You were abused as a child, now you're going through a divorce – these events must have triggered your inherited chemical imbalance from your mother who was depressed." Baffling? Illogical? Of course. Psychiatrists actually aren't dumb enough to deny the existence of real-life causes for emotional difficulties, but they are dumb enough acknowledge them alongside some 'coincidental' chemical imbalance that is the impetus for their drugging. Digging deep enough, the whole agenda in psychiatry so easily crumbles in contradiction and illogical beliefs. They will say *anything* to bust out that prescription pad.

Returning to our central issue, what *if* such neurological changes implied by the chemical imbalance theory were shown? What implications would such a discovery have? In my opinion, it wouldn't give the slightest justification to administer drugs to anyone. The first reason is that which I touched on above: that the labeling of anything an imbalance is purely subjective. Say someone was indeed born with some chemical predisposition to depression (not that, in a larger philosophical and spiritual scope, such a condition could be simply understood as chemical). The idea that

the uniqueness of this person should be stamped out because someone's perspective won't tolerate it is simply immoral and unethical. All types of people are born into this world, with all types of difficulties and peculiarities – most of which, when left alone, turn out to be sources of great success and triumph. More importantly, the difference between labeling an emotion an "imbalance" and labeling it simply as an emotion, is huge. The perception of "this is okay" as opposed to "this is not okay" is probably the central factor in determining whether or not one will suffer – in all aspects of life. And there is nothing inherent in any emotion that can qualify it as objectively disordered or "imbalanced." Thus even if lab tests were to show a chemical difference, nothing could imply the difference to be an imbalance, and therefore nothing could warrant the use of drugs as "treatment."

Secondly, in the event that there was shown to be such a chemical difference in depressed persons, how might drugs *ever* help? It seems we've learned pretty well as a culture that drugs do not fix or aid any emotionally difficult problem in an ultimate way. They do the very opposite: they deceive us into thinking they are helpful due to their short pleasures, and lead us to pay the price – sometimes it is quite high, as in the case of drug addicts. And so we've outlawed them, rightfully so I believe, in the efforts to promote clear-minded living in our society. So why the sudden shift when it comes to psychiatric drugs?

Here is where we get to the crux of the problem. It is not so much the chemical imbalance theories that are the issue, but instead the drugs themselves. We are completely blindsided by these substances, thinking they are somehow magical concoctions, different from any other high-producing drugs. Speaking from six years of miserable experience on virtually the whole class of SSRI antidepressants, along with dabbling into many of the common street drugs, I can speak quite directly as to the place of psychiatric drugs within the realm of all mood-altering drugs. Simply put, just

as marijuana differs in action from cocaine, and as cocaine differs from LSD – and yet their nature remains utterly similar – so it is with psychiatric medications in relation to street drugs. There are slight differences in their effects, but the heart of the mechanism is the same.

To elaborate: At a particularly low point in the depression that struck my teens, I took my first hit of ecstasy. My mood began to lift within about an hour, and things became very trancelike. Particularly loving and blissful feelings came over me, albeit ones that were tainted by a distinguishable synthetic, icky feeling; a false happiness – a 'high' in the utter sense of the word. I ended up drifting into sleep at a point that I don't remember, and when I woke up there was hell to pay. Drowning in a chemically-induced state of depression, I felt like the ground had been lifted from under me. The only solution was to wait it out.

***"This is the point
where a patient is
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When I took SSRI antidepressants, the specific effects were different, but not at all in a separate compartment. I noticed a slow lifting in my mood over about a month or two, it was very gradual. If I were to describe the nature of what antidepressants feel like, I would similarly say the experience was colored with an icky, synthetic vibe (in comparison to a drug like marijuana, which bore a more organic tone). Most of all, I would certainly not exclude them from creating a 'high'; an imitative, false happiness. And so while the street drugs came on quite quickly, the major difference I noticed with antidepressants was that they came on ever so slowly. But just like any other drug, the feeling would be gone in time – after several

months in this case – and not without repercussions. This is the point where, if you review almost any psychiatric patient's history, the patient is switched to a new drug. They are often constantly put on every drug in the market, in a never-ending pursuit to find one that works – when none ever really do. No drug proves to be exempt from inefficacy for emotional problems; they simply don't work. This has become so clear to me, and I believe it is clinically clear as well. We simply don't want to acknowledge it.

I have brought this up – this clear parallel between psych drugs and other mood-altering drugs – to several believers in psychiatry. "Don't you see it as another drug?" I ask, "doesn't it just get you high? I mean what else can it possibly do?". "No," they reply, "it just makes me feel normal." "But isn't that a high in itself," I respond back, "feeling 'normal,' *higher* than you did previously?" This understanding clearly depicted my experience, but I seem to have been unable to get it through to anyone else. What is one's idea of normal? Is it perfection, where only states of happiness and pleasure prevail? Is it some fantasy land that we envision 'normal' people to be living in? If you walk into any Alcoholics Anonymous or Narcotics Anonymous meeting, in fact, you will find just such a description of drugs and alcohol. "When I had my first drink," the common speaker might say, "it was like everything was normal again. I felt like a million bucks, like all my problems had been swept away." Thus we tend to have very grandiose ideas about what 'normal' is.

The moral of the story is that, whatever drug you turn to – whether it's crack cocaine or it's the newest isomer of Celexa – you cannot get away from their ravaging effects. It is as if every grain of chemical pleasure that one experiences from a pill must be paid for – and often paid for painfully. In my experience, and in the experience of many others I've heard from and perceived in, antidepressants are probably the most deceptive of all drugs. The creators of these drugs were indeed very clever, in a most truly harmful and disastrous way. Whereas street drugs will often let you know their negative sides right away – a come down, a craving to get more – I've found the dark side of antidepressants to be much more subtle, yet much more

devastating. Horrific side effects will creep up on you (as your psychiatrist tells you to just endure them), and they will often evolve in a most permanent way. The nature of these long-acting substances is to have long-lasting withdrawals as well, many times taking years, if ever, to completely subside. Everything from one's sex drive, to one's clarity, to one's intimacy in his or her relationships is affected in a lasting manner – much less receding than the quick-high producing street drugs.

The problems with antidepressants and the other psychiatric drugs go well beyond side effects, however. While the side effects must not be overlooked (because the experience of their disastrousness is quite greater than how the words may appear on paper), the heart of the matter is that these substances are in fact drugs. They are toxic not only in their chemical nature (anything *but* organic or natural), but also in their effects of those suffering with mental difficulties. The *last* thing you want to give anyone who suffers with depression or anxiety, or even hallucinations or paranoia, is a mind-altering substance. This

will just throw them completely out of wack, out of touch with their feelings. It pushes back the issue to be dealt with at a later date, when the high has lost its effect. This is why it is ridiculous to say that someone who is suicidal should be a specific case where antidepressants are ethical and allowable. By not addressing the issue, antidepressants throw the situation into a complete mind-funk. The suicidal person may feel the temporary calm – just as if they had taken a hit of ecstasy – but those unpleasant emotions will have their day, and they will likely strike much, much more severely. Either this or the recipient will find him or herself floating throughout life in an absent-minded daze, operating on a prescription-drug autopilot. It is this kind of emotionally-numbed dullness that I think most Americans on antidepressants suffer from. They are limited in all of body, mind, and spirit from their true potential and humanity.

Our emotions are indeed peculiar in that the more we try to run away from them or avoid them, the harder

and more painfully they will strike against us. As is evident in any therapeutic or spiritual setting, our mental phenomena seem to desperately want to be heard. Drugs, be them street drugs or socially-acceptable psychiatric drugs, counter this to the utmost degree. In Freud's day, it was the issue of repression that was cited as the cause of most neuroses. When drugs are used, we go above and beyond repression. We try to physically stamp out the emotions we don't like – and the results are evident in a variety of unpleasant ways. Thus whether our emotions are of a chemical nature, or, more realistically, the intricate workings of a vast combination of psychological, social, familial, and spiritual factors, drugs can never do more than cause tremendous harm to the body and mind. We must focus not so much on the reasoning behind the drugging, but rather on the fact that there is nothing to be gained in such a treatment – and everything to be lost.

THE VALUE OF DEPRESSION

By Al Galves, Ph.D.

[Note: This is the first in a series of four articles that explore the meaning, function and potential usefulness of states of being which lead people to be diagnosed with mental disorders. The next three will address mania, anxiety and psychosis in that order.]

The biggest problem with the conventional wisdom about mental illness is that it encourages people to ignore the meaning of the symptoms that are used to diagnose them. That is a problem because it deprives people of vital information that can help them live more the way they want to live. The conventional wisdom about mental illness is that it is caused by genetic factors, chemical imbalances and brain abnormalities. If you believe that, you have no interest in exploring the meaning of the symptoms or listening to what they may have to tell

you. Rather, you are encouraged to get rid of the symptoms as quickly as possible and pay no further attention to them.

But what if those symptoms had important information for people, information they need in order to lead healthy, fulfilling lives? If you believe in evolution and natural selection you would conclude that the symptoms must have some survival value, must be useful in some ways. Were they not useful, they would have been wiped away by natural selection a long time ago. After all, human beings have been evolving for about 30 million years, the estimated time since humans split off from the other members of the primate family. Any human faculty which has lasted for 30 million years must be useful to our survival and well-being in some way.

If that is true, let's look at some of the symptoms of mental illness and see how they might be useful to us. Here are the symptoms that are used to diagnose the most common mental illness – depression. (Yes folks, the symptoms that are listed below, and nothing else, are used by doctors and psychiatrist to diagnose clinical depression). You would think – considering the conventional wisdom about mental illness – that there was a more “medical” way of diagnosing depression, a blood test or brain scan. But no, the way it is diagnosed is the doctor, psychiatrist or other mental health professional asks the patient to give a self report on the following questions:

- Have you felt sad or empty most of the day, nearly every day for the past two weeks?

- Have you experienced a markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day for the past two weeks?
- Have you experienced significant weight loss when not dieting or weight gain (a change of more than 5 % of body weight in a month) or increase or decrease in appetite nearly every day for the past two weeks?
- Have you experienced insomnia or hypersomnia (excessive sleep) nearly every day for the past two weeks? Have you experienced psychomotor agitation (jittery, jerky, jumpy stomach) or retardation (slowed down, sluggish, groggy) nearly every day for the past two weeks?
- Have you felt fatigue or loss of energy nearly every day for the past two weeks? Have you experienced feelings of worthlessness or excessive or inappropriate guilt nearly every day for the past two weeks?
- Have you experienced diminished ability to think or concentrate, or indecisiveness, nearly every day for the past two weeks?
- Have you experienced recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide?

If the patient responds “Yes” to five or more of those questions and if those symptoms are causing significant distress or impairment in social, occupational or other important areas of func-

tioning, the patient is diagnosed with clinical depression. So if we assume that these symptoms must have some survival value, how might they be useful? What might be going on with a person who is experiencing these symptoms?

It sounds as if s/he is very upset about something. Something is not going right in her life. Something is threatening her ability to live the way she wants to live, to love the way she wants to love, to work (express herself) the way she wants to work. Something precious has



Al Galves with Faye Karpouzis, between presentations at the Syracuse conference.
(Photo: Andrew Crosby)

been lost. He is concerned about his life, where it is going. Is it the job, the relationship, the kids, the demands of parenting, his social status? He’s not going to live forever. Maybe he needs to do something about it.

It sounds as if s/he’s under a lot of stress or, perhaps shutting down after being under a lot of stress for a long time. Perhaps this is the body’s way of protecting itself from prolonged stress. There are worse things that could happen – a heart attack, a stroke, cancer. In fact, research has found a strong link between high levels of stress and depression. This sounds like a wake-up call, a message that something is not right and something needs to be done about it. The body-mind is saying: “Stop doing what you’re doing. Stop focusing on the outer world, on other people, on your spouse,

your clients. It’s time to quiet down, go inside, take a serious look at your life, get in touch with what is going on. Stop avoiding this by drinking, drugging, working, playing, sexing, competing, winning. You need to make some important decisions or, perhaps, accept what is true about you and your life and become more comfortable with it. You need to do some inner work.”

Perhaps this is a reaction to the loss of something that is very precious to us. It wouldn’t have to be the loss of a per-

son, a job, financial security or a relationship. It might be the loss of youth, or certainty or a sense of comfort. If something precious has been lost, perhaps it would be healthy to spend some time experiencing the pain of that loss.

How could the painful experience of loss be helpful? If I believe that all human faculties which have survived through the 30 million years of human evolution have to be useful, that is

an obvious question. And an answer that makes sense comes to me. Loss is useful because it tells me what is precious to me. It tells me what I want to protect and nurture and tells me in a very powerful way that I better do what I can to protect and nurture those precious things. Valuable information indeed.

What if depression is a state of being that forces people to take a look at their social relationships and that gives them impetus to do something about changing them?

That is the hypothesis of Paul Watson, a behavioral ecologist at the University of New Mexico: “It induces us to be attentive to the structure of our social network: Who has power? Who has what opinions? How do these opinions of different social partners interact to constrain or enable us to make changes in

life? Depression may have a social planning function which helps us to plan active negotiating strategies in a sober, ruminative state so we can go out and actively negotiate ourselves into a better social position with the people who have power to help or hinder us.”

Edward Hagen, an evolutionary biologist, has a similar idea. In the ancestral situation, when humans lived in small hunter-gatherer tribes, depression may have had value in compelling other people in one’s life to make changes that were in one’s interest – to induce the members of one’s tribe to come to one’s aid.

In his book *Care of the Soul*, Thomas Moore has a chapter entitled “Gifts of Depression”. Here is one of them: “Depression grants the gift of experience not as a literal fact but as an attitude toward yourself. You get a sense of having lived through something, of being older and wiser. You know that life is suffering, and that knowledge makes a difference. You can’t enjoy the bouncy, care-free innocence of youth any longer, a realization that entails both sadness because of the loss, and pleasure in a new sense of self-acceptance and self-knowledge. This awareness of age has a halo of melancholy around it, but it also enjoys a measure of nobility.”

Medical researcher Antonio Damasio found that people who couldn’t feel bad couldn’t make good use of their reasoning powers. In his book *Descartes’s Error*, he describes his work with people who couldn’t process feelings because of lesions in the amygdalas of their brains. Not being able to feel bad, they were unable to make good decisions about their finances, business practices, relationships, etc. They might buy a stock and see that it was losing value. But, not feeling bad about it, they wouldn’t take any corrective action.

But wait a minute. Let’s not get too sanguine about this. Depression is associated with suicide. It is a very debilitating disease. Severe depression keeps people from doing any of the things that make life worth living – loving, working, playing, expressing, enjoying. Let’s be careful not to make light of a serious illness.

Yes, we need some balance here. Perhaps, depression is like many things which are good and useful in moderate amounts but dangerous and deathly in extreme amounts.

Included in that list would be the stress response, alcohol, strychnine and water, among others. Perhaps what makes sense is to make a distinction between moderate depression and severe depression. Perhaps, keeping severely depressed people from killing themselves, hurting others or falling into permanent disability calls for extreme measures – psychotropic drugs, treatment in psychiatric hospitals.

***“So how do we
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Several possibilities
come to mind.”***

Balance makes sense. But that’s not where we are today. Today, more and more people respond to symptoms of moderate depression by ingesting antidepressant drugs, drugs which make it harder for them to experience the emotions and thoughts which might be valuable to them. Antidepressants are among the five most heavily prescribed drugs in the United States. People are going to psychiatrists and other doctors. The doctor asks them what is wrong. They say, “I’m depressed” and the doctor writes a prescription. There is no time spent exploring what might be going on in the person’s life or how they are responding to their lives that might explain the symptoms.

And it’s not merely that the drugs keep people from receiving valuable information they could use to live happier lives. They also have powerful side-effects, including impairment of sexual functioning and increased risk of violence and suicide

and withdrawing from them is much harder than we’ve been lead to believe.

So how do we explain the willingness of so many Americans to use these drugs? Several possibilities come to

mind. From time immemorial, human beings have been ingesting substances that make them feel better. Witness the use of mescaline, peyote and mushrooms by ancient cultures and the use of alcohol, marijuana, cocaine and amphetamines in today’s world. Ingesting a substance is a lot easier than wrestling with one’s demons and then having to do something difficult and scary in response to the insights gained from that process.

Perhaps this is the shadow side of scientific medicine. Medical researchers and doctors have made some miraculous advances. They’ve conquered polio, malaria, smallpox and syphilis. They can transplant hearts, lungs, and kidneys. They’ve developed medicines that reduce the risk of heart disease and stroke. Now, they’ve developed drugs that cure mental illness. At least, that’s what people have been led to believe. In fact, almost all of the psychotropic drugs are only slightly more effective than placebo and have very damaging side effects. And, since they don’t address the fundamental cause of the symptoms that cause mental illnesses, they don’t cure anything. They impair some of the most valuable of human faculties. But they do appear to be another notch in the gun of scientific medicine.

Or maybe this is another example of the cult of professionalism, the belief that the experts know best. After all, they have advanced degrees so they must be very smart. So we put our trust in psychiatrists and other doctors. If they think these drugs are good for us, they must be. The danger of both scientific medicine and the cult of professionalism is that they may cause us to lose faith in the brilliance and power of nature, to lose trust in the ability of our bodyminds to heal themselves and to ignore the valuable information that our emotions and bodily sensations can provide to us.

So I might do well to pay attention to these depressive symptoms, to see what I can learn from them and to use them to become healthier and harder and to live more the way I want to live. Of course, most of us don’t have the luxury of taking off two or three days to contemplate our navels. But we could find some time during every day to quietly allow ourselves to experience what is going on inside. We

could even take some vacation time or sick leave to spend several days on it, perhaps with the help of friends or a therapist.

If you decide to do that, here are some suggestions. I would recommend that you find a psychotherapist to work with, somebody with whom you feel comfortable, who you sense will respect you and help you come up with your own answers. There is something healthy about being able to say things to another human being that you have not said to anyone else, to let your hair down and expose yourself, knowing that nothing you say or do will go out of the

room.

I would recommend that you spend some time just sitting by yourself in quietness, perhaps using some of the simple relaxation or meditation exercises that you can find on the internet or in various books. Just sitting and noticing whatever thoughts or feelings come up and paying some attention to them - not necessarily hanging onto them or doing anything with them - just noticing them.

I would recommend that you do some things that are enjoyable - perhaps reading books or articles that you want to read and definitely getting some good exercise - running, walking, bicycling,

swimming, skiing.

The bottom line is that I urge you to regard the symptoms, no matter how painful and debilitating, as a message of meaning, a message that contains valuable information that can help you live a healthier and more satisfying life. And I encourage you to make an effort to understand the meaning of the symptoms and to use the information they offer to live more the way you want to live.

Movie Review

“Take These Broken Wings”

A Film by Daniel Mackler, LCSW

Reviewed by Andrew Crosby, MA

Think about this: The phenomena we call schizophrenia has been part of the human experience probably for as long as humans have been experiencing, yet the general population continues to have little understanding of what it's about. This is one of the first impressions I garnered upon watching Daniel Mackler's documentary, “Take These Broken Wings.” It was the first of many.

The film hinges predominantly on Mackler's revealing interviews with former patients - meaning former *schizophrenics* - Joanne Greenberg and Catherine Penney. It is the rest of the material in the film, however, along with innumerable deft editing touches, that give the scenes with Greenberg and Penney much of their power. Of course it can be argued that they need little help: Greenberg, many will recall, is the author of the autobiographical novel “I Never Promised You a Rose Garden” while Penney was the subject of “Dante's Cure,” authored by psychiatrist Daniel Dorman, her psychotherapist for some eight years. Mackler isn't kidding around; by constructing “Wings” around these key players he signals 1) he's got a real point to make, and, 2) he knows whose going to help him make it.

As if that's not enough, the rest of the cast features prominent names from both ICSP and ISPS (International Society for the Psychological Treatment of the Schizophrenias) to offer their professional views on schizophrenia and its treatment. These include “Mad in America” author Robert Whitaker, Peter Breggin, Ann-Louise Silver, Bertram Karon, and Daniel Dorman himself. There are also effective snippets from Danielle Knafo, Al Galves, and Martin Cosgro.

Adding crucial elements to the context, however, Mackler also interviewed a hundred or so members of the general population - at least in so far as visitors to New York City's Washington Square Park can be considered so. *A hundred?* you might wonder. As I said, Mackler has a point to make.

Bits from the Washington Square Park interviews open the film and provide counterpoint throughout. Mackler introduces the first topic as a slow panning shot of the park's arch and fountain yield to steady shots of passers by who agreed to clip on a microphone and be filmed: “When you hear the word *schizophrenia*,” Mackler asks, “what's the first thing that comes to your mind?”

The responses dance around familiar themes. “Somebody with emotional

problems.” “People who are afraid.” Many sound uncertain: “A mental disease?” “Problems in the brain?” A couple are cool: “Imagine if you had a counter-factual voice in your head telling you horrible things about yourself.” “They hear voices all the time; I can see how it can drive ya nuts.” Most, however, say, “Mental illness.”

Mackler flirts with frustrating his audience at this early juncture, introducing Penney and Greenberg by splicing in bits of their interviews rapid fire, phrase by phrase at times, with those of the Washington Square Park passers-by who serve as a control group of sorts. Rather than frustrate, however, this shows intriguing parallels - some congruous, some not - and hooks the viewer who now wants to know what *the general public* will get right and what they'll miss.

Parallels - that's another impression one picks up on as interview material from Peter Breggin, Bert Karon, Robert Whitaker, and others is introduced. Now that the film is getting underway, the segments are longer, and Mackler allows Penney and Greenberg to stretch out and tell their stories. Both are spontaneous, articulate, and eminently likable. Both also seem comfort-

able, Penney in her California living room and Greenberg on the back porch of her Colorado home. Their narratives interweave and often overlap, both with one another and with what the experts are saying. When Penney describes witnessing her stepfather threatening her mother, she says, "As a small kid seeing that, *it just terrifies you.*" A moment later, Bert Karon advises about schizophrenics, "You have to assume their life has been God awful. You also have to assume they're terrified." Al Galves tells us that "all symptoms are functional in some way; they help protect you." This is after Greenberg says, "I was building a fort," and before she says, "One thing that schizophrenia does is it saves you from real world traumas" (immediately after which she discloses a whopper). Also in there, Cosgro says that psychosis is "a way to distance yourself from something that's so overwhelming." One gets the feeling that these distinct, and geographically distant, voices are unknowingly collaborating on an epic tale.

Mackler effectively organizes the film into sections covering the early, middle, and late stages of Greenberg's and Penney's treatments, during which periods of progress and regress are explored. Dorman's commentary regarding his side of the powerful therapeutic relationship with Penney is splendid, and blends well with Penney's. One deeply wishes that Greenberg's therapist, Frieda Fromm-Reichmann, were still around to give her side things, but Ann-Louise Silver is competent as her stand-in, of sorts, and Greenberg herself offers insights into how Fromm-Reichmann handled key matters.

Just as striking are sections where Mackler asks what causes schizophrenia and whether schizophrenics can get by

without medications. The Washington Square participants are unequivocal here: schizophrenics suffer from "overloaded brain activity" and "a chemical imbalance," and medication is essential to any degree of stability. Robert Whitaker is especially passionate in these sections, almost leaping out of his chair at times as he details what the



Dan Mackler (right) with conference organizer Michael Gilbert, out by the book tables at the Syracuse conference. (Photo: Andrew Crosby)

"broken brain" and chemical imbalance research actually tells us. *He* is unequivocal as well: "This is the crux of the fraud," Whitaker explains before quoting the deceptions of established psychiatry and excitedly concluding, "They lied to us!"

Breggin, Knafo, and Silver speak to the problems of relying on psychiatric drugs here as well. Of the many points made is the non-scientific one that when people improve without drugs, they can be certain they did so on their own. Greenberg and Penney also discuss their non drug treatments and recoveries, with Penney clarifying that Dorman had insisted to her parents that she not be given drugs, specifically because he wanted her to know that when she got better, she did so herself. Greenberg, meanwhile, began her treatment before the first antipsychotic drug was introduced, although she reports she did receive "a

bumfull" of other stuff to help her (or make her?) sleep.

A number of other parallels occur in these sections, providing themes and continuity. Greenberg says of her work with Fromm-Reichman, "We were miners; I had the map, she had the light." A moment later, Knafo, in her office maybe a thousand miles away, explains that many times "therapists have to carry that hope for our patients ... *We have to carry that light.*" Similarly, when discussing the connection she was forging with Dorman, Penney explains that "he appealed to the health in me." Soon afterwards Greenberg is asked if her therapist loved her. After a thoughtful pause, she responds, "She loved the health in me."

A particularly strong segment follows during which outcomes for schizophrenics are discussed. Mackler returns for a stretch to rapid fire splicing of Washington Square Park fragments with those of a still revved up Robert Whitaker. The general public's consensus is that schizophrenics don't recover, and they require medication for any semblance of stability. Whitaker shoots these notions to pieces, citing the handful of long term outcome studies that exist which demonstrate that schizophrenics can and do recover, and that of those who recover, the vast majority had ceased taking psychiatric drugs. Why is the general public unaware of this work? Whitaker passionately explains, "The (National Institutes of Mental Health) didn't promote it! Psychiatry didn't promote it! And they didn't promote it because it didn't tell the story they wanted it to." He adds, "That's dishonest science. That's of a discipline that's dishonest, because when they get results they don't want, they don't

broadcast them to the public.”

We see Penney’s and Greenberg’s stories converge again while discussing their post-hospital lives (though they continued with outpatient therapy), when each, largely recovered, was returning to world the rest of us ostensibly share. Hardly triumphant successes at first, each experienced near devastating blows. Penney failed a semester at college while Greenberg, after striving to just *be present* with people, was told by an acquaintance that she seemed “odd” and “to be not here.” Though each felt crushed, they struggled though, in part by relying on the health they’d developed in their relationships with their therapists, and with support from others who’d become part of their lives. Each, it turns out, had indeed rejoined the world – in defiance of popular belief.

Across the board the interviews feel genuine and spontaneous. Penney and Greenberg are thoughtful and at ease, and all comments by the professionals feel extemporaneous and convey the complexity of the phenomena under discussion. The result is a film that depicts warmth and humanity as well as tremendous, and worthwhile, struggle.

Technically there are only minor glitches, none of which detract from the substance. It was mildly distracting that some of those who were interviewed (Al

Galves and Martin Cosgro) were featured only briefly early on, then never appear again. Also, some of the footage of Robert Whitaker is out of focus – he is often so animated that he leans forward and backward throughout – but his energy and enthusiasm more than cover for this. Overall, Mackler appears to have prepared substantially for his first film making effort.

Mackler also adds several unique flourishes. We see photos of Penney and Greenberg as children; relevant segments of Penney’s hospital records are shown with highlighted phrases; when Bert Karon talks of how therapists need not be perfect, rather just “try your damndest to understand a person,” a halo appears over his head. Similarly, during some of Whitaker’s material, Mackler inserts question marks and – most appropriately – exclamation points beside him. Among the most touching of these flourishes, however, occurs when Dorman speaks about when Penney heard voices telling her to kill him. He said to her, “For you, tenderness can be a horror. It puts you in a position of smallness and dependency.” And as he continues discussing his interpretation of Penney’s hallucination as perhaps indicating that she is feeling close with him – actually a very *good* thing – Mackler shows us footage of a duckling scampering across

a pond to snuggle safely with its mother. The image is effective, and pretty damn cute.

Mackler also includes an interesting selection of extras on the DVD, the best of which is an interview of himself addressing, among other matters, why he made the film and its shortcomings. He really put some thought into “Wings,” and he will no doubt speak to questions the film might raise for you. Extra interview footage is also included, as are music videos he made for two of his most popular songs (did I mention the guy writes songs?), “Little Bottles” and “Glory Medication.”

Finally, you’ll want to sit through the closing credits – Greenberg’s church choir sings throughout, and, yes, it’s beautiful. And at the *very* end, Mackler shows snippets of the final moments of several Washington Square Park interviews as he thanks each participant. They say the usual, “You’re welcome,” or “Thank *you*,” as they unclip their microphones, but Mackler just couldn’t help himself from one last bit of cuteness: Just before the screen goes dark, one lady, just as she’s turning away, says softly, “I hoped I helped you.”



Daniel with Bulletin co-editor Delores Jankovich at the 2009 gala in Syracuse.
(Photo: Andrew Crosby)

Editor’s Notes:

“Take These Broken Wings” is available for \$30.00 from Daniel Mackler’s website, iraresoul.com. You can also check out his music CDs, including the satirical “Songs from the Locked Ward,” which start at \$10.00.

Daniel Dorman’s book, “Dante’s Cure: A Journey Out of Madness,” (Other Press, New York) was favorably reviewed by Dr. Grace Jackson in the Summer 2005 ICSPP Newsletter. It is available from Amazon and other book sellers.

Letter to Ange

How's it going in Heaven?
Did you finally get your wings?
Are you sitting under a rainbow
while the golden choir sings?
Is your gown long and white?
Does your halo glow above your head?
Do you ever talk to God
every now and then?
You'll never know how much I miss you,
but I'm glad you're where you are.
I know that you are up there,
every night I whisper to the stars.
I guess I can never fathom
why he took you when he did.
I'm glad we had some time together;
of course, He takes back what He gives.
The trick is to cherish
all the good while you can,
no matter all the heartaches
is it ever really that bad?
They say you never know what you had
until it's finally gone...
But you see, I never had that much.
It was you, and you alone.
I'm looking up, the sky is blue.
There's just one cloud above.
I squint my eyes, a smile appears,
I can see you through the sun.
I love you, Ange, always will.
Maybe I'll talk to you soon.
And when I go, I'll probably never get to Heaven.
I don't think I've been that good.
If you sit with God one more time
before I "buy the farm"
Tell him please to watch over you.
That's all I ever want.

You'll never know ...

- Kenn B.

A Look At Syracuse 2009



Special Night at the Gala

Neurologist Dr. Fred Baughman Jr. (above, right) was honored for his life-time work against the diagnosis of fake diseases such as ADHD. Here, Peter Breggin speaks of Baughman's accomplishments and commitment to ethical practice. (Photo: Robert Slicen)

Dom Riccio (top, right) was also honored for his long-time commitment to ICSPP, as exemplified by his almost 7-year tenure as international executive director. Here, Dom's successor, Toby Tyler Watson, presents him with a plaque as Dom receives warm and well deserved thanks from the audience. (Photo: Andrew Crosby)

We also had unique entertainment at the Gala as Daniel Mackler (left) performed several tunes from his satirical CD "Songs from the Locked Ward." Check page 16 for info on how to score yourself a copy or two of the disk, along with Dan's documentary film, "Take These Broken Wings." (Photo: Robert Slicen)



(Left) Dom Riccio was happier than ever while attending his first conference since stepping down as ICSPP's executive director. Here, he impresses Carolyn Crowder by offering to carry her books to the next workshop.

(Photo: Andrew Crosby)

(Right) Leo the Therapy Dog attended again, along with his colleague, Elizabeth the Therapy Human. Leo has now attended more conferences than most members of the ICSPP board of directors.

By the way, look for Elizabeth Root's book, "Kids Caught in the Psychiatric Maelstrom: How Pathological Labels and "Therapeutic" Drugs Hurt Children and Families."

Also look for Leo's upcoming book, "Puppy Prozac: Barking Up the Wrong Tree" available soon.

(Photo: Andrew Crosby)



Tom (Gunfighter) Bratter is excited to chill with Bulletin Editor Andrew (Sorry This Issue is Late) Crosby between sessions in Syracuse.

"He's a great guy," Bratter says of Crosby, "and he's so much more photogenic than me!"

(Photo: Robert Sliclen)

Whistleblowers And Troublemakers



We had no shortage of troublemakers. Above is journalist Allison Bass, author of “Side Effects: A Prosecutor, a Whistleblower, and a Bestselling Antidepressant on Trial.” She spoke about her work exposing GlaxoSmithKline’s misleading practices regarding Paxil. (Photo: Andrew Crosby)

At right is “Pennsylvania Super Lawyer” (for real - that’s an actual award he’s won) Stephen Sheller, with Peter Breggin. Sheller spoke about his work which cost Eli Lilly & Co. and Pfizer, Inc. billions. (Photo: Robert Sliclen)



And at left we see perennial ICSPP presenter Jim Gottstein.

Jim’s trouble making has been extensively documented in The ICSPP Bulletin, as well as other publications you may have heard of - *The New York Times*, for example.

If for some reason you have yet to do so, please do yourself the favor of checking out the many articles and legal documents Jim posts on his website, psychrights.org. (Photo: Robert Sliclen)

Jay Joseph (left) between sessions with Gary Kohls. Joseph, author of encyclopedic works such as “The Gene Illusion” and “The Missing Gene,” spoke about the genetic theories ADHD and autism while Kohls, editor of the Preventative Psychiatry Newsletter, addressed what holistic mental health caregivers should know about psychotropic drug withdrawal.

(Photo: Andrew Crosby)



On the left we see Dom Riccio, former executive director (*former*, hence the irrepressible smile) chatting with Bob Folz. Folz is a frequent conference presenter, maintains a private practice, and teaches at the Chicago School of Professional Psychology. In his spare time, he is editorial manager of our journal, *Ethical Human Psychology and Psychiatry*.

(Photo: Andrew Crosby)



Susan Parry (left) points out how much more photogenic she thinks Nolene Weatherby-Fell is compared to Brian Kean. (*Editor’s Note: We think it’s a tie.*)

Weatherby-Fell presented on “Taking the Time to Talk,” while Kean’s topic this year was “Inclusive Childhood Education.”

(Photo: Andrew Crosby)





Photo: Robert Slicen



Photo: Andrew Crosby



Photo: Andrew Crosby



Photo: Robert Slicen



Photo: Andrew Crosby



Photo: Andrew Crosby

Clockwise from top left: Our Australian contingent - Brian Kean, Nolene Weatherby-Fell, Faye Karpouzis, and Jock McLaren; Fred Baughman chats at the gala; Stephen and Sandy Sheller, both of whom presented, with Peter and Ginger Breggin; ICSPP resident magician Vince Boehm hypnotizes the gala crowd; presenters Sarah Edmunds and Dave Stein; Bose Ravanel with Brian and Nolene.

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 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.

2000 - Psychosocial Solutions vs Psychiatric Drugs: The Ethics and Efficacy of Treating Children and Adults with Brain Disabling Drugs When Science Indicates That Psychosocial Approaches are More Effective and Non-Toxic

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
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

(2004 Continued)

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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2010

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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