

ICSPP Bulletin

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

"The Conscience of Psychiatry"

2010 – Number 1

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Andrew Crosby, MA
Editor

Delores Jankovich, MA,
LMSW
Co-editor

And Introducing ... !

Maria Mangicaro
Co-editor

and

Albert Galves, Ph.D.
Contributing Editor

Statement from ICSPP Board of Directors Regarding the ICSPP Website

This statement is being issued to explain what happened to the ICSPP website, which had been redirected to Dr. Breggin's new organization. By way of background, in 2002, after founding ICSPP and running it for many years with his wife, Ginger, looking towards the future, the Breggins handed complete authority and control to new leadership and removed themselves from the board of directors. However, they continued to be active in supporting the organization in many different ways, including Dr. Breggin being featured at all of ICSPP's annual conferences.

Dr. Dominick Riccio became Executive Director in 2002 and held that

position, until last year, when Dr. Toby Watson was elected to the position. A few weeks ago, Dr. Breggin expressed great dissatisfaction with Dr. Watson and lobbied the Board of directors to remove him. A Board meeting was held by teleconference, and after much discussion and consideration of the facts there was very broad Board support for keeping Dr. Watson.

Once informed of the Board's decision, Dr. Breggin decided to break all association with ICSPP, urged the Board to dissolve ICSPP and start a new organization. Dr. Breggin then

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Executive Director Toby Watson receives the proverbial torch passed by then director Dom Riccio at our 2008 conference.
(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.

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 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.

(Continued from page 1)

claimed ownership of the ICSPP.org Internet domain, and has the password controlling it. He changed the Internet address so that people wanting and expecting to go to ICSPP's website instead find themselves at Dr. Breggin's new organization's website. It is ICSPP's position ICSPP is the owner of the ICSPP.org domain.

The board of directors' responsibil-

ity is to the organization and its mission of bringing the truth out about psychiatric practice, and at a special meeting held last night has decided to work diligently to resolve the matter. **In the interim, the website is now available at ICSPPOnline.org.**

The Board admires Dr. Breggin's work and is saddened and disappointed by Dr. Breggin's reaction to the Board's decision to retain Dr. Watson as Executive Director. Every member of the

Board is also committed to ICSPP's mission and determined to make the organization an even greater success. We hope you will join us October 8-9, 2010 in Syracuse, New York as we enter our exciting new phase.

ICSPP Bulletin and Website Updates

Bulletin (Slowly) Joins 21st Century

With many thanks to Maria Mangicaro, who's been managing the ICSPP website for us since taking over for Andrew Levine, we are finally—that's *finally!*—getting our newsletter back issues posted on the website in PDF format. For those of you who, like me, don't know much about technical matters, "*PDF*" is computer talk for "*Really Good Quality*."

The obstacle had been the once-state-of-the-art but more re-

cently why-didn't-you-replace-that-thing-sooner computer we'd been using at Bulletin headquarters (it wasn't Andrew Levine's fault is the point there).

So ... go to the website, click on the "Newsletters" link, and check out our back issues any time you like. The quality is clear and the format is easy to navigate - just click on one of the issues, adjust the size, and scroll on through. And the pictures are in

color, which, as our director, Toby Watson, points out, makes us all look younger. (Editor's Note: Toby now looks twelve.)

We should also do a shout out to Vinnie Almonte and his boy Angel at XclusivePC, Inc. They put together this new machine for Bulletin HQ, and we couldn't be happier.

Bulletin Staff Welcomes Reinforcements

As you've probably noticed, we've had trouble getting issues out to you on time recently. The truth is that upon taking over editorship four years ago I had so much fun with my new hobby I developed and expanded the newsletter to the point where someone (thank you, Burt Seitler) suggested that a new moniker was warranted. Thus the ICSPP Newsletter became the ICSPP

Bulletin. Great news, in a way, but a mixed blessing as well.

While I've always enjoyed the work it has become just that - *work*. What to do about that problem? Well, I put out a call for help. And the call, ladies and gentlemen, has been answered.

So Delores and I welcome website coordinator Maria Mangicaro to our staff as co-editor. We

also received an offer of support from none other than Al Galves, whom many of you know quite well. We haven't quite settled on a title for Al yet, so we're going with Contributing Editor for now to see how that works.

So, again, welcome Maria and Al ... and thanks for cooling off at least some of my burnout.

Now ... back to work!

ICSPP and the World Wide Web

By Maria Mangicaro

CORE INFORMATION:

The use of contemporary internet services and marketing techniques to enhance ICSPP's Mission, service the needs of current members, and attract new membership.

KEY CONCEPTS:

ICSPP has been incorporating the use of free internet services to enhance communication and help inform the public on the important accomplishments of ICSPP and ICSPP Members. This effort, like all other involvement in ICSPP's newsletters and conference arrangements, is on a volunteer basis and is "work-in-progress". Updating the website has been a slow process and still has a long way to go. However, thus far, these efforts have been successful in generating more traffic to the main website. The ICSPP site has as seen a substantial increase in activity on a monthly basis, with more than a 40% increase in hits from one year ago.

The ICSPP main website serves many purposes. It acts as a single portal for internet users to connect with ICSPP as an organization. The use of blogs, press releases, the Amazon Bookstore and the social network Facebook, helps to expand the reach of ICSPP and has the potential of creating a synergistic effect, or in some cases a symbiotic relationship with other websites, organizations, businesses and possibly media outlets.

As an analogy, a stand-alone website is like fishing in the ocean with a single line-pole. Whereby, implementing available internet resources, site optimization techniques, and creative contemporary concepts, helps to broaden an organization's reach, much like fishing with a net in the ocean covers a larger surface area in less time, becoming more efficient than the use of a single line-pole.

USE OF KEY PHRASES AND SEARCHABLE TERMS:

One link of vital importance on the ICSPP main website is the "Places to Get Help" link. This very important link serves as a "junction" for people seeking information and the professionals who have the potential to change not only their lives, but those of generations to come. ICSPP is in the process of creating a focused direction to fortify this junction and gain a solid presence on the internet of an organization committed to its Mission Statement and reaching those in need of help.

A technique that is being implemented on the ICSPP internet connections is the use of more key phrases and searchable terms. While the concept of mental illness and the DSM labeling process is fraught with difficulty, and some have argued that it should be abandoned altogether, the assignment of DSM-IV diagnoses are used worldwide by clinicians and researchers, as well as insurance companies, pharmaceutical companies and policy makers.

DSM-IV diagnoses provide key phrases and searchable terms necessary for those seeking the vital "junction" the ICSPP website provides. DSM-VI labels are cautiously being implemented as "anchor text" to help individuals find information on the ICSPP website. As well, a "Note of Caution" has been added to the ICSPP website as a disclaimer.

ICSPP'S USE OF BLOGS:

Currently, two blogs are linked to the main website set up through the free site, blogspot.com. The ICSPP Blog is used to post regular entries on description of events, conference related topics, relevant news stories, and other material such as videos and publications to help promote ICSPP professional members books and articles.

Key phrases and words used in the blog are additional "anchor text" that are hyperlinked to the ICSPP main website. The blog helps drive traffic to the ICSPP site and increases ratings on search engines like Google. Recent news stories, or stories on celebrities especially help to generate hits and spike ratings.

The second blog is a Video Blog, or V-Blog. Many professional members from ICSPP are involved in public interest stories and have been interviewed by the media, or have posted information to youtube. The Video Blog helps to organize this form of communication so that it is in one spot and those seeking information on ICSPP and their members have a simple means of learning more.

Many individuals with symptoms of mental illness, or on psychiatric medications, experience cognitive deficits and find it much easier to absorb video/audio information, rather than in written form. The ICSPP V-Blog will enhance the chances of communicating effectively to this audience. The V-Blog also provides ICSPP members with a quick and easy method of locating video from other members.

ICSPP'S FACEBOOK FAN PAGE:

A Facebook Fan Page is also being used by ICSPP. The fact that "word of mouth" is still the best, or the worst, form of advertisement a business can have, it is no surprise that the "friend-casting" of information through this popular social-network has propelled Facebook into a major force in directing traffic around the Web. In the past months Facebook has passed the search-engine giant Google to become the top source for traffic to major portals like Yahoo and MSN.

The purpose of the ICSPP Fan Page is to support ICSPP's Mission of a

Research and Educational Network. A link to the ICSPP Facebook Fan Page is posted on the Mission Statement page of the main website. It can also be accessed by doing a search on Facebook for ICSPP.

Fan members on Facebook will receive quick updates on conference information, relevant news stories, events sponsored by other ICSPP members, along with information regarding books and media spotlights involving ICSPP members.

To improve rankings on Facebook, it helps when Fans click on the "like" link, so that it helps capture the attention of others. Also, suggesting the Fan page to others who you think might be interested helps expand the range of the information ICSPP distributes through the Facebook community.

ICSPP recognizes the nature of Facebook as a social-network and

many Facebook users who choose to post personal information, or have professional interests and the need to respect this. ICSPP requests that ICSPP Fans please respect the privacy of others who use Facebook for personal use only.

Keeping in mind, word of mouth is a powerful form of advertisement, ICSPP's Leadership strives to maintain the utmost amount of professionalism on all sources of the communication and this is especially critical on the social network of Facebook.

ICSPP'S AMAZON BOOK-STORE:

The ICSPP Amazon Bookstore was established to help support professional members of ICSPP who have authored books, produced videos or CD's, or other products that

are available through Amazon. The Amazon Affiliation helps provide ICSPP with an additional resource for financial support. The Bookstore is also a marketing technique to help attract potential members who have written books on related topics and would like to have their work promoted through professional membership with ICSPP.

HOW ICSPP MEMBERS CAN HELP:

ICSPP Members are welcome to submit events or information for the blogs.

Use word of mouth whenever possible to help support the growth of ICSPP.

Visit the website and blogs for updates.

Support the ICSPP Amazon Bookstore.

Join ICSPP on Facebook, make positive comments when possible.

ICSPP Announces First Ever Sale on DVDs

For years you've seen ICSPP conference DVDs advertised in the Bulletin for \$200.00 per set. Well, they're just not moving fast enough, so we've made some adjustments to help things along.

For a limited time we are chopping the price down to a size that will generate some excitement. How much are we cutting the price? How does 50 to 70% grab you?

That's right. Until further notice DVD sets of past ICSPP conferences are ranging from **\$40.00 to \$100.00 per set.**

We're talking about conferences going back to 2000, and featuring a tremendous array of speakers, to say the very least.

Not content with us saying the

"For a limited time all ICSPP Conference DVDs are going at great discount rates."

very least? Neither are we. Check out pages 6 and 7 for much more on this special offer.

Viewing these DVDs is a great way of catching what you missed if you've been unable to attend *and* it's a great way to review important material and concepts if you were there.

Conference DVDs are also a great way to generate more interest in our efforts. Sharing ICSPP conference DVDs with colleagues and friends, or showing segments during presentations or lectures, can make a difference. It can lead to skeptics learning important truths, and may bring on some new members.

So read on and see what's available, and see what creative way you can use these DVDs to help spread the word.

The ICSPP Conference DVD Sale

See What We've Got!

***Up To
70% Off!***

***Full Conference
Details
at icspponline.org***

***Now Only
\$40.00 to
\$100.00!***

Past Conference Highlights You Should Know About

From 2000:

David Cohen, Ph.D. Drugs In Psychiatry As A Socio-Cultural Phenomenon

Gerald Coles, Ph.D. and 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

From 2003:

Brian Kean, M.A. The Dangers of Diagnosing Children: Results of the Multi-Modal Treatment Approach Study

Kevin McCready, Ph.D. Psychodynamic Therapy with Children and Families

Dominick Riccio, Ph.D. Family Therapy: The Treatment of Choice for Working with Difficult Children

David Stein, Ph.D. A Drug-Free Practical Program for Children Diagnosed with ADHD and Most Other Behavioral Disorders

From 2004:

Vera Sharav Screening for Mental Illness: The Merger of Eugenics and the Drug Industry

George W. Albee, Ph.D. A Radical View of the Causes, Prevention, and Treatment of Mental Disorders

Nadine Lambert, Ph.D. The Contribution of Childhood ADHD, Psychostimulant Exposure, and Problem Behavior to Adolescent and Adult Substance Abuse

From 2005:

Bertram Karon, Ph.D. Treating the Severely Disturbed Without the Luxury of Long-Term Hospitalization

Elliot Valenstein, Ph.D. Biochemical Theories of Mental Illness: Some Hard Facts About Soft Science

Grace Jackson, MD Allostatic Loads: Exploring the Long-Term Consequences of Psychiatric Drugs

To Order:

Email: tobywatson@abcmedsfree.com with you name, MC/VISA #, Exp. Date, Billing & Mailing Address, Telephone number, and the Years you want.

Or

Order Online at icspponline.org

Or

Use the Order Form on page 25

Past Conference Highlights You Should Know About

From 2006:

Graham Dukes, MD The Law and Psychiatric Drugs: Strengths, Weaknesses, and Experience

Robert Dinerstein, J.D. Human Rights and People with Mental Health Disabilities: The Issue of Capacity

Karen Effrem, MD The Origins and Dangers of Child Mental Health Screening

Joseph Glenmullen, MD SSRIs, Akathisia, and Suicidality: The History of the FDA's 2005 Black Box Warning on Antidepressant-Induced Suicidality

From 2007:

Fred Baughman, MD Who Killed Rebecca Riley?

Robert Folz, Ph.D. Treating Mood Disorders in Youth: Understanding the Evidence

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

James Gottstein, J.D. The Psychiatric Drugging of America's Children: Legal Rights of Children and Parents

From 2008:

Robert Whitaker Anatomy of an Epidemic: A Look at What's Causing the Astonishing Rise in the Number of People Disabled by Psychiatric Disorders in the U.S.

Joseph Tarantolo, M.D. You are Not Broken

Bruce Levine, Ph.D. A Treatment Resistant's Guide to Depression: An Alternative Model With Common Sense Solutions

Graham Dukes Three Hundred Years of Disease Mongering: A Question of Ethics?

From 2009:

Jay Joseph, Ph.D. Genetic Theories of ADHD, Autism, Bipolar Disorder: A Critical Evaluation

DuBose Ravenel, M.D. Training for Self Control: An Evidence Based, Common Sense Approach

Brain Kean, Ph.D. Inclusive Early Childhood Education: Preventive Measures for Achieving Social and Emotional Well-Being in Early Childhood

Allison Bass, MA. The Story of How American Consumers are Routinely misled about the Safety and Effectiveness of New Drugs and Treatments.

International Center for the Study of Psychology & Psychiatry, Inc

13th Annual Conference

Critical Psychology and Empathic Counseling & Psychotherapy

October 8-9, 2010

PreConference Workshops - October 7

Renaissance Hotel
Syracuse, New York

Hotel Reservations:

Renaissance Syracuse Hotel

701 East Genesee Street

Syracuse NY 13210

Special Rate - \$119 per night (deadline 9/6/10)

Call 1-800-960-5059 ask ICSP Conference Block

Online www.renaissancesyracuse.com

Click on "Special Rates & Awards". In the box labeled "Group Code", they will insert **IC-SICSA** for a Single Room (one king bed); **ICSICSS** for a Double Room (two double beds). Your group rate of \$119 will automatically appear.

CALL FOR PAPERS

Critical Psychology and Empathic Counseling & Psychotherapy

Thirteenth Annual Conference of the
INTERNATIONAL CENTER FOR THE STUDY OF PSYCHIATRY AND PSYCHOLOGY, INC.
(ICSPP)

in collaboration with
It's About Childhood & Family Inc.

Syracuse, New York – Friday, October 8th - Saturday 9th, 2010
Thursday Oct 7th Pre-Conference Workshops

Renaissance Syracuse Hotel, 701 East Genesee Street, Syracuse, NY 13210

Focusing On:

Critical Psychology – Legal and Ethical issues
Empathic Counseling and Psychotherapy
Psychopharmacology and Brain Research

Presentations & Panel Discussions: 45-90 minutes. Please indicate if you are willing to participate in a panel discussion in lieu of an independent presentation.

Half Day & Full Day Workshops: 3 or 6 hours for Thursday 10/7 only.

Awards: \$250 by ICSPP for Best Student Presentation. \$250 prize for Best Presentation by Past-Current Psychiatric User: by Law Project for Psychiatric Rights

Past Participants: Academic and educational researchers, best selling science writers and authors, psychologists, social workers, students, medical practitioners, lawyers, and members of the public.

The majority of attendees find the annual conferences "the most stimulating, useful, educational, intellectually challenging and friendly" conferences they have attended.

Presentations may include, among other topics:

Counseling and Psychotherapy (e.g., individual, couple, group, play, CBT, psychodynamic)
Grief and Trauma Issues
DSM-V diagnoses and proposed diagnoses: Bullying, Sex Addiction, Delayed PTSD and more.
Cross-Cultural Counseling
Ethics in Psychology
School & Educational Issues (e.g., bullying, social-emotional learning, learned helplessness)
Psycho-Social Solutions to Challenging Behaviors of Children and Adolescents
Future Directions in the Field
Legal Issues
Review on the efficacy and safety of psychotropic interventions

Accepted Presentations: Eligible for publication in peer-reviewed *Ethical Human Psychology and Psychiatry: An International Journal of Critical Inquiry*. Presenters are responsible for: registration and travel costs.

CEU credits awarded for accepted presentations separately submitted and approved for that purpose.

Submission of Abstracts
13th Annual ICSPP Conference

Syracuse

Your presentation must include the following elements:

Oral discussion, Lecture or Poster, and if you will join panel discussion instead of your presentation

Title of presenter: Dr., Prof., Mr., Mrs., Ms.

Last name, First name, Initial

Highest academic degree and institution

Affiliations

Full mailing address

Telephone and Fax

Email

Title of presentation

Aims and contents of presentation (for inclusion in program handbook: do not exceed 150 words.)

Biography of presenter (for inclusion in program handbook: name, profession, experience, interests, accomplishments – do not exceed 80 words)

Length of presentation (45 – 90 minutes) or Workshop (3 or 6 hours) – length not guaranteed

Audiovisual aids required (e.g. projector, screen, amplification)

Seating Format (e.g., classroom, circle, no preference)

*Send by email as **Word attachment** only to:*

binsightfl1@optonline.net

Deadline for Submission May 30, 2010

For more information contact: Dr. Michael Gilbert at mgilbert@iacaf.org

For more than three decades ICSPP (www.icspp.org), a nonprofit, 501(c), has been providing research, educational services and networking to professionals and lay persons throughout the world. **ICSPP's** annual conferences serve as unique thought provoking forums to exchange critical ideas about the impact of contemporary mental health ideologies, practices and interventions on personal and community values and clinical outcomes, and serve to disseminate models of therapeutic intervention that disavow all coercion and the compromise of ethics, rationality and scientific principles.

Books You'll Want to Check Out

Agnes's Jacket By Gail Hornstein

Reviewed by Lindsay Koskinen, MSW, LCSW

If you thought *Toxic Psychiatry*, *Psychotherapy of Schizophrenia*, *Mad in America*, *Broken Brains or Wounded Hearts*, *Rethinking Psychiatric Drugs* and *Banished Knowledge* hit the mark, you must read *Agnes's Jacket*. Gail Hornstein, a professor of psychology at Mount Holyoke College, who splits her time between that college and Cambridge University in the U.K., provides fascinating personal testimonies of psychiatric survivors as well as relevant clinical research. The book offers information and citations from a plethora of journal articles, books, conference papers and videotapes from clinicians and survivors in the United States and Europe. It will offer additional insights and resources to ICSPP members as they journey on their quest for truth and healing.

Hornstein provides first hand accounts from people with a variety of symptomatology including paranoia, auditory hallucinations and catatonia. The accounts offer increased understanding of the anguish some people experience as they seek healing in a mental health system that pushes medication. Survivors describe treatment approaches that have

been most helpful to them. The importance of a support group for people who hear voices is emphasized. "Since the groups focus on understanding, not labeling, people can risk examining their feelings and learn better ways of coping with difficulties. By challenging the critical content of the voices, the group helped me to feel more able to control of my own fate."

***"Hornstein shares
the strain of
dealing with the
animosity of
colleagues who
disagree with her
approach."***

Hornstein compares and contrasts treatment approaches in the U.K. and in the states. In Britain, she notes, there is much more opportunity for patients and clinicians to work collaboratively.

Conferences such as *Beyond Belief* provide forums for people suffering with auditory hallucinations and clinicians to present first hand accounts of their experiences.

Hornstein shares the strain of dealing with the animosity of colleagues who disagree with her approach to treatment.... something we can all relate to. She notes that since the 1970s American psychiatry has increasingly narrowed its focus by first rejecting psychoanalytic ideas and then, in the past decade, describing mental illnesses as "biologically based brain disorders" (NAMI). Hornstein contrasts treatment approaches in the U.S.A. with Britain, Germany and Netherlands where social psychiatry remains a potent force.

Agnes's Jacket is one of those books that you will read with pen in hand, underlining often the insights that will be useful in your practice.

Kids Caught in the Psychiatric Maelstrom: How Pathological Labels and “Therapeutic” Drugs Harm Children and Families

By Elizabeth Root, LCSW

Reviewed by Andrew Crosby, MA

If you're looking for a solid primer or reference book that covers virtually *every* topic ever discussed by an ICSPP conference presenter or author (and then some), Elizabeth Root may have done you a nice favor with her debut effort. With “Kids Caught in the Psychiatric Maelstrom” perennial conference attendee Root demonstrates she's been paying close attention, *and* that she's kept up with ICSPP's recommended reading list.

Wisely starting with the concept of informed consent, which she elucidates with the help of kindergartener Alice Compton and her mom, Root explains the two basic approaches to understanding and helping people – the medical and psychosocial. It's a good overview as to how proponents of each ideology perceive children who have been deemed in need of professional help: either they need to be diagnosed with an illness that needs medication or they are reacting to social or family stresses with the only means at their developmental disposal – behavior. In short, “The belief system of the clinician drives the course of treatment.”

It's fitting that she discusses former American Psychological Association president Dr. George Albee's 2004 ICSPP conference presentation here. Albee lamented, if not condemned, psychology's decision to adopt psychiatry's medical model as its own in its formative years. Albee's thesis, which is shared by many of us, and most certainly by Root, was that psychology missed a very important psychosocial boat in doing so. Not to be outdone or passed over, Root informs, the guild of Social Work soon committed the same blunder. The result has been that too few children

are understood as reacting to or struggling with, for example, parental discord or verbal or physical violence, rather they are regarded as having chemical imbalances or malfunctioning brains.

Root then tells us why the medical model is a problem. For one thing, diagnoses are rendered using a manual assembled by mostly white males, many of whom have held financial ties with the drug industry. She uses several news media sources, as well as fine references such as Mindfreedom's David Oaks and Herb Kutchins and Stuart Kirk, authors of (one of my all time favorite books) “Making Us Crazy.” Reliance on drugs is the natural second step, and Root gives an overview as to how these create, rather than resolve, chemical imbalances in our brains. Twelve-year-old Mary helps us grasp the next problem, identification with the diagnosis. Mary was one of the children with whom Root worked at a community clinic, and like so many of these children, once diagnosed Mary viewed everything through that prism: “My friends don't understand me being bipolar” is how she responds to a question about her conflicts with others.

The focus for chapter two is on ADHD, and Root presents a decent history of this diagnostic boondoggle. Fred Baughman is cited, not surprisingly, as a key critic of the 1998 National Institutes of Health Consensus Conference on ADHD. Pediatrician William Carey is also cited in an effective bit that shows us that some physicians have formally spoken out against the ADHD consensus as the phenomena that constitute the alleged condition are “not distinguishable from normal behavior” and “biological causation has not been scientifically proven.”

This chapter also features a nice

piece on ICSPP's Al Galves and his colleague David Walker for their detailed criticism of a move by the American Psychological Association's psychotherapy division. In 2002, Root informs, APA collaborated with Celltech pharmaceuticals on an ADHD brochure, and Galves and Walker challenged the information for perpetuating falsehoods, such as ADHD being biological in origin. Galves and Walker discussed the lack of definitive biological evidence and cited family and parent characteristics that have been found to be associated with ADHD. They also noted how biological explanations neglect volumes of writings and findings on attachment and trauma, stuff you'd think psychologists would find of interest. (For those keeping score, that's ICSPP 2, APA 0.)

Root then explores established psychiatry's endeavor to find the Holy Grail of ADHD, the ever evasive it-must-be-there-we-just-haven't-found-it-yet-but-we're-going-to-keep-looking-anyway biological marker. Root relies heavily on Grace Jackson's work, as well as critiques by DuBose Ravenel, Jonathan Leo, and David Cohen as she discusses what we *have* and have *not* learned from technology such as brain imaging.

As Root's focus is on children, bipolar disorder gets especially thorough treatment in “Kids.” The diagnosis is traced from its former status as a rare occurrence in adults through its “discovery” in temperamental children in the mid 1990s. The accompanying explosion in the use of the label, and in the neuroleptic prescriptions which followed, is well covered, as are the disastrous consequences. Root tells about the tragic death of 4-year-old Rebecca Riley, who was diagnosed bipolar at age 2 and prescribed a cocktail that ultimately proved fatal. She also introduces

us to several other young victims, some of whom she tried to help in her capacity as a therapist at the clinic. While these accounts are not all dire, they are less-than-success stories as Root shows how psychiatrists hold loftier positions than her in the clinic's decision making hierarchy.

This chapter also covers the top movers and shakers in the bipolar world. The roles and influences of Steven Hyman (one-time director of the National Institutes of Mental Health), Dmitri and Janice Papolos (authors of the "The Bipolar Child: The Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder"), and Joseph Biederman (director of the pediatric psychopharmacology team at Massachusetts General Hospital) are placed in context. Root again uses many news media sources, including from television as relevant features from *60 Minutes* and *Frontline* are discussed.

By this point in the book Root has covered substantial ground but she is still gaining momentum. Her chapter on pediatric pharmacology, and the forces that promote this sad social policy, is the longest and perhaps most jam packed. Antidepressants, neuroleptics, stimulants, and mood stabilizers are all examined in all their facets, including research and development, safety and adverse effects, ethical concerns, and the political machinations of the Food and Drug Administration and pharmaceutical industry. The valuable – and neglected – longitudinal work of Nadine Lambert is discussed as are watershed events (for the industry, that is) such as the Multimodal Treatment Study of Children with ADHD (MTA). As expected, the efforts of critics such as Grace Jackson, Jim Gottstein, DuBose Ravenel, and pediatrician Lawrence Diller are all featured nicely.

Still going strong, Root next tackles the combined efforts of government and the drug industry to promulgate Orwellian universal mental health screening in our schools and communities. Coverage of the New Freedom Commission, Teenscreen and its reincarnations, and The Mother's Act is thorough, with emphasis on the politics and relationships between government entities and organizations such as the National Alliance for the



The author, perennial conference attendee Elizabeth Root, seen here with Leo the Therapy Dog at the 2009 conference.

Root also presented at the conference. Her topic was "What to do About Nature Deficit Disorder."

We look forward to seeing them both back in Syracuse this October. And we look forward to Elizabeth's next book.

(Photo: Andrew Crosby)

Mentally Ill (NAMI). Again, the proponents of these efforts as well as the critics, such as Karen Effrem and Vera Sharav, are all discussed and placed in context.

Root winds things down a bit by exploring alternative explanations for the difficult behavior we see in our culture's children. Social changes and economic pressures that we'd prefer to ignore (lest we feel the need to assume responsibility for ameliorating them) are discussed, such as the emphasis on academic achievement over play. Environmental toxins and the influences of electronic media are also elucidated. And hey – good old-fashioned child development is discussed, as are the socio-environmental influences of our families, neighborhoods, and communities. Interestingly, it would seem, many explanations and answers can be found in an introductory psychology or social work text book. (I've been saying that for years, but my colleagues – like so many others – are just *so* impressed by all those damn brain scan photos.)

Finally, Root discusses non-drug, non-medical ways to help children and families who are struggling. David Stein's Caregiver Skills Program and Howard Glasser's Nurtured Heart Approach are two examples that Root used in her work, and that she shares with readers. She then fills things out by also discussing Loren Mosher's Soteria Project and the World Health Organization's repeated findings that the best outcomes for schizophrenia occur in *non-developed* countries where drugs are

used rarely, if at all.

So "Kids" is a thorough, many-faceted primer that covers subject matter from probably every ICSPP conference program. And, as indicated, one finds an impressive sampling of the ICSPP membership among the references. There are even two citations for the ICSPP Newsletter and its much admired editor, Andrew Crosby. [Editor's Note: *I couldn't resist that.*] All in all we would do well to add "Kids" to our reading lists and book shelves.

While "Kids" is informative, however, its scope makes it a bit of a hefty read. Root moves briskly at times making it difficult to digest one large chunk before encountering the next. One result is that some pieces – especially the accounts of the children with whom Root personally worked – feel incomplete. Root does well to make us feel, but seems to be in a rush at times when some readers may wish to linger, and get to know the kids a little better.

As a last word I comment on the book's first words: It is fitting that "Mad in America" (and now "Anatomy of an Epidemic") author Robert Whitaker wrote the forward. For one thing, Root, like so many of us, appreciates and acknowledges Whitaker's contributions to the cause. For another, Root may wish to follow in Whitaker's literary footsteps. Whitaker is a tough act to follow, but she's off to a nice start and raises the hope that "Kids," her first book, won't be her last.

A Song

What Are They Doing To Our Children?

By Frank Szajkowski and Filomena LaForgia

fil@filanthropists.com

I LOOK INTO YOUR EYES, YOU LOOK AWAY
I'M CALLING OUT YOUR NAME, CAN YOU PLEASE ACKNOWLEDGE ME
I JUST WANT TO HOLD YOU, HOLD YOU SO TIGHT
AND SOMEHOW LET YOU KNOW, IT'S GOING TO BE ALL RIGHT
SOMEDAY IT WILL BE ALL RIGHT.

WHAT ARE THEY DOING TO OUR CHILDREN?
WHAT ARE THEY DOING, PLEASE EXPLAIN
WE PUT OUR TRUST IN THOSE WHO CLAIM
THEY KNOW IT ALL; DON'T BE AFRAID
JUST TAKE A SHOT OF ETERNAL PAIN

IT MUST BE TERRIFYING FEELING ALL ALONE
TRAPPED IN A WORLD THAT NO ONE KNOWS
JUST A FRIGHTENED CHILD IN AN OMINOUS WORLD
CAN'T ASK FOR HELP WITHOUT THE WORDS
BLARING SOUNDS ALL AROUND, YOU CAN'T CONTROL
OR TUNE THEM OUT
EVERYTHING IS AMPLIFIED, SUPERSIZED
WITH SO MUCH INPUT CONFUSING YOU
THERE'S STIMULATION FROM EVERY VIEW
WHAT SHOULD WE ASK OF YOU?

WHAT ARE THEY DOING TO OUR CHILDREN?
WHAT ARE THEY DOING, PLEASE EXPLAIN
WE PUT OUR TRUST IN THOSE WHO CLAIM
THEY KNOW IT ALL; DON'T BE AFRAID
JUST TAKE A SHOT OF ETERNAL PAIN

WE'RE IN THIS THING TOGETHER
I'LL ALWAYS BE THERE FOR YOU
WE WILL LIVE OUR LIVES AS ONE
THESE THINGS I PLEDGE TO YOU

WHAT ARE THEY DOING TO OUR CHILDREN?
WHAT ARE THEY DOING, PLEASE EXPLAIN
WE PUT OUR TRUST IN THOSE WHO CLAIM
THEY KNOW IT ALL; DON'T BE AFRAID
JUST TAKE A SHOT OF ETERNAL PAIN

WHAT ARE THEY DOING TO OUR CHILDREN?
WHAT ARE THEY DOING TO OUR CHILDREN?
WHAT ARE THEY DOING TO OUR CHILDREN?
WHAT ARE THEY DOING TO OUR CHILDREN?

An Essay

Gifts from My Mother

By Delores Jankovich

Emily Dickinson was said to have remarked often, "If only I had a mother." I often thought the same and yet I did have a mother, as we all did, at least as a way to enter this world.

Mother's child-like response to most things, together with her woundedness, made me aware that I was in charge. Had my mother been able to feel her pain, perhaps she would not have created pain around her and in her children, her only way to tell her story.

And yet I loved her fiercely, and became determined at an early age to protect and heal her. In my innocence, I was unaware I

could do neither.

My greatest gifts, over time, from my mother became my strong investigative bent; my present ability to "follow the thread 'til I find the cloth" – was born out of my need to "know the answer" – the answer to why my mother was not present to me.

And my joy in connecting with others, with nature and all living creatures, came from my desire to connect with my mother.

Because of her inability to feel, I have spent a lifetime awakening feeling in me. These awakened feelings create a tapestry of experience, symbolizing the vibrant colors of my mother's

quilts, as she pieced together her life.

My rage from longing for connection has become passion for life and my childishness is now transformed into wonder. How aware I am of the patterns of darkness and light within me, and how similar they are to the patterns within my mother.

It was only after I transmuted those things that plagued me, that I could allow my mother to be who she was.

Short Fiction

Play Ball

By Andrew Crosby

Hands stuffed into the pockets of his cargo pants, Chris strolled through the automatic glass doors of Glenwood Hospital's emergency room as they swished open to admit him. He eased to his right to allow an elderly couple on their way out to pass, and as he did, the woman smiled warmly and said, "Thank you." This surprised Chris, though he was quick to smile and nod in return. It was only then that he realized he'd been humming a favorite Black Crowes tune since he'd gotten out of the car, and, as such, he must be exuding good cheer. He thought it curious that he was in a good mood. After all, he was here on serious business. Officially, in fact, this was a *crisis*.

But Chris knew better. He knew Kevin too well, and had seen the boy exceed too many dire predictions by so-called mental health professionals, to get worked up. Mental health professionals were lousy prognosticators in matters pertaining to mental health, but especially so in matters pertaining to Kevin. As a mental health professional himself, Chris's opinion of his peers seemed to lose ground daily.

Chris perceived the present matter to be significant only for its insignificance. He knew, however, that not everyone shared his opinion, and damage control may be needed. He was already scheming, even as he hummed, but Kevin's mental status was the least of his concerns.

Chris entered the waiting area. He scanned the large room, pleased to see it was sparsely populated. Kevin was easy to spot, seated on the far side, gently cradling his wounded hand in his lap. Though only a high school junior, Kevin was six-two, broad-shouldered, and distinctively attired in black jeans, black

biker boots, and a black t-shirt. He'd also recently died his hair - no surprise - jet black, and was caped in a black flannel shirt, unbuttoned to reveal a portion of the t-shirt's lettering. Chris smiled with anticipation; he could hardly wait to see what socially inappropriate slogan Kevin was sporting today.

In an absurd contrast, Allison, the school social worker, stood beside Kevin attired in what Chris guessed to be the latest that Giorgio Armani had to offer. All the colors of the rainbow were represented on the girl's slender frame as she dug through her designer tote.

Sensing his approach, Allison looked up and greeted Chris with an awkward smile. Kevin, meanwhile, had tracked Chris from the door, the boy's chiseled features revealing little of what transpired behind his deep set eyes.

"Change of the guard?" Kevin asked Chris, feigning lack of interest.

"How's it going, slugger?"

"I see you're in one of your clever moods today," the boy teased. He averted his gaze to nowhere in particular and added, "How annoying."

Chris smiled and looked to Allison as she withdrew a delicate hand, now holding a sheet of paper, from her tote. "Don't move," she said to Kevin, wagging a well-manicured finger at the boy. "I need to talk to Chris about you behind your back."

Allison took Chris by the elbow and led him back across the lobby, Chris enjoying her floral perfume as she led him around a corner before stopping and facing him. Her expression was serious, but that was typical for Allison. Chris focused primarily on her eyebrows; it must take *hours* to get eyebrows that perfect.

"Thanks for driving him here,"

Chris said.

"No problem," Allison said, her expression softening. "Can you stay with him now, and take him back to the shelter?"

"Sure," Chris said. "How's he doing? He seems his usual self."

"His hand is fine," Allison said, "aside from a little swelling. The doctor already checked him and said nothing looks broken. They want to do an X-ray to make sure."

"And otherwise?"

"He's doing *good*," Allison said with some surprise. "He's sucking up the attention like a little kid with a boo-boo. It's actually ... *sweet*. For Kevin, anyway."

Chris asked for more detail on what happened and Allison filled in the gaps. During English, a football player had trash talked Kevin about his former, though still legendary, prowess regarding illicit substances as the two worked side by side diagramming sentences at the board. Kevin had told the jock to shut up, but the guy, apparently unaccustomed to taking instruction from anyone not carrying a whistle, had failed to heed. Kevin repeated his request, and the jock asked, "What if I don't?" Kevin had responded, "Then I'll do *this* to your face," illustrating his remark with a decisive punch to the dry erase board. The resounding *smack* had its intended effect. The jock flinched, stopped yammering, and backed off. With that, the matter was done; hardly an unusual occurrence for a suburban high school.

But nothing was simple for kids like Kevin. People reacted. Still, Chris was pleased with the report. Allison read his expression and matched his smile.

"I know what you're thinking,"

Allison said, "and I totally agree."

"The old Kevin would have broken that kid's jaw."

Allison nodded. "You got *that* right."

"He's come a long way."

"He certainly has," Allison said. "But that's the *good* news."

Chris sensed where this was heading. "So, what's the fallout?"

"Dr. Bolton freaked," Allison said, referring to the principal from Hell. "He wanted to call the police and have Kevin hauled out for a psychiatric evaluation."

"That's what I was afraid of," Chris said. "What happened?"

Allison smiled reassuringly. "You can relax. I talked him down."

"Really," Chris said. He made no attempt to disguise his relief. "That couldn't have been easy."

"Not even close. It took all the charm I had." She looked at Chris for long moment as he appeared lost in reflection. "This anniversary means a lot to you, doesn't it?"

"It means a lot to *Kevin*."

"Right," Allison said. She reached out and patted Chris's shoulder. "You just keep telling yourself that."

Chris gestured to the sheet of paper in Allison's hand. "Looks like you have something for me."

Allison held up the form. "I told Bolton I'd do a safety contract with Kevin. Here's a copy for your file."

"A safety contract?" Chris said. He took the document, regarding it with disdain.

"It was an *incident*, Chris," Allison said. "Kevin needed to be taken to the hospital for an X-ray, even if it's just a precaution. I had to do *something* to get Bolton to back down from the evaluation."

"Yeah, I get that," Chris said. "It's just that contracts are so ... *doofy*."

Allison smirked. "I also promised Bolton *you* would do a contract with Kevin."

"You really know how to hurt a guy," Chris said, smirking himself now.

"Hey, it worked. Bolton backed down. I know you think safety contracts are hypocritical and coercive -"

"- And stupid," Chris interrupted. "Don't forget stupid."

"Well, our *stupid* contracts are Bolton's condition to allow Kevin back in school. Without them, he'll be suspended."

"And Bolton will at long last have something solid to use against Kevin."

"Exactly," Allison said.

Chris paused. "Actually, that sounds weird," he said. "Bolton's letting Kevin off *this* easy?"

"That *is* weird," Allison said, crinkling her perfect eyebrows. "You suppose he's got something up his sleeve?"

"Let's find out."

***"Very persuasive,"
Allison said,
smiling. "I knew
your inner
psychopath would
come up with
something."***

Chris pulled his cell phone from a side pocket and dialed. He reached Bolton without the usual hassle, and immediately launched into the filibuster he'd been scheming, along with some freshly improvised elements. He explained that he'd just completed an extensive and detailed safety contract with Kevin - "due to the serious nature of this incident" - adding that the boy had appeared appropriately remorseful. He then called for an urgent meeting with Kevin in Bolton's office. It was imperative, Chris explained, that Kevin be thoroughly warned that no further threatening incidents would be tolerated. He blabbed further, citing several "incidents" from earlier in the school year, and insisting that the boy be warned that "an escalating pattern was emerging, which would not be tolerated."

Though prepared to expound further, Chris came up for air to gage Bolton's response thus far. After a pause, Bolton surprised Chris by agreeing. Chris asked if Bolton thought these measures to be "sufficient given the gravity of the situation." Again to Chris's surprise, Bolton assented. "Can you think of anything else we need to do to ensure everyone's safety?" Chris asked, testing the waters further. Bolton

said no, and told Chris to be in his office, with Allison and Kevin, at 9:00 AM the next day.

Chris ended the call, pocketed his phone, and shrugged. "Bolton may be drunk - he agreed to everything," Chris said. "But we'll know for sure tomorrow morning."

"Very persuasive," Allison said, smiling. "I knew your inner psychopath would come up with something."

"Thanks again for blocking that evaluation," Chris said. "That was very persuasive."

Allison smiled knowingly. "Happy anniversary, Chris."

Allison waved good-bye to Kevin from across the waiting room as she headed for the exit. Kevin smiled and waved his swollen hand in response. Chris returned to the boy.

"So, what was that about?" Kevin asked as Chris stood before him.

"I'm sorry, Kevin," Chris said solemnly. "I've got bad news."

Kevin braced. "What is it?"

"We just talked with the doctor who examined your hand. You've got severe nerve damage."

Kevin looked at his hand, his mouth open. He swore under his breath, and looked helplessly back to Chris. "So ... What's that mean?"

Chris put a hand on Kevin's shoulder. "There's no easy way to say this. Kevin ... they're going to have to remove your testicles."

Kevin swatted Chris with his good hand and belted out a string of profanity-laced threats, not the least of which was to render useless Chris's own reproductive glands via strategic application of his boots. Any malice, however, was lost in Kevin's uproarious laughter. Chris smiled, enjoying a job well done.

Still guffawing, Kevin dragged his book bag off the seat beside him, dropping it at his feet. Chris took its place.

Picking up a tattered magazine, Chris scanned the waiting area. The other emergency room visitors cast disapproving glances their way and shifted uncomfortably in their seats as the echoes of Kevin's outburst subsided. Chris thumbed open the magazine.

"That's even funnier," Kevin said, "You reading *Sports Illustrated*."

"You turned me on to following baseball," Chris said. "I think the Packers will win the Stanley Cup if they work

on their full court press.”

“You ought to do commentary for ESPN.”

“What’s ESPN?” Chris said, looking around. “You got the swim suit edition on your side?”

Kevin leaned forward, raised a pant leg, and pulled a shiny copy of the vaunted special issue from his right boot. He handed it to Chris. “Knock yourself out. I got extras.”

“Why don’t you keep your porn in your book bag like a normal teenager?”

“Can’t,” Kevin said sadly. “Bolton has it searched every day. Thinks I’ll have a bomb in there.”

Chris raised an eyebrow. “Do you have a bomb in there?”

“Hey, really,” Kevin said. “What were you and Allison talking about?”

A cute nurse passed. “Don’t remember,” Chris said. “I got distracted.”

“Yeah. There’s lots of distractions here. Did you see the one in the pink blouse a minute ago?”

“Pony tail, hoop earrings, and sandals?”

“That’s the one.”

“Nope. Didn’t notice.”

Chris flipped through the pages while Kevin returned his attention to his wounded hand, examining it closely for signs of damage, and secretly hoping to find some. Soon, however, the pair were invested in their well-practiced routine of people watching. Together they confabulated the circumstances which had brought their varied waiting room companions to Glenwood’s emergency room on this lovely spring afternoon: The little girl with the cough had rammed a stolen Ferrari into a Starbucks while eluding police – her cough was from the tear gas used to extricate her from behind the condiment counter; the woman who repeatedly crossed and uncrossed her legs was hearing voices – one demanding, *Cross your legs*, the other countering, *Don’t listen to her*; the short guy with the limp had fallen off a step ladder while performing cunnilingus.

Before long Kevin was called in for his X-Ray, and he and Chris meandered through a ridiculous maze of halls trying to recall the directions they’d been given.

“Two rights, then a left, right?”

“I thought it was two lefts, right, then another left.”

“Oh, right.”

“*Right?* I thought it was *left?*”

Once Kevin was safely escorted to the X-ray lab, Chris strolled off to find a men’s room. He happened upon a sign directing patrons to the hospital’s chapel. He considered the detour, but felt no pressing need for a formal setting in which to silently voice the prayer over which he’d been mulling since Allison’s phone call.

***“Somewhere
beneath the swirling
delirium, Kevin
struggled between
the need to fight his
despair and the need
to end it.”***

Patients on gurneys floated by; a young couple parted to avoid collision with a nurse; a man of about sixty, staring nowhere, passed by so slowly he left no wake: these were Chris’s fellow worshippers in the chapel of his choosing.

He paused by a water fountain, and closed his eyes for a peaceful moment.

It was a two-part prayer, the first of which pertained to Dr. Bolton’s potential retaliations. This wasn’t the first time Chris had beseeched a higher power to put the brakes on Bolton. The guy was on a mission, and Chris, with Allison’s help, had been countering his repeated attempts to undercut Kevin since the beginning of the school year.

It hadn’t been easy. Bolton’s loathing for Kevin dated back two years, much of which comprised Kevin’s slide into misery, drugs, and frightening outbursts. This had been precipitated by his mother’s addiction to pain killers, which had also precipitated the estrangement of his father, which had precipitated a worsening of his mother’s addiction. This, in turn, had precipitated his fa-

ther’s relocation to a city five states away.

Hardly concerned with precipitating factors, however, Bolton had just wanted Kevin, and his dark moods and outbursts, gone. His strategy was effective. He’d alerted several agencies and programs designed to contain such matters, and had lobbied them incessantly. He’d called meetings during which he used language well; in every discussion, formal or otherwise, Bolton’s favorite terms had been *risk*, *danger*, and *Columbine*.

It had worked. Kevin was designated *Emotionally Disturbed* and was bounced into an out-of-district school placement. Next came more illicit drugs and more outbursts, two of which had landed Kevin in the hospital. Kevin’s drugs of choice were replaced by society’s drugs of choice – to correct and balance his ostensibly incorrect and unbalanced brain.

“It’s *medicine*,” he was told. “It’s to *help* you get *better*.”

Numbly, Kevin had wondered, *This is help? This is better?*

It had been a mild Friday evening when Kevin apologized to his mother, and said good-bye. Slumped unconscious on the couch, a lit cigarette crooked in her burn-scarred fingers, she’d taken the news of her son’s imminent suicide without protest.

Awash in gray moonlight, and feeling as unreal as a ghost, Kevin had walked the quiet suburban sidewalks to Delmar Park. Throughout little league and his middle school years, Kevin had played most of his baseball games on this field, setting records for stolen bases which still held.

But that had felt like lifetimes ago. Or like somebody else’s lifetime.

Kevin had entered the woods beyond the third base line, sat on the warm earth, and popped the caps off four plastic containers. Choking on tears pushed up from beneath the numbness, Kevin had forced down their contents with gulps of bottled water. Somewhere beneath the nausea and swirling delirium, Kevin struggled between the need to fight his despair and the need to end it. But he no longer knew how to fight. The struggle was over. Kevin had lost.

Still, he liked the message he was sending; his death would come at the hands of his medicine – that which had been intended to *help* him get *better*.

It was a fluke that he'd been discovered in time. Fortunately, the two eleven-year-olds who'd stolen cigarettes from their parents had shared Kevin's affinity for Delmar Park and its surrounding woods.

After four weeks in the hospital, Kevin was deemed stable. His mother, however, had been deemed otherwise, so Kevin was released into the care of his uncle, whose own fondness for pain killers was less apparent at the time. Also, just before discharge, a case management agency was called in to help with planning. The file landed on Chris's desk.

Finalizing discharge arrangements turned out to be trickier than expected due to Kevin's refusal to sign a contract agreeing to certain terms. Actually, the terms with which he disagreed most were *medication* and *compliance*, both of which appeared in the contract's final stipulation. Another problem was that Bolton didn't want to grant Kevin his greatest wish – to return to regular school and get back in step with his peers.

"I ain't taking no more pills," Kevin had insisted to Chris during their first meeting, spicing up his pronouncement with a well placed f-bomb. He'd clarified his reasoning at great length, ending with, "Lock me up if you want to, but I will *never* take that crap again!"

Chris's reply had surprised Kevin into silence: "I might be able help with that."

The psychiatrist, Kevin's uncle, Dr. Bolton, and Chris's own administrators were dismayed with Chris's position. "Medications didn't *prevent* Kevin from trying to kill himself," Chris had reasoned. "And when he did try – look what he used."

The debate had continued. Chris rounded up allies, one of whom was Allison, who'd represented the school at the discharge meetings. Her mission, under orders from Dr. Bolton, was to block Kevin's return. Chris had persuaded her to cross over from the dark side, however, mostly by allowing her to get to know Kevin. Chris had also found a reliable therapist, one who'd read some of the same books, and attended some of the same conferences, as Chris. It still took some wrangling, but eventually Kevin was released from the hospital sans prescriptions.

Hence, the second part of Chris's

prayer, that pertaining to a certain anniversary. Kevin had vowed upon discharge to neither take a psychiatric drug, nor be subjected to a humiliating evaluation, ever again. The pundits had predicted Kevin's doom within a week. He'd surpassed that mark 50 fold, however, and thus the one year mark was close at hand. Although Kevin made few references to the milestone, Chris sensed it was of great importance. Accordingly, Chris planned a dinner to mark the occasion, inviting several people who'd helped along the way.

Dr. Bolton had been omitted from the guest list.

"It requires talent to be that crude and insulting," Chris said. "You are truly gifted."

After completing his prayer and finding the men's room, Chris rejoined his irradiated accomplice, who dutifully waited outside the X-Ray lab. Ambling up to Kevin without speaking, Chris parted the flaps of the towering boy's flannel shirt to behold the t-shirt's previously hidden message: *I Gave Your Mom a Ride*.

"It requires talent to be *that* crude and insulting," Chris said, craning his neck to look up to the boy's face. "You are truly gifted."

Soon the X-Ray was read, and Kevin was free to go with only an Ace bandage and an ice pack. "Don't look so disappointed," Chris said as they walked to the car. "You don't need to be injured to gain acceptance."

"Do we have to time to stop for food before heading back to the shelter?"

"Pizza or tacos?"

"Which do *you* want?"

"Tacos," Chris answered.

"Then let's get pizza."

Chris pressed the clicker to unlock the car doors. "My mom says hi, by the way."

"You're gross."

"She's wondering what you're doing this weekend."

The pizza at Tony's was awesome as usual, and Kevin had three slices to Chris's two, also as usual. As they ate, Kevin further detailed his encounter with the jock and the dry erase board. Chris probed discreetly, hoping to get a sense of Kevin's insight into how and why he had not escalated and mauled the kid. Kevin was nonchalant, however, revealing little. To him, the matter seemed over and done with. At least insofar as the jock was concerned.

"Hey, we need to do a safety contract," Kevin said, reaching for his Coke. "You and me. Allison said Bolton's insisting."

"For real?" Chris asked. He wiped a sting of cheese off his chin with a napkin. "Sounds a little extreme, don't you think?"

"Come on," Kevin said. "Don't make like Allison didn't tell you."

"It just sounds extreme. That's all I'm saying."

"It'll keep my ass from getting suspended," Kevin said. "That's all *I'm* saying."

Chris's laugh was muffled by his next bite of pizza. "I got you," he mumbled. "What's it need to say?"

"Same as last time, I suppose." Kevin sprinkled pepper on his second slice. "Although it might be a good idea to lay it on pretty thick."

Chris was impressed. He didn't need to lead Kevin at all anymore, it seemed. "Why thick? What's your thinking?" He raised his Sprite for a sip.

Kevin looked out the window as the glare of the late afternoon sun angled through to reach him. "My thinking is Bolton hasn't been able to bounce me out of his school all year, despite trying like crazy. He just might want to make the most of this opportunity."

Chris told Kevin about his phone call to Bolton, and the meeting the next morning. "I didn't get the vibe Bolton's got any dirty tricks waiting for us," he said, "but I don't trust the fink. Yeah," he concluded, "let's make that contract over the top."

"Yeah," Kevin said, nodding. "Bolton wants to play ball, so let's play ball."

Chris shook his head. "Haven't heard *that* one in a while."

Kevin smirked. "You remember

the first time you used that on me?"

"Oh, yeah," Chris said. "How could I forget?"

It had been Kevin's greatest trial since leaving the hospital. After five months of slow but steady progress, he'd gone missing for two days after a fight with his uncle, who'd been busted for possession of narcotics. He'd made bail, but Kevin was enraged since the guy's caretaking days were up – and there was nowhere else for him to go.

Knowing Kevin was out of options, Chris made arrangements with the county youth shelter, in the hopes Kevin would surface soon enough – and intact enough – to be admitted. Kevin did surface. He'd called Chris's work cell phone around 10:30 the second night. He sounded fine, and explained he'd been with his buddy, Ray, but couldn't stay any longer.

Chris told Kevin about the shelter, adding that he'd also convinced Bolton to give him a shot to remain in school as long as he had a clean drug test. "Tell me where you are," Chris had said. "I'll come get you." He'd picked Kevin up, impressed at how together the boy seemed given the huge upheaval his life had just taken.

"Listen," Chris had said as they drove. "There's this guy at the shelter, works the nightshift. His name's Morgan. First thing you do when you get there is make yourself his best buddy. Understand?"

"He's cool?" Kevin had asked.

"He's a blood sucking demon from Hell," Chris advised. "He's gotten more of our kids thrown out of there than I want to count. Even if he can't get you kicked out, he'll make you so miserable you just might run."

"Scum bags like him don't scare me," Kevin had said.

"It doesn't matter if he scares you or not," Chris said. "What matters is he can ruin your shot at staying in this county. *Your* county. You loose that, you loose your school."

"Who cares about *that* anymore?"

"Do you ever listen to yourself when you talk?" Chris had asked. "You're biggest goal is to finish high school where you started - mainly to spite Bolton. That's a good mission,

Kevin. Don't give up on it."

After a long pause, Kevin had asked what to do, what to say, if this Morgan guy messed with him.

"I suggest a preemptive strike," Chris had said. "Morgan loves baseball. Lives and breaths it. He's knows every stat from every team."

"So do I."

"He's a Yankee season ticket holder, *and* he played two seasons of Triple-A ball with the Pawtucket Red Sox before blowing out his knee."

"No shit?" Kevin had asked excitedly. "He played ball with the *Paw Sox*?"

"Schools are just institutions designed to manufacture soul-dead conformists," Chris said. "Don't you read any of those books I loan you?"

"Yeah, he played ball," Chris had said. "And you need to play ball, too. Got it?"

"I guess," Kevin had said. Then, looking out the window, he'd mumbled to nobody in particular, "I can totally play ball with someone who played for the *Paw Sox*."

And Kevin *had* played ball. He was doing better at the shelter, and at school, than anybody had dared to hope. If his mother could pull herself together, even just halfway, Kevin stood a shot of returning home before too long. His life just might return to semi-normal.

Kevin was halfway through his third slice of pizza, and Chris was just starting his second. Neither had spoken for a long moment. Kevin looked out the window again, cleared his throat, then faced Chris.

"I had a gun."

Chris was still chewing. He held

his gaze with Kevin, until Kevin lowered his eyes to the table.

"That night," Kevin continued. "The night you picked me up and drove me to the shelter."

Chris was impressed at how intricate clinical challenges can pop up at the damndest times. Like over pizza.

"I stole it from Ray's father that night," Kevin said. "He kept it in a closet in the basement."

Chris sensed Kevin wanted him to speak. All he could come up with was, "No shit."

"I was going to do it," Kevin said. He looked Chris in the eye and shrugged. "That was absolutely *it*. I was going to shoot myself in the head that night."

Chris leaned forward, his elbows on the table. Kevin cleared his throat again, but when he spoke, his voice was soft and relaxed.

"I couldn't go back to my uncle's. My mother had stopped going to rehab. My father had changed his phone number again. Bolton was going to throw me out of school sooner or later." He shook his head. "I had *nothing*. It was *all* gone."

The late afternoon sun now beamed across their table. Chris watched the long shadow cast by Kevin's arm as the boy took a long sip from his soda.

"I was back in the woods," Kevin continued. "My favorite spot at Delmar Park. Sitting there, holding the gun, just looking at it. It was loaded and ready to go. Then ... this wacky thought occurred to me: *Hey, maybe I should call Chris.*"

"Must have been 10:30 or so," Chris said, after a pause.

"Exactly," Kevin said. "I didn't think you'd answer."

Chris picked up his pizza again, and took a small bite.

"I remembered all the times I'd thought there was no way out of something – I mean, *no way*. Yet you always seemed to have some idea. Or you'd just say something – *something* – that changed things. So, I figured I'd call you. Just to see."

Kevin slowly worked his way toward the crust of his last slice. "You know what was *really* weird?" he asked.

"What?"

"Once I'd made up my mind to kill myself, it felt like the pressure was off. I could do it *anytime*; one more day didn't

matter. I could call you, and if things worked out, fine. If not, I could kill myself the next day.” He shrugged, took a bite of crust, and added, “Or the day after that.”

“And things worked out,” Chris said.

“Yeah,” Kevin said. “You had a plan.”

Chris set his pizza crust down on his plate and nodded. Kevin looked down at Chris’s plate, and asked, “You going to eat that?”

Chris pushed his plate across the table.

Walking out to the car, Kevin asked if they could write up the safety

contract when they reached the shelter.

“That way I’ll get to stay in school.”

“Schools are just institutions designed to manufacture soul-dead conformists,” Chris said. “Don’t you read any of those books I loan you?”

“If you keep bothering me I’ll tell your mother when I see her this weekend.”

“The contract will be your homework assignment for tonight,” Chris answered. “You know what to do.”

“Hey, you know what?” Kevin asked as they drove off. “Next Tuesday it’ll be a year to the day since I left the hospital. *To the day.*”

“A year, huh?” Chris said. “Are you sure?”

“Don’t make like you don’t know,”

Kevin said, “I see right through you.”

Chris shook his head. “No way it’s a year already.”

“I’m positive,” Kevin said. “No hospitals, no doctors, and *no psychiatric drugs* for a whole year.”

“Who keeps track of that kind of thing?”

“You are such a lying sack.”

“I have no idea what you’re talking about.”

“This calls for a celebration.”

“Yeah,” Chris said. “We should get you a t-shirt or something.”

Article

Methadone as Pain Management: A Deadly Deception

By Kathleen Shannon, M.A., L.P.C., L.I.S. , A.C.

Methadone is a synthetic opioid that, until the 1990’s, was sparingly relegated to pain management for critically ill patients as well as ongoing maintenance for recovering heroin addicts. The liquid form has been in use to treat opiate withdrawal since 1964 as a daily maintenance program in order to enable heroin addicted patients to function more normally. In drug rehabilitation settings, methadone is administered as a liquid and dispensed at approved clinics. In the last two decades prescriptions for the pill form of the drug, although approved for use since 1947, have increased due to its use for pain relief. Along with the increase in prescriptions of the substance, the death rate has had an equally alarming increase.

The surge in the prescription of this drug for pain control is due in part to the efforts of the medical establishment in

their attempt to stop the widespread abuse of oxycodone and other opiates. It was believed that because of some of its properties, such as slow metabolism in the body and lack of an immediate feeling of a high from it, it was considered to be a safer drug with less chance of abuse than others such as oxycontin which have a high street value and an immediate feeling of euphoria. This has not proven to be the case and because of its longer lasting effects in comparison with the other pain medications, the potential for lethality is much higher.

Methadone hydrochloride, sold also as Dolophine, and manufactured in bulk by the German Company, Mallinckrodt Inc., of St Louis, MO, is unlike other opioid pain medications such as morphine, heroin and similar opiates. Its slow onset and long duration of action is one major difference that separates it

from its quicker-acting counterparts. In addition, according to UF News (2002), it is said to have a slow serotonin/norepinephrine reuptake which may help to avoid the depressive symptoms of other opiates. The drug is sold at a relatively low cost in comparison with the other pain medications which is another element that has helped to boost its desirability as a choice for pain control in the last few years.

According to Psychiatric News (2009), health experts have seen a “five-fold increase in methadone-associated overdose deaths from 1999 to 2005,” as cited in a report from the Centers for Disease Control and Prevention. Since the late 1990’s there has been an equal increase in prescriptions for the use of this synthetic opioid as pain medication. The increased prescribing of the drug in pill form for home pain management has

offered more opportunities for patient error and misuse as well as illegal trading of the drug. Because of the death of some famous figures from the use of this drug, the growing availability, and an alarming increase in mortality rates, federal agencies have begun to maintain better research on the problem in the last 3 years.

This is my second article on the problems created by the drug following the death of my daughter from an accidental overdose of this drug in 2004. Included is the most recent research and conclusions about the use of this medication.

History

Following its introduction in 1946 in Germany, the first published reports of the use of methadone for pain came in 1947, according to Sharon Watanabe (2001). Statistics were gathered on 4000 patients who were given the drug in place of morphine. It was found to be as good or greater in "potency and duration of action" as a pain substitute, than morphine. At the time of this study, it was noted, however, that the drug accumulated in the body, with continued doses culminating in a build-up in the system. Because of this, the danger outweighed the positive effects and use of it was relegated to a small number of critical cancer patients. The next extensive research into the effects of the drug for pain management as well as for use as a substitute and treatment for heroin addiction, came in the 1970s and 1980's. These findings were to elucidate further the method of absorption and elimination from the body. This study offered some underlying reasons for the dangerous build-up of the drug which culminated in respiratory depression and ultimately death due to toxicity in the body.

According to Watanabe (2001), when first ingested, methadone has a rapid distribution into the body tissues. The elimination from the body is much slower. Repeated doses of the drug create a longer lasting pain control effect, but also produce a build-up of medication in the system. This accumulation in the body has been known since its introduction, however, it was either ignored by its advocates, or the research they were able to access did not place enough emphasis on this effect. In spite of the contraindications and lack of continued research, the

pharmaceutical company, with the help of a very large ad campaign, extolled the virtues of methadone to the medical community with little or no information on its deadly side-effect.

Methadone has long been widely used as a replacement for heroin use in addiction treatment to help addicts remain off of the drug, and to help them to gradually withdraw from the use of opiates with doses of the liquid metered out at licensed clinics. This has not been proven to work as well as first expected as it ultimately creates an addiction to a similar opiate such as heroin. According to the FDA, methadone was deemed safe for both pain control and treatment of addiction. Recently however, due to a more informed public, a warning on the dangers of its dosage has been put on the label at the request of the Federal Drug Administration.

The Center for Disease Control (CDC) data, according to the United States Government Accountability Office, Washington D.C. (2009), shows that "from 1999 to 2005 the number of these deaths increased more than five-fold, from 786 to 4462." According to the publication, in "Maine, Florida and North Carolina, all states in which distribution through pharmacies for the use of pain medication exceed the national average, there was a five-fold increase" (CDC, 2009) in methadone deaths during this same period. Physician prescription orders were identified in 75% of these cases. Nationwide, methadone-related emergency room visits due to toxicity from methadone overdose, nearly doubled from 5426 to 10725 between 1997 and 2001.

Biological Effects

According to DAWN (Drug Abuse Warning Network), Methadone-involved Deaths in 8 Metropolitan Areas (2001), methadone is stored extensively in the liver and secondarily in other body tissues. Its' elimination half-life averages 24 to 36 hours at a steady state but may range between 4 to 91 hours. Because of this long half-life according to Sharon Watanabe (2001), balancing the drug elimination time with steady serum methadone levels (SML's) in which drug elimination is in balance with the amount of drug in the body, requires on average from 4 to 5 days, although it can take much longer in some individuals. If

doses are excessive, SML's can build up in the body. Due to liver enzyme activity, methadone is broken down to form a number of inactive metabolites, according to an article in "Addiction Journal" (Shannon, 2004) and in "The International Center for the Study of Psychiatry and Psychology Newsletter" (Shannon, Spring, 2005). Drugs that cause activity of these enzymes can accelerate the metabolism of methadone, and so shorten the duration of the effects, which can precipitate the withdrawal effect. Conversely, drugs that inhibit these enzymes can slow methadone metabolism, raise the SML and lengthen the duration of the drug's effect. These effects can result in unpredictable over or under medication and could and do cause intoxication to the point of respiratory depression.

The pill form Methadone is a long-acting opioid medication and is sold as a solid tablet that comes in 5 to 10 milligram doses. The therapeutic level can average around 60 milligrams a day. Depending upon the patient's tolerance to the dosage, it may take several pills over time to lead to overdose. Some people uninformed about the drug's delayed effects don't get the relief they want and take more of the drug which leads to toxicity in the body. It is a central nervous system depressant which lowers blood pressure and heart rate and slows the respiration. The most common cause of methadone-related death is respiratory failure. Other effects that have not been ruled out in the deaths due to methadone toxicity have been identified, including combining the drug with other CNS depressants, drugs that have tranquilizing effects, anti-convulsive medications, some antidepressants, as well as alcohol. Torsades de Points, which is a fatal cardiac arrhythmia, has also been linked to methadone as a cause of sudden cardiac arrest.

Methadone's delayed narcotic effect and its lack of a potent effect, or high feeling, are important reasons it can be so dangerous. According to the GAO report, March 2009, the dose that can cause the toxic effect may vary widely and if taken with alcohol or other drugs it can be lethal. In Florida for example, according to the GAO report, "of the 1095 methadone-associated overdose deaths in 2007, 124 deaths were caused by methadone

alone, while 971 deaths or about 89% were caused by methadone in combination with other drugs.” Due to the synergistic effect of these drug interactions a toxic level can easily occur.

Contributing Factors

Lack of knowledge among many practitioners about the safety risks and unique pharmacological properties of the drug that set it apart from other drugs contribute to the lethality of methadone, states the report in the article by Jun Yan (2009.). Following a recent warning on the label of methadone at the request of the FDA in November of 2006, the instructions now carry safety warnings, dosage guidelines and suggestions for the daily dose amount to treat pain, according to the GAO report as reprinted in the article by Jun Yan.

Withdrawal

Over long periods of time, methadone can lead to a very long withdrawal period. As compared to other opiates in which the withdrawal period is a week to 10 days, heavy methadone users can expect recovery to take as long as 5 or 6 weeks. Withdrawal should be done in a safe setting with frequent outpatient visits to the physician. Flu like symptoms, restlessness, anxiety, grouchingness, diarrhea, insomnia, fever and sneezing begin on the first day without the drug. During the second or third day without treatment the individual begins having muscle spasms, nausea, increased diarrhea, vomiting, severe backache, stomach pains, hot and cold flashes, intestinal spasm, repetitive sneezing, rise in blood pressure and bone and muscle pain. Depression and suicidal ideation can be concomitant with the withdrawal effects. The extensive and difficult withdrawal symptoms have added to the danger and subsequent mortality rate for the use of methadone for pain. Most patients, including those who don't fit the criteria for addictive behavior, would avoid the painful withdrawal from the drug and thereby increase the chances for dependency.

Although there is conclusive evidence to the contrary in the research beginning with its inception in

1947, in the last decade methadone has been prescribed nation-wide in a variety of situations to a variety of patients, many of which could have been helped by less dangerous medications, meditation and alternative pain management efforts. The drug companies have not adequately educated the physicians, and the physicians have not adequately educated themselves or the public on these dangers. The pharmaceutical industry and the medical community have been culpable in the deaths of thousands over the last few years by not publishing and reporting the deadly consequences from the use of this drug. According to Steven Passik, etc. (2003), “far too many patients are getting opioids when other, safer alternatives are available.” He relates that “a friend of his had a glass of wine with his opioid prescription. The friend became confused, took his medication again and died.”

Although the risks of this medication have been enumerated from the beginning, the burgeoning mortality rate shows that there is a great deal of denial and ignorance surrounding its use. The pharmaceutical company is complicit in keeping this information from the public. The opiate class in general has shown a problem of dependency and toxic effects due to overdose or combination with alcohol and other medications. The sad fact is that as each new and ‘better’ drug of this type comes out, the deadly side-effects and harm to society in general have only been published following the loss of many lives. Such is the case with this drug. Even though very early research disclosed some dangerous effects of methadone, this information was relegated to a very small minority of researchers in the field. The pharmaceutical companies as well as the FDA failed to follow up on this research before the deadly consequences were finally brought out into the light some 50 years later.

The answer lies not in a better drug but in more research into pain management in general. However, the payoff to the pharmaceutical industry would be less and the huge amount of advertising and prizes for the medical profession who prescribe these medications might have to give way to more thorough research and honest reporting. This research would have to include thorough examination, publication and education regarding the negative as well as the positive effects of the drugs, as well as better education for the medical profession and their patients. The govern-

ing body which is paid to protect the safety of individuals by scrutinizing the drugs that are continually being sold to the public, the FDA, needs its own oversight community. There are often dual roles by researchers, FDA employees, investors in the drug companies and board members of these companies, which lead to unethical and prejudicial practices.

As of the writing of this paper there have been dozens of more thorough reports on the deadly effects of methadone for pain management since first investigated and written about by this writer in 2004 and 2005. Had this scrutiny and statistical review of the mortality rates been done long before the drug was widely prescribed, thousands of lives could have been saved. From its inception in the 40's the dark side of this drug was known. Had this information not been withheld from the public by the pharmaceutical companies and had the attending physician sought out the information before prescribing it for pain, my daughter Nadine would be alive today.

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