

# ICSPP Bulletin

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

*"All The Conference Info You Need."*

2010 – Number 2

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Co-editor

**Albert Galves, Ph.D.**  
Contributing Editor

## 2010 Conference Right Around Corner It's Time to Re-energize - Register Now!

October is coming, and that's when I re-energize by getting together with a group of like-minded people - *you* - for a long weekend at our annual conference.

Our organizers, Michael Gilbert, Burt Seidler, and Lloyd Ross, have been doing all the behind-the-scenes business, like sorting presentation proposals, planning the schedule, booking the hotel and meeting rooms, and much more. Their hard work is paying off, and we'll all benefit from the time and energy they've invested.

Once again we have great speakers lined up. Highlights include Stuart Kirk (co-author of "The Selling of DSM" and "Making Us Crazy"), Robert Whitaker

("Mad in America" and "Anatomy of an Epidemic"), and Jeffrey Lacasse and Jonathan Leo.

And this year marks the return of a favorite presenter from years gone by, David Cohen, Ph.D., who has authored over 50 articles and who co-authored "Your Drug May be Your Problem."

We'll also have some favorites such as Elizabeth Root, Sarah Edmunds, David Stein, and Brian Kean. Registration and Hotel info are on page 3, and the tentative schedule follows on pages 4 through 6. You can register on line, or use the form on pages 7 and 8. Check it all out and register today. Join us and get re-energized.



Robert Whitaker, author of "Mad in America" and "Anatomy of an Epidemic" (to be reviewed in next issue), will present again this year. Here Whitaker speaks at the 2008 conference in Tampa, Florida.  
(Photo: Robert Sliclen)

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

# Critical Psychology and Empathic Counseling: Era of Evidence-Based Practice, Ethics and Supervision

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

**Syracuse, New York – Friday, October 8<sup>th</sup> - Saturday 9<sup>th</sup>, 2010**  
**Thursday Oct 7<sup>th</sup> Pre-Conference Workshops**

## **Focusing On:**

**Critical Psychology – Legal and Ethical issues**  
**Empathic Counseling and Psychotherapy**  
**Psychopharmacology and Brain Research**  
**Outcome Based Non-Medication Treatments**

## **Featured Conference Speakers Include**

David Cohen PhD  
Tomi Gomory PhD  
Rober Whitaker  
David Stein PhD  
Keith Hoeller PhD  
Jonathan Leo PhD  
Jeffrey Lacasse PhD  
Norbert Wetzel ThD  
Jaqueline Sparks PhD  
Stuart Kirk PhD

*Registration Online or by Mail*

*Registration Form and Details  
on Pages 7 and 8*

## **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 for ICSPP Conference Block

Online [www.renaissancesyracuse.com](http://www.renaissancesyracuse.com)

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

# Tentative Schedule and Speaker Bios

## 10/7/10 WORKSHOPS

David Stein PhD

### **Effective Parenting: Caregivers Skills Program (CSP)**

A how-to workshop in which you will learn realistic, sensible, and easy to master parenting skills. An approach based on sound scientific research representing over thirty years of Dr. Stein's work as a professor, clinician, writer, and speaker.

Jacqueline Sparks PhD

### **How to Listen to Clients, Not Prozac**

Client-directed, outcome-informed work as a powerful alternative to prescriptive medical treatment.

Norbert Wetzel ThD

### **Justice Matters: A School and Community-Based Counseling Model for Multi-Stressed Adolescents and their Families**

A conceptual foundation and practical implementation of the "Family Empowerment Program" (FEP) - a model for working with multi-stressed adolescents and their families.

Wendy West-Pidkaminy LCSW

### **Nurtured Heart Approach (NHA)**

A parenting/teaching approach, developed by Howard Glasser, that fosters the child's inner strength (character and spirit), giving them the moral compass necessary to effectively deal with and solve problems as well as succeed socially and emotionally. It transforms the child to a higher level of happiness, security, conduct, and achievement.

## 10/8-10/9/10 PLENARY AND BREAKOUT SESSIONS

Stuart Kirk, PhD, Tomi Gomory, PhD, and David Cohen, PhD

"Community Treatment, DSMs, and Drugs: Fifty Years of Fake Psychiatric Progress."

David Cohen PhD

"Banishing the Psychoactive: FDA Evaluations of Psychiatric Drugs."

Tomi Gomory

"What's the Evidence on Evidence-Based Practice?"

Keith Hoeller, PhD

"Medical Ethics and Psychotherapy: The Existential Therapy of Thomas Szasz."

Robert Whitaker

"Anatomy of an Epidemic"

Jeffrey Lacasse Ph.D. and Jonathan Leo Ph.D.

David Stein PhD

"Treating Adolescents"

Jacqueline Sparks PhD

"Being Consumer-Directed in a Medical-Directed Universe"

Norbert Wetzel ThD

"Justice Matters: A School and Community-Based Counseling Model for Multi-Stressed Adolescents and their Families"

**David Cohen Ph.D.** is the Principal Investigator on the Critical Skills Curriculum on Psychotropic Medications project. He is Professor of Social Work at Florida International University, where he teaches courses on psychopathology, psychopharmacology, and research methods. Recently, he co-authored *Your Drug May Be Your Problem* (2nd revised edition, 2007) and co-edited *Critical New Perspectives on ADHD* (2006). His French-language books include *Critical Guide to Psychotropic Drugs* (1995) and *Medicalization and Social Control* (1998). He is also author or co-author on more than 50 articles in journals in social work, psychology, sociology, medicine, psychiatry, law, ethics, and nursing, as well as 25 book chapters. He has given numerous conferences to academics, professionals, and consumers in several countries on the personal, clinical, social, and cultural uses of prescribed psychoactive drugs. Dr. Cohen has received funding for research projects from governmental and private foundations in Canada, France, and the United States. He has contributed to clinical practice by elaborating methods to help clients undergoing withdrawal from psychiatric drugs. In 2003, he received the Elliott Freidson Award from the American Sociological Association for Outstanding Publication in Medical Sociology. Dr. Cohen received a B.A. from McGill University, an MSW from Carleton University, and a PhD in Social Welfare from the University of California, Berkeley. He practices as a Licensed Clinical Social Worker in Florida.

**Tom Gomory** (Ph.D. Berkeley, 1998) is an Associate Professor and Fulbright Scholar at the College of Social Work, Florida State University. He has published articles and book chapters on mental health treatment and policy, philosophy of science, and social work education. He may be the sole living critic of Assertive Community Treatment, the most well promoted and researched Evidence Based Practice among treatments targeting the "Severely Mentally Ill." Before beginning his academic career, he spent ten years working as a social worker, beginning in Brooklyn NY as a clinician in Catholic Charities' run Human Service Centers, working his way into administrative roles including being the first director of the very first adult homeless shelter in Brooklyn in the mid 1980s and a stint as the San Francisco project director of the Robert Wood Johnson and HUD coordinated federal Homeless Families Model Project.

**Robert Whitaker**, author of *Mad in America*, has won numerous awards as a journalist covering medicine and science. In the past few years, he has won the George Polk Award for Medical Writing and a National Association for Science Writers' Award for best magazine article. Mr. Whitaker also wrote ["The case against antipsychotic drugs: a 50-year record of doing more harm than good,"](#) an excellent summary that appeared in the scientific journal *Medical Hypotheses* (Volume 62, Issue 1, January 2004).

In 1998, he co-wrote a series on psychiatric research for the *Boston Globe* which was a finalist for the Pulitzer Prize for Public Service. He previously worked as director of publications at Harvard Medical School, and was a features/medical writer at the *Albany Times Union* newspaper, in Albany, N.Y., for a number of years. In 2005, he wrote a chapter in the book, *Bipolar Children Cutting Edge Controversy, Insights, and Research*. In his new book, *Anatomy of an Epidemic*, Whitaker investigates the astonishing increase in the disability numbers during the past fifty years and raises an obvious question: could the widespread use of psychiatric medications--for one reason or another--be fueling this epidemic? The book focuses on the long-term outcome studies in the research literature.

**Norbert A. Wetzel, Th.D.**, a New Jersey licensed psychologist and marriage and family therapist, is co-founder of the Princeton Family Institute. He was visiting professor at the Graduate School of Applied and Professional Psychology, Rutgers University, specializing in couples and family therapy. Dr. Wetzel was previously faculty at the Family Institute of the University of Heidelberg Medical School. Among other books and numerous articles, he has co-authored *The First Interview with the Family* (Stierlin, et. al). Dr. Wetzel is currently Director of Training at The Center for Family, Community & Social Justice, Inc. He frequently lectures and conducts seminars for counseling professionals in the United States and Europe as well as training and organizational consultation in the public and private sectors. Dr. Wetzel is an approved supervisor of the American Association of Marriage and Family Therapists (AAMFT). He is a charter member of the American Family Therapy Academy (AFTA) which awarded him the 2010 award for "Distinguished Contribution to So-

cial Justice”.

**David Stein Ph.D.** is currently Associate Professor of Criminal Justice at Virginia State University. He was formerly Professor of Psychology at Longwood University, where he served for 22 years. He is a Diplomat Forensic Examiner Psychologist. In addition, he has trained with the Virginia State Police. Dr. Stein is the author of several books about how to treat children and teenagers without the need for psychiatric drugs. Among his recent works are: *Stop Medicating, Start Parenting: Real Solutions for Your Problem Teenager* (2005); *The Ritalin is not the Answer Action Guide: An Interactive Guide to the Best-selling Parenting Program* (2000); *Unraveling the ADD/ADHD Fiasco: Successful Parenting without Drugs* (1999); *Ritalin is not the Answer: A Drug-free Practical Program for Children Diagnosed with ADD/ADHD* (1998).

**Jonathan Leo Ph.D.** is Associate Professor of Neuroanatomy and Associate Dean of Students at Lincoln Memorial University. Dr. Leo was editor and contributor to book “Rethinking ADHD: International Perspectives (2009)”. He has published numerous articles about the biological theories of mental health, covering topics such as the genetic basis of schizophrenia, the serotonin theory of depression, the pediatric trials of selective serotonin reuptake inhibitors, and ADHD. His articles have been published in *Society*, *Skeptic*, and *The Journal of Mind and Behavior*. He is the past Editor-in-Chief of *Ethical Human Psychology and Psychiatry*. A recent article explored the disconnect between the scientific literature and the popular advertisements regarding serotonin and depression. The paper was published in *The Public Library of Science (PLOS)* and was subsequently covered by numerous media outlets including *WebMD*, *Nature*, *Forbes*, *The Scientist*, and the *Wall Street Journal*.

**Jeffrey Lacasse Ph.D.** is Assistant Professor in School of Social Work/College of Public Programs, at Arizona State University. Dr. Lacasse’s research focuses on barriers to evidence-based behavioral health treatment. His current research projects examine the promotion and utilization of psychiatric medications, and industry influence on mental health research and practice.

**Jacqueline A. Sparks, Ph.D.** is an associate professor of family therapy in the Department of Human Development and Family Studies at the University of Rhode Island. Her primary interests include teaching accountability via outcome management, researching feedback and change in couple and family therapy, transforming systems of care to privilege client goals and promote social justice, and critical analysis of child psychotropic medication. She is co-author of *Heroic Client* and *Heroic Clients, Heroic Agencies: Partners for Change*, and co-founder of the Heroicagencies Listserv, an international discussion forum for client-directed, outcome-informed implementation.

**Keith Hoeller Ph.D.**, is editor of the *Review of Existential Psychology & Psychiatry*, and the book series *Studies in Existential Psychology* and *Thomas Szasz: Moral Philosopher of Psychiatry*. He lives in Seattle, WA, where he teaches philosophy and psychology in the community colleges.

**Stuart A. Kirk Ph.D.** is Professor and holds the Marjorie Crump Chair in Social Welfare at the UCLA School of Public Affairs. A former psychiatric social worker, he has taught at Columbia and other universities, and served as Dean of the School of Social Welfare at the State University of New York at Albany in the 1980s. He is a former editor-in-chief of the journal ‘Social Work Research’. His books on mental disorder include ‘The Selling of DSM: The Rhetoric of Science in Psychiatry (1992)’, ‘Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders (1997)’ and the edited ‘Mental Disorder in the Social Environment: Critical Perspectives (2005)’. He has published other books, chapters and over 100 articles in social welfare, psychology, psychiatry and other journals.

# Critical Psychology and Empathic Counseling: Era of Evidence-Based Practice, Ethics and Supervision

October 8-9, 2010

Preconference Workshops - October 7

Renaissance Syracuse Hotel

Renaissance Syracuse Hotel, 701 East Genesee Street, Syracuse, NY13210

Call 800-960-5059 for Hotel Reservations

\$119 ICSP Conference Code "ICSICSS"

For questions email Dr. Gilbert at: [mgilbert@iacaf.org](mailto:mgilbert@iacaf.org)

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

Seminars on: Ethics, Supervision, Evidence Based Treatments, and Mental Health Research

Featured speakers: Robert Whitaker, David Cohen, Tomi Gallory, Keith Hoeller

Psychiatrists, Psychologists, Authors, Administrators & Teachers!

Best Selling Authors, Attorneys, Researchers, International Experts and Professors and Educators:

Jay Joseph, PhD, DuBose Ravenel, MD, FAAP, Jim Gottstein, JD, Dominick Riccio, PhD, Brian Kean, PhD (Australia), Fay Karpouzis, DO, Dc, MSc (Australia) Dorothy Cassidy, M.Ed. and More

2010 ICSP Syracuse, New York List of Presenters:

<i>Benda, John, MSW</i>	<i>Presley, S.</i>
<i>Bratter, Tom</i>	<i>Root, Elizabeth, MSW</i>
<i>Caccia, Lew, Ph.D.</i>	<i>Ross, Lloyd Ph.D.</i>
<i>Crowder, Carolyn, Ph.D.</i>	<i>Rucci, Crisilda M.A.</i>
<i>Edmunds, Dan, Ph.D.</i>	<i>Seitler, Burton Ph.D., Ross, Lloyd Ph.D., and</i>
<i>Edmunds, Sarah, Ph.D.</i>	<i>Sliclen, Robert Ph.D. (panel presentation)</i>
<i>Felio-Skudina, B.</i>	<i>Seitler, Burton Ph.D.</i>
<i>Deborah Felio, M.A.</i>	<i>Seitler, Jeanne Psy.D.</i>
<i>Galves, Al Ph.D.</i>	<i>Sparks, Jacqueline, PhD</i>
<i>Nature Kean, Brian Ph.D.</i>	<i>Stolzer, Jeanne Ph.D.</i>
<i>Kean, Brian Ph.D.,</i>	<i>Stone, George MSW</i>
<i>Weatherby-Fell, Noelene Ph.D.</i>	<i>Szlek, Elizabeth J. Ph.D.</i>
<i>Lacasse, Jeffrey, PhD</i>	<i>Tarantola, Joseph, M.D.</i>
<i>McKenzie, Clancy, M.D.</i>	<i>Tenaglia, Phillip M.A.</i>
<i>McLaren, Niall, M.D.</i>	<i>Wetzel, Norbert Th.D.</i>
<i>Parker, Judith V. Ph.D.</i>	<i>Wetzel, Norbert Th.D.</i>



# Critical Psychology and Empathic Counseling: Era of Evidence-Based Practice, Ethics and Supervision

## 2010 REGISTRATION FORM

Name(s) \_\_\_\_\_  
 (Please print the names the way you want it to appear on your certificate and name tag)  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Country \_\_\_\_\_ Zip Code \_\_\_\_\_ Tele \_\_\_\_\_  
 For confirmation: Email \_\_\_\_\_ and Fax \_\_\_\_\_

### 13th ICSPP Conference Fee Schedule & Payment Options

#### Early Registration

Fri. or Sat. (circle one or both)	1 or 2x\$125 =	+ \$
Fri. or Sat. (2 or more registrants)	2 or __x\$110 =	+ \$
Fri. or Sat. (5 or more registrants)	5 or __x\$100 =	+ \$
Thursday (Oct. 7th)	\$25 x _____	+ \$
Add \$25: 10 Days Prior to Conference		+ \$
<b>Less \$25:</b> ICSPP member or Student (1 discount)		\$
<b>Less \$25:</b> Registration for Both Days		\$
Add: DVD of Main Presenters \$150		+ \$
Add: \$50 Gala Award Dinner Sat Night		+ \$
ADD: \$10 Thurs, Fri, Sat Lunch each		+ \$
Add \$25: Continuing Education Certificate		+ \$
<b>TOTAL</b>		\$

Questions & Hardship?: Call Dr. Michael Gilbert @ 315-445-0007 or email him at [mgilbert@iacaf.org](mailto:mgilbert@iacaf.org)

**Fax Registration:** 920-694-0999

**Email Registration:** [mgilbert@iacaf.org](mailto:mgilbert@iacaf.org)

#### Mail Registration To:

International Center for the Study of Psychiatry and Psychology, Inc  
 PO BOX 281,  
 Jamesville, NY 13078

Or register online at: [www.ICSPPOnline.org](http://www.ICSPPOnline.org)

Credit Card (circle): Visa M.C.

\_\_\_\_\_  
 Credit Card Number Exp. Date

\_\_\_\_\_  
 Name on Card

Authorized Signature \_\_\_\_\_

International Center for the Study of Psychiatry and Psychology, Inc. & It's About Childhood and Family Inc.



## **ICSPP Statement Regarding Website Change & ICSPP Name And Website Confusion**

On April 22, 2010, International Center for the Study of Psychiatry and Psychology, Inc., hereinafter, referred to as ICSPP, issued a statement regarding the then recent, unauthorized, redirection of ICSPP's URL ([www.icspp.org](http://www.icspp.org)) by Dr. Peter Breggin to a new organization he has formed. This unauthorized redirection and disassociation from ICSPP by Dr. Breggin occurred immediately after the ICSPP Board of Directors expressed broad support for the International Executive Director, whereby the board agreed to revisit Dr. Breggin's dissatisfaction in October, 2010. ICSPP maintains its original core principal values and mission statement.

Since the above statement was released, ICSPP contacted the URL provider and informed them that ICSPP is the rightful owner of the URL and domain name. In turn, the company without ICSPP's permission redirected the URL to a general pro psychiatric medication and biological illness mental health page. Unfortunately, as is policy with these situations, the URL company told only Dr. Breggin they planned to freeze the URL for 30 days, but did not tell ICSPP about the 30 day deadline. During that time, ICSPP attempted to resolve with Dr. Breggin the taking of the website URL. ICSPP expressed willingness to allow a shared, one-page visitors' website link with Dr. Breggin so that visitors to the original [www.icspp.org](http://www.icspp.org) would be redirected to either ICSPP's new website URL ([www.icsppOnline.org](http://www.icsppOnline.org)) or to one of Dr. Breggin's new websites.

Unfortunately, Dr. Breggin has not returned control of the URL and has not created the joint page. Instead, after the 30 day freeze, Dr. Breggin decided to redirect the URL to yet another new organization; however, this time he now is using the ICSPP acronym, a spin off ICSPP's name. This has led to massive confusion when visitors are trying to reach the real ICSPP, but are directed to Dr. Breggin's mock ICSPP instead.

The public is finding it confusing that Dr. Breggin also is promoting a Syracuse, NY conference like ICSPP has been for the past year. Thus, when visitors are attempting to register for the ICSPP conference, join ICSPP and gather information from ICSPP, they might be joining, registering and reading Dr. Breggin's new information.

ICSPP at this time is seeking arbitration through the URL provider company, and hopes to regain the URL shortly. Upon resolution by the arbitrator, ICSPP will redirect the energy spent on this issue back to our educational reform work and our international educational conference: October 8-9, 2010, in Syracuse, NY. For more information, please visit [www.icspponline.org](http://www.icspponline.org).

Board of Directors

# The PsychRights® Report

*The Law Project for Psychiatric Rights (PsychRights) is a non-profit, tax exempt 501(c)(3) public interest law firm whose mission is to mount strategic litigation against forced psychiatric drugging and electroshock. Currently, due to the massive growth in psychiatric drugging of children and youth, PsychRights has made attacking this problem a priority. PsychRights' website, <http://psychrights.org>, is a tremendous resource.*

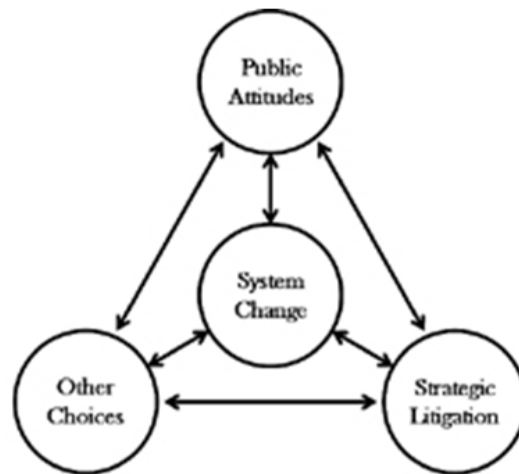
We first want to thank the ICSPP for giving PsychRights the opportunity to report on PsychRights. Since this is the first PsychRights Report, it seems background information is in order.

## The Transformation Triangle

PsychRights sees the effort to reform the mental illness system's reliance on harmful drugs as requiring a three pronged approach depicted to the right. These three prongs reinforce each other, with changing Public Attitudes being the most important. Ultimately, things won't change significantly regardless of people's legal rights until society understands the drugs (& electroshock) are ineffective and counterproductive for most, harmful to all, and make people less safe.

The way the three prongs reinforce each other is as follows. First, if Public Attitudes recognized that Other Choices eschewing psych drugs & electroshock produce far better results for the vast majority of people, more support (money) would flow to such approaches. It works the other direction too. To the extent Other Choices can be brought into existence and the public sees they work better, that will tend to change Public Attitudes in favor of Other Choices.

At the bottom of the chart, people have the constitutional right (currently ignored as a matter of course) to the least restrictive or intrusive alternative, i.e., Other Choices. Otherwise, the state has to let the person go. Strategic Litigation asserting people's right to such Other Choices will tend to encourage the creation of Other Choices. At the same time, however, judges are reluctant to let people go because no Other Choices



exist. Thus, the existence of Other Choices will also tend to cause the judges to honor people's right to Other Choices.

With respect to Public Attitudes/Strategic Litigation, people's rights to Other Choices are ignored as a matter of course primarily because the judges and, sadly, even the lawyers assigned to represent psychiatric defendants, reflect society's belief that if the person wasn't crazy, she would know the drugging is good for her. Therefore they don't let her pesky rights get in the way. To the extent Public Attitudes change and society understands locking people up and drugging them against their will is not only ineffective and counterproductive for most, harmful to all, and make people less safe, rather than more safe, the courts will tend to honor people's right to Other Choices. It is harder to see how Strategic Litigation can change Public Attitudes, but the Supreme Court's decision in *Brown v. Board of Education* is perhaps the exemplar. Before *Brown*,

the Supreme Court had ruled segregation was constitutional and a large percentage of people supported segregation. *Brown* changed that to such an extent now hardly anyone believes segregation is acceptable.

Because Jim Gottstein, PsychRights' president, lives and is licensed to practice law in Alaska, it has been possible to employ these principles there -- with encouraging results.

## The Alaska Experience

Since its founding in late 2002, PsychRights has won four Alaska Supreme Court Decisions. The 2006 decision in *Myers v. Alaska Psychiatric Institute (API)* ruled Alaska's forced drugging procedures unconstitutional because they didn't require the State to prove (1) the forced drugging is in the person's best interest, and (2) there are no less intrusive alternatives available. *Myers* has been called "the most important State Supreme Court decision" on forced

drugging in 20 years by mental health law scholar Prof. Michael Perlin, who was a plenary speaker at ICSP's 2006 conference. In 2007, *Wetherhorn v. API* held Alaska's involuntary commitment statute unconstitutional to the extent someone could be committed as gravely disabled without the state proving the person was unable to survive safely in freedom. The 2008 *Wayne B. v API* decision ruled the State could not dispense with the requirement of a transcript when involuntary commitment and forced drugging cases are referred to a master for hearing and recommendations. In 2009, *Bigley v. API* held on constitutional grounds (a) if there is a less intrusive alternative that is "feasible," the state must provide it or let the person go, (b) a forced drugging petition must include information about the patient's symptoms and diagnosis; the medication to be used; the method of administration; the likely dosage; possible side effects, risks and expected benefits; and the risks and benefits of alternative treatments and nontreatment, and (c) the hospital must give the person's lawyer their medical chart sufficiently in advance to allow for adequate preparation.

Mr. Gottstein has a policy of accepting all the speaking invitations he can and has helped create Other Choices in Alaska. CHOICES, Inc., is a non-coercive program for people in the community allowing people to eschew psych drugs. Soteria-Alaska is an alternative to psychiatric hospitalization that also allows people to choose non-drug approaches. As a result of his and others' efforts, especially Susan Musante, the Executive Director of both CHOICES, Inc., and Soteria-Alaska, and Dr. Aron Wolf, a long time and well-respected Alaskan psychiatrist who worked at Chestnut Lodge before coming to Alaska, it is fair to say Public Attitudes have changed. Whereas "psych drugs for everyone, of course" was the standard in 2002, there is now significant mental health system support for people having Other Choices. The timeline resulting in the Alaska mental health system's funding of Soteria-Alaska is illustrative of this process:

- 2002, The Alaska Mental Health

Board: Not Endorse (Robert Whitaker's information about the neuroleptics) -- Just Educational

- 2003, The Executive Director of the Alaska Mental Health Trust Authority (Trust Authority): Robert Whitaker's Information Implies the Need for Non-Drug Alternatives
- 2004, Trust Authority Board: Soteria-Alaska Proposal Needs More Development
- 2005, Executive Director of the Trust Authority: Not If, But How.
- 2006, Trust Authority formally supports Soteria-Alaska, but wants State General Fund financial participation.
- 2007, Trust Authority funds Soteria-Alaska when didn't get General Fund financial participation.
- 2009, Opened through Trust Authority funding.

2010, Partial General Fund financial participation.

#### **PsychRights' Medicaid Fraud Initiative Against Psychiatric Drugging of Children & Youth**

Currently, PsychRights is focusing its efforts on using the federal False Claims Act (FCA) to put the brakes on the catastrophic, massive, harmful, psychiatric drugging of poor children and youth through Medicaid, especially those in foster care. Medicaid is not allowed to pay for off-label outpatient prescriptions unless such use is scientifically "supported" by specified references and well over half of psychotropic prescriptions to Medicaid recipients under 18 are false (Medicaid Fraud). Under the FCA, anyone with "non-public" information of fraud, such as specific offending prescriptions, can bring a lawsuit on behalf of the government to recover for the fraud and share in the monetary recovery, if any. Each offending prescription carries a minimum penalty of \$5,500, which means any psychiatrist caught in this will be bankrupted. Psychiatrists are liable because the FCA covers people not only if they submit false claims, but also if they "cause" false claims to be submitted. Psychiatrists cause false claims when they prescribe non-covered

psych drugs to Medicaid recipients.

That Congress restricted payment for off label prescriptions is being vigorously disputed by defendants such as WalMart in PsychRights big Medicaid Fraud case, *U.S. ex rel PsychRights v. Matsutani, et al.*, against 32 defendants, including psychiatrists, mental health agencies, state officials, and other pharmacies. However, the Department of Justice, in the settlements it has extracted from Pfizer over Geodon, Astra-Zeneca over Seroquel, and Eli Lilly for Zyprexa are based on such off-label prescriptions constituting Medicaid Fraud.

PsychRights has developed a Model Complaint for people around the country to sue not only psychiatrists, but also pharmacies, which have enough money to make lawyers interested in pursuing these cases. The Model Complaint is designed for former foster youth to sue their psychiatrist(s), but can be adapted for use by anyone with non-public information about offending prescriptions, such as parents, mental health workers, educators, i.e., ICSP members. We are optimistic PsychRights' Medicaid Fraud Initiative will be extremely effective at putting the brakes on the practice of psychiatrically drugging children once psychiatrists realize they face financial ruin by continuing the practice. We will be reporting more on this in the next edition of the ICSP Bulletin, but for now, more information is available at <http://psychrights.org/Education/ModelQuiTam/ModelQuiTam.htm>.

#### **Further Reading**

- Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course, 25 Alaska L. Rev. 51 (2008), <http://psychrights.org/Research/Legal/25AkLRev51Gottstein2008.pdf>.
- How the Legal System Can Help Create a Recovery Culture in Mental Health Systems, <http://psychrights.org/Education/Alternatives05/RoleofLitigation.pdf>.
- Report on Multi-Faceted Grass-Roots Efforts To Bring About Meaningful Change To Alaska's Mental Health Program, <http://psychrights.org/Articles/AKEffortsRevMar08.pdf>.

# I am the oppressed and the oppressor

God grant me the strength to accept the people I cannot change  
The courage to ride my bike through the night in the rain  
And the wisdom to face my pain and keep my palms open to the oppressors  
I seek to build and to grow, to share my story with those causing my  
distress hurt  
I want to keep my mind open to my own role in expanding the world's desert  
Of those who have less, of those we repress through our own ignorance  
I want to never stop learning, keep my own joy alive and burning  
Wake people up, say enough is enough, it's time to decide  
We're all on the same side its not about yours or mine  
Or what we can grab as this world starts to ebb away  
Having the courage to say we all need a space to seek our own version of grace  
Which is what I need to get through today what we might need to save  
And create a future, to listen to our torturers  
To hear all those living on the scorched earth  
To find another brother working together listening to one another  
To share in the next steps to demand redress to keep bearing witness  
And the trick of all this is how to keep from closing my fist.

- *Corinna West, MS, CPS*



In addition to writing poetry and mastering judo, Corinna (left) of Kansas City, Kansas, is an avid cyclist and motivational speaker.

She is also Creative Director for Human Hand Wordworks. To learn more about her, check out her website ...

[www.corinnawest.com](http://www.corinnawest.com)

# **“Despite the Slaying”: The Reality of Psychosis, Mania and Crime**

**by Maria Mangicaro**

Florida Criminal Defense Attorney John Musca gave this account in his July 22, 2009 criminal defense blog regarding the connection between violent criminal behavior and psychiatric medications:

According to January 1999 national news reports, ten days after Ryan Ehliis, a college student in Bismark, North Dakota, began taking Adderall to control his Attention Deficit Disorder and to help him with his college studies, he slipped into a psychotic fog, shot and killed his infant daughter, then shot himself in the stomach. He said God told him to do it.

The criminal court found Ehliis innocent after testimony by a psychiatrist and by Shire US, Inc., that the “psychotic state” was a very rare side effect of Adderall use. Various doctors testified Ehliis suffered from an “Amphetamine-Induced Psychotic Disorder”. (DSM-IV Code 292.11)

Medical experts and Shire US, Inc., the manufacturer of Adderall, commented that “despite the slaying, Adderall remains a safe and effective drug for controlling AD/HD.”

In a later civil court case, the United States Court of Appeals, District Court of North Dakota, affirmed the lower court's decision to dismiss a lawsuit brought by Ehliis against Shire. Ehliis contended Shire knew Adderall could induce psychosis and failed to adequately warn of the associated risks and side effects. The court ruled the “learned intermediary doctrine” barred the claims of failure to warn.

This doctrine provides that a pharmaceutical manufacturer has a duty to warn a physician of the risks involved with a drug, and the physician acts as a “learned intermediary” between the manufacturer and the patient. “Thus, a warning to the physician is deemed a warning to the patient; the manufacturer need not communicate directly with all ultimate users of the prescription drugs.”

The treating psychiatrist for Ehliis stated he (1) knew substance-induced psychosis was “within the DSM-IV,” meaning diagnostic criteria exist for this condition, regardless of the psychosis was caused by stimulant or other medication; (2) was aware some people can become psychotic without overdosing on certain medications, including Adderall; (3) knew the risks of psychosis was listed and identified in the package insert as a side effect for Adderall when he prescribed Adderall for Ehliis; (4) believed the statement in the insert was accurate; (5) continues to prescribe stimulant medications for adults since the incident involving Ehliis; and (6) continues to prescribe Adderall, because Adderall is a good medication.

Ryan Ehliis was found not guilty because the criminal court found the medication Adderall was responsible for his psychotic state of mind. Other individuals have not had access to the truth that psychiatric medications can be the cause of murders and suicide.

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Kim Crespi is a member of ICSPP and has attended the Annual Conferences

for the past two years and is planning on attending this year as well. She is a strong victim's advocate as her husband, David Crespi, is currently serving two life sentences in North Carolina for the killing of their five-year-old twin daughters in January of 2006.

On the day of the tragedy, David was under the care of a psychiatrist and was attending counseling sessions with a therapist for anxiety. He was medicated on a cocktail of sleep aids (Ambien for 3 weeks and Lunesta for the night before the tragedy) and anti-anxiety medication (Trazadone for 3 weeks) and 7 days of Prozac after weaning from Paxil only months before. They were not advised by the psychiatrist of the risks associated with SSRI withdrawal and were not aware that David could be experiencing withdrawal effects for 6 months to 2 years after the medication was stopped.

Upon arrest and under the care of the State of North Carolina, David was further medicated with an antipsychotic medication (which one is unknown to Kim), an antidepressant (Lexapro) and a mood stabilizer (Lithium). David, in this further drug induced state, entered into a plea agreement of Murder due to the threat of the death penalty within 6 months of the tragedy.

“We were not warned of devastating harmful side effects of these medications, nor were David or this family warned of the possibility of psychosis or even what psychosis looked like and definitely not the uncontrollable, unpredictable and possibility danger-

ous outcomes of psychosis.”

Kim knew immediately that the medication had to be the problem but that truth was ignored by the lawyers and mental health professionals brought in for the case. Kim was not even allowed to talk to the psychiatrists who evaluated David for the criminal hearing. It wasn't until 2008 that Kim found some key publications that brought to light the truth as she knew it. David remained drugged and spell bound for 2 ½ years in prison after the tragedy. Kim and David participated in key media events (The Oprah Winfrey Show, 20/20 and People Magazine) where medicated spell bounded and brain disabled David was supportive of the doctor's medicating him as a Bipolar patient even though he had never been called that prior to prison and the psychosis that took the lives of his daughters.

The truth began to surface for Kim with the publication of Dr. Tim Scott's book, "America Fooled." It was through an email to and then from Dr. Scott that Kim was directed to read Dr. Peter Breggin's work. The 2008 publication "Medication Madness" provided the best initial source of explanation for David's actions. Kim learned of the possibility of "drug-induced psychosis" and read the many stories outlined in the book which were similar to theirs. She also learned of the ICSPP conference and made plans to attend. Through ICSPP and the professionals involved, Kim became further aware of the realities of "drug induced psychosis" and similar cases like Ryan Ehliis. Kim has created a web site to support her mission of victim's advocacy. You can find the information at <http://www.crespifamilyhope.com/>

Her online story levels criticism at doctors, who she believes mistreated her husband's mental state, and prescribed medication she believes led him to a violent psychotic episode the day he stabbed his daughters to death. Why did a loving, soft-spoken, gentleman, who was never violent a day in his life, basically one day kill the people he loves most?"

"Why wouldn't we ask why?"

"For society?"

"Why leave it at the fact that he killed our two little girls?" she asked.

David has safely withdrawn from all psychiatric medication in prison and per Kim, is now back to his engaged, brilliant self. He daily feels the losses brought to him by misguided treatment, devastating medication and psychosis. The layers of loss to the Crespi Family continue with the punishment of David in prison and misunderstanding by the community. The family continues to work and hope for justice and continues to educate all of the dangers of these drugs.

At the 2009 ICSPP Conference, I had the opportunity to meet Kim while she passed out lighted pens with the <http://www.crespifamilyhope.com/> website printed on them. Kim impressed me as an amazing woman, with God's gifts of hope, faith and love as she openly and honestly shared her family's story.

After listening to the unedited 911 call David Crespi made that day, it is clear that the operator immediately recognized a medication was involved in David's

psychotic state. During the 12 minute conversation the operator repeatedly asked David if he was on any medications. She even pointed out that he was on a new medication.

The fact that David Crespi was 45 years old at the time of the incident and had no prior history of a primary psychotic disorder, should have alerted clinical evaluation to the possibility of a Substance Induced Psychotic Disorder (DSM-IV Code 292.11). The reality of drug induced psychosis was tragically disregarded by the professionals involved in this case.

Despite the tragedy, Kim Crespi finds hope in many places like in the words of the song "The Call" as the truth just keeps getting louder and louder. Thanks to the new friends joining together at ICSPP...light is shining in the darkness.

"The Call", by Regina Spektor from the Chronicles of Narnia Soundtrack has special meaning for Kim and her family and is posted on the ICSPP Online Blog.



Kim and David Crespi.

(Photo courtesy of Kim Crespi.)



# THE PSYCHOUT CONFERENCE IN TORONTO

By Al Galves, Ph.D.

It was a diverse group of people – young, old, academics, students, disabled (some more obviously than others), survivors, transgendered, gay and lesbian, old hands, newbies, victims, users, consumers, ex-patients. It seemed to me that the one distinguishing characteristic was comfort with the states of being that lead people to be diagnosed with “mental disorders”. They weren’t much put off or afraid of those states. They didn’t see them as alien or shameful. Most had come through them with a greater appreciation for the vagaries of human experience and for the value of periods of despair, unfocused rage, discomfort, confusion and pain. They had survived and received the gift of compassion for others who had gone through or were going through the same.

They came together in Toronto on May 7 and 8 to a conference entitled “Organizing Resistance Against Psychiatry”. Here is what I saw and heard.

The group was heavily weighted with feminists, gays, lesbians and transgendered persons. That gave me an opportunity to learn more about their grievances against psychiatry. I learned that they see psychiatry as part of the patrimonial, corporate, co-opted state power elite that oppresses women, people of color, people who are different and people who don’t share the elite’s values and don’t want to cooperate or comply with them. I detected the influence of Foucaultian,

post-modern deconstruction, an antipathy towards “neo-liberalism”, a term I had not heard before.

This group which was comprised largely of women and young people sees no value in focusing on individual victims of oppression. For them, to focus on individuals is to ignore the fundamental cause of the harm that is being done – an oppressive social or



Al Galves (left) was presented with ICSPP’s Lifetime Achievement Award in 2007. Here, Al is handed the award by then Executive Director, Dom Riccio.

(Photo: Andrew Crosby)

der which hurts people and finds all kinds of ways – including psychotherapy and conventional academic discourse – of obfuscating that crime and portraying its victims as deficient and worthy of at least being marginalized. So it doesn’t make sense to spend much effort on helping individual victims and whatever way they find of coping is OK even if it hurts them and others. To classify any coping mechanism – including drugs, self-harm and even practices that hurt others – as a defect or pathological is to blame the victim and give the real perpetrators a pass. This was also the position of

young people at the conference who are understandably upset that the “criminological” approach to dealing with deviant young people is being replaced by a mental health approach which is erroneously considered to be more humane and less oppressive.

I found myself thinking that this position is extreme, unreasonable and irresponsible. Is it really OK to ignore the need to help individuals who have been hurt by social oppression? It doesn’t make much difference why they are hurting. They are hurting and are worthy of being helped. The idea that focusing on them is to blame them is ridiculous. They didn’t choose their parents or their early experience. And their later experience is a function of their early experience. At one point I

said: “I understand that social forces do great damage to people. But there are many young people who have been hurt to the point at which they are hurting themselves, jeopardizing their lives, hurting others. What do you think should be done to help them?” The immediate response was to reiterate the fact that this damage was done by social forces and that is where we should focus our attention. That was followed by what I thought was a more reasonable response – the problem is that the help au-

thorities never ask young people what kind of help they want, what would “work” for them.

Other thoughts crept in:

- This is what happens with all movements. They take extreme positions to make the point clearly. They avoid the nuances and complexity of reality. Remember the Marxist dictum that everything is a function of who owns the means of production. Well, that’s obviously untrue but it won’t help to parse language



and use words like “some”, “often”, “in some cases”. That clouds the issue too much. According to dialectical materialism, this position is a thesis which will be countered by an antithesis and be transmuted into a synthesis. So it has some value and its extreme nature contributes to that value.

- After all, I am a representative of the patrimonial, corporate power elite that oppresses women, queers and youth. I have an Ivy League degree, a professional credential. I live in a nice house in a nice neighborhood. Life is good.

- If we describe psychiatry as the medical model which sees symptoms as the result of chemical imbalances, genetic dynamics and biological phenomena and treats them with drugs, electroshock and other psychosurgery, I agree. That is definitely part of the oppressive system and should be eliminated as quickly as possible.

- These are young people. Remember when you were their age you thought that, in order to realize true equality of opportunity, all children should be raised in cookie-cutter boarding homes. Remember Winston Churchill's line: anyone under 35 who isn't a radical doesn't have any heart; anyone over 50 who isn't a conservative doesn't have any brain.

So what do I come away thinking? The position of the feminists and youth at the conference is way too extreme. I can't go along with not helping individual victims because that takes the focus away from social oppression. I don't agree that any method of coping, no matter how harmful to self or others is OK. I hate the idea that, if we focus on helping victims accept the fact that they are responsible for their recovery, we are “blaming the victim”. And I agree that the fundamental causes of hardship and human suffering are social forces which we should and could do a much better job of confronting. I can see how people would regard the practice of helping individuals adapt to a flawed and oppressive social order as futile and an obstacle to progress. But it's not futile or harmful to the individual who is being helped.

In her keynote address, Bonnie Burstow, a professor of adult and community education at the University of Toronto and the main academic sponsor of the conference, described her model for abolishing psychiatry. It's an attrition model, she said, acknowledging that we're up against a powerful foe which seems to be winning at the moment. It's going to take years and years of biting away at the edges, exploiting chinks in the armor, fighting rear guard actions, bits of sabotage. It reminded me of the collapse of the Soviet Union. That seemed to happen quickly, all of a sudden, in the late 1980's. But the seeds had been sown fifty years before and watered and cultivated over the years through private conversations in bedrooms and living rooms and the occasional acts of dissidents.

She listed three questions which could be used to decide what to support and what not to support:

1. If successful, will the action or campaign being contemplated move us closer to the abolishment of psychiatry?
2. Is the action or campaign likely to improve or give added legitimacy to the current system?
3. Does the action or campaign avoid widening psychiatry's net?

As examples of actions which she had supported but wouldn't on the basis of these questions, she listed:

- Working for the removal of noxious diagnoses in the DSM;
- Advocating for culturally sensitive psychiatric services.

Both of these have the effect of improving the quality of psychiatric services, she explained, and in so doing don't contribute to the abolishment of psychiatry.

She listed actions which don't pass the test of the three questions:

- Sitting on boards and commissions designed to improve psychiatric services;
- Improving psychiatric services with programs such as Assertive Community Treatment.

And then some which do:

- Directly suing the state, hospitals and providers for damages;
- Challenging the constitutionality of laws which support psychiatry;
- Moratoria on the construction of hospitals and other psychiatric facilities;
- Cutbacks in public funding of psychiatry;
- Supporting human rights initiatives;
- Supporting non-psychiatric psychotherapies;
- Consciousness raising;
- Foundational critiques;
- Attacks on certain treatments.

As an example of an action which had been questioned by the anti-psychiatry movement but which should be supported wholeheartedly, she mentioned the ban on electroshock for people under 16 years of age. She understood the reasoning that supporting such action implies support for electroshock for other people but concluded that banning it for any group was a step in the right direction, a bite at the edges, and could then be expanded to include other groups.

Burstow made a plea for participants at the conference who represent different positions to look for common ground on which to collaborate rather than emphasize the differences which divide us.

As I listened to Burstow, I was engaged in my usual practice of looking for reasons to disagree – a nasty symptom experienced by people whose egos were wounded early in life. If by psychiatry she is including all efforts to help people love the way they want to love and express themselves the way they want to express themselves, I'm not in favor of abolishing it, I thought. But as her talk went on, she appeared to be defining “psychiatry” as the medical model which regards “mental disorders” as brain-based diseases that are properly treated with drugs and psychosurgery. I can get on board with abolishing that, although it's going to take years and years of attrition for that to happen.

In the plenary session which closed the conference, the participants, after a couple of hours of deliberation, adopted a resolution calling for a ban on the public funding of electroshock in Ontario – period. The main issue was whether or not public funds should be used to support electroshock for people who wanted it. Eventually, people who argued that there is no such thing as “informed consent” for electroshock won the day.

My libertarian streak has a problem denying electroshock to people who want it. But, as David Oaks points out, they can have it if they pay for it themselves or find some private source to pay for it, a feat which will be easy to pull off in the United States. I like the distinction that David makes between eliminating electroshock (which I support) and banning electroshock (which I don’t think will work very well).

One of the Toronto newspapers covered the conference. The paper ran a story that was dismissive of participants as “self-absorbed crack-pots”, gave lots of coverage to opponents and focused most attention on one of the participants who killed his 11-year-old son while on psychotropic drugs. Another example of mainstream media

supporting the biopsychiatric belief system. David Oaks again has an answer. We need to be our own media. With the internet, You-tube, Facebook, Wikipedia, we have an opportunity to do that and need to take advantage of it.

Other highlights of the conference were:

- A rousing, inspiring opening address by David Oaks in which applause erupted when he said the biopsychiatric perpetrators should be imprisoned and we should reform the prisons while we’re at it. David made his usual plea for revolution not reform, for civil disobedience and “shutting down the system” and identified the 2012 American Psychiatric Association annual convention in Philadelphia as the next best opportunity to do that;
- Some focus on the United Nations Convention on the Rights of Persons with Disabilities as a tool for opposing forced treatment throughout the world. The UN is considering the inclusion of forced psychiatric treatment as torture and there is a possibility that Amnesty International will take it on as such.
- The litany of reports by participants of harm from biopsychiatry fol-

lowed by cover-ups, official stonewalling, lies, doctored records, obfuscation, etc and claims that it’s the “disease” that’s at blame;

- A tribute to Judi Chamberlin, the American activist who died earlier this year;
- A lifetime achievement award to Don Weitz, a long-time Toronto activist;
- A wonderful group of young people who did a great job of staffing the conference.
- Flawless sound and video technology;

I went to the conference thinking I would connect with some allies and pick up some ideas on how better to eliminate biopsychiatry. I’m glad I went because I was impressed with the intelligence, energy and commitment of the participants and it gave me a better view of the landscape of the anti-psychiatry movement. But I didn’t gain much in the way of strategic approach – except to keep plugging along.



After accepting his award, Al demonstrates his chiropractic expertise on an unsuspecting Riccio. (Photo: Andrew Crosby)



Al with pediatrician, and fellow board member, Karen Effrem, also at the 2007 conference. (Photo: Robert Sliclen)

# PSYCHIATRIC NURSING

By D.C. Kirk

I'd started looking for a job in Michigan; within a month I had expanded my search to surrounding areas that turned out to be as economically depressed and lacking in job possibilities as the county in which I lived. Salaries were so low I wondered to myself how people managed to keep body and soul together. One nursing job offered \$20 per hour, far less than what I'd made almost two decades previously. I was frightened, and as the bills piled up I accumulated stacks of newspapers to comb through employment ads each Sunday. My husband was gone only a few months by then, and I was still grieving mightily over his death, but my fear of financial ruin drove me to keep looking for a job.

I graduated from nursing school at the age of 37. It was my way out of a miserable first marriage. Though I eventually went on to get a master's degree in counseling psychology, I never gave up my nursing license. I'd been proud of the accomplishment and hung onto it more as a reminder of my own ability than from any thought that I'd ever again be employed as a nurse. I could not have predicted that my nursing license was destined, once again, to be my way out of a bad situation.

Though I'd been practicing as a LPC (licensed professional counselor) in Michigan for years, I couldn't continue that career after Michael died. Many insurance companies don't reimburse for services performed by a master's level counselor unless they're supervised by a doctoral level psychologist, and I'd put my new office building on the market for sale in an effort to relieve myself of the mortgage payments that I couldn't afford. My options were to look for sustaining work in Chicago as an RN or to limp along financially as a counselor without an office. So, I renewed my CPR certification. After more than 15 years, I was going to be a nurse again.

I'd first found my niche as a new RN in psychiatric nursing at a large teaching hospital in a suburb of Chicago.

It was while I was there that Michael and I had formed the friendship that eventually blossomed into marriage. My experience as a registered nurse was almost exclusively in psychiatric nursing, and it was too late to try for another specialty. I didn't have time to train all over again.

I drove into Chicago for interviews, getting lost with such regularity that I had to allow myself an extra hour to find my way in unfamiliar neighborhoods. At one psychiatric facility where I interviewed for a job, I made the observation that one couldn't tell the staff from the patients, so poorly were the staff members dressed in baggy jeans that revealed their underwear, t-shirts with rock band logos and heavy chains hanging from their pockets. The nurses behind the desks looked like they were counting the minutes until they could escape. Who could blame them? The director of nursing was a woman whose primary focus was on her long curly blonde hair; we talked for the better part of an hour while she constantly fluffed her hair, readjusted what fell on one side or the other of her part, and shook her head to toss yet more hair out of her face. I wanted to loan her some barrettes and noted with satisfaction that she had a huge behind.

***"The nurse's job is  
to make sure all the  
blanks are filled in  
and the form is  
signed. No matter  
that the forms are  
not read."***

Friends who were not at all familiar with the economic climate that existed in Michigan were baffled that I read the

want ads every week and reported to them that I'd found not one ad for a psychiatric nurse. The economic downturn, as they came to call it on television, had already hit and hit hard. I called it the Second Great Depression. Real estate wasn't selling, and my realtor was beginning to sound uncomfortable with my weekly inquiries. Well-meaning meaning friends and relatives who lived elsewhere in the country suggested that I volunteer at the "local mental health center," that I find some wealthy vacationers to rent my home, that surely there must be work of some kind. As I watched my bank balance dwindle to a frightening number, I thought to myself, "I'm not ready to ask, 'Do you want fries with that?'"

I'd sent an application to a small hospital in Indiana. About a week later, wanting to know if the advertised position had been filled, I called the human (read "Inhuman") resources department.

"Good morning. I am calling to find out if the position advertised in the Tribune has been filled."

"You lookin' for a job?"

"Yes, I am."

"Well, the nurse recruiter don't take no phone calls!"

I'm not really advocating violence, but with all the jokes about people going postal, I want to ask, what terrible thing did a post office ever do compared to the tortuous experience of submitting one's desperate hopes to a callous human resources department?

When I finally found a job, it wasn't the one I wanted, or the one I thought myself to be best suited for, but it was a job and it would pay my bills, at least some of them. I was hired as a psychiatric nurse at a hospital in Chicago, not far from Lake Michigan. The nursing supervisor who hired me was someone I'd known years before when I worked at a suburban hospital prior to the move Michael and I made to Michigan. I hadn't known her well, and if I had, I think I would have run the other way. I subsequently found out that she'd been fired from several management positions before she came to the hospital where she hired me. Inappropriately cold and sarcastic, habitually sucking up to the medical director,

lazy and unwilling to acknowledge obvious problems on the unit, she created an atmosphere not unlike the Gulag where people must voice the party line and only the party line, despite all evidence pointing to the contrary.

It had been years since I'd been in a hospital setting. Things had changed. The completion and signing of forms now occupies more than seventy percent of a nurse's day. Each patient has numerous "flow sheets" that must be completed; the nurse's job is to make sure that all the blanks are filled in and that the form is signed. No matter that no one can read the writing on the forms; that they are filled out appears to be of utmost importance. No matter that the information on the forms is not read. That is, unless there is a lawsuit, which is always the driving force behind the creation of the excessive and repetitive documentation. The oft-repeated mantra for nurses is "If it isn't documented, it isn't done." It means that in a court of law, the assumption would be that unless a task has been documented, there is no proof it has been done. So, when a doctor is called to report that a patient has a fever, there must be documentation that the call was made. If the patient refuses his or her medication, the nurse must notify the doctor in writing. Nothing is left to mere verbal exchange; the result is that nurses hurry out of their station, spend approximately 90 seconds with a patient, then hurry back to chart on every aspect of the ninety-second interlude, which takes them twelve minutes or more, depending upon how many physicians are standing at the desk in learned helplessness asking the nurse to hand them a chart that is eighteen inches away from their manicured doctoral hands.

Shortly after I started working on the unit, I noticed that observation of patients, which was supposed to be every fifteen minutes, was not consistently being done. Nurses and counselors alike, who were responsible for making the observations, were documenting on a form that they'd done the rounds, but they hadn't; the reality didn't match the documentation. I sat down to talk to the nurse manager and told her what I'd observed.

She narrowed her eyes and said,

"Of course they are."

It was clear to me that the pursuit of my concern was going to get me nowhere, and we moved to other subjects. I came to regret that I didn't push the issue, but my survival as a nurse depended upon acquiescence, and I had already learned not to point out the elephant in the room.

I'd been there for over a year when there was an outbreak of bedbugs on the unit. I recognized the problem easily enough when one patient after another came to the nurses station covered with multiple insect bites and complaining of a mad itch. I approached one clinician after another to share my concern about the infestation of bedbugs. About a week later, the nursing supervisor sauntered into the room of one of the afflicted patients, peered at the mattress and declared that there were no bedbugs. The outbreak continued, and I told the medical director, the nurse educator, every nurse with whom I worked, and I told physicians. Still, nothing happened other than the writing of numerous prescriptions for calamine lotion for the patients' itches. That is, until the Illinois Department of Public Health was expected to visit as a result of what they call a "sentinel event," meaning that a couple patients on the unit had been found dead.

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***"The death of a patient is tragic, even for nurses who have become emotionally detached."***

All of a sudden, the supervisor, who'd had no interest whatsoever in my concern about bedbugs, was issuing orders for the unit to be painted, for exterminators to visit, and on one frantically busy morning, for one of the nurses to spend hours stapling a flowered border around each of the numerous bulletin boards on the unit while the rest of us scrambled madly

to pass medication and calm manic patients. All this, to properly impress the inspectors that were coming and to convince them that the unit was being appropriately managed. I could just see it in the "requirements" section of a book listing expectations of the Illinois Department of Public Health for psychiatric facilities: An alphabetical listing that includes "Bulletin Boards, Flowered Borders."

The death of a patient is a tragedy, even for nurses who have become emotionally detached as a result of burnout. Two deaths occurred within a short time while I was at that hospital. The first death appeared to be of natural causes, but I cannot help wondering about the psychotropic medication he'd been taking and what effect it had on his heart. The patient had been admitted for psychiatric reasons, but he had been HIV positive for years, and I think it had taken a toll on his body. He had clearly been dead for some time when a staff member noticed that he wasn't breathing. Efforts were made to resuscitate him, but they were futile. It's hard to perform CPR on a body already stiff from rigor mortis. Though the standard of care had required staff to check on each patient every fifteen minutes, it was apparent that the checks had not included observation of his respirations. Blame and recrimination was spread around generously by the manager I'd talked to about fifteen minute observations, and people were fired after that incident. Numerous meetings were held with the goal of emphasizing that observation of respirations was an important part of the fifteen minute checks.

The second death was the suicide of a man who hung himself in the bathroom. I wasn't there that day, and hadn't known the patient, but the event resonated with everyone who worked there. Each one of us asked ourselves if there was something, anything, that could have prevented the suicide.

Administrators decided to paint the unit, initiate efforts to appropriately monitor the patients, create flowered borders on the bulletin boards, and fire the nursing manager along with a few hapless counselors. A few nurses quit; they'd had enough. The hospital would continue to run the

lucrative unit.

Accredited hospitals are inspected at least once every three years by agencies whose job it is to make sure that care of the highest quality is being provided. The inspections are very detailed, and the visits from these agencies are anticipated with anxiety, some trepidation and redoubled efforts to make sure everything in the hospital, including patient care and the facility itself, conforms with rules, regulations, standards and expectations. An entire team of inspectors will often spend a week pouring over documentation of patient care, checking to ensure that protocol is being followed for the benefit of patients. For months prior to these visits, there is heightened vigilance as staff is urged to review policies, to correct deficiencies, to clean up in every way so that the hospital will pass the inspection in order to maintain the coveted accreditation. Purses are removed from under the sink in the medication room, doors usually open for easy access by nurses are closed and locked, medication is locked away and floors are scrubbed with vigor. These visits are anticipated with heightened awareness regarding the correct completion of documentation, and nurses are exhorted daily to review charting in an effort to avoid any fault-finding by the team of inspectors. Everyone spends at least a week memorizing the location of fire extinguishers, disaster plans and the latest mandates about correct identification of patients. The visits of the inspectors put everyone into near frenzy as the anticipated site visit draws near, and when they arrive at the hospital with clipboards and briefcases in hand, e-mails are sent out to every manager notifying them of the inspectors' presence. Tension mounts, and everyone works in a state of heightened vigilance until they finally leave. There is a collective sigh of relief, and then another e-mail goes out to every department in the hospital thanking everyone for their cooperative efforts in preparing for the Joint Commission's "unannounced visit."

There are psychiatric facilities and then there are psychiatric facilities. The one I worked at held patients who were all said to be suicidal. The primary reason for this claim is that insurance companies will provide reimbursement only if a psychiatric patient is a danger to himself/herself or to others. So, of

course, the admitting psychiatrist cites suicidal ideation (or, rarely, homicidal ideation if the patient has been aggressive) as one of the admitting diagnoses. The truth is that many of the patients were homeless and were no more suicidal than anyone in the general population, but they'd learned that the system requires them to claim otherwise in order to ensure the provision of three meals a day and a warm place to sleep. This, of course, was particularly true in the winter months and each month when their money ran out prior to the mailing out of their social security checks. Almost all of the patients had a history of dozens of psychiatric hospitalizations, some as many as seventy, and they knew all the medical lingo.

Some would demand, "I want my PRN Norco STAT." And they got their addictive drugs STAT; this is the system our society has created.

The answer to the problem of what should be done to promote the health and well-being of those with severe and chronic mental illness is complicated. Resources are limited because mental illness is still, despite decades of effort by such groups as the National Alliance for the Mentally Ill, (now renamed the National Alliance on Mental Illness) considered to be an illness that is embarrassing and shameful. Most people would rather say that they have rectal cancer than admit to having a mental illness.

---

***"No psychiatric unit  
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has ever had a  
psychologist on  
staff."***

Homelessness and mental illness often go hand-in-hand (although the economic crisis of the past few years has certainly served to alter statistics on such co-existing problems), but most Americans are happy to continue believing that homeless people are

undomiciled because they choose to be so, and that the mentally ill are sick because they simply haven't pulled themselves up by their own bootstraps.

What's more, the treatment of these patients typically consists of side-effect-causing medication and then more side-effect-causing medication for treatment of the side effects, all with no corroboration of diagnoses by psychological testing and only the vaguest semblance of group therapy. Staffing is often so minimal that there was no time for 1:1 interaction excepting the mandatory questions asked by nurses who administer medication: "Is your headache improved? How would you rate your pain on a 1-10 scale now?"

In my recent years of working on an inpatient psychiatric unit, I have known of only two patients who had the benefit of psychological testing. Any inquiries or statements I have ever made about the benefit of testing have been met with disinterest and even disdain. I suppose, given the medical model as it is practiced in most psychiatric facilities, that makes sense, because regardless of the diagnosis, medication appears to be the primary answer. No psychiatric unit where I have been has ever had a psychologist on staff. This is the reality of the "medical model" of treatment for mental illness.

EPS, extra pyramidal symptoms, are neurological side effects from antipsychotic medications. It was not uncommon to see patients stumbling and shuffling around, sometimes drooling or suffering from involuntary movements, often sleeping day and night, their personhood having been robbed of them by the powerful chemicals coursing through their nervous systems. Our society has no place for the chronically severe mentally ill; they are homeless or, if they are lucky, they are placed in care facilities called "group homes", where they continue to receive medications that keep them dull and lifeless. A number of them are regulars at the hospital; staff members know them well. In and out of this hospital, then another, and another, then back to the first one. This is the way our tax dollars are spent. Nurses in larger hospitals are now expected to aspire for their hospital to achieve what is referred to as "Magnet" status, a designation that is not unlike a 5-star rating for a restaurant. It is supposed to certify

that excellent patient care is the top achieved priority and that all the nurses are happy folk who meet regularly to engage in dialog with supportive supervisors and administrators. Hospitals all over the country are now madly at work creating committees in order to be so designated, and as soon as they can, they'll be claiming the status. But it will not mean better working conditions for the nurses because short staffing, arrogant physicians, head-in-the-sand administrators and impossibly long hours spent filling out forms will still be the real story.

Where I worked, one of the psychiatrists sometimes made loud racial comments as he was walking down the hall; staff and patients alike would cringe.

The medical director was observed laughing with the unit secretary at a letter written by a patient who was pleading for a transfer of her care to a different psychiatrist. The psychiatrist that the patient wanted to fire was well-known for dialogue with his patients that was nothing short of abusive and coercive. He regularly got into power struggles with patients by insisting that they accept the long-acting injections of antipsychotic medication that they did not want, threatening that they would not be discharged unless they took the medication.

The problem was that the director of the unit was loathe to facilitate the wishes of the patient because her psychiatrist brought in a lot of money to the hospital by sending patients from nursing homes far and wide. In short, the only way a patient could get a change of psychiatrists was to plead with the fox that was guarding the henhouse. I had read the letter myself and found nothing in it that was uproariously funny; I guess a patient in emotional pain can be entertainment if that's where you're coming from.

The psychiatrist baited nurses constantly, and wrote his orders in a scribble that created hours of extra work as attempts were made to read them. If he had feathers, he would have preened when nurses asked him constantly for clarification of his written scrawls. This was a doctor who screamed, "Don't interrupt me!" when I told him I couldn't hear an order he'd given on his cellphone while in

traffic with his car windows down. What do you do with a crazy man like that when your job pays the bills?

Then there was the psychiatrist who was clearly manifesting symptoms of heavy drug use; nurses would call him for orders in the mid-afternoon and he'd complain with slurred speech that he'd been awakened from a nap. Sometimes, he'd simply not show up to see his patients. He frequently would fail to answer his phone for days at a time. This went on for years until he outdid himself with a particularly long absence. The funny thing was that no one ever validated the existence of the problem as nurses reported the difficulties they had with this doctor; he simply never came back to the hospital, and another psychiatrist took over the care those patients. No announcement was ever made that Dr. X wasn't going to return; the elephant in the room was huge and not once was it acknowledged, except by patients who missed their source of easily written prescriptions for addictive medications. To this day, other psychiatrists continue to refer patients to him. I imagine the referrals serve them well.

---

***Her psychiatrist  
slowly looked up,  
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asked, 'What could  
possibly be the  
benefit of that?'"***

One of the things that amazed me is that most of the patients are deemed to have miraculously healed from their mental illness exactly on the date their insurance runs out. That, and the fact that a number of the psychiatrists managed to refer the patients to themselves for psychotherapy. Never mind the blatant disregard for the ethics of self referral. That didn't stop them. They hired a herd of therapists who worked for them and farmed the patients out to their employees, taking a major cut of

each insurance check for each visit until, you guessed it, the insurance ran out.

Medication and more medication was the essence of the treatment. Several times daily, nurses would line up to use the machine that held pills, capsules and syringes full of mind-numbing medication. It often took at least thirty minutes for each nurse to assemble the various drugs for his or her assigned patients. It wasn't unusual for patients to refuse the medications, but those brave souls paid a price with threats from their psychiatrists that they would have to remain in the hospital until they agreed to bare their behinds for the injections of long-acting antipsychotics or to swallow the pills. They almost always gave in.

There has been a national imperative for all psychiatric facilities to reduce the number of restraint episodes. It was the driving force behind numerous lectures on the safe application of physical force for aggressive patients. We practiced safe holds and became certified by the Crisis Prevention Institute, a company that brilliantly markets their strategies for intervention with aggressive patients. I was all for it, since the sight of a human being strapped to a bed is nothing short of horrific. Patients have died while in restraints, and I can only imagine the emotional trauma of such physical intervention. Psychiatric facilities have, in large part, been successful in reducing the frequency of restraint applications, and that's a good thing. But the use of such restraints has only increased the alternative use of chemical restraints, the forced administration of powerful drugs that alter the chemistry of the brain. Forcing medication, almost always with injections, is an ugly event. It often takes as many as four or five people to hold the patient down while the nurse gives the injection.

What's more, it is not unknown for psychiatrists to suggest to staff that they should provoke a patient to the point of aggression in order to justify the administration of drugs by injection. Such provocation, when it ends in the unwanted administration of medication, is considered to be therapeutic. Taunting, the enforcement of ridiculous rules, and harsh directives

are among the favorite methods of provocation by staff members who appear to have an inclination toward sadism.

Occasionally we had a patient with an eating disorder. I recall one woman in particular who refused all food and drink for days. Her lips and tongue were dry and a check of her skin showed clear evidence of dehydration. She refused to get out of her bed and refused to take any of the medication prescribed for her. She remained mostly mute and was clearly angry at the directive that she must eat. Apart from offering this patient medication that she'd refused, the only therapeutic intervention specific to her eating disorder had been the token presence of a bottle of liquid supplement on each of the meal trays that she had refused. In a staff meeting held to discuss the care of patients, I suggested that she might benefit from being transferred to another hospital where there is a specialty unit for patients with eating disorders. Suddenly, there was stark silence in the room as her psychiatrist slowly and pointedly looked up from the chart in which he'd been writing, glared at me and asked, "What could possibly be the benefit of that?"

"Well," I ventured, "for starters, she could get treatment specifically for her eating disorder." The room remained silent. I looked around the table, my eyes meeting those of nurses and social workers who knew full well that the patient wasn't getting the treatment she needed. I knew I had broken the unspoken rule – never, under any circumstances, acknowledge that the patients are getting anything less than optimal treatment.

Our country has a system that positively invites abuse of insurance benefits, and every taxpayer is footing the bill. That insurance companies pay fewer dollars for D.C. mental health treatment than they do for medical treatment is another travesty. God may help the insured person who has complications from pneumonia or breast cancer, but woe to the millions who suffer from depression, anxiety, or schizophrenia. It remains to be seen whether the Mental Health Parity Act, supposed to take effect January 1, 2010, will make a difference for millions of Americans whose insurance companies have imposed a higher financial cost for psychiatric treatment than for treatment of physical

ailments. The legislation was enacted in order to force insurance companies to provide coverage for mental health on a par with physical ailments.

Nurses grumble and complain to one another, but most of them are sheep-like, accepting the status quo of having no power in the hierarchy of a hospital setting. The hospital where I worked is an institution run by those who long ago endorsed that the world should be run by men or by women who have adopted the demeanor of men. The hostility of the psychiatrists and the arrogance of many of the physicians is accepted and even endorsed with a shrug of the nurses' shoulders on a daily basis. That collaborative relationships among doctors and nurses in a hospital setting could improve patient care does not appear to matter.

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***"I am guilty of  
having encouraged  
women to become  
nurses over the  
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As for nursing management, I never saw any sign that the director of nursing wanted to know what was really going on from her high perch in administrative offices, where she crossed her feet in impossibly pointy-toed shoes under a desk far away from the madness that went on floors below her. Yet, there she was greeting employees early in the morning at the entry door where nurses typically entered the hospital from the parking area. I never quite got the purpose of this greeting by administrators who were never otherwise seen by the nurses who did the grunt work of patient care. Every morning I'd walk through the door to be greeted with a vapid smile and a "good morning" by one of the administrative faces not otherwise seen. I always thought the real message was, "Hey, we're up at 6:45 a.m., too. Aren't we just falling all over ourselves to show

you that we're a team!"

I am guilty of having encouraged several women to become nurses over the years; each one of them now expresses regret that she pursued a career in nursing. I mentored members of my own gender into one of the most sexist occupations that exist (my apologies to male nurses who are unlikely to get the same treatment by male physicians). If I had it to do over again, nursing would be the last occupation I would either choose or recommend. There is a nursing shortage in this country, and it should be no mystery that younger American women, having grown up in a climate of more equality between sexes than I knew as a kid, would eschew the kind of occupation that requires nurses to support the arrogant and capricious behavior of physicians who behave like junior gods.

There are exceptions. I think that every city block in the Philippines must have a huge sign proclaiming that thousands upon thousands of nursing jobs are waiting for anyone who can go to nursing school and then travel to the United States for employment. And, thousands upon thousands of Philippine women have done exactly that. Typically hard working, these quiet and compliant women have become the answer to every nurse manager's staffing needs. Frequently, these are nurses who work 80 hours a week, sending money back home to support the next shipment of country-women who will also work long hours in our hospitals.

I had to pay my bills, so I went to this place five days a week, never failing to think, as I walked past the BMWs and the Jaguars in the physicians' parking area located closest to the hospital, how my life had changed so much that I had become one of the plodders, the underlings, a member of the low-caste group of those whose cars must be parked several stories higher in the parking garage, far from the entrance where I'd be greeted daily with insipid smiles from administrators who remained floors away from what was really going on. I had a job; it was just a job.



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