

ISEPP Bulletin

International Society for Ethical Psychology and Psychiatry, Inc.

"Save These Conference Dates: Nov 13-16, 2014"

2014 - Number 2

What's Inside:

Executive Director's Message

ISEPP Leadership Transition

The Mind is a Terrible Thing to Waste - new Board Chairman

Psychiatry Now Admits It's Been Wrong in Big Ways - But Can It Change? By Bruce Levine

Bert Karon Insight About Suicide

Full Steam Ahead: New Era For ISEPP Bulletin Gets Under Way

The Return of:
All in the Family

Bulletin Staff:

Managing Editor
Dominick Riccio, Ph.D.

Editors
Lloyd Ross, Ph.D.
Robert Sliclen, Ph.D.
Andrew Levine, MSW

New Bulletin Editors And 2014 Conference

Beginning with this issue of the Bulletin, there is a new editorial staff. It will consist of Dominick Riccio, Ph.D., Managing Editor; Lloyd Ross, Ph.D., Feature Editor; Robert Sliclen, Ph.D., Arts Editor; and Andrew Levine, MSW, Technical Editor. There are four co-editors because the Bulletin is an enormous volunteer job that requires much time, effort and coordination. Also we like to work with each other and have a lot of fun banging our heads together.

We want to thank Jill Littrell and her co-editors for the fine job they have done, and Andrew Crosby for the wonderful job he did recreating and reorganizing the Bulletin for many years. Andrew Crosby continues to help with the Bulletin by coaching us from the sidelines. Thanks, Andrew!

If you are new to the International Society for Ethical Psychology and Psychiatry (ISEPP), Welcome! and the Bulletin is one of the benefits of membership. It is ISEPP's way of communicating quarterly with the membership and it is also a way that the membership can communicate with each other. As such, we encourage all members to submit articles, biographies, poems, photos and life experiences to the managing editor, at my email address: djriccio@aol.com. Each issue of the Bulletin will feature communications from our Chairman of the Board, Chuck Ruby, Executive Director, Brian Kean, and past Chairman, Joe Tarantolo. In addition, there will be editorial, scientific, and professional articles. For example,

(Continued on page 11)



Left to right: Lloyd Ross, Robert Sliclen, Dominick Riccio, Andrew Levine

Photo: Andrew Crosby

International Society for Ethical Psychology and Psychiatry, Inc.

5884 Joshua Place, Welcome, MD 20693

email: psychintegrity@gmail.com

website: www.psychintegrity.org.

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

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

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

ISEPP Bulletin Submission Policies

We want the Bulletin to reflect and serve our varied membership and much of what appears in our pages is from the membership. Some items are from outside, however, because we're interested in anything that might interest our readers. Our submission policies therefore are quite simple.

Authors may submit work to the Bulletin while simultaneously submitting to other publications or forums if they choose. Where this is the case, we ask that authors inform Bulletin staff so that our readers may be advised accordingly.

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

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

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 ISEPP'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.

Executive Director's Message

Brian Kean, Ph.D.

The ISEPP Annual Conference held in Greensboro NC in 2014 was a positive successful event with many new members joining the organization. There were also many attendees who were former members of ICSPP who participated in the Conference.

At the Annual Board Meeting in Greensboro several changes to the Board occurred. Dr Bose Ravanel retired from the Board. As Executive Director I would like to acknowledge the great work that Bose has done for ISEPP over many years. Bose played a key role in the organization of the conference at Greensboro and has been active on the Board for many years. Other long term Members of the Board who stepped down included Dorothy Cassidy, Adina Lambert, Andrew Crosby, Jeffrey Lacasse and Larry Plumlee. I thank them all for their contributions to ISEPP over many years. Nominations for positions on the Board were called for and at the most recent Board meeting Ty Colbert was elected to the Board.

As I noted in my address at the Conference Dinner in Greensboro, the Board of ISEPP is a self-electing. Members of the Board nominate potential candidates who are identified through their work and participation in ISEPP. The Board election process is designed to prevent ISEPP being taken over by any external group or organization.

I, somewhat reluctantly, was elected to the position of Executive Director of ISEPP in June last year. In taking on the role I set myself the task of consolidating the organization with a view to expansion over the coming year. The success I will have with this mission will depend on the Executive Committee, the Board of Directors and current members working for ISEPP in a targeted way.

To assist with the mission I have

expanded the ISEPP Executive Committee. The current members are: Chuck Ruby, Ph.D (Chairman of the Board of Directors), Michael Gilbert, Psy.D. (Treasurer & Conference Director), Al Galves, Ph.D. (past Executive Director), Joe Tarantolo, M.D. (past Chairman of the Board of Directors), Robert Slicen, Ph.D. (Secretary & Membership), Noeline Weatherby-Fell PhD (Secretary & Membership), Dominick Riccio, Ph.D.



Photo: Courtesy of Brian Kean

(past Executive Director 2002-2008), Laura Delano.

This year the Annual Conference returns to Culver City, Los Angeles. ISEPP held the first conference under its new name there in 2011. The conference will be held on the weekend of November 14-16. Professor David Cohen, in conjunction with the ISEPP Conference Director Michael Gilbert, is playing a major role in structuring the conference program. The tentative title for the conference is 'TRANSFORMING MAD SCIENCE AND THE MENTAL HEALTH SYSTEM'. David has noted that the conference theme will focus on "*how to effect change*, at any and all

levels of interest. Change from what? From a system fueled by an unsupported disease/medical model and dominated by a psychopharmaceutical-industrial complex supporting and supported by countless institutions, groups and interests". Consider booking your travel early. One of the major expenses in travelling to the Annual Conference is the airfare.

ISEPP this year needs to expand its membership base. JFK once said "My fellow Americans, ask not what your country can do for you, ask what you can do for your country." As Executive Director of ISEPP I ask the same question of our members. My fellow ISEPP members, ask not what ISEPP can do for you, ask what you can do for ISEPP. My answer is to request that every ISEPP member recruit at least two new members to the organization this year and encourage them to attend the Annual Conference. Any ISEPP member who signs up ten new members will be given free registration to our Annual Conference this year!

I am looking forward to seeing all our ISEPP members in Culver City in November.

Best wishes for a happy, safe and successful year,

Brian

Brian Kean Ph.D.
Southern Cross University, Lismore, Australia
Executive Director, International Society for Ethical Psychology and Psychiatry (ISEPP)
<http://www.psychintegrity.org/>
Editor-in-Chief, Ethical Human Psychology and Psychiatry (EHPP): An International Journal of Critical Inquiry, Springer Publishing Co.
<http://www.springerpub.com/product/15594343#.UwdC0Sjzfd4>

ISEPP Leadership Transition

2013 was a year of transition in the leadership of ISEPP. At our annual conference, Chuck Ruby took over the role of Chairperson of Board of Directors from Joe Tarantolo. In June 2013, Brian Kean was introduced as the new Executive Director following Al Galves' tenure. We would like to express our gratitude for the dedication and all the effort Joe and Al have given to ISEPP's mission in their previous roles.



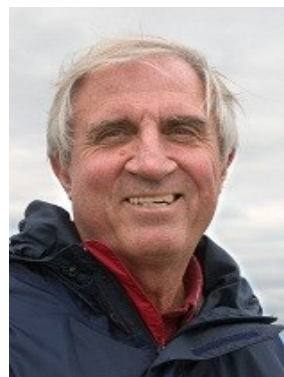
Chuck Ruby Ph.D.



Brian Kean Ph.D



Joe Tarantola MD



Al Galves Ph.D.

THE MIND IS A TERRIBLE THING TO WASTE: Confusion! Unfortunate Setback!

By Chuck Ruby

I am referring to the presidential edict known as the Decade of the Brain, signed by President George H.W. Bush in 1990. It was supposed to celebrate our great scientific/ neurological knowledge and promote research that was destined to bring quick relief to mental woes through biological and physiological manipulation. It hasn't! Instead, as a result of this scientific-political juggernaut, the coffers of the pharmaceutical industry have been filled and we now have a culture of foolish scientism entrapping millions of children and 10's of millions of adults on the pharmaceutical carousel for their problems of living.

I use the term "entrap" advisedly. Is that fair? Let me explain. I have assisted 100s of patients with being weaned off of psychotropic drugs. By the time they get to me they have begun to suspect that drugging themselves out of their problems is ill advised. I always ask: "Well, you know you had problems that had to be dealt with, so why did you fall for it, why did you take drug after drug, one on top of the other?" (Most are stuck on 4-5 drugs.) The answer usually has the following components: (a) An expert told me to do it, experts should know the right thing to do; (b) I liked the idea of simply fixing myself; (c) I was insecure; (4) I thought there was something wrong with my brain! These components create a potent situation for entrapment; as my colleague Grace

Jackson says, "A Perfect Crime."

Central to this sad state of affairs is the confusion between "Brain" and "Mind". It is easy to define and characterize the brain, a corporeal substance: It weighs 2 ½- 3 lbs, it is organized around distinct areas such as Parietal, Frontal, Temporal cortices; it is made up of a panoply of fatty substances; there are pathways and neurotransmitters and we can even watch-grossly-how it operates with such primitive tools as functional MRIs. Ahhh, but the Mind -- that's a different story.

Marilynn Robinson, a world class novelist (see her award winning "Gilead" and "Home") and student of philosophy and religion, in her turgid dissertation, "Absence of Mind" speaks out against "the polemic against the Mind" (p. 74). She is a critic of the rationalists and materialists such as Freud who make no room for metaphysics and religious faith. Another brilliant critic, Hannah Arendt, supports Robinson's view. Arendt was the controversial author of "The Banality of Evil" about the trial of Holocaust organizer, Rudolf Eichman. She labels two functions of the mind. The first is, of course, to comprehend. Even our biologist brothers would agree with that. But the second is more mysterious: to wonder. That is the miracle of the mind. And it is the importance of this capacity to wonder that gets lost in the unenlightened view of biological de-

terminism. An example: Rita Carter, a medical journalist clearly in the camp of unenlightened biological psychiatry, states in her mixed up titled book "Mapping of the Mind" that "emotions are generated in the limbic system"(p 15). Really? What a peculiar observation! So the weeping at a friend's funeral or the anger of an adolescent who becomes violent after a childhood of deprivation and neglect, these emotions were generated by the limbic system? A truly funny way to understand life. Wouldn't it make more sense to say that what "generated" the emotions was grieving and longing for help and sustenance? Indeed things do happen in our limbic system (and our cardiovascular system, and our gastrointestinal system, etc.) when life happens. It is life that "generates" and we react to what gets generated. As the late Thomas Szasz said: "Machines function, animals behave, humans act." (I recently told a therapy group in my practice that they were "high functioning" and that was not a compliment.) Szasz simplified the notion of mind: it is our internal conversation. I call it our interior dialog. In mental illness it is this dialog that gets damaged early in life and then re-damaged later in life; it is this damaged mind that wreaks havoc on our interpersonal life.

With the help of my colleague Ann Louise Silver, a psychiatrist and psychoanalyst who eschews the out-of-control use

of psychotropics by our profession, I recently started a discussion group at the Washington School of Psychiatry (WSP) entitled: "Treating Psychosis Without Neuroleptics." Harry Stack Sullivan founded the WSP in 1939 to escape the New York/European orthodoxy of psychoanalysis and to establish a school that welcomed the input of all the social sciences. This school was the first of its kind, promoting the idea of Interpersonal Psychiatry, exploring all social forces that damage or support it.

One of the readings suggested by Ann Louise was a 1959 article out of the now defunct Chestnut Lodge in Maryland published in "Psychiatry, Journal for the Study of Interpersonal Processes." The title is "Loneliness" written by the brilliant Frieda Fromm Reichman. (The psychiatrist in "I Never Promised You a Rose Garden" was modeled after her.) Her dissertation using both literary and scientific writing touched me, both personally and clinically.

We humans all spend our lives contending with our need for connection. In Sullivanian terms, we do this to

maintain "self-worth." Sensory deprivation, isolation, poverty, ostracism, social and familial disdain all set the stage for the derailment of basic cognitive functioning. This derailment leads to a profound collapse of emotional well being. Language for seeking succor is lost in convoluted-bizarre-disjointed-metaphorical speech. The schizophrenic loses his ability to wonder. It should be no surprise that in the psychotic state death and emotional isolation become virtually synonymous. "I am not going to let any one kill you, I will not abandon you, I am here for you." These are all necessary interventions with the mad patient. Remember, as Sullivan often reminds, the mentally ill person, the schizophrenic, the mad man is merely human. So the therapist must connect with his own terror of loneliness. And this is not a "Brain" problem but a human struggle.

the brilliant Frieda Fromm Reichman. (The psychiatrist in "I Never Promised You a Rose Garden" was modeled after her.) Her dissertation using both literary and scientific writing touched me, both personally and clinically.

ically.

We humans all spend our lives contending with our need for connection. In Sullivanian terms, we do this to maintain "self-worth." Sensory deprivation, isolation, poverty, ostracism, social and familial disdain all set the stage for the derailment of basic cognitive functioning. This derailment leads to a profound collapse of emotional well being. Language for seeking succor is lost in convoluted-bizarre-disjointed-metaphorical speech. The schizophrenic loses his ability to wonder. It should be no surprise that in the psychotic state death and emotional isolation become virtually synonymous. "I am not going to let any one kill you, I will not abandon you, I am here for you." These are all necessary interventions with the mad patient. Remember, as Sullivan often reminds, the mentally ill person, the schizophrenic, the mad man is merely human. So the therapist must connect with his own terror of loneliness. And this is not a "Brain" problem but a human struggle.

Poems of Tom Greening

ESCAPE

My colleagues practice mindfulness
but I prefer forgetfulness.
The past is fortunately past,
I pray the present will not last.
The future lurks somewhere ahead—
the thought of it fills me with dread.
My goal? To be oblivious,
obliterate my consciousness,
escape this dreadful mortal coil,
the hound of heaven somehow foil.

RIPPLED GLASS

This is an old apartment building
and the window glass is uneven
So that the ripples in it
make the outside world waver
or is it my eyes,
or my mind?
When the police car parks
I briefly panic
and review what I might have done
to invite this visit.
But he merely writes a parking ticket
for a Mercedes, and I remember
this is a new century
in which the police have no reason
to be interested in me
unless it is for my crime
of remembering

Psychiatry Now Admits It's Been Wrong in Big Ways - But Can It Change?

Wednesday, 05 March 2014 10:05 **By Bruce E Levine, Truthout | News Analysis**

<http://truth-out.org/news/item/22266-psychiatry-now-admits-its-been-wrong-in-big-ways-but-can-it-change>

When I interviewed investigative reporter Robert Whitaker in 2010 after the publication of his book *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*, he was not exactly a beloved figure within the psychiatry establishment. Whitaker had documented evidence that standard drug treatments were making many patients worse over the long term, and he detailed the lack of science behind these treatments.

Whitaker's sincerity about seeking better treatment options, his command of the facts, and his lack of anti-drug dogma compelled all but the most dogmatic psychiatrists to take him seriously.

For *Anatomy of an Epidemic*, Whitaker won the 2010 Investigative Reporters and Editors Book Award for best investigative journalism. This and other acclaim made it difficult for establishment psychiatry to ignore him, so he was invited to speak at many of their bastions, including a Harvard Medical School Grand Rounds at Massachusetts General Hospital, where he faced hostile audiences. However, Whitaker's sincerity about seeking better treatment options, his command of the facts and his lack of anti-drug dogma compelled all but the most dogmatic psychiatrists to take him seriously.

In the past four years, the psychiatry establishment has pivoted from first ignoring Whitaker to then debating him and attempting to discredit him to currently agreeing with many of his conclusions. But will Whitaker's success in changing minds result in a change for the better in treatment practices?

I was curious about Whitaker's take on the recent U-turns by major figures in the psychiatry establishment with respect to antipsychotic drug treatment, the validity of the "chemical imbalance" theory of mental illness and the validity of the DSM, psychiatry's diagnostic bi-

ble. And I was curious about Whitaker's sense of psychiatry's future direction.

Bruce Levine: In 2013, the director of the National Institute of Mental Health (NIMH), Thomas Insel, announced - without mentioning you - that he agreed with your conclusion that psychiatry's standard treatment for people diagnosed with schizophrenia and other psychoses needs to change so as to better reflect the diversity in this population. Citing long-term treatment studies that you had previously documented, Insel came to the same conclusion that you had: In the long-term, not all, but many individuals who have been diagnosed with psychosis actually do better without antipsychotic medication. Was it gratifying for you to see the US government's highest-ranking mental health official agreeing with you?

Robert Whitaker: Shortly before Thomas Insel wrote that blog, I had posted my own on madinamerica.com, related to a recent study by Lex Wunderink from the Netherlands. Wunderink had followed patients diagnosed with a psychotic disorder for seven years, and he reported that those randomized, at an early date, to a treatment protocol that involved tapering down to a very low dose or withdrawing from the medication altogether had much higher recovery rates than those maintained on a regular dose of an antipsychotic.

I wrote that in the wake of Wunderink's randomized study, if psychiatry wanted to maintain its claim that its treatments were evidence-based, and thus maintain any sort of moral authority over this medical domain, then it needed to amend its treatment protocols for antipsychotics. I don't know if Dr. Insel read my blog, but his post did nevertheless serve as a reply, and as you write, he did basically come to the same conclusion that I had been writing about for some time.

I suppose I took some measure of personal gratification from his blog, for it did provide a sense of a public acknowl-

edgment that I had indeed been "right." But more important, I felt a new sense of optimism, hopeful that maybe psychiatry would now really address this issue, which is so important to the lives of so many people. A short while ago, *The New York Times* published a feature story on Dr. Insel, noting that he had recently raised a question about the long-term use of antipsychotics, which had caused a stir in psychiatry because it contradicted conventional wisdom. That is a sign that perhaps a new discussion is really opening up.

In *Anatomy of an Epidemic*, you also discussed the pseudoscience behind the "chemical imbalance" theories of mental illness - theories that made it easy to sell psychiatric drugs. In the last few years, I've noticed establishment psychiatry figures doing some major backpedaling on these chemical imbalance theories. For example, Ronald Pies, editor-in-chief emeritus of the *Psychiatric Times* stated in 2011, "In truth, the 'chemical imbalance' notion was always a kind of urban legend - never a theory seriously propounded by well-informed psychiatrists." What's your take on this?

The "disease model," as a basis for making psychiatric diagnoses, has failed.

This is quite interesting and revealing, I would say. In a sense, Ronald Pies is right. Those psychiatrists who were "well informed" about investigations into the chemical imbalance theory of mental disorders knew it hadn't really panned out, with such findings dating back to the late 1970s and early 1980s. But why, then, did we as a society come to believe that mental disorders were due to chemical imbalances, which were then fixed by the drugs?

Dr. Pies puts the blame on the drug companies. But if you track the rise of this belief, it is easy to see that the American Psychiatric Association promoted it in some of their promotional materials to the public and that "well informed" psychiatrists often spoke of this metaphor in their interviews with the media. So what

you find in this statement by Dr. Pies is a remarkable confession: Psychiatry, all along, knew that the evidence wasn't really there to support the chemical imbalance notion, that it was a hypothesis that hadn't panned out, and yet psychiatry failed to inform the public of that crucial fact.

The low-serotonin theory of depression has been so completely discredited by leading researchers that maintaining the story with the public has just become untenable.

By doing so, psychiatry allowed a "little white lie" to take hold in the public mind, which helped sell drugs and, of course, made it seem that psychiatry had magic bullets for psychiatric disorders. That is an astonishing betrayal of the trust that the public puts in a medical discipline; we don't expect to be misled in such a basic way.

But why now? Why are we hearing these admissions from Dr. Pies and others now? I am not sure, but I think there are two reasons.

One, the low-serotonin theory of depression has been so completely discredited by leading researchers that maintaining the story with the public has just become untenable. It is too easy for critics and the public to point to the scientific findings that contradict it. Second, a number of pharmaceutical companies have shut down their research into psychiatric drugs [see Science, 2010], and they are doing so because, as they note, there is a lack of science providing good molecular targets for drug development. Even the drug companies are moving away from the chemical-imbalance story, and thus, what we are seeing now is the public collapse of a fabrication, which can no longer be maintained. In the statement by Dr. Pies, you see an effort by psychiatry to distance itself from that fabrication, putting the blame instead on the drug companies.

Challenging the validity of DSM is, in many ways, potentially much more of a paradigm-changer than are the scientific reports that detail how the medications may be causing long-term harm.

And recently, establishment psychiatrists have even been challenging the validity of psychiatry's diagnostic bible, the DSM. Last year, NIMH director Insel, citing the DSM's lack of scientific validity,

stated that the "NIMH will be re-orienting its research away from DSM categories." And psychiatrist Allen Frances, the former chair of the DSM-4 task force, has been talking about how the DSM is a money machine for drug companies ("Last Plea To DSM-5: Save Grief From the Drug Companies"), and Frances thoroughly trashed the DSM-5 in his 2013 book Saving Normal.

I think this challenging of the validity of DSM is, in many ways, potentially much more of a paradigm-changer than are the scientific reports that detail how the medications may be causing long-term harm. Our current drug-based paradigm of care, which presents drugs as treatments for the symptoms of a "disease," stems from DSM III. The APA [American Psychiatric Association] and its leaders boasted that when DSM III was published in 1980, that the field had now adopted a "medical model," and thus its manual was now "scientific" in kind.

In fact, the APA had adopted a "disease model," and if you carefully read the DSM III manual, you saw that the authors acknowledged that very few of the diagnoses had been "validated." The APA's hope and expectation was that future research would validate the disorders, but that hasn't happened. Researchers haven't identified a characteristic pathology for the major mental disorders; no specific genes for the disorders have been found; and there isn't evidence that neatly separates one disorder from the next. The "disease model," as a basis for making psychiatric diagnoses, has failed.

We are now witnessing, in Insel's statements and those by Allen Frances, an acknowledgment of this failure. And here is why this is potentially such a paradigm-changer: The foundation of any medical specialty begins with its diagnostic manual, which should be both reliable and valid. If the disorders listed in a manual haven't been validated, then you can't conclude they are "real," in the sense of the disorders being unique illnesses, and the diagnoses being useful for prescribing an appropriate treatment.

Thus, when Insel states that the disorders haven't been validated, he is stating that the entire edifice that modern psychiatry is built upon is flawed, and unsupported by science. This is like the King of Psychiatry saying that the discipline has no clothes. If the public loses faith in the DSM and comes to see it as unscientific, then psychiatry has a real credibility problem on its hands, and

that could prove to be fertile ground for real change.

So do you feel you have accomplished your mission? And can dissident mental health professionals - who have for years been talking about invalid diagnoses, pseudo-scientific theories of mental illness, and drug treatments that cause moderate and acute problems to become severe and chronic ones - now have reasons to be optimistic about their profession? Or are you pessimistic that the recent admissions of establishment psychiatry will result in substantive changes in treatment?

My "mission" would be to see that our society would actually build a system of care that was truly "science" based, particularly in its use of psychiatric drugs.

This is a good question, and I vacillate in my personal response between guarded optimism and complete pessimism. From an intellectual, scientific standpoint, I think psychiatry is facing a deep crisis. There is an understanding, within psychiatric research circles, that the DSM diagnoses haven't, in fact, been validated. And, at the very least, there is a recognition that psychiatry's drug treatments are inadequate. In 2009, Insel wrote an article stating: "For too many people, antipsychotics and antidepressants are not effective, and even when they are helpful, they reduce symptoms without eliciting recovery." And I do think that my book *Anatomy of an Epidemic* has contributed to an awareness of the limitations of the drugs, and at least a discussion, in some psychiatric circles, that the drugs may be worsening long-term outcomes.

But in terms of accomplishing my mission, well, I guess my "mission" would be to see that our society would actually build a system of care that was truly science-based, particularly in its use of psychiatric drugs. I think this is such an important story for our society and one of extraordinary moral importance when it comes to medicating children and adolescents, none of whom could be said to have really "consented" to such treatment. I turned madinamerica.com into a webzine with the hope that by providing a forum for a community of writers interested in "rethinking psychiatry" and combining their voices with reports of research that provide a foundation for such rethinking, it could become a real force for change. We'll see if that happens, but our readership is steadily increasing.

I should note, as you say, that dissident mental health professionals have been plugging away at promoting such change for a long time. I hope that madinamerica.com is providing that community a forum for voicing their criticisms and making them known to a larger audience.

And now for why I can be so pessimistic. Even as the intellectual foundation for our drug-based paradigm of care is collapsing, starting with the diagnostics, our society's use of these medications is increasing; the percentage of children and youth being medicated is increasing; and states are expanding their authority to forcibly treat people in outpatient settings with antipsychotics drugs. Disability numbers due to mental illness go up and up, and we don't see that as reason to change either. History does show that paradigms of psychiatric care can change, but, in a big-picture sense, I don't know how much is really changing here in the United States.

I think dissident mental health professionals also have to confront this question. Can they be hopeful that their professions will change their ways, and their teachings? I think so, but there is so much that needs to be done.

Any medical specialty has guild interests, meaning that it needs to protect the market value of its treatments.

Is it really possible for psychiatry to reform in any meaningful way

given their complete embrace of the "medical model of mental illness," their idea that emotional and behavioral problems are caused by a bio-chemical defect of some type? Can they really reform when their profession as a financial enterprise rests on drug prescribing, electroshock and other bio-chemical-electrical treatments? Can psychiatry do anything but pay lip service to a more holistic/integrative view that includes psychological, spiritual, social, cultural and political realities?

I think we have to appreciate this fact: any medical specialty has guild interests, meaning that it needs to protect the market value of its treatments. If it is going to abandon one form of treatment, it needs to be able to replace it with another. It can't change if there is no replacement in the offing.

When the APA published DSM III, it basically ceded talk therapy to psychologists, counselors, social workers and so forth. Psychiatry's three domains, in the marketplace, were diagnostics, research and the prescribing of drugs. Now, 34 years later, we see that its diagnostics are being dismissed as invalid; its research has failed to identify the biology of mental disorders to validate its diagnostics; and its drug treatments are increasingly being seen as not very effective or even harmful. That is the story of a profession that has reason to feel insecure about its place in the marketplace.

Yet, as you suggest, this is why it is going to be so hard for psychiatry to reform. Diagnosis and the prescribing of drugs constitute the main function of psychiatrists today in our society. From a guild perspective, the profession needs to maintain the public's belief in the value of that function. So I don't believe it will be possible for psychiatry to change unless it identifies a new function that would be marketable, so to speak. Psychiatry needs to identify a change that would be consistent with its interests as a guild.

The one faint possibility I see - and this may seem counterintuitive - is for psychiatry to become the profession that provides a critical view of psychiatric drugs. Family doctors do most of the prescribing of psychiatric drugs today, without any real sense of their risks and benefits, and so psychiatrists could stake out a role as being the experts who know how to use the drugs in a very selective, cautious manner, and the experts who know how to incorporate such drug treatment into a holistic, integrated form of care. If the public sees the drugs as quite problematic, as medications that can serve a purpose - but only if prescribed in a very nuanced way - then it will want to turn to physicians who understand well the problems with the drugs and their limitations.

That is what I think must happen for psychiatry to change. Psychiatry must see a financial benefit from a proposed change, one consistent with guild interests.

Poems by Dominick Riccio

Homage to Billy Collins

I never even heard of you
Until that lovely Lolita poetess
Struck with picnic lightning.

I barely knew you
When you rescued me from drowning
In a three year divorce.

I consulted you daily
While perched on porcelain,
On matters of death and the heart.

And I flocked to hear you
When the 92nd street Y finally
Acknowledged the new Poet Laureate

You seldom disappoint
With your sly wit and x-ray vision
Of everyday life.

I salute you
Oh, great transformer!
Of the ordinary into the extraordinary.

And I thank you
For the many moments of pleasure
Infused into my too-human voyage.

Romeo Reflects

Love is time.
For what marks love more
than precious moments spent
ensiemo;
touching, caressing,
soul surfing;

O Juliette!

Suicide

Bertram P. Karon, Ph.D., ABPP

Suicidal patients bother therapists because we do not want them to die. Every seriously mentally ill patient considers suicide. Avoiding talking about it only makes the suicide more likely. There is no danger that talking about suicide will suggest it to the patient. Any patient who talks about suicide should be taken seriously. Every suicidal patient tells someone about it. As Jensen and Petty (1958) pointed out, the suicidal patient projects his super ego (conscience) on to the person he tells about his intention. Implicitly, he is asking, "Do I deserve to live or die?" If that person does nothing, the suicidal person interprets it as indicating that the patient deserves to die. Whatever else the therapist does, he must make it clear that he does not believe the patient deserves to die.

The suicidal patient is always expressing hostility toward someone else, whom he expects to suffer as a result of the suicide. It should always be pointed out that it does not work, that the patient is inflicting a lot of pain on himself, in order to inflict a little pain on someone else. That assumes that the other person likes the patient. If the other person does not like the patient, they will not suffer, they will be glad. Even the patient's parents, who might feel bad, it can be pointed out, will not feel as bad as the patient. The parents may have felt bad about how they have treated the patient, but if he kills himself, they will not think it was their fault, but that they had a crazy kid. And people

will feel sorry for them, and they might even enjoy that. It may also be pointed out that you (the therapist) are not interested in dead people, but you are interested in helping the patient with any problem. If the patient dies, you will simply get another patient. If they have any sibling rivalry, the idea of another patient seeing you in their hour is not something they want.

We must make clear that we will deal with anything, and we do not believe their situation is hopeless. While hopelessness is not a sufficient condition for suicide, it is a necessary one. No one with a strong hope of attaining something they want commits suicide.

It is not necessarily that we can solve their problem in one session. But we can help them solve their problems. What are the reasons that people commit suicide? We know that people can live even if a spouse or lover leaves them, that there are other people in the world. We know that people can live even if they lose a job, and have to live on a reduced income.

It is helpful to be available to patients over the phone. Very few patients abuse that privilege, but I have had a number of patients who did not commit suicide because they were able to tell me their intention and discuss it on the phone.

No one is perfect, and in over 50 years of practice, with many suicidal

patients (in fact, many were referred to me specifically because they were suicidal), only one actually committed suicide. I reviewed the case with two experienced psychoanalysts, each of whom said they would have done some things differently, but that it would not have prevented the suicide. I recommend such a review if a suicide is not prevented, because I have known good therapists who have had difficulty continuing to practice after a suicide.

The most effective suicide prevention is competent psychotherapy. Hospitalization can prevent a suicide while the patient is in the hospital, but I have known cases where the patient was able to commit suicide despite being in a locked ward. Having a relative or friend who will stay with the patient continuously can be helpful. Antidepressant medications do not help, they actually greatly increase the risk of suicide, which is why there is a black box warning not to use them with patients under 26. However, they increase the risk of suicide with all patients, just more dramatically for younger patients. Years ago it was found in England, suicides in depressed children treated with antidepressants was four times as frequent as in depressed children receiving no treatment at all. Electroconvulsive therapy does not prevent suicide. It seems to temporarily defer suicide. The patient can't remember why they wanted to commit suicide. When the memory returns, they kill themselves. Ernest Hemingway, whose depression

was treated with electroconvulsive therapy, is a classic example. He did not kill himself in the hospital, but he did shortly afterwards. The fear of being given electroconvulsive therapy again has been reported as a precipitant of suicide in patients who have been given electroconvulsive therapy previously.

Hispanic Americans in jail or in mental hospitals have a higher risk of suicide apparently because it interferes in their relationship with their family. If a further interference occurs, like the family moving out of town, they become acutely suicidal, but the suicide can be prevented by their being under observation for 24 hours.

It is well known that seriously

depressed patients often seem to be getting better, and then kill themselves. This is often explained as they did not have enough energy to kill themselves, but that is not what is going on. As George Atwood (1972) described, some patients make a decision to kill themselves and then seem to improve because they have a solution. Then they carry out their solution. You can tell the difference by three criteria:

(1) If they are getting better, they have more insight into why they were depressed. If they are going to kill themselves, they do not have any more insight.

(2) If they are getting better, they talk more about the future. If they are going to kill themselves, they do not

talk about the future because they do not have any.

(3) If they are getting better, they are increasingly willing to talk about suicide. If they are going to kill themselves, they will not be willing to discuss suicide.

If all three of these are in the same direction, it indicates whether they are really getting better or whether they are about to kill themselves.

A more detailed description of the appropriate treatment for suicidal patients may be found in Karon & VandenBos (1981), pages 262-271.

(Continued from page 1)
New Bulletin Editors

this issue contains an article on suicide by Bertram Karon, Ph.D. and a biography of Mary Karon, his wife, by Lloyd Ross. Robert Sliclen initiates a poetry and arts section with several poems by the ISEPP adopted bard Tom Greening and others. Robert also hopes to get a photography section started. Please email him or me your jpegs. If you have any ideas, comments, criticisms, praise, please communicate them to us. We always like to hear from our fellow members and want to

create a dynamic flow of ideas and communications.

Finally I want to remind you that the leadership of ISEPP is planning a truly international conference this year in Los Angeles, CA. David Cohen, a past Board of Directors Chair, has offered his considerable talents and expertise to organize our extraordinary conference together with our conference co-chair, Michael Gilbert. Save these dates: November 13-16. The conference drew its inspiration from David Cohen's new book, *Mad Science: Psychiatric Coercion, Diagnosis and Drugs*.

The conference will feature some of the most important speakers and opinion makers in the world on the topic of clinical psychiatry, psychology and research. This will be an opportunity you will not want to miss! I hope all of you will make our conference your next professional or personal destination for this year!

We hope you enjoy this issue of the Bulletin.

Full Steam Ahead: New Era For ISEPP Bulletin Gets Under Way

By Andrew Crosby, Former Editor

You might be wondering why you're looking at a shot of a train in the ISEPP Bulletin. Well, this is a different kind of image because this is a different kind of Bulletin. This is a *new* Bulletin, the product of a new editorial team, with new energy and ambitions.

As Jill Littrell steps down after two years of service Andrew Levine, Lloyd Ross, Robert Slicen, and Dominick Riccio - familiar names to many of you - are stepping up. And they're doing so in a big way.

Go Big or Go Home!

The main thing that's big is their enthusiasm to make the Bulletin special. They want it to be great. I've talked with these guys so I know of what I speak. They're excited, and believe you want to be excited too.

The new Bulletin will be interesting, as it's always been, but your new team also wants to impress and surprise you. They will cover the current events and issues that are important, as the Bulletin always has, but they also want to take you into new creative realms to explore important themes in unique ways.

So What's Really New?

For one thing this is the first time ISEPP has had a team handling the Bulletin. Yes, in my day Delores Jankovich and I were a team, and good one. But Robert, Lloyd, Andrew, and Dominick are four long-time members who have held, and continue to hold, leadership positions. They know ISEPP



After waiting for a track maintenance crew to clear the way, Canadian Pacific train #930 is let loose. Here the train rumbles along the western shore of New York's Lake Champlain.

Photo: Andrew Crosby
Port Henry, N.Y., September, 2013

as well as anyone and they know what's relevant to you.

With four committed and knowledgeable minds at work a variety of ideas are already flowing. Some of these ideas are here in the following pages, while others you'll see soon enough

These guys also have skills the Bulletin never enjoyed in such abundance. Robert is an accomplished photographer with an eye for editorial detail and nuance. Andrew starts with computer background I had to learn from the ground up. Dom and Lloyd will gather and contribute material, and all will figure out what to do with it.

To wit another new element: These guys know one another well, and have worked

together for over a decade. Collaboration is their game.

It seems fitting that circumstances have brought these guys and the bulletin together.

Final Word on How Big This Will Be

You know, I have a feeling your new editorial team wants to top what I did during my five-and-a-half years in the corner office of Bulletin Headquarters. Well, records are made to be broken, ladies and gentlemen, so more power to them.

Besides, these guys are well under way, and they're too determined to stop at this point.

The Return of **ALL IN THE FAMILY**

Several years ago I introduced a column to this paper that I called "**ALL IN THE FAMILY.**" The column was intended to provide members of ISEPP, which at the time was still called ICSPP, with some insight and familiarity with our key members. At that time, I wrote columns about Jim Gottstein, Bertram Karon, Peter Breggin, and others. Because I got tied up in other things, the column stopped for a number of years. However, due to some recent prompting from Dominick Riccio, I decided to bring it back.

In terms of who to start it off with, I was quite clear about that. I decided to write the first column about a modest, gentle woman who both welcomed people into this organization, and who was the motivator behind the great researcher in the field of psychotherapy. I will begin this below.

ALL IN THE FAMILY

By Lloyd Ross

Mary Karon, A Soft, Quiet, Yet Powerful Influence On Us All

Back in the early 1990s, I attended my first international meeting of what was then called The International Center For the Study of Psychiatry & Psychology in a small hotel in Bethesda, Maryland. I drove there with my wife, Susan, daughter Holli, and a colleague, Dr. Robert Sliclen. Other than that, I knew no one. As I roamed about the lobby with my daughter we were approached by a very slight lady who introduced herself as Mary Karon and she began to tell us just how important the organization was and the reason why she and her husband always made it their business to attend these conferences.

My wife and Dr. Sliclen joined into the conversation and afterward, they all pointed out to me what a sweet, wonderful, and knowledgeable woman we had met. That evening, Mary introduced us to Dr. Bertram Karon, her husband, whose book, "**The**

Psychotherapy of Schizophrenia: Treatment of Choice," I had read and reread. I treated it like it was the bible for psychotherapists. After dinner that night, we stayed up until 2:00 A.M. listening to Bert's stories, which were particularly interesting to me because my old supervisor was Margaret Mahler and Bert knew her well. Finally, at about 2:00 A.M. Mary pulled Bert away, saying, "You need to get some sleep."

Later on, Bert told me that throughout her life Mary always went out of her way to help people. He said that when he told her that he didn't have enough time to help, she would say: "Make time!" She would then do everything she could to make sure that he helped. And if he really could not, she would find a way to help on her own. This was never more obvious than when the Karons were in an auto accident in 2007 that left Bert a paraplegic. Whenever Bert was about to give up on the painful treatments and hours of exercise necessary for improvement, she would say to him, "There are people you can help. You have to do it." Mary even en-

listed me, knowing my own medical history, to goad him on, which I did aggressively. She was adamant that Bert was going to get better and that no matter what anyone said, he would help more people. That is what got Bert through those times and he continues to work with people and write, teach, and lecture today. At one point Mary told me in a phone conversation that she didn't know how much time she had due to a severe heart problem that she had for a while, and that she wanted to make sure that Bert would continue the fight after she was gone. She was right and she did accomplish that.

One of my last personal experiences with Mary Karon was shortly before she died. A man from Canada contacted her to talk to Bert. However, because of the accident, Bert was unable to deal with him at that time. So Mary took over. I will let the man's name stay anonymous, but he had a young adult son who was experiencing psychotic symptoms, was quite delusional, and was hallucinating. The father had him seen by multiple psychiatrists and he was on multiple

medications and experiencing horrible side effects from them. The father did his homework and tried to contact Bert Karon for help. Not only did Mary take over but she had him make contact with a well known psychologist on the west coast regarding a treatment plan for the father to use since there was no one up in Canada that would see this young man without even more medication. Mary and I spoke multiple times about this man and his son and not only did he follow through, but in the end, the young man became drug free and was able to go back to college. Yes, Mary was able to coordinate a bunch of people to get help for this family and followed through with it to great success, all the while, keeping her husband informed of what she was doing and using his ideas and advice.

Mary Katherine (Mossop) Karon was born in 1923 in Ottawa, Ontario. She had two boys from a first marriage who lived with the Karons. Bert and Mary met when he was a graduate student with a fellowship at the Educational Testing Service in Princeton and Mary was a secretary in the re-

search department. During Bert's internship working with Schizophrenic patients in an unusual setting that treated them with psychoanalytic psychotherapy quite successfully, the two of them talked a great deal. They were married in 1957 and Bert went into private practice in Philadelphia. They also had a third son together. Because of Mary's influence, Bert treated ordinary people, not the wealthy, and Mary did not care if he charged them or not, as long as they got help. In 1962, Bert joined the faculty at Michigan State University. There, Mary liked the fact that they had a psychological clinic that provided treatment free of charge to any resident of Michigan. She helped Bert write his first book, a study of the effects of segregation, which was based on his Ph.D. Dissertation. He dictated parts of the book to her that he had some difficulty completing. Mary also found the time to get several years of college courses under her belt during that time. When Linda Andre's book, "**Doctors of Deception**" came out, about the destructive effects of electroconvulsive therapy, Linda told them that she was hav-

ing trouble getting the book reviewed. Even though Bert was even unable to hold the book at the time due to the accident, Mary insisted that they would do the review, and they both completed the review, with Mary reading the book aloud to Bert.

It took me longer to write this than I thought it would because a lot of tears at her loss got in the way. The older ISEPP members who knew Mary and all that she did will never forget this little, quiet, yet powerful woman, and those younger members of ISEPP who did not get to know her should at least know about her. After her death, we instituted the "**Mary Karon Humanitarian Award**," which is given out very sparingly by ISEPP. It is in memory of the lady who was, and continues to be, even in death, the motivating force behind the most significant research and writer on successful non-drug psychotherapy with those diagnosed as psychotic in history. Both I and my wife Susan feel extremely fortunate to have known this wonderful, kind, no-nonsense hero of a woman.

Poem by Robert Slicen:

cell phone ring
real life recedes
talk's cheap

cocky young men
patrol recon base attack
virtue is lost

dog lapping water
stillness of the morning
peaceful world

ISEPP Offices and Directors Around the World

International and North American Offices

International Executive Director

Brian Kean, Ph.D.
Lecturer in Education
Southern Cross University
PO Box 157, Lismore, NSW, 2480
Australia
(066) 262-42330

United States Regional Director

Lloyd Ross, Ph.D.
27 North Broad Street
Ridgewood, N.J. 07450
(201) 445-0280

Executive Director Emeritus

Dominick Riccio, Ph.D.
1036 Park Avenue, Suite 1B
New York, N.Y. 10028
(212) 861-7400

Ethical Human Psychology and Psychiatry: A Journal of Critical Inquiry

Brian Kean, Ph.D. - Managing Editor
James Tucker, Ph.D. - Editor
Leighton Whitaker, Ph.D. - Editor

ISEPP Bulletin Staff

Dominick Riccio, Ph.D. - Managing Editor
djriccio@aol.com
Robert Sliclen, Ph.D. - Editor
sliclen@optonline.net
Andrew Levine, LCSW - Editor
alevine98@gmail.com
Lloyd Ross, Ph.D. - Editor
dr.lloydross@gmail.com

ISEPP Website Coordinator

Maria Mangicaro
mangicaro829@aol.com

ISEPP Membership Director

Robert Sliclen Ph.D.
450 Washington Ave.
Twp Washington, NJ 07676-4031
201-664-2566
sliclen@optonline.net

Regional Offices

USA-SEPP Great Lakes

Toby Tyler Watson, Psy.D.
2808 Kohler Memorial Drive
Sheboygan, WI 53081
(920) 457-9192
tobytylerwatson@charter.com

USA-SEPP Mid-Atlantic

David Stein, Ph.D.
Virginia State University
Criminal Justice, 201 Colson Hall
Petersburg, VA 23806
(804) 395-2322

USA-SEPP New England

Emmy Rainwalker
187 Merriam Hill Road
Greenville, NH 03048
(603) 878-3362
emmy@emmyrainwalker.com

USA-SEPP Northeast

Lloyd Ross, Ph.D.
27 North Broad Street
Ridgewood, N.J. 07450
(201) 445-0280

SEPP CANADA-Quebec

Jean-Phillipe Vaillancourt
445 Croissant du Trianon
Mascouche, Quebec J7K0L8
514-358-9254
jpvail@gmail.com

SEPP-Australia

Brian Kean, Ph.D.
Lecturer in Education
Southern Cross University
PO Box 157, Lismore, NSW, 2480
Australia
(066) 262-42330

SEPP South America-Brazil

Lis Beatriz Fleck
R Eng. Alvaro N Pereira
Porto Alegre, RS 90570-110
Brasil
lia@orion.ufrgs.br

Return Address:

Robert Sliclen Ph.D.
450 Washington Ave.
Twp Washington, NJ USA 07676-4031

NON-PROFIT

US Postage

PAID

Permit # 1040
Leesburg, FL
34748

Regional Offices (Continued)***SEPP Belgium***

Phillip Hennaux, M.D.
Medical Director, La Piece
71 Rue Hotel Des Monnaies
1061 Buxelles, Belgium
2-646-96-01

SEPP Switzerland

Piet Westdijk, Dr. Med. [M.D.]
FMH Psychiatry & Child Development Psycho-
therapy
FMH Child Psychiatry & Child Psychotherapy
Sattelgasse 4, CH-4051 Basel, Switzerland
(41) 61 262 2222

SEPP South America

Alberto Ferguson, M.D.
Av. 82, No. 9-86, Apt. 402
Bogota, Columbia, S.A.
(11)(571) 636-9050
U.S. Address:
4405 N. 73rd Avenue
Miami, FL
33166-6400

SEPP Great Britain

Joanna Moncrieff, MD
Mascalls Park, Mascalls Lane
Brentwood, Essex
CM14 5HQ UK