Herman van Praag: Religion and religious identity

Deference to Doubt: A young Man's quest for religious identity in first century Judaism

Barry Blackwell's comment

I was delighted and intrigued to read Herman's review of his own book on doubt in religion for two reasons. It was comforting to learn how Judaism could view doubt with benevolence, perhaps due to how that faith is so embedded in a supportive culture. Secondly its arrival coincided with reading another recently published book, *Faith in Human Nature,* written by a distinguished neuroscientist and anthropologist who is also an atheist (Konner 2019). Together these two books caused me to reflect on the role of doubt, skepticism and faith in my own career, told in the essay that follows.

Searching for Faith in Science, Spirituality and Religion.

Doubt, skepticism and faith are nouns that convey different meanings in the scientific, religious and spiritual domains in various ways and times during my own career extending from medical graduation (1961) to my third and final retirement from medical practice (2010). Both prose and poetry explore these terms and their nuances.

The Oxford English Dictionary (OED) provides two definitions of "Faith"

1. **Complete Trust and Confidence**
2. **Strong Belief in a Religion based on spiritual conviction, rather than proof.**

The difference between these two definitions lies in the fact that in science and spirituality faith can be quantified on a probability scale from extreme doubt to grades of skepticism about

"things known," while in most Catholic, Anglican and Non-Conformist Religions complete faith in "things unknown" is the *sine qua non* for belonging. This dichotomous viewpoint becomes blurred in some humanistic faith traditions and perhaps in Judaism. Herman van Praag, a devout Jew, supports his mythical son Amos's conclusion, "Spiritually, I'll be a wandering Jew. I'll never get there. The distinction will ever evade me, like the horizon whenever you approach it." His father considers this "an exhilarating prospect." In other faith traditions such doubt led to the Crusades and the Inquisition.

In his book (*Believers: Faith in Human Nature)* Melvin Konner neuroscientist, anthropologist and atheist, provides a spirited effort to demonstrate that contemporary neuroscience has crossed a threshold by which the first OED definition, perhaps even the second, can be fairly applied to various forms of religious and spiritual experience. The claim cast a wide anthropology net, including the major faith traditions. Christianity, Judaism, Islam, Hinduism, Buddhism, conversion experiences (James 1902), Jungian concepts, primitive tribal beliefs and religiosity in epilepsy and psychoses (Konner 2019). At the neuroscience level Konner explores the linkage of neuro-anatomical location, neurochemical activity and genetics to various spiritual practices, including prayer and religious ritual, meditative techniques and psychedelic drug effects from hashish, marijuana, cannabis and soma to modern psychedelic compounds.

This body of research yields the following conclusions and predictions.

Conclusions

1. Religious experiences are highly variable but always include a conviction of things unknown.
2. Religious inclinations and capacities are built into the human brain, not universally or uniformly, but with increasingly known pathways and chemistry. This distinction between (1) "experiences" and (2) "inclinations and "capacities" shifts the burden of proof from the unknowable to the measurable, from faith to doubt or skepticism.
3. Religious inclinations and capacities develop during childhood partly due to genes. Individual differences are sometimes influenced by exposure but are not related to indoctrination or moral development.

4. Religion serves many adaptive functions (such as managing fear or grief) that evolve by natural selection and have survival value.
5. A third of people lack religious belief ("nones") and the remainder are equally divided between those with conventional beliefs and those who claim they are spiritual.

Predictions

1. The number of "nones" will grow and conventional religious groups will continue to shrink, partially replaced by unconventional spirituality.
2. In every major religion the most faithful have more children so genetic evolution favors faith and will remain in competition with cultural evolution.

Konner provides a comprehensive and ambitious overview of faith in religion and spirituality which deserves critical analysis by others, more expert than I in his fields of endeavor. What remains unclear is a more precise estimate of the probability levels appropriate to each of the conclusions and predictions - the levels of faith, doubt and skepticism appropriate to each. Konner acknowledges that this continuum exists but the book's index makes only single mentions of doubt and skepticism. Freud's essay, *"Future of an Illusion,"* traces doubt as far back as religious claims exist and philosopher Bertrand Russell, in an essay published posthumously, *"Is there a God,"* defines skepticism as a universal attribute, a defense against absurdity.

My Career of Doubt, Skepticism and, Finally, a Search for Faith

Born British, I was raised by parents who, like increasing numbers of the world's citizens, were "nones," those who when asked to declare their religion, check "none of the above." My father was an undemonstrative remote role model, a highly successful world sales director for a major tea company. My mother was an extroverted but mildly anxious caretaker who chain smoked and later became an alcoholic leading to death due to *delirium tremens* following surgery for an obstructed bowel in mid-life. From age 5 till 18 I spent two thirds of each year in boarding schools, separated from parents, safe from city germs (in India) and German rockets (in England). I excelled intellectually and athletically, captaining most of the sports teams, becoming a senior prefect and

the first member of my family to attend university. As a young child I was emotionally fragile, subject to bouts of abdominal migraine and, announcing at about age seven while "treating" my mother's bunions with colored paint, that I wanted to become a doctor. This was enthusiastically endorsed by parents but only understood by myself when I became a poet in mid-life.

Wounded Healers

(Blackwell 2016a)

Infants born in orphanages,

torn from a mother's breast,

die from a drought of love.

Kids abandoned or abused

at home or sent away

from bombs or city germs

are divorced from love.

First, they cry, then wonder why?

When feelings fade, ideas intrude,

they ponder what to do,

ask what conditions love

if self is not enough.

What soothes an aching void?

Kids compensate, choose who to be:

care providers for a world of want.

Tendering kindness for kindred souls,

solace for unmet needs.

"Mother Love", by other names.

late in life some burn out,

giving what they went without,

wounded, healing others, not themselves

The Path to Medicine

Throughout childhood and as an adolescent I remained faithless. At Methodist boarding school I was compelled to attend chapel twice daily but declined confirmation. During the military draft in the Korean War I was trained as a Hygiene Assistant (a military sanitary inspector), given a motorcycle, promoted to sergeant and posted to Salisbury Plain, close to Stonehenge, where I inspected the Reserve Army training camps, their latrines and cookhouses.

At Queens' College Cambridge, in pre-med, I played rugby for the Sixty Club (the university second team), frequented the pubs, joined the social clubs and achieved a mediocre degree.

At Guy's Hospital in London I captained the oldest rugby club in the world, fell in love with clinical medicine and published my first article in the Lancet as a junior house officer on "Why patients come to a casualty department" (Blackwell 1962). I decided on psychiatry as a career during my OB/Gyn rotation after caring for a pregnant "primip" terrified of childbirth who my consultant forced into labor after denying my suggestion first for a psychiatric consultation, then for a Cesarean section, which he ridiculed, based on statistical outcomes. I sat by her bedside as she screamed throughout labor. That very week the Lancet published a leading article on "Human Relations in Obstetric Practice" by the Chair of Obstetrics at another London teaching hospital (Morris 1960). Two weeks later the Lancet published my letter to the editor (using the same title) setting the record straight (Blackwell 1960). My belief that emotion trumped statistical

outcomes was based largely on ignorance for which I paid a heavy price. When I took the final exams for graduation six months later (with no anonymity) the examiner in the obstetrics practical invited me to do a vaginal exam on a pregnant patient, mocked my clumsy attempts to don size six gloves on my size seven hands, and commented "*I see you don't do this very often Mr. Blackwell."* He exerted his ability to fail me for the entire exam; I spent the next six months doing nothing but obstetrics before finally qualifying.

Training to be a Psychiatrist

After six months as a senior house officer on a neurology service I joined the Maudsley Hospital and London University Institute of Psychiatry. Lacking Board Certification in Internal Medicine, which Aubrey Lewis preferred, I was posted to the B stream at the Bethlem Royal Hospital in the suburbs. Within six months I had discovered the interaction between MAO inhibitors and tyramine containing foods like cheese, later published in the *Lancet* (Blackwell 1963). I was promoted to the Professorial Unit and required to wear a symbolic white coat under the eagle eye of Sir Aubrey. Pleased with what he saw, he offered me a two-year Fellowship in Psychopharmacology contingent on renouncing any intention of undertaking a psychoanalysis in which I had shown no interest. My work in rats, cats and humans earned me a Doctoral degree in Medicine and Pharmacology from Cambridge University.

By now I was a scientifically trained skeptic, writing anonymous leading articles and annotations for the *Lancet* and devoted to the scientific model of Maudsley training that Sir Aubrey designed for trainees expected to become worldwide leaders in academic departments of medicine. (Goldberg and Blackwell 2015). After graduation I was assigned to be a Research Associate working with Michael Shepherd on two research projects, both published in the *Lancet*.

Shepherd was a brilliant clinician and scholar - skeptical to an extreme, harsh and demanding with students, colleagues and staff which made him unpopular. But he treated me with respect and made me the senior author on both of our publications. The first, published in the *Lancet* (Blackwell and Shepherd 1967), was a review of the emerging contemporary research methodology in drug trials, the difficulties and need for rigorous double-blind and statistical methods to protect against bias.

The second publication sparked an international controversy that persisted almost half a century, recorded in detail (Blackwell 2014a). This second paper was a critical review of the first claim by Scandinavian research workers, Baastrup and Schou, that lithium had a prophylactic effect by reducing recurrent episodes of bipolar disorder.

Perhaps, partly due to our first publication, Shepherd had been invited to present a paper at a small private meeting as an expert on trial methodology where Schou also gave a pre-publication account of his innovative research on lithium in which he revealed his brother suffered from lifelong recurrent episodes of illness in bipolar disorder, not benefitting from either ECT or imipramine.

The following year when these results were published in the *Lancet* our critical evaluation, published in the same journal, was titled "Prophylactic Lithium; Another Therapeutic Myth." Our discussion expressed concern the trial was not double-blind, had other questionable design and statistical features but also hinted that Schou's familial history might have introduced bias. As senior author, I was unaware of the reason for Shepherd's skepticism, which he never discussed, although I fully endorsed the methodological and statistical flaws.

Some years later, after I had moved to America, worked for industry and prescribed lithium myself, my skeptical opinion of lithium became mellow and I acknowledged we had "been wrong for the right reasons" (Blackwell 2014a). "Wrong" because all the original discoveries, including lithium (in mania and prophylaxis), were made in small numbers of asylum patients in clinical conditions without research constraints (Ayd and Blackwell 1970). But "right" because what ensued were many potentially highly profitable but often "me-too" products produced by industry that must be proven "safe and effective" compared to placebo in controlled studies. The lesson learned - skepticism was a moveable feast, shaped by experience.

By the time I graduated as a psychiatrist I was married with three children under the age of six, still playing club rugby for the Saracens, a Major in a Reserve Army Field Ambulance, a published author and confirmed atheist.

A year in Family Practice

Not convinced I was ready to give up medicine for psychiatry, I spent a year in suburban family practice as junior partner to my friend and Commanding Officer of the Field Ambulance. At the same time, I collaborated with David Goldberg, a friend and Maudsley colleague working in the Social Psychiatry Unit, on the development of the first rating scale to identify mental illness in primary care, the General Health Questionnaire (GHQ). Together we confirmed its specificity and sensitivity in a primary care setting and published our findings in the *British Medical Journal* (Blackwell and Goldberg 1968; Goldberg and Blackwell 1970). David would go on to a distinguished career, eventually head of our alma mater and knighted by the Queen. Our findings lent scientific understanding to the wide variability of estimates about the prevalence of mental illness in primary care, clearly an "eye of the beholder" phenomenon. I enjoyed primary care and learning about the early manifestations of mental illness and its natural history, mostly mild mixtures of anxiety and depression that responded readily to low dosages of medication. I also recognized I wanted an environment conducive for research that allowed more time to deal with individual patients. I was ready to emigrate to America, still the "land of opportunity," and accepted a position as Director of Psychotropic Drug Research at the Merrell Pharmaceutical Company in Cincinnati. I would have one day a week to consult and teach at the University of Cincinnati University Departments of Psychiatry and Pharmacology.

Working for the Pharmaceutical Industry

Merrell had recently been sanctioned by the FDA for marketing thalidomide as a safe hypnotic for pregnant women, causing phocomelia, congenital dystrophy of the infant's limbs. Public outrage led Congress to pass the Harris-Kefauver Amendments empowering the FDA to introduce strict double-blind controlled methodology for establishing the safety and efficacy of new drugs prior to marketing. These guidelines were in synchrony with my skeptical experiences at the Maudsley with Michael Shepherd.

Prior to the FDA's new requirements, the American Pharmacopeia was packed with panaceas, placebos and products enthusiastically endorsed by prominent physicians and experts in their fields, but without scientific proof. The cost of proving these drugs safe and effective, often years after their discovery, would be prohibitive and the likelihood of success slender. Any suggestion

that statistical methods were superior to clinical wisdom was anathema to many practicing physicians, although firmly held by me.

Inevitably the FDA mandated the removal from the Pharmacopeia and cessation of advertising for many of these old products. This, in turn, unleashed a flood of testimonials from patients and providers which FDA promptly rejected; these were no substitute for scientific evidence. There would be no "humanitarian" exceptions. The FDA left industry to respond and explain to any such plaintiffs.

Merrell marketed several such drugs. In the mental health arena one such compound was azocyclonal (Frenquel), a mild sedative with the unique claim that the drug alleviated hallucinations, whatever the cause. It was also unusual; available in both oral and intravenous forms, the dose by injection was higher than by mouth.

So, the FDA's new guidelines set the stage between faith and skepticism; I was theoretically in agreement but practically placed in the middle, as an adjudicator.

Soon I was scheduled to visit New York on a business trip and shortly before received a phone call from an aggrieved psychiatrist treating a patient with Frenquel whose hallucinations responded to that and nothing else. I listened, became curious and agreed to stop by his office and meet the patient.

The office where the cab let me off was in Greenwich Village, next to a homeless drop-in center. The doorbell was answered by a polite, casually dressed, older physician who greeted and ushered me into the basement, furnished more like a doctor's office than a psychiatrist's den. In the center of the room stood an examining table rather than a couch, with an attached shiny aluminum tray on which lay a large syringe containing a colorless liquid I assumed was Frenquel. Sitting on the table, legs dangling and wearing a brightly colored, mildly revealing, dress, was an attractive young woman. Almost before I could take in the scene, she leapt to the floor, faced me and began to shout, "so you're the f---ing drug company man that's going to ruin my life!"

The doctor moved quickly to take her arm, guided her back to the table and did his best to calm her. She settled down and lay back, still eyeing me furiously, pulling up the sleeve of her dress to expose the veins in the hollow of her arm. This was obviously a well-practiced routine, which the doctor performed often. He inserted the needle and gently pushed the plunger as the

patient closed her eyes and appeared to drift into a light sleep. Visibly relieved, the doctor removed the needle and lay down the syringe, then leaned toward her, "It's all right Martha, you can get up now." Her eyes opened, she smiled at us and thanked me for coming so far out of my way to help her.

Another surprise awaited me; the doctor suggested the three of us have lunch together. We walked to a nearby bistro, and over a meal paid for by Merrell, I spent an hour in the company of two friendly, apparently normal people. Over lunch, the doctor explained that the alcohol and drug detox center adjoining the homeless center used Frenquel often to "bring down" people in drug withdrawal.

On the flight back to Cincinnati, I wrote up my "trip report" explaining I had found two new "off label" uses for Frenquel: to calm someone who, most likely, had a borderline personality and to facilitate drug or alcohol detoxification. I didn't suggest Merrell pursue research into these potential new indications, but perhaps I was wrong. New uses for old drugs are often discovered by chance, looking for one thing but discovering another. It's called serendipity. On the other hand, it seemed more likely that everything attributed to Frenquel might be due to suggestion or the placebo response. My skepticism was stronger than either the patient or the doctor's belief; faith lost!

The best aspect of my time at Merrell was that I became a friend and colleague of Frank Ayd, a consultant for the company, who introduced me to researchers all over America and sponsored my membership in the American College of Neuropsychopharmacology (ACNP).

Return to Academia in 1970

Together Ayd and I planned and implemented the Taylor Manor Hospital Conference in Baltimore on "Discoveries in Biological Psychiatry," (Ayd and Blackwell 1970). This brought together all the clinicians and scientists to tell first-person stories of their discoveries. These discoveries were all made in small sample sizes devoid of scientific or statistical constraints, largely in an asylum setting. This included lithium in acute mania, chlorpromazine, imipramine, the minor tranquilizers, the MAO inhibitors and lithium for prophylaxis in bipolar disorder. Their work converted skeptics into believers about drug efficacy and some, like Kuhn with imipramine,

remained skeptical of statistical protocols, placebo controls and large sample sizes (Baumann and Ferraro 2016).

As a faculty member at the University of Cincinnati I held professorships in pharmacology and psychiatry as well as being the head of the Psychosomatic Unit at Cincinnati General Hospital. The Chair of Psychiatry and almost all the faculty were psychoanalysts while most of the residents were in analysis with a faculty member. It was a somewhat hostile environment although the Chair was supportive, (he had authored a book on Psychiatry in Family Medicine). Margaret Mead, the anthropologist and a visiting professor, was also supportive at a time when the American Medical Board had removed the requirement for rotating medical internships so graduates could become psychiatric trainees without any medical practice experience.

In the two previous decades, 1950-1970, psychoanalysis had achieved almost total hegemony over academic psychiatry in America. During this period, elsewhere in the world, psychopharmacology flourished, developing and approving safe and effective drug treatments for all the major mental disorders. This remarkable disparity was enabled by the contrast between European scientific skepticism, epitomized by the Maudsley, and uncritical acceptance of Freudian ideology in America.

Psychoanalytic therapy directed at anxiety as the sole etiologic factor in mental illness achieved the status of unquestioning belief, held by its practitioners as faith. The only benefit attributed to drugs was to reduce anxiety, facilitating therapy and acceptance by the patient. Residents in training who used drugs hoping to relieve depression or moderate psychosis were accused of sadistic impulses triggered by therapeutic impotence. Those who sought training in the new discipline of psychopharmacology were similarly castigated.

But in 1970 the tide was beginning to turn. A US/UK Cross Cultural Study that exposed the parsimony and poverty in American diagnosis was also confirmed by an ingenious research project, “On Being Sane in Insane Places” (Rosenham 1973). This revealed the ease with which normal subjects faking mental illness could be admitted to asylums and “treated” there.

Nevertheless, in Cincinnati I found students in pharmacology, medicine and some in psychiatry eager to learn about psychotropic drugs. I was even able to dissolve their skepticism about the placebo response as volunteer subjects in a class experiment taking one or two red or

blue capsules (all placebo), but labelled as “sedative” or “stimulant” and blindly predicting, with accuracy, the different levels of cognitive and physical response to each dose and capsule color. Published in the *Lancet* (Blackwell, Bloomfield and Bunch 1970), it was criticized by the Chair of Pharmacology as “unethical” but the students awarded me their annual “golden apple.”

The psychiatry faculty were, as expected, ambivalent about my presence. They warned residents that working on my unit might “ruin their career.” This was dealt with on several fronts. I challenged the leading analyst to a public debate with success and held my own clinically at Grand Rounds Presentations. A skit undertaken by the residents without my knowledge contributed. At a Christmas party given by the Chair for faculty, staff and residents they presented a quasi-research project. A female resident with acting skills had phoned each on-call faculty member past midnight behaving as a hysterical patient using a written script and rating each response on an empathy scale. To everyone’s surprise, I won!

Potent external forces were also in play changing the academic climate. After funding psychiatry departments psychodynamic research efforts for several decades with little or no effect the NIMH, foundations and the pharmaceutical industry began to support research and education in psychopharmacology. To help bolster medical input to training programs NIMH began to recruit and fund primary care physicians willing to change careers by enrolling in psychiatry residency programs with success (Blackwell 2019).

On the Psychosomatic Unit I was fortunate to find a talented psychologist and head nurse (later my wife). Groundwork for change may have been left by my predecessor, George Engel, both an internist and training analyst who became a leading advocate for a biopsychosocial model of illness after moving from Cincinnati to become Chair of Psychiatry in Rochester.

The patients I inherited on the Psychosomatic Unit were mainly anxious and hypochondriacs, seeking attention and medication for mostly medical complaints that failed to benefit from psychoanalytic interventions, were unlikely to need medication and were at risk for addiction.

Together the staff and I designed a cognitive-behavioral treatment program for what we designated as “illness behavior; disability disproportionate to any detectable medical disorder” (Wooley, Blackwell and Winget 1978).

At the Maudsley half of my entire psychiatric education was spent in laboratory work on cats and rats; the only outcome measure in my doctoral dissertation was blood pressure and compounds influencing it. My sole close faculty contacts were Aubrey Lewis and Michael Shepherd (with whom I completed two drug studies), in addition to David Taylor, with whom we completed an early effectiveness study on use of the MAO inhibitors in outpatients. I escaped the Jungian and Freudian analysts as well as Eysenck, head of psychology.

A year in primary care taught me usually to wait and see whether complaints got better, worse or stayed the same before deciding on the likely benefits of treatment or expensive investigation.

In Cincinnati, exposure to both cognitive and psychodynamic concepts broadened my skeptical mind in novel directions and led to expression of them in scientific articles and in creative medical writing. Below are three examples:

It Only Hurts When I Cry

(Blackwell 1987)

> Linda did not look like a clown. She was short, skinny and sad. At her outpatient evaluation the staff were preoccupied with her many pains, wheezy chest and ailing heart. Her hobbies hardly seemed significant and went unexamined.
>
> After she was admitted to the Psychosomatic Unit, Linda's cardiac condition was stable, her pain was chronic and she remained sad. Lucinda grudgingly agreed there was nothing malignant or fatal that caused her suffering, yet she was unable to give up her aches and their audience until she glimpsed solace elsewhere.
>
> Lucinda's slow progress changed abruptly soon after she told us that four generations of her family were clowns, including men and women, from grandparents to grandchildren. Each clown created his or her own unique face; either White (the provocative French mime), Auguste (the boisterous German bully) or Tramp (the downtrodden American bum). Lucinda was too old for Mime and too slender for Tramp. She chose Auguste, a jovial extrovert who jostled other clowns.

One day Lucinda brought her clown regalia to the hospital and painted on her face to entertain the other patients. It was a metamorphosis as dramatic as caterpillar to butterfly. Lucinda's crescent lips curved upwards into a smile that spread as far as the crow's feet around her eyes. As she went into her routine Lucinda shed her limp, her shoulders lifted and her voice lost its weary timbre.

Once clowns are attired, they adopt an etiquette. Profanity, smoking and drinking are forbidden. If children rush up to tweak their bulbous nose or tread on their oversized shoes, clowns are enjoined to banter back. Irritability and anger are outlawed. Lucinda played her role to such perfection that her aches were no longer obvious. Nobody knew for sure if they still existed. Talking about pain makes it worse, so in social situations staff and patients are instructed not to enquire. But, at morning rounds, when we wore our white coats, we were allowed to ask. Lucinda told us her pain was hardly present when she clowned. She sounded surprised, although it was what she had noticed years before but ignored. Instead, the worse the pain the less she performed, so that even the clowns in her "ally" left her alone.

Once Lucinda learned she could control her pain everything else came quickly. She mastered biofeedback and learned to relax, reached her exercise quotas and slept soundly. When we asked her what helped most, she talked about learning to be assertive with her family and no longer letting the kids take advantage. She learned to set limits on their demands without needing to suffer or be sick.

Our time on the inpatient unit ran out together. My monthly stint as attending physician was over the day Lucinda was discharged. At morning rounds the patients sit in the day room waiting for us to see each of them in turn. As I looked up Lucinda was waiting in the wings, ready to walk on stage. She smiled and sat down. The rehearsal ended and the show was about to begin. I asked how she would make it in the real world without greasepaint? Lucinda laughed and said she thought she could, "now that can be a clown without letting the kids walk all over me."

Single case studies are an attractive way of communication but weak at dissolving skepticism about the belief they attempt to convey. I participated in a World Congress organized by the Australian psychiatrist Izzy Pilowsky and co-edited a book of the

proceedings that included research data gathered over two years from the Cincinnati Psychosomatic Unit (Blackwell and Pilowsky 1987) but even this did not include a precise replication of our findings by others. Our definitions, data and results, were unique and within a decade became impossible to repeat when, in the 1980s insurance companies in America declined to fund expensive multi-disciplinary inpatient care to reduce illness behavior even though economic analyses clearly showed a "medical offset" in reduction of medical costs after psychiatric intervention. The best example was the savings in emergency room costs when patients were taught how to recognize and treat panic attacks.

When I visited Britain and presented our research to a conference at the Maudsley the audience's skepticism was polite but palpable.

Light Touch

(Blackwell 1986a)

Tickle is a curiously dilute form of pain; it travels the same path through the body to the brain. Both sensations are enhanced by the presence of another person. Biologically it makes perfect sense. Suffering and pleasure are meant to be shared, nourished by comfort and communication. Talking amplifies pain, inviting solace. Tickling is for two. When nobody is there the sensations dwindle or disappear.

In my practice I often see chronic pain. Intractable but benign, it ruins life rather than ending it. I witness its contortions and attend to its sighs. Seduced by its presence I become its significant other. Only when we can discover some new pleasure in a patient's life can I be emancipated from charts as thick and as heavy as tombstones, often we cannot. Bad thoughts, scant sleep and poor coping collude with the pain. To break this cycle, I am sometimes tempted to prescribe. Drugs named antidepressants block rumination, induce sleep and restore coping. When that happens I wield my pen lightly. It feels like a feather.

This short essay was published in the *Annals of Internal Medicine*. As a psychopharmacologist I knew about the analgesic property of imipramine, the neuroscience that underlay its effect and the practical value of its use in the pain clinic where I worked part time. In Cincinnati I supervised two psychiatric residents in conducting a placebo controlled double-blind research project with imipramine for pain relief in chronically ill male inpatients. Imipramine and the placebo were equally effective! The residents, in analysis, were delighted that empathy equaled medication. (Evans, Gensler, Blackwell and Galbrecht 1973). Part skeptic, part believer, I explained this to myself as an attribute of a particularly needy, attention deprived population of veterans.

Twice in a While

(Blackwell 1986b)

In every age there are medicines of the moment that divide doctors down the middle. In the 18th century it was opium; in the 19th century bromides; and in the early 20th century barbiturates. The 1960s ushered in the benzodiazepines, like Valium. In an era of John Kennedy's Camelot. By George Orwell's *1984* it became clear some people were more equal than others; these drugs were being prescribed more often to women, the indigent, the elderly and the maimed.

These drugs were so safe they could be used more often and for less reason, raising hackles on segments of the public. Were mind-tampering drugs being used to correct a social or a chemical imbalance? Were doctors dabbling in existential predicaments beyond their bailiwick? Was there a medicine for "mother-in-lawness" or a pharmacologic lid to Pandora's Box?

These are all appropriate questions to be asked in an age that has amplified "anxiety" and invented "safer" tranquilizers to stifle it. But the problem is more broad and older than that. It has existed since there have been panaceas, physicians to prescribe them and a public to seek such comfort. Even if the correct agenda is caretaking and not chemicals the drugs often help in uncertain ways.

Which drug it is doesn't really matter. But how it happens does. It could be (and has been) various tonics, liver extract, Vitamin B 12 shots, iron tablets, thyroid pills or THC derivatives. They are given to patients who visit doctors when life events have loaded up on them. Often these are symptom-sensitive people with the amplifier turned up on their autonomic arousal. They voice distress in body language and invite doctors to collude with diagnoses and prescriptions.

After they leave the office, life subsides or the pills placate them. A cycle is set. Next time a spouse leaves, a job ends or a child sickens they return expectantly for more. "Those pills you gave me really helped they say."

Doctors disagree about all this. Prescribers are "chemophilic hedonists" say those who withold. Witholders are "pharmacologic Calvinists" say the prescribers. My partner and I sit in friendly disagreement on opposite sides of this rhetorical fence. She is younger than I and knows where the benzodiazepine receptors are in the brain. When her patients see me, we talk briefly about their troubles. Some in a minor way, seem more tranquil. Others sense the skepticism with which I write their refills. "There isn't any harm" they ask, "if I just take them once in a while?" "The only risk," I reply, is "twice in a while."

This skeptical essay has deep roots. Its origins began during the 1960s when the benzodiazepines began to appear and I was a family doctor in London with psychiatric training. In 1973, working at the University of Cincinnati and consulting with industry I had access to national prescribing data on psychotropic drugs and wrote a leading article for *JAMA* describing a remarkable increase in the use of diazepam (Blackwell 1973). The upward trajectory suggested it would not be long before the entire nation was tranquilized. Over the next two decades sustained controversy persisted, reviewed and summarized in an essay, "The Anxiety Enigma" (Blackwell 2014b). This vast body of knowledge documents the social, psychological and pharmacologic data concerning the use and response to anxiolytic drugs that have proven effective under artificial trial conditions sufficient to stifle skepticism about the pharmacology of what is in the bottle, but inadequate to quell endless debate about appropriate prescribing and use.

Moving On

After four years of academia in a psychoanalytic department I was ready to move on. The national climate was swiftly veering toward a more eclectic and less rigid clinical ideology, open to new ideas. In 1973 Maury Levine the chair in Cincinnati fell sick with acute leukemia. Famous for his *Memos from Maury,* he sent one to me from his sick bed promising that when he recovered we would jointly teach a seminar devoted to the integration of psychodynamic and biological principles. Sadly, Maury died and I moved on to become the Founding Chair and Professor of Psychiatry, Medicine and Pharmacology at Wright State University in Dayton, Ohio.

Medical School and Modest Expectations (Blackwell 1985)

For more than 50 years medical educators had expressed concerns about the end-product of the Flexner tradition from apprenticeship to scientific medicine in ivory tower universities. In 1927 Francis Peabody, a distinguished internist and educator, complained that "young graduates have been taught a great deal about the mechanism of disease but very little about the practice of medicine, they are too scientific and do not know how to take care of patients."

Fifty years later George Engel, whose psychosomatic unit I inherited, echoed the same sentiments and proposed a new biopsychosocial model: "Medical education has grown increasingly proficient in conveying to physicians sophisticated scientific knowledge and technical skills about the body and its aberrations. Yet, at the same time, it has failed to give corresponding attention to the scientific understanding of human behavior and the social and psychological aspects of illness and patient care."

Wright State was among the last of 30 Federally funded new medical schools in a community setting throughout America, fueled by academic and public sentiment for a need to produce primary care physicians with a humanistic bent who might be willing to serve in urban or rural underserved locations.

With experience in psychiatry and primary care I felt equipped to tackle this challenge, recruiting a psychoanalyst and cognitive behavioral psychologist as senior faculty. We designed innovative and integrated curriculum, recruited a diverse student body and conducted a national

survey which revealed that the amount of time already devoted to teaching behavioral sciences had increased from 26 to 362 hours in the four year-long medical school experience (Blackwell and Torem 1982).

For example, we designed a novel "Meeting the Cadaver" experience. The day before beginning to a dissect, students were introduced to their cadaver and asked to write an essay about the persona. Faculty that participated included psychiatry, anatomy, medicine, surgery and medicine in society (ethics and social work). Analysis showed that most described versions of themselves and I knew we had failed when one of the students cut off his cadaver's penis and flashed it on campus.

Some years after the first class graduated and I had moved on I described the experience in "Medical School and Modest Expectations" (Blackwell 1985). The problem, in a nutshell, is that the irrefutable core of medical education resides in the hard sciences of saving or prolonging life against which the social and psychological nuances compete poorly. Both requirements are still designed to fit in the same short four years of curriculum. On graduation increasing debt drives the best students to select the most technical, highest paying specialties.

Innovative attempts at novel biopsychosocial curriculum compete poorly with skeptical students' needs for scientific certainty in a life-saving model.

A Challenge of a Different Sort

Older and wiser in 1980 I became Chair and Professor of Psychiatry, Medicine and Pharmacology at the Milwaukee Campus of the University of Wisconsin Medical School in Madison. Situated at Mount Sinai Jewish Hospital in downtown Milwaukee, this location provided a diverse and large low-income inner-city population for training residents and medical students, not available in Madison.

I quickly recruited faculty, obtained accreditation for a Residency Training Program and filled our slots with a combination of American and Foreign graduates.

My professional persona was a mellow blend of scientific skepticism and faith in human nature, but in religious life I remained an atheist married to a Catholic wife keen to raise our son

in her faith. At age 46 I would be exposed to the Jewish and Catholic faiths at work and home at the same time as I began taking poetry classes at the University of Wisconsin, Milwaukee.

We toyed with the idea of Judaism but on meeting a prominent Rabbi discovered a reluctance to proselytize or convert either an atheist or a Catholic.

More welcoming was the Catholic Church my wife attended with our reluctant son and I considered converting to her faith. After a few sessions with our vicar I applied for a marriage annulment which was granted, then consummated with a white wedding.

My acceptance into the Catholic Church led to important changes in my immature spiritual life. I was invited to become the psychiatric consultant to the Archdiocese's Annulment Tribunal. When a narcissistic plaintiff, whose request was denied, threatened to kill me the Tribunal gave me his photograph and advised me not to open our front door before admitting visitors.

The Auxiliary Bishop, a saintly man, made me a member of his panel adjudicating treatment plans for victims of sexual abuse. He also gave me two confidential assignments. The first to evaluate the correspondence between serial killer Jeffrey Dahmer and a Catholic nun after he had a conversion experience in prison, just before he was killed by a fellow prisoner. Should these letters be archived or destroyed? The letters were mundane, had no significant forensic or spiritual significance and I recommended they be destroyed.

The second task was to evaluate a Catholic youth minister at a local parish who had performed a charismatic ritual, "speaking in tongues and being slain in the spirit" at a youth retreat on an adolescent girl who was in psychiatric treatment for an eating disorder. She became hysterical and her parents, who had not given permission and were wealthy donors, filed a complaint. I recommended clarification of the church's regulations concerning charismatic practices and oversight in youthful and vulnerable individuals.

My involvement in the parish deepened; I read lessons and taught confirmation classes our son attended but resolutely rejected, which made me wonder if atheism was genetically transmitted.

In the mid 1990s I was invited to take a sabbatical at the NIMH in Washington DC as the Program Director of a Federal Inter-Agency Task Force on Homelessness, a topic I became

involved in when Milwaukee enrolled in the Robert Wood Johnson multi-city program. I authored a five-city report on "Psychiatric and Mental Health Services" for the book, *Under the Safety Net* (Blackwell 1990).

My experiences at the NIMH and with Federal inter-agency politics were frustrating and disappointing; separated from family I became depressed. So, I resigned and returned to Milwaukee to face an even more dismal scenario. In two decades (1980-2000) six Milwaukee Hospitals became bankrupt and closed in what I described as a "Healthcare Holocaust" (Blackwell 1994). Although our Jewish Hospital survived its Catholic partner closed and Mt. Sinai was taken over by a health care corporation which closed the psychiatric inpatient unit because it could not make a profit from mental illness. The residency program collapsed, I resigned and for several years worked as a consultant to Blue Cross and Blue Shield, then as Medical Director of a small Managed Care Company. Then I retired for the first time, in Spring of 1998.

In the search for a theme for retirement I began to re-consider my spiritual life. As an early adult a blend of atheism and hubris made me disparage those who espoused religious or spiritual convictions. I viewed them as self-deluded folks, lacking intellectual vigor or easily misled. As a young psychiatrist I seldom enquired about a patient's faith. By the time I retired I was wiser. In my contacts with Catholics I envied those who claimed a spiritual dimension and wondered what I might be missing. I undertook a personal retreat at the Holy Hill Basilica on my own and, after experiencing a form of conversion, decided to enquire about joining a master's degree program in Applied Pastoral Studies (MAPS) at the Milwaukee Catholic Seminary. There were hurdles to cross: two interviews with former graduates to assess my suitability and capability; next an essay for the dean describing my purpose; and finally an interview with a psychologist to screen out emotionally troubled or immature applicants. Before enrolling I was required to take prerequisite 101 courses in Religion and Philosophy.

Saint Francis Seminary was a short distance from the Archdiocese headquarters I was already familiar with, looking towards Lake Michigan and nestled in several acres of woodland. It offered a variety of educational opportunities in addition to priestly vocations. In addition to the MAPS program there was more rigorous Master of Divinity (M.Div).

Faculty was outstanding, many had doctoral degrees and academic standards were demanding, including oral and written exams at the end of each course. Essays had to be formatted and

footnoted to precise requirements. I took meticulous notes on 4x6 index cards I kept on my person to memorize. Competitive by nature I was determined to maintain an A average, not insignificant alongside seminarians 40 years my junior. Classes were small and intimate, usually six to ten individuals including the all-male seminarians and lay students, mostly women seeking second careers as educators or lay administrators in local parishes coping with the priest shortage, many of whom had stifled aspirations to ministry.

Also important was the social environment and sense of community. Saint Francis is approached through an avenue of tall trees, arching over a long driveway and leading to a statue of Saint Francis at the entranceway. Inside the hushed corridors led to a solemn chapel; the wall beside the altar adorned with a gold and crimson painting of Jesus as teacher and rabbi. Faculty, students and the bishops mingled at meals round common tables in the rectory, worshipped together in the chapel and shared in a rich variety of extracurricular lectures and seminars. Presiding overall was Archbishop Weakland, former Head of the Benedictine Order and a talented Julliard piano graduate.

I became immersed in all these activities, was elected to the Student Council and helped lobby for more attention to women's issues, a plea the church was not ready to hear. In class I asked the probing questions many were reticent to ask and received honest and open answers.

I kept my work to a modest six to eight hours each week and other than domestic chores had only one other commitment. The year I retired the Governor of Wisconsin appointed me to the State Mental Health Council for an initial three-year term, followed by a second when I served as Chair. This was a pragmatic counterpoint to my spiritual quest but also an opportunity for good works in the mental health arena.

Wisconsin is well-known for its commitment to innovative mental health policies; it pioneered the case management model of community care in the mid-1960s to unite fragmented agencies and services to help prevent the recurrent hospitalization of those with severe and persistent mental illness. During the time I was on the Council Wisconsin made another major contribution to innovation, the so-called "Procovery" movement. This sought to empower people with mental illness to capitalize on their intellectual, emotional and spiritual strengths in order to play a larger role in their rehabilitation even when full recovery was unattainable. State funds were allocated

to support this at the community level and several leaders in the movement were appointed to the Council.

Later during my time in the Seminary I took advantage of this to organize a "not for profit" 501©3 organization called "Faith in Recovery" in several ecumenical (but mainly Catholic) faith communities, then obtained IRS approval and raised funding from churches and foundations to support the project, including a "tool kit" and website to help Procovery-minded individuals initiate new programs. After I obtained sufficient course credits I planned to make this my dissertation.

At the turn of the century tensions at the seminary were rising. Our liberal Archbishop was close to retirement and his reputation had been sullied by a midlife homoerotic affair with a graduate student who betrayed his trust to extort funds. Meanwhile the Archdiocese was struggling to cope with the pedophile crisis and its financial fallout. A new more conservative Archbishop arrived and was facing bankruptcy at a time when the hierarchy's response to the shame and chaos was a return to more rigid and traditional liturgical practices, including reversion to its paternalistic and misogynist roots. Both the seminarians and the lay students picked up the scent.

My time at the seminary was running out. I had completed the course work and my dissertation topic was approved. But my primary task had yet to be accomplished. The intellectual and social accomplishments in class and the community were satisfied but the spiritual aspect was in limbo. For more than a year I had been seeing my spiritual director monthly. A kind, wise and empathic nun from the adjacent nunnery had patiently borne my intellectual contortions in a long search for a spiritual dimension. She suggested centering prayer, a strategy designed to obliterate the self and stifle the ego but I dozed off. After that and other meditative forms failed she wondered if focusing on the daily gospel might work. But my busy medical mind dissected the literal meaning and missed the metaphor. Each time we met she asked kindly, "And where has God been in your life this month?" Although I got used to this question my initial response was to feel guilty and flinch. I felt called to discover, recollect, even invent, some divine revelatory intrusion into my everyday experience.

Throughout my time in the seminary I kept writing poems. Here is one that touches on the essence of my problem, but not the solution:

Seek and Find

(Blackwell 2016b)

Man may find God

In anxious prayer

Or maybe not.

Man may find God

In tedious work

Or maybe not.

Man may find God

In glorious nature

Or maybe not.

Man may find God

In pious churches

Or maybe not.

Man may find God

In joyous play

Or maybe not.

Man may find God

In obvious places

Or maybe not.

God will find man

Somewhere he searches

And never not.

This poem contains not so much the solution to my predicament but an explanation in a book written by a prominent theologian, *On Knowing God* (Gill 1981). He suggests that intellect cannot fill a spiritual void. Experience of the divine is only obtained, as the poem suggests, in the kind of conversion experience described by William James (1902) that I had before setting out on my search. This resonated with my seminary experience in that the religious role models I came to admire were all caring people I felt sure were capable of unconditional love – the only kind of love sufficient to sustain a relationship of faith with the unseen. This was the part missing in me.

Another poem (below) expresses those features of personality that stand in the way of a full faith in the unknown, diminishing a capacity for unconditional love. I had previously attended a national conference for mental health professionals on the Myers-Briggs Personality Inventory which all those attending were required to take. I learned I had an INTJ profile typical of Skeptics and atheists; introverted, logical and a decision maker. By contrast the profile typical of faith-filled believers was ENFP: extroverted, intuitive, feelers and perceivers.

Late Harvest

(Blackwell 2012a)

Prayer is a want

God plants at birth,

But unmet needs,

A drought of love

Force weeds to grow

Our haste to speak,

Our introspection,

Our must control,

Our self-perfection,

Our lack of trust.

These faults that nip

The buds of faith

Yield no crops; just

Silence between

God and me.

Despite these doubts

We will keep vigil.

Divine seeds sprout –

What God has sown

He means to reap.

Towards the end of my time in the seminary I felt content to acknowledge I was “spiritually handicapped,” comfortable as a skeptical scientist. Any sadness I felt was ameliorated by the storm clouds that were gathering: misogyny, chauvinism and pedophilia.

Muted misogyny is a bedrock of the Catholic Church, built on a foundation of masculine theology and male chauvinism. My first acquaintance with this was discovering the burial and memorial grounds in the woodlands surrounding the seminary.

Seminary Cemetery

(Blackwell 2012d)

Two hundred eighty-one women

in consecrated ground.

Lined like Veterans,

named and dated

under humble headstones.

All born and dead

unemancipated,

between two Councils.

Men are in short supply,

scattered sparsely about,

each lying alone

beneath marble monuments

with etched eulogies.

Their proud tombstones fractured

or toppled over

by teenage gangs.

Looking on, God wonders

why she gave them genders?

My concern about misogyny was shared by many of my middle-aged women colleagues in the MAPS program. Towards the end of my time there I learned the distinction between male and feminist theology at a seminar given by a female theologian from Marquette University in Michigan. Out of the 20 members of my class I was the only male who attended. None of the seminarians were present, fearful that their new conservative Archbishop would disapprove.

A question posed by one of my female companions triggered the poem that follows.

Question in Feminist Theology Class

"Does a then and now analogy

Reveal a he and she theology?

(Blackwell 2012e)

Early Councils dictated dogma

leaving naught to chance.

Today's debate embraces metaphor

and celebrates nuance.

The past taught uniformity,

negating every heresy.

The present sought inclusivity

creating more diversity.

Patriarchy defines a heavenly faith

for Christendom from birth.

Matriarchy aligns its path toward

God's Kingdom here on earth.

In my last week at the Seminary my female classmates, frustrated aspirants denied access to ordination, invited me as their only male guest to participate in a secret celebration of Mass, with wine and hosts, held in a small attic under the Seminary roof. The time I had spent seeking faith ended in risking ex-communication!

Departure left my MAPS dissertation incomplete, but the "Faith in Recovery Program" was up and running and I already had two master's and two doctoral degrees. During my time at the seminary I became aware the Archdiocese had four Catholic Charities clinics in Milwaukee County, staffed by social workers and psychologists without a psychiatrist. They served a low-income population that was either without mental health insurance or on Medicaid and unable to find a psychiatrist willing to accept Medicaid payment for medication visits.

The clinics operated on a sliding fee scale down to zero dollars and I agreed to work for less than average remuneration and absorb the cost of travel to the four suburban clinics. If their billing was inadequate to cover my salary I would re-negotiate.

My three-year spell at Catholic Charities was intensely satisfying, working in close collaboration with accomplished therapists and finding free medication for patients from sympathetic and obliging pharmaceutical company representatives who knew me from my academic days.

A second retirement was precipitated when the pedophile crisis threatened the Archdiocese with bankruptcy; their billing for my services were virtually non-existent. So, I was told to resign immediately, leaving almost a hundred patients with nobody to prescribe medication.

Disheartened by the pedophile revelations and the misogyny in our parish my wife and I decided to leave the Catholic Church. My wife transferred to an Episcopal parish and I lapsed back into a benevolent atheism, no longer searching for faith that eluded me for reasons I understood and accepted. Two poems from that time reflect on the sexual origins of Catholic misogyny and pedophilia.

Immoral Theology

(Blackwell 2012g)

Two Millenia of all-male morality
have soured sex, confessed it to death,
condemning untold souls to purgatory.
The celibate Magisterium wed power,
mating with authority.

Forbidden impulses, fear of lust,
shame and disgust suppressed,

hid in Pandora's box.

Theologians second guessed divine intent,

nature, nor faulty reason, was invoked.

Truth revealed in Moral Manuals,

sex concealed in Latin text.

The Curate's Egg: Today

(Blackwell 2012f)

Don't ask and don't tell,

pedophilia's the way

priests have paved to hell.

This pithy Haiku is named after a cartoon published in 1895 in the British satirical magazine *Punch*. A curate is having breakfast with his bishop and is served a rotten egg. When the bishop expresses concern the curate replies, "Oh no, My Lord, parts of it are excellent." Originally intended to convey false modesty, the term "the curate's egg" became incorporated into the English language to describe a bad situation portrayed as better than it is.

My second retirement lasted only a short time. A priest at my wife's Episcopal Church was also Director of Psychological Services for the Wisconsin Correctional System. Would I be interested in joining the psychiatric staff? So, I began part-time work at the women's medium security prison in Waupun, the only psychiatrist looking after about 200 inmates of whom a third had a mental illness.

The nature of the work intrigued me; widespread failure of the community mental health care system, coupled with the closure of asylums meant prison became the de-facto destination for low income or homeless individuals often for relatively minor infractions of the law.

The pay was generous, in a single 10-hour day, plus four hours travel time, I earned enough to help pay my youngest son's annual medical school $40,000 tuition. The medical school provided no medical care but offered him an additional $10,000 to buy insurance. We declined, so he obtained Medicaid which came with food stamps!

Work in the prison was rewarding, collaborating with an experienced full-time psychologist, well-trained nurses and surprisingly empathic correctional officers. The problems were predictable and endemic. The prison formulary stocked the cheapest and least addictive medications, recidivism rates were high, reflecting the low level of community care and poor inter-agency collaboration. The acute medical care at Taycheeda Correctional Institution was under court supervision and excellent, but after transfer to minimum security was unsupervised and less sympathetic. Three poems reflect these predicaments.

The Prison Doctor*'s *Dilemma

(Blackwell 2012i)

In minimum security
one third of women are marred
by abuse, breached boundaries,
male brutality
and psychic scars.

Mean families and broken homes
magnify each faulty gene.
Alone, burdened by childcare,

Illness quickens urban angst.

When sickness is dosed with

liquor, crack, heroin or pot

prison is one wrong day away.

Inside, inmates suffer DSM disorders,

with substance abuse in forced remission,

Diagnoses embroidered by penal epithets,

“malingering” or “manipulative”,

abusive echoes eclipse redemption.

Prescriptions take weeks to work,

from a formulary stripped of

expensive or addictive drugs.

We offer safety over swift solace.

Denied solitude or comfort,

Primal fears and fractured sleep

Sometimes elude our panaceas.

Rehab

(Blackwell 2012j)

There are women jailed

that's done some wrong,

whose minds have failed

and don't belong.

They broke our laws,

got locked in cells,

behind steel bars

they're taking pills.

But once let out

they'll soon be back,

revoked without

the skills they lack.

DOC "Doc"

(Blackwell, 2012j)

There's a prison doc I know well

with a bedside manner from hell.

Blind to feelings of every kind,

he tends bodies but never minds.

***DOC*=**Department of Corrections

Commentary

There is a distinct difference between the two definitions of faith in the OED that this essay examines in the context of my life.

The variable gap between doubt and belief in general matters and the necessity for full faith in the unknown as the essential component for religious belief. Each will be discussed separately.

Belief in Psychiatric Practice

Multiple factors mediate belief in clinical affairs. Access to informed knowledge, vastly enhanced by the internet, the validity and reliability of diagnostic categories, treatment paradigms and etiologic theories, the prevailing scientific climate (*zeitgeist*), the fervor of anti-psychiatric ideologies, as well as the cultural, familial and, perhaps, genetic influences on youthful observers.

I grew up in Britain, a largely agnostic culture, second child of atheist parents and trained as a psychiatrist and psychopharmacologist in a skeptical and critical environment at the Maudsley Hospital under Aubrey Lewis.

My clinical and research career on the front lines of the discipline lasted 46 years from 1961 to 2007, followed by 13 years as an amateur historian, for the first four years helping Tom Ban complete the *Oral History of Psychopharmacology* (OHP) in time for the 50th anniversary of the American College of Neuropsychopharmacology (ACNP), then becoming a Founding Member of the International Neuropsychopharmacology History Network (INHN) and its website (2013-Present).

This six-decade time span includes belief systems evolving in a roughly dichotomous manner reflected in the title of my forthcoming book, *Treating the Brain; An Odyssey* (Blackwell In Press). This contrasts a Pioneer Period (1949-1980) with what followed (1981 to the present).

The first period includes discovery of all the modern drug treatments for major mental disorders, from lithium for acute mania (Cade 1949) to its prophylactic use in bipolar disorders (Baastrup and Shepard 1968). A prolonged ideologic struggle between psychodynamic and biological etiologic theories persisted well into the mid 1970s.

In the biological arena etiologic theories of drug action focused sequentially on neurochemical compounds; acetylcholine, norepinephrine, serotonin and dopamine fostering false hopes of treatment specificity. Molecular hypotheses gave way to genetic theories that also dwindled. During this first period cognitive behavioral etiology and treatment methods also enjoyed modest success.

Anti-psychiatry movements of various intensity or duration sprang up worldwide some triggered by the Church of Scientology, others in America by the CIA MK-Ultra brainwashing experiments and elsewhere by libertarian, communist and anti-Nazi ideologies that alleged psychiatric treatments infringed personal liberty.

Nineteen-eighty became the tipping point for dramatic clinical, political, and economic change. In America there was a profound new diagnostic conversion from psychoanalytic and ICD-9 systems based on anxiety driven psychoanalytic theory and European classification based on nosology and natural history replaced by the multiaxial Diagnostic and Statistical Manual (DSM) derived from symptom clusters developed by expert consensus.

Nineteen-eighty also began an eight-year period of Republican rule in America producing legislation that permitted information transfer from federally funded academic programs to industry, fostering collaboration that became increasingly monetized and corrupt. The FDA was empowered to increase the cost of new drug proposals, creating a conflict of interest to lower standards.

This year also marked the beginning of income disparity and an economy that fostered profit driven health care. Greedy insurance companies and large, allegedly not-for-profit healthcare corporations driven by bottom lines, prospered. Within two decades the profession of medicine became a business. Psychiatry, biologically driven by the DSM system and insurance constraints, now focused on “med-checks,” a practice which segregated drugs from therapy, the latter now performed by other mental health professionals.

Concurrently, the pharmaceutical companies switched from discovering innovative new compounds to aggressive marketing “me-too” drugs, yielding vast profits used to co-opt and corrupt physicians and their professional organizations, suborning leading academics to endorse

their products (Key Opinion Leader - KOLs). Conflicts of interest flourished but were never adequately sanctioned by academic institutions or professional organizations.

Worse still, NIMH closed the Early Clinical Drug Evaluation Units (ECDEU) and drug development was taken over by industry-funded companies who employed academic "ghost" authors. Psychiatric journals became complicit, publishing corrupt study results approved by industry-biased advisory boards and seduced by drug advertising revenue.

NIMH ceased funding drug research and switched first to genetics and then to basic neuroscience. Concerned about the poor reliability and validity of the DSM system they banned its use as an outcome measure and substituted an esoteric and complex system of its own that attracted little new research.

This alarming catalogue of malign influences has had a profound effect in stifling the contemporary arena of psychopharmacology research. The leading organization considered changing its name by replacing Neuropsychopharmacology with Neuroscience and Psychiatry, preserving its acronym, ACNP. It decided otherwise but, nevertheless, morale and hopes of change remain mired in the doldrums, no end in sight, well beyond the reach of the most profound skepticism about, or chance of correcting, the false products of this corruption.

Faith in Religion

In lieu of a personal example I offer a biography I wrote for INHN based on a memoir by John Smythies and his wife Vanna: "Two Coins in the Fountain; A Love Story" (Blackwell 2015).

John's career began in 1952 as a psychiatric resident in Britain when he proposed the first neurochemical theory of schizophrenia, the transmethylation hypothesis. In a distinguished career he went on to publish 16 books and more than 200 articles that included orthomolecular theory and philosophical speculations on the mind-brain relationship.

His interests and career trajectory were profoundly influenced by a conversion experience after he graduated as a physician but was struggling to find a career path and mired in depression. This impelled him to dedicate his life to emulating Albert Schweitzer. "I would get a thorough professional grounding in medicine, philosophy and ethics as well as psychology and the science

of the brain" (Blackwell 2015). And so he did. John would also develop a lifelong interest in parapsychology and he published a book of poems late in life.

The way in which he fulfilled his commitment and the complex spiritual philosophical and neuroscientific findings and speculations he derived are detailed in the review and supported by references.

Conclusion

I conclude with two poems written in the seminary that address the core issues of faith, doubt and reason.

Faith

(Blackwell 2012b)

Our ancestors evolved
at a high price.
Bigger brains knew and counted
the sources of sustenance;
flesh, water, grains.
Then humankind
gained prescience,
the certainty of death.

Cave dwellers
imagined higher powers,
placating them with sacrifice,
their price for peace of mind;

quelling grief and angst
about famine, drought,
meagre supplies
and brief lives.

Greeks, Romans and Hindus
sought certainty in life
and afterlife beyond;
from pantheons of deities
with human, animal
or hybrid forms,
whose lives and fate
they sought to emulate.

The Trinity came late,
God's son a sacrifice.
The entry fee
at heaven's gate
to all eternity:
Belief, without uncertainty,
that mythic truth
called faith.

Without Doubt: Beyond Reason

(Blackwell 2012c)

Is faith a truth,
God's planted seed,
or psychic fruit
of human need?

Some seek facts
and reason to believe,
others find conviction
easier to achieve.

Works don't find
the key to heaven's gate,
unbelievers. Good or kind
are doomed to wait.

When in doubt
skeptics are rejected.
Those without
more readily
accepted.

A Final Word

The contemporary state of psychopharmacology that has emerged since 1980 might well turn a desperate true believer towards prayer. But an atheist or agnostic must look elsewhere. Last year I visited Monticello which re-acquainted me with Thomas Jefferson and his version of the Christian faith. Stripped of Old Testament ferocity and improbable miraculous outcomes it focuses on the Sermon on the Mount and what it says about ideal human behavior. So, one last poem (below) portrays the issue in a different manner.

Might natural selection through evolution, rather than divine intervention, create the possibility of a benevolent culture and a world free of violence and hate? This would place responsibility for such an outcome on the shoulders of mankind, not a remote deity. If so the answer today rests not with prayer but on how we vote and the Republic we create.

I Or We?

(Blackwell 2012h)

Our brains are wired
for altruism or desire,
layer and layer
of options, decisions,
from cortex to limbic lobe,
orchestrating a symphony
of character and persona,
generosity or greed,
compassion or cruelty,
love or lust, trust or deceit.

will it be

I or we?

Religion claims

the moral ground,

names choice, conscience.

What if survival of the fittest

prevails instead

and doing good is best

for humankind?

Without divine intervention,

without the imposition of

crusades and inquisitions

or more *Just* wars.

No deity, only we.

I and Thee?

Wolves don't laugh or weep

yet species evolve

when law and love trump tooth and claw.

When genocide, holocaust, homicide,

guilt, failure and despair

invoke a higher power

answers come not from Holy writ

but in genetic code.

If both pathways transmit spiritual gifts

of hope, compassion, love and trust

then brain and faith agree;

the future lies

Not with I, but we.

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