Lived Experience and Procedural Due Process

Personal and Professional Reflections While Moving Toward a Human Rights-Based Approach to Mental Health

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September 2025

Slides to be available on the NARPA website and now available here:

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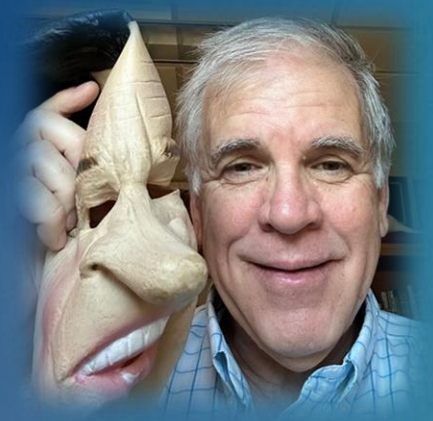
IN MEMORY OF

Jillian Vella, PhD

pioneering peer support facilitator
and human rights advocate:
2019-2025

Lived Experience and Procedural Due Process



I present today as an unaffiliated psychologist with personal and professional lived experience relevant to my presentation.

I have worked for decades at a research university in the southeast United States at a student mental health agency. Yet, I present today as an unaffiliated psychologist with lived experience relevant to my presentation.

In light of recent legal restrictions, I will acknowledge staff members have worked to occupy any overlap between *genuine* legal compliance and efforts to serve each individual in distress who walks through the doors as well as they are able within those limitations.

I, too, will continue to serve empathy for anyone who walks into my office. And I will continue focus my advocacy on the human rights of anyone who is, has been, or may become a mental health service user—as evidence cited by the British Psychological Society suggests, all of us, everyone.

While I acknowledge reasonable concern of inadvertently saying anything which might be misconstrued, I hope to move between limited expressions of what I have experienced, historically—working in collaboration with colleagues—and talking about how I, myself, work with service users (with curiosity about what you might experience if you ever will or may already be engaging in roughly similar ways within a mainstream agency).

All this is relatively small.

We need so much more change and longer-lasting community engagement in our worlds, . . . but we have been carrying a torch and impacting those individuals we could, in the time we have available.

Beyond supporting a brief introduction to this material, today, these *content-heavy* slides also support documenting and disseminating this work in more depth (as an essential aspect, I have found, of working in these ways in a mainstream mental health agency in an academic setting).

Following up: A publication supporting this process

Jim Probert. (2021).
Moving Toward a Human Rights Approach to Mental Health
Community Mental Health Journal.

Given restrictions established after publication, references to the author's workplace have been removed from this copy of the article.

2021 CMHJ article. For unaffiliated use.

Also introduced at ISPS-US 2018, World Hearing Voices Congress 2018, American College Health Association 2022, NARPA 2023, et al.

What is Procedural Due Process?

- At the agency level, an essential process which providers and service users have experienced as contributing to increased mutual trust for engaging support during crises and intense ongoing distress.

- This process is supported, and in some instances cultivated further, through individual consultations with professional clinicians who have relevant lived experience and have also participated in service user movements.

Why Procedural Due Process?

Understood, at the most essential level, as a process we have experienced as contributing to increased mutual trust for engaging support during crises and intense ongoing distress.

If mental distress were understood to be caused (or even exacerbated) by trauma/adversity, might mental health professionals be trained and supported to work in ways consistent with awareness of the dangers of adding to the trauma burden of distressed individuals?

Why Procedural Due Process?

Understood, at the most essential level, as a process we have experienced as contributing to increased mutual trust for engaging support during crises and intense ongoing distress.

- Lifetime suicide risk for service users is highest following discharge from psychiatric hospitalization (Crawford, 2004).
- A post-hospitalization impact on trust, among individuals 17–27, included "unwillingness to disclose suicidal feelings and intentions" (Jones, et al, 2021).
- In the Adverse Childhood Experience (ACE) study, individuals with the highest ACE Scores demonstrated a 3000–5100% increase in suicide attempts over those with the lowest scores (Dube et al., 2001).
- Evidence from large-scale general population studies indicates that symptoms of psychosis are as strongly related to childhood abuse and neglect as the symptoms of other mental health difficulties. (Read, J. et. al., 2005).

See also:

- Emanuel, N., et al. (2025) A Danger to Self and Others: Health and Criminal Consequences of Involuntary Hospitalization. *FRB of New York Staff Report No. 1158.*
- Gottstein, J., et al. (2023). Report on Improving Mental Health Outcomes. *The Law Project for Psychiatric Rights (PsychRights).*

Why Procedural (Justice) Due Process?

Rather than procedural *justice*--which may suggest an ideal that providers either achieve or do not--we might keep orienting and reaching toward this *process*.

- Perceived coercion during admission into psychiatric hospitalization increases risk of suicide attempts after discharge. (Jordan & McNiel, 2019).

- The "experience of coercion or being subjected to restrictive interventions associated with involuntary admissions," often leads to a "potentially spirit-breaking" vicious cycle of repeated hospitalizations (Brophy, et al., 2019).

- The amount of coercion a patient experiences in the mental hospital admission process is strongly associated with the degree to which that process is seen to be characterized by "procedural justice." (MacArthur Coercion Study, 2004).

What is Procedural Due Process?

At the agency level, an investment in every-day work in crisis intervention through deep engagement and connection

An aspiration for providers to engage service users through this process *before* (and frequently, whenever possible, *instead of*) moving into involuntary interventions. Intended to be consistent with moving toward rights-based approaches, including:

- The National Coalition for Mental Health Recovery (2011) guideline, "Involuntary interventions should only be used as a last resort, when all other approaches have been exhausted."

- The United Nations call for "immediate measures towards... radical reduction" of "non-consensual measures" (Dainius Pūras, 2017, UN Human Rights Council Report).

- "We must pursue new routes to suicide prevention that invest in fortifying healthy, respectful, and trustful relationships and community connectedness"(D. Pūras, 2019, UN Human Rights Council, "...A rights-based approach to suicide prevention.")

Aspiring to
Procedural Due Process

Balance assessing current danger, exploring clinical risk factors, safety planning, etc....

. . . with listening deeply and staying with the trail of expressed intense emotion through an individual's own worldview, and life experience.

- How does this person understand and express, for example, why they may have to die or why they cannot plan to live through the next day(s)?

- Not only a way to work with anyone in acute crisis—whether or not they are facing suicide danger--but also with those who experience frequent or recurrent suicide danger or who are experiencing "extreme states" (conventionally understood as psychosis, mania, et al.).

- This is a process that can take significant time in a crisis. Understanding the value of investing that time and energy . . . versus the experience too many hospitalized individuals have had of not experiencing any genuine degree of due process leading up to their hospitalization(s).

Aspiring to

Procedural Due Process

In our context, this process is also frequently invaluable with those who experience frequent or recurrent suicide danger or who are experiencing “extreme states.

Experiences of those engaging in this practice are largely consistent with Joiner, et al's (2007) observations:

- "interventions during" an engagement can impact the final level of suicide risk at the end of an engagement;
- "an individual's self-assessment of suicide risk may outperform clinical judgments," (particular at the end of an engagement);
- the best practice of lethality assessment is, therefore, "a highly collaborative process.”

Joiner, et al. (2007). "Establishing Standards for the Assessment of Suicide Risk among Callers to the National Suicide Prevention Lifeline." *Suicide and Life-Threatening Behavior*.

One context for this process

Where a number of us who have contributed to--or taken leadership roles in creating*--agency programs trained and gained experience.

(*E.g., colleagues who, historically, established our on-call system also contributed *significantly* to co-creation of the peer support group program.)

The Alachua County Crisis Center:

Lethality assessment, suicide prevention, and crisis intervention in the context of empathy/connection as a primary principal* . . . without abandoning the Integrity or thoroughness of the work (on the contrary).

*In my own work as training coordinator at this crisis center (1996-2001), I understood this principal to be consistent with the crisis intervention approaches of pioneering social psychiatrists, Erich Lindemann and Gerald Caplan

This is an inherently non-pathologizing process for which there may be little or no formally acknowledged *experiential* space within many current conventional diagnostic/empirical-psychological practices.

Erich Lindemann.(1979). *Beyond Grief: Studies in Crisis Intervention*

Gerald Caplan. (1964). *Principals of Preventive Psychiatry.*

"Grief Work" and Crisis Intervention

The social psychiatrist, Erich Lindemann, "spent much of his career researching loss. He soared to national prominence after conducting a historic study of bereavement in the wake of the deadly fire at Boston's Cocoanut Grove nightclub on Nov. 28,1942. His work — on Cocoanut Grove and beyond — would reshape the way the medical world understood grief and redefine the landscape of mental health treatment in the United States,"

Rosenfeld, E.K. (2018). The Fire That Changed the Way We Think About Grief. *Harvard Crimson.*

In the perspective and experience of the crisis intervention work I learned and taught at the AC Crisis Center, the kind of human support a person receives often impacts how well they move through a crisis. People who do not complete essential "grief work" (Lindemann, 1979) may resolve crises less productivity, less meaningfully, with more psychological challenges, and potentially with emerging or increased suicide danger. This is consistent with Lindemann's student, Gerald Caplan's, (1964) idea of "preventive psychiatry"—and even the possibility that a crisis may provide opportunity for coming more alive or reworking detrimental impacts of previous crises.

What is grief work? As Lindemann described his research outcomes, a bereaved individual needs, first, to experience the intense emotions involved in loss and move through them. That is, "the mourner must expect an expression of emotion of the first magnitude, involving grief. . . .[and that in many people's lives] there is little tolerance for such emotional expression. . .Thus the first mental health considerations have to do with giving the person permission to feel suffering and to express it."

Second, after a death or some other significant loss, the person also needs to find some way to reinvest the energies and reestablish the connections that were lost, into a new life. This does not mean, for example, that an individual whose parent died must literally reinvest in finding a new parent. The form may be different, but to create a new life that reaches toward being vital and full. Lindemann addressed this through a formal "Systematic Life Review." While we generally supported this work less formally at the ACCC, we still understood addressing tangible needs, whenever possible, tends to be more effective only after or with enough emotional engagement.

We understood, too, that individuals whose suffering did not fit a literal model of grieving, may still often be supported through similar emotional engagement as they navigated other life challenges.

[The work of trauma therapist Peter Levine (see later citations) may also support the possibility of "titrating" this work as needed and possible.]

Publications Supporting this Process for Addressing Suicide Danger

My first version of the article ("Part 2") was published *inside* the American Association of Suicidology's *Organization Accreditation Standards Manual* (2006, 2008, 2011).

My revision-- after attending my first peer-run conference--was:

--Published internally by AAS as a Crisis Center Best Practice (2012);

--Republished by SAMHSA's Recovery to Practice Initiative (2014), with an invited introduction.

--Posted as a Crisis Alternative, by the National Empowerment Center (2014).

Jim Probert. (2014). Part 1. Toward a more trauma- and recovery-informed practice of lethality assessment and suicide prevention. *SAMHSA Recovery to Practice Highlights.* [Invited invitation to Part 2.]

Jim Probert. (2014). Part 2. Further discussion for the need to develop more comprehensive guidelines for lethality assessment, revised, 2011. *SAMHSA Recovery to Practice Highlights*.

Parts 1, 2, and References have now *all* been posted on the National Empowerment Center website, (Near the end of "*Other Crisis Alternatives.*") Also available on PsychRights.

Part 1. Toward a more trauma- and recovery-informed practice of lethality assessment and suicide prevention.

- "It is not possible to estimate suicide danger, or respond to it appropriately, without understanding the depth of terror, rage, hopelessness, and powerlessness—and the potential for escalation of suicide danger—that can be evoked within many distressed individuals by the threat of involuntary hospitalization and all that can go with it.

- "Yet instead of being heard with empathy—and with an awareness of the potential for either trauma reenactment or trauma renegotiation—the resistance of suicidal individuals to hospitalization, if it is voiced at all, may be dismissed as merely an indication of a symptomatic lack of insight into the necessity of medical stabilization for their disorders."

Part 2. Further discussion for the need to develop more comprehensive guidelines for lethality assessment, revised, 2011.

- "We would also never want to forget that a suicide crisis can actually present a distressed individual with the opportunity to move through experiences of loss and trauma, feelings of hopelessness and perceptions of inevitable defeat toward re-empowerment--by making a conscious, active choice to live (and thus both to escape life-threatening danger and to value him or herself in a different way). Knowing life will remain difficult and waves of overwhelming emotion will return" distressed individuals "can also plan to engage internal and external resources available to support this choice over time.

- "This is consistent with classic principals of crisis intervention and trauma recovery. From this point of view, the lethality assessment process is not only an essential tool of suicide prevention. It can also be a tool of recovery and healing."

Two "critical indicators" for moving toward fulfilment of the UN Human Rights Council report

- Availability of non-compromised peer support alternatives
- Education and training on the use of non-consensual measures

Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. (2017).

Support for moving toward critical indicators introduced in
Moving Toward a Human Rights Approach to Mental Health, *CMHJ* (2021).

"Informed consent is a core element of the right to health, both as a freedom and an integral safeguard to its enjoyment."

Dainius Pūras, 2017,
UN Human Rights Council Report

Education & training addressing non-consensual measures

What essential empirical evidence, position statements from mainstream mental health leaders and service users, and philosophical and human rights considerations are often missing from conventional professional training … and that if providers only knew might revitalize conventional practice?

The potentially invaluable role of professional staff with lived experience-- in catalyzing and supporting this process

My Own Psychiatric Hospitalizations, 1982-83

"A highlight of this journey has been observing the values of the service user movements becoming part of the fabric of . . . efforts embraced" within the author's agency. As "explained in an invited presentation to a SAMHSA-funded Roundtable on Collegiate Recovery Supports … this journey also:

> included years spent working with other campus clinicians–whom I grew to respect and even love for their dedication and passionate efforts to support students, even when I did not agree with their approach. It broke my heart to see therapists--with tremendous capacity for supporting trauma recovery and individual empowerment--stop doing this same work with individual students whose distress they perceived to be caused by an intractable genetic condition.

Jim Probert. (2021). Moving Toward a Human Rights Approach to Mental Health *Community Mental Health Journal.*

For a more in-depth view: Slides from a training seminar

(A brief review, with examples of material presented in the seminar, will be provided today—with aspects related to procedural due process unfolded more explicitly)

Mental Health Recovery:
Reclaiming Our Lives in the World.

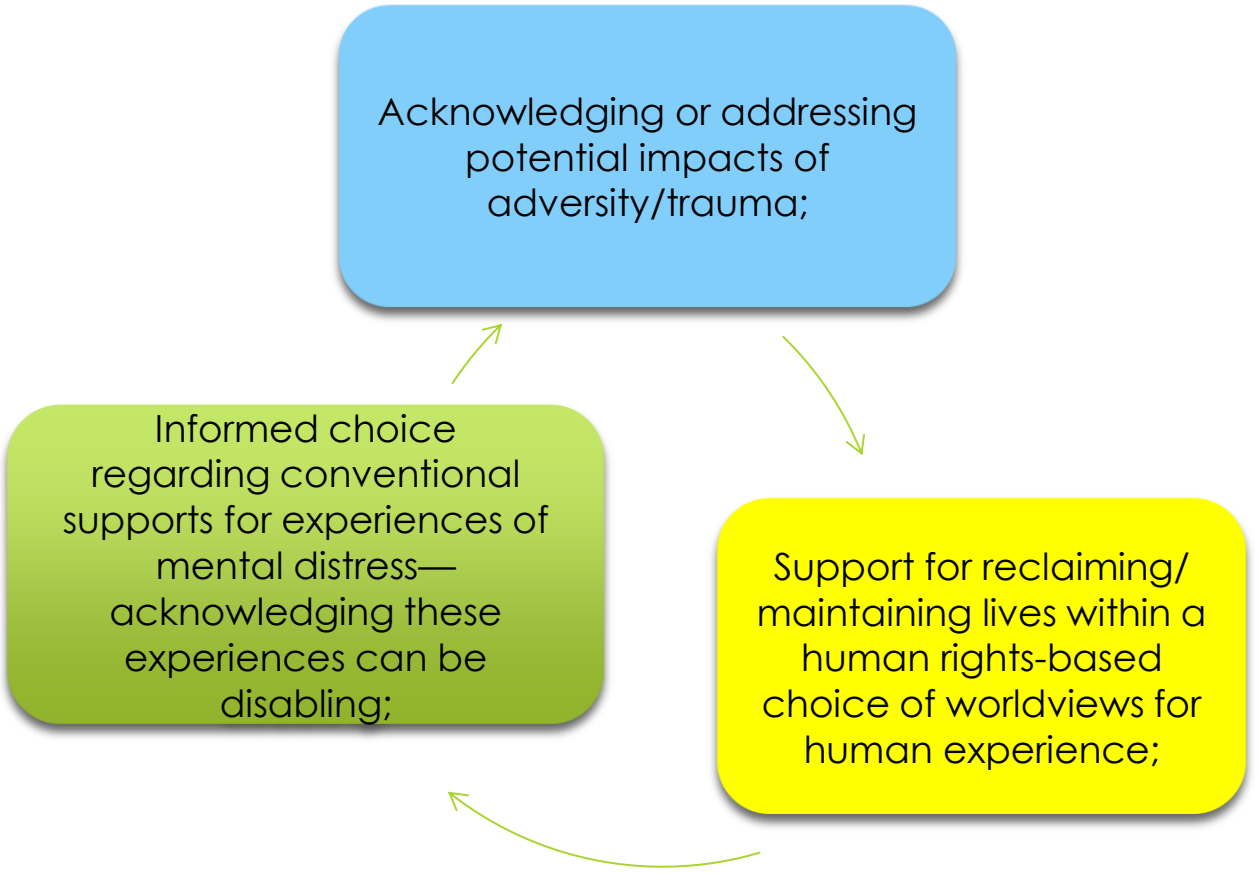
Given current restrictions, references to the author's workplace have been removed from this copy of the slides.

Reclaiming Our Lives Seminar. For unaffiliated use.

[Part 2 of this seminar more specifically addresses Moving Toward *Procedural Due Process and* a Human Rights-Based, Trauma-Informed Approach to Suicide Danger]

Two slides near the *heart* of the take-away message of the training/onboarding seminar

One Framework of Essential Rights for Anyone Experiencing Mental Distress



Based on (2021). Moving Toward a Human Rights Approach to Mental Health. *Community Mental Health Journal.*

This may be relevant to *any* overwhelming experience which can be diagnosed by professionals--or understood by service users--as an incurable mental illness.

"Psychotic disorders have a recognized place among the risk factors for suicide, primarily because of the unpredictability of behaviors associated with them. . . With characteristic youthful resistance to accepting any chronic disorder, each period of remission is interpreted as freedom from illness, a perception that is dashed by a subsequent acute episode. Frequently the acute recurrence is precipitated by the person feeling so confident they are no longer ill they discontinue their antipsychotic medication." [Frequently precipitously.] . . . "High risk is triggered when, in remission, it is finally clearly seen that the disorder is not going to go away, and that it will have to be coped with indefinitely."

Jerry Motto. (1999). Critical points in the assessment and management of suicide risk. In *The Harvard Medical School Guide to Suicide Assessment and Intervention.*

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"A longitudinal perspective about" [individuals diagnosed with] "schizophrenia should imbue everyone with a renewed sense of hope and optimism. . . Even in the second and third decades of" [diagnosed] "illness, there is still potential for full or partial recovery."

(1994). Courtney Harding & J.H. Zahniser . Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatr Scand Suppl.*

Why there can be so much professionals too rarely learn, about the ways many of us have actually reclaimed our lives in the world, and about obstacles making it tremendously challenging or virtually impossible for so many more of us to do so.

Understandings "of mental disorder held by" professionals "are complex, sometimes contradictory, and do not fit easily within the biological psychiatry paradigm."

Awais Aftab, et. al. (2020). Conceptualizations of mental disorder at a US Academic Medical Center. *Journal of Nervous and Mental Disease.*

"Aftab et al. suggest that the understandings 'of mental disorder held by' professionals 'are complex, sometimes contradictory, and do not fit easily within the biological psychiatry paradigm.'

"Yet, however expressive those results may well be of genuine personal beliefs, there is also a vital need to explore systemic pressures many professionals face . . . to provide narrowly medicalized explanations, especially to individuals who communicate experiences perceived as threatening, including suicide danger or experiences conventionally understood as symptoms of mania or psychosis.

One goal of my own training/onboarding seminars has been "to open dialogue, moving beyond pressures training seminar participants have acknowledged experiencing, to avoid challenging conventional approaches. As one participant reported to the author . . . 'I'm afraid if I do anything unconventional, I'll be sued or fired.'"

Probert, J. (2021). Moving Toward a Human Rights Approach to Mental Health, *CMHJ*

Larger contexts of pressures often experienced by professionals . . . and service users

"The vast experimental literature on human error agrees with history of medicine, folklore, and superstition in discrediting knowledge claims based solely on anecdotal impressions. Since clinical experience consists of anecdotal impressions by practitioners, it is unavoidably a mixture of truths, half-truths, and falsehoods. The scientific method is the only known way to distinguish these."

Paul Meehl, former American Psychological Association president, (1997). Credentialed persons, credentialed knowledge. *Clinical Psychology: Science and Practice.*

A scientist might hesitate to report anomalous experiences because of his or her social and professional context and the sociology of this particular mode of knowledge. There are subtle and explicit forms of censorship that effectively suppress such reports to protect the present reigning interpretation of the world—classical or conventional materialism. We do not call these "disciplines" for nothing. They discipline us, and they discipline the world.

Jeffrey Kripal , Rice University, professor of comparative religion. (2019.) *The Flip: Epiphanies of Mind and the Future of Knowledge*.

Insel, T. (April 29, 2013.) NIMH Director's Blog: Transforming Diagnosis.

Insel T. & Lieberman J. (May 3, 2013). DSM–5 and RDoC: Shared Interests. *NIMH Science News.*

See also: Edward F. Kelly, et al.(2007). *Irreducible mind: Toward a psychology for the 21st century.*

- "In 2013, as NIMH Director, Thomas Insel withdrew support for all research based on DSM categories, acknowledging their lack of scientific validity and the absence of any valid biomarkers.

- Two weeks later, a joint statement by Insel and the President-Elect of the American Psychiatric Association also acknowledged DSM and ICD are "no longer sufficient for researchers" while supporting ongoing clinical use of this approach as a "consensus standard" of care.

- Despite acknowledging the lack of scientific validity and the absence of any valid biomarkers as supporting evidence, Insel and Lieberman (2013) also stated, "It is increasingly evident that mental illness will be best understood as disorders of brain structure and function . . . " [consistent with Kelly, et al.'s (2007) description of a prevailing scientific perspective of strictly "bottom up" physical causation of mental experience among "contemporary mainstream scientists, psychologists and neuroscientists"].

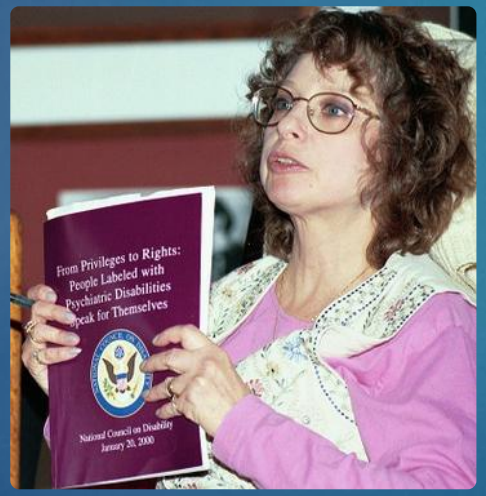
Why there can be so much professionals too rarely learn…

The Soteria House, 1972
NIMH Study

Lauren Mosher. (1999.) Soteria and Other Alternatives to Acute Psychiatric Hospitalization: A Personal and Professional Review.
The Journal of Nervous and Mental Disease.

See also: Robert Whitaker. (2010). *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*

Why there can be so much professionals too rarely learn…



"I've been a good patient, and I've been a bad patient, and believe me, being a good patient helps to get you out of the hospital, but being a bad patient helps to get you back to real life."

Judi Chamberlin. (1998). Confessions of a non-compliant patient. *Journal of Psychosocial Nursing*

Pat Deegan.

"Reclaiming your power during medication appointments with your psychiatrist. " *National Empowerment Center website.*

"Most psychiatrists believe in the primacy of biology. Most have a mechanized and materialist world-view. Thus, chances are that if you have a diagnosis of major mental illness and you talk to your psychiatrist about ecstatic spiritual experiences, mystical experiences, psychic abilities, or similar experiences, these will be perceived as crazy or symptomatic.

". . . recognize that you have control over what you share with a psychiatrist and what you choose to keep private . . .

"A meeting with a psychiatrist need not be a confession! Talk with mystics about your mystical experiences. Talk with psychics about telepathy, etc."

"On Being Sane in Insane Places."

David Rosenhan. (1973). *Science*

In the foreseeable meantime:

Falling into a world in which *everything you do and are* may be seen—even by ourselves--through the lens of a virtually inescapable mental illness diagnosis.

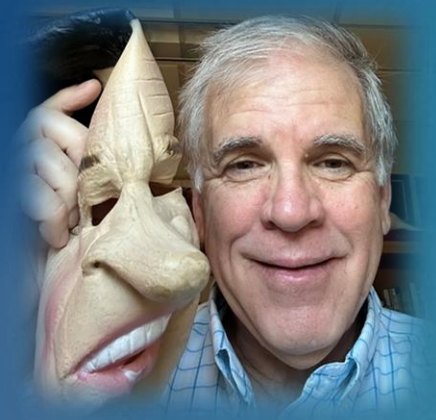
Bessel van der Kolk and Peter Levine have described trauma as a response to experiences of *inescapable* defeat.

Beyond individual "recovery" —how can service users navigate impacts of falling into being perceived and responded to in these enduring, often-inescapable ways?

Within the dilemma illuminated by Rosenhan--and Chamberlin--a person who has been hospitalized and overwhelmed by distress can achieve significant personal healing yet still suffer being perceived and subject to interventions and disparities on the basis of having received an incurable mental illness diagnosis (making the former aspect of healing more difficult to experience or maintain).

This may be an interminable experience and is an aspect of "recovery" even nuanced professional therapy approaches for trauma, extreme states, and suicide danger often underestimate or omit.

Lived experience in professional training



Beyond My Own Psychiatric Hospitalizations, 1982-83

(Recovering) My Own Life & Narrative

Jim Probert. (2014) Toward a More Trauma- and Recovery- Informed Practice of Lethality Assessment and Suicide Prevention.
SAMHSA Recovery to Practice Highlights

I began telling my own story publicly in 2006--in an effort to advocate with psychiatrists, then still working in the same agency, to move toward more collaborative, harm reduction approaches.

Jim Probert. (2014) Toward a More Trauma- and Recovery- Informed Practice of Lethality Assessment and Suicide Prevention, *SAMHSA RTP Highlights*

My Own Psychiatric Hospitalizations, 1982-83

"I never thought about suicide at all until after my two hospitalizations, when I finally accepted what I was told to be true—that I had a severe and incurable mental illness. . . . in which I heard commanding voices, became Superman and Jesus, experienced a terrifying demon seizing control of my face and mind, and had many other experiences a good southern Presbyterian choir boy and National Merit Scholar was not generally expected to have. The medications held of those experiences but did not alleviate the misery of severe depression, anxiety, panic, and so much inner torment that remained. And I understood, then, after the hospitalizations, that my continuing misery was caused by an incurable chemical imbalance in my brain—which was not corrected by medication and over which I had no possible influence. . ..

"During my hospitalizations, no one even appeared to consider the potential impact of life experiences and childhood trauma. . .. the teasing, repeated assaults, and death threats … or the sexual abuse by a mentor . . .the traumatic impact of being overwhelmed .. . by my own inner states . . . [or] the traumatic impact of the hospitalization itself—of being handcuffed, put in isolation and restraint, and medicated with Haldol so I could barely walk and until my legs began to move uncontrollably, of being told what I must do to be released from the locked ward, and of becoming a mental patient, as we are conventionally treated in our world."

Reclaiming My Whole Life

" . . I have heard researchers and even clinicians disparage those who try to understand and negotiate 'mental illness' in terms of religion, spirituality, or other traditional and nonscientific terms. Yet I did eventually reclaim my human right to make sense of my own 'inner experience'—which is not in any event subject to verifiable empirical measurement. This included reclaiming my right to understand my experience from many very different perspectives.

"For instance, I can now view and experience my emotions as emotions again—drawing on my experiences of heart-to-heart connection with so many individuals experiencing a full range of painful and joyous life events. I can look at the impact of traumatic experience—continuing to heal the deepest roots of old traumas as well as the impact of working as a therapist with so many traumatized people. I have also reclaimed my right to look at my spiritual experience—and my whole life—from a spiritual perspective."

Jim Probert. (2014) Toward a More Trauma- and Recovery- Informed Practice of Lethality Assessment and Suicide Prevention. *SAMHSA Recovery to Practice Highlights*

[Yet we may find little or no formally acknowledged *experiential* space for this kind of exploration and healing to be worked through within many conventional diagnostic/empirical-psychological practices.]

Disappeared…

"The people memorialized by the Suitcase Project spent decades at Willard; most of them died there. . . . They had careers, families, artistic or intellectual aspirations; many had dealt with significant personal losses. Each of their stories provides an opening to consider some of the broader issues that affected these people: poverty, poor health, trauma, displacement, loss of loved ones, voice-hearing and idiosyncratic beliefs, religious guilt and acts of redemption . . . ."

Seminar participants have learned about individuals who experienced extreme states—not unlike those acknowledged by the presenter, a senior staff member in their agency (and often less conventionally severe)—but who spent the last decades of their lives in a NY state hospital.

The Lives They Left Behind: Suitcases from a State Hospital Attic. (2008). Darby Penney & Peter Stastny; Photographs by Lisa Rinzler.

Steven Hyman
(2013)

Former NIMH Director

In 2013, Director of a joint Harvard/MIT psychiatric research center

Hyman, S. E. (2013). Psychiatric drug development: Diagnosing a crisis. *Cerebrum: Dana Foundation*.

- "The molecular and cellular underpinnings of psychiatric disorders remain unknown . . . psychiatric diagnoses seem arbitrary and lack objective tests; and there are no validated biomarkers with which to judge the success of clinical trials."

- Hyman also described a crisis in psychopharmacology, reporting available psychiatric medications work well for some individuals, have partial effectiveness for others, and do not work at all for those remaining.

NIMH Director, Thomas Insel

Insel, T. (April 29, 2013.) NIMH Director's Blog: Transforming Diagnosis.

Insel T. & Lieberman J. (May 3, 2013). DSM–5 and RDoC: Shared Interests. *NIMH Science News.*

- "In 2013, as NIMH Director, Thomas Insel withdrew support for all research based on DSM categories, acknowledging their lack of scientific validity and the absence of any valid biomarkers.

- Two weeks later, a joint statement by Insel and Jeffrey Lieberman, President-Elect of the American Psychiatric Association, acknowledged DSM and ICD are "no longer sufficient for researchers" while supporting ongoing clinical use of this approach as a "consensus standard" of care. Despite the lack of scientific validity or the reported evidence of any valid biomarkers, Insel and Lieberman stated, "It is increasingly evident that mental illness will be best understood as disorders of brain structure and function . . . "

- Neither of these statements included any support for providing informed consent to service users, family members, or the public regarding the scientific limitations acknowledged.

The role of genes . . .?

Richard Bentall, University of Sheffield (UK) Clinical Psychology Professor, (2016). *All in the brain? An open letter in response to Stephen Fry's exploration of manic depression in the BBS series, "In the Mind."*

"Of course, genes play a role in making some people more vulnerable to" [experiences diagnosable as] "psychiatric disorder than others, but the latest research in molecular genetics challenges simplistic assumptions about 'schizophrenia' and 'bipolar disorder' being primarily genetic conditions. The genetic risk appears to be shared across a wide range of diagnostic groupings – the same genes are involved when people are diagnosed with schizophrenia, bipolar disorder, ADHD and even, in some cases, autism. More importantly, genetic risk is widely distributed in the population with hundreds, possibly thousands of genes involved, each conferring a tiny increase in risk."

British Psychological Society. (2011).
Response to the American Psychiatric Association: DSM-5 Development

- Contemporary diagnostic categories "do not meet the criteria for categorization demanded for a field of science or medicine.“
- A focus on "illnesses . . . located within individuals . . . misses the relational context of problems.”
- “. . . overwhelming evidence” suggests that mental distress, in general, is “on a spectrum with 'normal' experience"
- Also stated “that psychosocial factors such as poverty, unemployment and trauma” are “the most strongly-evidenced causal factors.”

Other evidence and position statements presented in training seminar—(with a brief summary here)

- The overwhelming majority of individuals diagnosed with mental illness will never be violent toward others (Binder, 2015; Davidson, 2013);
- After being diagnosed with serious mental illness, far more people reclaim their lives, or move into the process of reclaiming their lives, than most professionals or members of the public realize (Davidson & Roe, 2007; Harding et al., 1987);
- The kinds of support available are distinctly related to recovery rates (DeSisto et al, 1995; Whitaker, 2010);
- Literature reviews indicate continuing risks for electro-convulsive therapy, including high risk of long-term memory loss (Read & Arnold, 2017; Read & Bentall, 2010; see also Dundas, 2013);
- While many do find them helpful, the role of medications in all this is not nearly as simple, nor are medications as universally helpful, safe, and necessary as often conventionally portrayed (Guy et al., 2019; Harrow & Jobe, 2013; Horowitz & Taylor, 2019; Ostrow et al., 2017).

A *brief sample of* other evidence and position statements provided in onboarding seminars:

The American Psychological Association's Society for Humanistic Psychology (2011)

"Further, growing evidence suggests that though psychotropic medications do not necessarily correct putative chemical imbalances, they do pose substantial iatrogenic hazards. For example, the increasingly popular neuroleptic (antipsychotic) medications, though helpful for many people in the short term, pose the long-term risks of obesity, diabetes, movement disorders, cognitive decline, worsening of psychotic symptoms, reduction in brain volume, and shortened lifespan."

For Example:

Informed consent and withdrawal from neuroleptic/ "antipsychotic" medication

Martin Harrow, Thomas Jobe, and Tong, L. (2021). Long-term effectiveness of antipsychotics. *Psychological Medicine*.

"This design. . . led to the paradoxical discovery, published in multiple previous papers, that individuals who dropped out of treatment, even in cases with worsening symptoms in which illness morbidity led to non-adherence of medication and leaving treatment, often had better long-term outcomes than patients who stayed under treatment.

"Our findings support the view that providers and recipients of mental health care should enter into a partnership to assess the unique cost benefit in each individual case of long-term antipsychotic treatment and make informed decisions from time to time regarding evidence based deprescribing when appropriate

See also, for example:

Horowitz, M.A., et. al. (2021, March 23). A Method for Tapering Antipsychotic Treatment That May Minimize the Risk of Relapse. *Schizophrenia Bulletin.*

Moncrief, J. Gupta, S. Horowitz, M.A. (2020). Barriers to stopping neuroleptic (antipsychotic) treatment in people with schizophrenia, psychosis or bipolar disorder. *Therapeutic Advances in Psychopharmacology.*

Mark A. Horowitz & David Taylor. (March 4, 2019). Tapering of SSRI treatment to mitigate withdrawal symptoms. *Lancet Psychiatry.*

Guy, A., Davies, J., Rizq, R. (eds). (2019). *Guidance for Psychological Therapists: Enabling Conversations with Clients Taking or Withdrawing from Prescribed Psychiatric Drugs.*

For more context regarding informed consent and human rights/medication optimization/harm-reduction perspectives—suggesting possibilities of more open dialogue, ongoing engagement, or views of medication as one possible tool among others which may support recovery/life reclamation"—see training seminar slides:

Mental Health Recovery:
Reclaiming Our Lives in the World.

"Informed consent is a core element of the right to health, both as a freedom and an integral safeguard to its enjoyment."

Dainius Pūras, D. (2017). Special Rapporteur. UN Human Rights Council.

- - -

I do not recommend anyone start, stop, or reduce medications. There are dangers and possibilities all around. I also do not give medical advice. I hope for individuals to make well-informed, carefully-planned, cost-benefit decisions, engaging the best supports they are able--and with, in general, any decisions to reduce or withdraw proceeding very slowly. I hope these training resources will support professionals in moving toward becoming as supportive as possible in that process, especially in providing informed consent which includes resources that have often not been presented in previous professional training.

Jim Probert

Again, other related impacts of adversity/trauma presented in training seminar

- Lifetime suicide risk for service users is highest following discharge from psychiatric hospitalization (Crawford, 2004).
- A post-hospitalization impact on trust, among individuals 17–27, included "unwillingness to disclose suicidal feelings and intentions" (Jones, et al, 2021, para. 3).
- In the Adverse Childhood Experience (ACE) study, individuals with the highest ACE Scores demonstrated a 3000–5100% increase in suicide attempts over those with the lowest scores (Dube et al., 2001).

See also:

- Emanuel, N., et al. (2025) A Danger to Self and Others: Health and Criminal Consequences of Involuntary Hospitalization. *FRB of New York Staff Report No. 1158.*
- Gottstein, J., et al. (2023). Report on Improving Mental Health Outcomes. *The Law Project for Psychiatric Rights (PsychRights).*

Evidence from large-scale general population studies indicates that symptoms of psychosis are as strongly related to childhood abuse and neglect as the symptoms of other mental health difficulties.

John Read, et. al. (2005). Childhood trauma, psychosis and schizophrenia : a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica.*

"For some, simply making a connection between their life history and their previously incomprehensible symptoms may have a significant therapeutic effect."

Lived experience in professional training

Becoming Superman

When I was hospitalized for the second time, in 1983, I was told my experience of becoming Superman was another symptom of the incurable chemical imbalance in my brain.

Yet, just before my second hospitalization, I watched Christopher Reeve, in Superman 2, getting beat up after he lost his powers. Then, after being re-empowered, I saw Superman standing up for himself again. I had been beat up and sexually abused when younger, and something deep inside me seemed to recognize ,"I'm like that! I could do that!" Only, then, I was swept away by the wild and ecstatic, I-can-break-free-from-the-danger energy, "I am Superman!".

I have understood this process more deeply over time. Yet, when I was in graduate school, I had already learned to navigate this kind of "poetic experience"--and release trauma energy--while holding onto my competence and life.

Becoming Superman

In this context, procedural due process might include:

- Exploring and dialoguing about whether an individual who tells us, for example, they are Superman also believes (or may risk being overwhelmed by the directed energy/idea) they can jump off a tall building or stop a speeding semi-truck with their outstretched arm?

- Balancing assessing current danger to self or others, exploring clinical risk factors, capacity for essential self care, engagement with material and consensual realities, safety planning, etc. with listening deeply and staying with the trail of experience and intense emotion through an individual's own worldview.

- Addressing--or at least acknowledging--potential impacts of adversity/trauma—at least as informed consent, consistent with Read, et al.'s (2005) conclusion.

The psychiatrist, John Fryer
1972 American Psychiatric Association meeting

Understanding conventionally identified symptoms as *inherently contestable** and recognizing the precedent to separate conventionally diagnosable human experience from any invariable or irrevocable assumptions regarding demonstrating competence and capability in professional and other social roles** . . . (as well as regarding meeting criteria for non-consensual interventions).

*This language is from Randal, P., Geekie, J., Lambrecht, I., & Taitimu, M (2008). *Dissociation, psychosis and spirituality: Whose voices are we hearing?*

**With reasonable accommodations, if needed.

Still "in the closet"?

Borysenko, J. (1990). *Guilt is the Teacher, Love is the Lesson*. Warner Books.

Read, J. (2016). Hearing voices is more common than you might think. *The Conversation: Academic rigor, journalistic flair.*

British Psychological Society Division of Clinical Psychology. (2000). *Recent advances in understanding mental illness and psychotic experiences.*

- Joan Borysenko–a co-founder of the mind/body clinic at Harvard—quoted Daniel Goleman in referring to the U.S. as a "nation of closet mystics."

- Borysenko also cited Andrew Greeley's University of Chicago research in the 1980s, which confirmed nearly one-third of randomly sampled U.S subjects reported having visions, one-half reported having had contact with a dead loved one, and two-thirds reported having an ESP experience. "When pollsters went back to some of these people to get further details, most of them said . . .that they had rarely or never shared their experiences with another person."

- John Read, University of East London Clinical Psychology Professor, reports, "Although less than 1% of the population receive" [a schizophrenia] "diagnosis, international surveys, in different cultures, find that about one in eight people experience" what Read describes as an "auditory hallucination at least once in their life."

- The British Psychological Society's Division of Clinical Psychology has suggested, "If there are any factors that distinguish" what the authors describe as "'normal hallucinators' from people who come into contact with mental health services," those factors would be "the distress caused by the experience" itself and "the degree to which these experiences are seen as normal."

Procedural Due Process: Advocating for experiential space for healing . . . and demonstrating competence.

Mental health professionals, in their work and at future professional meetings? Other service users, in their lives?

"We are at the epicycle stage of psychiatry, where astronomy was before Copernicus and biology before Darwin."

Allen Frances (Chair, DSM-IV task force)

Allen Frances & Helen Egger. (1999). Whither Psychiatric Diagnosis. *Australian & New Zealand Journal of Psychiatry*

Without more reflexivity/mindfulness and critical thinking: DSM IV and the trauma/human overwhelm response

- "Delusions that express a loss of control over mind or body . . . are generally considered to be bizarre; these include a person's belief that his or her thoughts have been taken away by some outside force . . . .that alien thoughts have been put into his or her mind. . . or that his or her body or actions are being acted on or manipulated by some outside force. If the delusions are judged to be bizarre, only this single symptom is needed to satisfy Criterion A for Schizophrenia."

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders : DSM-IV. (p.275)*

- Yet, Peter Levine—who earned his first PhD in biomedical physics from U.C., Berkeley and served as a NASA consultant during graduate school--specifically describes the trauma/overwhelm response as involving modern, rational human consciousness being commandeered by a deep level of the nervous system which he frequently refers to as the reptile brain (within a "triune brain" evolutionary model of the human nervous system also including the mammal emotion brain.)

Peter Levine & Ann Frederic. (1997). *Waking the Tiger: Healing Trauma: The Innate Capacity to Transform Overwhelming Experiences.*

A central message from Peter Levine's approach to healing trauma:

Deep animal levels of our body-mind need to complete alarm responses--on terms often incomprehensible to the modern rational mind--moving in and out of immobility, through fight or flight, and back into vital living.

"The sub cortical areas of the brain, the evolutionarily more primitive parts that are not under conscious control and possess no language, have a different way of representing past experiences . . ."

- Individuals who have fallen into a post-traumatic stress response are repeatedly "at the mercy of … sensations, physical reactions and emotions" which replay the previously overwhelming experience as "reactivated unintegrated fragments of traumatic stress"—represented in vastly different, often unrecognizable ways than our usual conscious awareness.

- "Traditional psychotherapy relies on top-down techniques to manage disruptive emotions and sensations. These are approached as unwanted disruptions of 'normal' functioning that need to be harnessed by reason . . .. This understanding may help them override automatic physiological responses to traumatic reminders" but "is unlikely to allow the reconfiguring of the alarm systems of the brain." [Traumatized individuals may (at whatever pace) demonstrate ability to cope and even function well in the world, without *healing* more deeply.]

- " . . . modern neuroscience has made us realize that effective treatment of PTSD needs to involve promoting awareness, rather than avoidance of internal somatic states. . .. Mindfulness, awareness of one's inner experience, a "felt sense" is necessary . . .."

Bessel van der Kolk. (2002). Posttraumatic therapy in the age of neuroscience. *Psychoanalytic Dialogues,*

Procedural Due Process: Experiential space for healing.

- ". . . it is universally true that the renegotiation of trauma is an inherently mythic-poetic-heroic journey."

- " In many cultures, the internal world of dreams, feelings, images and sensations is sacred. Yet, most of us are only peripherally aware of its existence. We have little or no experience of finding our way around in this internal landscape."

Peter Levine & Ann Frederic. (1997). *Waking the Tiger: Healing Trauma: The Innate Capacity to Transform Overwhelming Experiences.*

(In the foreseeable meantime--within many conventional diagnostic/empirical-psychological perspectives and practices--we may find little or no formally acknowledged *experiential* space for this exploration and potential healing to be worked through.)

Not only traumatic stress responses to literal life-threatening events may be relevant . . . but a broader human overwhelm response.

Peter Levine has acknowledged, “when I first started developing my approach to trauma. . . way before the definition of trauma as PTSD—I noticed how many different kinds of seemingly ordinary events could cause people to develop symptoms that would later be defined as trauma, as PTSD”

Levine, P. & Ruth Buczynski, R. (N.d.). *What Resets Our Nervous System After Trauma?* National Institute for the Clinical Application of Behavioral Medicine (NICABM).

Bessel van der Kolk called the study of trauma the "soul of psychiatry. As he explained, with Alexander McFarlane, our modern understanding of PTSD re-introduces the idea that what clinicians once called “neurotic” symptoms are not actually caused by “some mysterious, well-nigh inexplicable, genetically based irrationality” but rather emerge from “people's inability to come to terms with real experiences that have overwhelmed their capacity to cope."

van der Kolk Bessel. A. & McFarlane A. C. (1996). The Black Hole of Trauma, In B.A. van der Kolk, et. al. (eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*

Informed consent regarding other *possible,* disciplined scientific worldviews

Paul Feyerabend,
U.C., Berkeley, Philosopher of Science. (1988). *Against Method*.

- "People all over the world have developed ways of surviving in partly dangerous, partly agreeable surroundings. The stories they told and the activities they engaged in enriched their lives, protected them and gave them meaning. The 'progress of knowledge and civilization'. . . destroyed these wonderful products of human ingenuity and compassion without a single glance in their direction. . . .

- "Physicians, anthropologists and environmentalists are starting to adapt their procedures to the values of the people they are supposed to advise....Such a science is one of the most wonderful inventions of the human mind."

Remember two "critical indicators" for moving toward fulfilment of the UN Human Rights Council report

- Availability of non-compromised peer support alternatives
- Education and training on the use of non-consensual measures

Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. (2017).

Support for moving toward critical indicators introduced in
Probert, J. (2021). Moving Toward a Human Rights Approach to Mental Health, *CMHJ*.

Introduced in professional training (including as an aspect of informed consent).

Peer Support Groups

with agency service user & staff member peers engaging--collaboratively –through forms of support developed within service user movements

Intentional Peer Support groups

"Learning together" through dialogues informed by four "tasks":

- Connection
- Worldview
- Mutuality
- Moving Towards

Experiential Peer Support groups

- For exploring voices, visions, plurality, presences, premonitions, and other extreme, 'unusual,' poetic, spiritual or otherwise alternative beliefs, perspectives, or experiences" and more . . .

- Incorporating Hearing Voices Network training & values:

  "Despite the well-established link between hearing voices and traumatic life experiences, HVN explicitly accepts all explanations for hearing voices, and encourages people to explore their own beliefs, be they spiritual, religious, paranormal, technological, cultural, counter-cultural, philosophical, medical, and so on."*

*Jacqui Dillon and Gail Hornstein. (2013). Hearing voices peer support groups: A powerful alternative for people in distress.

"The variety of human experience "must be broadly understood, recognizing the . . variety of ways in which people process and experience life. Respecting that . . .is crucial to ending discrimination" based on experiences conventionally understood as mental illness.

"Peer-led movements and self-help groups, which help to normalize human experiences that are considered unconventional, contribute towards more tolerant, peaceful and just societies."

Dainius Pūras. (2017).
UN Human Rights Council Report.

When I discovered the Hearing Voices movement, in 2006, I would learn about groups which support members to acknowledge their voices, visions--or whatever they are actually experiencing–-and then work to change their relationship with the experiences, making sense of this process within their own chosen and developing worldview. For example, an individual may choose to understand and cultivate their experience of voices as a psychic experience. They may also learn to stand up to those voices or any other experiences which "denigrate them, interrupt their thoughts, or tell them to do harmful things" by learning how other psychics do this and through feedback from other group members--at least as possible starting points.

Jim Probert (2018). *A Human Rights Approach to Supporting Individuals Experiencing Extreme States on a College Campus.* ISPS-US conference (International Society for Psychological & Social Approaches to Psychosis—US Chapter).

Lived experience, in professional training and peer support

"Becoming" God

I immediately thought of my own experiences of becoming God, or of realizing I was God—when I was first hospitalized in 1982. By the time of grad school, I had been able to liberate myself, consciously, from imagining this as a meaningless random symptom of a disordered brain. I discovered world spiritual traditions in which experiencing union or connection with the divine is a goal. The stories and philosophies I discovered also described potential pitfalls and dangers along this path, understood in often very different ways. This helped me re-negotiate the experience of becoming God--which was transformed, from being disruptive, immersed in trauma, confusion, and painfully connected with memories of hospitalization--into a deep, peaceful source of meaning and sustenance, which I have been able to cultivate and consider through a number of worldviews.

This is deeply related to what I realized at 24. Then, I thought, who am I--feeling so small as a mental patient--to question what all these great authorities must know about what is wrong with me? At the same time, I remembered something profoundly beautiful, meaningful, and necessary at the heart of my madness. Losing this aspect of my life contributed to my wanting to die. So, I also asked myself, at 24 (essentially, and if not in these exact words)—who are scientists and doctors, however expert, to rule out my participation in the spiritual-existential quest which has been at the heart of the human experience for untold millennia? Then, I began an intentional process to reclaim this aspect of my being and my life.

Since then, I have also been able to relate this experience to what Richard Mollica, Director of the Harvard Program in Refugee Trauma, has described as the Self-Healing Response.* While I remain transparent about my own, ultimately transcendent view, I have supported service users to cultivate a source or practice of healing from a broad variety of theistic, non-theistic, atheistic, agnostic, existential, committed scientific, and other backgrounds and worldviews.

Procedural due process might support the potential, when chosen, for individual psycho-spiritual-existential exploration--respecting the context of service users' own backgrounds and chosen-and-developing worldviews for making sense or meaning of their experience and the contexts of their lives--while also offering to support service users to live intentionally in the face of whatever they experience and the demands of their lives.

*Mollica, R., et al. (2011). "Demystifying Trauma: Sharing Pathways to Healing and Wellness: SAMHSA Training Teleconference."

Informed consent regarding another perspective (among many) on the cross-generational conflicts and traumas contributing to this current dilemma.

Where wars have been waged . . . and angels fear to tread . . .

(No longer *holding my breath* as I continue advocating for change.)

Gregory Bateson,
University of California, Santa Cruz, anthropologist/social scientist/philosopher whose focus on system dynamics contributed to the birth of family therapy.

Bateson, G. (1991). *A Sacred Unity: Further Steps to an Ecology of Mind*

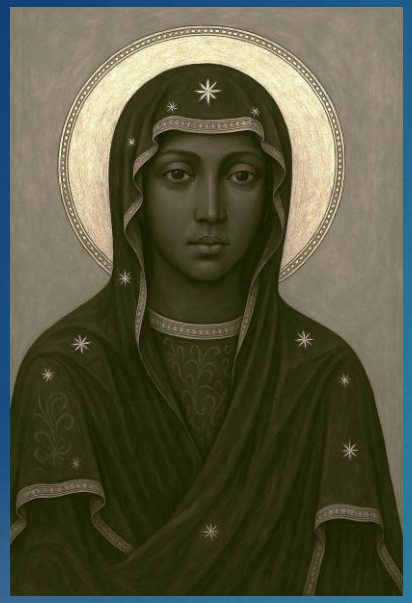
- Gregory Bateson described himself as a "fifth generation unbaptized atheist. We are sort of ultra-Protestant. We protested even against protest."

- He suggested we live in a "peculiar Protestant universe." He suggested the problem goes back to a time when Protestants and Catholics burnt each other at the stake over the question of whether the wine *is* the blood or *stands for* the blood. "This difference seemed to them one for which it was reasonable to burn people and reasonable to be burned."

- From Bateson's perspective, there is a part of the brain which cannot tell the difference. As he explained, "the part of the brain that dreams, which on the whole is the part that the artist uses most, is perfectly willing to accept the statement that 'the bread is the body.'" Yet, he also suggested, the logical "Protestant" (from this perspective) part of the brain will not tolerate this.

- Discussing a missing dimension in contemporary western culture more broadly, Bateson offered "the sacred" as the coming together of these two elements, the healing of the split. "We have lost a wholeness of being which would include 'that' and the 'other' side together."

[It is essential to note, peer services organizations and their allies are as a rule implicitly or explicitly (e.g., MindFreedom Int.) committed to peaceful/non-violent means . . . (and to note, again, the overwhelming majority of individuals diagnosed with mental illness will never be violent toward others;--e.g., Binder, 2015--and that fear-driven public images supporting this association are "extremely hurtful to tens of millions of Americans who are working hard at their recovery"--e.g., Davidson, 2013.)]



Without more reflexivity/mindfulness and critical thinking: DSM IV and the Virgin Mary

Language in the DSM-IV, appeared at least to acknowledge a need to consider cultural factors when diagnosing schizophrenia:

"In some cultures, visual or auditory hallucinations with a religious content may be a normal part of religious experience (e.g. seeing the Virgin Mary or hearing God's voice)."

[Yet, if we are not from one of those cultures--however deeply challenging having experiences at odds with the expectations of the culture in which we were born, now live, or have chosen to embrace, may be—would the same essential experiences then become invariable evidence of an incurable brain disorder?]

American Psychiatric Association. (1994).
Diagnostic and statistical manual of mental disorders : DSM-IV. (p.281)

Additional informed consent regarding cross-generational conflicts and traumas contributing to pressures still frequently experienced by professionals . . . and service users.

"The vast experimental literature on human error agrees with history of medicine, folklore, and superstition in discrediting knowledge claims based solely on anecdotal impressions. Since clinical experience consists of anecdotal impressions by practitioners, it is unavoidably a mixture of truths, half-truths, and falsehoods. The scientific method is the only known way to distinguish these."

Paul Meehl, former American Psychological Association president,

"Newton's mechanics worked wonders . . . but said nothing about the mental world…The eventual result was an entirely objective, mechanical reality completely devoid not only of God but of any mental or conscious dimension whatsoever, a reality entirely independent of any conscious observer or personal dimension. . . The full truth about the material world resides only in mathematics, meaningful concepts can only be stated as quantities, and no other language is real knowledge."

Jeffrey Kripal , Rice University, professor of comparative religion.
(2019.) *The Flip: Epiphanies of Mind and the Future of Knowledge*.

Informed consent sometimes provided (in professional training and peer support consultation sessions) regarding other *possible,* disciplined academic worldviews

U. Va. neuroscientist, Edward F. Kelly, et al.(2007). *Irreducible mind: Toward a psychology for the 21st century.*

"Current mainstream scientific opinion holds that all aspects of human mind and consciousness are generated by physical processes occurring in brains. The present volume demonstrates--empirically--that this reductive materialism is not only incomplete but false. Topics addressed include phenomena of extreme psychophysical influence, memory, psychological automatisms and secondary personality, near-death experiences and allied phenomena, genius-level creativity, and "mystical" states of consciousness both spontaneous and drug-induced.

"The authors show that these "rogue" phenomena are more readily accommodated by an alternative "transmission" or "filter" theory of mind brain relations--a theory that ratifies the commonsense conception of human beings as causally effective conscious agents and is also fully compatible with leading-edge physics and neuroscience."

"I focus on the extraordinary experiences of scientists, medical professionals, engineers, computer scientists, and highly trained intellectuals, including some Nobel laureates . . . "

Jeffrey Kripal. Rice University, professor of comparative religion, 2019.) *The Flip: Epiphanies of Mind and the Future of Knowledge*.

"Classical materialists accounts of human consciousness, and especially religious phenomena [as well as other reported anomalous experiences documented here by Kripal] have to take off the table so much of the human experience to retain the illusion of the completeness of the materialist model.

"This is not a judgement . . . on the scientific method. It is simply an observation . . . [that] can prevent . . . missteps [which] all come down to two fundamental errors: trying to explain something with the scientific method that is not amenable to the scientific method, and then assuming that anything that cannot be so explained must not be real or important, or, worse yet, must be fraudulent or faked.

"Obviously, other methods are needed . . . that engage texts, stories and the interpretation of meaning. What are needed are the humanities . . . . [and] the most basic method [of the humanities] .. . is reflexivity, which is the ability of thought and awareness to turn back on themselves in order to think about thought and become aware of awareness.

"Once we become sufficiently reflexive, it becomes painfully apparent that our deepest convictions, beliefs, thoughts, even emotional reactions and sensory impressions are not . . . . neutral photographs of the world [but] are constantly being shaped, redirected, and distorted by all sorts of influences, of which we are generally completely unaware . . . [This] is a very humbling realization, but it is also a kind of secular spiritual practice, since such reflexivity allows one to 'step back' or 'step away' from oneself."

Informed consent regarding other possible, disciplined academic worldviews

Jeffrey Kripal. (2019.) *The Flip: Epiphanies of Mind and the Future of Knowledge*.

Across his writings, Kripal documents how individuals--including non-professionals and non-academics--engage aspects of critical thinking and reflexivity to cultivate, maintain or move toward more grounded perspectives and lives after being shaken by anomalous experiences.

- "I mean to highlight . . extreme life changing experiences that intellectuals, scientists and medical professionals …have written about with increasing visibility and effect over the last few decades.

- ". . . a radically new real can appear with the simplest of 'flips,' or reversals of perspectives, roughly from 'outside' of things to 'the inside' of things, from 'the object' to 'the subject.'"

- *"And this can occur without surrendering an iota of our remarkable scientific and medical knowledge about the material world and the human body."*

Dainius Pūras. (2018).
Closure of the ceremony.
World Hearing Voices Congress.
The Hague, Netherlands.

- In 2018, the Psychiatrist and UN Special Rapporteur, Dainius Pūras, specifically included hearing voices as a human right.

- Remember, Peter Levine wrote, ". . . it is universally true that the renegotiation of trauma is an inherently mythic-poetic-heroic journey" and that "in many cultures, the internal world of dreams, feelings, images and sensations is sacred."

- Imagine if professional mental health approaches simply introduced and acknowledged a sphere of human experience, without *inherent* pathology, for this exploration to be worked through--acknowledging each individual's own chosen and developing worldview–in the context of the "variety of ways in which people process and experience life" which Pūras named in his 2017 UN Human Rights Council report.

Remember:

John Fryer, psychiatrist
1972 American Psychiatric Association meeting

Understanding conventionally identified symptoms as *inherently contestable** and recognizing the precedent to separate conventionally diagnosable human experience from any invariable or irrevocable assumptions regarding demonstrating competence and capability in professional and other social roles** . . . (as well as regarding meeting criteria for non-consensual interventions).

*This language is from Randal, P., Geekie, J., Lambrecht, I., & Taitimu, M (2008). *Dissociation, psychosis and spirituality: Whose voices are we hearing?*

**With reasonable accommodations, if needed.

Moving toward procedural due process:

Individual peer services consultations sessions

Historically provided by one or two agency professionals (at times, just me)—incorporating our lived experience as current or former service users--meeting with agency service users who may or may not also be participating in therapy or a peer support group—yet, in any event, who may benefit from this specifically focused (and otherwise often unavailable) engagement.

These sessions may address suicide danger and/or extreme states (and other intense emotional-experiential challenges). Of course these are often intertwined.

(Often, but not always, these sessions are related to navigating "shared risk"* for peer support group participation.)

*Sherry Mead. (n.d.). Shared risk: Redefining safety. *Intentional Peer Support*.
Probert, J. (2021). Moving Toward a Human Rights Approach to Mental Health, *CMHJ*.

Moving toward procedural due process:

One trauma-informed, lived-experience based approach to suicide danger

Psychiatric hospitalizations, suicide attempts, and other experiences of pressing suicide danger are often also sources of profound human trauma—which professional training may often leave clinicians unprepared to recognize. (For example, if an individual presented for mental health services after a homicide attempt or repeated death threats, would more professionals be aware of and respond to potentially significant post traumatic stress responses?) In the wake of these experiences, as well, intense suicide danger may return, at times unexpectedly, through trauma re-enactment. This return of trauma might also be mindfully re-negotiated with empathic support.

In peer services consultations, I offer service users opportunity to work toward being more prepared to live through any traumatic return of the state of being which accompanied their suicide attempt(s), other hellish periods in their lives associated with suicide danger, as well as any psychiatric hospitalizations.

This process includes being as transparent as possible about my own potential clinical responses to their experience of suicide (or other) danger. Dialoguing openly abut how my potential to hospitalize them may be activating for them—while detailing specific ways in which I will work to provide trauma-informed, rights-based procedural due process—may also support the service user to re-negotiate past hospitalization trauma while we work together to cultivate a more trusting engagement.

Moving toward procedural due process:

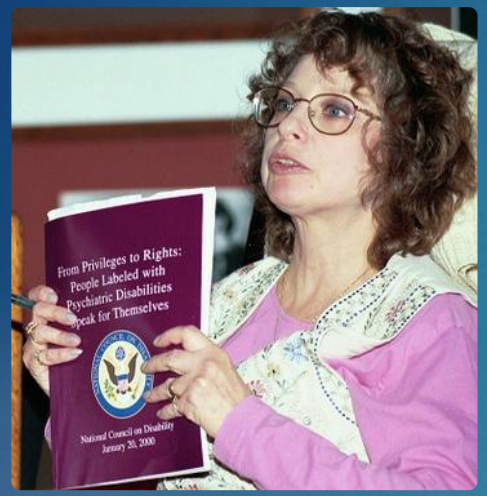
One trauma-informed, lived-experience based approach to suicide danger

The consultation process most often starts with individuals who have been referred to explore if a peer support group might be a mutual fit.

As many of these individuals have experienced significant suicide danger, including many who have been hospitalized, I offer an early, very specific statement clarifying my own clinical practice: when I would and would not even consider hospitalization and my own practice of procedural due process (through ongoing engagement and with involuntary intervention as a genuine last resort).

We discuss navigating "shared risk" as a part of moving into a different way of responding to danger, including suicide danger, within peer support groups. Co-creating this space within our mainstream mental health organization---establishing that we are in no way looking away from suicide danger, but engaging it differently, consistent with the peer support process—has necessitated service user participants to be able, essentially, to say, "I've got this,"… I can take responsibility for talking about suicide danger before taking steps to end my life.

This leads to an in-depth dialogue with each service user, not only involving their personal experiences facing suicide danger, but within a context other clinicians may not be trained or have the lived experience to engage as readily. I have experienced these dialogues often supports service users to change their relationship with suicide danger, sometimes significantly. As a result, we may continue this dialogue, sometimes even after service users join a peer support group or even after others have decided not to join at all.



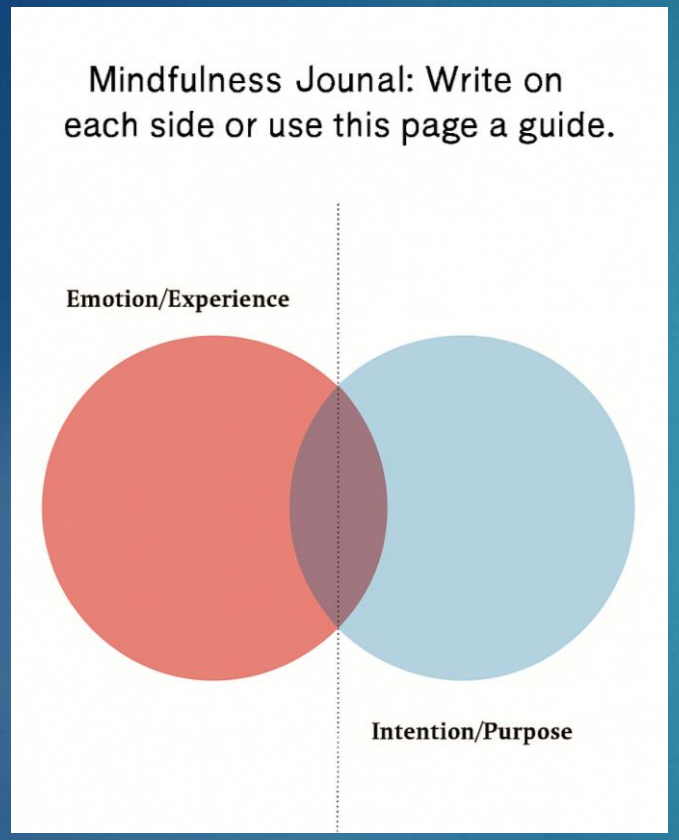
Often included in my session notes for this process

"Our dialogue included a discussion of a trauma-informed understanding of suicide danger, framed in part from a perspective of lived experience. This included dialogue about Judi Chamberlin's lesson from "Confessions of a Non-Compliant Patient": that individuals often learn through hospitalization to tell professionals, essentially, "I am much better now, all the symptoms are gone," and to say, "Thank you for doing so much that is helping," even when an intervention is harmful or traumatic, and to say, "I will comply with everything you tell me" to get out or stay out of the hospital. But that actually moving forward with their lives means actually dealing with what is not better and with what they are actually experiencing."

Also often included in these notes: one trauma-informed approach to suicide danger

"Then, we talked about suicide attempts and/or other intense experiences of suicide danger as a potentially significant trauma. We talked about how healing from trauma in the presence of this ongoing life-threat may be in many ways as difficult as healing from trauma while living through domestic/interpersonal violence as an ongoing danger. This allowed us to talk about the value--in terms of long-term healing from trauma--of creating some distance from that danger, whether it is posed by someone else or ourselves. This included a metaphor of falling into a tiger enclosure at the zoo and how difficult it would be to study, cultivate relationships, process painful emotion, or begin long-term healing from trauma while still in the tiger enclosure. We talked about steps (such as a life pact or a decision to practice unconditional self-acceptance or kindness to self) which might be like coming up out of the tiger enclosure or at least building a guard rail or a fence between ourselves and that immediate danger."

Tools Offered for this Process:



Journal template available in my 2017 Alternatives Conference workshop handout

"We would also never want to forget that a suicide crisis can actually present a distressed individual with the opportunity to move through experiences of loss and trauma, feelings of hopelessness and perceptions of inevitable defeat toward re-empowerment--by making a conscious, active choice to live (and thus both to escape life-threatening danger and to value him or herself in a different way). Knowing life will remain difficult and waves of overwhelming emotion will return" distressed individuals "can also plan to engage internal and external resources available to support this choice over time."

Jim Probert. (2014). Part 2. Further discussion for the need to develop more comprehensive guidelines for lethality assessment, revised, 2011. *SAMHSA Recovery to Practice Highlights*.

Starting-point examples of statements which may support unconditional self-acceptance or kindness to self

I have experienced and observed similar practices may transform the process of engaging the "self healing response," even in the face of significant adversity; transform relationships with professionals; and may sometimes, but not always, also be excruciatingly challenging for individual service users to work toward incorporating—if they choose to--within their own worldviews and experience.

<u>Two decisions/statements which may support a practice of unconditional self-acceptance or kindness to self</u>

"I have decided to believe my life is worth living and I am worth loving no matter what happens and no matter what I feel, think, or experience."

"I have decided to believe the potentials for "love" (mutual connection), "work" (a valued social role) and coping with my emotions even during times of distress are within me."

<u>The Albert Ellis description of unconditional self-acceptance*</u>

"Accept yourself as good, worthy, or deserving of life and enjoyment just because you are human, alive, and a unique person; and don't evaluate, rate, or measure your self or personhood at all, but only your individual thoughts, feelings and behaviors on the basis of your chosen goals and purposes."

*Ellis, A., & Blau, S. (2001). *The Albert Ellis reader.*

From my 2017 Alternatives Conference Handout: An Approach to "Emotional Fitness," Including the "Two Story" Approach to Trauma Recovery

Entering into dialogue . . .

A few narratives and perspectives on engagement within this framework/process/practice—from shorter and longer-term consultations and therapy.

Again, the scope of this work is relatively small. We need so much more change and longer-lasting community engagement . . . but we are carrying a torch and impacting those individuals we can, in the time we have available.

Moving toward procedural due process:

Cultivating a Space and Process for Experience

"In many cultures, the internal world of dreams, feelings, images and sensations is sacred. Yet, most of us are only peripherally aware of its existence. We have little or no experience of finding our way around in this internal landscape."

--Peter Levine

Offering this space, now.

Offering this space, now.

While this space might certainly be considered in the context, for example, of phenomenology, any given individual's whole-life choices are not limited to academic traditions as the only potential source of critical thinking, mindfulness/reflexivity, or viable human right's-based perspectives.

- *Offering* a space where experience might be considered (even momentarily) as a natural part of the human condition—rather than through an implicit perspective (commonly grappled with among research university students in my work) of any distressing emotion/experience as an inherent disease process interrupting *normal* human consciousness (potentially understood implicitly as limited to 1) only direct material observations of the senses and 2) the rational mind behaving itself--with, *perhaps,* well-measured intrusion of reasonably behaved emotions in reasonable proportion to external events.)

- On a research university campus this work with students has most often included an overt goal of cultivating adequate capacity for significant intellectual effort, in the midst of whatever challenges students face (or developing an intention to withdraw or reduce coursework, through available processes--adapted to be more trauma-informed and rights-based in the presenter's own work with students).

Beyond my own psychiatric hospitalizations, 1982-83 . . .

and beyond my decision, in 2006, to start speaking openly about that aspect of my life

I recovered my life in the world through facing and accepting what happened, while engaging—and changing my relationship with—my own experience, and while reclaiming agency and authorship of my life. Pat Korb*, a gifted, loving Gestalt therapist supported me to begin this journey in earnest.

Through that process, I began to develop my own practice of a kind of mindfulness or reflexivity: to meditate; paint; write a song, poem, or essay; engage in a soulful dialogue with a loved one, colleague, or peer; or use the Gestalt dialogue approach to engage my own "inner" energy & images. Essentially, I found healing, over time, through learning to give voice to--and otherwise experience, express, and engage--the same or similar energies, mindfully, that I was originally overwhelmed by and diagnosed for experiencing and expressing spontaneously.

While I did anticipate a need to be prepared for possible professional and social responses from others, an unexpected impact of revealing my life history publicly has been also discovering an unexpected need to communicate more clearly, including publicly, about intentionally engaging this practice--to avoid my own "inner" world becoming increasingly constricted toward a more "normal" passing (but for me, at least, less healthy) experience of reasonable logic and undifferentiated somaticized stress. (Having survived MRSA, which damaged my lungs and immune system in 2007, and having very nearly contributed to the statistic of current or former public mental health patients dying 25 years early—also considering the ACE study, regarding physical health impacts of unresolved trauma, in my circumstances, including secondary trauma as a professional—living without adequate self-care is not a wise or sustainable choice for me.)

*Korb, M.P., et al. (2011). *Gestalt Therapy: Practice and Theory, 2nd Ed*.

Moving toward procedural due process:

While any external party gaining their release might intend to reinterpret my session notes from more conventional perspectives, this language establishes a human rights claim for the work. It also bridges/recovers invaluable professional approaches (e.g., see next page) within a rights-based frame that also includes approaches and addresses essential issues identified by service users (e.g. challenges also illuminated through Rosenhan's 1973 study).

A human rights context identified in all my own peer services consultation sessions notes:

"This session, and any exploration of [agency] peer support group processes, was conducted (as any future sessions will be) from a human rights perspective consistent with Probert, J. (2021). Moving Toward a Human Rights Approach to Mental Health. Community Mental Health Journal as well as with my [agency] Training presentation "Mental Health Recovery: Reclaiming our lives in the world" and my other professional presentations [e.g. (2018) SAMHSA BRSS TACS Roundtable on Collegiate Recovery Supports] . . . ."

Cultivating a Space and Process for Experience

Included in my session notes for this process

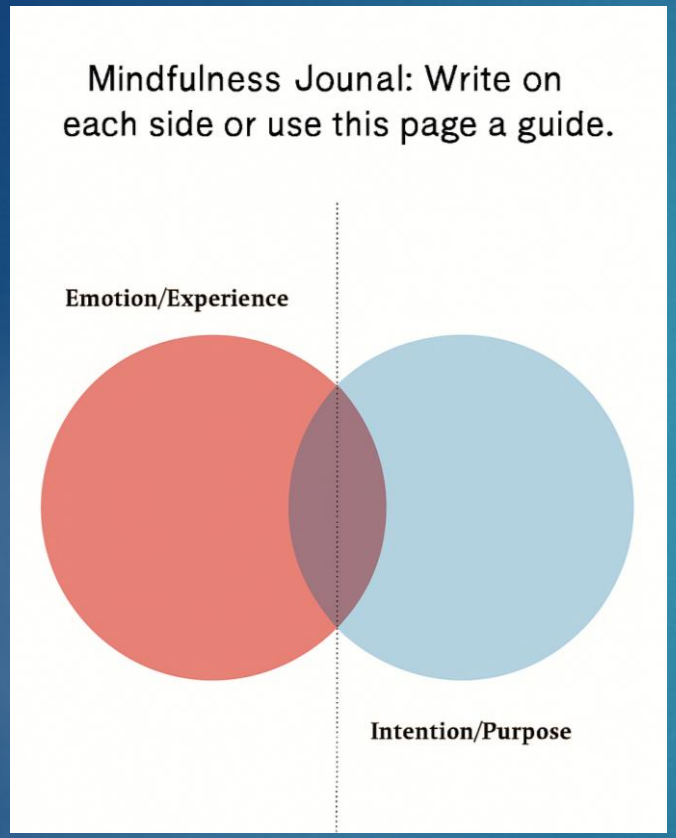
"We talked about potentially entering into a framework which includes making space for a healthy sphere of human experience consistent with Peter Levine's description of healing trauma as a mythic-poetic-heroic journey--as well, potentially, as with creative exploration of psycho/spiritual/existential freedom as an essential human right for making meaning of their experience within the many contexts of their lives. This practice may include cultivating an intentional, imaginal framework--for example, incorporating gestalt therapy/internal family systems/object relations/archetypal psychology--for creatively engaging and expressing experiences which allows experience, if chosen, to be taken seriously but not literally* (at least not without mindful consideration, if then).

"This may include practices like the emotional-relational-engagement/crisis intervention approaches of Erich Lindemann and Gerald Caplan as well as practices like those which Marsha Linehan described for cultivating "wise mind" (or what Joan Borysenko and Gordon Dveirin have called, the "essential core of love and wisdom within")—which, incorporating Linehan's description, may be engaged through this process of moving toward living more intentionally while coming to terms with all ways of emotional knowing and experiencing (in many ways like, for example, the experience of "Self" emerging through IFS practice).

"Any of this is offered, not prescribed, within a context of respect for each individual's own freely chosen and developing worldview being understood as essential for engaging a self-directed healing process--which, for example, Richard Mollica has called the self-healing response. This process might also be considered in terms of potential contributions to healing through the integrative medicine/mind-body approaches, for example, of Bernie Siegel or Joan Borysenko."

*Adapted from James Hillman. (1983). Archetypal Psychology.

Tools Offered for this Process



From my 2017 Alternatives Conference workshop handout

An approach to "Emotional Fitness," including the "Two Story" approach to trauma recovery

Practices and perspectives for healing and maintaining or reclaiming our lives.

Not separate strategies for any separate population of human beings, but language intended to make practice more inclusive. I offer some of these tools as a starting point, essentially, to everyone I work with—regardless of conventionally perceived severity, intensity, or risk.

For example, offering a mindfulness or reflexivity practice of living intentionally (rather than, *reasonably*, potentially implying only consensual understandings of what is reasonable) with radical acceptance of *experience* (rather than specifically, *emotion)*.

I also practice engaging these wellness tools and perspectives in my own life and as a general starting place for making sense of all my work with others.

An approach to "Emotional Fitness," including the "Two Story" approach to trauma recovery

From my 2017 Alternatives Conference workshop handout

Our dialogue included a focus on an experiential re-living of past events as if they never ended, what Levine calls re-enactment—and moving from re-enactment into renegotiation. I described an example (created from a number of de-identified individuals I have worked with) of a service user who found themself hiding as if a childhood perpetrator were walking outside their apartment--when in fact they were now living on their own as an adult--and who found a way to stay with experiencing both stories, simultaneously, including the experienced safety of immobility as well as finding a way to walk carefully and safely out of their apartment in a manner consistent with trauma re-negotiation.

A central message from Peter Levine's approach to healing trauma:

Deep animal levels of our body-mind need to complete alarm responses--on terms often incomprehensible to the modern rational mind--moving in and out of immobility, through fight or flight, and back into vital living.

Tools Offered for this Process

An approach to "Emotional Fitness," including the "Two Story" approach to trauma recovery

A way to understand trauma recovery as involving "two stories" which each deserve attention

From my 2017 Alternatives Conference workshop handout

For example, A mnemonic: "Back and Forth or In-Between."

In-Between (Bessel Van der Kolk): We might gain just enough perspective on our "inner" thoughts/ feelings/experiences of inescapable defeat that we can observe our sensations/ emotions/experiences without either (1) being completely overwhelmed and "losing our wits" entirely or (2) engaging in "avoidance maneuvers" and disconnecting from them entirely.

Or Back-and-Forth (Peter Levine): The idea of "pendulation" that we might move naturally or intentionally back and forth between the overwhelming experience of defeat and immobility and cultivating experiences of (relative) safety, comfort, and vitality.

Levine, P.A. and Frederic, A. (1997). *Waking the Tiger : Healing Trauma : The Innate Capacity to Transform Overwhelming Experiences.*

van der Kolk, B. A. (2002). Posttraumatic therapy in the age of neuroscience. *Psychoanalytic Dialogues.*

Outside the *door*
. . . of this cultivated space and practice

These consultations often also include dialogue about how we may choose to talk about our experience with other professionals, loved ones, and the world.

While the collective mental health fields have yet to acknowledge the difference (or even the possibility, formally)—and have little or no adequate descriptive language within their worldviews--I, myself, am careful not to use the very same language to cultivate, understand, or communicate experiences--which have now been interwoven within and genuinely changed by these creative practices of cultivating competence, mindfulness/ reflexivity, health, and wholeness--as I do those experiences which once emerged in a fragmented way, impacted by complex trauma, without having those resources available, then, as my sanity was overwhelmed. Now, I enter into, engage in, and understand and communicate through this process, both while engaging in it and back outside the door—all intentionally mindful of, and referring intentionally to, the larger context explored in this workshop. [Without this intentional practice, as I addressed in a previous slide, I start clamming up and moving toward becoming a still logically competent but less nuanced, less deeply authentic, less deeply effective—and from my experience, consistent with the ACE study, and principles of integrative healing and trauma recovery and "stewardship," (e.g., van Dernoot Lipsky, L. & Burk, C., 2009)--potentially less physically healthy human being and professional.)

With service users, I am providing informed consent and talking about my own wellness tools from a peer support perspective, not advising anyone who is suffering to avoid engaging support—certainly not anyone in danger of killing themselves, or less frequently, as evidence shows, anyone else. On the contrary, I am working to support more engagement. I take all these dangers very seriously, including dangers to service users.

In the years before team members built our programs, I had experienced individuals--whom I did not hospitalize because they did not meet criteria while engaging through this process--experience involuntary interventions, without due process, elsewhere. When I had not talked with them about navigating these challenges elsewhere, they often stopped engaging with all professionals, including me and other providers in our system. In the years since we have built these programs--where service users frequently report experiencing what we have called procedural due process, including often dialoguing about potential impacts of non-consensual interventions on their willingness to speak genuinely (e.g., what Judi Chamberlin, 1998, reported)—we experience service users frequently staying more engaged.

Respect and the possibility of individuals considering multiple perspectives over time

- Before moving toward joining a peer support group or even moving deeper into dialogue with me, I have sometimes asked service users who describe improvement through what I experienced as more literal engagement with the diagnostic perspective: Will talking with anyone who does not embrace the diagnostic worldview as clearly, and is doing well anyway, throw off your own healing program?

- I have also sometimes offered individuals an opportunity to place a diagnostic perspective "on the shelf" while they considered an aspect of their lives from some other perspective, even momentarily, before reclaiming the diagnostic approach, as needed, on their way back out the door.*

*Probert, J. (2002). *Crisis intervention and suicide prevention.* American Association of Suicidology Conference. See also, George A. Kelly (e.g., 1969. The autobiography of a theory. In B. Maher (Ed.*), Clinical psychology and personality: The selected writings of George Kelly)*.

Entering into dialogue . . .

A few narratives and perspectives on engagement within this framework/process/practice—from shorter and longer-term consultations and therapy.

Again, the scope of this work is relatively small. We need so much more change and longer-lasting community engagement . . . but we are carrying a torch and impacting those individuals we can, in the time we have available.

An essential step in moving toward procedural due process . . .

The potential transformation of the mental health fields through collaborative engagement of future professionals--and other current or former service users--with lived experience of "inherently contestable," conventionally diagnosable experiences, including those who have navigated impacts of non-consensual mental health interventions.

With or without other changes in the legal system, changes in mental health practice which require genuine human connection will also require genuine buy-in from mental health professionals on the ground, as well as determined advocacy within professional mental health organizations.

Without formal professional and legal acknowledgement of the potential to separate conventionally *diagnosable* human experience from any invariable or irrevocable assumptions regarding competence, capability (and dangerousness)--current and former service user, including those who are also professionals, may not reasonably be expected to risk illuminating to (other) professionals either how damaging non-consensus interventions frequently have been or the ways many of us are actually reclaiming our lives (often through changing our understanding of and relationship with "inherently contestable," conventionally diagnosable experiences).

Lived Experience and Procedural Due Process

Personal and Professional Reflections While Moving Toward a Human Rights-Based Approach to Mental Health

Jim Probert, PhD
Psychologist
September 2025

Slides to be available on the NARPA website and now available here:

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