

## DEADLY PSYCHIATRY AND ORGANIZED DENIAL

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Book Report and Comments by David G. Schwartz, M.D., Part 2

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Getting symptoms of psychiatric drug withdrawal confused with symptoms of the underlying illness can easily occur. For example, when patient with depression or schizophrenia is stable, taking medications, then the drug is stopped and withdrawal symptoms occur. Doctors often assume it is symptoms of the disease. “See, you need to get back on the medication because you need it to control your disease.” The problem with this assumption is that withdrawal symptoms can occur quickly, but depression or psychosis would take much longer to develop if the person really had been in remission. Then when the drug is re-started, for the symptoms to disappear quickly, it should be obvious that this is the disappearance of withdrawal symptoms. For depression to improve from taking a drug, it is supposed to take weeks for the drug to take effect.

Psychiatry is also prone to adding more diagnoses of other psychiatric conditions and adding more drugs and higher doses, if the desired effects are not achieved, all because the worsening symptoms are due to adverse effects of the drugs. The doctors are taught that these drugs very seldom have side effects, so they assume the disease is getting worse, and the patient doesn't know what to think.

I say, whatever happened to “First do no harm?” If a symptom could be caused either by the disease or by the drug, why not put the burden of proof on vindicating the drug, rather than assume it is the disease, and that the drug is innocent? In my training, I was told that whenever a new or unusual symptom or sign occurred, to first suspect the medications.

To do any treatment for any mental illness, first there has to be a diagnosis, to show that the person actually has a problem for which the treatment would be indicated. Mental, emotional, and behavioral disorders are very nebulous and difficult to diagnose, with very few clear-cut criteria. What to one person may be a disease, to another person or culture, may be normal. The Diagnostic and Statistical Manual (DSM) 5, the most recent version, has greatly loosened and expanded the criteria, for symptoms to be diagnosed as a disorder or disease. The DSM is not verified by laboratory tests or scientific studies, but is based on consensus opinions by “experts” in the field. So drugs are being increasingly given even to children at alarming rates, because it is easy to diagnose a disorder. If a child now has a disease for which a psychiatrist prescribes a drug, parents are put in a bind because they could be considered negligent if they refuse to give the child the drug. What used to be variations of normality are now disorders treatable by drugs. Shyness and stage fright now become social phobia. Sadness, grief, and toxic stress now become depression. Premenstrual symptoms now become premenstrual dysphoric disorder. Hyperactivity and restlessness stemming from an unnatural physically confined schoolroom environment now becomes ADHD. Hearing voices becomes schizophrenia. And so on. And then antidepressants are being dispensed like candy for many conditions for which the drug is not indicated, like urinary

incontinence, minor anxiety, etc. Pharmaceutical companies have paid huge fines for illegally marketing the drugs for “off-label” uses, along with other criminal activity. That’s just the cost of doing business.

Some do-good organizations want to get depressed people into treatment. People don’t recognize that these social organizations are given funding and propaganda by pharmaceutical giants. The public is swallowing the fiction that drugs are an easy fix for depression. These organizations are recommending preventive care and early diagnoses, that all primary doctors screen people for depression, in case patients don’t know they are depressed. Screening questionnaires could make many normal people be categorized as depressed. The purpose of a screening tool is to take notice of something that could possibly be a problem, but not to make a diagnosis. When a doctor sees high scores on the questionnaire for symptoms of depression, very often the doc does not carefully rule out other conditions, but after 3 minutes of talking with a patient, writes an Rx for an SSRI (selective serotonin reuptake inhibitor).

Regarding depression, the risk of suicide is markedly increased on SSRI’s, according to several studies, some showing double the risk over placebo, and some of these showing 6 times higher. In addition to that, suicide risk is even greatly underestimated in many of the trials. The investigators often don’t report or don’t look for suicide attempts, or the events are coded as something else, such as “agitation.” Only people at low risk for suicide are recruited for trials. Events occurring shortly after the end of the study were rarely reported. Risk of suicide is lower in trials than in usual medical practice because people have the support of participating in a group and are more closely monitored.

The author notes there had been 15 times more suicides on antidepressants than were reported by the FDA in its meta-analysis of 100,000 patients in 2006. What makes people more likely to be suicidal is the akathisia that SSRI’s as well as the antipsychotics can cause, and the withdrawal also can cause this. Akathisia is an extreme restlessness and agitation that patients describe as “wanting to jump out of my skin.” This gets worse with increasing dose. Some people suicide on the SSRI’s, who were not even depressed, after being given the drug for some other problem, such as urinary incontinence.

The other tragic thing that can result from akathisia is homicide, though less common than suicide. It is listed in the PDR (Physicians Desk Reference) for SSRI’s as a possible adverse effect, as well as abnormal thinking, depersonalization, emotional lability, hostility, adjustment disorder, etc. In most of the investigations of homicides, the killers had been given antidepressants for indications other than depression, for family stress, financial anxiety, academic difficulties, work harassment, divorce, etc. They also had defects in CYP450 genes that changed their metabolism of drugs. They never had signs of mental illness or violent behavior or tendencies prior to taking the drugs. They had akathisia prior to the homicides, and their behavior returned to normal after being off the drugs. Often they had been taking the drugs for only days or weeks. The author narrates several horror stories of normal happy families being murdered by a loving family member who suddenly “lost it.”

Although drug studies showed increased hostility in patients taking an SSRI than people taking placebo, companies denied those tendencies and refused to include warnings in the product labeling for many years. Then for the first time in history, in 2001, a jury found a pharmaceutical firm liable for deaths caused by an antidepressant, when a man, after taking paroxetine for only 48 hours, killed wife and children and himself. In almost every one of the mass shootings in the U.S., the shooter was on a psychiatric drug, yet this gets no attention in the mainstream press, amidst the controversy about the availability of guns. Yet on the Internet there is a collection of 5000 stories about violence involving antidepressants and ADHD drugs. Before 1955, mental patients discharged from hospitals committed crimes at the same rate or lower than the general population, but studies between 1965 and 1979 found significantly higher rates than the general population.

Dr Gotzche designed a skit for You Tube, viewed by thousands. I will try to summarize as best I can an abridged version: The doctor asks the patient, "How's the pregnancy going?" "Fine, no problems." "Are you aware that it's possible to have depression without knowing it?" "No, but I'm fine." "I think you should do a screening test." "What if it's positive?" "I may give you a drug to help you." "There's nothing wrong with me. Why should I undergo the test?" "The Board of Health recommends it." "Is there a "Cochrane review for it?" "Yes, it recommends against screening people." "How many get a wrong diagnosis?" "About one third." "Holy Smokes! How does the drug work?" "Like an amphetamine, and it's difficult to quit, the drug increases risk of suicide, causes sexual problems, and birth defects." "My goodness! Thanks for information, Doc. Count me out."

The extent of corruption involved with the makers of SSRI's is astounding, fulfilling all the criteria of organized crime. The criminal activities of Glaxo Smith Kline (GSK), maker of Paxil (paroxetine), included making false statements to state officials, obstructing federal investigations, lying to the FDA, paying kickbacks to doctors, and withholding incriminating documents. It pled guilty to illegal marketing in 2011 and paid \$3 billion in fines (small change compared to profits from Paxil, for a large corporation that is "too big to nail.") No one went to prison. It's just the cost of doing business. I say, remember from Deadly Medicine, how company after company settled for paying huge fines for criminal activity, with no convictions, and they would turn right around and continue committing the same crimes over again? How can there be any trust in the safety of the drugs coming from the context of such corruption?

GSK testified to Congress that it did not know until 2006 that paroxetine was associated with suicidality in adults, but investigators found that it had known about it in 1998.

Even publicly funded studies can be as deceptive as those done by the industry. The Star\* B Study costing \$35 million done by the National Institutes of Mental Health (NIMH), did selective reporting, false claims, contradictory statements, and pure fiction, making the antidepressants look better than they were. To me, this is an example of how,

aside from the pharmaceutical industry, the whole medical profession and the psychiatric profession are both caught up in the delusion of the primacy of psychiatric drugs.

The anti-anxiety drugs, the benzodiazepines, after the patents ran out and they were no longer so lucrative, were finally recognized as addictive. They were largely replaced by the new SSRI's, which were actually less effective for anxiety, but not yet considered to be addictive, as they were new, and more profitable. The benzodiazepines were found to cause panic symptoms with long-term use, and led to many suicides and homicides. They were also found to cause brain damage.

Childhood ADHD has been considered to be a brain disorder, but the brains of these children are no different from brains of other children. The criteria for diagnosing this condition are very ambiguous and unclear. Many symptoms of adult ADHD can be found in a huge majority of the population. The drugs for ADHD are stimulants with effects similar to amphetamines and cocaine, and can cause addiction, mania, other psychoses, brain damage, hallucinations, homicide, and sudden cardiac death. The drug trials, like for many other psychiatric drugs, were also rigged, manipulated, un-blinded, had missing data, etc.

The effects of these stimulants are to reduce overall spontaneous mental and behavioral activity, including social interest, and causing apathy and indifference. In some studies, half of the children developed depression and compulsive behavior. Animal studies also confirm this. A systemic review in 2001 showed that stimulants reduced symptoms but did not improve academic performance. Compulsive behavior can be misinterpreted as improvement, although the child may be copying carefully everything shown on the board without learning anything. So why do we hear about kids doing so much better in academic performance after starting these drugs? As with other conditions, such as depression, when people get better within days (long before the effect of the drug is supposed to take place), we are impressed with how well the drug is doing. Well, without blinding and placebo controls, with the parents, teachers, and the child all believing strongly in the benefits of the drug, why wouldn't there be improvement? We need safer placebos.

In my view of ADHD, many normal kids are diagnosed with that and treated, as if they have a disease, yet maybe they are just naturally more active and kinetic than other kids, and they could be reacting to poor discipline and to family stresses. Often there are nutritional factors that, when addressed, make enormous improvements, like cutting out junk food and sugar, addressing gastrointestinal dysbiosis, etc. Special education with adaptive schoolroom environment has helped many children with their academic performance, without drugs. The school system wants these kids on drugs to control them. Could it be that the problem is the educational system and not the kids? The system is designed for conformity, not creativity. It helped to train students for working on the assembly line in manufacturing as adults. Our economy is requiring much less of that conformity and tedious work now, and needs workers who can think creatively to solve problems, to communicate, and to collaborate with teams.

Are these hyperactive kids the “canaries in the coal mine,” showing us that it is not healthy for any kids to have to submit to the regimens of classrooms as they are currently being used, dampening their desire to learn? Forcing children to sit still for hours and to not be allowed to talk or go to the bathroom? This is not a normal situation. In some circumstances, this could be considered torture. See my article on the book, Nature Fix. When kids with ADHD were taken out hiking, they were in “7<sup>th</sup> Heaven” and functioned normally. They can’t bounce off the walls if you take away the 4 walls. Children learn biology, math, physics, and other studies much more enthusiastically in the woods and by growing schoolyard gardens. Putting more resources into education by hiring more teachers and having smaller classes would boost academic performance, give every kid “special education,” and cut discipline problems enormously.

Schizophrenia’s treatment has a sordid history of imprisonment, removing teeth and intestines, malarial infections, insulin coma, electroshock, barbiturate overdose, and frontal lobotomy.

One contrasting therapy in the 1800’s, by the Quakers, was kindness, respect, and organized social activities. What a novel idea! This was very effective. Half of the patients lived normal lives after that, and only 1/3<sup>rd</sup> remained chronically ill. This stands out in great contrast to the high degree of permanent disability for people with this problem currently.

Then came along the first chemical “lobotomy” drug, chlorpromazine (Thorazine), a neuroleptic that kept patients under control, calmed them, with amazing effectiveness. What a relief for caretakers! The patients still had delusions and hallucinations, but they were less disturbed by them. A 1999 survey showed 90% of patients on neuroleptics were depressed, 88% were sedated, and 78% had poor concentration. At a Senate hearing in 1975 a senator called neuroleptics, “chemical handcuffs that assured solitary confinement of the mind.” The “anti-psychotics” could as well be named, anti-personality, anti-human, anti-feeling, anti-social, and anti-cognition. No wonder the patients hate them and try to stop them. When I was in medical school in 1969, we visited a psychiatric hospital, and I noticed that the patients were walking around very slowly, mechanically, had flat affect, like “zombies.” I thought that was part of the disease. No one told us that this was the effect of the drugs.

The studies on these drugs, as mentioned previously, were seriously flawed. The newer “atypical antipsychotics” such as olanzapine, risperidone, and quetiapine, fared no better in effectiveness or safety than the older drugs, haloperidol, stelazine, chlorpromazine, prolixin, etc. The new drugs can cause weight gain, adverse lipid profiles, diabetes, cerebro-vascular disease, and cardiac arrest. People with schizophrenia live 20 years shorter lifespan than average. The increased mortality correlates directly with the dose and the number of drugs.

One of the key features of schizophrenia is that people hear voices, have auditory hallucinations. If that is the only major problem they have, there are support networks

that allow people to talk to other people freely about the voices and to live a normal life. More about this is at [www.hearingvoices.org](http://www.hearingvoices.org).

Electroconvulsive Therapy (ECT) provides no evidence of lasting benefit, causes brain damage, destroys people's memories, and can cause death. It may temporarily reduce symptoms by reducing the patients' ability to think. Would you repair your computer by just giving it a huge jolt of electricity?

Part 3 next month covers the slow, careful process of withdrawing from psychiatric drugs, forced treatment, and successful natural therapies.