DEADLY PSYCHIATRY AND ORGANIZED DENIAL

By Peter Gøtzsche

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

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The front cover of this book shows a tombstone for 500,000 Americans and Europeans killed by psychiatric drugs in 2014. I wrote a report (in the archives of my previous articles) about Dr. Gotzsche's previous book, Deadly Medicine and Organized Crime, about the pharmaceutical industry as a whole corrupting health care and qualifying as having all the characteristics of the mafia. Deadly Psychiatry exposes the psychotropic drug industry as the worst part of this scandal. This market is huge. In his home country of Denmark, sales of these drugs are so high that 1/4th of the population could be under treatment. In the United States in 2009 the most sold drugs were the anti-psychotic drugs.

In Part 1, I write about psychiatry's historical perspective, and the corruption of science with its fraudulent portrayal to the public. Part 2 is about specific drugs, their psychiatric indications, and their deadly effects. Part 3 covers forced treatments, drug withdrawal process, and non-drug therapies and promotion of mental health.

The data is so weak for effectiveness of the antidepressants, anti-psychotics, stimulants, Alzheimer drugs, anti-anxiety drugs, "mood stabilizers," or electroshock therapy, and the harms are so great, that the author says they should not be used at all, with the exception of short-term use, in rare cases, of certain drugs.

Dr. Gotzsche refers frequently to Robert Whitaker, winner of the Investigative Reporter and Editors 2010 book award. He wrote Anatomy of an Epidemic, which I have studied, and Mad in America, in both of which he gives the historical perspective on mental illness in the U.S. Before the introduction of psychiatric drugs, people with psychiatric disorders would typically have one episode that would last a few weeks or months, have a 50% chance of no recurrence for the rest of their lives, and if they had more episodes, it may have been one more, or maybe 4-5 in their whole life, but the rest of the time their lives were functional and normal. Mental illness was mainly episodic and sporadic. Now people are chronically disabled for life from these conditions at alarmingly increasing rates far above that in the 1950's. For example, the incidence of bipolar disease is now 250 times that of the pre-drug era. (Antidepressant drugs and stimulants frequently convert people's depression into bipolar.)

A World Health Organization's 8-year study showed that of people in poorer countries with schizophrenia, 64% after 5 years were functioning and normal. Only 18% of those in rich countries fared so well. In the rich countries 61 % were maintained on anti-psychotics, whereas in the poorer countries only 16% could afford them. (Mad In America)

These startling statistics should shock us into making a very intense scrutiny of what is going on. Whitaker does careful investigation and reporting, and Dr. Gotzsche has had

years of experience and expertise in evaluating research and publications. He co-founded the Cochrane Collaboration in 1993, which does meta-analyses of many studies, critically evaluating the validity of the research methodology. His books are detailed, thorough, and well documented. He has the credentials to do critical analysis of the research that supposedly authenticates modern psychiatric treatments. He has many detractors in the psychiatric community because he unearths factual information that devastates the very logical foundations of modern psychiatry. "Organized Denial" characterizes psychiatry's refusal to recognize the harms of these drugs, their distortion and omission of data and manipulation of the "science," to the extent that psychiatry lives in a fantasy world. I ask, "Who is saner, the patient, or the doctor?"

In 1980, psychiatrists' training was 50% psychotherapy, and 50% drugs. Now their education is almost entirely in psychopharmacology. Most of the rest of medicine has been drug – oriented for nearly a century, and it had more status than psychiatry, because medicine was supposedly "hard science," reductionistic, based on chemistry and hard end-points. This was very compatible with our materialistic culture that has high regard for "better living through chemistry" and wants simple, concrete solutions to complex problems. Well, in my perspective, medicine has gone down the wrong path anyway, giving pills to remove symptoms and focusing less on healing long-term, holistic, life issues, fooling people into thinking they can take the easy way out, a shortcut by taking a pill. This is making people sicker and killing people with chemistry much of the time. Well, then psychotherapy was considered a soft, nebulous, and ambiguous practice that took a lot of time. It didn't have much status in the medical community. When I was in medical school working in the hospital, when the intern thought a medical student was performing poorly, he said, "Maybe you should go into psychiatry." Psychiatrists would have liked to have higher status, more on par with the rest of medicine.

Enter the pharmaceutical industry that proposed the specious theory that mental illness was caused by a chemical imbalance and could be corrected by a drug, like insulin for a type I diabetic, and it was all too glad to present this bogus theory to the eager psychiatrists. Now the psychiatrists could quit listening to patients so much and give them a "scientifically based" drug treatment. That would give them medical credibility along with the rest of the doctors. The drug companies made a marriage of convenience with the psychiatrists, much more cozy than with the rest of medicine. This was so appealing that the American Psychiatric Association (APA) bought it, "hook, line, and sinker," and "sold it's soul to the devil," so to speak, (my metaphors), so thrilled to have drugs in their toolbox. The APA and its members were willing to succumb to a legion of corrupt practices in partnership with the pharmaceutical industry, such as outright denial of evidence, lying, distortion of data, spouting pseudo-science, autocratic intimidation of patients and families, and accepting huge, deviously routed financial payments from the drug industry. It took a wrong turn down a sinister path that lead to what we have today as the wholesale slaughter of patients with drugs. (My comment.)

This also has lead to the style of medical treatment that is autocratic, less personal, spending less time with patients, disrespecting patients' feelings, ideas, and opinions, less shared decision – making with patients and families. The doctor is the authority, armed

with "scientific knowledge." No one should contradict the doctor, not patients, families, nurses, social workers, or psychologists. Especially if the patient has a chemical imbalance, the propensity for which is innate and permanent, that leads to brain malfunction. Why consider the patient's input if he or she is mentally deficient and has faulty thinking?

The "chemical imbalance" idea was supposed to take away the social stigma of mental illness, with less personal responsibility and guilt for the emotional and behavioral problems, and to make it less "mental" and more physical. Physical disease allows higher social esteem than mental. Also it seems easier in the short run to take a pill than to spend time in counseling. But better social esteem came with loss of personal self-esteem. If the disease was now innate, nothing the person could do now but be dependent on drugs for the rest of his or her life, what does that do to self-esteem? Defective material. Hopeless. On top of that, when adverse effects of the drug resulted in more diagnoses, requiring more drugs (It's always the disease is getting worse, not the drug causing the new symptoms.), and at higher and higher doses, how does that feel? Antidepressant drugs can turn depression into bipolar disorder. Then more diagnoses like schizo-affective disorder, etc., may be added. Then, if a drug cannot be stopped because of severe withdrawal symptoms (addiction), and the doctor says the disease is worsening instead of letting the patient know that adverse effects of the drug are damaging the brain, what does that do for self-esteem, empowerment, personal growth, and confidence? This sets up a power game, overriding the scientific data, when the authority of the doctor, the sacredness of the drugs, the esteem of the APA, and the profits of the drug companies become more important than the health of the patient, who becomes a pawn in a power game, and eventually has a much shorter lifespan because of the drugs. How's that workin' for your self-esteem now? (My sarcasm.)

Let's look at the science behind my tirade, and behind Dr. Gotzche's recommendation that these drugs should not be prescribed, and above all that no one should be treated with drugs or electroshock against their will under any circumstance (consistent with Article 12 of the United Nations Convention on the Rights of Persons With Disabilities.)

To examine all the research in detail is tedious, highly technical, and hard for the reader to follow, but Dr. Gotzsche does that for each of the major disorders, depression, anxiety, bipolar disorder, schizophrenia, ADHD, dementia, etc. It is important to take a close look at the research, because this is what causes the "house of cards" to fall. I will try to summarize the consistent patterns in the drug research. Any health professional or any person who is concerned about this area would be advised to read the whole book.

Let's take a look at the basics of doing randomized, prospective, double-blind, placebo - controlled drug trials. For the hypothesis that a single drug will achieve a predetermined "end-point," such as improved symptoms, generalized to all patients, not just the ones in the study, the drug in question has to be compared to a placebo, a blank pill disguised to appear to be the same as the real one. Every treatment has a "placebo effect," an improvement in symptoms over and above the actual treatment. This is usually in the range of about 30%, varying with the situation. So for a drug to be proven

effective, it has to be significantly better than the placebo effect. The patient and doctor are both blinded as to which is the real pill. Usually half the patients are given the placebo and half the drug, each half of the group being selected to be roughly similar in demographic characteristics to the other half. Patients are selected randomly as to which side they are on. This sounds very precise and scientific. If the drug performs better than the placebo, it is declared effective for the general population that has the disorder in question.

Not so fast. Often there is a "run-in" period of time, maybe 2 weeks, when the drug is tried, and if intolerable adverse effects occur in some people, those patients are dropped from the study. And we may not know how many were dropped. This is also true of trials of non-psychoactive drugs, such as the "statins" used for cholesterol. No wonder many patients in real life complain about muscle pain and weakness from statins, yet the doctor tells the patient that those side effects were actually rare in the studies, and patients' complaints are not given credibility.

Now for the placebo group, what was their history before the study? Seldom are placebo subjects treatment-naïve, that is, not on any drug prior to the study. They are taken off whatever psychiatric drugs they were on previously, "cold turkey," and given a run-in period, which may be too short to detect many withdrawal symptoms. Then during the trial, they may have severe withdrawal symptoms that can mimic symptoms of their disease. This causes their performance to be worse in comparison to the drug, so the drug comes out looking better than the placebo group, even if it has no drug effect. Then there is the problem of "un-blinding." The people in the placebo group, since they feel so bad from withdrawal, think they are not taking the actual drug, so they are no longer blinded, and they have an extra negative placebo effect, giving them an even worse result, making the drug look better. The people in the active treatment group may feel as good as they did on the previous drug they were taking before the study, not having withdrawal, so they believe they are taking the actual drug, and that gives them additional positive placebo effect. So the "double-blind" effect is invalid.

The problem of dropouts is seldom addressed. When a large number of people drop out of a study, often due to adverse effects, they are not accounted for properly, because nobody knows for sure why they dropped out or what happened to them afterward. A large number of dropouts in any study should invalidate the study, but the interpretation of the study may gloss it over. Adverse effects in the treatment arm of the study may be minimized, like a suicide attempt labeled as "agitation."

A drug may have several trials, some favorable, and some unfavorable. Since the drug industry does most of the trials or underwrites and controls them, they can "cherry-pick" the favorable trials and not publish the unfavorable trials. That information is not available to the public. It is considered "proprietary information." This by itself produces biased results. Much of this unreliability in research is present in all of medicine, but it appears to be much more egregious in psychopharmacological research.

In spite of the many ways the "deck is stacked" in favor of making the drug look good, I have read about many studies in which the drug was no more effective than placebo, especially antidepressants.

The whole of medical research is plagued with corruption. (See my article in the Archives, Sept. 2014, "Is Medical Science Scientific or Even Credible?") The drug company is in major control of how studies of drugs are designed, run, and interpreted, even when done by public universities that receive funding from the drug industry. The names of prominent doctors at the university appear as authors of the studies even though they had little or nothing to do with the studies, but the results are really "ghost written," by authors from the industry.

Then after publication, the results of the studies and interpretation are marketed by paying large sums to prominent doctors, "opinion leaders," and members of advisory boards that set standards of practice. These doctors lecture other doctors at seminars about the use of the drugs. Even at continuing medical education seminars that are supposed to not promote any particular drug, they end up being corrupted by the speakers' freedom to distort the data or to make frankly false statements. Just because the forum discloses each speaker's conflict of interest (working in collaboration with several drug companies, etc.), it doesn't eliminate the conflict of interest. The conference may be sponsored by an "unrestricted grant" from such and such a pharmaceutical company. Dr. Gotzche says "unrestricted grant" means "corruption."

So if the evidence is so lacking, if existing at all, that psychiatric drugs are effective, how can we in good conscience use them at all, especially when they have such deadly harms? There is no evidence that schizophrenia or depression or any other mental illness shrinks the brain, but people on long - term anti-psychotic drug treatment have brain shrinkage, in a dose – dependent manner, and in no relation to the severity of the psychosis. It occurs also in primates that are given the drugs. Cognitive decline, personality changes, emotional flatness or irritability, have been documented in the usage of virtually all of the psychiatric drugs, related to length of exposure, and worse with higher doses. These symptoms improve when tapered off the drugs, but many persist long after the drugs have been discontinued. Psychiatrists don't generally tell their patients that, but they say that depression and schizophrenia cause brain damage, and that the drugs protect against brain damage.

Then there is the problem with addiction and drug dependence, which psychiatrists deny. A historical perspective shows that it took 40 years for doctors to recognize that barbiturates were addictive, and 20 years to recognize that for benzodiazepines. Now SSRI's are documented also to have dependence, with severe withdrawal symptoms, yet the drug companies and psychiatrists deny it.

This problem is so severe, that patients should not stop these drugs abruptly, and the usual way to taper off most medications doesn't work for these drugs. Sometimes several weeks and months are needed to taper off. Danish psychiatarist Jens Frydenlund had one patient that took 8 years to get off an SSRI! More about that in Parts 2 and 3.