Facts on Psychiatric Drugs

Psychiatrists have tried for decades to find a biological cause for human behavior, such as a deficiency in serotonin that supposedly causes depression or an excess of dopamine that supposedly causes schizophrenia. Despite what the advertising and marketing campaigns conducted by Big Pharma would have us believe, research has failed to find any significant functional, anatomic, genetic, or biochemical cause of conditions such as ADHD, anxiety, bi-polar disorder, or depression.

The American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5), falsely assumes this biomedical or disease model is true. The DSM includes hundreds of arcanely named "disorders," but other than a handful of clearly biologically based conditions, such as dementia, the psychological conditions are not really illnesses at all. They are merely "normal reactions to abnormal events," as many have described them.

The disease model and the DSM are promoted by psychiatry and the pharmaceutical companies, two industries that make billions of dollars selling and prescribing psychoactive drugs despite well-documented harmful side effects and lack of efficacy. Big Pharma, colluding with their paid researchers in academia, has spent millions of dollars convincing physicians and the American public that popping a pill will "fix" the neurotransmitters in one's brain and "treat" depression, ADHD, or schizophrenia. This theory has never been proven to be true. For more on the problems with the DSM read my webpage.

- It is important to understand how psychotropic drugs affect the brain. Read this and learn about the brain's functioning and how all psychiatric drugs perturb the normal functioning of neurotransmitters. This leads to compensatory changes that leave the brain damaged.
- Neurotransmitters cannot even be measured in the brain to determine if there is some presumed shortfall or excess. Peter Breggin, MD, a longtime advocate for appropriate prescribing of psychiatric medicine, writes that the idea of biochemical imbalances is sheer speculation aimed at promoting psychiatric drugs.
- Psychoactive drugs often make mental health and functioning worse, as noted by many authors, including Robert Whitaker in "Anatomy of an Epidemic." All classes of psychiatric drugs produce chronic brain impairment, frequently prevent recovery, and can cause chronic or permanent disability.
- **Summary of Long-term Evidence on Antidepressants:** The Mad In America website has an excellent summary of the research on SSRI effectiveness, including this statement: "The scientific literature tells a story that stretches over the span of fifty years. When the antidepressants are introduced, at least a few psychiatrists worry that the drug treatment is causing a chronification of the disorder. Over the next two decades, researchers find that patients treated with antidepressants are relapsing more frequently than before. Studies in the 1990s and early 2000s do indeed find that the majority of depressed patients do not achieve a sustained recovery. Medicated depression is found to run a more chronic course than it had in the pre-antidepressant era. Numerous studies since 1995 tell of how patients treated with antidepressants are more likely than unmedicated patients to remain symptomatic over longer periods of time. Studies find that antidepressants increase the risk that a person suffering from an episode of depression will become disabled by the disorder. In country after country, the increased prescribing of antidepressants has been accompanied by an increase in disability due to mood disorders."
- No Different than Placebo: Irving Kirsch and collaborators, in their meta-analyses of industry-funded clinical trials, have reported that the difference in symptom reduction between the medicated and placebo groups is less than two points on the Hamilton Rating Scale of Depression (HAM-D). The National Institute of Clinical Excellence in the UK has stated that there needs to be at least a 3-point difference on this scale to be clinically relevant, and Kirsch found that it was only in a subset of patients, those severely depressed, that SSRIs met this standard. Kirsch and others have calculated "effect sizes" of around .30 for antidepressants based on symptom scores. This means that there is an 88% overlap in the distribution of outcomes for the drug-treated and placebo patients. Thus, the risk benefit equation from this symptom-reduction data can be summed up in this manner: Is exposure to the adverse effects of drug treatment worth the 12% chance of a better outcome? Or

to put it another way: **12% of patients will benefit from the treatment, while the remaining 88% will suffer the adverse effects of treatment without any additional therapeutic benefit beyond placebo.** Those are the odds that a person contemplating taking an antidepressant drug might want to know.

- Martin Harrow and Thomas Jobe began a study, funded by the National Institute of Mental Health, in the late 1970s about the long-term effects of antipsychotics and other psychiatric drugs. In 2007, they reported that the long-term recovery rate for schizophrenia patients off antipsychotic medication was eight times higher than for those on the medication (40% versus 5%). Antipsychotics induce a dopamine supersensitivity that made patients more biologically vulnerable to psychosis than they otherwise would be in the natural course of the illness. Antipsychotics may worsen those symptoms over the long term and worsen the long-term course of schizophrenia and other psychotic disorders.
- Chronic treatment with an SSRI may lead to a 50% reduction in serotonin receptors in the brain. At that point, the brain has become "desensitized" to serotonin. This leads to dependence, so doses may have to be increased to get the same effect.
- In an NIMH study of "untreated depression," 23% of the non-medicated patients recovered in one month; 67% in six months; and 85% within a year. "If as many as 85% of depressed individuals who go without treatments spontaneously recover within one year, it would be extremely difficult for any intervention to demonstrate a superior result to this," the investigators wrote. (The naturalistic course of major depression in the absence of somatic therapy. Posternak, M., Journal of Nervous and Mental Disease 194 (2006):324-9.)
- In contrast, in a large NIMH trial of 4,041 "real-world" outpatients, known as the STAR*D study, only 108 patients given antidepressants stayed well and in the trial during the one-year followup, a stay-well rate of 3%. (Efficacy and Effectiveness of Antidepressants. Pigott, H., Psychotherapy and Psychosomatics 79 (2010):267-279.) *Would you take a drug with a 3% effectiveness rate?*
- In an 18-month NIMH study that compared four types of treatment (two forms of psychotherapy, an antidepressant, and placebo), the group that was initially treated with the antidepressant had the lowest stay-well rate by the end of the study. (Course of depressive symptoms over followup. Shea, M., Archives of General Psychiatry 49 (1992):782-87.)
- If Adderall and Ritalin decrease growth in children by 2 inches then what do they do to the brain?

How to Talk to Your Doctor

If you are interesting in being prescribed medications, please consider getting fully informed consent. Ask your prescriber these questions:

1) How are you deciding to prescribe THIS medication versus another?
2) What are you basing my "diagnosis" on?
3) What are the specific short-term and long-term harms, side effects and benefits of this drug?
4) How long should I plan to be on the medication? Why?
5) Why is medication preferred over psychotherapy?
6) What is the plan at outset for withdrawing?
7) What experience do you have working with withdrawal?
8) What symptoms should I expect when I withdraw?
9) Will you prescribe reduced dosing or taper strips for withdrawal?
10) How often will this medication be reviewed and how will you determine I should stop it?
11) How will you and I monitor side effects?