



THE REAL CRISIS

In Mental Health Today

Report and recommendations on the lack of science
and results within the mental health industry by

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IMPORTANT NOTICE

For the Reader

The psychiatric profession purports to be the sole arbiter on the subject of mental health and “diseases” of the mind. The facts, however, demonstrate otherwise:

1. PSYCHIATRIC “DISORDERS” ARE NOT MEDICAL DISEASES. In medicine, strict criteria exist for calling a condition a disease: a predictable group of symptoms and the cause of the symptoms or an understanding of their physiology (function) must be proven and established. Chills and fever are symptoms. Malaria and typhoid are diseases. Diseases are proven to exist by objective evidence and physical tests. Yet, no mental “diseases” have ever been proven to medically exist.

2. PSYCHIATRISTS DEAL EXCLUSIVELY WITH MENTAL “DISORDERS,” NOT PROVEN DISEASES. While mainstream physical medicine treats diseases, psychiatry can only deal with “disorders.” In the absence of a known cause or physiology, a group of symptoms seen in many different patients is called a *disorder* or *syndrome*. Harvard Medical School’s Joseph Glenmullen, M.D., says that in psychiatry, “all of its diagnoses are merely syndromes [or disorders], clusters of symptoms presumed to be related, not diseases.” As Dr. Thomas Szasz, professor of psychiatry emeritus, observes, “There is no blood or other biological test to ascertain the presence or absence of a mental illness, as there is for most bodily diseases.”

3. PSYCHIATRY HAS NEVER ESTABLISHED THE CAUSE OF ANY “MENTAL DISORDERS.” Leading psychiatric agencies such as the World Psychiatric Association and the U.S. National Institute of Mental Health admit that psychiatrists do not

know the causes or cures for any mental disorder or what their “treatments” specifically do to the patient. They have only theories and conflicting opinions about their diagnoses and methods, and are lacking any scientific basis for these. As a past president of the World Psychiatric Association stated, “The time when psychiatrists considered that they could cure the mentally ill is gone. In the future, the mentally ill have to learn to live with their illness.”

4. THE THEORY THAT MENTAL DISORDERS DERIVE FROM A “CHEMICAL IMBALANCE” IN THE BRAIN IS UNPROVEN OPINION, NOT FACT. One prevailing psychiatric theory (key to psychotropic drug sales) is that mental disorders result from a chemical imbalance in the brain. As with its other theories, there is no biological or other evidence to prove this. Representative of a large group of medical and biochemistry experts, Elliot Valenstein, Ph.D., author of *Blaming the Brain* says: “[T]here are no tests available for assessing the chemical status of a living person’s brain.”

5. THE BRAIN IS NOT THE REAL CAUSE OF LIFE’S PROBLEMS. People do experience problems and upsets in life that may result in mental troubles, sometimes very serious. But to represent that these troubles are caused by incurable “brain diseases” that can only be alleviated with dangerous pills is dishonest, harmful and often deadly. Such drugs are often more potent than a narcotic and capable of driving one to violence or suicide. They mask the real cause of problems in life and debilitate the individual, so denying him or her the opportunity for real recovery and hope for the future.

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INTRODUCTION

Psychiatry's Lack of Science

How concerned should we be about reports that mental illness has become an epidemic striking one out of every four people in the world today? According to the source of these alarming reports—the psychiatric industry—mental illness threatens to engulf us all and can only be checked by immediate and massive increases in funding. They warn of the disastrous effects of withheld appro-

Professor Edward Shorter, author of *A History of Psychiatry*, stated, “Rather than heading off into the brave new world of science, DSM-IV-style psychiatry seemed in some ways to be heading out into the desert.”²

We formulated this report and its recommendations for those with responsibility in deciding the funding and fate of mental health programs and insurance coverage, including legislators and other decision makers charged



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priations. What the psychiatrists never warn of is that the very diagnostic system used to derive the alarming statistic—their own *Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV)* and its equivalent, the mental disorders section of the *International Classification of Diseases (ICD-10)*—are under attack for their lack of scientific authority and veracity and their almost singular emphasis on psychotropic drug treatment.

Professor Herb Kutchins from California State University, Sacramento, and Professor Stuart A. Kirk from the University of New York, authors of several books describing the flaws of the *DSM*, warn, “There are indeed many illusions about *DSM* and very strong needs among its developers to believe that their dreams of scientific excellence and utility have come true. ...”¹

The “bitter medicine” is that *DSM* has “unsuccessfully attempted to medicalize too many human troubles.”

with the task of protecting the health, well-being and safety of their citizens.

The results of the widespread reliance by psychiatrists on the *DSM*, with its ever-expanding list of illnesses for each of which a psychiatric drug can be legally prescribed, include these staggering statistics:

- Seventeen million schoolchildren worldwide have now been diagnosed with mental disorders and prescribed cocaine-like stimulants and powerful antidepressants as treatment.

- Psychiatric drug use and abuse is surging worldwide: More than 100 million prescriptions for antidepressants alone were written in 2002 at a cost of \$19.5 billion (€15.9 billion).³

- One in seven prescriptions in France includes a psychotropic drug and more than 50% of the unemployed—1.8 million—take psychotropic drugs.⁴

Meanwhile, driven by *DSM*-derived mental illness statistics, the international mental health budget has skyrocketed in the last 10 years.

■ In the United States, the mental health budget soared from \$33 billion (€29.7 billion) in 1994 to more than \$80 billion (€72 billion) in 1999.

■ Switzerland's spending on mental health increased from \$73.5 million (€65 million) in 1988 to over \$184.8 million (€165 million) in 1997.

■ Germany currently spends more than \$2.6 billion (€2.34 billion) a year on "mental health."

■ In France, mental health costs have soared,

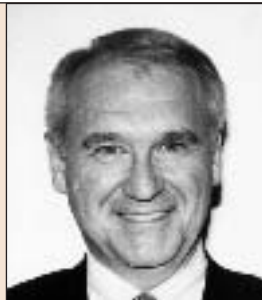
screening for mental disorders of young children in schools.

The claim that only increased funding will cure the problems of psychiatry has lost its ring of truth. Fields of expertise that are built on scientific claims are routinely called upon to deliver empirical proof to support their theories. When the Centers for Disease Control receives funds to combat a dangerous disease, the funding results in the discovery of a biological cause and develop-



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contributing \$400 million (€361 million) to the country's deficit in 1996.⁵

In spite of record spending, countries now face record levels of child abuse, suicide, drug abuse, violence and crime—very real problems for which the psychiatric industry can identify neither causes nor solutions. It is safe to conclude, therefore, that a reduction in the funding of psychiatric programs will not cause a worsening of mental health. Less funding for harmful psychiatric practices will, in fact, improve the state of mental health.

The evidence presented herein has been drawn from physicians, attorneys, judges, psychiatrists, parents and others active in the mental health or related fields. The consensus of these experts is that *DSM*-based, psychiatric initiatives such as the broadening of involuntary commitment laws and the expansion of so-called community mental health plans are detrimental to society in human and economic terms. The same applies to programs such as the

ment of a cure. Biological tests exist to determine the presence or absence of most bodily diseases. While people can have serious mental difficulties, psychiatry has no objective, physical test to confirm the presence of any mental illness. Diagnosis is purely subjective.

The many critical challenges facing societies today reflect the vital need to strengthen individuals through workable, viable and humanitarian alternatives to harmful psychiatric options. We invite you to review for yourself the alternatives we have included. We respectfully offer the information in this report for your consideration so that you may draw your own conclusions about the state of mental health and psychiatry's ability, or the lack thereof, to contribute to its resolution.

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IMPORTANT FACTS

1 More than 6 million U.S. children have been put on mind-altering psychiatric drugs for an invented mental disorder called "Attention Deficit Hyperactivity Disorder" or "ADHD."

2 Another 1.5 million children are prescribed antidepressants known to cause suicidal ideation and violent behavior.

3 Australia's stimulant prescriptions for children increased 34-fold in the past two decades, while in Britain it increased 9,200% between 1992 and 2000.⁶

4 In Spain, the consumption of methylphenidate (Ritalin) increased 363% between 1991 and 2000, while in Mexico, sales of methylphenidate rose 800% between 1993 and 2001.

5 The U.S. Drug Enforcement Administration (DEA) reported that neither animals nor humans can differentiate between cocaine, amphetamines and methylphenidate: "[T]hey produce effects that are nearly identical."⁷





CHAPTER ONE

The Drugging of Our Children

Are children being overdrugged? An examination of data and statistics such as those summarized on the preceding page reveals the alarming rate at which children are being medicated for mental disorders.

In addition to the more than 6 million children in the United States who have been prescribed mind-altering psychiatric drugs for so-called Attention Deficit Hyperactivity Disorder (ADHD), 2 million have been put on antidepressant and antipsychotic drugs.

These soaring numbers of children internationally being drugged parallel the increase in the number of mental disorders in the fourth edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV)* and the mental disorders section of its counterpart, the *International Classification of Diseases (ICD)*. (See Chapter Two for more information about *DSM* and *ICD*.)

In 1952, the first edition of the *DSM* contained only three "disorders" for infants or children. By 1980, there was a nearly ten-fold increase in the number of child disorders. Today, children barely out of diapers are already diagnosed with mental illness, leading to a substantial increase in prescribed

psychiatric drug consumption by very young children in the last 15 years.

Community and Government Response

In the United States as of 2004, seven states had passed laws prohibiting schools from coercing parents or expelling a student if his parents refused to put him on a psychiatric drug.

A mother in New York fought to preserve this fundamental right of parents. After school psychologists and psychiatrists coerced Patricia Weathers to drug her 8-year-old son when he was diagnosed with ADHD, the child became withdrawn, could not eat or sleep and ran away from home.

Recognizing that these problems started with the ADHD medications, Mrs. Weathers gradually withdrew her son from the drugs. Medical tests showed that he suffered from allergies and anemia, and when treated,

his behavior problems disappeared. He is now drug-free and doing well.⁸

In 1987, ADHD was voted into existence by members of the American Psychiatric Association. Talking in class, being distracted, fidgeting or losing pencils can result in a child being labeled "ADHD" and drugged.

Dr. William Carey, a respected pediatrician at the Children's Hospital of Philadelphia, says: "The

"Legislators and the general public should not be hoodwinked. Behaviors cannot be diseases."
— Jeffrey A. Schaler,
adjunct professor of psychology,
Chestnut Hill College, Philadelphia, 1998

current ADHD formulation, which makes the diagnosis when a certain number of troublesome behaviors are present and other criteria met, overlooks the fact that these behaviors are probably usually normal.”⁹

Psychologist Bob Jacobs warns that psychiatrists and pharmaceutical companies have turned behavioral problems in children into disorders: “Nobody has ever presented any evidence of a condition called ADHD except to say all these children are hyperactive; all these children are inattentive, and therefore they all have a disease.”¹⁰

The U.S. National Institutes of Health concluded in 1998, “... our knowledge about the cause or causes of ADHD remains largely speculative.”

In 2002, the Netherlands Advertising Commission ordered the country’s “Brain Institute” to stop falsely advertising ADHD as a *neurobiological* or *genetic* disorder because no scientific evidence exists to prove this true.

The APA concedes that there are “... no laboratory tests that have been established” to diagnose ADHD.¹¹

Israeli physician Louria Shulamit is one of a strong and growing international coalition of responsible professionals who object to giving children psychiatric drugs for emotional problems: “We don’t need drugged students. We should put our efforts into finding [the] reasons. Some of them are health problems like food intolerances or vitamin deficiencies. Some are learning problems. As

doctors, we need to find the real problems instead of drugging children.”

The Risks of Psychotropic Drugs

“Ritalin took me as low or lower than anything else I used in the 60s and 70s—including heroin, cocaine, LSD—the whole horror show ...,” said one Ritalin addict from New Zealand. “The rush was euphoric—it’s like poor man’s coke. But the side effects were devastating. You’d get paranoid even faster than with coke. ... You’d think your friends were going to turn you in, the cops were about to beat down the door, that you’d taken an overdose and your heart would jump out of your chest. But I was so addicted to the few seconds of euphoria, I’d put up with the hours of insanity, pain and [aggression].”

At the same time that child psychiatric drugs are broadly promoted as safe and effective, many governments classify them as abusive and as addictive as morphine, opium and cocaine. The stimulants prescribed for ADHD were already listed as controlled substances under Schedule II of the 1971 United Nations Convention on Psychotropic Substances because they constitute a substantial risk to public health, have little therapeutic usefulness but have a high potential for addiction.¹²

According to a special study by the U.S. Drug Enforcement Administration, “Psychotic episodes, paranoid delusions, hallucinations, and bizarre behavioral characteristics similar to amphetamine-like stimulant toxicity, have been associated with



Many psychotropic drugs prescribed for children are classified as abusive and are as addictive as morphine, opium and cocaine.

CASE REPORTS

Child Deaths

While psychiatrists proclaim psychoactive drugs safe and effective for children, many parents know from tragic personal experience that this is false.



Shaina Dunkle— 1991–2001

Vicki Dunkle's daughter Shaina's life had been filled with dance classes, Girl Scouts, piano lessons and softball games. But in 1999, when Shaina was in second grade, teachers said she was "too active" and "talked out of turn."

Without diagnostic tests or physical exams, a psychiatrist concluded she suffered from ADHD and prescribed a psychiatric drug. On February 26, 2001, Shaina suffered a seizure in the doctor's office. Her mother rushed to hold her in her arms, where, minutes later, she died. "Shaina looked into my eyes as her life ended and I could do nothing to save her. It's been two years and I relive those last few minutes every day. Believe me, it is a nightmare no parent should ever have to live with," Mrs. Dunkle said. An autopsy revealed that Shaina had died from toxic levels of the prescribed amphetamine.



Matthew Smith— 1986–2000

At age 7, Matthew Smith was diagnosed with ADHD. His parents were told he needed to take a stimulant to help him focus and that non-compliance could bring criminal charges for neglecting their son's educational and

emotional needs. "My wife and I were scared of the possibility of losing our children if we didn't comply," says Matthew's father, Lawrence. The parents acceded to the pressure after being told that there was nothing wrong with the "medication." But on March 21, 2000, while skateboarding, Matthew suffered a heart attack and died. The coroner determined that Matthew's heart showed clear signs of the small blood vessel

damage that is caused by stimulant drugs like amphetamines and concluded that Matthew died from long-term use of the prescribed ADHD stimulant. "I cannot go back and change things for us at this point. However, I hope to God my story and information will reach the hearts and minds of many families, so they can make an educated decision," Mr. Smith said.



Samuel Grossman— 1973–1986

In 1986, Samuel Grossman, 13, died after being prescribed a stimulant for "over-activity." The autopsy revealed an enlarged heart caused by the psychiatric drug. According to the boy's mother, "Giving this

drug to a child is like playing Russian roulette. No one knows which child will get the brain damage and/or those who will die. I played the game and I lost."



Stephanie Hall— 1984–1996

Stephanie Hall was a shy first grader in Ohio who loved books and school. After her teacher reported that Stephanie had a hard time "staying on task," a doctor diagnosed attention deficit disorder and prescribed

a stimulant. Over the next five years, Stephanie complained of stomachaches and nausea and displayed mood swings and bizarre behavior. On January 5, 1996, at age 11, Stephanie died in her sleep from cardiac arrhythmia. Mrs. Hall remembers the last words exchanged with her daughter: "I said, 'It's 9 o'clock, Steph, get to bed,' and she replied, 'OK Mom, I love you.'" The next morning when her father went to wake her for school, she didn't respond. "We called paramedics and the police ... Stephanie was so cold. I kept saying to them, 'She is supposed to bury me, not me bury her.'"

methylphenidate (Ritalin) abuse. Severe medical consequences, including death, have been reported.¹³

Even when not abused, side effects of Ritalin include blood pressure and pulse changes, angina (severe pain, often in chest), arrhythmia (heart irregularity), weight loss and toxic psychosis. Suicide is a risk during withdrawal.¹⁴ Studies also reveal that stimulants do not actually improve academic performance.¹⁵

Journalist Lou Dobbs reports that while the U.S. federal government spends nearly \$1 billion a month to fight the war on illicit drugs, more than 1 million prescriptions were written for a new drug for ADHD in its first six months on the market.¹⁶

Nearly 3 million U.S. adolescents ages 12 to 17 abuse many highly addictive prescription drugs such as painkillers, tranquilizers and sedatives.

In Japan, large numbers of methylphenidate addicts and “advisors,” called “Ritalers,” use the Internet to promote how to best use the drug and offer drug swaps.¹⁷

Robert Whitaker, science writer and author of *Mad in America* said, “What we have after years of soaring use of psychotropic drugs is a crisis in mental health, an epidemic of mental illness among children. Instead of seeing better mental health with ever more medicating, we see a worsening of mental health.”¹⁸

“It’s big money,” says Peyton Knight, legislative director of the American Policy Center, “The more diagnoses there are every year, the more Ritalin and other mind-altering drugs they are going to be able to market and sell.”¹⁹

Antidepressant Deaths

As for antidepressants, between 1995 and 1999, the use of these for 7- to 12-year-olds in the United

States increased 151% and 580% for children under six, resulting in some as young as five committing suicide. In 2003, the British medicine regulatory agency warned doctors not to prescribe Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants for under 18-year-olds because of the risk of suicide.

Following that warning, an FDA Public Health Advisory of March 22, 2004 stated, “Anxiety, agitation, panic attacks, insomnia, irritability, hostility, impulsivity, akathisia (severe restlessness), hypomania and mania have been reported in adult and

pediatric patients being treated with [SSRI] antidepressants ... both psychiatric and non-psychiatric.”²⁰ Bizarre dreams and violent behavior have also been reported.²¹ The Australian, Canadian and European agencies also issued warnings. Then in October 2004, after parent testimonies of children killing themselves,

the FDA ordered a “black box” warning of suicide risk to be placed prominently on SSRI antidepressants.

However, such warnings came too late for Matt Miller and Cecily Bostock. Matt hanged himself in his bedroom closet after one week of taking an SSRI antidepressant.²² Cecily stabbed herself in the chest with a kitchen knife two weeks after she began taking an antidepressant.²³ “To die in this violent, unusual manner without making a sound ... [the drug] must have put her over the edge,” said Cecily’s mother, Sara.

“Black box” warnings will do nothing to stem the fact that children are dying, are killing others or being turned into addicts because of these and other psychiatric drugs. Their future will only be safeguarded when the unscientific “mental disorders” they are diagnosed with are abolished and dangerous psychotropic drugs are prohibited.

The stimulants prescribed for ADHD ... have little therapeutic usefulness but have a high potential for addictiveness.

— United Nations Convention on Psychotropic Substances

SCHOOL VIOLENCE

A Critical Perspective

Senseless acts of violence are devastating and shocking, even more so when committed by children and teens. We ask, "How could this happen?"

The dangers of psychiatric drugs and psychological programs in schools demand examination.

■ Seven out of 12 U.S. school shootings were committed by teens taking prescribed psychotropic drugs known to cause violent and suicidal behavior.

■ At least five teens responsible for school massacres had undergone "anger management" or other psychological behavior modification programs such as "death education." Anger management aims at curbing aggressive or violent behavior. No data exists to prove it has any positive effect.

■ For decades, schools around the world have taught "death education," a psychological experiment in which children are made to discuss suicide and what they would like placed on their coffins, and write their own epitaphs—to "get kids more comfortable with death."

■ Columbine, Colorado high school shooters Eric Harris and Dylan Klebold are prime examples of the failure of "anger management" and "death education." Harris was also taking an antidepressant that can cause violent mania. He and Klebold had attended court-ordered psychological counseling, including "anger management." As part of a school "death education" program Harris was told to imagine his own death. He later dreamt that he and Klebold went on a shooting rampage in a shopping center. After turning the story of the dream in to his teacher, Harris and Klebold acted it out by killing 12 students and a teacher, before shooting themselves.²⁴

■ In February 2004, 15-year-old Andreas of Germany shot and killed his foster father. He had been undergoing psychiatric treatment for years and was taking prescribed psychotropic drugs.²⁵

■ On May 17, 2004, 19-year-old Ryan Furlough of Maryland was convicted of the 2001 first-degree murder of a school friend. Ryan was taking several prescribed antidepressants at the time of the killing.

■ In Japan, a 14-year-old beheaded his 11-year-old friend, while another teen stabbed an elderly neighbor to death because he wanted to experience killing someone.²⁶

A dramatic increase in school violence has also been reported in Canada, Israel and France.²⁷

The combination of psychological value systems with violence-inducing psychiatric drugs is a powder keg waiting for a spark.



Psychiatric drugs and psychological practices have been behind the rising violence in U.S. high schools, such as the shootings at Columbine in 1999.

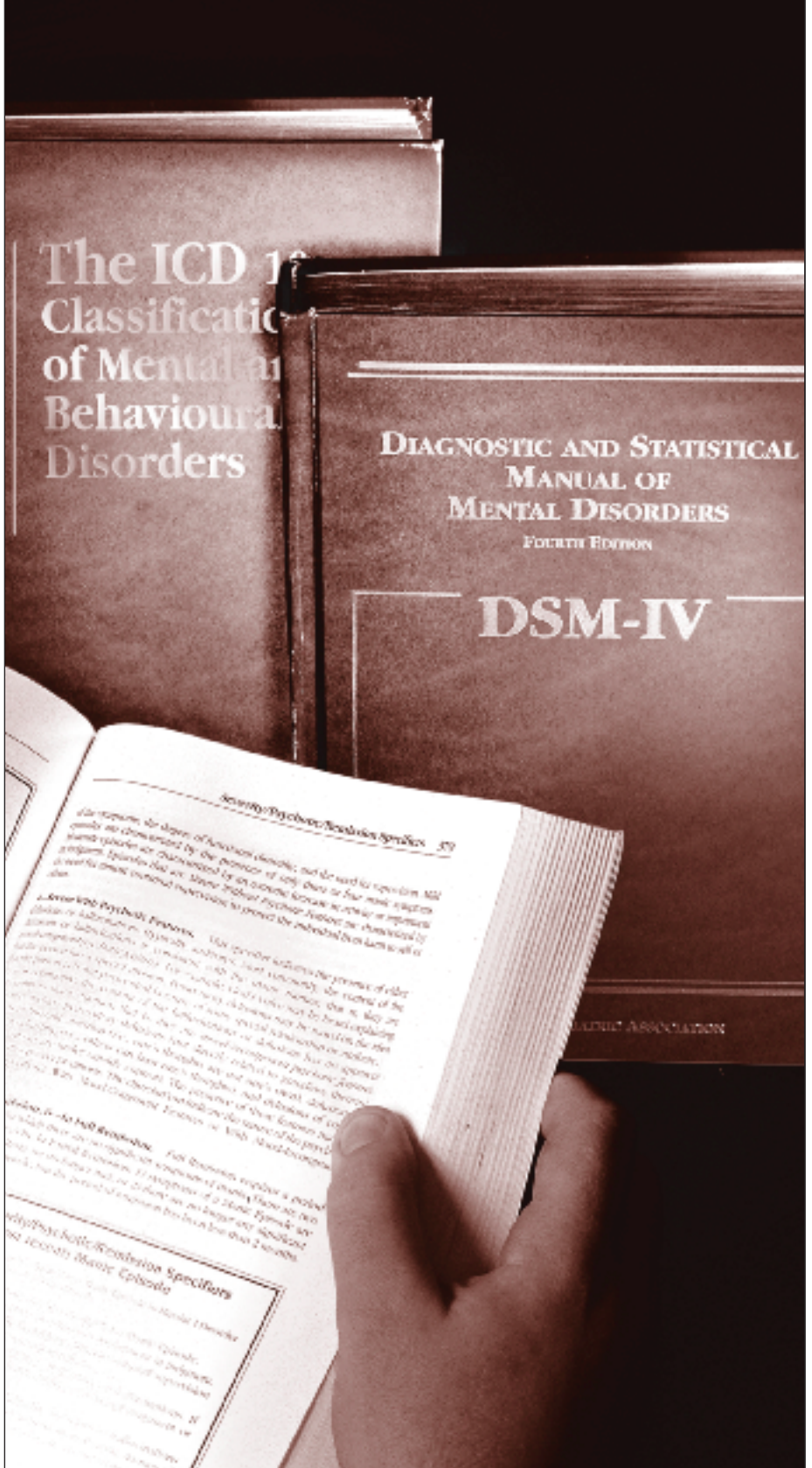
IMPORTANT FACTS

1 Houston psychiatrist Theodore Pearlman says of the *DSM-IV*, “There are too many diagnoses without any objective basis or biological support.”

2 Harvard University Medical School’s Dr. Joseph Glenmullen states, “[T]he current *DSM* are ... cursory, superficial menus of symptoms. ... Any attempt to help patients understand themselves and to effect real change is lost in the rush to diagnose and medicate them.”

3 Despite their lack of scientific validity, the *DSM/ICD* are used heavily as diagnostic tools, not only for individual treatment but also for child custody battles, court testimony, education and more.

4 When legislators “think about mental health, they think about schizophrenia,” says Karen Ignagni, President, American Association of Health Plans. “I don’t think they are aware of ... terms used ... which could increase costs for conditions that are not supported by the scientific research.”





CHAPTER TWO

Harmful Psychiatric Labeling

Psychiatrists proclaim a worldwide epidemic of mental health problems and urge massive funding increases as the only solution. But, before we commit more millions, do we know enough about the “crisis?” To answer this, it is first necessary to understand more about psychiatry and its *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

Dr. Thomas Dorman, internist and member of the Royal College of Physicians of the United Kingdom and Canada, wrote in 2002: “In short, the whole business of creating psychiatric categories of ‘disease,’ formalizing them with consensus, and subsequently ascribing diagnostic codes to them, which in turn leads to their use for insurance billing, is nothing but an extended racket furnishing psychiatry a pseudo-scientific aura. The perpetrators are, of course, feeding at the public trough.”²⁸

In 1995, psychologist Jeffrey A. Schaler said: “The notion of scientific validity, though not an act, is related to fraud. Validity refers to the extent to which something represents or measures what it purports to represent or measure. When diagnostic measures do not represent what they purport to represent, we say that the measures lack validity. If a business transaction or

trade rested on such a lack of validity, we might say that the lack of validity was instrumental in a commitment of fraud. The *Diagnostic and Statistical Manual (DSM-IV)* published by the American Psychiatric Association ... is notorious for low scientific validity.”²⁹

With the *DSM* under attack from all sides, governments must be warned that they cannot rely on the statistics derived from the *DSM* or *ICD* for mental health funding decisions. Funds

are appropriated for a general “mental health crisis” that does not factually exist, but is fabricated by psychiatry to perpetuate their bloated budgets.

Funding is thus diverted from workable programs that can resolve the social problems psychiatry has failed to solve.

“The way to sell drugs is to sell psychiatric illness.”

— Carl Elliot, bioethicist,
University of Minnesota

The Unscientific Basis for Mental Disorder Diagnosis

While medicine’s scientific procedures are verifiable, psychiatry’s lack of any systematic approach to mental health and, most importantly, its continued lack of measurable results, have contributed greatly to its declining reputation, both among science-based professions and the population at large.

The development in 1948 of the sixth edition of the World Health Organization’s *International*

Classification of Diseases (ICD), which incorporated psychiatric disorders (as diseases) for the first time, and the publication of *DSM* in the United States in 1952, were psychiatry's early steps towards a system of diagnosis. They represented an attempt to emulate and gain acceptance from medicine, which, over the course of many centuries, had earned a reputation for being able to resolve physical ailments.

"Mental disorders" are established by a vote of APA Committee members. A psychologist attending *DSM* hearings said, "The low level of

intellectual effort was shocking. Diagnoses were developed by majority vote on the level we would use to choose a restaurant. You feel like Italian, I feel like Chinese, so let's go to a cafeteria. Then it's typed into the computer. It may reflect on our naiveté, but it was our belief that there would be an attempt to look at things scientifically."³⁰

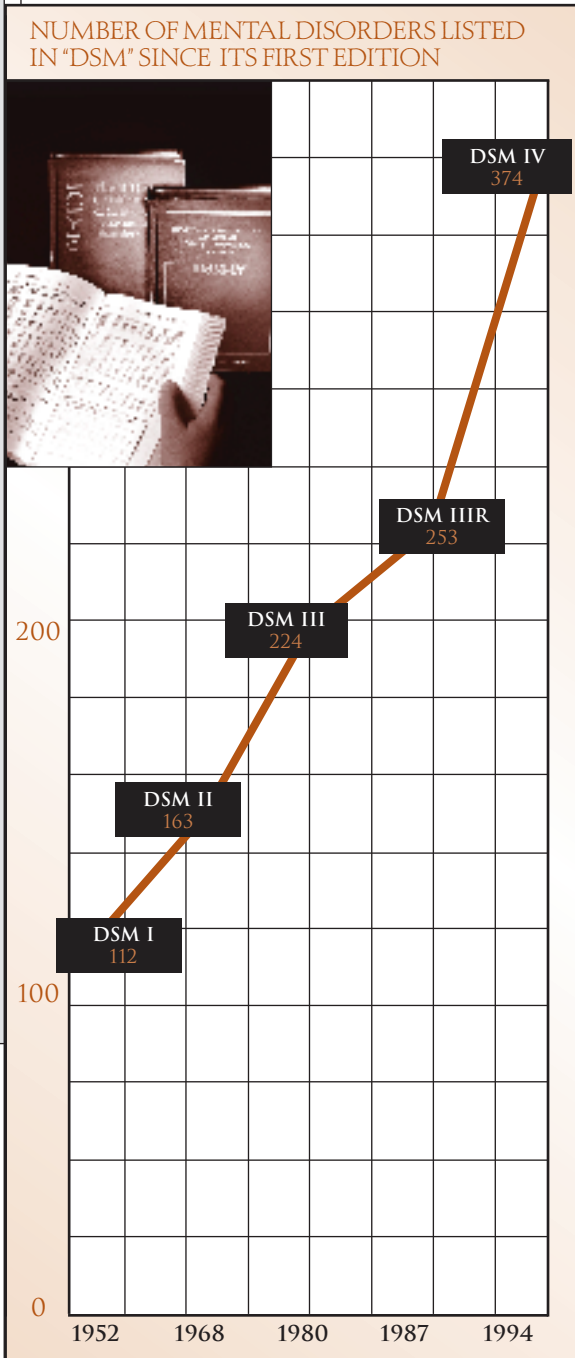
Dr. Margaret Hagen, professor of psychology at Boston University, summarily dismisses the *DSM*: "Given their farcical 'empirical' procedures for arriving at new disorders with their associated symptoms lists, where does the American Psychiatric Association get off claiming a scientific, research-based foundation for its diagnostic manual? This is nothing more than science by decree. They say it is science, so it is."³¹

In the absence of objective, scientific evidence, psychiatry has decreed the following to be mental illnesses:

- Expressive Language Disorder
- Phonological Disorder
- Caffeine Intoxication/Withdrawal Disorders
- Conduct Disorder
- Mathematics Disorder
- Nicotine Use or Withdrawal Disorder
- Non-Compliance with Treatment Disorder
- Separation Anxiety Disorder
- Sibling Rivalry Disorder
- Phase of Life Problem
- Sexual Abuse of a Child Problem

In his book *A Dose of Sanity* the late neurologist and psychiatrist, Sydney Walker III, wrote of the dangers of the *DSM*, concluding, "It's important to remember ... that a number of *DSM*-oriented psychiatrists have, to a large degree, abandoned the science of differential diagnosis, and thus consider most psychiatric illnesses 'incurable.' This leaves them with only two weapons: psychotherapy and drugs. It's not surprising that they're among the first to leap on each new drug bandwagon; like long-ago doctors who recommended bleeding for every ailment, they have little else to offer."

DSM-IV listed 374 disorders (each eligible for funding), up from 253 in the previous edition and 112 in the first edition in 1952.



PSYCHIATRIC DRUGS

The Chemical Imbalance Lie

"We do not yet have proof either of the cause or the physiology for any psychiatric diagnosis. In every instance where such an imbalance was thought to have been found, it was later proven false."

— Joseph Glenmullen of Harvard Medical School, author of *Prozac Backlash*, 2001

Much of the information about mental disorders that is provided by psychiatrists or pharmaceutical-funded psychiatric interest/support groups, includes references such as "neurobiologically based condition" or "treatable brain disorder."

Reputable physicians agree that for a disease to exist, there must be a tangible, objective physical abnormality that can be determined through tests such as, but not limited to, blood or urine, X-ray, brain scan or biopsy. No scientific evidence exists that would prove that ADHD is a "brain-based disease" or that a chemical imbalance in the brain is responsible for any mental disorder.

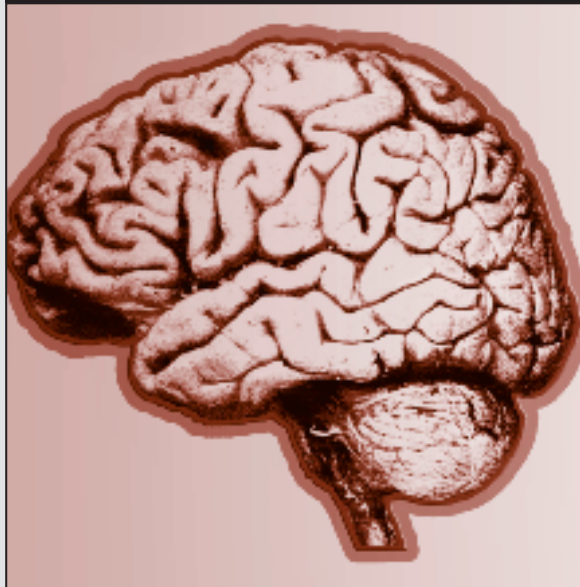
■ Pediatric neurologist Dr. Fred Baughman Jr. states that claiming ADHD is a "disease" or "neurobiological" condition makes it so "real and terrible that the parent who dares not to believe in it, or allow its treatment, is likely to be deemed negligent, and no longer deserving of custody of their child. ... This is a perversion of science and medicine and is a lie."³²

■ Ty C. Colbert, a clinical psychologist and author, says: "Biopsychiatrists have created the myth that psychiatric 'wonder' drugs correct chemical imbalances. Yet there is *no basis for this model*



Dr. Fred Baughman

Elliot S. Valenstein



BOGUS BRAIN THEORY: *Presented in countless popular magazines, the public has been assailed with the latest theory of what is wrong with the brain. What is lacking, as with all psychiatric pontificating, is scientific fact. As Dr. Valenstein explains, "There are no tests available for assessing the chemical status of a living person's brain."*

studies of ADHD-diagnosed subjects. They confirmed that every study concerned medicated children, a major variable because stimulant drugs "cause very persistent changes in the brain." They also reviewed a 2001 National Institute of Mental Health (NIMH) study, widely promoted by psychiatrists, which claimed that unmedicated ADHD children had significantly smaller brains. However, the comparison group was two years older, so naturally the younger children had smaller brains.³⁶

Psychiatric assertions of "chemical imbalances" and "treatable brain disorders" are always accompanied by a strong pretense of scientific rigor, but are in fact no more than anecdotal reports.

because no chemical imbalance has ever been proven to be the basis of a mental illness."³³

■ In his 1998 book, *Blaming the Brain*, biopsychologist Elliot S. Valenstein says the "biochemical" theory is held onto because it is "useful in promoting drug treatment."³⁴

■ In 2003, Australian psychologist Philip Owen warned: "The claim is continually made that the drugs repair chemical imbalances in the brain. This claim is false. It is still not possible to measure the exact levels of neurotransmitters in specific synapses within the human brain. How, then, is it possible to make claims about chemical imbalances?"³⁵

■ Jonathan Leo, professor of anatomy at Western University of Health Sciences, and Professor David Cohen of the School of Social Work at Florida International University, reviewed 33 of the most recent brain-imaging

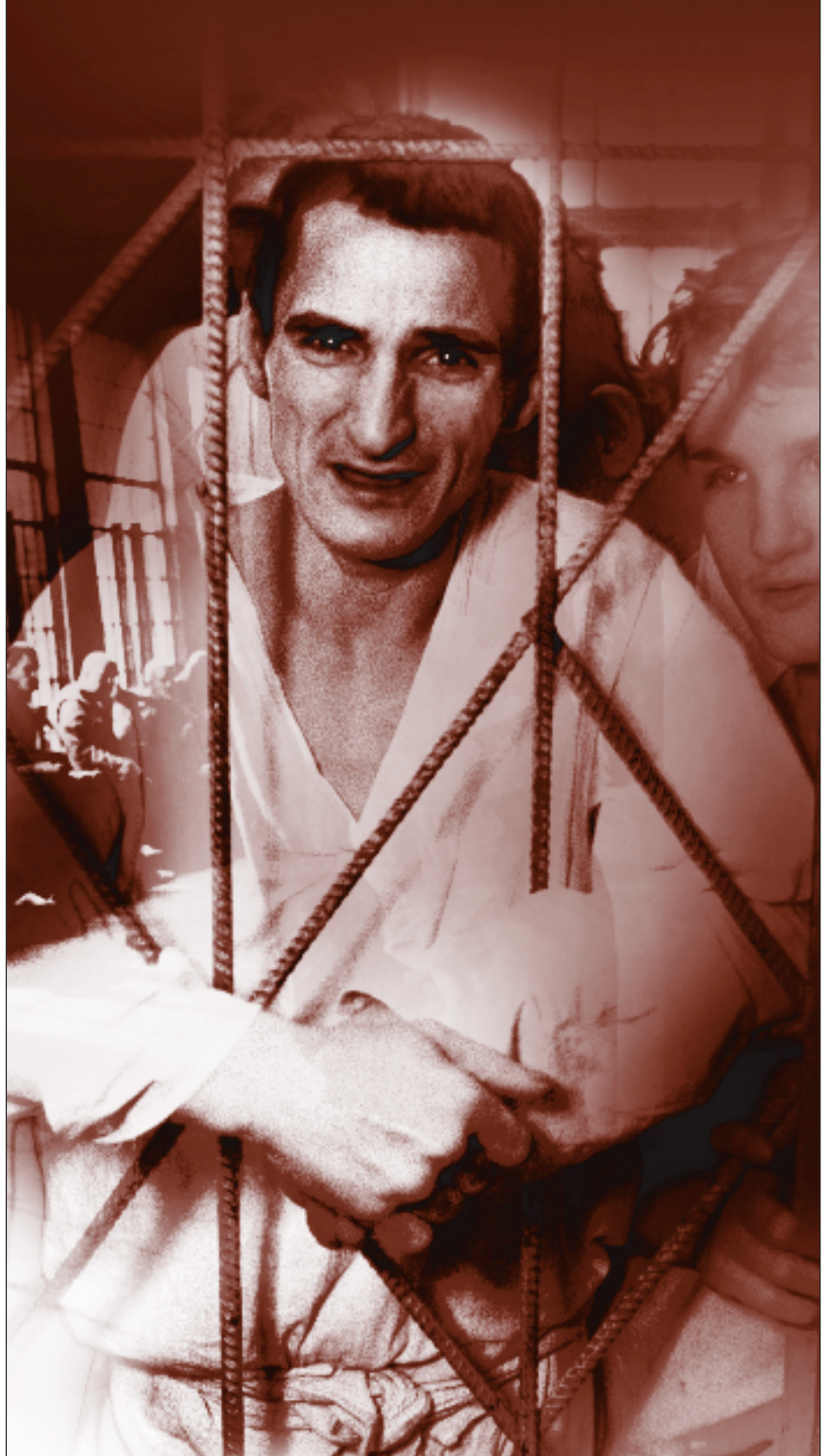
IMPORTANT FACTS

1 Despite more than \$6 billion (€4.89 billion) in taxpayer money spent on psychiatric research, Rex Cowdry, Director of the U.S. National Institute of Mental Health, said, "We do not know the causes [of mental illness]. We don't have the methods of 'curing' these illnesses yet."

2 In 2002, the European Commission found that, despite reforms, involuntary commitment has increased and many patients remain inadequately informed about their rights.

3 Community Mental Health programs have been an expensive and colossal failure, creating homelessness, drug addiction, crime and unemployment all over the world.

4 Mental health courts assert that criminal behavior is caused by a psychiatric problem and that treatment will stop the behavior. There is no evidence to support this.





CHAPTER THREE

Coercive 'Care' in Psychiatry

While proponents of commitment and enforced psychiatric treatment argue they are protecting the person's "right to treatment," a strong opposition points out that because of their far-reaching powers, involuntary commitment laws—including forcing "treatment" onto people in the community—are totalitarian.

Michael McCubbin, Ph.D., associate researcher, and David Cohen, Ph.D., professor of social services, both of the University of Montreal, say that the "right to treatment" is today more often the 'right' to receive forced treatment."³⁷

George Hoyer, professor of community medicine at the University of Tromsø in Norway, wrote, "Seriously mentally disordered patients neither lack insight, nor is their competency impaired to the degree previously believed."³⁸

Robert Hayes, formerly of the Australian Law Reform Commission, stated, "The fact [is] that mental illness is rarely defined, even in psychiatric textbooks, that faith in psychiatry is not always borne out by results ... and that without ... a real prospect of useful curative treatment, commitment to a hospital may be oppressive."

Most commitment laws are based on the concept that a person may be a danger to himself or others if not placed in an institution. However, an APA task force admitted in a 1979 Amicus Curiae Brief to the U.S. Supreme Court, "Psychiatric expertise in the prediction of 'dangerousness' is not established."

In 2002, Kimio Moriyama, vice president of the Japanese Psychiatrists Association, expressed psychiatry's inability to foresee correctly what

"It is dishonest to pretend that caring coercively for the mentally ill invariably helps him, and that abstaining from such coercion is tantamount to 'withholding treatment' from him. ... All history teaches us to beware of benefactors who deprive their beneficiaries of liberty."

— Thomas Szasz, professor of psychiatry emeritus

a person's future behavior might be: "A patient's mental disease and criminal tendency are essentially different, and it is impossible for medical science to tell whether someone has a high potential to repeat an offense," he said.³⁹ Another expert stated, "When it comes to predicting vio-

lence, our crystal balls are terribly cloudy."⁴⁰

Individuals are sometimes forced to pay for a legal defense against treatment that they do not want and against incarceration that consumes their insurance coverage. This occurs in the United States, Austria, Belgium, France, Germany, Luxemburg and the Netherlands.⁴¹ This is comparable to being kidnapped and imprisoned, only to be ordered later by the court to pay the kidnapper for room and board.



Community Mental Health

In 1955, a five-year inquiry by the U.S. Joint Commission on Mental Illness and Health recommended replacing institutions with Community Mental Health Centers (CMHCs). According to Henry A. Foley, Ph.D., and Steven S. Sharfstein, M.D., authors of *Madness in Government*, “Psychiatrists gave the impression to elected officials that cures were the rule, not the exception” and “inflated expectations went unchallenged.” Cost estimates recommended doubling the mental health budget within five years, and tripling it in ten.

Europe followed suit about a decade later, with Holland, Belgium and England adopting community mental health in the hope of greater efficiency and reduced costs.⁴² “On the contrary,” later wrote Dr. Dorine Baudin of the Netherlands Institute of Mental Health and Addiction, “it appears to be more expensive.”⁴³ Furthermore, it created homelessness, drug addiction, crime, disturbance to public peace and order, unemployment and intolerance of deviance.⁴⁴

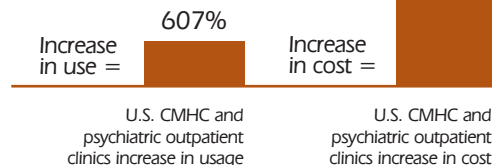
In truth, the CMHCs became legalized drug dealerships that not only supplied drugs to former mental hospital patients, but also supplied psychiatric prescriptions to individuals not suffering from “serious mental problems.”

As a result, as author Peter Schrag wrote in *Mind Control*, by the mid-seventies, enough neuroleptic (nerve seizing) drugs and antidepressants “were being prescribed outside hospitals to keep some three to four million people medicated full-time—roughly ten times the number who, according to the [psychiatrists’] own arguments, are so crazy that they would have to be locked up in hospitals if there were no drugs.”

After a decade of the Community Mental Health program, consumer advocate Ralph Nader called it a “highly touted but failing social innovation.” It “already bears the familiar pattern of past mental health promises that were initiated amid great moral fervor, raised false hopes of imminent solutions and wound up only recapitulating the problems they were to solve.”⁴⁵

6,242%

Spending on Community Mental Health Centers (CMHCs) has increased over 100 times faster than the increase in number of people using CMHC clinics. Despite eating up taxpayer billions, the clinics have failed their patients and become little more than legalized drug dealerships for the homeless.



Other countries experienced similar outcomes. In Australia in 1993, federal Human Rights Commissioner Brian Burdekin announced that de-institutionalization was a “fraud” and a failure. In 1999, British officials also acknowledged the failure of community mental health care.⁴⁶

As for the funding of CMHCs and psychiatric outpatient clinics, the fact is that psychiatry’s budget in the United States soared from \$143 million in 1969 to over \$9 billion in 1997—a more than 6,000% increase in funding, while increasing by only 10 times the number of people receiving services. The estimated costs today are around \$11 billion.

Mental Health Courts

“I cannot imagine a more dangerous branch than an unrestrained judiciary full of amateur psychiatrists poised to ‘do good’ rather than to apply the law,” said Judge Morris B. Hoffman of the District Court, Denver, Colorado.⁴⁷

“Mental health courts” are facilities established to deal with arrests for misdemeanors or non-violent felonies. Rather than punishing individuals or allowing them to take responsibility for their crimes, they are diverted to a psychiatric treatment center on the premise that they suffer from “mental illness.”

Nancy Wolff, Ph.D., Director of the Center for Mental Health Services and Criminal Justice Research, reports, “There is no evidence to show that mental illness per se is the principal or proximate cause of offending behavior. ... Although believing in treatment as a protective shield is appealing ... most clients who

were actively involved in assertive community treatment programs continued to have frequent contacts with the criminal justice system ... those clients who were the most criminally active were receiving the most expensive set of services.”⁴⁸

Wolff states further: “This type of special status for offenders who have mental illness holds the illness responsible for the behavior, not the individual, and as such, opens the opportunity for individuals to use illness to excuse behavior.”⁴⁹

In a review of 20 mental health courts, the

Bazelon Center for Mental Health Law found that these courts “may function as a coercive agent—in many ways similar to the controversial intervention, outpatient commitment—compelling an individual to participate in treatment under threat of court sanctions. However, the services available to

Community Mental Health Centers became legalized drug dealerships that not only supplied drugs to former mental hospital patients, but also supplied psychiatric prescriptions to individuals not suffering from “serious mental problems.”

the individual may be only those offered by a system that has already failed to help. Too many public mental health systems offer little more than medication.”

In summary, there are clear indicators that governments’ endorsement of mental health courts and “community policing” (as it is referred to in some European countries) will see more patients forced into a life of mentally and physically dangerous drug consumption and dependence, with no hope of a cure.

Only an independent and critical assessment of psychiatric programs such as the Community Mental Health plan will uncover their actual costs to governments and communities, in dollars and in social blight.

CASE REPORTS

Abused in Institutions

With billions in government appropriations allocated for mental health treatment, just how safe and effective are psychiatric institutions? The following cases illustrate the dangers of a system that lacks scientific understanding of causes of mental health problems, with a subsequent lack of workable remedies and the terrible consequences that result.

■ In 2001, a psychiatric nurse found a 53-year-old man unresponsive 12 hours after he had been medicated for “hostile, cursing behavior.” The man died within hours. An autopsy revealed that he suffered from multiple sclerosis (MS). Facility staff thought “MS” on his admission form meant “mental status.”

■ Carl McCloskey says his son, John, 19, was sodomized with a broom-like handle in a psychiatric hospital, tearing his bowel and puncturing his liver. The teenager became violently ill, lapsed into a coma and died 14 months later.⁵⁰

■ Seventeen-year-old Kelly Stafford agreed to enter a psychiatric facility, expecting a brief respite from troubled family relationships. But once the door was closed, she was kept for 309 days, many of them spent behind blackened windows in darkness. Her arms and

legs were strapped for months at a time. Others in the facility were forced to sit motionless and silent for 12-hour stretches. “I had to eat Thanksgiving and Christmas dinner in restraints,” Ms. Stafford said. “There’s not a day that goes by that you don’t think about it.”⁵¹



“The time that psychiatrists considered they could cure the mentally ill is gone. In the future, the mentally ill will have to learn to live with their illness.”

— Norman Sartorius, former president
World Psychiatric Association, 1994

■ In 2003, Masami Houki, head of Houki Psychiatric Clinic in Japan, was charged with manslaughter after he plugged the mouth of a 31-year-old female patient with tissue and adhesive tape, injected her with a tranquilizer, tied her hands and feet, and forced her to lie on the back seat of a car while being transferred to the clinic. She was dead on arrival.

■ In Athens, Greece, the Ntaou Pendeli psychiatric institution kept children in a ward with mentally handicapped adults. Some of the children were naked; all were housed in cold,

barren rooms and often left to lie in their own feces and urine. A teenager had been locked up for years after he misbehaved when his father left his mother for another woman. He witnessed horrors such as the rape of other children by psychiatric nurses.

■ An 8-year-old from Massachusetts, who suffered from epilepsy, was rushed by his parents to



the hospital for a medication adjustment after he experienced hallucinations. Instead of adjusting his medication, staff committed him to a psychiatric facility. It took the frantic parents an entire day to secure his transfer to a medical hospital for appropriate care.

■ Dana Davis was slammed face down on his living room floor and handcuffed by police before his horrified wife and 6-year-old son. This occurred after he walked out of the office of a psychiatrist he didn't like. As he was leaving, she asked, "Can you promise you will not commit suicide between now and our next meeting?" Jokingly he quipped, "I'm no soothsayer!" Thirty minutes later, the three police officers were taking him to the hospital where he was found not suicidal and released.

■ A psychiatrist committed Ruchla "Rose" Zinger, a 64-year-old Holocaust survivor with an

understandable history of mental instability, to an institution. The psychiatrist relied solely on reports by family members. To carry out the involuntary commitment, police broke down the door to her house, handcuffed her and shoved her down the stairs. She suffered a heart attack and died.

■ In 1999, psychiatrists in Germany involuntarily committed a 79-year-old woman because neighbors reported she had acted "strangely." Despite her long-term diabetes and liver, kidney and heart conditions, she was prescribed between five and 20 times the normal dosage of powerful tranquilizers. Six days later the woman had to be rushed to a hospital emergency room, where she died. Doctors reported she had needed urgent medical attention at least a day earlier and the autopsy showed that she died of breathing difficulties—a complication of tranquilizers.

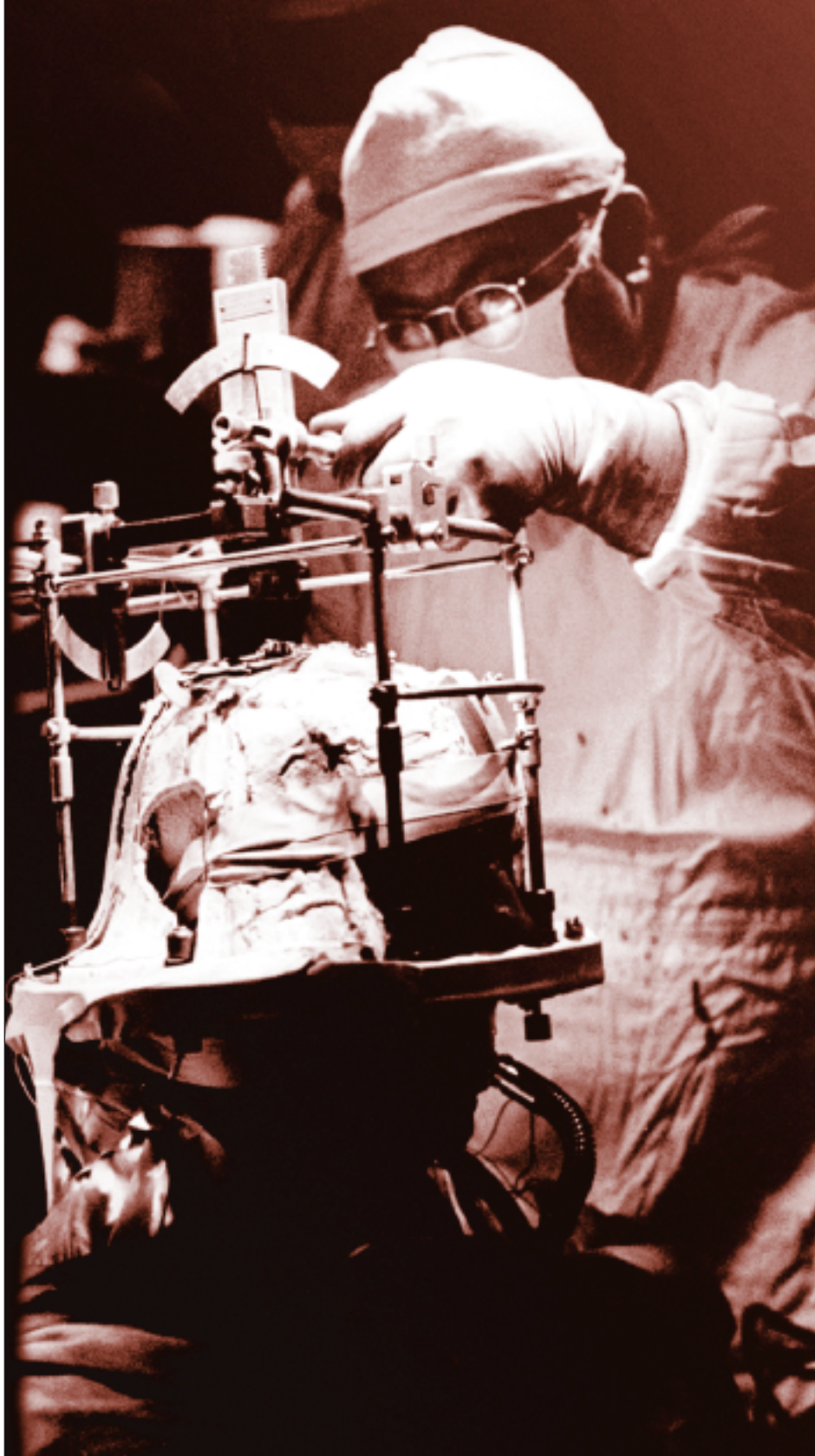
IMPORTANT FACTS

1 Studies show that electroconvulsive therapy (ECT) creates irreversible brain damage, permanent memory loss and may result in death. Up to 300 patients die each year from ECT in the U.S.

2 In 2003, the U.S. Medicare health insurance program stopped coverage of "multiple seizure" electroshock treatment, after an investigation revealed the practice is unworkable and places patients at severe risk.

3 Many medical studies reveal that psychiatric drugs create violence. The newer neuroleptic (antipsychotic) drugs cause severe debilitating and potentially deadly effects.

4 These drugs, once touted as "wonder pills", cause blindness, fatal blood clots, heart arrhythmia (irregularity), swollen and leaking breasts, impotence and sexual dysfunction, blood disorders, seizures, birth defects, extreme inner-anxiety and diabetes.





CHAPTER FOUR

Psychiatry's Destructive 'Treatments'

When governments and courts are lobbied to strengthen involuntary commitment and community treatment laws, and to establish "mental health courts" to promote treatment rather than punishment, they are never told of the lack of scientific basis for psychiatric methods, of the consequences of those treatments for the patient or of the lack of accountability for those treatment outcomes.

Electroshock and Psychosurgery

Despite the general belief that electroshock treatment stopped when the Jack Nicholson character died in *One Flew Over the Cuckoo's Nest*, it is still widely used. More than 100,000 Americans are given ECT each year; two-thirds of these are women.⁵²

Electroshock—also known as electroconvulsive therapy, shock treatment and ECT—was pioneered by psychiatrist Ugo Cerletti in the mid-1930s. In a Rome slaughterhouse, Cerletti witnessed butchers incapacitate pigs with electricity before slitting their throats. The attendants would walk through the pig pens with a large pair of electrically wired pincers with electrodes on each pincer arm. Once electroshocked, the animal would fall to the ground paralyzed, whereupon it could be easily

killed. Cerletti decided to develop this technique for use on humans to control their behavior.

Documented studies show that ECT creates irreversible brain damage, often causes permanent loss of memory and may result in death.

■ A 1994 British paper stated, "contrary to the claims of ECT experts and the ECT industry, a majority, not 'a small minority,' of ECT recipients sustain permanent memory dysfunction each year as a result of ECT."⁵³

■ A 2001 Columbia University study found ECT so ineffective at ridding patients of their depression that nearly all who receive it relapse within six months.⁵⁴

Because of the brain damage associated with ECT, today a new approach, repetitive transcranial (passing through the skull) magnetic stimulation, is being pushed as the latest "solution." A psychiatrist uses a hand-held

wire coil to produce a controlled, rapidly fluctuating magnetic field. Around 1,000 magnetic waves pulse through the brain over a 10- to 15- minute period, supposedly "stimulating" the brain. While the Food and Drug Administration (FDA) has not approved the new procedure, it is nonetheless being inflicted on patients experimentally and costs up to \$3,000 (€2,444) for a course of 20 treatments.

"Nobody understands ... precisely how ECT does anything. But ... there's really no possibility of disputing that ECT causes damage to the brain. It's just a question of how subtle or how coarse or gross is it and how long does it last."

— Dr. Colin Ross, psychiatrist

Today, the administration of electroshock brings in an estimated \$5 billion annually to the psychiatric industry in the U.S. alone.

In psychosurgery's heyday in the 1940s and 50s, the psychiatric community successfully convinced state governments that psychosurgery could reduce their mental health budgets. It was a lie.

Unlike medical brain surgery that alleviates actual physical conditions, psychosurgery attempts to brutally alter behavior by destroying perfectly healthy brain tissue. By the late 1940s, the crippling and lethal effects of psychosurgery were well known to psychiatrists and included meningitis (serious infectious disease in the brain), a death and suicide rate of up to 10% and epileptic seizures in 50% of recipients.

Although psychosurgery has largely fallen into disuse today, up to 300 operations are still performed every year in

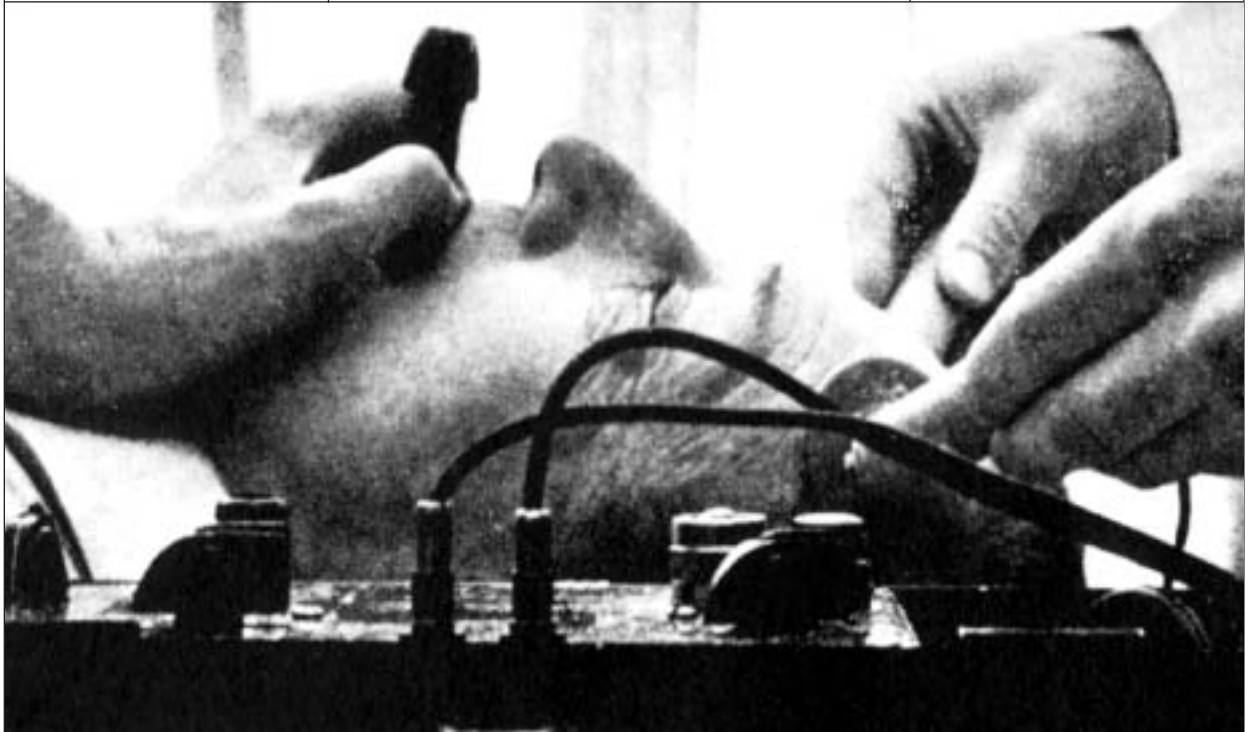
the United States, including the "prefrontal lobotomy."

In Russia, between 1997 and 1999, 100 psychosurgery operations were conducted on teenage drug addicts in St. Petersburg. "They drilled my head without any anesthetic," Alexander Lusikian said. "They kept drilling and cauterizing [burning] exposed areas of my brain ... blood was everywhere. ... During the three or four days after the operation ... the pain in my head was so terrible, it was as if it had been beaten by a baseball bat. And when the pain passed a little, I again felt the desire to take drugs." Within two months, Alexander reverted to drugs.⁵⁵

In 2002, one new procedure—"deep brain stimulation," where wires are threaded through the skull to a battery pack implanted in the chest, producing a high-frequency current in the brain, cost around \$50,000 per operation.

Governments should be aware that psycho-

Today the administration of electroshock brings in an estimated \$5 billion annually to the psychiatric industry in the U.S. alone.



surgery and ECT are unscientific, abusive practices that bear no resemblance to therapy, and they provide no individual or community gain. They should be abolished in the interest of protecting the patients, their families and the larger community.

Abuse Cases

Psychiatrists persist in inflicting psychosurgery and electroshock on patients even though no valid medical or scientific justification exists for these practices. After more than 60 years, psychiatrists can neither explain how they are supposed to work nor justify their extensive damage.

■ When Jennifer Martin's 70-year-old mother experienced headaches and nausea and stopped eating and talking, a psychiatrist claimed she was in shock from recent deaths in her family and gave her ECT. Less than 24 hours later she was dead. An autopsy revealed that the problem was not depression, but a brain stem complication. "Shock treatment killed her," Ms. Martin said.

■ A grieving husband says a psychiatrist recommended electroshock because it would release a chemical in the brain that would make his wife, Dorothy, feel better. Although aware of her earlier heart attacks, he administered 38 electroshocks. The last one killed her.

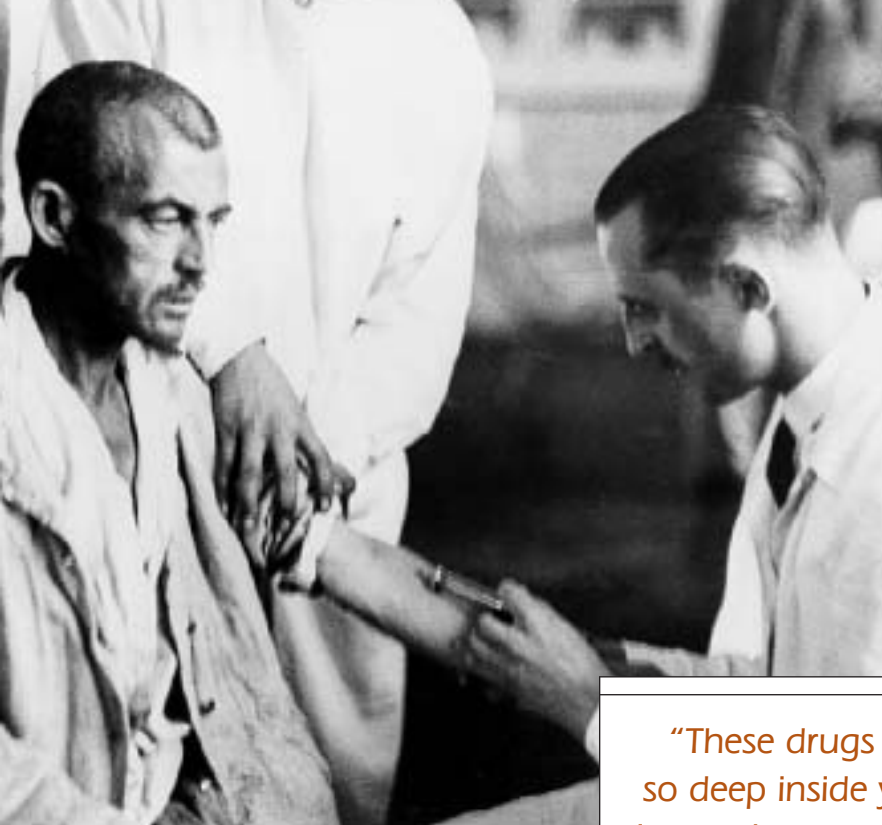
■ In 2001, the New Zealand government was forced to formally apologize and pay \$6.5 million (£5.3 million) to 95 former patients of the Lake Alice Child and Adolescent Psychiatric Unit for torture and abuse they suffered at the direction of psychiatrist Selwyn Leeks in the 1970s. ECT had been applied to victims' legs, arms and genitals without anesthetic.

■ At 28, Gwen Whitty was a wife and mother of two with another child on the way. When she developed difficulty breathing, psychiatrist Harry Bailey recommended "deep sleep therapy" for a "rest"—which turned out to involve heavy doses of barbiturates and sedatives while shackled to a bed, kept unconscious for two to three weeks, and given repeated electroshock. Ten years later, a doctor discovered two jagged steel plates in her head, attached to the bone by Bailey to cover holes in her skull.



VICTIMS' BATTLE FOR JUSTICE:

More than 1,000 people were subjected to Deep Sleep Therapy (DST) in Sydney, Australia. The deadly combination of a drug-induced coma and electroshock ultimately killed 48 people before it was banned in 1983. One of the surviving victims, Gwen Whitty (highlighted), was shackled to a bed, kept unconscious for two to three weeks and given repeated electroshock, then psychosurgery.



drugs themselves—including the newest neuroleptics or antipsychotics—that can create the very violence or mental incompetence they are prescribed to treat.

■ A 1985 investigation into a commonly prescribed tranquilizer, reported in the *American Journal of Psychiatry*, found that 58% of the treated patients experienced serious “dyscontrol,” i.e., violence and loss of control compared with only 8% who were given a placebo. Episodes included “deep neck cuts,” “tried to break own arm,” “threw chair at child,” “arm and head banging,” and “jumped in front of car.” The findings revealed the patient who threw a chair at her child had no history of physical violence toward the child. The patient who cut her neck had no previous episodes of self-mutilation.⁵⁷

■ A 1990 study determined that 50% of all fights in a psychiatric ward could be linked to neuroleptic drugs, which induced a side effect called *akathisia* (severe

restlessness). Patients described that they experienced “violent urges to assault anyone near.”⁵⁸

■ A New Zealand report stated that withdrawal from psychoactive drugs can cause new symptoms. Antidepressants, according to the report, can create “agitation, severe depression, hallucinations, aggressiveness, hypomania [abnormal excitement] and akathisia.”⁵⁹

Dr. Joseph Glenmullen warns, “Mistaking withdrawal for a return of their original symptoms, many patients restart the medication, needlessly prolonging their exposure to the drug.”⁶⁰

Robert Whitaker’s research established that when patients abruptly stop taking neuroleptics they “would likely suffer intense withdrawal symptoms, and they would be at much higher risk of relapsing than if they had never been exposed to the

“These drugs ... attack from so deep inside you, you cannot locate the source of the pain. ... You are overwhelmed because you cannot get relief.”

— Jack Henry Abbott,
In the Belly of the Beast

Dangerous Drugs

As Jack Henry Abbott observed in his book, *In the Belly of the Beast*, “These drugs ... attack from so deep inside you, you cannot locate the source of the pain. ... The muscles of your jawbone go berserk, so that you bite the inside of your mouth and your jaw locks and the pain throbs. For hours every day this will occur. Your spinal column stiffens so that you can hardly move your head or your neck and sometimes your back bends like a bow and you cannot stand up. ... You ache with restlessness, so you feel you have to walk, to pace ... in such wretched anxiety you are overwhelmed, because you cannot get relief.”⁵⁶

Whenever a “mental patient” commits an act of senseless violence, psychiatrists invariably blame the tragedy on the person’s failure to continue his medication. Such incidents are used to justify mandated community treatment and involuntary commitment laws.

Statistics and facts show it is psychiatric

drugs. The use of neuroleptics diminished the possibility that a person, distraught in mind and soul when first treated, could ever return to a healthy, non-medicated life."⁶¹

While heralded by psychiatrists as new "wonder drugs" with fewer side effects than their predecessors, the latest neuroleptics actually have even more severe side effects: blindness, fatal blood clots, heart arrhythmia, heat stroke, swollen and leaking breasts, impotence and sexual dysfunction, blood disorders, painful skin rashes, seizures, birth defects and extreme inner-anxiety and restlessness.

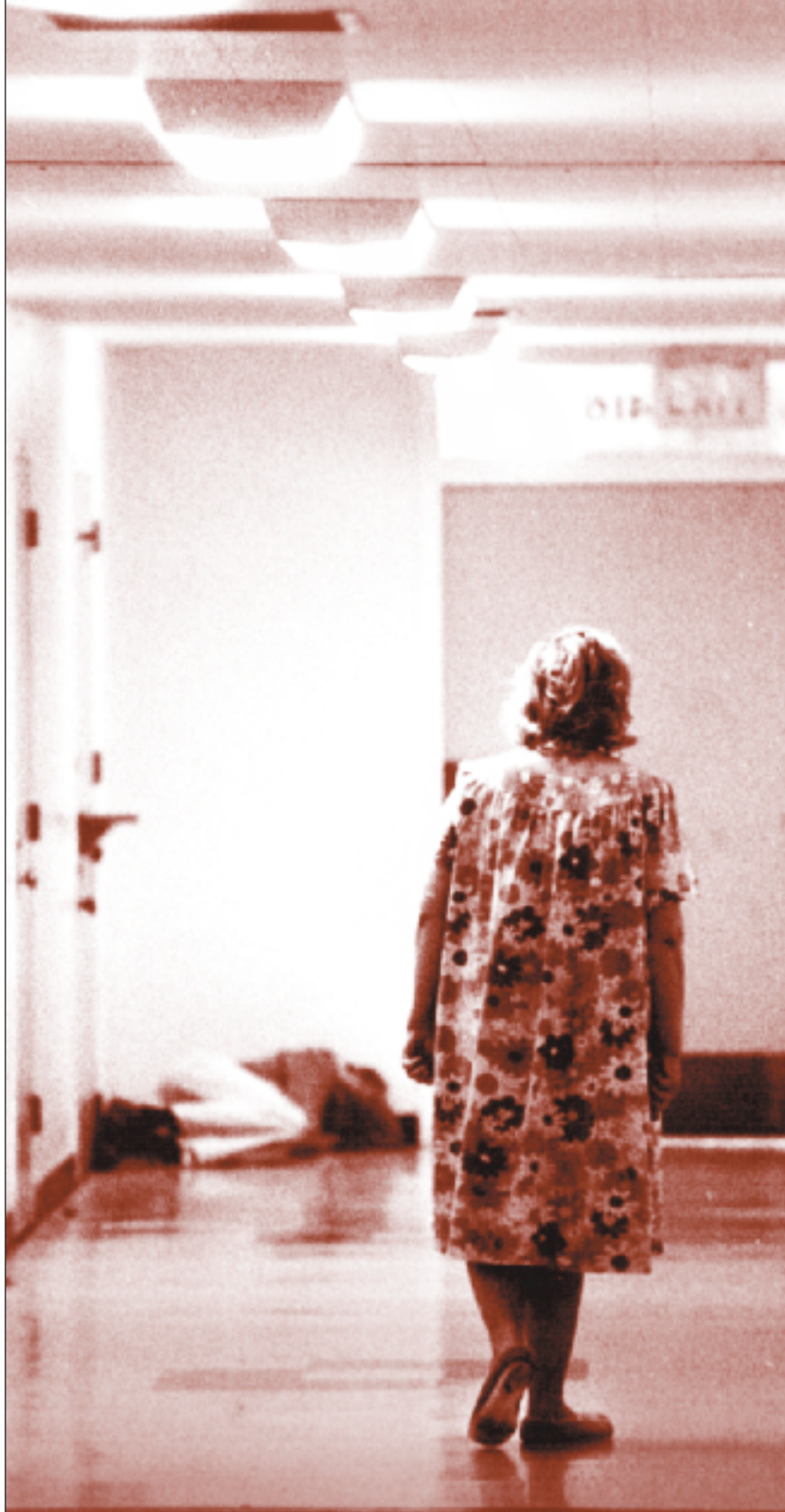
■ In April 2003, *The Wall Street Journal* reported that over an 8-year period (1994–2002), 288 patients taking the new antipsychotics developed diabetes; 75 became severely ill and 23 died.

■ Also in 2003, *The New York Times* reported, "... the states, which pay enormous sums for the atypicals [new drugs] in caring for the severely mentally ill, are questioning whether the benefits of the new drugs are worth their costs."⁶²

The state can treat 8 to 10 people with an older neuroleptic for the same price of treating one patient with a month's supply of one of the atypicals. In 2002, Ohio, one of America's larger states, spent \$174 million (€142 million) on antipsychotic drugs, close to \$145 million (€119 million) of that on atypicals.⁶³

■ In May 2003, researchers presented a study on the cost effectiveness of one atypical neuroleptic in treating patients at 17 Veterans Affairs medical centers. The study, led by Dr. Robert Rosenheck, a professor of psychiatry and public health at Yale, found that the drug cost from \$3,000 (€2,444) to \$9,000 (€7,334) more than earlier drugs per patient, with no benefit to symptoms, Parkinson's-like side effects or overall quality of life.⁶⁴

As reported by Whitaker, the new neuroleptics are "a story of science marred by greed, deaths, and the deliberate deception of the ... public." Switzerland's Dr. Marc Rufer says that prescribing massive dosages of drugs only makes people dependent upon psychiatrists and the drugs administered to them.⁶⁵



"The states, which pay enormous sums for the atypicals [new drugs] in caring for the severely mentally ill, are questioning whether the benefits of the new drugs are worth their costs." — *New York Times*, 2003

DISASTROUS EFFECTS

Restraint Deaths and Abuse

Being denied human rights is not the only loss that a patient risks in psychiatry's coercive system. The patient's life can be at risk from chemical and physical restraints. Today, there are several methods used—all violent, all potentially lethal—in which hospital staff physically and brutally restrict a patient's movement, usually just before drugging him or her into unconsciousness.

Mechanical restraints include straitjackets, leather belts or straps that cuff around each ankle and wrist. Debilitating drugs are administered as a means of chemical control and frequently induce violent responses.

A lawsuit in Denmark revealed that hospitals received additional funding for treating violent patients. Harvard psychiatrist Kenneth Clark reported that in America patients are *often provoked* to justify placing them in restraints, also resulting in higher insurance reimbursements—at least \$1,000

a day. The more violent a patient becomes—or is made—the more money the psychiatrist or facility makes.

In 1999, it was revealed by the *Hartford Courant* that up to 150 restraint deaths occur without accountability every year in the United States alone. At least 13 of the deaths over a two-year period were children, some as young as six years old.

Steps taken to curb the death toll have had little effect. Despite the passage of restrictive federal regulations in the United States in 1999, another nine children had died of suffocation or cardiac arrest from violent restraint procedures by 2002.

A sampling of horrific restraint deaths follows:

■ In 1998, 16-year-old Tristan Sovern was held face down by at least two mental health assistants with his arms crossed under his body. When he screamed, "You're choking me ... I can't breathe," staff at the U.S. psychiatric facility shoved a large towel over his mouth and tied a

bed sheet around his head. Tristan died of asphyxiation.

■ The night before 15-year-old Edith Campos was sent to Desert Hills psychiatric facility in Tucson, Arizona, she made colorful computer drawings for her family. If her mother missed her, all she needed to do was look

Roshelle was slammed face down on the floor, her arms yanked across her chest, her wrists gripped from behind by a mental health aide. "I can't breathe," she gasped. Her last words as she died were ignored.

at the picture and think of her daughter and that she would soon be home. Two weeks later, Edith came home in a coffin. During the time she was hospitalized, her parents were not allowed to speak to her. On February 4, 1998, Edith apparently died of asphyxiation, her chest compressed when she was held to the ground for at least 10 minutes after reportedly raising her fist during a confrontation with staff members.⁶⁶

■ On August 18, 1997, 16-year-old Roshelle Clayborne died during restraint at a psychiatric facility in San Antonio, Texas. Roshelle was slammed face down on the floor, her arms yanked across her chest, her wrists gripped from behind by a mental health aide. "I can't breathe," she gasped. Her last words were ignored. A syringe delivered 50 milligrams of Thorazine into her body and with eight staffers watching, Roshelle became suddenly still. Blood trickled from the corner of her mouth as she lost control of her bodily functions. Her limp body was rolled into a blanket and dumped in an 8-by-10-foot room. There she lay in her own waste and vomit for five minutes before anyone noticed she hadn't moved. By the time a registered nurse arrived

and began CPR, it was too late. Roshelle never revived.

■ In 1998, psychiatric staff forced 13-year-old Canadian Stephanie Jobin to lie face down on the floor while they placed a beanbag chair on top of her. A female staff member sat on a chair to pin her down while another staff member held her feet. She had already been dosed with five different psychiatric drugs. After 20 minutes of struggling, Stephanie stopped breathing and later died. Her death was ruled an accident.

■ In Denmark in 2002, a patient who was punished by being put into restraints was compensated in a damages suit against the treating psychiatrist. This was the first time ever that compensation was awarded to a patient harmed by the restraint procedure.

"I had to eat Thanksgiving and Christmas dinner in restraints. There's not a day that goes by that you don't think about it."

— K. Stafford, 17 years old,
psychiatric victim



IMPORTANT FACTS

1 Proper medical screening by non-psychiatric diagnostic specialists could eliminate more than 40% of psychiatric admissions.

2 In 2002, the Parliamentary Assembly of the Council of Europe recommended more research into “the impact of proper tutoring and educational solutions for children exhibiting ADHD symptoms, into behavioral effects of such medical problems as allergies or toxic reactions, and into alternative forms of treatment such as diet.”

3 In 2002, the U.S. President’s Commission on Excellence in Special Education found that 40% of American children [2.8 million] in Special Education programs labeled with “learning disorders” had simply never been taught to read.

4 The *DSM* is the key to escalating mental illness statistics and psychotropic drug usage worldwide. Untold harm and colossal waste of mental health funds occur because of it. The *DSM* diagnostic system must be abandoned before real mental health reform can occur.





CHAPTER FIVE

Better Solutions

According to psychiatric thinking, the “solution” for everything from the most minor to most severe personal problem is strictly limited to:

A 1. Diagnosing symptoms using the scientifically discredited *Diagnostic and Statistical Manual of Mental Disorders*.

2. Assigning a mental illness label.
3. Designating a restrictive, generally coercive and costly range of treatments.

As decades of psychiatric monopoly over the world’s mental health reflects, this unilateral approach leads only to upwardly spiraling mental illness statistics, continuously escalating funding demands—and away from cures.

Fortunately, many non-psychiatric, humane and workable practices exist in the quest for the achievement and recovery of mental health, even for the most severely disturbed individuals. While psychiatry strenuously denies it, much knowledgeable and skillful help is administered by non-psychiatric professionals.

The following perspectives are presented in support of these courageous and caring pioneers who dare to stand against the tide of psychiatric opinion. From their good work, the reality is slowly emerging that, while answers to our mental health problems may already exist, the

wrong place to look for them is in psychiatry.

■ Medical studies have shown time and again that for many patients, what appear to be mental problems are actually caused by an undiagnosed physical illness or condition. This does not mean a “chemical imbalance” or a “brain-based disease.” It does not mean that mental illness is physical. It does mean that ordinary medical problems can affect behavior and outlook.

■ According to a California study, up to 40%

of psychiatric facility admissions would be unnecessary if patients were first properly medically examined. This represents enormous potential savings in terms of dollars and suffering.

■ Former psychiatrist William H. Philpott, now a specialist in nutritional brain allergies, reports, “Symptoms

resulting from B12 deficiencies range from poor concentration to stuporous depression, severe agitation and hallucinations. Evidence showed that certain nutrients could stop neurotic and psychotic reactions and that the results could be immediate.”⁶⁷

■ *Anorexia nervosa*, a condition marked by loss of appetite and self-starvation to the point of death, can be diminished with doses of zinc or amino acids.

■ Medical doctors have established that environmental toxins, mercury poisoning and allergies

Medical studies have shown time and again that for many patients, what appear to be mental problems are actually caused by an undiagnosed physical illness or condition.

can affect behavior and academic performance and can create symptoms that are falsely diagnosed as ADHD. Laura J. Stevens, author of the book *Twelve Effective Ways to Help Your ADD/ADHD Child*, says, "Gases, cleaning fluids, formaldehyde, scents and other chemicals can make a child irritable, inattentive, spacey, aggressive, depressed or hyperactive."⁶⁸

■ Dr. L.M.J. Pelsser of the Research Center for Hyperactivity and ADHD in the Netherlands found that 62% of children diagnosed with "ADHD" showed significant improvements in behavior as a result of a change in diet over a period of three weeks.⁶⁹

■ Dr. Sydney Walker, author of *A Dose of Sanity*, said that thousands of children put on psychiatric drugs are simply "smart." "They're hyper, not because their brains don't work right, but because they spend most of the day waiting for slower students to catch up with them. These students are bored to tears, and people who are bored fidget, wiggle, scratch, stretch, and (especially if they are boys) start looking for ways to get into trouble."⁷⁰

■ If a child is labeled with "hyperactivity"

or a "learning disorder," he or she should first be tested for allergies, toxins or other medical problems. Tutoring and educational solutions that consider the academic ability of the child should also be considered of primary importance.

■ Funding should be directed to those mental health facilities that have a full complement of diagnostic equipment and competent medical (non-psychiatric) doctors.

■ It should be established that before health insurance coverage for mental health problems is provided, searching and competent physical examinations must be undertaken to confirm that no underlying, physical condition is causing the person's mental condition. This alone would save countless people from being unnecessarily and falsely labeled and then treated as mentally ill through the use of the *DSM/ICD*.

While life is full of problems,
and sometimes those problems can be
overwhelming, it is important for you to
know that psychiatry, its diagnoses
and its drugs, are the wrong direction
to go. The drugs can only chemically
mask problems and symptoms; they
cannot and never will be
able to solve problems.

The same waste of lives and funding occurs wherever the *DSM* is used to evaluate an individual's mental health or actions. Although a mammoth task, it is nevertheless vital that the *DSM* diagnostic system is universally rejected before any chance of meaningful mental health reform and advancement can occur.



RECOMMENDATIONS

Recommendations

- 1** Mental health hospitals must be established to replace coercive psychiatric institutions. These must have medical diagnostic equipment, which non-psychiatric medical doctors can use to thoroughly examine and test for all underlying physical problems that may be manifesting as disturbed behavior. Government and private funds should be channeled into this rather than into abusive psychiatric institutions and programs that have proven not to work.
- 2** Establish rights for patients and their insurance companies to receive refunds for mental health treatment which did not achieve the promised result or improvement, or which resulted in proven harm to the individual, thereby ensuring that responsibility lies with the individual practitioner and psychiatric facility rather than the government or its agencies.
- 3** Clinical and financial audits must be done of all government-run and private psychiatric facilities that receive government subsidies or insurance payments to ensure accountability and the compilation of statistics on admissions, treatment and deaths, without breaching patient confidentiality.
- 4** Establish or increase the number of psychiatric fraud investigation units to recover funds that are embezzled in the mental health system.
- 5** All mental disorders in the *DSM* should be validated by scientific, physical evidence. Government, criminal, educational, judicial and other social agencies should not rely on the *DSM/ICD-10* mental disorders section and no legislation should use this as a basis for determining the mental state, competency, educational standard or rights of any individual.
- 6** Abolish mental health courts and mandated community mental health treatment.
- 7** The pernicious influence of psychiatry has wreaked havoc throughout society, especially in hospitals, educational systems and prisons. Citizens groups and responsible government officials should work together to expose and abolish psychiatry's hidden manipulation of society.



Citizens Commission on Human Rights International

The Citizens Commission on Human Rights (CCHR) was established in 1969 by the Church of Scientology to investigate and expose psychiatric violations of human rights, and to clean up the field of mental healing. Today, it has more than 130 chapters in over 31 countries. Its board of advisors, called Commissioners, includes doctors, lawyers, educators, artists, business professionals, and civil and human rights representatives.

While it doesn't provide medical or legal advice, it works closely with and supports medical doctors and medical practice. A key CCHR focus is psychiatry's fraudulent use of subjective "diagnoses" that lack any scientific or medical merit, but which are used to reap financial benefits in the billions, mostly from the taxpayers or insurance carriers. Based on these false diagnoses, psychiatrists justify and prescribe life-damaging treatments, including mind-altering drugs, which mask a person's underlying difficulties and prevent his or her recovery.

CCHR's work aligns with the UN Universal Declaration of Human Rights, in particular the following precepts, which psychiatrists violate on a daily basis:

Article 3: Everyone has the right to life, liberty and security of person.

Article 5: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 7: All are equal before the law and are entitled without any discrimination to equal protection of the law.

Through psychiatrists' false diagnoses, stigmatizing labels, easy-seizure commitment laws, brutal, depersonalizing "treatments," thousands of individuals are harmed and denied their inherent human rights.

CCHR has inspired and caused many hundreds of reforms by testifying before legislative hearings and conducting public hearings into psychiatric abuse, as well as working with media, law enforcement and public officials the world over.



MISSION STATEMENT

THE CITIZENS COMMISSION ON HUMAN RIGHTS

investigates and exposes psychiatric violations of human rights. It works shoulder-to-shoulder with like-minded groups and individuals who share a common purpose to clean up the field of mental health. We shall continue to do so until psychiatry's abusive and coercive practices cease and human rights and dignity are returned to all.

Dr. Ben Ngubane
Minister for Arts, Culture, Science
and Technology, South Africa:

"I congratulate CCHR for having identified the inhumanity inflicted on the mentally ill and their untiring campaign to bring this to the world's notice. As a country and government, we will work with organizations such as CCHR seeking to protect all citizens from the type of terror and oppression experienced by the majority of the citizens of South Africa during apartheid."

The Hon. Raymond N. Haynes
California State Assembly:

"CCHR is renowned for its long-standing work aimed at preventing the inappropriate labeling and drugging of children. ... The contributions that the Citizens Commission on Human Rights International has made to the local, national and international areas on behalf of mental health issues are invaluable and reflect an organization devoted to the highest ideals of mental health services."

The Hon. LeAnna Washington
Commonwealth of Pennsylvania:

"Whereas, [CCHR] works to preserve the rights of individuals as defined by the Universal Declaration of Human Rights and to protect individuals from 'cruel, inhuman or degrading treatment' ... the House of Representatives of Pennsylvania congratulates [CCHR International] ... its noble humanitarian endeavors will long be remembered and deeply appreciated."

Bob Simonds Th.D.
President, U.S. National Association
of Christian Educators:

"We are deeply grateful to CCHR for not only leading the fight to stop the criminal psychiatric abuse of our public-school children, but for serving as a catalyst to all religious, parent and medical groups to fight this abuse. Without CCHR's compelling research and credibility, these groups could not be as effective."

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CCHR's Commissioners act in an official capacity to assist CCHR in its work to reform the field of mental health and to secure rights for the mentally ill.

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Citizens Commission on Human Rights

RAISING PUBLIC AWARENESS

Education is a vital part of any initiative to reverse social decline. CCHR takes this responsibility very seriously. Through the broad dissemination of CCHR's Internet site, books, newsletters and other publications, more and more patients, families, professionals, lawmakers and countless others are

becoming educated on the truth about psychiatry, and that something effective can and should be done about it.

CCHR's publications—available in 15 languages—show the harmful impact of psychiatry on racism, education, women, justice, drug rehabilitation, morals, the elderly, religion, and many other areas. A list of these includes:

THE REAL CRISIS—*In Mental Health Today*
Report and recommendations on the lack of science and results within the mental health industry

CHILD DRUGGING—*Psychiatry Destroying Lives*
Report and recommendations on fraudulent psychiatric diagnosis and the enforced drugging of youth

MASSIVE FRAUD—*Psychiatry's Corrupt Industry*
Report and recommendations on a criminal mental health monopoly

HARMING YOUTH—*Psychiatry Destroys Young Minds*
Report and recommendations on harmful mental health assessments, evaluations and programs within our schools

PSYCHIATRIC HOAX—*The Subversion of Medicine*
Report and recommendations on psychiatry's destructive impact on health care

COMMUNITY RUIN—*Psychiatry's Coercive 'Care'*
Report and recommendations on the failure of community mental health and other coercive psychiatric programs

PSEUDOSCIENCE—*Psychiatry's False Diagnoses*
Report and recommendations on the unscientific fraud perpetrated by psychiatry

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REHAB FRAUD—*Psychiatry's Drug Scam*
Report and recommendations on methadone and other disastrous psychiatric drug 'rehabilitation' programs

CITIZENS COMMISSION ON HUMAN RIGHTS
The International Mental Health Watchdog

WARNING: No one should stop taking any psychiatric drug without the advice and assistance of a competent, non-psychiatric, medical doctor.



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“In short, the whole business of creating psychiatric categories of ‘disease,’ formalizing them with consensus, and subsequently ascribing diagnostic codes to them, which in turn leads to their use for insurance billing, is nothing but an extended racket furnishing psychiatry a pseudo-scientific aura. The perpetrators are, of course, feeding at the public trough.”

— *Thomas Dorman, M.D.*
Fellow, Royal College of Physicians
United Kingdom and Canada