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Anatomy of an Epidemic: Psychiatric Drugs and the Rise of Mental Illness in America

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The percentage of Americans disabled by "mental illness" has increased dramatically since 1955, when Thorazine – remembered today as psychiatry's first "wonder" drug – was introduced into the market.

There are now nearly 6 million Americans disabled by "mental illness", and this number increases by more than 400 people each day. A review of the scientific literature reveals that it is our drug-based paradigm of care that is fueling this epidemic. The drugs increase the likelihood that a person will become chronically ill, and induce new and more severe psychiatric symptoms, often psychiatric drug-induced, in a significant percentage of patients.

E. Fuller Torrey, in his 2001 book *The Invisible Plague*, concluded that insanity had risen to the level of an epidemic. This epidemic has unfolded in lockstep with the ever-increasing use of prescription psychiatric drugs.

The number of disabled "mentally ill" has increased nearly six-fold since Thorazine was introduced.

The number of disabled "mentally ill" has also increased dramatically since 1987, the year Prozac was introduced.

Anti-psychotics, antidepressants, and anti-anxiety drugs create perturbations in neurotransmitter functions. In response, the brain goes through a series of compensatory adaptations. Neurons both release less serotonin and down-regulate (or decrease) their number of serotonin receptors. The density of serotonin receptors in the brain may decrease by 50% or more. After a few weeks, the patient's brain is functioning in a manner that is qualitatively as well as quantitatively different from the normal state.

Conditions that disrupt brain chemistry may cause delusions, hallucinations, disordered thinking, and mood swings – the symptoms of insanity. Infectious agents, tumors, metabolic and toxic disorders and various diseases could all affect the brain in this manner. Psychiatric medications also disrupt brain chemistry. Psychotropic drugs also increase the likelihood that a person will become chronically ill, and they cause a significant percentage of patients to become ill in new and more severe ways.

CAN THE "CURES" BE WORSE THAN THE "DISEASE"?

Neuroleptics (AKA Anti-psychotics, Anti-schizophrenics, Major Tranquilizers)

In an NIMH (National Institute of Mental Health) study, short-term (6 weeks) anti-psychotic drug-treated patients were much improved compared to placebo (75% vs. 23%). However patients who received placebo treatment were less likely to be re-hospitalized over the next 3 years than were those who received any of the three active phenothiazines.

Relapse was found to be significantly related to the dose of the tranquilizing medication the patient was receiving before he was put on placebo – the higher the dose, the greater the probability of relapse.

Neuroleptics increased the patients' biological vulnerability to psychosis. A retrospective study by Bockoven also indicated that the drugs were making patients chronically ill.

There were three NIMH-funded studies conducted during the 1970s that examined this possibility (*whether first-episode psychotic episodes could be treated without medications*), and in each instance, the newly admitted patients treated without drugs did better than those treated in a conventional manner (*i.e. with anti-psychotic drugs*).

Patients who were treated without neuroleptics in an experimental home staffed by nonprofessionals had lower relapse rates over a 2-year period than a control group treated with drugs in a hospital. Patients treated without drugs were the better functioning group as well.

The brain responds to neuroleptics – which block 70% to 90% of all D2 dopamine receptors in the brain – as though they are a pathological insult. To compensate, dopaminergic brain cells increase the density of their D2 receptors by 30% or more. The brain is now supersensitive to dopamine and becomes more biologically vulnerable to psychosis and is at particularly high risk of severe withdrawal symptoms should he or she abruptly quit taking the drugs.

Neuroleptics can produce a dopamine supersensitivity that leads to both dyskinetic and psychotic symptoms. An implication is that the tendency toward withdrawal psychosis in a patient who had developed such a supersensitivity is determined by more that just the normal course of the illness.

With minimal or no exposure to neuroleptics, at least 40% of people who suffered a psychotic break and were diagnosed with schizophrenia would not relapse after leaving the hospital, and perhaps as many as 65% would function fairly well over the long term. However, once first-episode patients were treated with neuroleptics, a different fate awaited them. Their brains would undergo drug-induced changes that would increase their biological vulnerability to psychosis, and this would increase the likelihood that they would become chronically ill (and thus permanently disabled).

In the mid 1990s, several research teams reported that the drugs cause atrophy of the cerebral cortex and an enlargement of the basal ganglia. The drugs were causing structural changes in the brain. The drug-induced enlargement of the basal ganglia was associated with greater severity of both negative and "positive" *(schizophrenic)* symptoms. Over the long term the drugs cause changes in the brain associated with a worsening of the very

symptoms the drugs are supposed to alleviate.

Antidepressants

The story of antidepressants is a bit subtler, and it leads to the same conclusion that these drugs increase chronic illness over time. Well-designed studies, the differences between the effectiveness of antidepressant drugs and placebo are not impressive. About 61% of the drug-treated patients improved, versus 46% of the placebo patients, producing a net drug benefit of only 15%.

At the end of 16 weeks (in a study comparing cognitive behavior therapy, interpersonal therapy, the tricyclic antidepressant imipramine and placebo) there were no significant differences among treatments, including placebo plus clinical management, for the less severely depressed and functionally impaired patients. Only the severely depressed patients fared better on a tricyclic than on placebo. However, at the end of 18 months, even this minimal benefit disappeared. Stay-well rates were best for the cognitive behavior group (30%) and poorest for the imipramine group (19%).

Antidepressants were making people chronically ill, just like the anti-psychotics were. In 1985, a U.K. group reported that in a 2-year study comparing drug therapy to cognitive therapy, relapse was significantly higher in the pharmacotherapy group. Long-term use of antidepressants may increase the patient's biochemical vulnerability to depression and thus worsen the course of affective disorders. An analysis of 27 studies showed that whether one treats a depressed patient for 3 months or 3 years, it does not matter when one stops the drugs. The longer the drug treatment, the higher the likelihood of relapse.

Benzodiazepines

Xanax *(a benzodiazepine class "minor" tranquilizer)* patients got better during the first four weeks of treatment; they did not improve any more in weeks 4 to 8, and their symptoms began to worsen after that. A high percentage relapsed and by the end of 23 weeks, they were worse off than patients treated without drugs on five different outcomes measures. Patients tapered off Xanax suffered nearly 4 times as many panic attacks as the non-drug patients and 25% of the Xanax patients suffered from rebound anxiety and insomnia more severe than when they began the study.

Today's drug-treated patients spend much more time in hospital beds and are far more likely to die from their mental illness than they were in 1896. Modern treatments have set up a revolving door and appear to be a leading cause of injury and death.

MANUFACTURING "MENTAL ILLNESS"

It is well-known that all of the major classes of psychiatric drugs – anti-psychotics, anti-depressants, benzodiazepines, and stimulants for ADHD – can trigger new and more severe psychiatric symptoms in a significant percentage of patients. It is easy to see this epidemic-creating factor at work with Prozac and the other SSRIs.

Prozac quickly took up the top position as America's most complained about drug. By 1997, 39,000 adverse-event reports about it had been sent to Medwatch. These reports are thought to represent only 1% of the actual number of such events, suggesting that nearly 4 million people in the US had suffered such problems, which included mania, psychotic depression, nervousness, anxiety, agitation, hostility, hallucinations, memory loss, tremors, impotence, convulsions, insomnia and nausea.

The propensity of Prozac and other SSRIs to trigger mania or psychosis is undoubtedly the biggest problem with these drugs. The American Psychiatric Association warns that manic or hypomanic episodes are estimated to occur in 8% to 20 % of patients treated with anti-depressants.

Anti-depressant-induced mania is not simply a temporary and reversible phenomenon, but a complex biochemical mechanism of illness deterioration. Yale researchers reported that 8.1% of all admissions to a psychiatric hospital they studied were due to SSRI-induced mania or psychosis.

Thus the SSRI path to a disabling mental illness can be easily seen. A depressed patient treated with an anti-depressant suffers a manic or psychotic episode, at which time his or her diagnosis is changed to bipolar disorder. At that point, the person is prescribed an anti-psychotic to go along with the anti-depressant, and, once on a drug cocktail, the person is well along on the road to permanent disability.

CONCLUSION

There is an outside agent fueling this epidemic of mental illness, only it is to be found in the medicine cabinet. Psychiatric drugs perturb normal neurotransmitter function, and while that perturbation may curb symptoms over a short term, over the long run it increases the likelihood that a person will become chronically ill, or ill with new or more severe symptoms. A review of the scientific literature shows quite clearly that it is our drug-based paradigm of care that is fueling this modern-day plague.

Robert Whitaker's ground-breaking book, Mad In America: Bad Science, Bad Medicine and the Enduring Mistreatment of the Mentally Ill was published in 2002, That critically acclaimed book should be, but is not, required reading for everybody in the medical profession, including psychiatric patients and their loved ones. (www.madinamerica.com)

Whitaker's latest book (published in 2010) Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America, further documents the epidemic of "mental illness" disability (which, in many cases, are not mental illnesses at all, but rather drug-induced neurological illnesses that manifest psychological symptoms or drug-induced withdrawal both of which can be mis-diagnosed as mental illnesses).

Each of these books have been essentially black-balled by the pharmaceutical, medical and psychiatric industries, neither book having even been reviewed in any mainstream medical journals.

Excerpted, with minimal editing, by Gary G. Kohls, MD

Dr. Kohls warns against the abrupt discontinuation of any psychiatric drug because of the common, often serious withdrawal symptoms that can occur with the chronic use of any dependency-inducing psychoactive drug, whether illicit or legal. Close consultation with an informed physician who is familiar with treating drug withdrawal and who is also willing to read and study the above books and become familiar with the previously poorly understood dangers of these drugs.

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