

Manufacturing Madness: The Pseudoscience of Modern Psychiatry

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Twenty-six years have passed since Prozac, the antidepressant drug, was introduced to the US market and quickly achieved the label of a "wonder drug." In the decade that followed, other antidepressant drugs including [paroxetine](#) (Paxil), sertraline (Zoloft), fluvoxamine (Luvox), and citalopram (Celexa) would be released, creating an entire class of medications known as selective serotonin reuptake inhibitors (SSRIs). Since hitting the shelves, the popularity of SSRIs has skyrocketed. Today, 1 in every 10 Americans reaches for antidepressants daily. [1] This ratio jumps to an incredible 25% among women between the ages of 40 and 59.[2] Approximately 5% of children ages 12 to 19 are also taking antidepressants.[3] Worldwide, mental illness is now the leading cause of disability among children.[4]

Active members and veterans of the US military have become especially dependent on psychiatric meds. Today, about 1 in 6 service members is using antidepressants, sedatives, and other psychiatric drugs in an attempt to cope with post-traumatic stress disorder and other afflictions. [5] From 2001-2009 alone, psychiatric drug use in this demographic rose by 76% and in 2010 alone, the Pentagon spent more than \$280 million on psychiatric drugs.[6] [7]

Along with the rise in antidepressant use in recent years, we have witnessed the creation of many new clinical diagnoses in the field of psychiatry. What would have been considered just a few years ago to be rebellious behavior among teenagers is now termed Oppositional Defiant disorder;

what was once looked upon as a child not wanting to do math homework is now classified as Mathematics Disorder. As the psychiatric establishment increasingly asserts its importance by pathologizing normal human behaviors, tens of millions of Americans are popping pills in an attempt to find mental wellbeing. All the while, [Big Pharma is making a killing](#); in 2010 alone, SSRI sales topped \$70 billion. [8]

Considering how widely SSRIs are prescribed, you would be forgiven for thinking that this class of drugs is highly safe and effective. In point of fact, these drugs come with a host of devastating and sometimes deadly health implications. Examining the state of the medical industrial complex deeper still makes one thing abundantly clear: Psychiatry is NOT a science but a massively destructive unscientific experiment fueled by a medical industrial complex that values profits over human life and wellbeing.

Let's break it down:

FACT: Psychiatric Drugs are Dangerous

Volumes of solid scientific evidence collected over the last quarter-century demonstrate that SSRIs carry serious and sometimes deadly side effects. These adverse effects include akathisia (a condition in which a person feels compelled to move about), permanent neurological damage, bone fracture, birth defects, sexual dysfunction, suicide (especially in children and teenagers) and acts of violence. [9] [10] [11] [12] [13] Shockingly, evidence indicates that SSRI use in patients can, in fact, increase the length of bouts of depression and significantly promote relapse. [14]

Especially concerning is the alarming link between suicides and psychiatric drug use. At present, 22 US veterans commit suicide each day. [15] In fact, more active-duty American soldiers are ending their own lives than are dying in combat. [16] Could it be that the rising rates of suicide among members of the US military are actually being fueled by SSRI and other psychiatric medicine use? A body of research suggests that the answer is yes.

A meta-analysis appearing in the British Medical Journal, which pooled data from more than 700 studies and 87,650 patients, found that there exists an "association between the use of SSRIs and increased risk of fatal and non-fatal suicide attempts"[17] The researchers stated in their conclusion that methodological limitations may have caused them to actually underestimate the real risk of suicide attempts. [18]

It has been ten years since the FDA required SSRI manufactures to place a black box label on their drugs stating suicide as a side effect of taking this class of drugs. How many more deaths have to occur before the FDA bans these dangerous pills?

FACT: Psychiatric Drugs are NOT Effective

Numerous studies show that SSRIs are generally no more effective than a placebo (sugar pill) in treating depression. [19] The authors of a 2008 meta-analysis examining the effectiveness of using SSRIs in patients with depression remarked that:

"These findings suggest that, compared with placebo, the new-generation antidepressants do not produce clinically significant improvements in depression in patients who initially have moderate or even very severe depression, but show significant effects only in the most severely depressed patients"[20]

Upon closer investigation, it's little wonder that these drugs aren't efficacious. Psychiatric authorities still contend that mental illness has its roots in "chemical imbalances" in the brain (particularly related to levels of serotonin) that may be mediated through pharmaceuticals. The only problem with this is the fact that no compelling evidence exists to confirm this hypothesis. A growing body of evidence actually debunks the chemical imbalance theory altogether. [21] [22] Further still, studies have proven that SSRIs disturb normal brain function, ultimately reducing the brain's ability to respond to serotonin. [23] This is a possible reason that individuals on SSRIs are more likely to suffer from depression for longer periods of time, and relapse more frequently.

FACT: Psychiatric Diagnoses Have No Basis in Science

The American Psychiatric Association's Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is the definitive guide for psychiatric diagnoses. Of the nearly 300 mental disorders outlined in the DSM-5, not one of them is based on objective data drawn from double-blind, placebo-controlled studies. Rather, the criteria for determining mental illness are based solely on subjective described behaviors. There are no blood tests, no brain scans or urine samples- not one biological marker to validate the existence of these so-called conditions.

The flawed nature of mental health diagnoses has been pointed out for years. In a 2010 opinion piece for the LA times, Allen Frances, chairman of the taskforce that created the DSM-4, commented on the absurdity of the ever-expanding pool of mental disorders stating the following:

The first draft of the next edition of the DSM, posted for comment with much fanfare last month, is filled with suggestions that would multiply our mistakes and extend the reach of psychiatry dramatically deeper into the ever-shrinking domain of the normal. This wholesale medical imperializing of normality could potentially create tens of millions of innocent bystanders who would be mislabeled as having a mental disorder. The pharmaceutical industry would have a field day -- despite the lack of solid evidence of any effective treatments for these newly proposed diagnoses.

Even more damning was a deathbed confession in 2009 by the eminent child psychiatrist, Dr. Leon Eisenberg. In his final interview, Eisenberg reportedly revealed that "[ADHD](#) is a prime example of a fictitious disease." [24] The bombshell came at the end of Eisenberg's long career developing foundational theories in modern psychiatry that led to the creation of ADHD and other mental disorders.

Given the lack of scientific rigor with which the APA concocts new disorders, it shouldn't come as a surprise that the DMS-5 even outlines "caffeine use disorder" and "internet gaming disorder" as conditions that warrant further study. [25] The bottom line is that psychiatry's diagnostic handbook has as much credibility as a comic book.

FACT: The Psychiatric Establishment is Bought and Paid for by Big Pharma

Like the other branches of the medical-industrial complex, [psychiatry](#) is infested with conflicts of interest. One of the most outspoken critics of the pharmaceutical industry's extensive influence over modern medicine is Dr. Marcia Angell, the former editor-in-chief of the New England Journal of Medicine who now serves as a senior lecturer in social medicine at Harvard Medical School.

In an essay written for The New York Book Review. Dr. Angell recounts the systemic corruption that has plagued the field of psychiatry:

As psychiatry became a drug-intensive specialty, the pharmaceutical industry was quick to see the advantages of forming an alliance with the psychiatric profession. Drug companies began to lavish attention and largesse on psychiatrists, both individually and collectively, directly and indirectly. They showered gifts and free samples on practicing psychiatrists, hired them as consultants and speakers, bought them meals, helped pay for them to attend conferences, and supplied them with "educational" materials. When Minnesota and Vermont implemented "sunshine laws" that require drug companies to report all payments to doctors, psychiatrists were found to receive more money than physicians in any other specialty. The pharmaceutical industry also subsidizes meetings of the APA and other psychiatric conferences. About a fifth of APA funding now comes from drug companies. [26]

Dr. Angell goes on to describe how pharmaceutical companies manipulate study results to maximize profit streams from their drugs:

...drug companies make very sure that their positive studies are published in medical journals and doctors know about them, while the negative ones often languish unseen within the FDA, which regards them as proprietary and therefore confidential. This practice greatly biases the medical literature, medical education, and treatment decisions. [27]

Upon further investigation we find that not only are unflattering study outcomes concealed while positive ones are publicized, but Big Pharma has become embroiled in scandals involving fabricated study results. It surfaced in 2009 that Scott S Reuben, a Massachusetts anesthesiologist and researcher, had faked data for 21 studies on major medications. Several of the drugs reviewed in Reuben's studies, including Wyeth's antidepressant, Effexor FX, were shown in a favorable light. [28]

Evidence suggests that Reuben is not alone in his dishonesty. A 2013 article appearing in The Economist titled "Unreliable Research: Trouble at the Lab" covers the work of Dr. Daniele Fanelli of the University of Edinburgh, who has studied the flaws of academic research outcomes. The article explains that

Fraud is very likely second to incompetence in generating erroneous results, though it is hard to tell for certain. Dr Fanelli has looked at 21 different surveys of academics (mostly in the biomedical sciences but also in civil engineering, chemistry and economics) carried out between 1987 and 2008. Only 2% of respondents admitted falsifying or fabricating data, but 28% of respondents claimed to know of colleagues who engaged in questionable research practices. [29]

Collusion and deception have become hallmarks of the medical establishment. Here are some additional examples of psychiatry's corruption by the pharmaceutical cartel.

A 2012 study carried out by psychologist Lisa Cosgrove and her colleagues examining the conflicts of interest in DSM panel members revealed how the stranglehold of Big Pharma on psychiatric medicine has only increased in recent years. The authors of the study noted that "69% of the DSM-5 task force members report having ties to the pharmaceutical industry. This represents a relative increase of 21% over the proportion of DSM-IV task force members with such ties (57% of DSM-IV task force members had ties)."[30]

Cosgrove goes on to point out that panel members are eligible to help create the DSM as long as they are not paid more than \$10,000 from drug companies per year (through consultancies and other jobs). In addition, members are permitted to have up to \$50,000 in stock holdings in pharmaceutical firms and still serve in their position. [31]

The American Psychiatric Association meets in secret to develop the DSM. All task force members are required by the APA to sign non-disclosure agreements. This practice has been assailed by many, even former DSM chairman Robert Spitzer, who stated in an interview that "When I first heard about this agreement, I just went bonkers...transparency is necessary if the document is to have credibility." [32]

In March 2009, The APA made an announcement that it would phase out the practice of accepting contributions from pharmaceutical companies for medical education seminars and food provided at conventions. The pledge was short lived, however. Less than two months later the organization accepted \$1.7 million from Big Pharma for its yearly convention in San Francisco. [33]

Groups such as the National Alliance on Mental Illness (NAMI) and the Anxiety and Depression Association of America (ADAA), which were allegedly founded to advocate on behalf of people with mental disorders, have since been exposed as nothing more than front groups created to push Big Pharma's profit-driven agenda.

In the 1970s and 1980s, leaders at the National Institute of Mental Health played a key role in helping found these groups, which have effectively lobbied lawmakers in Washington and state capitols to fund more research into psychiatry. These organizations have enjoyed a steady stream of generous financial support from drug makers for years. Congressional records reflect that from 2006-2008, the pharmaceutical cartel poured \$23 million into NAMI coffers, accounting for about 75% of its donations. [34]

Given the overwhelming evidence implicating modern psychiatry as a sick and twisted farce designed to profit from human suffering, how could it be that this issue doesn't receive any substantive media coverage? Why hasn't this been exposed by The New York Times, Dateline, and 60 Minutes? Could it be the hundreds of millions of dollars in advertising that the corporate media receives from Big Pharma each year? Perhaps this could lead to self-censorship.

The Dangers of SSRIs

We will now take a deeper look at the dangers of associated with [SSRIs](#), particularly Prozac. This new drug consists of the single active isomer of Celexa.) [35] The most controversial issue surrounding the use of SSRIs--a possible connection to suicidal thoughts and behavior in some users--made news in mid-2003 when the Food and Drug Administration recommended that Paxil not be used to treat depressed children and adolescents because regulators were reviewing reports from clinical trials of an increased risk of suicidal thinking and suicide attempts in young users of the drug. [36]

Zoloft, Paxil, and Prozac were the [top-selling antidepressants](#) in the US in 2001, and antidepressants themselves were the largest category of prescription drug that year, with US retail sales of \$12.5 billion.[37] Prozac was the leading antidepressant worldwide in 2000, but its share of prescriptions has been declining since the mid-1990s due to competition from other drugs and from generic fluoxetine.[38] Eli Lilly's US sales of fluoxetine products fell 73% in 2002 following the introduction of generic fluoxetine here in August 2001. [39] Generic paroxetine and fluvoxamine also are available in the US market.

Although the Prozac era has ended for Eli Lilly, the availability of less costly generics means that fluoxetine may be more affordable for tens of millions of uninsured people. [40] And in addition to gaining approval for Prozac for indications besides depression (obsessive-compulsive disorder, bulimia nervosa, and panic disorder), Eli Lilly now markets two Prozac-related products that have their own patents: Sarafem is the version of Prozac approved in 2000 for the treatment of premenstrual dysphoric disorder (PMDD). It was the first prescription drug in the US with this indication. The second drug is Prozac Weekly, intended for the longer-term treatment of depression when symptoms have stabilized. It was approved in 2001. [41] [42] [43]

IMS Health has noted a trend toward "lifestyle indications" for antidepressants. [44] In addition to major depression and OCD, both Paxil and Zoloft are indicated for panic disorder, posttraumatic stress disorder, and social anxiety disorder. Zoloft also is approved for premenstrual dysphoric disorder, while Paxil also is approved for generalized anxiety disorder. [45] [46] Doctors, for their part, prescribe SSRIs for a wide range of conditions, such as headaches, substance abuse, eating disorders, back pain, impulsivity, upset stomach, irritability, hair pulling, nail biting, premature ejaculation, sexual addictions, and attention deficit disorder. [47]

One growing market for SSRIs is their use with children, even though some studies have found that antidepressants are no more effective than placebos in these patients. [48] [49] [50] [51] [52] [53] A study in the Journal of the American Medical Association in 2000 found that psychotropic medications prescribed to preschoolers had "increased dramatically between 1991 and 1995" in the three sites studied. [54] An analysis of prescription claims among young Medicaid patients in North Carolina found that the use of Ritalin-type stimulants and Prozac-type antidepressants among children rose dramatically in the 1990s and that more were taking both drugs at once. In 1998, 10.7% of children aged 6 to 14 were receiving stimulants and 1.7% were receiving SSRIs (30% of these also took stimulants). Lead author Jerry Rushton, MD, MPH, stated, "... the consistent increase in SSRI use and in dual prescriptions is especially surprising. We need further information about whether this is due to new unrecognized mental disorders, substitution for other therapies, or over prescription." [55]

Serotonin and side effects

Prozac relieves depression by affecting the level of serotonin, a neurotransmitter that connects receptor sites and fires nerve cells. Joseph Glenmullen, MD, a clinical instructor in psychiatry at Harvard Medical School, explains in his book Prozac Backlash that the drug inhibits the reuptake of serotonin--a process in which a cell that releases this chemical messenger reabsorbs any unused portion of it. By blocking the reuptake of this neurotransmitter, Prozac boosts the level of serotonin and prolongs the serotonin signals in the brain. [56]

Dr. Glenmullen points out, however, that neurotransmitters like serotonin, adrenaline, and dopamine are connected by complex circuitry and function interdependently. Changes in one neurotransmitter can set off changes in another. Thus, the idea that Prozac-type drugs work "selectively" on serotonin is an illusion. When the level of serotonin is artificially increased, the primary reaction in the brain is a drop in dopamine--a powerful secondary effect that was not understood when the new class of serotonin boosters was introduced. The severe effects of the

SSRIs are thought to be caused by the connections between the serotonin and dopamine systems. "Drugs producing a dopamine drop are well known to cause the dangerous side effects that are now appearing with Prozac and the other drugs in its class," Dr. Glenmullen writes. His term for these compensatory reactions in the brain is "Prozac backlash." [57]

Peter R. Breggin, MD, also reports in *Talking Back to Prozac: What Doctors Aren't Telling You About Today's Most Controversial Drug*, that Prozac acts as a stimulant to the nervous system. [58] Therefore, it can produce side effects that mimic those of amphetamines and are exaggerations of the desired effects of Prozac in relieving depression.

According to Dr. Breggin, the FDA psychiatrist who wrote the agency's safety review of Prozac stated that the drug's effects--including nausea, insomnia, and nervousness--resembled the profile of a stimulant drug rather than a sedative. [59] Dr. Breggin notes that nearly all of the Prozac side effects listed in the *Physician's Desk Reference* "fit into the stimulant profile." Among others, these stimulant symptoms include headaches, nervousness, insomnia, anxiety, agitation, tremors, weight loss, nausea, diarrhea, mouth dryness, anorexia, and excessive sweating. [60] He adds in *The Antidepressant Fact Book* that all of the SSRIs can cause insomnia, anxiety, agitation, and nervousness. These same effects and others are caused by the classic stimulants--methylphenidate, amphetamine, methamphetamine, Ecstasy, and cocaine. [61]

A drug that acts as a stimulant also can overstimulate the body systems. In *Talking Back to Prozac*, Dr. Breggin offers the example of a person who takes Prozac to relieve depression (the beneficial effect) and suffers from agitation and insomnia (the negative effects). These adverse reactions "are inherent in the stimulant effect that produces feelings of energy and well-being," he writes. "In this sense, the difference between 'therapeutic effects' and 'toxic effects' are merely steps along a continuum from mild to extreme toxicity." [62]

The Food and Drug Administration has received approximately 45,000 adverse reaction reports on Prozac. [63] It is not unusual for serious adverse effects to surface after a drug has hit the market, perhaps requiring that a major new warning be added to the label or that the drug be withdrawn. The FDA informs doctors, but not the public that the approval of a drug does not mean it is safe.

An analysis of 548 new drugs approved between 1975 and 1999 was published in the *Journal of the American Medical Association* in 2002. It found that 56 of the drugs acquired a black box warning or were withdrawn (16 drugs) from the market. There was a 20% chance that problems will arise with any given drug after its approval. The researchers conclude that serious adverse drug reactions commonly emerge after FDA approval. They add, "The safety of new agents cannot be known with certainty until a drug has been on the market for many years." [64] [65]

Dr. Glenmullen says that popular psychiatric drugs follow a "10-20-30 year pattern" in revealing their dangerous effects and falling into disfavor: About 10 years after their debut, the earliest signs of problems appear. At 20 years, there is enough data for the problems to be undeniable and a significant number of physicians to voice their concerns. At 20 years (or more), professional organizations and regulators actively work to stop overprescribing of the drug. At this point, drugs have become passé and lost their patent protection, and the manufacturers move on to more profitable drugs "that can be promoted as 'safer' because their hazards are not yet known." [66]

Comparisons of efficacy

The SSRIs have no more specific effect on depression than do other antidepressants, including the tricycles and monoamine-oxidase inhibitors (MAOIs), according to Charles Medawar. As he explains in "The Antidepressant Web," patients generally respond to antidepressants in about 60% to 70% of cases, while the typical response to placebo is 30% to 35%. Therefore, the popularity of SSRIs is due to the fact that most experts believe they are safer or otherwise more acceptable than the alternatives. And, in fact, promotional messages for SSRIs state three advantages: the drugs produce fewer unwanted side effects, are more acceptable to more patients, and are safer in overdose. [67]

Despite the safety-related claims made in the medical literature, however, "the evidence overall does not suggest that SSRIs show any great and decisive safety advantage over alternatives in day to day use," says Medawar. Consider the results of trials comparing SSRI efficacy and safety with that of other antidepressants: "Two independent meta-analyses, each starting with a careful

search of the literature to identify all properly controlled trials, have reached broadly similar conclusions--the SSRIs do have the edge on alternatives, but not by much." [68] One analysis of 62 trials found a 49% dropout rate for SSRIs versus a 54% rate for tricyclic antidepressants. [69] A second analysis of 63 trials (16 comparing an SSRI with a nontricyclic) found that 3% fewer people stopped taking an SSRI because of the side effects. [70]

Other recent reviews also have found that the newer antidepressants are no more or less effective in treating depression than older-generation drugs. [71] [72] In a government study conducted by Dr. Cynthia Mulrow and colleagues, the researchers analyzed more than 300 randomized controlled trials and concluded there were no significant differences in efficacy between newer and older agents or in overall discontinuation rates. Fewer people taking SSRIs stopped treatment due to adverse effects than those taking first-generation tricyclics (the rate difference was 4%). More than 80 studies did find that newer antidepressants were more effective than placebo in treating major depression in adults. The response rate was 50% for the drugs, versus 32% for placebo. [73] [74]

A more troubling conclusion was reached by Dr. Irving Kirsch and colleagues who analyzed data sent to the FDA for approval of the six most commonly prescribed antidepressants between 1987 and 1999 ([Prozac](#), Paxil, Zoloft, Effexor, Serzone, and Celexa). [75] Their analysis found that the response to placebo was almost as great as the response to the antidepressants. The mean difference on the Hamilton Rating Scale for Depression was two points, according to a report in *Psychiatric Times*. The difference was statistically, but not clinically, significant. [76] The article states, "More than half of the clinical trials sponsored by the pharmaceutical companies failed to find significant drug/placebo difference, and there were no advantages to higher doses of antidepressants." The authors add, "The small difference between antidepressant and placebo has been referred to as a 'dirty little secret' by clinical trial researchers ..." [77]

Several recent studies have reported similar results, finding that an SSRI did not differ significantly from placebo in the treatment of depression. [78]

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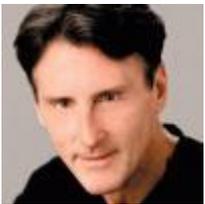
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