

Peter C. Gøtzsche

# **Deadly Psychiatry and Organised Denial**

Chapter 14: Deadly psychiatry and dead ends

**People'sPress**

## **Deadly Psychiatry**

© Peter C. Gøtzsche og People'sPress, København 2015

© This edition: People'sPress, 2015

Cover: Stine Trampe

Lay out: LYMI

ISBN: 978-87-7159-623-6

1. Edition, 1. Print

Printed in Denmark 2015

All rights reserved. No part of this publication may be reproduced, transmitted, or stored in a retrieval system, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior permission of the publishers.

This book is sold subject to the condition that it shall not, by way of trade or otherwise, be lent, re-sold, hired out or otherwise circulated without the publisher's prior consent in any form of binding other than that in which it is published and without a similar condition including this condition being imposed on the subsequent purchaser.

People'sPress  
Vester Farimagsgade 41  
1606 København V

[www.artpeople.dk](http://www.artpeople.dk)

# Contents

Abbreviations .....	9
Acknowledgements .....	9
About the author .....	10
1 Introduction .....	12
Silverbacks in the UK exhibit psychiatry's organised denial .....	16
2 What does it mean to be mentally ill? .....	25
On being sane in insane places .....	28
The demons attack you .....	31
Let there be disorder .....	32
Psychiatric drugs lead to many wrong diagnoses .....	38
The Goodness Industry .....	40
Patients are not consumers .....	41
More funny and fake diagnoses .....	41
3 Depression .....	46
Screening for depression .....	46
Antidepressant drugs don't work for depression .....	50
Other important flaws in placebo controlled trials .....	56
Fluoxetine, a terrible drug, and bribery in Sweden .....	58
Harms of antidepressant drugs are denied or downplayed .....	60
The FDA protects Eli Lilly .....	62
Massive underreporting of suicides in the randomised trials .....	66
FDA's meta-analysis of suicides in trials with 100,000 patients is deeply flawed .....	69

Another dirty trick: using patient-years instead of patients . . . . .	78
Case stories of suicide on SSRIs . . . . .	79
Akathisia is the main culprit . . . . .	92
Lundbeck: Our drugs protect children against suicide . . .	94
Totally misleading observational studies of suicide . . . .	96
Antidepressant-induced homicides . . . . .	103
The pills that ruin your sex life . . . . .	109
Damage to the foetus . . . . .	110
The fraud and lies of GlaxoSmithKline . . . . .	113
Trial 329 of paroxetine in children and adolescents . . . .	116
The STAR*D study, a case of consumer fraud? . . . . .	118
 4 Anxiety . . . . .	 132
Sleeping pills . . . . .	135
 5 ADHD . . . . .	 137
Childhood ADHD . . . . .	137
Adult ADHD . . . . .	142
ADHD drugs . . . . .	145
ADHD drugs for children . . . . .	145
ADHD drugs for adults . . . . .	150
Harms from ADHD drugs . . . . .	151
 6 Schizophrenia . . . . .	 156
Human guinea pigs in America . . . . .	160
The chemical lobotomy . . . . .	161
Drug trials in schizophrenia . . . . .	165
Antipsychotics kill many people . . . . .	172
A patient history . . . . .	175
Pushing antipsychotic drugs . . . . .	177
Eli Lilly's crimes related to olanzapine . . . . .	180
Stigmatisation . . . . .	183
Hearing voices . . . . .	184
 7 Bipolar disorder . . . . .	 189
"Mood stabilisers" . . . . .	192
A young man's experience . . . . .	194

8	Dementia .....	197
	We make people demented with psychotropic drugs ....	204
9	Electroshock .....	207
10	Psychotherapy and exercise .....	212
	Psychotherapy for anxiety and depression .....	214
	Psychotherapy for obsessive compulsive disorder .....	217
	Psychotherapy for schizophrenia .....	218
	Exercise .....	223
11	What happens in the brain? .....	227
	Calling psychiatric drugs “anti”-something is a misnomer .....	227
	Genetic studies and transmitter research .....	231
	Chronic brain damage .....	233
	Addiction to psychiatric drugs .....	237
	Drug regulators, the extended arm of industry .....	240
	Drug dependence is often misinterpreted as relapse of the disease .....	242
	The chemical imbalance nonsense .....	247
12	Withdrawing psychiatric drugs .....	255
	The worst drug epidemic ever .....	255
	How can it be done? .....	259
13	Organised crime, corruption of people and science, and other evils .....	267
	Lundbeck’s evergreening of citalopram .....	273
	Psychiatry’s fantasy world .....	275
	A Danish witch hunt .....	278
	Lecture tour in Australia .....	284
	Psychiatry is not evidence-based medicine .....	287
	Can we reform psychiatry or is a revolution needed? ....	290
14	Deadly psychiatry and dead ends .....	297
	The connection between psychotropic drugs and homicide .....	300
	How few drugs do we need? .....	303

How many people are killed by psychotropic drugs? . . . .	307
15 Forced treatment and involuntary detention	
should be banned . . . . .	314
Human rights in Europe . . . . .	315
Forced treatment . . . . .	316
Patients' rights . . . . .	317
My comments . . . . .	319
Forced treatment must be banned . . . . .	324
United Nations forbids forced treatment and involuntary detention . . . . .	333
Dear Luise . . . . .	337
16 What can patients do? . . . . .	354
17 What can doctors do? . . . . .	359
18 Helpful websites . . . . .	365
Index . . . . .	367

# 14 Deadly psychiatry and dead ends

I've spent most of my professional life to evaluate the quality of clinical research, and I think it is particularly poor in psychiatry. Industry-sponsored studies ... are selectively published, are often transitory, are designed to favor the drug and demonstrate such small benefits that they probably do not outweigh the long-term damage.

MARCIA ANGELL, FORMER EDITOR OF *NEW ENGLAND JOURNAL OF MEDICINE*<sup>1</sup>

Psychiatry's almost manic obsession with ineffective, addictive drugs has led to a disaster in public health so big that nothing I have seen in other areas of medicine comes close.

Robert Whitaker is convinced that most psychiatric patients would be better off not receiving drugs at all.<sup>2, 3</sup> Whitaker once invited me to give a lecture at the Safra Center for Ethics at Harvard University in Boston, to which he belongs, and I have lectured with him on several occasions in different countries. Every time there have been psychiatrists in the audience who shared our views that the way we currently use psychiatric drugs causes far more harm than good.

On one such occasion, I gave an invited talk in Los Angeles at the annual conference of the International Society for Ethical Psychology and Psychiatry, which has been described as North America's leading organisation of critical thinkers in the mental health field.<sup>4</sup> The title of the meeting was punchy, "Transforming Mad Science and Reimagining Mental Health Care," and the press release announced that the plenary speakers "shared the controversial belief that a 'medical model of care' – the idea that distress and misbehavior have physical causes that are best treated with physical means like medications – is causing more harm than good to individuals and to society." These speakers included leading

psychiatrists like Allen Frances and David Healy, psychologists, psychotherapists, social workers, neuroscientists, and a previous patient. Peter Breggin, who was not at the meeting, has also concluded that psychiatric drugs do more harm than good.<sup>5</sup>

It was a fascinating meeting that made it clear that we need a revolution in psychiatry. Psychiatric survivor Laura Delano described how small groups of people gather to support each other in coming off psychiatric medications, de-indoctrinating themselves from the biological model of mental illness and supporting each other through psychological crises and social change. When she read Whitaker's book, *Anatomy of an Epidemic*,<sup>2</sup> which won the 2010 Investigative Reporters and Editors book award for best investigative journalism, it suddenly dawned on her that she should reclaim her humanity and free herself from the prison of psychiatric "care." She had become dehumanised by psychiatry, she was called treatment-resistant, was on five drugs, and her drug-induced weight increase was even given a psychiatric diagnosis: binge eating! Whitaker's book saved her and helped her live with her pain more peacefully, until she had built up enough faith in herself to heal, so that she no longer felt the need to remind herself over and over again that she didn't need to believe everything her mind was telling her, as it was still under the influence of drugs.

Laura has connected with many practitioners who are slowly coming to understand the inefficacy and harm of the current "treatment" standard, but who feel powerless and afraid to do anything differently, fearing they could lose their licenses, face a lawsuit, get fired, or not get promoted. We must find ways to change this so that it becomes acceptable *not* to medicate people, which mainstream psychiatry considers "irresponsible," "dangerous," or even "life-threatening." We need to create a heightened consciousness around just how oppressed and harmed the patients have been by the "quick fix" mentality we have as a society, and to realise how false the "quick fix" story is in the first place, so that the demand for "psychiatric care" will lessen.

The organiser of the meeting, psychologist David Cohen, wasn't surprised to hear that people coming from different backgrounds independently had arrived at similar perspectives on the problems we're facing in psychiatry and how to go about solving them. He also reminded the audience that, over the last few years, mental



health authorities have acknowledged an absence of findings from biological or genetic research that have translated into a difference in patient care. They have recognized that 50 years of increasingly sophisticated treatments have not reduced the burden of mental disorders; in fact they have increased it substantially.<sup>2</sup> At the same time, powerful conflicts of interest have been exposed that keep practitioners and patients uninformed about the true effects of drug treatments.

Usually, people who are extreme are few in number, but in this case it is the vast majority of psychiatrists that are extreme. It is truly extreme that psychiatrists have built their specialty on a number of myths, lies and highly flawed research, which have harmed our nations to the extent we have seen. Marcia Angell has noted that psychiatrists should consider that other medical specialists, unlike psychiatrists, would be very reluctant to offer long-term symptomatic treatment without knowing what lies behind the symptoms, e.g. if a patient suffers from nausea or headache.<sup>1</sup> In my own specialty, internal medicine, we are on much safer ground when we intervene. Furthermore, apart from chemotherapy for cancer, it is difficult to identify a class of drugs in general use as toxic as antipsychotics.

In 2014, a senior psychiatrist at Rigshospitalet, the national university hospital in Denmark, which is where I work, underlined involuntarily just how necessary the revolution is. He was interviewed by a newspaper and said that SSRIs protect against suicide, with reference to observational studies. He also said we didn't overuse SSRIs, as the consumption reflects the number of ill patients. This is a sick system, which we must fight with all the means at our disposal.

Psychiatrists are slowly waking up to the tragedy they have created, and mainstream psychiatric journals, such as the *British Journal of Psychiatry*, now publish papers that are highly critical of the current model of biological psychiatry. For example, one paper stated that the research into biological mechanisms of mental and behavioural responses has failed to deliver anything of value to clinical psychiatrists and is very unlikely to do so in the future,<sup>6</sup> and another predicted that the current biology-based model will be ruinous to the profession due to its consistent failure to deliver.<sup>7</sup> It is noteworthy that these pessimistic statements come after more than 60 years of research in biological psychiatry.

It seems that many billions of research money have been wasted

on false leads. Even Thomas Insel, the director of NIMH, is critical. He has pointed out that there is no evidence for reduced morbidity or mortality from any mental illness from new drugs developed over the last 20 years, in striking contrast to the steadily decreasing mortality rates for cardiovascular disease, stroke and cancer, and that there is little evidence that the prospects for recovery have changed substantially in the past century.<sup>8</sup> That's a strong statement, but it's actually an understatement, as there is solid evidence that the prospects for recovery have *worsened* substantially because of the drugs we use. But what the public has heard about are reforms, revolutions, progress, innovations and paradigm shifts.<sup>8</sup> Empty barrels make the loudest noise.

### **The connection between psychotropic drugs and homicide**

Whether they are legal or illegal, it's unhealthy to perturb normal brain functions with drugs, and psychotropic drugs can lead to violence, including homicide.<sup>9-13</sup> An analysis of adverse drug events submitted to the FDA between 2004 and 2009 identified 1,937 cases of violence, 387 of which were homicide.<sup>11</sup> The violence was particularly often reported for psychotropic drugs (antidepressants, sedatives/hypnotics, ADHD drugs and varenicline, a smoking cessation drug that also affects brain functions).

We know that antidepressants and ADHD drugs can lead to homicide,<sup>11</sup> but if we read the newest scientific literature, we are led to believe that it isn't clear whether antipsychotics increase or reduce violence. However, the observational studies in this area are just as problematic as the observational studies that claim that the use of antidepressants reduce the risk of suicide (see Chapter 3). We therefore shouldn't pay much attention to them, but I shall comment on a 2014 study from Sweden published in the *Lancet* that linked a crime register with a prescription register.<sup>14</sup> The authors acknowledged that the evidence that drugs can reduce the risk of violence is weak. But they also said that in their own study, violent crime fell by 45% in patients receiving antipsychotics compared with periods when participants were not on medication.

Such studies are highly misleading. Patients might stop taking the drug because it gives them bad feelings that predispose to crime. Withdrawal effects also predispose to crime, and patients with

severe psychopathology might have committed a crime and avoided taking drugs.

I debated with Norwegian psychiatrists in 2015 in a newspaper, and one of them wrote that it is the untreated patients that are dangerous. However, the study he referred to cannot be used to substantiate this claim.<sup>15</sup> It showed that the risk for murder is greatest in first episode psychosis and decreases when patients are treated. But we don't know whether this risk would have been reduced equally, or perhaps even more, if the patients had *not* been treated with antipsychotics.

Curiously, our most prestigious journals have published some of the most misleading studies or commentaries I have ever found. An NIMH study reported that patients with serious mental illness – schizophrenia, major depression, or bipolar disorder – were two to three times more likely to be assaultive as people without such an illness. A professor of psychiatry who commented on the study in the *New England Journal of Medicine* mentioned that although it didn't specifically monitor the treatments, “it seems possible that treating psychiatric illness does not just make patients feel better; it may also drastically reduce the risk of violent behavior.”<sup>16</sup> This wishful thinking is contrafactual. Antipsychotics and antidepressants can cause violence and it will usually be the drugs, not the disease, that on rare occasions can make psychiatric patients commit horrendous acts. Studies that do not separate medicated from unmedicated patients are not worth the paper they are written on, and these patients were medicated!

In contrast to such flawed studies, it is pretty revealing to look at studies conducted before the advent of antipsychotics.<sup>3</sup> *Before 1955, four studies found that patients discharged from mental hospitals committed crimes at the same or lower rate than the general population, whereas eight studies conducted between 1965 and 1979 found higher rates.*

Akathisia, the well-known causal factor for violent actions and crime, was given little attention in these years, and physicians generally interpreted the restless behaviour as a sign that patients needed a higher dose of the drug, which only increases the risk of crime. When the psychiatrists finally took an interest in their patients, the results were shocking. In one study, 79% of mentally ill patients who had tried to kill themselves suffered from akathisia.<sup>3</sup> A 1990 study reported that half of all fights at a psychiatric ward were

related to akathisia and another study found that moderate to high doses of haloperidol made half the patients markedly more aggressive, sometimes to the point of wanting to kill their torturers, the psychiatrists.<sup>3</sup>

Psychotropic drugs can cause people to lose some of their conscience, so that they lose control over their behaviour.<sup>10</sup> Such people are at greatly increased risk of committing acts of crime and violence.

Several high-profile homicides have been committed by patients in a drug-withdrawal state, which also may cause akathisia,<sup>5, 10</sup> and a clear sign that the psychiatrists generally don't know what they are doing and what they are causing is that they have virtually always interpreted such events as meaning that the patients need to be kept on their drug, rather than acknowledging the peril of using the drug in the first place.<sup>3</sup> It is therefore their fault that the media have failed to write about it or investigate it. As David Healy says: "Violence and other potentially criminal behaviour caused by prescription drugs are medicine's best-kept secret. Never before in the fields of medicine and law have there been so many events with so much concealed data and so little focused expertise." When one of the teenage shooters in the Columbine High School massacre, Eric Harris, was found to have an antidepressant in his blood, the American Psychiatric Association immediately denied a causal relation and added that undiagnosed and untreated mental illness exacts a heavy toll on those who suffer from these disorders as well as those around them.<sup>17</sup> This sickening marketing speak comes right from the drug industry, which provides generous funds to the association (see Chapter 13). Harris' partner, Dylan Klebold, had taken sertraline and paroxetine.

Adam Lanza killed 20 school children, six members of staff, his mother and himself in Newtown, Connecticut, in 2012. After this crime, the International Society for Ethical Psychology and Psychiatry called for an inquiry into the connection between such acts of mass murder and the use of psychotropic drugs.<sup>18</sup> The media had noted that Lanza was taking prescription drugs to treat a neurological-development disorder, but nothing was revealed about the nature of these drugs. The society mentioned a number of other mass killings where psychotropic drugs might have had a causal role and noted that in 14 recent school shootings, the acts were committed

by persons taking or withdrawing from psychiatric drugs, resulting in 58 killed and over 100 wounded.<sup>18</sup> In other school shootings, information about the shooters' prescription drug use and other medical history was kept from public records.

It is difficult to know when psychotropic drugs are the major factor in these crimes, as the people who take them may suffer from severe personality disorders. But there is no doubt that these drugs can cause homicide, and the mass murders should therefore be routinely investigated for this possibility. There is enough evidence, for example, that antidepressants increase the risk of suicide and violence for the US Food and Drug Administration and its Canadian counterpart to require that drug companies include a black box warning to that effect on their packages. Antidepressants appear to more than double the risk of hostility events in adult and paediatric placebo controlled trials,<sup>18</sup> and in our systematic review of studies in human volunteers, we found that antidepressants double the incidence of activating effects<sup>19</sup> (see also Chapter 3).

### **How few drugs do we need?**

We could have a much better psychiatry almost without drugs. Some psychiatrists hardly use any drugs at all. One is Lois Achimovich, Australia, a child psychiatrist for 40 years, who has never used stimulants or antipsychotics. He only uses diazepam, in low doses and only short-term, when a child cannot sleep in an acute situation, e.g. after the death of a parent. Peter Breggin once had a debate with a paediatrician who tried to look very judicious by stating that he only medicated a small number of children each year. He challenged Breggin to say what was wrong with that, and Breggin replied, "Doctor, I would not know which child to poison."

Several psychiatrists I have met have never used antidepressants, as they don't believe they work while they cause much harm. Like Achimovich, the only drugs Peter Breggin uses are benzodiazepines, and only temporarily, if people feel badly during drug withdrawal. Perhaps people like them don't see the worst cases, but they have nevertheless demonstrated that we very rarely need drugs.

One way to go, which David Healy and David Cohen have suggested, could be to make psychotropic drugs freely available over the counter. This is an interesting suggestion, provided that

marketing to the public became forbidden of course. If there were no doctors as intermediaries, with all their false beliefs about chemical imbalance, targeted therapy and false reassurances about safety and drugs producing recovery and preventing relapses, many patients would give up taking psychotropic drugs very quickly, as their side effects are so horrible.

We could also take the opposite approach. More than 40 years ago, Archie Cochrane, whom the organisation I work for is named after, wrote:<sup>20</sup>

“I would ban the prescription of amphetamines and put a large number of other psychotropic drugs on a list which could only be prescribed by psychiatric consultants. I do not suggest this because I think consultants know better than GPs which of these drugs will do more good than harm in the long run. I do not think anyone knows, but they may know more about side effects and, much more importantly, there are fewer consultants than GPs and it will make the prescriptions more difficult to get. Psychiatry, in my view, must be criticized as using a large number of therapies whose effectiveness has not been proven. It is basically inefficient.”

It's remarkable that Cochrane wrote this so long ago, as it's still the case today that psychiatric drugs are pretty inefficient.

Peter Breggin has suggested that we should prohibit giving psychiatric drugs to children, just like we have prohibited physical and sexual abuse.<sup>21</sup> I agree completely that psychiatric drugging of children is a form of child abuse that should be prohibited, with very rare exceptions. We are not allowed to beat our children but are allowed to destroy their brains with drugs. We medicalise the inevitable conflicts that arise between parents and children, and methylphenidate (Ritalin) has become the modern version of the cane. This is a flagrant abuse of a faulty disease model and a serious violation of the children's human rights, which must be stopped.

The drugged child's brain cannot develop in its intended manner but develops in response to a toxic internal environment. Furthermore, the stigmatisation and loss of self-esteem, which often follows psychiatric diagnosis and treatment (see Chapter 6), is especially ominous in children who have yet to shape their personalities, and it can hamper future opportunities even without considering the potential brain damage caused by the drugs. Children may learn to view themselves as physically or genetically disabled, with impaired

self-determination and increased feelings of helplessness.<sup>21</sup> It's horrible.

Also for adults, psychiatric drugs are a dangerous weapon that doctors cannot handle and most of them do far more harm than good. We could therefore take them off the market and spare a few for acute situations and for legitimate purposes outside psychiatry, e.g. for induction of anaesthesia and for treatment of epilepsy. This would mean tremendous progress for mental health, as far fewer people would be in treatment and far fewer would be harmed.

I shall try to estimate how little we need psychiatric drugs. I will leave out epilepsy drugs, as I don't know how much of the usage is for psychiatric purposes (at any rate, I believe these drugs shouldn't be used for psychiatric diseases). This leaves us with five drug groups: antidepressants, ADHD drugs, antipsychotics, anti-dementia drugs, and benzodiazepines and similar sedatives.

As antidepressants likely don't work, whereas they actually cause much harm, including deaths, personality changes, sexual disturbances and addiction, we shouldn't use them at all.

We shouldn't use ADHD drugs either. They might give some short-term relief but are clearly harmful when used long-term, which they almost always are.

Antipsychotics kill many people and destroy many more people's lives, and it's likely we could use benzodiazepines for the same indications. Whitaker has estimated that we could halve the two million adults disabled by schizophrenia in the United States if we used antipsychotics in a selective, cautious manner.<sup>2</sup> I have no doubt he is right. But it can be discussed whether we need this class of drugs at all.

Anti-dementia drugs shouldn't be used, as they don't work and are pretty harmful.

Benzodiazepines and similar drugs are also very harmful but we need drugs for sedation in acute situations and they are less harmful than antipsychotics.

I shall use Danish statistics (<http://medstat.dk/>) to illustrate how little we need psychiatric drugs. Currently, we use so many of these drugs that one out of seven Danes could be in treatment with a psychiatric drug every day for their entire life, from cradle to grave, if they took one drug each (Table 14.1).

Table 14.1. Usage of psychotropic drugs in Denmark in 2013. Defined daily doses per 1000 inhabitants per day; sales in million DKK.

	Usage current	Usage needed	Sales current	Sales needed
N05A Antipsychotics	14.3	1.2	591	34
N05B Anxiolytics	9.6	0.5	83	4
N05C Hypnotics and sedatives	19.9	1.0	88	4
N06A Antidepressants	80.0	0	367	0
N06B Psychostimulants	8.1	0	335	0
N06D Anti-dementia drugs	3.4	0	71	0
Total	135.3	2.7	1,535	42

Antipsychotics are used long-term although they are very harmful when used this way. We should only treat acute conditions, which is roughly about 5% of current usage, or less. The current usage is 14.3 defined daily doses per 1000 inhabitants per day (DDD), of which 1.1 is lithium. Lithium is perhaps an important drug, as it perhaps reduces suicides (see Chapter 7).<sup>22</sup> On the other hand, most cases of bipolar disorder are caused by antidepressants and ADHD drugs, and if we stop using these, there wouldn't be much need for lithium; 0.5 DDD would seem more than enough. Thus, the 14.3 DDD could be reduced to 0.5 plus 5% of 13.2, which is 1.2 DDD.

It is not very often we would need a drug for acute anxiety or sleeping problems, and it should be short-term. Since most people on anxiolytics take them for years because they have become dependent on them, we could somewhat generously say that only 5% of current usage is needed.

If we used psychotropic drugs prudently, we would not need 135.3 DDD but only 2.7, which is 2% of current usage (see Table 14.1).

*Our current usage of psychotropic drugs could be reduced by 98%.*

In Denmark, 97% of all psychotropic drugs are used outside hospitals. We should therefore primarily target doctors who work in specialist practice, particularly general practitioners who prescribe most of the drugs by far. If we restricted psychotropic drug usage to hospitals, we could curb our drug epidemic. I am aware that this proposal seems radical but it actually isn't. We don't usually give



chemotherapy outside hospital, and psychotropic drugs are also toxic and dangerous. This would be too restrictive, though, as psychiatrists in specialist practice need the possibility to use drugs in acute situations.

The potential financial savings are even larger than 98%. Our costs would only need to be 3% of current expenditure (Table 14.1), but this is before we have taken into account that clinicians often use drugs that are five to ten times more expensive than equivalent drugs. We could therefore easily save 99% of our current expenditure. For Denmark, this would mean annual savings of around DKK 1.5 billion; for the United States it would mean annual savings of a good deal more than \$15 billion, as there is virtually no price control in that country.

Note that the contest is not between drugs and psychotherapy or any other specific mental health approach. The potentially earth-shaking contest takes place between drugs and real life, between an artificially distorted mental life and a clear mind and spirit.<sup>10</sup> Peter Breggin has cautioned that the people most in need of help are the least likely to benefit from any form of help. Being drugged only pushes them deeper into helplessness, further crippling them psychologically and socially. Although he is himself a psychiatrist, Breggin advises that the most disturbed patients need to be protected from psychiatrists.<sup>10</sup>

## **How many people are killed by psychotropic drugs?**

Psychiatric drugs are much, much more dangerous than you have ever, ever been led to believe by the doctors who are prescribing them. I genuinely believe that if most people knew how dangerous the psychiatric drugs really were, most people would never start on them, and I also believe that if most prescribers had even the faintest idea how dangerous they were, they would stop prescribing them. How is it that so many people can be ignorant about psychiatric drugs? Well, the truth is that's because they are all getting their information from the drug companies.

PETER BREGGIN<sup>23</sup>

Likely all psychotropic drugs can lead to confusion and impaired coordination and balance, which can lead to falls and traffic accidents.<sup>24-29</sup> Antidepressants are by far the most used psychotropic drugs (Table 14.1). They can cause orthostatic hypotension, sedation, and confusion and they double the risk of falls and hip fractures in a dose-dependent manner.<sup>28, 29</sup> Hip fractures are often deadly, which makes psychotropic drugs a silent killer, as we will rarely suspect that it was the drug that caused the fall.

If we want to find out how many people psychiatric drugs kill, we might think that placebo controlled randomised trials would be ideal, but that's not the case, and schizophrenia is a prime example. The cold-turkey design of most of these trials has caused some patients to commit suicide in the placebo group (see Chapter 6). We therefore need to find patients who were not already in treatment with antipsychotics before they were randomised.

In trials in dementia, pre-treatment is not so likely. A meta-analysis of such trials proved that antipsychotics kill people,<sup>30</sup> but the authors of a study about antipsychotic prescribing in UK primary care toned down the unwelcome news when they quoted this meta-analysis by saying that dementia “may be associated with” increased all-cause mortality.<sup>31</sup> No “may be” and no “associated with” are appropriate here; the meta-analysis proved that antipsychotics kill people.

The meta-analysis included trials of newer antipsychotics, aripiprazole (Abilify), olanzapine (Zyprexa), quetiapine (Seroquel) and risperidone (Risperdal), in patients with Alzheimer's disease or dementia, and deaths were recorded up till 30 days after discontinuing the double-blind treatment. For every 100 patients treated, there was one additional death on the drug (3.5% versus 2.3% died,  $P = 0.02$ ). Elderly patients are often treated with several drugs and are more vulnerable to their harmful effects, which means that the death rate is likely higher than in young patients. On the other hand, the trials generally ran for only 10-12 weeks although most patients in real life are treated for years. Furthermore, deaths on drugs are often underreported in industry-sponsored trial reports.<sup>13</sup> I therefore believe a death rate of 1% is a reasonable estimate to use.

The authors of the meta-analysis also reported that 32% dropped out on the drug and 31% on placebo. Discontinuation rate is a good outcome, as it combines perceptions of benefits and harms from the

drugs, and the result indicates that the drugs are pretty useless.<sup>32</sup> So elderly patients are killed in huge numbers for no benefit, and yet, in the United States, a third of people in nursing homes take antipsychotics.<sup>32</sup>

With regard to benzodiazepines and similar drugs, a cohort study of 34,727 patients found that increased doses increased mortality, and the drugs doubled the death rate, although the average age of the patients was only 55.<sup>33</sup> The excess death rate was about 1% per year. Another large cohort study of such drugs used for sleeping problems also found increased mortality with higher doses.<sup>25</sup> The authors did not report on absolute death rates but estimated that sleeping pills kill between 320,000 and 507,000 Americans every year.

With regard to SSRIs, a UK cohort study of 60,746 patients older than 65 showed that they led to falls more often than the older antidepressants or if the depression isn't treated, and that the drugs kill 3.6% of patients treated for one year.<sup>34</sup> The study was done very well, e.g. the patients were their own control in one of the analyses. Some may argue that since it was an observational study, it hasn't been proved that antidepressants kill elderly people. But it's a strong message that even when the patients were their own control – which is a good way to remove the effect of confounders – the lethal effect was clear. Another cohort study, of 136,293 American postmenopausal women (age 50-79) participating in the Women's Health Initiative (WHI), found that antidepressants were associated with a 32% increase in all-cause mortality (hazard ratio 1.32, 95% CI 1.10 to 1.59) after adjustment for confounding factors.<sup>35</sup> This corresponded to 0.5% of people killed by SSRIs when treated for one year. Thus, the death rate was only one seventh of that found in the UK cohort but there are good explanations for this. The authors warned that their results should be interpreted with great caution, as the way exposure to antidepressant drugs was ascertained carried a high risk of misclassification, which would likely make it more difficult to find an increase in mortality. Further, the patients were much younger than in the UK study, and the death rate increased markedly with age (0.3% for 50-59 years, 0.6% for 60-69 and 1.4% for 70-79).<sup>35</sup> Finally, the women who were exposed and not exposed were different for many important risk factors for early death, whereas the people in the UK cohort were their own control.

Table 14.2. Usage of antipsychotics, benzodiazepines and similar, and antidepressants in Denmark in 2013 in people aged at least 65 years, and estimated number of drug-induced deaths. Defined daily doses per 1000 inhabitants per day. The estimated use at hospitals (1-3%) has been included.

	Usage	Population	Death rate	Deaths
Antipsychotics				
65-79 years	14.3	811,720	1.0%	116
80+ years	10.4	239,409	1.0%	25
Total				141
Benzodiazepines and similar				
65-79 years	61.1	811,720	1.0%	496
80+ years	94.2	239,409	1.0%	225
Total				721
Antidepressants				
65-79 years	119.3	811,720	2.0%	1937
80+ years	186.7	239,409	2.0%	894
Total				2831
Total, all three classes of drugs				3693

I therefore find that the 3.6% annual death rate is more reliable than the 0.5% rate but will use a conservative estimate of a 2% death rate.

We can now estimate how many patients are killed each year by antipsychotics, benzodiazepines and similar drugs, and antidepressants. I will use Danish data again, as they are pretty typical for psychotropic drug use in the western world, e.g. 12% of those aged 65 to 79 are in treatment with an antidepressant drug (Table 14.2); in the United States, usage is 14.5% in those at least 60 years of age.<sup>36</sup>

Table 14.2 shows the estimated number of drug-induced deaths per year in those aged 65 and above caused by antipsychotics, benzodiazepines or similar, and antidepressants. The total number of deaths per year correspond to 209,000 deaths in the United States and to 539,000 deaths in the United States and the European Union combined.

*Psychotropic drugs kill more than half a million people every year aged 65 and above in the western world.*

There are some uncertainties related to this estimate. Some people are in treatment with two or even three different types of drugs and you can only die once. There is also survivorship bias, i.e. those who continue for years are those who tolerate the drug. On the other hand, death can occur at any time, also in people who have taken a drug for years. For example, both antipsychotics and antidepressants prolong the QT interval on the ECG, and these drugs topped the list among all drugs in the FDA's Adverse Events Database for this side effect;<sup>37</sup> thus, a patient might die when another drug is added. We also know that benzodiazepines increase the mortality of antipsychotics,<sup>38</sup> so this combination is also risky. Furthermore, far more people are exposed to the dangers of these drugs than the data in the table shows, as I have assumed that all patients are treated for a full year.

Even focusing only on those aged 65 and above, the estimates show that psychotropic drugs are the third major killer after heart disease and cancer, which in 2010 killed 600,000 and 575,000 Americans, respectively.<sup>13</sup> I have deliberately been conservative, and have not factored in deaths occurring in those under 65.

Based on studies in Europe and the United States, I previously estimated that our prescription drugs kill 200,000 people every year in the United States.<sup>13</sup> This estimate now seems to be far too low, as psychotropic drugs alone kill more than this.

We could also look at the total sales figures for drugs, for example for Eli Lilly's best-seller, fluoxetine. In 2004, the company was under attack and sent this written statement: "Prozac has helped to significantly improve millions of lives. It is one of the most studied drugs in the history of medicine, and has been prescribed for more than 50 million people worldwide. The safety and efficacy of Prozac is well studied, well documented, and well established."<sup>39</sup> When drug companies face trouble, they often try to escape by using big numbers. Prozac has not improved millions of lives. Prozac has made millions of lives miserable, so let's estimate how many patients the drug has killed. In Denmark, 45% of total usage of antidepressants occurs in those aged 40 to 64, and 31% in those aged 65 and above, and using the same assumptions as above, Prozac has killed 311,000 people worldwide in the age group 65 and above up to 2004.

## References

- 1 Angell M. "The illusions of psychiatry": an exchange. *New York Rev Books* 2011 Aug 18.
- 2 Whitaker R. *Anatomy of an Epidemic*. New York: Broadway Paperbacks; 2010.
- 3 Whitaker R. *Mad in America*. Cambridge: Perseus Books Group; 2002.
- 4 Wipond R. Where critical psychiatry meets community resilience. <http://www.madinamerica.com/2014/11/critical-psychiatry-meets-community-resilience/> (accessed 22 Nov 2014).
- 5 Breggin P. *Psychiatric drug withdrawal: a guide for prescribers, therapists, patients, and their families*. New York: Springer Publishing Company; 2013.
- 6 Kingdon D, Young A. Research into putative biological mechanisms of mental disorders has been of no value to clinical psychiatry. *Br J Psychiatry* 2007;191:285–90.
- 7 Kleinman A. Rebalancing academic psychiatry: why it needs to happen – and soon. *Br J Psychiatry* 2012;201:421–2.
- 8 Kirk SA, Gomory T, Cohen D. *Mad science: psychiatric coercion, diagnosis and drugs*. New Brunswick: Transaction Publishers; 2013.
- 9 Healy D. *Let them eat Prozac*. New York: New York University Press; 2004.
- 10 Breggin P. *Medication madness*. New York: St. Martin's Griffin; 2008.
- 11 Moore TJ, Glenmullen J, Furberg CD. Prescription drugs associated with reports of violence towards others. *PLoS One* 2010;5:e15337.
- 12 Lucire Y, Crotty C. Antidepressant-induced akathisia-related homicides associated with diminishing mutations in metabolizing genes of the CYP450 family. *Pharmgenomics Pers Med* 2011;4:65–81.
- 13 Gøtzsche PC. *Deadly medicines and organised crime: How big pharma has corrupted health care*. London: Radcliffe Publishing; 2013.
- 14 Fazel S, Zetterqvist J, Larsson H, et al. Antipsychotics, mood stabilisers, and risk of violent crime. *Lancet* 2014;384:1206–14.
- 15 Nielssen O, Large M. Rates of homicide during the first episode of psychosis and after treatment: a systematic review and meta-analysis. *Schizophr Bull* 2010;36:702–12.
- 16 Friedman RA. Violence and mental illness – how strong is the link? *N Engl J Med* 2006;355:2064–6.
- 17 Healy D, Herxheimer A, Menkes DB. Antidepressants and violence: problems at the interface of medicine and law. *PLoS Med* 2006;3:e372.
- 18 ISEPP Statement on the Connection Between Psychotropic Drugs and Mass Murder. [http://www.psychintegrity.org/isepp\\_statement\\_on\\_the\\_connection\\_between\\_psychotropic\\_drugs\\_and\\_mass\\_murder.php](http://www.psychintegrity.org/isepp_statement_on_the_connection_between_psychotropic_drugs_and_mass_murder.php) (accessed 29 Dec 2014).
- 19 Bielefeldt AØ, Danborg P, Gøtzsche PC. Systematic review of adverse effects of antidepressants in healthy volunteer studies. *Proceedings of the 23rd Cochrane colloquium*. Vienna, Austria; 2015.
- 20 Cochrane AL. *Effectiveness and efficiency: random reflections on health services*. London: Nuffield Provincial Hospitals Trust; 1972.
- 21 Breggin PR. The rights of children and parents in regard to children receiving psychiatric diagnoses and drugs. *Children & Society* 2014;28:231–41.

- 22 Cipriani A, Hawton K, Stockton S, et al. Lithium in the prevention of suicide in mood disorders: updated systematic review and meta-analysis. *BMJ* 2013;346:f3646.
- 23 Breggin P. Psychiatric drugs: more dangerous than you ever imagined. Video, available from: <http://cepuk.org/>.
- 24 Leipzig RM, Cumming RG, Tinetti ME. Drugs and falls in older people: a systematic review and meta-analysis: I. Psychotropic drugs. *J Am Geriatr Soc* 1999;47:30-9.
- 25 Kripke DF, Langer RD, Kline LE. Hypnotics' association with mortality or cancer: a matched cohort study. *BMJ Open* 2012;2:e000850.
- 26 Glass J, Lanctôt KL, Herrmann N, et al. Sedative hypnotics in older people with insomnia: meta-analysis of risks and benefits. *BMJ* 2005;331:1169-73.
- 27 Hemmelgarn B, Suissa S, Huang A, et al. Benzodiazepine use and the risk of motor vehicle crash in the elderly. *JAMA* 1997;278:27-31.
- 28 Hubbard R, Farrington P, Smith C, et al. Exposure to tricyclic and selective serotonin reuptake inhibitor antidepressants and the risk of hip fracture. *Am J Epidemiol* 2003;158:77-84.
- 29 Thapa PB, Gideon P, Cost TW, et al. Antidepressants and the risk of falls among nursing home residents. *N Engl J Med* 1998;339:875-82.
- 30 Schneider LS, Dagerman KS, Insel P. Risk of death with atypical antipsychotic drug treatment for dementia: meta-analysis of randomized placebo-controlled trials. *JAMA* 2005;294:1934-43.
- 31 Marston L, Nazareth I, Petersen I, et al. Prescribing of antipsychotics in UK primary care: a cohort study. *BMJ Open* 2014;4:e006135.
- 32 Carey B. Drugs to curb agitation are said to be ineffective for Alzheimer's. *New York Times* 2006 Oct 12.
- 33 Weich S, Pearce HL, Croft P, et al. Effect of anxiolytic and hypnotic drug prescriptions on mortality hazards: retrospective cohort study. *BMJ* 2014;348:g1996.
- 34 Coupland C, Dhiman P, Morriss R, et al. Antidepressant use and risk of adverse outcomes in older people: population based cohort study. *BMJ* 2011;343:d4551.
- 35 Smoller JW, Allison M, Cochrane BB, et al. Antidepressant use and risk of incident cardiovascular morbidity and mortality among postmenopausal women in the Women's Health Initiative study. *Arch Intern Med* 2009;169:2128-39.
- 36 Pratt LA, Brody DJ, Gu Q. Antidepressant use in persons aged 12 and over: United States, 2005-2008. *NCHS Data Brief* 2011;76:October.
- 37 Healy D, Howea G, Mangin D, et al. Sudden cardiac death & the reverse dodo verdict. *Int J Risk Safety Med* 2014;26:71-9.
- 38 [Usage of antipsychotics among 18-64-year old patients with schizophrenia, mania or bipolar affective disorder]. *København: Sundhedsstyrelsen*; 2006.
- 39 Lenzer J. FDA to review "missing" drug company documents. *BMJ* 2005;330:7.