

## 2006 debate about whether Drugs do more harm than good

A public debate, sponsored by the James Nayler Foundation.  
This house believes that "Psychiatric drugs do more harm than good"

For: Dr Peter Breggin, seconded by Dr Joanna Moncrieff. Against: Dr Mark Salter, seconded by Dr Trevor Turner (who also appears in "The Doctor who hears voices")

On Friday 7th April 2006,  
coffee 5:30 -- debate 6 - 8 pm  
at The Guardian Seminar room, 60 Farringdon Rd, London, EC1R 3GA.

admission by ticket only --  
limit of 90 in all -- donations welcome.

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Bob: Thank you. I would like to welcome you on behalf of the James Nayler Foundation, which is a small mental health charity of which I am the co-director. My name is Bob Johnson and I delighted to see so many of you here. There are some very important subjects that we are discussing tonight, and I hope we have lots of light and not too much heat. I would like to introduce you to David Brindle who is the Public Services Editor of the Guardian. I am very grateful to him for chairing this event, and I shall hand over to him, and ask him to introduce the speakers. Thank you.

David: Well welcome to the News Room as we call it at the Guardian. It needs to be said up front that the media's coverage of the mental health could be better. But at the Guardian we like to think we do a better job than most, and that goes to both fostering events like this discussion and this coverage that you might have seen today -- quite a substantial article from Mind in a writer reply on a piece we did on deep brain stimulation and depression.

I am going to try to keep order this evening. It's going to be an interesting debate, and passions will run high, but I plead for a civilised debate if I may. Certainly let's give the speakers on both sides of the issue the courtesy of a fair hearing. We will have plenty of time for discussion and contributions from you when we've heard from the four speakers. The two main speakers for and against will speak for 10 minutes and the seconders will speaking for 5 so by process of deduction we will have almost an hour for debate there after. Two service notes -- please check your phones are off or on silent mode as a courtesy to everybody else. And secondly the event is being recorded so that we can have a transcript afterwards -- so just be aware of that, in anything you choose to say.

[Laughter]

David: So, the motion is 'Psychiatric Drugs Do More Harm Than Good'. Proposing that motion we are going to have Peter Breggin and seconding it Joanna Moncrieff. Opposing the motion is Mark Salter, and seconding him is Trevor Turner. I will introduce each as we go along. We are going to start with Peter Breggin, who as most of you will know is an acclaimed authority in the field, author of Toxic Psychiatry, founder of The International Centre for the Study of Psychiatry and Psychology in the States, campaigner now for thirty years or more on these issues, robust opponent of Ritalin, fantastic track record and Peter's going to speak for Psychiatric drugs do more harm than good. Peter.

Peter: Thank you for that warm introduction. To address the question of whether psychiatric drugs do more harm than good, I am going to go into the lion's den, right into the prototype of the psychiatric science, if it may be called that. Which is the use of Neuroleptics or antipsychotic drugs to treat people who are labelled schizophrenic, because if that bastion of psychiatric authority has feet of sand, than clearly so does the rest of psychiatry in terms of medications and drugs. There are two basic arms to the proposition:

1. Neuroleptics can only work by damaging the brain and producing brain dysfunction. That is, by disrupting dopamine neurotransmission to the frontal lobes and also the reticular activating system, these drugs inevitably, when they are given in sufficient dose to work cause, a chemical lobotomy of the frontal lobes. And also of the reticular activating system. Both of which are energised by Dopaminergic. So it is a scientific fact, not a metaphor, that we are dealing with a lobotomy phenomenon. And what the patient's experience is the disinterest and apathy typical of the older classical surgical lobotomies. They don't lose their so called hallucinations and delusions -- they lose interest in everything about themselves, their family lives, rooting for their football team, the whole array of human life within them is muted by the drugs.

That's the first general principle. Also remember that when the term medication is used which we'll be using tonight in drugs, we're actually talking about this essential poisoning of the dopamine system. Blocking up to 90% of a major neurotransmitter system, and the newer drugs block, as well as dopamine, the serotonergic system which goes throughout the brain including to the highest mental centres. That's the first part that I want you to understand.

The second part is that the people we call patients to which these drugs are given are actually people. They are human beings that run really the full range of people in our society. In many ways, in America today, children are becoming major targets of drugs like Risperadol, Zyprexa, Seroquel, the so called second generation drugs. All of which block dopamine, I don't know how the professionals have forgotten this, they all block dopamine.

These drugs are used everywhere that control is required or wanted. They were used in Russian psycho prisons, they are still used in China and Cuba, they are used in nursing homes when old ladies get rambunctious, or resistant, or restless. And they are of course used on virtually everyone who was incarcerated in our great state mental hospitals, which are now somewhat smaller but largely pretty much everyone in them are going to be on these drugs regardless of their diagnosis.

What you may not know is these drugs are being used in veterinarian medicine; they're used in veterinarian medicine. When you see the tiger that's been tranquillised by a dart it's got a Neuroleptic in it often as well as a sedative. The main difference in veterinarian medicine they're very careful not to use it for a long period of time because they don't want to hurt the animals.

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Despite the blunting effects of these drugs, the fundamental lobotomising effects which I believe is a self evident truth, once you know the simple physiology of it all. The drugs also cause a great deal of suffering in particular they cause akathisia this terrible inner agitation that forces people to move about. The older drugs, Haldol, and drugs like that, 50% or more of the individuals on these drugs get some degree of akathisia it may be less now but it's hard to tell.

So the patient, the person -- let me turn to that person for a minute. Our classic model for the person who gets these drugs is a person labelled schizophrenic, and who is that person? Above all others that's a sensitive individual, that is a frightened individual, that is a hopeless feeling individual, that is a person who needs more than anything on the face of the Earth a trusting relationship with another human being. Because when we talk about a loss of contact with reality, we really mean human reality. That person who's in front of us no longer believes that other human beings can be remotely trusted or related to and is withdrawn into a nightmarish world.

The way out of that world we know from multiple studies, and I get to mention some of them, is through a human relationship, not through poisoning the highest emotion regulating centres of the brain with Dopamine, and now Serotonin blocking agents. Because these drugs are so toxic, they're toxic to cells, they're Cytotoxic and they're particularly toxic to Dopaminergic cells, the cells they block. Tardive Dyskinesia in older drugs, a neurological disorder with abnormal movements and brain damage, occurs at a rate of 5% to 8 % a year cumulative. It's at least 15% the first three years of people getting a disfiguring, and I also see as a consultant, disabling cases of Tardive Dyskinesia. Claims are made for lower rates with the newer drugs, but we're not learning the tricks of the drug companies, the studies involve lower doses of their Dopamine blocking agents, they cause Tardive Dyskinesia. I myself have probably evaluated a dozen cases of Risperidol induced abnormal twitches in children, because we're giving it to children so often.

Now we know the atypicals are also causing obesity, hypercholesterolemia, the blood lipids going up, fatal diabetes, and fatal pancreatitis. Let me tell you how serious the diabetes and pancreatitis issue is. I was a medical consultant in a huge class action suit for diabetes and pancreatitis caused by Zyprexa Olanzapine and was settled for ¼ of a billion dollars by the drug company. You heard me right, billion dollars. Probably no one here knows it, I doubt it if my fellow psychiatrists know about the settlement. So much is the media in the U.S. controlled by the drug companies that it barely squeaked out and all the data was suppressed because the company settled, and I can't tell you the data behind it.

Now NIMH [National Institutes of Mental Health, Bethesda, Maryland USA] hot off the presses, April this month, the American Journal of Psychiatry the bastion of the authority system, and we have the CATIE study from NIMH being reported for Olanzapine, Risperidone, and Zipraxadone and so on. What did they find? They tried to do an 18 month study and they found the average drop out was 2.9 months. And why were the drop outs? Well this is an editorial, which sounds like me; it was an editorial -- they're catching up slowly here. This an editorial of this month's Journal of the American Psychiatry Association &ldquo;Sky high drug discontinuation rates were seen, suggesting rampant drug dissatisfaction and inefficacy&rdquo;.

The editorial says the side effects were &ldquo;staggering in their magnitude and extent&rdquo; and warned my fellow psychiatrists will have to become medical doctors just to treat the disorders. &ldquo;Blood pressure cuffs, scales, body tape measures, plasma chemistry monitoring, and electrocardiograms and qualified consultants for medical questions

become important components of practice. We're going to have to be in the middle of medical clinics just to be testing for the diabetes, the hypercholesterolemia, the obesity, and the drugs don't even hardly work when we try to study them.

What do the follow up studies show? Clearly the drugs work. If we gave everybody in this room a Neuroleptic, everybody in this room would lose interest in what I'm saying. It would work! You'd all be easily led around, taken out for a walk. They'd work. But multiple studies indicate that they have no specific effect on hallucination or delusions. How could they, on this integrated brain of ours? We blow out Dopaminergic neurotransmissions and that's going to specific for something like a thought or an action? Of course it isn't.

All the studies done at NIMH and elsewhere indicate that relapse rates are greater after the drugs are given than without having had the drugs. Well, we've got a lot of other things that might come up in terms of the social approaches that have worked, Lauren Mosher of Soteria House. My own work as of 50 years ago as a college volunteer, there are many social approaches to these patients and there are two big lessons.

First people frequently recover on their own or from psycho social interventions, but they rarely recover from long term exposure to the Neuroleptics. So just consider when these fragile distressed out of touch human beings come to us for help and they need a social relationship to begin with, human contact, and instead we poison them. Thank you.

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David: Right, opposing the motion that psychiatric drugs do more harm than good we have Dr. Mark Salter consultant psychiatrist in general and community psychiatry in the East End. Mark.

Mark: Can you see that? [referring to slide projected on the screen] Is that bright enough for you? It's a picture of a nice smiling lady, a catalogue girl, a model, and what is that she's holding? She's holding a very large gun. I am a member of Amnesty International a wonderful charity that represents the importance of human beings. The people Dr. Breggin so clearly stated, that we need to understand, respect and love, show faith and help to. I do that everyday talking to people. What's my job? I look after sick people who are stuffed, I mean stuffed by suffering. I mean to go through mental illness is a pretty damned awful thing to experience. Ok, so I'm a lobotomiser, I'm a poisoner, I'm a murderer of souls basically if you believe Dr. Breggin.

Now we've heard a very radical, angry, punishing argument here, and when we're talking about something like guns and Amnesty International is satirising something where there is no good involved. You don't need a good application for a rocket propelled grenade launcher, I can't think of one. But if you give a drug skillfully -- now we're looking at something different. These drugs, whatever Dr. Breggin will tell you, if used skillfully and appropriately can transform radically an unhappy, unhealthy, chaotic life into a healthy one. Now I'm not for a minute saying that these drugs are the answer, what I'm saying is that they are part of an answer. I see actually no reason why a skillfully prescribed Neuroleptic, benzodiazepine, or Lithium, remember tonight we're talking about psychotropic drugs not just Neuroleptics. I see no reason what so ever why one of those drugs if skillfully used at a far less toxic, non lobotomising dose. What of these words, lobotomy. The very words carry this idea of... forgive me I was thinking I was an S.S. doctor. This kind of polemicism is no help what so ever, particularly to those poor unfortunate individuals who have to struggle with psychotic illness day in and day out. And I will tell you something else, the people who take these drugs for whom they benefit are quiet, but it is the dissatisfied that speak the loudest.

It is the polemic, the extreme ranters of this world's profession who I find frankly are doing no good to the other 95% of the patients who benefit tremendously from these drugs. And while we're at it, how do we quantify this? If the people for whom it is doing good are silent -- how do they know how much the other 5-10% are actually being harmed... 20%...30%? It is a very, very difficult thing to quantify. The notion of harm versus good is something that is simply impossible to clock up with a straight forward calculus, but what we're having instead thanks to Dr. Breggin's radical angry polemic approach...

[Random Woman In Crowd:] He wasn't angry!

Mark: ...is, as I see it, a harmful approach. Because what we're really doing is throwing out the baby with the bath water. Just because the system doesn't work, or just because we're misusing the system, that's no reason to abandon the system. Rather we need to think it more effectively how we use these drugs. Poisons? Yes, but subtle poisons.

One of the critics of psychiatry that I admire the most in this country said this, "I do not doubt that the accidental discovery of therapeutic chlorpromazine was a major breakthrough in the treatment of severe mental illness". Frequent trials consistently demonstrated in his experience fewer psychotic complaints or rather Dr. Breggin would say ignore... or encouraged... or poisoned into ignoring their complaints is how he put it. But no -- look if skillfully used, these people get better. I see it day in, I see it day out. I know that because I have a trusting relationship with my

patients that Dr. Breggin espouses.

What am I arguing for? This extremely and no doubt eloquent supporter of the use psychotropic drugs, is a balanced appraisal, a balanced scientific appraisal here, not necessarily raving passion. What we need here is something honestly is about looking at the truth and denying all this. What we need to do is avoid straight forward blanket rejecting of either argument on either side.

The author of that statement is a radical activist psychiatrist known as Dr. Richard Bentall himself. This book is what I regard in many ways as the U.K. equivalent of Dr. Breggin's book, is a superb book. I advocate and strongly recommend all of you read it. Buried in here is a central argument. These medicines if used at the heart of a much broader understanding that allows people to look at their souls, their spirits, their relationships, work, life, living in society that respects and values every single one of those citizens, then these drugs can be used, and they can be used for good as well as for harm.

More harm, more good? I don't know how to balance that one, but my gut feeling in my day to day clinical job and my experience in my 20 to 25 years as a doctor is there is good in there. To label me as a lobotomising rocket propelled grenade launcher frankly is unhelpful, unfair, and dishonest.

Peter's book is a book about remarkable compassion and concern. Leaving aside his obvious anger and his use of unhelpful examinations that misleads us, it's a book that he stresses by making an utterly individual human value to every single patient that we see. There's nothing new about that, Hippocrates told us that years ago. Also what did he tell us? He tells us that the truth can come from our understanding of the problems of the mind will come from the brain. The brain, mind you is a squishy thinking bag of molecules about the size of a bar sponge dipped in margarine. Shakespeare's central nervous system wrote Hamlet. My central nervous system chemicals loves it's mum. It's a complicated thing, the idea that somehow my love for my mum is a meta-phenomenon and has nothing to do with chemicals is frankly nonsense. The mind is the brain, chemistry is solid. Anyone who thinks other wise is frankly wrong.

[Random Outbursts From Audience: Indecipherable.]

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Mark: Let me help demonstrate this point with a very simple image. I want you to look at this slide. [Laughter] What you will see when you stop laughing and listen to me seriously, is a fact that there is either two faces or a vase -- no great news about that. Now notice how difficult it is apprehend with some degree of fullness, both of those images. You can see the faces very clearly, you can create in your mind the wholeness of the faces. You can see the vase clearly you can create in your mind wholeness the vases, the one single vase. Try now if you can to hold both of those images in your mind at the same time and create that same sense of completeness of both of them at the same time.

It is very hard to do. The fact of the matter is that human beings have this desperate need of certainty. When confronted by complexity or an attempt to hold two different images in our minds we have to lean on one side or the other. We are hard wired, our brain, our mind call it what you want. So look at the wholeness and we have to try and create something else. What we see here is very difficult. What we have here in understanding the mind, drugs, versus toxicity. Frankly is a similar conundrum to the one shown up by this illusion. The truth of the matter of course is Peter Breggin is right, and the truth of the matter is that I am right. We are both right in different ways. What we really need, frankly, is not to throw out the benzodiazepines, which do remarkable things in short term crisis. We will not throw out mood stabilisers for people who lives are crippled by bipolar disorder. We're not going to throw out Neuroleptics we should not throw out these things, babies with bath water. But no more than we should throw out the need to understand, cherish, and value the significance of the pain and suffering of every single one of our patients.

More harm than good? I really don't think so. More good than harm? Yes, probably. And it's easy as I've heard from these people giggling this afternoon, to boil it down into this angry snarling sarcasm. But, frankly I don't think that that is a mature or helpful way to take this argument forward. There are a lot of people out there who are suffering, I mean suffering big time. I know, they're my patients, I do my best to help them. Frankly, I think saying we're going around poisoning and lobotomising these people is doing more harm than good.

[applause]

David: Ok we move on to the seconds now, and seconding Dr. Peter Breggin we have Dr. Joanna Moncrieff, Senior Lecturer In Social And Community Psychiatry at University College London and honorary consultant psychiatrist with the North East London Mental Health Trust -- Joanna.

Joanna: Right, thank you. Mark Salter's talk made me think of quotation that's in Andrew Schole's book, which I can't tell you word for word, but I'll paraphrase. He's talking about how doctors, psychiatrists as doctors want to help their patients -- of course they do. The trouble is according to T.S. Elliot, some of

the greatest harm is often done by people who believe they are doing good.

[applause]

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But before the era of modern psychiatric drugs, psychiatrists believed that they had some effective psychiatric treatments. They believed that they had Insulin Coma Therapy, which was thought to be highly effective, specifically in schizophrenia. It's now known that it was not effective, no any better than just giving a placebo and its mortality was a staggering 5%. They also of course had ECT, [Electro Convulsive Therapy] which was thought to be highly effective in mood disorders, particularly depression and some people still think it is. I don't have time to go into the evidence about ECT, but I think there are severe doubts whether it is effective. Certainly no one shown that it can be effective after it's stopped being given, and we know that it causes cognitive impairment while it's being given, and disorientation.

So what I would like to suggest is, that in the same way psychiatrists were able to convince themselves that things like Insulin Coma Therapy, ECT, and frontal lobotomy were effective. They have also been able to convince themselves that the new generation of drugs are effective.

So what about the evidence that is supposed to back up these convictions? I'll just say a few words about anti-depressants first because most of the debate has focused on Neuroleptics. What the research shows on anti-depressants is that basically there is only a very, very small difference between the effects of anti-depressants and the effects of a placebo. There are many ways this difference could be produced. For example, trials on anti-depressants are not properly double blind -- people who take anti-depressants can tell they are on an active drug, because they have physiological effects. Most people who go into trials want an active drug, and there for you're going to get biased, because of expectancy effects. As well as that, anti-depressants cause a state of intoxication and following the same sort of arguments that Peter Breggin was making, this state of intoxication may itself dampen down feelings of depression. It may distract you, if you're struggling to stay awake and struggling against the intense cognitive impairment caused by a full, supposedly, therapeutic dose of the Tricyclics. You probably haven't got much energy, thinking capacity left, to focus on your problems, at least temporarily. Also, most anti-depressants have sedative effects, depression rating scales have lots of items like sleep difficulties, tension, anxiety, that are likely to respond to these sedative effects.

In conclusion, really we don't have any evidence that anti-depressants have a specific anti-depressant action. Does it matter? I think that the epidemic of anti-depressant prescribing is concerning not only because of the side effects that are well known about, because of suggestions that they might make people suicidal. But I think that the most important thing is the psychological impact. That if you tell people that their problems are due to a chemical imbalance and that the solution is a drug -- you are actually undermining people's confidence in themselves, in their own ability to overcome their problems, and I think very likely making people more vulnerable to relapse because of that. Because people don't learn that they can overcome their problems themselves.

I'll just say a couple quick words about Neuroleptics. I don't want to say much about the short term effects, but my concern really is about long term use of Neuroleptics. Many, many psychiatric people who have psychiatric problems are put on these drugs long term. Anyone who has a psychotic episode, especially if they are diagnosed with schizophrenia, is told they have to take these drugs for at least several years. The evidence to support this recommendation is severely flawed and that's because psychiatrists have ignored discontinuation problems. That what long term trials show -- if people have been taking Neuroleptics for a while and then come off of them, especially suddenly, there are a number of problems. They might get withdrawal syndrome, part of that withdrawal syndrome might even be a psychotic episode. You can show that, there are some case studies of normal people who've been on similar drugs like Neuroleptics who get psychotic when they stop them.

There's also evidence with anti-psychotics and with Lithium in particular, that when you discontinue these drugs, you become increasingly vulnerable to a relapse of the underlying problem. And your vulnerability is raised above what it would have been had you never gone on these drugs in the first place. So what I think the evidence which is supposed to demonstrate that long term use of these drugs is effective, really shows is there's a huge iatrogenic problem. That we're actually creating recurrent disorders and this is due to discontinuation problems in many cases.

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David: Ok, thank you. Seconding Mark Salter we have Trevor Turner consultant psychiatrist and clinical director in the city of Hackney and senior vice president of the Royal College of Psychiatrists. Trevor.

Trevor: Thanks very much for this. I hope that going in as 'tale end of Charlie' won't be too difficult for you. I'll try and sum up some of the arguments that we are making, and I'll try and focus on some key points particularly on two or three points. Especially some historical facts, the nature of how the brain works, and grows,

and thoughts about the myth of perfection or ideal states. Because I'm afraid we don't live in Eden, we live in a world where many people are dreadfully handicapped by dreadful illnesses. We take the instance for example diabetes; insulin can keep you alive. Until Banting and Best discovered it in the later part of the century people died within the space of three or four years, now people live very good lives. Well then dreadful things gradually start to happen, because the illness progresses despite the insulin, in thirty to forty years down the track. So of course, Joanna's argument about the problem when you go on with drugs. Well of course, the reason why is, there's an underlying illness that's progressing. And our ability to arrest this illness remains impaired; we are limited in our therapeutic armoury.

Peter mentioned something about rooting for a football team, and it reminded me of yesterday -- I was at a funeral when a man had been rooting for his football team very happily for over 30 years, supported a local club, liked music, all that kind of stuff, looked after his mother, his elderly mother, died at the age of 78. This man was sent to hospital in the 1950's with dementia, but then as the priest pointed out, thanks to new medications he came out of hospital, and then spent the next 30 -- 40 years living at home, looking after his mother, watching football, rooting for his football team, enjoying music, and living a very normal life. The type of dementia he had was what we used to call dementia praecox, which was the old term for schizophrenia. Part of the change of language was the view towards but it is actually what was meant by introducing the term schizophrenia, which was used by Bleuler at the turn of the century.

I just wanted to get that out as sort of a starter. Can I also mention a quote from Dr. Frank Ayd from the 1970's, about the pre drug era. This is the pre drug era and he's talking about. This in 1970 "An attitude of pessimism and despair towards mental illness was prevalent. Within the bare walls of isolated, overcrowded prison like asylums" as Peter's mentioned "were housed many screaming, calmativ individuals, whose behaviour required restraint and seclusion. Catatonic patients stood day after day, rigid as statues with their legs swollen or bursting with dependant oedema. Others were incessantly restless, pacing back and forth like caged animals, nurses in attendance spent their time protecting patients from harming themselves and others. They tube fed people to sustain life. Even though trained to be therapists, they were forced to function as custodians in a hellish environment where despair pervaded and death offered the only lasting respite for the suffering changes." I think when we think about the world as someone who might not be who they are. A world of possibly someone with chronic severe mental illness such as schizophrenia, and this by the way is Max Ernst "a man who can see another"; 1993. In a sense I'm trying to give you an image of the different faces of people under this dreadful illness and how it effects you.

This is called "Raving man chained". I just studied in the Tyas House Asylum which is a primary asylum for England, Sussex, 600 patients and I read the books from 1853 to 1890. And one of the major tasks of the nurses in that asylum was to force feed people, was to sedate them with hot mustard baths, and some people got better certainly. But to watch people die from syphilis of the brain, cured now by some anti-biotic. And about a third of the patients constantly grimaced, muttered, and became restless, but do you know what happened to them? They developed Tardive Dyskinesia; did they have a single dose of a Neuroleptic? No. It's been published and there are other studies for example 1921 David Cooper the Anti-psychiatrist refused to give any of his patients any anti-psychotics what so ever, and when followed up twenty to thirty years later they had the same instance of T.D. as patients on medication. A further study of Monsoon and Medrets carried out in India a couple of years ago, many patients in India don't receive any medications at all, and you think "Hey! How wonderful they're free to live their lives." But the same number of people had Tardive Dyskinesia in Indian patients who had no medication as those that had had medication. The difference was the ones who had medication were on the streets.

This is quite a wonderful thing -- James Tilly Mathews and the air loom machine. This was described in a wonderful book by Michael John Hasden in 1805 of a complex delusions of a man who clearly had a severe schizophrenic illness, indicating that this illness has been around for quite a long time, it's not a product of modern civilisation or eating Kellogg's Corn Flakes even.

You can see, this is actually the history of the asylum in England. If we go to the left, they built asylums, they built them. There were Lunacy Acts, and world wars -- but nothing can stop the rise of this monstrous caging of impossible to manage people.

I've seen the insides of asylums, I've heard stories of what went on. There were some good things and some bad things but essentially they were in the words of Andrew Schole a sociologist "Museums of Madness". Somewhere around the 1950's as you can see, the numbers start to come down, moving towards community care.

What's the reason for this? Well Chlorpromazine was introduced in 1954, but I don't think that was the only reason for this. I think it made it possible to do things, it changed zeitgeist of the open door movement -- normalisation the notion that these people are not to be locked up and put away. Even though we live in a government now, that has a risk management and public safety -- terrified of public agenda so you can't even have a tea party on the Westminster lawn. But you can't take away the fact that this all the intents of open door normalisation went hand in hand with the use of medication.

Let me show you a couple simple slides and boring graphs of how medication works. Number one is a depot injection. The active one is the alpha, the beta one is the placebo at the top, there's a big difference, a 50% difference in symptom scores over the course of weeks when given these medications. This is a fairly traditional study.

Relapse rates after stopping anti-psychotics, if you stop it gradually. Let me show you a picture of a brain, just to say that actually hallucinations, delusions, thought disorders, the dreadful symptoms of schizophrenia, they're not just of the imagination, they're abnormalities of brain function.

I can't show you a picture of a brain lighting up, I'm sorry. I'd like to show you a picture of a brain lighting up. I mean PET scan lights up when someone is hallucinating, when their brain lights up on a PET scan. It is a real illness, it is a brain illness, we have to treat it with medication. We know it's not the end thing, we know they're not perfect, but it's something that helps people communicate with us. It gives us a handle in to the psychosocial interventions and personal contact and the ability to talk.

One of the most tragic statements I've ever heard from one of the overcrowded acute wards that we all have to deal with because people are not prepared to fund mental illness. As soon as patients can talk to us, we discharge them. They come in mute, confused, perplexed, frightened. As soon as they can talk, any kind of sense -- they're kicked out into community care. Because there's a shortage of funding. Medications help them to some degree, but we know that psychosocial is much more important.

Finally, I would have shown you a slide of a man crawling through the desert, sweating away, his tongue hanging out, the sun beating down, and he's saying to himself "counseling&hellip; counseling&hellip;". Counseling can help, talking to counselors can help, but it can't help people who can not think straight for themselves. I ask you therefore, to think very seriously about this notion that psychiatric drugs do more harm than good, because if you're saying that, you're asking to go back to the terrifying era of that one terrifying thriller film by Warner Brothers of the Snake Pit neglect, abuse, and so forth.

Just to give you an olfactory sense of what it was like in the pre modern drug era, I have got here a little phial of stuff called Paraldehyde. Paraldehyde is horrible, it's a kind of anti-convulsant, and it's the only thing they had in the 20's and 30's to calm down furious, very angry, enraged people. I'll pass it around, have a sniff. Thank you very much.

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[applause]

David Brindle -- the man at the back first.

My name is Donner McCloud, I want to put to Mark and Trevor. Firstly you're responding to distress by trying to be belligerent, you can make anybody in the world happy by tampering with the brain in some way, in theory you can do that. Ok, there are all consequences as Peter says, but in theory maybe you can do that. I want to contrast firstly the method of drugs, everything is physical, this conversation is physical biochemical. But when you're actually giving people drugs, you're actually cutting interpersonal communication you're not communicating with the person like we're doing now.

I've actually supported people through psychotic states. I'm not a mental health professional, I'm from your hospital. I'm from Hackney. People were on Haloperidol, we actually got them off the Haloperidol, we've set up support groups around them and brought them through. But that's a biological process, we weren't using chemicals. There's a more appropriate biological process than the use of chemicals. I just like to also ask Trevor saying about the is an illness, this is like the abnormalities of function, is there any scientific, objectifiable, or verifiable kind of evidence of that, if you can actually verify.

Irene Clayton: Hi I am Irene Clayton, Manic Depressive of this term. I'm of Mind and we are user run, user lead. I would like to say thank you very much to Peter Breggin from a very personal deep heart felt thank you for giving me hope, because on this side of the table I don't get any. On this side of the table I don't see a recovery model, on this one I can recover. The more iniquitous part of this, the deeply iniquitous part of this whole debate is the medical model the one that says there's something wrong with my dopamine or my serotonin or what ever it is pathways, is due to something that's wrong here.

And therefore nothing to do with whatever trauma or abuse I might have suffered in my past. And therefore and this is why they're still desperate to find a genetic cause for my illness, society is exonerated. So long as it's something in my brain, society doesn't have to worry that this British wonderful society I live in, is the worst society one of the worst I know for child abuse, let alone abusing women, let alone for abusing everybody, I'm afraid except for certain middle class white men.

Odi Artist: I would like to stand up, my name is Odi. I am from Brighton, I am diagnosed schizophrenic. But I am not. I am a good artist as you can see what I've done. People have a line of personality. By this I mean, if you treat people with love and understanding, then there will be no need to think of helping people with medication. But when you think about holding the mind, or trying to justify how the mind works, we all came from different backgrounds. You can't use the same medication that you used on me, on that kind of person, that can react into many kinds of things.

I'm a shaman, I'm an African, I'm a shaman, I've been a shaman, and a doctor too. I can understand at the same time understand how the mind and how... get into the space or get into the mind of people, which you don't believe if I say something like that. Say spirit or say my ancestors. But if you can look back into history on how black people seeing slavery, seeing how they are generally being put down, or seen what is nigger and all these things. So why can't people see how the institution has made people mentally sick and again in trying to help people without their own understanding by pushing needle into your hand. That's what I wanted to say.

Susan Wolfe: Hi I am Susan Wolfe and I am from Laramie Wyoming in the States. And I am a social historian and I have studied and done primary research in the States and territorial mental asylums in the late 19th century and early 20th century. And I've studied social records of young women who were locked away for having sex with their boyfriends as late as 30's, 40's, and 50's. Of men who were locked up in asylums for masturbating, children at age seven who were locked up for life for masturbating. So I'm sorry Trevor you can not tell me, you can not show us pictures of people from another century tied up in chains and talk about how the drugs of this era have freed them from the chains. Those are two separate&hellip; I'm &hellip; inarticulate with my response to your argument because it makes no sense, it doesn't follow. That if you lock everyone up in chains they are going to have an emotional response to it. If you take anyone's personal freedoms away and put them in horrendous conditions, there is going to be a negative response to it. And so to justify the use of these drugs and say how much better people are then they were in those days when people were locked up with those things, is not an appropriate argument.

Man: that would be exactly the same as shooting the patients.

David: Trying to keep the balance is there anybody who wants to speak against the motion. Right, that gentleman right there.

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Terry Williams: It's true I'm afraid; I like many people here have a very sincere interest in this debate. My name is Terry Williams, and we have a son, our third son who has been diagnosed variously as schizophrenic, bipolar disorder, manic depression in those days. So for 18 years we've been trying to do what we can to help our son, and I must say when I read Peter Breggin's book Toxic Psychology I was bowled over by it. Because it said to me, the experts here with impeccable credentials are disagreeing. In any other branch of science that does not happen, and that made me understand that psychiatry is not a science. That's for sure. However over those 18 years we have&hellip; because of Peter's very instructive and well researched book, we have agreed with our son, that least medication equals best. And if least means nil, that's great, and for some periods it has been nil. None the less there have been relapses and when I say periods, I'm talking about two years, two and half years -- no medication what ever. However still relapses, and these relapses have become more frequent, so the question that arises now is fine, Peter's critique of the toxicity of these pharmaceuticals &hellip;

If psychiatry is not a science, then surely what we must do is use every weapon in the weaponry, and if that means psychology and it means some medication. Then certainly some medication may help. More for the research, but I would like to hear from Peter if there is a mass movement for this, just as there seems to be a mass movement to give medication.

David: Any more speakers against the motion?

Lady in Audience: I want to say the drug company marketing is extremely good for my shares, but I must admit this, I'm sorry. And also I would like to know a little more about the actual marketing of these drugs -- because it's very aggressive indeed, and despite people are supposed to be healthier it seems to me more people are being drugged on these drugs and becoming ill. One of example of this is diabetes, that needs help, and you need insulin. And it can be controlled just like the psychiatric drugs control... . A little at the right time controls some people.

The debate here is &lsquo;do psychiatric drugs do more harm than good&rsquo; -- and the way they're used they do. That is the point. Occasionally they might help someone through a trauma. They might help for a limited period of time, as sort of the case we've heard before. But what we've never had is a full physical examination of that patient to see if they're sensitive to any food&hellip; I know of a kid on Ritalin because he can't tolerate egg whites for goodness sake. As simple as that, that can be worked out without putting a kid on Ritalin which is an extremely dangerous drug. The marketing, how aggressively is the marketing in the Royal College of Psychiatry please?

David: Ok, we'll come back with that. Any more against the motion ?

Male Nurse: I'm Ray Rowden, and I used to give Paraldehyde to patients in a 1,000 bed mental hospital in the early 1970's as a nurse. I remember doing it, and it came out through the skin and the whole of the room stunk. I'm not sort of saying I'm totally pro the arguments on the other side of this debate, but I do have a lot of friends who have used medication who have experienced different experiences. And I find that if people can feel they can have some sense of control of their medication along side of other choices, diet, exercise, leisure, friendship, work, education, people I know who use services have some sense of choice and freedom about when they choose to use. Can I have a drug holiday please? Can I have a planned period where I might come off of this and try a different set of choices? I think that's a wise use of medication. To say it's all harmful I think, is not on, I think if you help people make their own informed choices that support them on that kind of journey, some of these drugs can help. Because I can remember these old asylums of a 1,000 beds and I wouldn't want them back.

Lady in Audience (again): But can I ask in your work as a nurse, how often were people given a complete physical examination before they were started on the drugs, and how properly and comprehensively monitored on those drugs, the physical damage because they do a lot of damage.

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David: Ok, thank you. Gentleman there, yes.

Cliff Bollard: My name is Cliff Bollard and I came with my son, along with my wife of about 15 years, sadly he committed suicide two to three years ago. I really don't want that to influence what I am saying, but I just wanted to give you an illustration. You guys may be experts in schizophrenia and manic depression but I, and my wife, and my colleague are experts of the illnesses of our sons. We see the symptoms and we see the side effects of the medications not just 20 minutes every so often but every day of the week. One of the points I wanted to make is this. When my son died I said to the psychiatrist that I thought it was possible that his suicidal ideation would of started as a result of surgery because frankly before that he had never talked about suicide, and she denied it categorically. She said there's no chance, I wasn't seeking a causal connection, and I was merely suggesting that it was a possibility, but it was dismissed. And this is a reflection of the attitude of the mind. In fact within a few weeks there were stories coming out about it. But I want to hasten on, because we belong to a very active carers' group in Hertfordshire and our view in fact from direct experience is that frankly the efficacy of pharmaceutical treatment of serious psychiatric illness is not very good. That is our experience. We've shared it with other groups who agree with us. Mind we think, say yes you have a point. We've made a very positive suggestion to the government and also to the Institute of Psychiatry, we said it's about time that you asked the users and carers' for their views of the efficacy of treatments and its side effects. And of course no one wants to hear that, and there's very good reason for it I think because probably they're very afraid of the result. But until we know what the real situation is in the real world, to my way of thinking we'll never make any progress.

One very other quick comment, our observation of modern psychiatry is it looks that way [Pantomiming tunnel vision], but it doesn't in fact look that way [Pantomiming open vision]. Clinical trials are the God and frankly as far as psychiatric medicine is concerned there must be a big question over clinical trials. Because as a psychiatrist said to me that 30% of his patients benefited from Olanzapine. What about the other 70%? And of course, he couldn't forecast which of the 30% in fact would benefit, so this puts a question over the scientific method. But what has been neglected is in fact the experience in the real world. The effect of for example of nutrition, that's just one example, the effect of talking therapies. But the vision is tunneled and what we really need to do is open it up as it were to all the other possibilities that there are for treating these dreadful diseases.

Bob: I'm going to try and get this machine to do what I wanted it to do, but it would seem as it is already temperamental. What I want to say is, that the drugs dull the patient's mind, which is why they're given, worse they drug the doctor's mind. My book here, is Unsafe at Any Dose. The reason I'm now happy with that title, which I wasn't ever so much to begin with, is because it deflects the medical mind from other approaches to this problem, which as we've heard is a quite severe one.

What I want to do now if my machine will cooperate even a slight degree, is to show you a very painful video. It's only two and half minutes, if it once goes we'll be in business. Now what this shows is a patient suffering acute psychosis, I apologise in a sense because it's very painful to watch. But this is the reality as we've heard of mental illness it's extremely painful or can be extremely painful. And what I want you to look for -- this patient starts off by saying that she's full of hatred, she gives very clear evidence of thought block, thought disorder, she can't string a sentence together, she is paranoid, she's clearly deluded, she thinks she's going to die, she's hallucinating, she's in a great deal of misery, she's in a lot of pain. She's actually weeping, and here she is &hellip; [trouble with the machinery]

David: Bob a question has been asked about the precise nature of this client, and the consent issue I think. Can we just

ask about&hellip;?

Trevor: Has she given consent?

Bob: Yes. She had given full consent. She asked if she would be blown up on a full screen  
[Video of Woman weeping]

Bob: She said she is dying, I&rsquo;m asking her why. She&rsquo;s thinking about it, very slow thinking as you can see.  
[Video Continues&hellip;]

Bob: So this is in the same interview.  
[Video Continues&hellip;]

Bob: &ldquo;My emotions are telling that without my Dad, I&rsquo;m dead -- this is WRONGGGGGG. Say that.&rdquo;  
Hatty: &ldquo;My emotions are telling that without my Dad, I&rsquo;m dead -- this is WRONGGGGGG&rdquo; [giggles]

Bob: Now that is within half an hour. What I want to say there is that is talk therapy as it should be done, uh&hellip; that is the way I do it I should say. If you are writing prescriptions and relying on a chemical approach, then you&rsquo;re going to ignore these three factors I&rsquo;ve highlighted here which is: Ignoring the Fear, Ignoring the Mind, and Ignoring the Software. If it&rsquo;s not a hardware problem, then it&rsquo;s a software problem, and the way to remedy a software problem in a disturbed mind is to talk, but you have to talk with the expertise as I tried to demonstrate a bit of there. I might say, I&rsquo;m a consultant psychiatrist and I very much enjoy my work because by talking to people about their earlier traumas or in this case their earlier mal-attachments, you can in fact get really dramatic results and sometimes the technology can show that. Thank you.

Lady in Orange: I apologise I arrived late. When I read Peter Breggin&rsquo;s book on Toxic Psychiatry I had already been well on the way in going to autism conferences where individual biochemistry is absolutely essential in recovering these young children and older people on the autism spectrum as well. I would like to understand why the clinical studies and the effective results that psychiatrists such as Abraham Hoffer have achieved in recovering schizophrenia why orthomolecular psychiatry has been marginalised and whole idea of a person&rsquo;s individual genetic biochemistry is totally ignored in the field of psychiatry, in one size fits all drugs. If he has a diagnosis of schizophrenia then it&rsquo;s two anti-psychotics two strikes you&rsquo;re out, then it&rsquo;s Clozapine. I don&rsquo;t understand how every other health issue takes into account a person&rsquo;s individuality and this isn&rsquo;t the case in psychiatry.

David: Ok, thank you. Um, yea the hand there and then the gentleman in the back.

Lady with Black Bonnet: I am a mother of a young man who&rsquo;s been diagnosed with schizophrenia several years ago, at the age of 15 in fact. I think one of the most terrifying things I&rsquo;ve found about contemporary psychiatry is that if a patient starts to deteriorate on medications year after year, including clozaril they are then seen as chronic treatment resistance and there is no question from the psychiatrists that my son&rsquo;s seen that this could have anything to do with brain damage from medications. I&rsquo;m watching this process with absolute horror, and the quantity of drugs he&rsquo;s been on maybe 8&hellip; 9 different anti-psychotics, anti-depressants, Benzodiazepine, mood stabilisers, from being a coherent intelligent sensitive young person, he&rsquo;s now almost like someone with severe dementia.

He can not speak, he can not do anything. He&rsquo;s only 26 and I&rsquo;m at my wits end about how to help him, where to go, so somebody will give him a chance and see how he is, off drugs, withdrawn gradually. And then if it&rsquo;s too late, or if he can&rsquo;t be helped I of course will go along with any drug possible or any form of help possible. But it&rsquo;s never been given this chance, once people get the label of schizophrenia, they are in a prison of drugs, of care in a community, or in a hospital. And one slight action like throwing something, breaking a vase, or shouting in the street or whatever, and that&rsquo;s it, straight back into hospital more and more drugs, and these sometimes isolated incidents, are never forgotten, even if it&rsquo;s two or three years back. &ldquo;Oh well it&rsquo;s a risk in the community, we can&rsquo;t ever have him off drugs&rdquo;. This is horrific for someone who has never harmed someone in the community or who has never self harmed, and that is my nightmare.

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David: Thank you very much. That gentleman right there.

Michael Corry: My name is Michael Corry, and I am from Dublin and I&rsquo;m a psychiatrist. I&rsquo;ve trained in other branches of medicine, and very fortunate of having trained in obstetrics, I did my paediatrics in England and was trained in Liverpool, and I worked in Alderney, and I worked in Africa as a surgeon. I then came back to Ireland and I studied psychiatry. The one thing that stuck me with psychiatry is that there is fundamental fault line running through. You never get physicians, you never get cardiologists, you never get people actually criticising its own profession.

The reason there is an anti-psychology movement has to be looked really, really seriously. There is a whole vast

constituency of people out there. Go out to the internet, there are gazillions of sites of people who are seriously worried about the way psychiatry is conducting itself. You do not get that in any other branch of medicine, and I have qualifications in three other branches of medicine. You don't get that. And this flaw has to be recognised, from my own perspective and we're all sharing interpretation, and I'd like to get my own view and I'll be very, very quick. We're not dealing with a disease, and this is the issue, we're dealing with something existential. We're dealing with something about spirit, we're dealing with something that is psychosocial.

Take a very, very simple example, depression which is sweeping throughout the nations throughout the world. The pharmaceutical companies want to make it a disease, they want to make that an endless threat. If you loose your job at the Guardian, and you have to meet financial commitments. Very simple example, you run into your financial problems, and you go into your family GP, and he prescribes an anti-depressant. As you're about to cash it in to get your prescription, your phone rings and you are told got your job back and you got promotion. Your depression is going to lift, and that does not happen in any other branch of medicine. Whether it's cystic fibrosis, or multiple sclerosis, so we're not dealing with a disease. I'm a scientist, I've trained in medicine; I've no agenda, I'm interested in scholarship. We have to take on board there's a fundamental fault line running through the practice of psychiatry.

David: Ok, thank you. Just about 15 to 20 minutes to go, if you can keep the contributions as brief as possible we can get in as many as we can. That gentleman right there has been trying to get in for quite some time.

Peter Bennet: Thank you, Peter Bennet and for thirty years I've been a police officer. So I've dealt with an awful lot or come face to face with a whole range of people with so called mental illnesses or ill health. I've seen those on drugs and then I saw a rapid increase in the number of people, particularly young ones with pockets full of various drugs, prescribed drugs, not so much the other ones that often gets the blame, you know for things like asthma. To jump ahead, I started looking at other factors, and looked into the background of psychiatric treatments going way back 100's of years. And there's one thing that kept on niggling me, it's been mentioned tonight several times, it's a four letter word, called diet or food.

And just as an illustration and a side track if you forgive me, in America in particular they have the Food and Drug Administration, food and drug both four letter words, actually going together. Food comes first, but the emphasis on concerns diseases and treatments particularly in America and that's repeated over here is -- drugs come first. I find that, and I work with people, particularly young people and they get ASBO's and a lot of them are immediately, first or almost first consultation with the GP and then perhaps some of them going on to consultants are put on the various drugs we've been mentioning tonight. There is no proper assessment of them, there's no routine consideration of other factors such as food, diet, nutrition. I repeatedly find that, and yet underlying all mental illness and a lot of physical illnesses there is a nutritional element. Now it's not just a matter of identifying those and finding them, it's usually some concomitant deficiencies in essential minerals, I will just quote a couple of them...

David: No, your point is clear and we really must move on. I'll take the hand here and the lady over there please.  
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Blonde Lady: Yea, I think there's a practicality about all of this in that when a person becomes very mentally distressed or emotionally distressed, they may find that they are unable to work. In this country, and I presume it is much the same as in America in order to get any kind of income if you can't work, you have to be signed off not signed off as distressed but signed off as sick. So you've got to go to a doctor and say, 'I'm sick can you sign me off of work, so I can get the benefits I need to live on?' Not only are psychiatrists prescribing drugs, but they're also determining whether you get an income or not. That's how it works in this country, and people are in a trap... Many people with severe mental distress are unable to work for many years, and we are virtually trapped by this whole situation we find ourselves in. You're literally railroaded into the psychiatric system and once you're there you're on drugs. I would like psychiatrists to appreciate that not only do they wield the power of getting people drugs, but they even wield power over our incomes and livelihoods.

Katherine Duncan: My name is Katherine Duncan and I am a patient at Maudsley Psychiatric Hospital in London. I was first prescribed Benzodiazepine when I was 16 years old. I am now 53 and I am still on them. I can not imagine how any psychiatrist can justify that. Of course I'm addicted to them now. Recently, in January I was changed from the SSRI I was on at the time to an SSNI a new drug Duloxetine. The side effect of that was, I could not sleep, I have not slept for more than 2 to 3 hours a night since January. So what did they do? They gave me Temazepam, to try and help me sleep on top of the Diazepam. I have tried asking to talk to somebody, no there's no psychologist available, you can see your psychiatrist in a few months. It's unbelievable and I totally agree with the lady who talked before me, that if I do not continue attending my programs at the Maudsley I will not continue to get the income I need to live on. So I feel I am in a catch 22 situation. I either go and I get the tablets or I have no income. I've now been a teacher with such a long history of mental health problems, I'm never going get back to being a teacher again. So because of an initial diagnosis, actually I don't even remember what that is. Right now they say I got bipolar

disorder, I've had so many diagnoses I can't even remember them all. Because of that, because of the number of hospital admissions I've had, I have now even been denied the opportunity to return to the job for which I am trained, and that is down to diagnoses that have put me in boxes and labeled me by psychiatrists. David: Thank you. Peter and Mark will be formally summing up at the end, I'm just going to ask Trevor and Joanna if they want to just at this point say anything in reply to some of the points that have been raised.

Trevor: There are many proper points raised by people tonight, and I deeply sympathize with everyone who feels they've been badly treated or who's had a bad illness, because these are awful conditions to have. We know that. I entirely sympathize with the last person's point, we spend our time being forced to fill out DLA forms, stacks of them everyday, and we think "Why do we have to do this? Why can't the person just carry on, they're obviously in control and can't think straight or whatever. Why are they making us do it?" We hate doing this sort of stuff. 90% of mental health consultations don't take place with psychiatrists, but with GP's. Which is perfectly reasonable and a more holistic approach, and with regards to the issue about, which is a very important one. The Royal College of Psychiatrists and drug companies -- everyone agrees within the College and there's been a change in policy the last 5 years or so, actually it was inappropriate the amount of sponsorship we were receiving. Partly because no one else is prepared to fund research in this country on mental health, by the way, literally no one else. You can get more money for old donkey's homes that you can for looking after mentally ill people. And you can spend more time in parliament arguing about fox hounds then getting a new Mental Health Act through. So I entirely sympathize with all those points.

David: Ok, Joanna.

Joanna: I wanted to support Lynn's point about the politics of it all I think that's so important. Psychiatry is drugging children who find the school regime difficult, drugging people who find jobs over pressurizing. And instead of society saying "Hey! What are we doing wrong? Maybe our working environments are wrong, and maybe our school systems are wrong. What can we do about this?" We're labeling these individuals as ill, and giving them drugs and this is such an important point, keep in mind. And that's why the drug industry promoting these drugs, making them so wide spread telling everybody that they are depressed -- everyone they're hyperactive -- is so dangerous.

The other points is just to pick up on are the carers points, because I think it is such a difficult thing to answer. If the drugs aren't any good what on Earth do we do? And I really don't think there is any easy answer at all. I think we need to help people to develop to their maximum potential and to try and create an environment where they can do that. I don't necessarily feel that there's absolutely no role for drugs in that, but my problem is that the way they're administered at the moment, they're being given as if they're a cure as if they're going to change a person into a different person and they are going to correct some biochemical abnormality. And instead we should be encouraging people to be themselves, and try to maximize what they can do, and be proud of what they can do, and to be proud of themselves, and to come out into the world as themselves rather than trying to change themselves into something else.

David: Lets take some rapid fire points from people that haven't had a say so far.

Dark Haired Lady: Who is making the money out of all of this? They're forgetting all of this, they've just done a big campaign on stop smoking, stop smoking, why? Because they've invented enough drugs that you can become addicted to instead of a cigarette. Why didn't they stop smoking years ago and it's the same with bloody mental health drugs they're handing out?

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David: Next.

Sally: I'm a mother of a 32 year old man with Asperger's syndrome. For 14 years he was treated for schizophrenia. He was therefore tried on Neuroleptics and lots of other psychiatric drugs, none of which helped what so ever, and our experiences when the drug didn't work, they upped the dose. Then they added another, and then add another. Fortunately seven years ago, we found a doctor, to cut a long story short, he's weaned my son off all medications and has been medication free for six years. And I wanted to talk about misdiagnosis, and it seems to me that psychiatrists are not willing to share their ideas, or contact someone that is an expert in autism and I know lots of people that I believe are being treated for schizophrenia who are not schizophrenic.

David: Right, thank you very quickly now.

Man Dressed in Blue: From the University Hospitals of Geneva, evidence is highly suggestive of a causative role of atypical anti-psychotic in the induction of manic hypermanic symptomology. Gentlemen?

Young man: In any other branch of medicine, such as pediatrics or let's say cardiology or whatever you have consent you are allowed to say no, in psychiatry you can't.

David: Good point. Lady there.

Young Dark Haired Girl: If I had any honesty with my psychiatrist when I was first taken into hospital, they would've labeled me schizophrenic but fortunately something inside of me told me it was a really dangerous place and don't tell the bastards anything. My follow up point to that is that after 10 years, going through the drug chemical nightmare hell, I finally took myself off of all medications completely alone, and changed my diet, wheat, dairy, and sugar were my allergens and my life is completely different now.

David: That lady over there.

Old Lady: I have a very keen interest in the matter raised by our shaman friend, because of my own personal connections as it seems to me that an awful lot of ethnic minority people get diagnosed schizophrenic but all they're really suffering from is that fact that racism is a central issue 24 hours a day to them, to us it is peripheral. We hardly notice it, and if society would just accept responsibility and treat everybody decently there would be no problems arising and they're certainly not schizophrenic. They're simply being subjected to improper pressures.

David: We're going to run over by 10 minutes. That lady there.

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Woman Behind Man's Head: My sister, she's been in psychiatry, diagnosed with schizophrenia, and she told the doctor she wanted to do support therapy and they said no you can't do that, and I just wondered why it wasn't possible to have alternative therapy?

David: A couple more I think, that gentleman over there.

Irish Man: I'm a practicing psychotherapist and I'm from Ireland as well, and an ex-cop with an interest with human rights issues. And I think with all due respect to the debate, we are probably uncovering one of the greatest human wrongs in history.

I want to give you a taste of what I am saying. In Ireland in the 30's the most respectable institutions in our country being Catholic, were the priests and the institutions who we entrusted our children to in thousands. Those children now, it has been discovered, were being abused by priests. Priests who were trusted by a very compliant majority who were positively stigmatized by the then doctrine that was prevailing.

Presently the doctrine that prevails at the hands of psychiatry is the good doctor. In the institutions of good medicine, there are so called psychopaths, as there were in these institutions. I'd like to see someone do a trawl for psychiatry in the same way as they did a trawl for priests like they did 50 years ago and find out what shenanigans are going on, and what's going on in this institution. And most importantly of all, the agenda that sets out because it's a very cruel and like the African gentleman said "Bad medicine...", to say to someone and this is well known in Africa, "And you've got an illness and there's no recovery", that is bad medicine. That's being practiced by doctors everyday.

Man at the front. Yea, I was a part of a research study about Haloperidol and other Neuroleptics a few years ago. I haven't had to have it ever again. And I was just wondered if Mark Salter or Trevor Turner have ever actually had Neuroleptics and what they made of the side effects. Or whether they should actually be a part of the psychiatric nurse training. And the doctors I know who have tried it themselves are actually more cautious about prescribing it in the future.

David: That's an excellent cue for Mark to sum up his arguments for the evening against the position that psychiatric drugs do more harm than good.

Mark: Just a comment on that last point in 1985 I thought two and half milligrams Haloperidol... two and a half milligrams a tiny dose and I could frankly not respond to these questions quite frankly had I taken that today. I took Procyclidine because I'm a coward just in case I got acute dystonia -- one of the side effects of it, so I'm not joking, I know exactly what these drugs are like, it's like having a hang over that lasted for 24 hours. That was a very tiny dose. Indeed as I said I did, a two and half milligrams.

I took Lithium for a month. Well I must say I found it a very strange experience. To answer that question, yes.

Someone in the Audience: I think you've been unfairly treated and I know you to be a very good doctor. And drugs isn't what it's all about, and I know you work in the community and you work with a complex amount of cases and have a great approach to level of care.

Mark: The one thing that's fascinating listening to what's been said here this evening, I think I agree with

virtually everything I've heard this evening, to be totally honest -- that's come from the floor. And what it tells me about, frankly this is a matter of utter complexity that no one's got the right answer. And I'm still thinking right now, that the little tricky thought experiment that I asked you at the end to imagine that all of us are right, or that maybe none of us are right -- is the truth.

Of all the things I've heard here today however, I must say there's one guy that's impressed me the most, with a clarity of his vision, and that's this bloke here. [Points at Male Nurse] This guy said, "Look, given choice -- it's all about what you want." It's about giving you power to make decisions, and drugs are just one tool that may or may not be a powerful thing for you. They may be deadly, if used properly or incorrectly otherwise they may not be, but I think the real enemy here is polemicism.

I think our anger and our passion is getting in the way of this little thing. All over this country, there is an army of people, I work as part of it, where nurses and doctors, social workers, occupational therapists, mum's, dad's, rabbi's, vicars, milkmen -- we are a silent army of people that are trying to show love and respect to a large number of people who's suffering was rather cheesily portrayed up there on that screen just now. I feel pretty uncomfortable watching that.

I see it day in, and day out. I wouldn't want to go to that guy. I didn't like the way he spoke to his patient. I found that offensive. I personally feel that he snubbed... how do we work that one out? Simply resorting to notions of poisons in the body, frankly is a dangerous over-simplification.

Outburst from the Audience: He doesn't examine the particular culture of the person... so how can you suggest...

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Mark: Sure I don't take a full dietary history of every single person. The point is that surely all of us are right and have won prizes, it seems to me, and at the end of the day the essence, is as this gentleman was saying, [Points at Male Nurse] we have to give our patients the right to speak out as human beings and not as struggling victims. But, isn't our society a little out to lunch, and addresses us as victims and don't we look elsewhere for an expert who's going to fix us? And are we not shooting the expert, the messenger? When actually it's human nature, or rather our crazy take on it in western civilization that is truly at fault. Put it this way... Jesus, Gandhi, Nelson Mandela -- you name the sage from history... what do they do? They say give people respect. Do we?

[from the audience -- several voices in a chorus] No you don't!

Woman: Peter don't be too angry, he's such a sweet man.

Peter: I am proud to be called angry and to be in the same company of people called schizophrenic. It's another way of assassinating the word of whatever is being said. I want to address choice, there's a few things I want to address.

Choice -- psychiatry is the only branch of medicine that exists on absolutely not given choice to patients. If psychiatry did not have involuntary treatment, it would have collapsed two hundred years ago. The whole basis of psychiatry is civil commitment and now being linked to disability. So you have to take your drugs, or you won't get your disability. The entire house is built on brutality and always has been, sadly. We have now, in the United States something which is growing here as well -- outpatient commitment. Where if the doctor happens to agree with one of them, instead of one of us, you are forced into treatment. They come right into your home in the U.S. Do you have that here?

The second specific point I want address and how...

Trevor: The Royal College of Psychiatrists opposed it.

Peter: I presume that means you won't practice it, the law.

Trevor: I will practice that law if I need to save someone's life.

Peter: But you're interrupting me. The issue of respect should be so clear here about the nature of respect. What kind of respect is built into us as psychiatrists now with our current attitudes and training? That's an aside.

I want to address one scientific issue Tardive Dyskinesia -- the idea that it is caused by the schizophrenic patient. Oh my God! We have more science on that issue than on any other single issue in all of psychiatry. Maybe a thousand controlled clinical trials. I can produce trials when these issues came up, 10 controlled clinical trials on old ladies and men in nursing homes who have no psychosis who developed TD at the rate of 20% a year is what the aged get that disorder. Shame, shame, shame -- on attributing it to the patient.

Now for the most shocking comment of all, and that is in May of this Year I'm going to be 70 years old. Now, first of all there's a lot of important things about that. One, I've survived that long speaking truth to power, to use the Quaker phrase. More important, I've been in practice for 40 years now. I've never started a psychiatric patient on a psychiatric drug, although I am forever helping people come off of them. I've never had a suicide, I've never had an act of violence by one of my patients, and maybe six or five in my career have gone to mental hospitals during my treatment, unfortunately we didn't have havens to go to. They had to go to mental hospitals. Am I a mad magician? No. I just don't shoot people with drugs. It's like, if somebody comes to you in a state of conflict and you've got a gun, and they don't, and you're in a conflict and you're talking -- you can shoot -- you can drug, you don't resolve, you don't solve, you don't work with, you don't make contact with, you don't relate to, and you don't talk to because you can end it by saying the other person is angry and out of control, or schizophrenic or something else.

But the other part of being as old as I am, that is more interesting are these pictures that were shown, as archival -- I worked in those hospitals. I began my career in reform in 1954 -- the year that the drugs were coming in. They hadn't hit our hospitals yet, I was running, well, the first year I was a volunteer, the second year I ran the Harvard Radcliff Mental Hospital volunteer program. I was a college student seeing with open eyes things that later might get trained out of me. So when the doctor said ECT killed brain cells, I knew it would have been ridiculous. I hadn't trained been yet.

But more important we forced the superintendent to allow us to develop a case aid program. And here I want to talk about this for a few moments if I can, about therapy and help. Because I got started as a helper. We convinced the hospital to allow us to have fifteen back wards patients -- so sick even we couldn't hurt them. And our only supervision was one courageous social worker for two hours a week for all of us, and we were given these patients just to relate to. We got thirteen out of fifteen out of the hospital within the first year. This is supposedly incurable backward patients that hopefully we wouldn't injure.

How did we do it? We tried to figure out what they needed. Some needed companionship, some needed to re-hook up with their families that they hadn't seen in ten years. My particular patient had a phobia that he'd have a heart attack if he walked or if he took little steps. So, I gave him little baby steps to do and so on. Literally that's what I did as a volunteer, talk to people about their feelings. This program became a part of the Harvard curriculum, and we got credit for it after I left. It became a center piece of the president's report on mental health and rehabilitation in '62. But by '75 with the biochemists coming fully in charge of the profession, a program like that had to be killed because it rejects the whole basis of the profession.

Now was this new? No. In Great Britain you have the whole 18th Century period of time and even earlier for moral hospitals to the Quakers -- they didn't even have physicians in the beginning. There's been intensive studies of that period of time, Bachoven and others, books, articles -- their rate of improvement for the worst sorts of patients coming in was almost everybody leaving the hospital.

So let me tell you, it's not schizophrenia that made people deteriorate in those hospitals. As volunteers we had to debrief each other after four hours in the hospitals. People got raped, beaten, and starved, and if that didn't work they got lobotomized, they got shot, those horrendous conditions were produced by psychiatrists not by schizophrenia, but by psychiatrists. The same conditions did not prevail in the moral era in the moral hospitals by Tuke, Pennel at least began to get rid of them in France, but certainly not the great liberator that the Quakers were in this country.

We have lots of examples about what people need, about the moral support, the social support, the family support, the economic support. Which is what I try and do in private practice. But which we could do far better if we were allowed to have havens and we've have had them. We've had Lauren Mosher and others produce voluntary havens, supervised by one social worker. The criteria for being a therapist was that you didn't judge people and the rates and controlled clinical trials -- these are controlled clinical trials -- could carry into a residential home with ordinary folks helping you, dedicated to your liberty and to your developing of your relationship and getting over being crazy. The rates of improvement were better than in mental hospitals and since they weren't getting Neuroleptics they didn't get Tardive Dyskinesia at a rate of 15% to 20% after three years.

And finally -- I mean obviously I can do a workshop on this issue, all these issues -- someone brought up the user carer model. It's one I deeply believe in. Judy Chamberlain and other Survivors of Psychiatry as they call themselves, have built models that have worked of people who've been labeled and gone through the system helping other people. Some combination of dedicated professionals and consumers is needed. The current problem is that every time they develop, they're killed off. If you want to stay in touch with what people are doing, you can go to the web to [www.icspp.org](http://www.icspp.org) an organization I founded in 1972 with my wife, and that my wife turned into an international organization, about 15 years ago and that I no longer run. I don't have anything to do with it, I gave it over to younger men and women to run, and they're actually doing it. And that's a group that among other things seeking the humane, the caring solutions of which there's already a tradition in moral psychiatry. And I volunteer to come back to Britain and consult with free, with any consumer user group that manages to get the funding and the wherewithal to actually set up an alternative approach.

David: Thank you. Well I'm starting to detect the mood of the meeting. We've had a formal debate, so we'll have a formal vote. And the proposition is, and it is a very bald proposition, bear this in mind &ldquo;Psychiatric drugs do more harm than good.”. All those in favour? And against. Thank you, and abstention.

[about 85 for, and 3 against, with 8 abstentions]

Bob: I just want to close now -- putting my hat on again for the James Nayler Foundation. I do want to thank you all for coming, I think it's been an interesting evening. I particularly want to thank the panel. [applause] I believe we've all behaved remarkably well under the circumstances. Now the difficult bit, that was the easy bit, donations. We put this event on, and it does cost over a £1000.00, we would ask you to give £10 if you can, or £20 if you can, for those who can't we do offer it free for those who can't pay. If you're interested in more on our conference tomorrow &ldquo;Successful healing of emotional distress&rdquo;, that takes place tomorrow in Friends House Euston Road and you're very welcome to attend. Thank you for coming this evening.

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