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Rapid response

Re: Does long term use of psychiatric drugs cause more harm than good?

Four of my Cochrane colleagues, the editor-in-chief and the editors responsible for reviews of antidepressants, antipsychotics and ADHD drugs, agree with me that the benefits of psychotropic drugs are exaggerated and the harms (including suicide) underestimated (1).

They are concerned, however, that my recommendation that we only need 2% of the drugs we currently use (1,2) could lead to patient harm. As they didn't explain how, this is a remarkably evidence-free postulate, particularly considering that I documented that psychiatric drugs kill more than half a million people every year in the United States and Europe (1,2). My recommendations would lead to healthier and more long lived populations and would spare tens of millions of people from becoming mentally crippled (2).

The Cochrane editors say that my recommendations are based on inappropriate interpretation of the published research and lament that some of my references are to my upcoming book. As they haven't read my book, they cannot know whether my interpretation of the science is appropriate. My book is evidence-based and has hundreds of relevant references.

The Cochrane editors are concerned that I step "beyond the accepted role of an independent researcher by appearing to recommend a course of action." I disagree vehemently. When doctors see harm on a massive scale, they have a duty to inform the public about it, and if they can suggest a solution, it is even better. It appears to me that by their non-evidence based attack on the messenger, the Cochrane editors protect psychiatry's guild interests rather than the patients.

The Cochrane editors say they cannot see what my estimates for total deaths and suicides refer to. However, I did use the term excess deaths (1). I also made the suicides clear: "there are likely to have been 15 times more suicides among people taking antidepressants than reported by the FDA" (1). I have several references for this estimate in my book and the studies are remarkably consistent (2). Here is one revealing observation (2). Thomas Laughren was responsible for the FDA's huge meta-anaysis of the randomised trials, which reported only 5 suicides in 52,960 patients on SSRIs, or one per 10,000 (3). Five years earlier, Laughren reported on 22 suicides in 22,062 patients randomised to antidepressants using FDA data, which is 10 per 10,000 (4), or 10 times as many as he reported five years later! There were only 2 suicides in 8,692 patients on placebo (4), which Laughren interpreted thus: "There is obviously no suggestion of an excess suicide risk in placebo-treated patients." No, but why didn't Laughren comment on the fact that flies in the face, namely that there were four times as many suicides on antidepressants as on

placebo, which was statistically significant (P = 0.03, my calculation)? When Laughren left the FDA, he established the Laughren Psychopharm Consulting with himself as director to help the drug industry with getting their drugs approved (2).

What I get out of the colossal underreporting is that SSRIs likely increase suicides in all ages. It is remarkable that it is so subjective how many suicides there are and also that several major drug companies have cheated with their reporting of suicides and suicide attempts (2). I doubt SSRIs are safe at any age, and they kill very many elderly patients by falls and hip fractures (2,6).

In contrast to what the Cochrane editors say, the Cochrane review of tricyclic antidepressants versus an active placebo containing atropine is not substantially out of date (7). It is from 2004, but according to Cochrane routines that doesn't make it out of date if no new relevant trials have been published, which is highly unlikely. The newest of the 9 included trials is from 1984. The drug industry doesn't use active placebos because then the whole world could see that the emperor has no clothes. It is also misleading when the editors say that the authors described their findings cautiously. Evidence-based medicine is about using the best available evidence, and this review is the most reliable evidence we have about the effect of antidepressant drugs (1,2). It didn't find any effect (1,2).

My interpretation of the science is shared by the patients who disagree strongly with the psychiatrists about psychiatric drugs, which they intensely dislike (2). It is telling that in meta-analyses of depression trials, both in children and in adults, the psychiatrists found effect sizes between 0.25 and 0.29 whereas there was no effect when the patients were asked (effect sizes 0.05 and 0.06) (2,8-10).

Surveys are similarly revealing. Although the psychiatrists deny it is a problem (2), about half the patients on antidepressants feel that the drugs change their personality (11,12). And in a large survey of 2,031 citizens from 1995, people thought that antidepressants, antipsychotics, electroshock and admission to a psychiatric ward were more often harmful than beneficial (13).

So whom should we believe? The psychiatrists who are often on industry payroll and know that if they report favourable results, they will be asked again? Or the patients?

The Cochrane editors think that my recommendations are extreme. I write about being extreme in my book: "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 [previously editor-in-chief of the New England Journal of Medicine] 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" (2).

Stopping psychiatric drugs abruptly is dangerous, as it can lead to suicide and homicide because of withdrawal akathisia (2). We need widespread withdrawal clinics because many patients have become dependent on psychiatric drugs, including antidepressants, and need help to stop taking them slowly and safely (1).

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