

Relentless and Tragic Marketing: Psychiatric Drugs from Before the Cradle to the Grave

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Working with others, we strive to alleviate distress and to support and enhance the personal growth, transformation, individuation, self-determination, and clear and expanded awareness of individuals. Necessity dictates that we also spend a lot of time challenging aspects of the mental health profession that do the opposite—creating more distress, suppressing growth and transformation, violating self-determination, and dulling and blinding awareness. We call it psychiatric oppression, the systematic, institutionalized mistreatment of those judged as “mentally ill.” This essay focuses especially on the ever expanding encroachment of psychiatric oppression to more and more of the population, and to individuals who are less and less in need of actual help. This encroachment takes the form of mass marketing for psychiatry and the pharmaceutical industry. One key aspect of oppression theory is the claim to virtue. For psychiatric oppression that claim is the notion that mentally ill people need their treatment; its growing extension is the concept of prevention, that *potentially* mentally ill people need treatment as well!

The Regressive Progression: Treatment to Prevention

“An ounce of prevention is a pound of cure.” Like all great aphorisms, this one, often associated with Ben Franklin, holds wisdom and is partly true, based on assumption. In this case, one must assume the role of victim of unnecessary malady that necessitates a cure...and that there is a felt connection or empathic relatedness to the one who suffers malady. Where these assumptions are not met, the aphorism is false. To wit, for the giant corporation of Halliburton and its government and military operations group, or for the mercenary army of Blackwater, going to war is worth a great deal more than diplomacy.

Focusing on the more obvious issues of health and disease, how does this old aphorism apply to our modern day United States? If you are Eli Lilly corporation, disease as in diabetes, or alleged disease as in “schizophrenia,” is worth a great deal—a cursory look at the profit points related to the drugs for diabetes, or Zyprexa for schizophrenia, show that the treatment is extremely profitable to the corporation. With scientifically validated disease like diabetes, the money issues are a concern where drugs are overpriced and not accessible to the poor, but for psychiatric diagnosis, based on behavior and with no objective indicator of physical or chemical abnormality, the ethical issues are enormous. In either case, for Eli Lilly, wellness is a wash. In today’s corporate world, two prime values reign—maximum profit and minimum liability.

Disability and Disease: Measures of Failed Development

Disability rates in the United States are incredible. Investigative journalist Robert Whitaker (2005) analyzed data on adult psychiatric disability in the United States. A century ago, one out of 500 people was considered “disabled” by mental illness and in need of hospitalization. By 1955, at the advent of the first mainline psychiatric drug, Thorazine, for serious “mental illness,” that number had jumped to closer to one in 300. Incredibly, in the next 50 years, a period when

psychiatric drugs have been the primary treatment, the disability rate climbed steadily. It is astounding that nearly one in 50 adults in this country receive Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) money from the government for psychiatric disability. Clearly, prevention is not happening. Psychiatric disability is epidemic; we are a failing society in light of adult well-being as defined by ability.

The data on schoolchildren with various “disabilities” rendering them eligible for special education amplifies the Whitaker data. As described in *The Wildest Colts Make the Best Horses* (2007), there has been an amazing increase in the number of children labeled as learning disabled (LD) or diagnosed with “disruptive behavior disorders” (DBD). These children are generally placed in special education. Federal legislation in the early 1960s created a big push for the growth of special education, spending reaching \$1 billion in 1977; by 1994 this was a \$30 billion industry. The 1991 expansion of the Individuals with Disabilities Education Act (IDEA) to include so-called Attention Deficit Disorder (ADD) as a qualifying disability was a huge spark in this growth. Incredibly, it is not unusual for a school district to have one-fourth of its students in special education one way or another—that would be one in four.

Very serious illnesses like cancer and diabetes are, of course, increasingly prevalent. It is true there is great noise about finding cures—witness Lance Armstrong’s recent initiative on taxpayer funding of cancer research in Texas. But how serious are we as a society in applying Franklin’s aphorism? Granted there is a good deal of movement and activity regarding wellness—exercise, fitness programs, gyms, diets, nutritionals, etc. This is very good. But how much have you heard about reining in corporate environmental toxicity, or developing attitudes and policies to seriously diminish pollutants from our profligate fossil fuel consumption, or the accumulation and dissemination of deadly radioactive substances from our nuclear program? How seriously does our leadership consider that cancer rates are related to these environmental poisons that are exceedingly preventable?

It seems there is massive resistance to facing certain simple truths about prevention of real disease. Most readers are likely aware that the United States has very high rates of childhood obesity and diabetes—both exceedingly preventable. How serious a campaign have you seen to rein in the more obvious forces contributing to this epidemic? How much pressure and disapproval, much less legislative controls, are being expressed toward the corporate entities that mass manufacture and mass advertise unhealthy, obesity and diabetes-promoting candies and cookies and junk foods and soda pop?

According to the Environmental Protection Agency in 2003, children are getting asthma at more than double the rate two decades ago, and one of every dozen women of childbearing age has blood mercury levels that could hinder brain development in a fetus. Have you noticed elder government leaders in responsible positions making decisions to enhance wellness in our children by confronting the forces perpetrating the poisons that cause asthma and poison the brains of unborn babies?

Is the explanation to such denial really so simple as the idea that any challenge to radical free market capitalism is anti-American? We think it is more the case that these corporate entities have achieved a degree of control over the government and the media that tends to defuse or

negate meaningful challenge. Are corporate profits the best answer to the question of how to enhance our children's well-being? If so, we should be doing better than ever. We are not.

We are clearly failing in prevention of these very real illnesses such as cancer and diabetes and asthma, including with our children. This failure pales, however, in comparison to psychiatric disease, or so-called mental illness. Childhood "mental illness" is now virtually pandemic in the United States as an estimated 1 of 7 school age children is on at least one psychotropic drug, and many are on several. Our analysis of the statistics showed an estimated 40-fold 4,000% increase in the number of children on psychiatric drugs between 1970 and 2000 (Breeding, 2000). This is, of course, immensely profitable, billions of dollars in sales for various specific drugs used to "treat" these children's "mental illnesses."

Pseudoscience and the Creation of Imagined Disease

This drugging of our nation's children is tragic because of the very dangerous, toxic nature of these substances. It would be tragic even if the so-called psychiatric diseases of childhood were real diseases like diabetes or asthma. It is beyond tragic, however, when one confronts the fact that these "illnesses"—ADHD, Bipolar Disorder, Depression, etc.—are only alleged or imagined diseases. Real disease is discovered by medical scientists, confirmed as an objective, identifiable physical or chemical abnormality such as a cancer tumor or a blood sugar imbalance. Alleged disease is proclaimed by fiat. Mostly these consist of so-called mental illnesses. Most common in our nation's children would be "Attention Deficit Hyperactivity Disorder" (ADHD), followed by others like the current rage named Bipolar Disorder, and Depression. These "diseases" are not discovered, and there is no verifiable physical or chemical abnormality. Rather, a group of "experts" from the American Psychiatric Association *decides* that certain behaviors (called symptoms) are abnormal and *votes* these sets of behavior into existence as diseases. For example, ADD was voted into existence in 1980, and ADHD in 1987. It is difficult to estimate the numbers, but we think it is fair to conservatively say that at least 12 million young people are on psychiatric drugs in this country today, and many of them are on a few or several!

The enormous expansion of special education described above in the section on disability reflects a perversion of the original intention of federal efforts to meet the needs of physically handicapped children with objective disabilities, like hearing and visual problems. This benevolent mandate has been systematically broadened to include ever more subjective diagnoses, such as non-specific learning disabilities and ADHD. It is absolutely astounding that today about 60% of children qualifying under IDEA have no verifiable physical disability. These children are selected solely on the basis of subjective criteria, given labels such as LD, ADD or ED (emotionally disturbed). Could it be that these diagnoses are a modern way of "blaming the victim?" It seems to us that labels like LD and ADD serve to justify our school and community failures to meet our children's real educational needs, and absolve us adults from responsibility to figure out and make the necessary changes to meet those needs.

Child psychiatry is not a legitimate medical science. Professional prescribers assert their faith that created entities such as the ubiquitous ADHD are biologically or genetically based. By such faith-based declarations, the real act of giving a child a drug to control or alter his or her mood and behavior (likely considered criminal) is magically transformed to an imagined—and hence

morally justified—as an act of medical treatment, giving “medicine to an unfortunate sick (mentally) child.

How Do You Prevent Imaginary Disease?

Regarding prevention, things get very thorny here. As suggested above, it is difficult enough, apparently almost insurmountable for our society, to meaningfully confront the conditions necessary to promote well-being amongst our nation’s children—to prevent unnecessary physical diseases. When one truly understands that these childhood “mental illnesses” are not even real diseases—that they are imagined, created, *not* physical or chemical pathologies, *not* disease—then how in the world can they be prevented? Or treated for that matter. Can you treat something that does not exist? Can you prevent it? Well, just as you can detain and torture a man you think is a terrorist, so you can select, label and drug a child you deem mentally ill. The difference, of course, is that some terrorists do exist, but no child identified as ADHD has been so labeled because they met a medical standard that confirms the existence of a specific pathology connoting disease. Can’t happen because no such standard exists. As hard as it may be to accept, the words of retired neurologist, Fred Baughman, Jr., are nonetheless absolutely true: “ADHD is a total, complete 100% fraud.” (www.adhdfraud.com)

You cannot prevent ADHD because it is not real. You can prevent children being stigmatized with the label, and you can certainly prevent drugging them with addictive stimulants, commonly called speed.

A Brief On Biopsychiatry

Biological psychiatry (biopsychiatry for short) assumes that problems in living, or perceived failures in social adjustment, are due to biological and/or genetic defects. Social and psychological distress, and challenges in personal growth and transformation are reduced to the chemical imbalance theory and the bad gene theory. This pseudoscientific theory justifies the practical mainstays of psychiatric practice—drugs and electroshock.

Incredibly, there is complete lack of scientific proof of these two postulates and the absence of any objective test or indicator of “mental illness.” See, for example, the work of Jay Joseph (2004) on the bad gene theory. Robert Whitaker’s new book, *The Anatomy of an Epidemic* (2010), is an excellent source on the failed chemical imbalance theory, and on the damage done by the licentious use of psychiatric drugs. Peter Breggin’s books are another excellent source. Breggin argues that psychiatric drugs and electroshock “work” by disabling brain and nervous system functioning; his latest, *Medication Madness* (2008), shows how psychiatric drugs severely impede awareness and responsibility, and so often lead to severe impairment and personal troubles and tragedy.

A very short summary of Whitaker’s book is as follows:

- 1) Scientific research fails to validate biopsychiatric theory;
- 2) Psychiatric drugs generally do not work any better than placebo;

- 3) Psychiatric drugs are very damaging, creating all kinds of real biological damage and disease;
- 4) Use of psychiatric drugs makes positive growth and transformation less likely;
- 5) Use of psychiatric drugs is largely responsible for the fact that the numbers are now approaching 1 in 50 adult Americans on permanent disability due to “mental illness;” hence the book title, *Anatomy of an Epidemic*.

As astounding as it may seem in light of the propaganda stream, not one problem routinely seen by psychiatrists has been scientifically demonstrated to be of biological or genetic origin. Not one diagnosis of “mental illness” can be made by an objective finding of physical or chemical abnormality. Besides the physical damage caused by the drug “treatments” and the disability documented by Whitaker, we would add that the emotional, mental, social and relational damage caused by the beliefs and practices of biopsychiatry are also vast and tragic (Breeding, 2000). Further, the “treatment of next resort,” electroshock, always causes brain damage and memory loss, sometimes causes death and doesn’t work. See Linda Andre’s book, *Doctors of Deception* (2009), and the website of the Coalition for the Abolition of Electroshock in Texas (www.endofshock.com), for thorough information on electroshock.

There is one more key piece to consider in an article that addresses the subject of mental health screening. Unlike the general field of medicine, psychiatry embraces coercion, the deliberate and systematic violation of liberty. The state psychiatric function of civil commitment utterly erodes the constitutional right of liberty for those judged as “mentally ill.” Together with the insanity defense, these two ubiquitous government psychiatric acts destroy the self-determination and accountability of citizens. Involuntary commitment really means incarceration and poisoning of innocent citizens, and the insanity defense really means destruction of the virtues of personal accountability and responsibility. Reading the work of Thomas Szasz (www.szasz.com) is the surest way to see through the obfuscating claims to virtue that justify incarcerating and forcibly drugging (or electroshocking) citizens who have not committed a crime. Bottom line: it is crucial to recognize and acknowledge that self-determination all too often gets overrun once an individual is labeled “mentally ill,” and that this includes mothers and children.

Further into the Abyss: The Creation of Real Disease

As Benedict Carey reported in the *New York Times* (9-3-07), an analysis of national outpatient medical records by Dr. Mark Olfson of Columbia University documented that another incredible increase, in fact a repeat of that 40-fold number cited above between 1970 and 2000, in the “diagnosis” of bipolar disorder in youth (0 to 19 years old) within a 10-year period (1994-2003). The researchers calculated the number of visits in which doctors recorded a diagnosis of bipolar disorder, and found that the numbers went up from roughly 20,000 such diagnoses in 1994 to about 800,000 in 2003. The primary treatment of so-called bipolar disorder, of course, is psychotropic drugs, specifically so-called mood stabilizers like Depakote, and antipsychotics like Abilify or Zyprexa. Olfson's other study finding: “nearly one in five psychiatric visits for young people included a prescription for antipsychotics.” Antipsychotics are very serious, very toxic, even more dangerous than stimulant speed. They are known to have caused probably the largest

epidemic of neurological disease in history—Tardive Dyskinesia—in millions of adults around the world. As Robert Farley reported in the St. Petersburg Times (7-29-07), “skyrocketing numbers” of children are being given these powerful neuroleptic drugs. Farley reports a 250% increase in Florida in the last 7 years. This is a nationwide trend.

Consider this even deeper twist on the theme of prevention. So-called bipolar disorder is a prime example of fictitious medical disease, now used to justify selling poisoning drugs like Zyprexa (Frank, 2005) and giving them to our precious children, resulting again in tremendous profits to companies like Eli Lilly, the maker of Zyprexa. Not only that, but a little closer look shows that a very large percentage of children diagnosed bipolar started off with an ADHD label. Typically, these so-called bipolar kids were taking stimulants for years before they were subsequently diagnosed bipolar. Once one has the information that psychosis, agitation, anxiety, mania and cognitive and mood deterioration are all listed effects of stimulant drugs, it is easy to see that long-term use can lead to symptoms that psychiatry, more and more frequently labels and treats as severe mental illness. Thus, treating an imagined illness called ADHD leads to more intense and severe drug-induced debilitation, misinterpreted as severe mental disease, leading to more damaging, and more expensive further “treatment.” The end result is a tragic and pathetic example of iatrogenic (caused by medicine or medical doctors) disease. Children are stigmatized, less functional, more disturbed, typically on several drugs, and physiologically damaged by the “cure.”

In the same sense as ADHD, you cannot prevent bipolar disorder, since it is also an imagined illness. However, as the above analysis reveals, there is one way to prevent even many of the troubled behaviors that psychiatry uses to justify its creation of the budding epidemic of “bipolar disorder”—simply do not put young children on toxic stimulant drugs.

We cannot imagine it getting much sadder than turning healthy children into chronic, lifelong, neurologically damaged mental patients. Incredibly, though, the perversions of prevention do get even more bizarre. We will provide one example from the 1990s and one from this decade to show what we mean.

Racist Violence Initiative

As described above, the notion that problems in living are due to biologically or genetically based mental illnesses is the claim to virtue that justifies the runaway train wreck, which is the massive drugging of our nation’s children with powerful, addictive toxic psychotropic drugs. This is the same kind of thinking that leads the American government to pursue programs such as the so-called federal violence initiative that seeks to screen inner-city youth for a genetic predisposition to violence. As Peter and Ginger Breggin report in their 1998 book, *The War Against Children of Color*, the National Research Council wants to look for “biological and behavioral characteristics of infants that increase their risk of growing up to commit violent crimes.”

This biopsychiatric view on aggression was seen in the face of the so-called Federal Violence Initiative. This incredible program, more aptly known as the "Racist Violence Initiative," was put forth several years ago by Frederick Goodwin, top-ranking psychiatrist in the Bush

administration and director of the National Institute of Mental Health (NIMH). The initiative included ongoing "research" into the supposed biological basis of inner-city violence and includes proposals for biomedical social control. The U.S. government was asking "Are Black People Genetically Violent?" and planning a psychiatric screening program that would, like screening for ADHD leads to Ritalin use, lead to mass drugging of innocent inner-city children, the vast majority of whom are young people of color. The National Science Foundation, the Centers for Disease Control, and the Justice Department were all involved. Elaborate pseudoscientific language, and much of the federal government's effort, goes into obfuscating and/or directly denying this initiative's plain racist intent. Thanks to the leadership of Peter and Ginger Breggin, and the work of many, this initiative was partly derailed. Nevertheless, "research" actually began in Chicago, and the push for this modern version of eugenics goes on.

The Federal Violence Initiative is a clearly racist practice, one legacy of a distorted biopsychiatric theory frighteningly analogous to the practices of Nazi Germany. As Dottie Curry, social activist and international leader in the Re-evaluation Counseling Community put it, "The 'violence gene theory' is now added to the 'stupid gene theory' to further convince society that the African will not fit in the USA, and is dangerous to the world."

The words of Goodwin demonstrate that the proponents of biopsychiatry represent the same awful lineage as the Nazi eugenicists. The following excerpt is from a speech he delivered on February 11, 1992, to the National Health Advisory Council, on the unveiling of the Federal Violence Initiative. Goodwin's quote is not an abusive anomaly; it is a faithful expression of the thoroughly flawed, morally bereft, and dangerous biopsychiatric worldview underlying psychiatric oppression. It graphically reveals the same distorted view of social Darwinism that guided the Nazis:

If you look, for example, at male monkeys, especially in the wild, roughly half of them survive to adulthood. The other half die by violence. That is the natural way of it for males, to knock each other off and, in fact, there are some interesting evolutionary implications of that because the same hyperaggressive monkeys who kill each other are also hypersexual, so they copulate more and therefore they reproduce more to offset the fact that half of them are dying.

Now, one could say that if some of the loss of social structure in this society, and particularly within the high impact inner cities have removed some of the civilizing evolutionary things that we have built up and that maybe it isn't just the careless use of the word when people call certain areas of certain cities jungles, that we may have gone back to what might be more natural, without all of the social controls that we have imposed upon ourselves as a civilization over thousands of years in our own evolution.

So experts like the preeminent psychiatric leader, Frederick Goodwin, believe this: prevention of the manifestation of the genetically based mental illness that is the root cause of violence may be handled by screening inner city youth. Given the predisposing belief—its falsity is irrelevant—it is a sure bet that those identified as having such an incipient mental illness would be treated accordingly. That means drugs.

Nothing to do with, for example, declining educational standards, poverty, scarcity of well-paying jobs. How about institutionalized racism? Did you know that 2/3 of all people imprisoned for drug offenses are black; add in Latinos and the number is about 80%? Only 22% of all monthly drug users are black or Latino. (Alexander, 2010)

Universal Mental Health Screening and Suicide Prevention

An even bigger push of late has been the effort of the government psychiatric industry to implement one of the pillars of President Bush's 2003 New Freedom Commission recommendations for our country's mental health system. There has been a storm of controversy about the commission recommendations for universal mental health screening, and suggestion that the 56 million young people in the nation's public schools would be a great place to do it. However, we have slowed them down a bit in Texas. We defeated the relentless push for New Freedom type mental health screening in the 2005 and 2007 legislative sessions. The Texas 2009 marketing push had morphed into screening for suicide prevention, and we defeated this as well.

In fact, programs like Teen Screen and other ways of trying to prevent suicide by identifying at-risk young people tend to have very high rates of false positives. Shaffer et al (2004) acknowledge that their screening tool "would result in 84 non-suicidal teens being referred for evaluation for every 16 suicidal youths correctly identified." The nightmare that Aliah Gleason and her family went through in Austin, Texas is a prime example (Waters, 2005). Aliah ended up taking at least 13 different psychotropic drugs. That is what happens to identified children in our system today.

These types of suicide prevention programs do not work. The United States Preventive Services Task Force found that screening for suicide risk does not reduce suicide attempts or mortality (<http://www.ahrq.gov/clinic/3rduspstf/suicide/suiciderr.htm#clinical>). What these programs do is select out more children to get labeled, pathologised and poisoned with toxic psychotropic drugs. They are very effective marketing campaigns for the psychiatric pharmaceutical industry.

See the Declaration of Refusal (Breeding, 2003), and related material on www.wildestcolts.com for a summary of the issue. Ken Kramer's PsychSearch website also has excellent information on the push for mental health screening of our nation's young people (<http://www.psychsearch.net/teenscreen.html>).

Infants and Toddlers: The Trend to Drug Younger and Younger Children

The expansion of the psychopharmaceutical market to younger and younger children is terribly egregious and tragic, deserving much more space than we have here. In the 1980's a market was recognized, and with the launching of ADD in 1980 and then ADHD in 1987, the expansion into the schools was underway. With the inclusion of ADHD as an "other health impaired" category in the Individuals with Disabilities Education Act (IDEA) in 1991, the numbers really exploded. Kindergarten and first grade became the main entry points into psychiatry. Now we see an exponential trend in the numbers of preschoolers and toddlers; even infants sometimes get drugged! There is a wealth of reporting on this now. We mentioned some of it above, including the horrible phenomenon of so-called bipolar kids. As reported, for example in a June 10, 2008

New York Times editorial titled “Hidden Drug Payments at Harvard,” Joseph Biederman and two of his colleagues took a very large amount of undisclosed drug company money (\$1.6 million each for Biederman and one associate, \$1 million for the third), as they acted as point men for the public relations behind children’s “bipolar.” PBS Frontline devoted an hour to a show called “The Medicated Child” (<http://www.pbs.org/wgbh/pages/frontline/medicatedchild/>), in which they revealed much more of this sordid affair. Boston Globe reporter Carey Goldberg (2008) wrote it up: “Newly disclosed court documents portray Dr. Joseph Biederman, a leading Harvard child psychiatrist, as courting drug company money by *promising* that his work at Massachusetts General Hospital would help promote the use of antipsychotic drugs for youngsters diagnosed with bipolar disorder.” (italics ours)

This regrettable trend is true for every category of psychiatric drug. We will only cite a few of the other most recent reports on the antipsychotics to come across our desks, which, recall, cause permanent neurological and metabolic damage in the preponderance of people who take them for very long. Researchers from Rutgers University and Columbia University show that antipsychotic prescriptions written for privately insured children aged 2 to 5 years doubled between 1999-2001 and 2007 (Olfson et al, 2010). Children covered by Medicaid are by far even more likely to be prescribed antipsychotic drugs than children covered by private insurance, and Medicaid-covered kids have a higher likelihood of being prescribed antipsychotics even if they have no psychotic symptoms (Kuehn, 2010).

It goes on and on. On May 12, 2006 Joseph Rhee of ABC News did a piece titled, “Recruiting Tots At Mass General To Be Used as Human Guinea Pigs in AstraZeneca’s Anti-Schizophrenia Drug (Seroquel) Trial.” He reported on a study, conducted by the Department of Pediatric Psychopharmacology at Massachusetts General Hospital, testing subjects from four to six years of age with Bipolar Disorder. An earlier Massachusetts General study of the anti-psychotic drugs Risperidone (Janssen’s Risperdal) and Olanzapine (Eli Lilly’s Zyprexa) recruited children as young as three years old. A previous clinical trial of Zyprexa was conducted by UCLA in 1998 on five children, aged 6 to 11. The authors of that study said treatment was discontinued within the first six weeks “because of adverse effects or lack of clinically significant therapeutic response.” It gets even scarier.

Schizophrenia Prevention

Consider this statement from an article called, “Can Schizophrenia Be Prevented,” by Peter Dkosch (2000), in *Neuropsychiatry Reviews*:

The danger of the "wait-and-see" approach is illustrated by a groundbreaking randomized trial led by Patrick D. McGorry, MBBS, PhD, MRCP (UK), Professor of Psychiatry and Director of the Centre for Young People's Mental Health at the University of Melbourne, Australia. The study, the only schizophrenia prevention trial completed thus far, involved 59 persons with prodromal symptoms who received either "supportive following" or a multimodal treatment regimen consisting of low-dose risperidone, cognitive behavioral therapy, and (if necessary) antianxiety or antidepressant medications. After six months in the study, schizophrenia was diagnosed

in 10 of the 28 control participants (36%) but in only four of the 31 of treated subjects (13%).

Ten years later, a new study, published in the American Journal of Psychiatry and headed by psychiatrist John H. Gilmore (2010), professor of psychiatry and director of the UNC Schizophrenia Research Center, claims to be able to detect “brain abnormalities associated with schizophrenia risk” in infants just a few weeks old.

Do you see the danger? McGorry sees as danger the possibility that we will miss opportunity to prevent citizens with untreated prodromal (early warning signs) symptoms of schizophrenia from manifesting their incipient disease. In actual fact, such preemptive drugging practices guarantee pathology, beginning at the moment the unfortunate citizen subject begins taking a brain damaging substance like risperidone.

Certain other facts render the idea of preemptive drugging as prevention even more absurd and tragic. As Robert Whitaker details in his 2002 book, *Mad in America*, there is a natural recovery rate of about 60% for those diagnosed as schizophrenia, both historically and even today in “undeveloped” countries. Whitaker points out the contrasting, almost 0% recovery in the United States; the obvious compelling difference lies in the ubiquitous use of antipsychotic drugs as treatment. Furthermore, there is actually an ample literature on successful non-drug assistance of people in extreme states of mind. For our purpose here, I leave it with a recent study on the subject. Martin Harrow and Thomas Jobe of the department of psychiatry at the University of Illinois in Chicago reported in the May 2007 issue of last month's *Journal of Nervous and Mental Disease*, that over 15 years, schizophrenia patients not on antipsychotics showed more periods of recovery than those taking antipsychotics. These researchers reported that, after 15 years, 65 per cent of patients on antipsychotics were psychotic, whereas only 28% of those not on medication were psychotic. The study's authors concluded that "not all schizophrenia patients need to use antipsychotic medications continuously throughout their lives."

In sum, in our society, we drug young people who are labeled mentally ill at an extreme rate. The trend is toward more children, at younger ages, with more and more powerful drugs in various combinations. The federal violence initiative and the push towards the practice of schizophrenia prevention and universal mental health screening take it even further, arguing for psychotropic drug use as prevention. That the “diseases” we are purporting to prevent are strictly imaginary from a medical science perspective starkly reveals the irrational and dangerous reality of this horrific affair.

The disability epidemic, cited above as documented by Robert Whitaker, does not only apply to adults. Whitaker notes in his book, *Anatomy of an Epidemic*, that this epidemic “now disables 850 adults and 250 children every day.” (p. 3) Whitaker reported that in 1987, there were 16,200 children under 18 years of age who received an SSI payment by virtue of disabling “mental illness”—5.5% of the 293,000 children on disability rolls. Starting in 1990, the numbers began to dramatically rise, so that by the end of 2007, there were 561,569 “mentally ill” children on the disability rolls, a 35-fold increase, the leading cause of child disability and 50% of the total number—250 children every day, enough to fill an elementary school auditorium! Children under six receiving SSI tripled to 65,928 just between 2000 and 2007.

A Note on Elders

Very briefly, we want to acknowledge that the “grave” part of this article’s title is already handled; it is our experience, and the overall evidence supports it, that about half of our elders in nursing homes are on psychiatric drugs. Some of them have to be because they have already been for decades. As Breeding (2000) notes in a chapter about his personal experience working in a nursing home, there is a tendency to use stimulants with those who are depressed and not wanting to eat, on the one hand, and to use neuroleptics with those who are cranky and feisty, on the other. In any event, it is clearly about management and control. Those who care about family and friends need to safeguard the elders equally as much as the young people.

The MOTHERS Act

The story of The MOTHERS Act is the latest perverse twist of beautiful sounding rhetoric, an Orwellian effort to extend the controlling and profiteering arm of the psychopharmaceutical industry into the lives of pregnant women and their babies in utero. The MOTHERS Act is a new federal law that seeks to increase screening of all new moms in the U.S.A. for perinatal mood disorders (during and after pregnancy), and which seeks to increase public awareness and “research” on Postpartum Depression. It stands for Mom’s Opportunity To access Health, Education, Research and Support for postpartum depression. Think PATRIOT Act – not so patriotic. The MOTHERS Act would be more appropriately referred to as The ANTI-MOTHERS Act, or The Giving Antidepressants to Mothers Act.

The MOTHERS Act was allegedly inspired by the story of a woman named Melanie Blocker Stokes, a pharmaceutical sales rep who became extremely distressed after the birth of her daughter Sommer in 2001. After psychiatry had its hand at “treating” Melanie, giving her four different cocktails of psychotropic drugs including antidepressants, anti-anxiety meds and anti-psychotics, as well as repeated electroshock sessions, she jumped from the 12th story window of a Chicago hotel. Her baby was only about 3 ½ months old. Some time prior to Melanie escaping from her home to go and kill herself, she told her husband that the electroshock and other treatments she was being subjected to were killing her. It only took 3 ½ months for psychiatry to destroy this woman and devastate her family forever.

The best way to get more drugs prescribed to a group of women for whom the drugs are not FDA-approved is to have someone else do your advertising. It would be illegal for a drug company to do a commercial for Zoloft targeted at breastfeeding moms with Postpartum Depression (PPD), but it’s not illegal for a state agency to do a commercial for PPD and refer viewers to a website featuring a person who will tell them to take Zoloft. The pharmaceutical companies can’t get away with screening moms directly for PPD – they need a middleman. Thus, “nonprofit” organizations, doctors and mental health workers can simply implement universal mental health screening of new mothers before they leave the hospital or birth center, and follow up at check ups. The messes left behind are ours to deal with.

In modern-day America, we take for granted what our forefathers made sure to write as the Fourth Amendment of the Bill of Rights—that “No State shall... deprive any person of life,

liberty, or property, without due process of law,” that we will have privacy in our homes and privacy and security of the person. Yet in many instances we have been willing to watch these rights slip away, and The MOTHERS Act is best understood as a severe threat in this regard—another violation of privacy and a significant step toward making your innermost thoughts the business of state psychiatry.

Screening is considered a medical diagnostic procedure, which like any other procedure requires the due process of informed consent. The law allows abrogation of that right in the event of an emergency mental health situation that effectively transfers authority to a doctor to screen them, or when a court adjudicates the person as being incompetent to consent to a screening. Yet with these screening programs, an even broader attempt is made to bypass the due process rights of the people, the result being to turn large groups of people into mental patients.

If the government were to initiate a “Take Your Zoloft Awareness Campaign” we would understand that it is for the benefit of Pfizer and not for our direct benefit. But somehow many have been fooled into buying the notion that a screening program for some “mental illness” like depression is for public health and for our benefit, when in actuality it serves the interests of those who stand to profit from the treatment of that “disease.”

Disease marketing is less offensive when it pertains to legitimate physical diseases with somewhat benign treatments. However, in the case of mandatory screening for postpartum depression, a woman’s thoughts and circumstances can be searched by anyone connected with health care, and subsequently used against the woman without her having any opportunity to maintain privacy or prevent due process rights violations. Although it is true that our coalition fought successfully to stop mandatory screening provisions from becoming explicit in this federal law, it is still possible that any screening initiated under the law could become mandatory by way of clinical guidelines, health agency codes and policies, or the state laws that are being passed one by one.

When national laws have uncertain enforcement, another strategy of the true believers in mental health screening is to pass state laws, where so few people will learn what is going on with the state legislature that the law often passes before it is noticed. Illinois and Texas have passed legislation relating to postpartum depression. Ironically the Texas law is called the Andrea Pia Yates law and it encourages screening and awareness—ironic because Andrea Yates was under the influence of various psychiatric drugs when she killed her children. Massachusetts recently passed their own version of The MOTHERS Act and many more states are likely to follow if pHARMA has anything to do with it.

But no state could be worse than New Jersey, where postpartum depression screening is mandatory. New Jersey also happens to be the home to many of the world’s pharmaceutical companies. Nowhere in the New Jersey law or its clinical guidelines is any mention of obtaining informed consent to screening.

Informed Consent means that the patient has given express written or verbal consent to the assessment or treatment after having been provided with complete and accurate information regarding the risks and benefits of the assessment, available “mainstream” and “alternative”

treatments, and no treatment. Informed consent also requires that once a diagnosis has been made, the patient is informed of the nature of the diagnosis, and whether it is based on a confirmed physical abnormality or a subjective opinion of the doctor. The right of informed refusal must be protected, but nowhere in the law is any mention of the right to refuse, or any requirement to inform women of a right to refuse screening, despite the firm language requiring doctors to screen all new mothers. If you live in a state with a law like this, it would serve you well to form a state coalition to try to find a mother who was screened against her will or who was screened with a very bad outcome, and to sue on Constitutional grounds. Alternatively, you could form a committee to lobby to have the law repealed by the state legislature, or to require adequate informed consent to be added to the law.

Postpartum Depression is a convenient label for an inconvenient set of widely varied circumstances, and not a distinct disease of its own; even the preamble to The MOTHERS Act stated that we don't know what causes PPD. In the implementation of the New Jersey law, the specific screening tool being used is the Edinburgh Postnatal Depression Scale. This instrument has been demonstrated to triple the number of women diagnosed with postpartum depression in practice (Georgiopoulos, et al, 1999). Due to its subjectivity almost anyone can be termed depressed or at risk of depression and treatment would be recommended. Swedish researchers examined the subjectivity of the EPDS and found:

Routine EPDS screening of Swedish postpartum women would lead to considerable ethical problems due to the weak scientific foundation of the screening instrument. Despite a multitude of published studies, the side-effects in terms of misclassifications have not been considered carefully. The EPDS does not function very well as a routine screening instrument... Public health authorities should not advocate screening of unproved value. Screening is not just a medical issue but also an ethical one. (Frantz et al, 2008)

Advocates of this instrument have even admitted that based on screening results, categories of varying risk are established such that 100% of new mothers are at risk of depression and candidates for treatment! There is no such thing as “no risk;” there is certainly tremendous risk with the use of psychiatric drugs by pregnant mothers. According to the FDA, more than 7,000 cases of birth defects, spontaneous abortions and intra-uterine deaths, heart disease, and premature births were reported as linked primarily to exposure from psychiatric drugs during pregnancy from 2004-2008 alone.¹

In a recent news article titled “Prescription Drug Epidemic Spreads to Babies,” Tampa doctor Mary Newport stated that prescription drug withdrawal is hurting more babies now than ever before (Martin, 2010). She stated that the amount of babies being treated in the past two years exceeded the number she had seen in the past 25 years combined. The treatment for babies involves more medication for prescription drug withdrawal than for heroin or cocaine. In addition, sudden withdrawal of a drug during the pregnancy can lead to miscarriage, or the baby could have a seizure and die.

¹ Tabulation of MEDWATCH Data submitted to the FDA on prenatal and neonatal psychiatric drug exposure-related complications: <http://twitpic.com/6g9gy/full>. Source: Citizens Commission on Human Rights International, release of FDA MEDWATCH data not previously published by FDA.

Drug company funding of “educational” activities on perinatal depression and other mood disorders has resulted in misinformed doctors placing pregnant and breastfeeding mothers on drugs toxic enough to cause fatal serotonin syndrome in adults and which can cause such side effects in breastfeeding babies as excessive vomiting, seizures, coma, and death. (See <http://tinyurl.com/medwatchdeath>.) Furthermore, drug companies have received reports of aspiration and deaths of babies linked to antidepressants that are not reflected in the MedWatch data cited above. Until adequate reporting is achieved and legitimate, corruption-free studies are done to demonstrate otherwise, we can only assume that the true incidence of injuries and deaths is much higher than we know. Only 1-10% of adverse events are ever reported to the FDA, and it is obvious that drug companies do not uniformly convey the information reported to them on the drug labels moms read.

As just one example of misinformation, the so-called research of Zachary Stowe has been cited in numerous studies on alleged drug safety for moms—trickling down to everyone from authors writing about PPD, to those busy promulgating policies and legislative agendas, to the breastfeeding counselors working with moms on a personal level. Stowe, a psychiatrist at Emory University, was recently investigated and exposed by the Senate Finance Committee for taking federal funding to do research on psychiatric drugs, pregnancy, and breastfeeding, while he was also accepting undisclosed payments from a pharmaceutical company and working with the same company’s public relations firm to publicize his misleading claims. (See <http://tinyurl.com/stoweexposed> for more information.) Common sense has flown out the window, and too many people who hold the lives of helpless babies in their hands have been dangerously misinformed.

This is not to say that moms don’t get depressed. Indeed they do. It would be difficult to believe a person who says that depression does not exist. But you can’t “treat” something with medicine if you don’t know what’s causing it—and simply giving someone an addictive psychiatric drug is not going to treat depression, although it will make the person high. There are so many factors that may cause a mother’s sadness. How much of so-called Post Partum Depression is an effect of stressful, unsupported pregnancy, or high tech stressful birth with labor inducing drugs and painkillers and unnecessary Caesarean deliveries with anesthesia and forced separation from the baby, and on and on? It could be that the new mother is sad because her father has been diagnosed with cancer, a disease you can actually see with a microscope. Or it could be that she is sad because she has no energy due to a low thyroid, a disease detectable with a simple blood test, not with a subjective checklist of questions. Ironically, if you cover up this undetected underlying medical condition with drugs, the thyroid function will get worse and the mother will still be sad. It would be hard to describe Melanie Stokes as cured. It would also be hard to consider a mother cured from depression if she takes a drug and it results in the death of her unborn or nursing child. Less dramatically and more simply put, if you ask a person whether they feel sad, and they answer yes, can you give them a pill and expect them not to feel sad any more?

Most parents don’t want to relive the loss of their child or the horrible injuries drugs have caused their child in any kind of public way, but thankfully a few brave parents have spoken out about their stories.² Matthew Schultz died from pulmonary hypertension (PPHN) caused by Effexor exposure. He lived for only two hours. Julie Edgington’s son Manie nearly died and has suffered

with a terrible heart defect caused by Paxil. Christian Delahunty of Utah lost her six-week-old daughter Indiana from pregnancy and breast milk exposure to Effexor. While some consider stories of infant loss and tragic injuries too hard to handle, these stories can be a lifesaver, so please share them. These parents became activists to save as many other babies as possible.

***How Psychiatric Drugs Nearly Turned Me into a Murderer
by Amy Philo***

Because of my experience on Zoloft, I can put myself in the shoes of Andrea Yates, Melanie Stokes, and all the other moms you hear about who kill their kids or commit suicide, when it seemed like they had everything to live for. I've been to the brink and back – I know what it's like to have thoughts in your head “telling” you what to do, thoughts that are not yours, thoughts that do not belong. Thankfully, I never acted on them. I like to think that's because I'm here for a very specific reason. I should further preface this story with the statement that I never had mental health problems in my life before I was on Zoloft, and never since. It's been six years since my last pill.

In July 2004, I had my first son, Isaac, a baby who was very much wanted, loved and protected. On his first day home from the hospital we had to go to Children's Hospital for a jaundice check, where we were told to feed him a bottle of formula. After we fed it to him he threw up most of it, then fell asleep, but soon began to turn blue. He was cold and I could not wake him so I called 911. Paramedics came to our house and sent us back to the emergency room of Children's Hospital in Minneapolis. Once we arrived, Isaac began to vomit but choked on the partially digested formula - probably because it was too thick. I screamed for help and pulled the emergency button, and the staff rushed in and began doing back blows and shoving tubes down his throat and nose. Finally the formula all came out and my baby was breathing. Had we not been in the right place at the right time Isaac may have died in his bassinet that night as we slept.

Children's admitted him overnight for observation. I was hysterically crying much of the night and afraid to feed him – a fear to which it is impossible to submit. I was assured that breast milk would be fine, but formula was the reason for his choking, so I continued nursing him with less fear.

Children's released us the next morning and then sent a nurse for a home visit the next day. I had a panic attack the night we got back home, and did not want to let Isaac out of my sight. The nurse found out about this and called my OBGYN to set up an emergency appointment for me, telling me I was at high risk of PPD and needed drugs immediately. My doctor gave me Zoloft samples and told me to start taking them right away, so I began taking them when Isaac was only 6 days old. When he was 9 days old, I had a visual hallucination that involved seeing a ghost of myself standing halfway down my stairs and throwing Isaac down to the floor at the bottom of the stairs.

I checked into the Coon Rapids, MN Mercy Hospital emergency room when he was 10 days old for suicidal urges. I was suicidal because I was afraid I would snap and do

something to hurt my baby. However the homicidal fears turned into homicidal obsessions and as I was “treated” by psychiatry for nearly four months, they became worse and worse. I was involuntarily hospitalized for two days and separated from my baby So I began to pretend like everything was fine in order to be released. Rather than admit to the adverse drug reaction, the psychiatrist kept me locked in the psych ward in order for me to “stabilize” on my meds. Brokenhearted and frightened, I resisted constant urges to cry and faked a miraculous “stabilization” in order to be released. Twice an outpatient psychiatrist raised my dose, and both times my homicidal thoughts got worse. On 150 mg of Zoloft I was overcome with intrusive thoughts of killing my mother, my husband, my son, my cats, and my neighbors before killing myself.

Thanks to activists who have been working hard for so long, the FDA’s black box suicide warning came out while I was on Zoloft. As a result, I did some research of my own for the first time. I was able to find out the truth – something none of the doctors I saw throughout that time would tell me. I went against medical advice and tapered off Zoloft with the help of my husband and my parents. By Thanksgiving I was off the drug and able to be alone with my son for the first time since he was 9 days old.³

My brief experience with psychiatry was the worst time in my life – during what should have been the greatest and most beautiful time in my life. Because my experience was so emblematic of everything that is wrong with The MOTHERS Act and screening of mothers for mental disorder “risk factors,” I decided not to sit idly by and watch The MOTHERS Act ruin motherhood - not without a fight anyway. This experience with screening and psychiatry is why I have become an activist. The stories of those I meet in this cause continue to spur me on in what I feel is an effort to change our society through education, while saving many lives in the process.

Acting for Mothers

In the world of modern mental health treatment, risk means biological or genetic defect, which means drug treatment. And it is astounding to consider that so many moms are already getting the “treatment.” The American Congress of Obstetricians and Gynecologists estimates that one third of pregnant women are exposed to psychotropic drugs at some point during pregnancy.⁴ In addition, at least 13% of U.S. women take antidepressants during pregnancy (Park, 2010). In part this is due to unplanned pregnancies but many women continue consuming medications while breastfeeding or pregnant, placing their infants at increased risk of injury and death.

The MOTHERS Act is not really for Melanie Stokes. Nor is it for moms and babies. It is for pharmaceutical companies. There have been groups focused on increasing screening of mothers for depression related to the pregnancy and postpartum periods for a long time and they are not going away any time soon. The pattern is that when a mother has killed her child or herself, one of these pHARMA front groups will jump on it and cry that we need universal screening of mothers; using the tragic story of Melanie Stokes to promote the MOTHERS Act is a prime example. Screening does not help; it perpetuates a cycle of drugging that all too often results in more violence, disease, and death—this is to be expected given that antidepressant drug labels admit to causing suicidal behavior, homicidal ideation, psychosis and hallucinations.

Drug companies benefit by drugging toddlers for so-called ADHD when these children grow up and become labeled with “bipolar disorder,” and they benefit when the administration of antidepressants, stimulants, mood “stabilizers” or neuroleptic drugs result in increasing cases of diabetes, for which the drug companies have treatments. Likewise, drug companies benefit exceedingly from The MOTHERS Act. This law, which was almost 9 years in waiting before it finally passed via Health Care Reform, will most assuredly result in an increase in the already disastrously high rate of mothers who use psychiatric drugs.

The sad fact is that the drug companies will benefit not only from increased sales of psychiatric drugs, but that the entire medical industry will benefit as more sick babies are born, become ill, and die. From the high-risk deliveries to the increase in pediatrician visits, to the surgeries, NICU stays and end of life care for infants, more and more will we see profits for doctors and drug and device manufacturers go up as the quality of life for these helpless infants will go down, and many babies will die preventable deaths. Similarly, doctors who care for mothers will see an increase in visits, and psychologists and psychiatrists will have a whole new batch of women who were placed on drugs to monitor. These will be women who never would have otherwise sought out psychiatric treatment but who will be told that they are “at high risk” of getting Postpartum Depression and should go on meds.

The New Jersey website, “Speak Up When You’re Down” which is used to promote Postpartum Support International, psychiatric drugs, and the state’s mandatory mental health screening for new moms, states that it’s ok to take antidepressants while breastfeeding. It adds that mothers should not stop taking medication just because they feel better, but should stay on medication for at least nine months after all symptoms are gone to avoid a recurrence of the depression—even though, as cited above in general terms in the summary of Robert Whitaker’s *Anatomy of an Epidemic*, the chemical imbalance theory has never been proven, antidepressants generally work no better than exercise or a placebo, and *on average their use actually inhibits rather than increases likelihood of recovery!*

Now for a bit of hope. In early 2008 a group of activists sent out a petition on the internet to stop The MOTHERS Act in Congress. This snowballed into an aggressive online, phone, email, fax and physical lobbying campaign to stop the legislation. By the end of the year, it died in Congress and had to be reintroduced the next year. By the summer of 2009, TIME Magazine was covering the controversy. It was only through Health Care Reform that the law ever passed, after it was slipped into one of the 3,000 pages without much fanfare. A core group of activists had been able to set off a much larger protest that effectively stalled this bill for the last nearly two years of its time waiting in Congress. As a result, people in-the-know from all around the world have heard of the law and will be more alert to similar legislation in the future.

Even deeper hope lies in the reclaiming of the sacredness of motherhood with full on support of pregnancy, childbirth and early parenting. Alice Walker (1997) quotes Samuel Zan, General Secretary of Amnesty International in Nigeria and activist for the abolition of the genital mutilation (female circumcision) of women:

“If the women of the world were comfortable, this would be a comfortable world.” (p 29)

We love the title of her book, *“Anything We Love Can Be Saved.”* It is cultural madness to think that salvation of our glorious mothers and precious babies lies in psychiatric labels and drugs. The solution lies in a much more beautiful realm, to which Walker points in amplifying Zan’s words: “Like Zan, I believe that if the women of the world were comfortable, so would the world be. In fact, I know this in my bones. Out of a woman’s security—which always means free agency in society, sexual and spiritual autonomy, as well as the well-being of her children and the sanctity of her home—comes ultimate security for the world.” (p 42)

This we can create.

The Ability to See and Act

Valid answers to the question of prevention can only come from the ability to see what is really going on and to translate the Orwellian language that perverts reality and results in poisoning our children. Here is an example of that translation:

Treating a mentally ill child with medicine for ADHD. This means...
Drugging a child judged as behaving poorly to control or alter their behavior.
Labeling and drugging a child to reduce adult discomfort.
Labeling children to create product points, to sell a product for profit.
Drugging a child to sell a drug.

Closing Thoughts on Prevention: The True Nature of Children

One of the authors wrote a book called *True Nature and Great Misunderstandings: On How We Care For Our Children According To Our Understanding* (Breeding, 2002). This book title is based on the premise, attributed to Anais Nin, that “We see the world not as it is but as we are,” and that we act accordingly. As long as people are so confused and misinformed that they think problems in living, specifically challenges with children, are due to biological or genetic defects in the children, then children (or mothers) will be blamed and hurt. Psychiatric drugs are an extremely powerful control device, a way to subdue children, and avoid adult responsibility for real understanding and real effort to meet children’s real needs.

Our view on the true nature of children is that we are born with brilliant intelligence, tremendous energy and zest, and intense relational desire. We also think that we can TRUST in the natural trajectory of human development, and do not need to tame and suppress our children. Breeding’s (2002) “21st Century Manifesto for Parenting” makes clear, however, that we are also strongly and regrettably aware that we live in a highly disturbed society, one not structured to meet well many of the developmental needs of our children nor the safety and support needs of pregnant and new mothers. Blaming the moms or children by labeling them defective and then suppressing them with drugs may provide a temporary false absolution of adult responsibility. The bottom line, however, is that such practice is pathetic, cruel and tragic. Let’s stop it now! The challenge is doing whatever it takes to be clear and strong enough as adults to fiercely defend them from unnecessary harm, and simply to enjoy and take delight in our beloved, spirited children, and the sacred experience of pregnancy and birth.

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Notes

¹ Tabulation of MEDWATCH Data submitted to the FDA on prenatal and neonatal psychiatric drug exposure-related complications: <http://twitpic.com/6g9gy/full>. Source: Citizens Commission on Human Rights International, release of FDA MEDWATCH data not previously published by FDA.

² The stories of Matthew Schultz, Julie Edgington and Christian Delahunty may be seen or read at the following. Schultz video at <http://tinyurl.com/inmemmatthew> and written story on his parents’ website, “Two Hours With Matthew,” here: <http://twohours.wordpress.com>. Julie Edgington’s story of her son Manie’s terrible heart defect caused by Paxil can be found at <http://tinyurl.com/bigpharmavictim>. Christian Delahunty of Utah spoke out about the loss of her six-week-old daughter Indiana from pregnancy and breast milk exposure to Effexor, and you can find her story here: <http://tinyurl.com/individ> and <http://tinyurl.com/indistory>.

³ For Amy Philo’s full story, go here: <http://tinyurl.com/amypvid> or <http://tinyurl.com/amypstory>.

⁴ “Clinical Management Guidelines for Obstetrician-Gynecologists Use of Psychiatric Medications During Pregnancy and Lactation: ACOG Practice Bulletin,” *Obstetrics & Gynecology* 2008; 111:1001–1020.
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