

A Special Interview with Robert Whitaker By Dr. Mercola

RW: Robert Whitaker

DM: Dr. Joseph Mercola, DO

DM: Welcome everyone. Today, I have with us a very prominent medical journalist. His name is Robert Whitaker.

He has written for some very impressive publications and actually was a nominee for Pulitzer Prize.

He is focusing much of his work nowadays on an area that is really near and dear to what we are teaching on our site and that is the use of psychiatric drugs and some of the natural course of history of typical psychiatric illnesses.

We have a very amazing discussion very shortly but before we start that, Robert, why don't you let our listeners know some of the publications you've written for and some of your journalistic achievements.

RW: Sure, I was a medical reporter at the Albany Times Union for a long time. Then I was the director of publications at Harvard Medical School for awhile. And then I did a lot of freelancing for magazines and newspapers and a series that I wrote related to psychiatry for the Boston Globe.

I was actually a finalist for the Pulitzer Prize in 1998.

And then in the past 10 years, I've been writing books. My first book was titled *Mad in America* and that was a history of the treatment of severely mentally ill.

My latest book is called *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs and the Astonishing of Mental Illness in America*. It's published by Crown and it's newly out.

DM: Thank you for that Robert. What I'd like to focus on now is really the use of the typical approach that traditional medicine has when it comes to psychiatric illness. Most of the information that we have on our site is really focused on natural adjustments to your lifestyle and this is primarily physical things.

But there is just no question, I have been a physician for almost 30 years now and it's very clear to me that some of the most important contributions to help in illness are really the emotional energetic component.

You can eat the healthiest diet in the world, have the best water, drink the best water, basically rid yourself of most toxic influences but if you have emotional challenges, it's definitely a problem.

So I appreciated this actually when I finished medical school. I knew that I understood that really well and actually became enamored with treating depression because it's such a pervasive issue and really one of the most common mental illnesses and depression can be a terminal illness. People die from suicide every day. That's not commonly appreciated.

I mean, you will know people that committed suicide but they don't realize the precursor for that is depression. It's got to be a pretty miserable feeling if you're willing to kill yourself over it. Obviously, there is a significant need here. The traditional approaches sought to use drugs to address this need. We believe that there are far better efforts.

What I'd like to discuss with you today is really creating some ammunition that many of our listeners can use to justify the approach and seeking a natural alternative to the conventional approach which is using these drugs. That in many cases, a lot of the recent studies and I'm sure you're familiar with it and can expand on it of course perform no better than placebo and are not without side effects.

So why don't we start there and we can start the discussion there.

RW: Sure and I think the ammunition I can provide is what does the research literature show both in terms of short term and long term, in terms of the effectiveness of this sort of pill oriented approach.

Right now, we've had a lot of talk about whether antidepressants are more effective than placebo over the short term and those are in six-week trials. And in those trials, what you see is that at least from mild to moderate depression basically the drug treated group doesn't do any better in any sort of clinically significant way in terms of relieving the target symptom of depression than the placebo group.

And as you said, all drugs have these benefit-risk ratios so if you're not getting a benefit over placebo on the target symptom, in this mild to moderate group, you really don't have a good rationale to use these as a first line therapy.

Maybe you're going to use them as a second line if other things don't work. Our focus right now is on the short term efficacy and it's sort of questionable.

But I think what your readers and your listeners need to know is what happens long term? What's the effect of antidepressants on the long term course of depression? And that's one of the things I looked at in this book and there are really two things you would find.

You find that even with major depression in the pre-antidepressant era and this is

depression so severe people were hospitalized; they could expect to get better. The episode would eventually pass. Usually for most people in six months, four months, six months, eight months etcetera.

So when antidepressants were introduced, the thought was okay, we really can hope to improve on this sort of natural recovery but maybe we can help people recover quicker. So that really was the rationale for the use of antidepressants.

But it's really interesting if you follow this course through forward in history, the minute they start using antidepressants in any sort of large numbers, doctors start saying, "Well, you know, my patients may be getting better, the depression maybe lifting faster but then we're noticing that they're also relapsing more frequently than before into depression."

So you right away you get this question, does the drug treatment actually put people on a more chronic course than before? And if you follow this epidemiological story forward, again, people used to have an episode, they would recover and then maybe two, three years later, they would have another major episode, maybe they wouldn't at all or maybe another 10 years.

It was very much like in a sense like the flu would visit for a time and it would take some time to recover.

Now, people are much more chronically ill and what seems to happen is they're put on an antidepressant and maybe the symptoms abate somewhat but they don't remit all the way. And what they found is that in those percentage of people that it doesn't remit all the way, they start heading down a chronic course.

So now, for example, if you look at the long term literature what it shows with major depression, only about 15% of patients that are treated with an antidepressant remit and stay well, basically for a long period of time.

The remaining 85% start having this relapsing course and it just becomes much more chronically ill.

And by the way, by the 1990s, this change in the long term course of depression was so pronounced that finally it would be actually addressed by researchers and there was a guy named Giovanni Fava from Italy who said, "Hey, listen, the course is changing with antidepressants. We're changing it from an episodic illness to a chronic illness and we really need to address this." Not only that the depression is sort of sinking into people in sort of a deeper way than before.

DM: Now when you say, sinking into people, this is the general population or those individuals who are placed on medications?

RW: Those placed on medications. As Fava says, it's almost as if the drug sensitizes

people to depression long term.

DW: I would like to interject a point here and I think its valid to the discussion with respect to the chronology of the antidepressants and as I mentioned earlier, one of my passions when I came out of medical school and admittedly I was founded and rooted in the conventional paradigm and I was not interested in practicing natural medicine.

One of my primary focuses was on depression and I became very skilled at using the drugs to treat depression. Now, this is in the mid-80's and the drugs available in the mid-80's, 25 years ago were significantly different than the newer ones that came out which were exemplified by Prozac which is a SSRI (selective serotonin reuptake inhibitor) but is really based on fluoride.

The biggest primary symptomatic difference was that these drugs, for the most part, did not have perceivable side effects using the drugs prior to the SSRI. It was like a nightmare and the biggest clinical skill that one had to get was to really understand how to carefully adjust the dosages to minimize the side effects so that people could tolerate them like with amitriptyline or Elavil. You have this tremendous dry mouth that's really a potent antihistamine and other side effects with it.

I'm wondering if your research has shown that this shift from those drugs which would have made it very difficult for patients to take long term to these easier ones without really annoying side effects at least acute side effects was responsible for some of the differences that you're seeing.

RW: I know exactly what you're saying; the switch from the tricyclics to the SSRIs. The chronicity seems constant in any sort of long term outcome studies. In other words, it starts showing up with the tricyclics fairly early on. Then switched to a chronic course but is also now seen in people treated with SSRIs.

And the problem is with major depression, so in other words, there has been studies by the NIMH in the 90's after Prozac that involved with the SSRI's and they find the same thing. You get a stay well rate of about 15% maybe and the other 85% end up with this relapsing course.

And it's really interesting, if you read the APA (American Psychiatric Association) textbook, I think it's like the 1999 one, they say, we used to think people would get well and that the long term course of major depression was pretty favorable. But now, we're seeing that's it a chronic pernicious disease but they're talking about medicated depression not unmedicated depression.

DM: Very important distinction. This appreciation developed in the mid-90's is your...

RW: Yeah, and here is what happened, so you have this guy in Italy named Giovanni Fava saying I think we're sensitizing the brain to depression long term with these drugs and this is the first major problem.

A very famous psychopharmacologist named Ross Baldessarini at Harvard Medical School. He's one of the fathers of psychopharmacology who says, "We really need to investigate this. This is what our research is showing." He says, it's not pleasant to consider but we have to look at this. Are these drugs depressogenic?

And then there was a response by a psychiatrist at Columbia University named Donald Kline and he says this, "Listen, stop talking about this. Nobody is interested in this question. The FDA is not interested The NIMH is not interested. Nobody is interested. We're just not going to investigate this and really you don't see the research done that would investigate it."

And that's the moment you can really see psychiatry sort of betraying its patients because here you have mainstream people writing about it seems like over the long term where we're turning depression into a chronic course that maybe these drugs in fact are depressogenic over the long term.

A major guy saying we have to investigate this and now, here's another major psychiatrist in America saying, stop talking about this. We don't really even want to think about this.

DM: Well, my suspicion is that the first one was honest high integrity clinician who wasn't necessarily in massive conflict of interest through subsidies from the drug companies.

RW: Well, you're exactly right and that's what he writes back. This dialogue actually happened in writing and Fava writes back, "Well, maybe you're not interested where you're under the influence of pharmaceutical companies but we're interested and we're going to keep on trying to understand what's going on."

Obviously, I think when people have a major depressive episode or depressive episode they do have two desires. One desire of course for the depressive episode to terminate and get out of that awful feeling but then they also want to think, am I going to be...how am I going to do long term? And they need to know the long term information at well. And long term with antidepressants is a very sort of discouraging course.

And by the way, when you were talking, we can go into this in a bit because Britain actually is starting to switch its recommendations in terms of how you treat depression but you talked about natural sort of lifestyle changes or things you can do to recover from depression. And there was a study by Duke University researchers in the late 1990's that had this -- this one really needs to be known -- it had this design.

It had three groups; there was exercise only, exercise plus drugs, and drug only. And after six weeks, the drug-only group was doing a tiny bit better than the other two groups. Then they followed up for 10 months and their hypothesis was that the best stay well rate would be seen in those with drug plus exercise.

But in fact, by far, it was in the exercise only group and therefore on the long term actually the drug being added to exercise was a hindrance to long term stay well rate and a notable one by the way. So there is an example of what is sort of a natural or healthy thing to do to recover from depression. Duke University's researchers looked at this. They said, "Exercise can help you sort of respond acutely but then it helps you stay well in addition."

Just so you can see how mainstream this is becoming in Britain, Britain has an advisory group, the national health service called the NICE (National Institute of Clinical Excellence). It recently, I think it was about four years ago, issued a paper on depression. It said, at least from mild to moderate depression, antidepressants should not be a first line of therapy. They are just not that effective even over the short term and as you said, they have all these side effects. So we need to look for alternatives.

And one of the things I said is exercise. Such that now in Britain, you can actually go to your GP and the GP, you can tell your general practitioner that you're depressed; he'll write you out a prescription for exercise.

And with that prescription, you will go and meet with an exercise counselor, that exercise counselor sets you up with a program usually at a gym because they also believe in additional exercise, it's good to be in social groups, community groups. You now get either a reduced rate or a free rate at a gym for six months.

Part of the exercise might be green gyms, and by that, they might be gardening outside, nature walks, repairing trails, hiking trails, and they are finding that people really like this, people comply with it as you know lots of people won't stay on antidepressants and what they say is when they've done interviews with people who have gone through this course and have been prescribed exercise, they say, rather than see themselves as a victim of depression and helpless before it that they have this sort of biological problem they can't do anything about, they say, "Aha, I can make a change, I can do something. It's in my willpower to do something that will help this problem, you know, lift. This mood lift.

So it empowers the patient in a different way that drugs do not.

DM: Well, that's very exciting to hear. When did they implement that program in Britain?

RW: It was in 2007, the Mental Health Foundation, they started running a campaign alerting GP's to the literature that they could in fact...GP's, they have been able to prescribe exercise for other physical illnesses as part of the rehab and now they started alerting GP's use it for depression too. Take advantage of these already existing programs.

DM: Prescribing exercise...

RW: Prescribing exercise, excuse me. So they mounted this campaign in 2007 and a

number of doctors now prescribe, GP's prescribing exercise has increased from around 4% two years ago and it's up to about a quarter, 25% of all doctors in Britain. And of course they want to keep this publicity campaign going and really make it sort of a frontline therapy.

DM: Well, that's very exciting to hear. I have not heard that before and it's encouraging. It's somewhat shocking and surprising to find out in light of the tremendous influence that the pharmaceutical companies have over that approach and really it's a serious loss of revenues. I mean, when someone is on exercise and they're not taking drugs, it's a loss of revenue. So there is going to be I would imagine an effort to thwart that type of intervention.

RW: I'm sure they will and there is a lot of pharmaceutical influence with doctors in the UK as well. But, of course, the UK has a national health service and they have been spending ever greater amounts of money on antidepressants. So, from that angle, they want to actually curb their spending on antidepressants because it's not getting them good results, cost efficient results.

DM: I'm a really strong proponent of exercise. I've been personally exercising for well over 40 years and was actually one of the reasons why I went to medical school to use it as a therapeutic modality. What I've learned though is that even though it's useful and there are a lot of specifics with exercise because there are so many different ways, there is like five or six primary different types of exercise you can use and they're all valid in their own way. B

ut, what I've learned is that there are modalities such as the foods that you're eating. If you're eating foods that are really high processed foods and high in these sugars, that's going to move production of your neurotransmitters to the point where they are relatively unhealthy.

Unhealthy fats are another issue or they have fat deficiencies such omega-3 fats or high concentration of highly damaged and toxic omega-6 fats. So these are all other elements, physical elements that can clearly have a major influence on one's ability to contract a mental illness like depression or certainly any of the others.

RW: You know, I didn't investigate this a lot but when I was doing my research on depression, one thing I found very interesting was the sense that depression really is a mind-body illness. And by that I mean is you do see it take hold in people who are not that physically healthy and whether that be from diet, lack of exercise, etcetera.

So, again, you're much more prone to depression and for whatever reason, if you're not in good health and eating the wrong foods can obviously contribute to that. And obviously one of the things that are happening with exercise, its improving your overall health.

And one of the things that's happening with the studies on exercise, they're even

showing that as your aerobic capacity improves which is a sign of health; there is a pretty good connection to the lifting of mood with aerobic capacity.

So there is a sense that depression just doesn't take hold in the mind and the brain that really it's this mind-body thing that happens and that good physical health can certainly lower your risk of developing depression in the first place.

DM: Yes, indeed. I think the newest folks on exercise is, as I mentioned that's one of my passions now is in this anaerobic capacity. Your ability to do this short term bursts which is much more physiological in what we see in nature and the way animals exercise.

I mean, it's very unusual to see an animal running 20, 30 miles until they crack. Typically, they do these bursts. I think incorporating more of those types of exercise could be pretty healthy but eventually, you can do all of these healthy lifestyle changes and really have an almost perfect approach and still have significant mental and emotional trauma.

That is because we are in a world that imparts that on a regular basis. It's just hard to live without encountering some type of challenge. What I found to be effective in my clinical practice is the use of these energy psychology techniques that are very useful. They are used by over 10,000 psychologists. It's not as commonly used in the psychiatric community but the simple tools where they are best represented by meridian tapping techniques or emotional freedom technique where you tap on these meridians and you essentially activate different memory traumas in the system and reframe it and improve that electrical circuitry so that these types of illnesses can improve dramatically that they are really quite simple to do.

The challenge with many of them though is that they are because they are so simple, the average person who is untrained in them thinks that they could do it themselves and really there is a significant art to it. So for serious illnesses as depression clearly can be if you're going to kill yourself and it's certainly wise to seek out that skilled professional who can assist that person. But, these other tools and options are clearly available.

What I'd like to focus on too is now is you have really compiled. You've done your homework. You put probably thousands or tens of thousands of hours into studying this issue very carefully and if you can enlighten our listeners as to aside from the central point which you've just brought up of going on this chronically to actually developing the depressive symptoms as a result of taking the medication some of the other side effects or concerns that one needs to be alerted to by choosing that route.

RW: We hear about a lot of side effects, sexual dysfunction etcetera and maybe sleeplessness, that sort of thing. But I think there are two side effects or risks that really need to be addressed and then everybody should be thinking about that do show up in the scientific literature.

The first risk is in fact that you'll convert from unipolar depression to bipolar depression.

And you definitely see this that the drugs are meant to rouse, right? That the risk of having a manic episode or a quasipsychotic episode when you go on an antidepressant is real and so one of the things we've seen with the use of the SSRI is of course is this incredible extraordinary boom in bipolar diagnoses and that is definitely tied to the widespread use of antidepressants.

Now, in kids, something like 25% to 50% of all kids placed on an antidepressant, who stays on that antidepressant for five years will convert to bipolar illness.

With adults, it seems like about 25% of long term of users that begin with a diagnosis of unipolar depression will convert to bipolar.

Now, by bipolar used to be a fairly rare disorder but now it's becoming much more common. Why is this so bad?

Well, when you convert from depression to bipolar, now you're in a category where you're often treated with a cocktail of medications including an antipsychotic medication and long term bipolar outcomes are really problematic in this country. Only about 35% of bipolar patients now are employed.

So you see this risk of disability. Bipolar patients today do a lot of cycling.

So my point is this, when you go on an antidepressant, you do have a risk of having a manic episode and that is a risk of becoming "a bipolar patient" and at that moment if you're into a much more long term problematic disorder with not a good outcome today. That's the first risk.

The second risk and that these people should appreciate it, the second real risk is there is a lot of evidence compiling that if you stay on antidepressants five, ten, fifteen years, there is some real worry with cognitive decline associated with that long term use.

Now, it's not as flushed out as we might like because of course no one is paying to study cognitive decline but as one researcher at Massachusetts General Hospital said when we look for it, we find that it's quite common. So, I would say that's a real concern and I think the marker for this if you talk to people who have been on SSRIs a long time, they'll often say, you know my memory is not very good anymore.

And memory is sort of the canary in the mine in terms of a very visible sign of some cognitive decline. So I would be worried about that with any long term use. Those are two risks that tell of long term significant harm done.

DM: There was actually another clinician at Massachusetts General who advocates the use of omega-3 fats for the treatment of depression and actually his book was written awhile ago but it was really one of the more popular ones and it would make sense too

because actually that the population that was deficient in omega-3 might be more predisposed to the depression but also, the population would be more predisposed to developing chronic degenerative neurological diseases like Alzheimer's.

So, it makes sense that they are correlated. It may not even be necessarily caused by the medication but it's certainly not going to help it once you're introducing something that clearly is only designed to treat the symptoms and in no way, shape or form, addresses the underlying reasons as to why that person is depressed.

RW: No, I mean, this idea that they fix a chemical imbalance is scientific nonsense. I'm talking about SSRIs.

DM: I totally agree with you and perhaps you can...I suspect you've really researched that well and that is the current theory that there is this "chemical imbalance" that exists within your brain and these drugs are going to correct that imbalance. And it's a really brilliant marketing metaphor and I'm wondering if you can expand on that because I think that really is the justification that most physicians are using to put people on these drugs.

RW: Yeah, I think this is important to understand because it ultimately it is a marketing statement. It's not a scientific statement at all.

And in this book, I do trace where that arose from and let's just say the low serotonin theory of depression.

That theory arose because they understood how the drugs acted on the brain. So, this actually arose before Prozac's arrival. But say they understand that a drug blocks the reuptake of serotonin into the pre-synaptic neuron and it therefore keeps serotonin longer in the synaptic cleft. While researchers hypothesize based on that mechanism of action since it was keeping serotonin longer in the cleft that people had low serotonin.

But it was just a hypothesis borne to try to explain why the drug might be fixing something. They investigated whether people had low serotonin. They really did these investigations in the 1970's and early 1980's. This is NIMH funded researchers and I could go over that research but I will tell you what they concluded.

In 1983, NIMH concluded basically there is no evidence that there is anything wrong in the serotonergic system of depressed patients.

And this was in 1983 before Prozac is released. So there was never evidence that people with depression characteristically had low levels of serotonin. As one doctor I interviewed about this who did some of this research said, the serotonin theory of depression is comparable to the masturbatory theory of insanity. It's just not a scientific statement.

So it was reborn in 1987 to help sell Prozac but it was reborn as a marketing slogan, not

as a scientific slogan.

And the other thing that you have to understand then is if you don't start off with the serotonergic problem when you're depressed, like you don't have low serotonin, but now you put yourself on a drug and this drug blocks then normal reuptake of serotonin, your brain actually will undergo changes to try to compensate for that blockade and what happens, the brain changes in two ways, the pre-synaptic neurons actually put out less serotonin and your post-synaptic neurons actually pair away the density of their serotonergic receptors.

So, you start out with a normal serotonergic system. You go on an anti-depressant and you actually physiologically end up with a low serotonergic state.

This is very well understood. So, in essence, I know this sounds ironic but drugs cause the very thing that was hypothesized to cause depression and that is for this low physiological state.

And the reason for this is it's well understood is that say for in this example the drug is trying to put down the accelerator on serotonergic transmission and the brain tries to adapt to that by putting on the brakes. So it's a compensatory adaptation and just final thing, so your listeners don't think this is just one medical journalist saying this, in 1996, Steven Hyman who is then head of the NIMH, today he is Provost of Harvard University. He's a neuroscientist.

He published this paper called Initiation and Adaptation: A Paradigm for Understanding Psychotropic Drugs. And here is what he said that drugs like antidepressants work. He says they work by, "Perturbing neurotransmitter systems not balancing them" and in response to that perturbation, he said, "The brain undergoes these compensatory adaptations" that I've just explained and then he says, at the end of this adaptation, the brain is operating in a manner that is, "Both qualitatively and quantitatively different than normal."

So these are not normalizing agents from a scientific point of view, really they are abnormalizing agents and once you understand that, you can understand why maybe they might provoke a manic episode, why they might be associated with sexual dysfunction or violence, acathisia, etcetera.

It's because they in fact are abnormalizing agents and you can also see why long term once you have this new way of operating with the accelerator down in one hand and the brake on the other, that you might have cognitive problems long term because you're going to be some dysfunction in those serotonergic pathways.

So, this is really key. Are these normalizing agents? No.

Are they abnormalizing agents? Yes.

DM: Yeah, the ultimate irony is that the drugs are causing the very things that they were designed to cure. For our listeners, I'm not sure if we mentioned it earlier but you've mentioned a few times the NIMH researchers and for those who aren't aware of that that is the National Institutes of Mental Health.

One of the most prestigious institutes in the United States and typically associated with impartial funding so that hopefully their results are unbiased and unprejudiced. What you just discussed too is how the research was focused on the serotonin receptors but I'm assuming they're similar effects with the dopamine or the norepinephrine receptors too.

RW: Yeah, basically what Steven Hyman was saying, this is how you have to understand all psychotropic drugs. Is they perturb something and it provokes an opposite response and I'll just give you an example.

Anti-psychotic drugs block dopamine receptors in the brain and they do this rather powerfully. They block 70% of D2 receptors. Well what does the brain do in response to that blockade? It says, "Uhoh, I'm going to try to maintain my dopaminergic pathways."

The pre-synaptic neurons at least for a time pump out more dopamine trying to compensate for this blockade and the post synaptic neurons increase the density of the dopamine receptors.

So, it drives the brain into...the brain becomes supersensitive to dopamine and believe it or not, researchers have found that over the long term, that probably increases the biological vulnerability to psychosis.

This is the problem with this whole paradigm of care. We don't know what's wrong; we don't know what the biology is. So the drugs perturb some functioning and then the brain tries to compensate for that perturbation and long term, it turns out that that is a very problematic model.

DM: It is. I mean this is some very interesting and compelling research that you have really explained to us. The typical person in the United States, the average consumer is my guess under the impression that most researchers and scientists and physicians are well intentioned and unbiased and unprejudiced and they are really seeking to provide the best possible care.

Unfortunately, this doesn't appear to be the case otherwise this information would clearly change the system that we're doing.

I'm wondering what type of factors you have uncovered that prevent or limit implementing this understanding of what the drugs are doing?

RW: Yeah, this is a really interesting story. By the way I agree with you. I think most doctors do want to do well by their patients, right? I think actually many; many

psychiatrists believe that their drugs fix chemical imbalances because they actually haven't looked at the research.

DM: Yeah, we're both in agreement. There is not some type of conspiracy from physicians or psychiatrists. They do believe what they're doing helps.

RW: That's right. But what happens at the very top levels and sort of psychiatry as a field and here is what happened because there is a historical story as to why our country is deluded, our society is deluded and believes in this chemical imbalance story.

In the 1970's, psychiatry as a discipline felt it was under siege. And it felt that it was under siege because there were a lot of other therapists entering the "therapy marketplace" social workers, counselors, psychologists. And they suddenly felt they were in competition for patients. That's the first problem.

The second problem they felt is in fact, their first generation of drugs was sort of failing in the market place.

Benzodiazepine for anxiety was being seen as addictive and very harmful. The anti-psychotics were seen as causing a permanent brain dysfunction called Tardive dyskinesia and sales of psychiatric drugs actually declined from about 1974 on for the next six years.

And psychiatry sort of circled the wagons and they said, "How can we revive and strengthen our field?" And they said, "What gives us our competition in the marketplace? It's that we have prescribing powers and these other therapists do not."

So there was a census, we have to revitalize the image of psychiatric medications in the public mind.

And they did this starting in 1980 with the publication of DSM3 which put psychiatry and psychiatric disorders into a medical model. They started touting the story. "These illnesses are known biological illnesses and our drugs like insulin for diabetes, they fix those biological ailments."

But that was all really done to sort of revive the market for psychiatric medications and it was done sort of the highest levels of American psychiatry.

And in fact, and I do this in the book, you can even chart how in 1981, the APA (American Psychiatric Association) set up a publicity arm and basically they start selling the public on this medical model and it was to revive and protect the market for psychiatric medications. That's the first problem.

In other words there is this competitive thing where psychiatry needs to make its drugs look good in order to maintain its advantage over the non-prescribing therapist.

The other thing that happened and this really is problematic, is that in 1980, the American Psychiatric Association, as its annual meeting, started allowing pharmaceutical companies to sponsor symposiums.

They had always been allowed to put up exhibits on the exhibit floor but now they were actually allowed to sponsor scientific “presentations.” At that point, they began hiring academic physicians, people at major medical schools, to serve as the speakers at those events. And this is where the wall breaks down between academic psychiatry and the pharmaceutical companies because now the top doctors in the country, the top psychiatrists are going to start becoming paid to tell a story that pharmaceutical companies basically want told.

And pretty soon they’re serving as advisors, they’re serving as consultants, they’re getting research grants as speakers. There is a lot money flowing to “the thought leaders” in psychiatry or the key opinion leaders. And in essence, they become the salesman for these product lines and they’re very effective salesmen and they have basically created this false story.

And unfortunately they get paid; they can make a lot of money. I mean, some of the amounts have come out of Senator Grassley’s investigation. We’re talking of millions of dollars going to the top key opinion leaders within psychiatry.

So that’s how come we got this delusion. We had these storytelling forces within society come together that wanted to tell a story of drugs that were safe, effective, wonder drugs that fix chemical imbalances.

And, unfortunately, that story was out of sync with the research. It’s just not a scientific story.

DM: That’s very impressive information and many of our listeners are not aware of that and thank you for sharing it because it does provide an important piece of information that most people are not aware of and that there are reasons for what appears to be irrational choices that are being made in prescribing these drugs.

RW: Yeah, I mean, if you got to follow the money and you got to look at what monetary forces shape these storytelling forces in our society and you can shape them, how they took cold in the 1980s and how of course we have embraced this model of care.

In 1985, when this sort of storytelling coalition took hold, the country spent about 600 million dollars on psychiatric medications. Today, we spend over 40 billion dollars.

The market has grown something like 70 times. It’s really astonishing.

And by the way, we in the United States, think of this, spend more on antipsychotic medications than the gross national product of Cameroon.

DM: That's quite startling but 40 billion dollars; I didn't realize it had grown to that much.

RW: It's grown to that much if you look at all psychiatric medications; it now tops 40 billion dollars in the United States.

DM: And my guess is that the new healthcare plan that the President was able to push through is going rapidly accelerate that process.

RW: I think probably so because there is even some sense of parody for psychiatric diagnoses.

DM: Yeah, and it's sad too but hopefully as we move more towards a socialistic model we'll be able to inject some sensibility into the system like what they have done in Britain or England and start using exercise as a valid option because what I failed to mention in all these lifestyle changes that are being recommended for depression such as the diet and the exercise, they're not exclusively limited to mental illnesses, they will improve every other chronic and degenerative disease that we know of; heart disease, cancer, arthritis, and diabetes. This will get all these diseases better. So it's not just mental health.

RW: Well I do believe mental health is related to physical health.

So any sort of lifestyle changes that improve your physical health it's going to help your mental health as well.

One thing on this, you know, like I said, I've been covering medicine science for a long time and I'm a big believer in evidence based medicine. The book that I wrote really is looking at what is the evidence base for psychiatric medications. I've been telling that story.

One of the reasons I write about in the solution sections about evidence is that there is a good evidence base for it. By that I mean, it's been tried, tested, and it shows to have this benefit over long term.

I'm not at all familiar with the literature on dietary or omega-3 etcetera and you can address that but I think in order to help convince the public or help the public understand the benefits of these alternatives, you need hopefully, good studies that can sort of document that in an evidenced based way. I don't know if it exists or not. I researched it for exercise but I haven't done it for other alternatives.

DM: Well it certainly exists for the omega-3 fats where the literature is somewhat sparse and we just started the trials and this is largely related to the lack of funding for these types of activities would be the use of energy psychology techniques.

There is really only a relative handful of studies that have been published but they clinically and anecdotally were quite phenomenally well. I mean they are nothing short

of miraculous from what I've seen. It's the closest thing to magic.

RW: Right. Well I guess just because of the history of medicine and all. As you know, the history of medicine is filled with a lot of remedies that for a time are sort of touted as very effective and then they don't have staying power and it helps the remedy have staying if it can be put sort of to the usual...and I understand there is the lack of money for it but sort of the usual trials that can create an evidence base.

DM: I couldn't agree more and eventually that literature will exist but in the meantime, there doesn't appear to be good scientific support for continuing a flawed system which will A. Not only be an effective at treating the symptoms but B. More importantly, make the problem worse in the long run.

RW: And you know, the evidence is really clear on this. It's not that depression has become less of a problem in our society, the disability numbers to depression are just soaring.

In fact, if you look at one of the things I looked at in this book is the number of people on SSI (Supplemental Security Income) and SSDI (Social Security Disability Insurance); this is government disability programs due to mental illness. This is people who can no longer work and they get a check.

Well, first of all, when Prozac was introduced, there were 1.25 million on government disability due to mental illness.

Today, 20 years later during this time our spending has exploded. There are four million people on disability.

The number of people going on disability is increasing. Adults at the rate of 850 people per day, 365 days per year. Very few of those people are now getting off once they go on.

And if you look at what's driving the increase, it's not psychotic disorders, its mood disorders. Its depression and bipolar illness and it used to be very few of those people ended up on long term disability.

So here we have this new embrace of a medication that is said to be a wonder drug and what do we see, we see disability rates do to depression and disability rates do to bipolar illness are skyrocketing.

DM: Yeah, we're definitely directionally don't want to heading like most areas in life, an ounce of prevention is worth a pound of cure.

So I'm wondering from the research you have reviewed and compiled if you can provide our listeners with some of the warning signals of depression. It's not just feeling blue. It certainly can be but there are very specific symptoms. It's a real clinical entity so I'm

wondering if you can...

RW: I'm sure you can do this better than I can. I'm sure you can do this better. What you'll see in my opinion when you look at sort of pathways to depression, you know, you often do see environmental triggers and by this I mean a loss of a job, a marriage breaks up, a loved one becomes sick, there is these stress triggers.

You'll see lack of sleeping is a big trigger that something is not going right. You know, you'll see depression and anxiety, those are very connected. You'll see people getting anxious as well.

So, environmental triggers, insomnia, anxiety, sort of appetite changes. And also you'll see that you still don't want to be among people as much, sort of withdrawal.

I mean, all those are things that you're sort of heading a little bit for a fall and that maybe if you can make changes before the fall really hits, you can sort of head off the depressive episode.

DM: I would just reinforce some of the elements you said. I think from my perspective, sleeping is clearly a key issue. If there is not some type of sleep disorder it's really hard to really qualify as depression although clearly you can be depressed without that. But it might be inability to fall asleep or you might be sleeping all the time.

Lack of interest, diminished interest, feeling guilty, inappropriate feelings of guilt, loss of energy and feeling tired. It's like you have no energy would be another major clue that something is going on, and the appetite. Most of the time you're going to be hungry but if your appetite goes away in a persistent basis you got to start thinking about some of these things and then the obvious and most significant one is suicide. Because people do die.

I forgot what the numbers are but I think it was somewhere about 30,000 a year. It's a hundred people a day.

RW: Yeah, that sounds about right.

DM: That's a lot of people. That's a big plane crashing everyday of people killing themselves from suicide.

RW: Right. When you put it in that framework it's obviously something we need to be paying attention to and trying to help people that hit that suicidal moment.

DM: This is pervasive. It affects pretty much most every one of us at some point or another. Not necessarily a major episode of depression but we're feeling...it's a spectrum and remissions might be a few days or so when we're not feeling that great and that we get over it quickly but this is an area that is significant and a concern and I really appreciate all the time, effort, and energy you went in to compiling this information

to document that traditional approach that is typically and routinely recommended is one that needs more serious evaluation if you're going to choose that and to do your homework and certainly if not for yourself, for your loved ones, your friends, your family that there may be better options.

Now, I guess one caution is that the majority of people who might acquire this information is they are not in the episode where they are suffering from the initial symptoms of depression and the pro-active preventive stages but they already have it and they have been placed on these medications perhaps for years or decades. So that presents a different challenge.

RW: Yeah it does present a different challenge and you know, to be honest with you, a worrisome challenge. I mean there is some evidence that really pretty consistent evidence that the longer you're on antidepressant medications frankly, the harder it is to get off. In other words, your vulnerability to relapse when you come off it increases.

DM: The perfect drug from the drug companies' perspective.

RW: Well, yeah, there a sense of the trap.

I mean, they are a perfect drug in the sense that, let's say they do help you. Let's say you have this sort of six week relief of symptoms, but then you become sort of depressed again.

And you see this by the way in the ads about how often people become depressed again. Television ads now, we have this new ad for Abilify which is an antipsychotic, it says, two-thirds of people with an antidepressant are still depressed. Now, add a drug.

Well, you want to say "well apparently the drug is not working too well if two-thirds are still depressed."

DM: That logic is too rational. That escaped me.

RW: There is a real concern here is that they are sort of trap because your brain goes through this compensation, this adaptation, and now let's go back to the accelerator-brake analogy.

So you've been on drugs and the drug is trying to put down the accelerator serotonergic activity and your brain responds by going through these physiological changes that put down the brake.

Now, imagine what happens and this is what happens when you go off the drug, you remove the brake. Well, now you're in this unbalanced state where you have the drug still trying to accelerate activity.

Anyway, it's quite clear that when that happens, you can have some very severe

withdrawal symptoms and it's not just symptoms of depression returning, you might have all sorts of odd symptoms and then what happens is withdrawal can be so difficult that people just say, "Heck, I'll just stay on my drug."

So that's a real problem in a way that the drugs can act like a trap and I do believe the longer you're on them, this isn't well studied but the longer you're on, the harder it is to come off.

Really, there is some sense; the harder it is for your brain to sort of renormalize and receptor density is to return to normal and all.

I wish we would study this but we don't really know a lot about what happens after long term on the drugs and what happens when you withdraw at that time.

DM: That information is strong support for a cautious approach to discontinuing these drugs. This is not something you want to stop because you're concerned about the long term dangers by yourself. You really need to do this with a qualified and knowledgeable clinician.

Now, my perspective is that most physicians would be able to [inaudible] you off of these drugs but they're based in a model that's going to want to replace it with another one.

So more than likely you're better off seeking a clinician who has rooted most of his framework in understanding the natural health and using natural healthy options such as the dietary changes, the exercises, and some of the energy psychology approaches to do this carefully.

But anyway, you just do not, and I want to emphasize it a lot, do not stop these medications cold turkey, you are just asking for trouble. You can, most of the time, wean off of them slowly. It might be a few weeks. It might be a few a few months but you just got to go off them slowly.

RW: That's truly what the scientific literature shows and I interviewed a number of patients. They reiterate that as well. You just don't want to be going off abruptly, but the other thing you said, I think is important.

It can really be helpful to have someone supporting you and watching you and sort of helping you understand -- I'm talking about if you're weaning yourself from medications - - and helping you understand some of the symptoms you maybe be feeling may be related to drug withdrawal and give you some sense of how long you may be experiencing those withdrawal symptoms, because you can have withdrawal symptoms even when you gradually withdraw.

So I think your message about having some professional support is a very good one.

DM: It doesn't make sense to harness the placebo effect--, and the placebo effect is not some type of nonsense. It's very real and the most powerful demonstration of that is a study that was published I think in the year 2000, it was published in the New England Journal of Medicine, one of the most prestigious scientific journals and it was double blind placebo controlled trial, multi-centered and Harvard is one of the six hospitals where it was done and they essentially looked at knee surgery or arthroscopy and they did a placebo or a sham surgery where they inserted the arthroscope and did no surgical intervention. They just put the scope in and I'm sure you've heard of it and then they did another where they actually did the surgical intervention.

And what they have found was that there was no difference between the two groups.

Now, that didn't mean that the procedure didn't work to me. I mean, you could interpret it that way. That's one interpretation.

My interpretation is that when you go through that type of intervention and you can even use cardiac bypass surgery as another example although it hasn't been studied like this because of the ethics I'm sure.

But, the central issue is that you can harness the power of your mind to accomplish incredible miraculous transformations.

At a physical level, let alone, be a mental emotional level which would seem to me far easier to do but I mean you can physically change your knee tissue. You can certainly change your brain so that the assistance with a really compassionate support of a healthcare professional will help. You may not even do it specifically for that purpose but it's going to happen. That placebo effect will be activated and you will get better just because of that.

RW: Well, there are two things here. Yes, the placebo effect is powerful in many areas of medicine both bodily and mental, but there is a real interesting history with active placebo in depression.

Trials that have compared drugs to active placebo and an active placebo rather than just being a sugar pill, is some agent that might cause dry mouth that will have some sort of side effect.

And when they have done trials that compare active placebo to drug for depressed patients, time and time again, there is no difference at all even in the short term results.

And what researchers who did these studies in the 70s said, what appears to be happening is the side effects enhances on the active placebo enhances the normal placebo effect because people get the dry mouth and say, "Aha, I must be getting the magic pill."

So once you have that effect going in an antidepressant trial even over the short term,

the antidepressant does not perform the active placebo and that led people to conclude in the early 80s maybe these drugs they are not antidepressants at all, they are just active placebo is what makes them work.

So that's one thing, but I would also caution there is another thing that I sometimes think gets confused between placebo and natural recovery rates.

Because placebo of course is when there is an intervention, something has happened.

But what is the natural recovery rate from depression? In other words, if you don't even have a medical intervention but let's say you get it, you're in your house and maybe you do make some changes in your life whether it be go for bike rides or maybe a job happens or whatever but my point to this is the human being does have sort of a natural capacity to recover from a lot of emotional states.

So that's beyond the placebo effect.

So when we think about whether we need to take a medication especially long term, you have to think both of the placebo effect but you also want to understand the sort of baseline natural recovery rate and for many mental disorders, that baseline recovery rate over the long term including depression is quite good.

DM: I think that's a clear point to emphasize is the natural recovery rate. This is pre-intervention with these drugs because the longer you've been on the drugs, the worse that recovery rate is going to be.

RW: Well exactly and that's one of the things again that comes up in the depression story is the NIMH, if you would become depressed in say 1970 and you had gone through NIMH literature, you know what they would have told you, the NIMH literature, whether you get treatment or you don't get treatment, you're going to get better.

You have every reason to believe it will not turn chronic because it's only a small percentage of people who end up with chronic depression.

DM: What was that percentage? Was it under 5%?

RW: Well, no, it was about maybe 10% of people entering...we're talking about hospitalized depression even the epidemiological studies of people so depressed they're ending up in the hospital.

Even among that group, it's only 10% maybe 15% ending up with some sort of chronic long term course.

DM: That's another piece of good news. I mean, it's a really powerful piece that I frequently forget to mention is to emphasize that you're going to get better as long as you don't choose the drug.

RW: Well you know, it is a very optimistic thing that, I think. Right now people said take the drug and you're probably going to become chronic anyway. But yeah, the natural history message is a very, very optimistic one.

Here is what the NIMH said in 1974 to depressed patients. This is from Dean Skyler, head of the depression section at the NIMH. As he wrote, "Most depressive episodes will run their course and terminate with virtually complete recovery without specific intervention."

That's quite optimistic.

Here is another one in 1969 an NIMH publication. Assurance can be given to a patient and to his family that that subsequent episodes of illness after a first depression will tend toward a more chronic course.

Here's another one, "Depression is on a whole, one of the psychiatric conditions with the best prognosis for eventual recovery with or without treatment. Most depressions are self limited."

Wouldn't that be nice to hear today?

DM: Well, it's going to be heavily suppressed by the drug companies that are for sure. They do not want that message out.

RW: No, of course not.

DM: So I mean the message that needs to be shared is one that you really compiled and put together and really reinforce is that you just got to avoid these medications. Now you studied these really carefully. I guess the fear of it is as a physician is that are there any indications, is there any subset of patients however remote or rare that may benefit from these drugs. Do you think they are ever clinically indicated?

RW: I do.

DM: Alright good. Tell us who those people are because let me give you an analogy. For the most part, I believe almost all Statins, the drug used to lower cholesterol are absolutely dangerous and should be avoided by almost everyone but there is a small subset of people about 1 in a thousand who have a genetic disease. It's called familial hypercholesterolemia and their cholesterols usually run about 350 or so and they seem to benefit from it. But that's 99.5% of people not needing it.

So who are the people in your evaluation review suggest benefit from these approaches?

RW: Well let's show who shows up in the short term clinical trials. There is a subset

that really does do better than placebo. And that's those with severe depression.

So they're on the Hamilton Scale. They are at a number puts them in "The severe category." And over the six weeks, they do seem to have an abatement of their symptoms that's clinically significant more than placebo.

So, this again is what the National Institute of Clinical Excellence in Britain concluded is that that shows there is some rationale for using antidepressants in that subset of depressed patients. Even sort of as a first line therapy.

And then I think once you see that rationale for use, I think you still want to look at the long term outcomes even in severe patients and given that in the preantidepressant era, severe patients regularly did get better and stay better.

By the way, the NIMH looked at this in the late 1990's what is the untreated course of major depression today and they found that those old epidemiological studies that showed that 85% were well at the end of the year, still held true.

You want to remember that, so I think the rationale use would be in this subset would be okay, use it to help people get out of the severe symptoms on a short term basis and as that happens, help them encourage to make changes whether it be diet, exercise, get in to community groups, join clubs, whatever it might be and then help them wean off, try to help them wean off after six weeks, eight weeks.

So use them as a short term crutch. I think that makes sense.

DM: And I like the term crutch because it really applies in the image of an acute injury like you're in an accident or you fall on a stairs and you are physically wearing a crutch and allows your bone to heal in that time frame and after that time, you'll wear a crutch the rest of your life, certainly for months typically.

RW: Exactly, so I think if you had a paradigm of care that said okay let's throw away the crutch and get people back to a non-medicated life, that would be terrific and the drugs, I'm talking about the SSRIs and pay attention to other side effects and the risk of mania and then they would have a sensible thoughtful use in place.

DM: I like your approach and I appreciate all you've done for helping us understand this at a deeper level. Are there any other pearls of wisdom that you'd like to share from the information that you have put together?

RW: Well, no, I just think the bottom line is this is that and when we're talking about antidepressants; people need to broaden their horizon in terms of as they try individually whether or not to go this route.

And they've got to broaden their horizon that includes long term effects, risk of mania, risk of cognitive decline and incorporate that into their decision making process. I think if

they did so and see this long term chronicity, people would be making different decisions.

And last thing is this, the one thing it seems to me in people I interviewed they got better and that depression is gone.

They talk about sort of the agencies, sort of making changes in their life that gave them a sense of control over their well being. I think anything that encourages that sense of control that you can do things to at least minimize the risk is a very good thing.

DM: Excellent. Well people want to learn more about the specifics and I'm sure they can look at your book and can you give us the name of that book again and I'm sure it's on Amazon.

RW: Yeah, it's called Anatomy of an Epidemic. Again, my name is Robert Whitaker. So you can order it there or you can go to Barnes and Noble or Borders and should be able to find it there as well.

DM: Excellent. Well, thanks for all the work you've done not only for this book but for the many years you've put in to help educate us about the truth and that really is clear. And that's one of my passions too.

I'm a medical journalist even though my initial training is a physician but I'm a medical journalist and trying to help people understand because they are just too...are largely busy, the economy kind (inaudible 1:02:13) tanked and we've all got things to keep us occupied and we just don't have the time which is really the key and limiting (inaudible 1:02:20) resource for most us to evaluate these things like we need to and it takes a lot of time to do that.

So, I really appreciate all the time you invested in helping uncover this because it's a big story that needs to be shared. So thanks for all you did.

RW: Well, thank you for having me. It's my pleasure being with you.