Chapter 1

Introduction
The Drug Deception

The Deception

America has been deceived—deceived by the drug companies, by psychiatry, by our children's teachers, by well-meaning physicians, and by mental health workers of all stripes. The deception has been so complete and successful that Americans believe the deception is fact. As a result of this deception, Americans are suffering.

The deception is that whatever one's problem—hyperactivity, short attention span, depression, shyness, sadness, obsessive-compulsive disorder (OCD), phobias, anxiety, panic, overeating, sexual dysfunction, poor athletic performance, sleeping difficulties, drug abuse, irritable bowel syndrome, and even schizophrenia, to name a few—there is a drug that can help the problem, if not cure it. But to keep the current customer base, the drug companies do not really want to permanently solve the problem. Rather, they want to keep selling Americans drugs. The drug deception is now widely entrenched, thus those with behavioral problems have been so completely fooled that they are now unknowingly reinforcing the deception. The deception has become self-perpetuating. In fact, many with behavioral problems and their advocates do not even consider their behavioral difficulties *behavioral*. No, they believe it is "fact" that their problems are "neurochemical" or "brain based." And if a problem is assumed to be neurochemically, brain based (although behavioral problems are not), then a logical—but often an incorrect—assumption is that the best way to help the problem is with chemicals, with drugs.

It is the nature of deceptions that they are believed to be true by those deceived. This is the case with the mental health community. The mental health community—the "professionals" and patients—has so completely bought the drug companies' and psychiatry's sales pitch that behavioral problems are "brain disorders," that now it too is perpetuating the deception. I was invited to be on the speakers' bureau of a local mental health organization "funded by a grant from the Ohio Department of Mental Health." Included in its mailing to me was the flier "Some Facts about Mental Illness," which included the statements: "Mental illnesses are disorders of the brain that disrupt a person's thinking, feeling, moods, and ability to relate to others. . . . Just as diabetes is a disorder of the pancreas, mental illnesses are brain disorders. . . . As a diabetic takes insulin, most people with serious mental illness need medication to help control symptoms." These "facts," and the logic behind them, are wrong.

The truth is, behavioral problems are *behavioral*. It is, the behavior that is dysfunctional and causing distress. A "chemical imbalance" in a person's brain does not cause most of these problems; rather, it is a behavioral imbalance. Or, as one child being screened for attention deficit disorder (ADD) told his doctor: "It's not a chemical imbalance, Dr. Diller—it's a *living* imbalance" (Diller, 1998, italics in original). Troublesome behavior causes troublesome feelings and may result in atypical chemical and neurological profiles more often than any supposed chemical imbalance causes troublesome behavior and feelings. That is, when behavior is out of balance, the body, including the brain, gets out of balance, and when behavior becomes more balanced, the body, including brain chemistry, returns to normal. Furthermore, behavioral treatments are almost always more effective, and more widely beneficial, than drug treatments. Behavioral treatments have advantages that drug treatments do not, and drug treatments have disadvantages that behavioral treatments do not.

Study after study will prove that behavioral treatment is more effective than drug treatment for behavioral problems. In a *minority* of cases for a *minority* of behavioral difficulties, drug treatment may be necessary, but only in combination with behavioral treatment.

However, profits, political lobbying, and marketing directed at America's quick-fix, fast-paced, immediate gratification-oriented culture have proven to be more powerful than careful, unbiased, outcome-based scientific research. The drug companies understand that children, parents, and others prefer, and are more likely to be influenced by, super-

heroes, comic books, and warm stories than they are by a scientific report. Superheroes, comic books, and warm stories are exactly what the drug companies are using to promote their drugs. In September 2001, just in time for the school year, the drug companies began to market their amphetamines (or closely related drugs) for children targeted directly at parents in leading magazines, including *Parents, Parenting*, and *Reader's Digest*, to name a few. The "soaps" (TV soap operas) might now more accurately be called the "drugs," because the advertisements have shifted from household cleaning products to drug solicitations.

But there may still be time to keep everyone on earth from being drugged. Some concerned professionals and parents are not swallowing the drug companies' would-be cure-all (e.g., Antonuccio, 1995; Diller, 1998). In almost all cases, safe, effective behavioral treatments exist for "mental disorders," psychological maladjustments, and behavioral difficulties. If effective nondrug alternatives exist, then why are they not more widely used and promoted? There are several reasons for the current state of affairs.

Drugs, the False Promises

When we are sick, we go to the doctor and we expect him or her to give us something to make us feel better. We expect to be cured. If we went home with nothing, we would feel cheated. Now that America believes that behavioral problems are diseases—brain disorders and chemical imbalances—when Americans go to a mental health professional they expect to be given something that will cure them. Doctors are more than willing to oblige. Many give amphetamines prescriptions for children based merely on one 15-minute consultation with parents (Diller, 1998). Patients and parents may feel cheated if instead of being given pills to "cure" the problem they were given homework exercises and firm advice on systematic, consistent, large-scale changes in their daily lives that may be necessary in order to live with and manage the behavioral difficulty. Given the desire for an easy, immediate quick fix, many reject the behavioral approach and seek out someone who will give them drugs. But the drug "quick fix" is a delusion, because for many psychological difficulties, behavioral treatments will produce beneficial results faster than drug treatment will.

For many real diseases—strep throat, flu, bacterial infections—vaccines can prevent or drugs can permanently treat, if not cure, the illnesses.

But despite claims to the contrary, there are no drug "cures" for behavioral problems. In the mid-1990s The Learning Channel (TLC) ran an episode on "out-of-control" behaviors on its show *The Human Condition*. One mother of a teenager with OCD claimed that her daughter was "cured" with "just two pills." The mother said that she wanted "buckets and buckets" of the drug (Prozac), and that the drug was "always" going to be in the house. This is a sad story, for without behavioral therapy, if the teen ever does go without drugs, relapse will occur, and the OCD may very well be worse than if no drugs had ever been taken. But behavioral therapy produces lasting change in OCD and other behavioral problems. The teen was not cured; her problem was just temporarily suppressed with drugs. For behavioral problems to be "cured," rather than drugging the individual, the actual behaviors of the individual must be addressed. Unnecessarily putting people on drugs for life keeps them from living—from experiencing life completely. It is unethical and disgraceful. Drugging people keeps them from experiencing the natural highs and lows of life.

Crutch

In addition to real physical dependency (such as my morning coffee) that may result after years of unnecessary drug use or abuse, drugs often become a lifetime crutch for behavioral problems that could have been effectively treated and managed without drug use. As a result of years of doctor-prescribed drug use, psychological patients come to believe, like other drug addicts, that they cannot function without their daily fix. In this case, drugs do not solve behavioral problems, they only create more.

Rebound

If a psychological problem is fully treatable with a behavioral approach, *without any drugs*, then drug treatment is obviously unnecessary. But if a drug treatment is stopped, then a behavioral rebound is likely, and the problem appears worse than it ever was before drug treatment. This rebound, or "contrast effect," strengthens the illusion that drugs are necessary. For example, a family member may argue: "She got worse when we took her off medication. Therefore, we need to keep her on drugs. Furthermore [it may be falsely argued], since she got worse when she

went off the medication, it proves the problem is biological, nothing we can do."

Placebo and Expectancy Effects

Many people who are given a sugar pill (placebo) and told it will improve sexual or athletic performance report that their sexual or athletic performance did in fact improve. Physicians have been aware for centuries of the power of these expectancy and placebo effects. Placebo effects have been a cornerstone of both medicine and quackery for as long as the fields have existed.

For example, antibiotics kill bacteria, but they have *no* effect on viral infections. Despite the fact that they have no effect, many people *insist* that their doctors give them antibiotics for viral infections such as colds. The doctors know that the prescription drug will not affect the virus causing the cold, but the patient leaves the office feeling satisfied. And when the body's immune system naturally fights off the virus, the patient falsely attributes feeling better to the drug. (Unfortunately, the practice of prescribing unnecessary antibiotics is resulting in drug-resistant bacteria and is becoming a serious public health concern.) If people believe alcohol causes uninhibited behavior and they are led to believe that they have drunk alcohol then they act less inhibited, even if they actually consumed no alcohol (e.g., Wilson, 1981). People often behave in accordance to expectations. This effect reveals another danger of labeling people with "mental disorders" and claiming they are "brain disorders." For example, a child labeled with ADD may believe that he is supposed to act "out of control" and misbehave. It is a brain disorder after all, not Johnnie's fault that he hit Susie. The ADD child is *expected* to act that way.

Likewise, instead of learning social skills and public speaking skills (behaviors), a person who gets nervous speaking in public (as most humans naturally do) can be labeled a "social phobic." Now the *behavioral problem* falsely becomes a *brain disorder*; the would-be speaker is expected to act that way. And since social phobia is a brain disorder "brought on" by fear of public speaking, then it becomes acceptable to avoid public speaking or to take drugs, likely Prozac or another selective serotonin reuptake inhibitor (SSRI), if the "brain-disordered" person must speak in public. Are we really ready to accept that people who get excessively nervous when speaking in public have a brain disorder

requiring drugs? Or can we accept that the person has a behavioral difficulty that can be addressed head-on and overcome with some effort and *without* any drugs?

Expectancy effects not only influence the person taking the substance or treatment but influence those around the person as well. For example, there is absolutely no evidence that refined sugar increases "hyperactivity" in children. Yet the urban myth continues. When adults believe that children have eaten sugar, *the adult's behavior changes*! Any changes, increased "hyperactivity" by the child who eats sugar, are more likely due to the changed behavior and statements of the adults, not the sugar itself. In short, many "improvements" from taking drugs, rather than "prove" the problem is due to a brain chemical disorder, are simply placebo or expectancy effects, and they usually are only temporary.

Remission

Whether or not one gets a drug, placebo, or nothing, many, if not most, behavioral and psychological problems will get better without any formal treatment whatsoever. For example, even in cases of severe depression, the probability of remission is close to 90% (Thase, 1990). When the depressive situation, the stressful life situation that precipitates the depression, is improved, when the living of life is reengaged, then the depression will lift.

In fact, spontaneous remission and placebo effects account for recent research results falsely heralded as evidence that drug treatment can "cure" depression. A team of researchers led by psychiatrist A. John Rush reported that one third of patients were helped by the antidepressant Celexa, meaning, of course, that two thirds were not helped by the drug. But if the patients who did not respond on the first drug were put on another drug after 14 weeks, about one third of those initially nonimproving patients improved. In all, about 50% of the patients improved after being but on one or more drugs. "After unsuccessful treatment with an SSRI [antidepressant drug], approximately one in four patients had a remission of symptoms after switching to another antidepressant" (Rush, Trivedi, Wisniewski et al., 2006, p. 1231). The message pushed in the press was: Take drugs, and if that does not work, take more drugs! "The big message is that symptoms can be eliminated in over 50% of people who receive two [drug] treatment steps," Rush proclaimed at a news conference. "Most patients should expect at least two [drug] treatment

attempts to become asymptomatic" (quoted from DeNoon, March 22, 2006, p. 1).

These results are invalid, because the Rush et al. 2006 study included no placebo control group. In other words, it is just as likely that as many, or more, patients would have improved if they had been switched to an inert sugar pill instead of another drug. Rates on remission also inform us that many patients' depression would have lifted without any treatment whatsoever. This information is available but conveniently ignored by those advocating drug use.

Arif Khan, S. Khan, and Walter Brown of the Northwest Clinical Research Center examined clinical trial data of the nine antidepressant drugs approved by the FDA between 1985 and 2000, comprising 10,030 patients, and the 13 anxiolytic drugs (anti-anxiety drugs) approved by the FDA between 1985 and 2000, comprising 8,340 patients (2002). Fewer than half of the drugs in either class were any better than placebo. "These data suggest that conventional psychopharmacologic treatments for depression and anxiety are superior to placebo less than half the time and call into serious question the widely propagated notion that placebo controls can be dispensed within clinical trials of these agents. Exclusion of placebo controls in favor of noninferiority trials would result in a high likelihood that ineffective antidepressants and anxiolytics would be foisted on the public" (2002, p. 193). But this is exactly what is happening. Irving Kirsch and his colleagues conducted a similar analysis of the 6 most widely prescribed antidepressant drugs, and they reached the same conclusion. "Approximately 80% of the response to medication was duplicated on placebo control groups. . . . If drug and placebo effects are additive, *the pharmacological effects of antidepressants are clinically negligible*" (Kirsch, Moore, Sloboria, & Nicholls, 2002, italics added). These results allow two conclusions, which are further developed in the book. First, antidepressant drugs and anti-anxiety drugs do not help problems such as depression or anxiety (but behavioral treatments do). Second, America's drug deception is deepened by studies that do not use placebo controls or take into account naturally occurring rates of remission.

Responsibility and Guilt

Convincing people that behavioral problems are physical ones, "brain based," has been an easy sell, because it frees the individual, the individual's

family, loved ones, teachers, coworkers, and employers from responsibility and guilt. It is no longer the child's, parents', or teachers' fault or responsibility that a child has no social skills, is behind academically, and is rude and aggressive. No, it is a brain disorder—have a pill. And even though there is no replicable scientific evidence that any "symptoms" of attention deficit or hyperactivity or aggression are caused by a chemical or structural imbalance in the brain, if one drug does not work, then others will be tried until the "imbalance" is corrected—until the child is drugged into compliance and complacency. If office workers or students get so nervous that they vomit, faint, or shake when they try to go to the office or school, then it is not because they are teased, harassed, overworked, or tormented at the office or school—"No, no," say the drug industry and psychiatry, "they have a chemical imbalance. Give them an 'anti-anxiety' drug." Because they supposedly suffer from a brain disorder, society is freed of guilt in establishing the environmental conditions creating the anxiety. Since the problem is falsely labeled "brain disorder," society has no responsibility to change the conditions responsible for the anxiety (the condition is argued to be in the brain, not the external environment).

REALITY

The truth, uncomfortable as it may be, is that problems in an individual's family, social, school, or work environment *are mainly responsible* for behavioral difficulties. For example, *U.S. News and World Report* writer Susan Brink reports: "Severe depression in a very young child is almost always caused by a major upheaval. 'In kids under 5, it's marital discord, divorce, witnessing violence,' says Glen Elliott, director of child and adolescent psychiatry at the University of California-San Francisco. A pill won't help. The daunting solution is to change family life or move from a dangerous neighborhood" (March 6, 2000, p. 49). In *Enjoy Old Age,* the late Harvard behaviorist B. F. Skinner gives the same advice. You may be depressed "simply because you can no longer do many of the things you have enjoyed. Perhaps you have liked talking to people but now there is no one to talk to. Perhaps you have enjoyed the countryside but are now cooped up in the city. Finding someone to talk to or some way of getting to the countryside will be better than remaining alone in the city taking Valium [or Prozac, Paxil, or another drug of your choice]" (Skinner & Vaughan, 1987, p. 118). Unfortunately, it is easier, and often

a cop-out, to drug young and old individuals who have behavioral problems than it is to address the environmental conditions that produce the problems. The reality is, dysfunctional behaviors are a product of dysfunctional contingencies in a person's environment.

Work and Happiness

People with behavioral difficulties and those who care about them must determine what a meaningful solution is worth to them. To overcome the dysfunctional, abnormal, troublesome behaviors, a person's dysfunctional contingencies must be changed. Most things in life that are worthwhile require some effort. Behavioral treatments often require some effort by both the people with problems and their families, teachers, employers, coworkers, and/or classmates. But drug therapy requires virtually no effort—reflecting its ultimate worth for most behavioral problems. By drugging children into compliance and docility, or by drugging adults into comfortable numbness, drug therapies work *around* the problem. But behavioral approaches work *on* or *at* the actual problem. They attack the problem—whereas drug approaches hide the problem.

Unfortunately, large portions of society have developed an aversion to work (Eisenberger, 1989). The "me generation" and "generation X" have been taught to expect immediate gratification and happiness as a birthright. They are told in song, "Don't worry, be happy." But there are things all people should worry about: their families, their country, their job, their academic performance. Many in society, perhaps a majority of "mental health professionals," now believe that all such worry is wrong. Rather than address, attack, or work directly on the sources of worry, such as problematic family, work, or school situations, Americans are expected to take a drug to mask the problem or to feel good despite it. As Skinner noted: "Americans take billions of pills every year to feel better about their lives even when their lives remain wretched" (Skinner & Vaughan, 1987, p. 118).

Happiness is not always a natural state of being or a U.S. birthright. Americans are guaranteed freedom of the *pursuit* of happiness. Happiness itself is not guaranteed. Biological psychiatry and the drug companies want Americans to pursue happiness in a pill. Of course, that is one possible and often-taken approach—with both legal and illegal drugs. But most *successful pursuits require planning, effort, and execution*—that is, the behavioral approach to happiness. Furthermore,

while many drugs are very efficient at making people feel good, "feeling good" is just part of *being happy.* The journey, pursuit, effort, and *behavior* make people happy and make them feel good. Feeling good while one's behavior remains dysfunctional and one's life remains wretched is not happiness. Drugged people cannot feel happiness anymore than they can feel pain. An absence of pain does not equal happiness.

THE FALSE DRUG SOLUTIONS

Despite their vast differences, for the spectrum of behavioral difficulties and "mental illnesses," all claimed to be caused by neurological-chemical imbalances, the same three general drug "treatments" are offered. Major tranquilizers and "antipsychotic" or "neuroleptic" medications such as chlorpromazine (Thorazine), haloperidol (Haldol), and thioridazine (Mellaril) are given to people to "treat" such widely different problems as schizophrenia, retardation, autism, and other severe but *nonrelated* problems. But other than sedating the patient (the victim?) and making the patient "more manageable," little is actually known about how these powerful and dangerous medications affect the person taking them (Gelman, 1999). Because the tranquilizers are so powerful, "minor" tranquilizers were developed. These "minor" tranquilizers, including alprazolam (Xanax), buspirone (Buspar), and diazepam (Valium), are referred to as "sedative hypnotics" and are often used to "treat" depression and behaviors associated with excessive anxiety. As the name suggests, they "sedate" or "hypnotize," but they do not address the causes or sources of the depression and anxiety (e.g., marital, family, or employment problems).

The monoamines are a class of neurotransmitters (chemicals released by one neuron to communicate with other neurons) generally associated with pleasure and arousal. The monoamines include serotonin, dopamine, epinephrine, and norepinephrine (the latter two formerly were called adrenaline and noradrenaline, and the phrase "to get your adrenaline pumping" accurately describes the generally pleasurable arousal produced by their increased activity). Several major classes of psychiatric drugs function to increase the activity of the monoamines. Like the tranquilizers, these drugs are given for a wide range of vastly different behavioral problems. Adderall, Ritalin, and other stimulant drugs are chemicals that are, or just slight modifications of, amphetamines. As the name suggests, the biological function of amphetamine-like drugs is

to *amplify* the mono*amine* systems. The older antidepressants, tricyclic antidepressants, and monoamine oxidase inhibitors also work to increase monamine activity.

In addition to the amphetamines and closely related drugs given to children and adults who have been labeled with "attention-deficit hyperactivity disorder" (ADHD) the so-called "miracle" drugs of the psychiatric-pharmaceutical conglomerate are the SSRIs. Popular brand names include Prozac, Paxil, Louvox, and Zoloft. The SSRIs work *selectively* on *serotonin* (a monoamine) to *inhibit* its *reuptake* by the neuron that released it, thereby increasing serotonin's effects. Serotonin's effects are vast, and complex, and much remains a mystery. Broadly, and often inaccurately, described as a "mood regulator," serotonin is involved in at least six major brain circuits involving almost all of the major structures of the brain, and there are at least 15 different serotonin receptors, all with different functions (Barlow & Durand, 1999). Thus although "SSRI" sounds scientifically specific, taking SSRIs amounts to a general chemical whitewashing of the brain and is associated with a wide range of side effects, from sexual dysfunction to indigestion to insomnia. Yet SSRIs are promoted as being specifically targeted for everything from eating disorders to depression to common phobias. This excessive drugging must be questioned.

Nevertheless, the American appetite for legal and illegal drugs grows unabated. This appetite is not without consequence.

The Disgrace

According to the National Association of Chain Drug Stores, the number of prescriptions filled has risen by more than 50%, to over 3 billion prescriptions since 1992 (Readers Digest, June 2001, p. 38), but has Americans' mental or physical health improved 50% since then? No. If enough money is involved, even the most ethical people can be tempted to bend their morals. Doctors and researchers are no exception. It is a conflict of interest for a stockbroker to recommend a stock he or she owns and unethical to recommend the stock at all unless interests are disclosed to the public. Likewise, it is a conflict of interest for a "scientific" researcher to promote a drug therapy if the researcher has financial interests in the company that makes the drug in question. It is unethical not to disclose such a conflict of interest, but this is exactly what frequently happens with regard to drug therapy. In an internal audit published in

February 2000, *The New England Journal of Medicine* editors found that 19 out of 40 drug therapy reviews failed to disclose the researchers' drug company support. If a leading journal in medical ethics regularly publishes such conflict of interest reports without acknowledging the conflict, then it is reasonable to expect that the less prestigious journals are publishing even more biased, questionable reports as unbiased "scientific" findings.

For the drug companies, business is business. The goal is to make money, not to help people—if they help, fine, but helping is clearly secondary, and ethics is a distant afterthought. The Immune Response Corporation paid researchers at the University of California-San Francisco (UCSF) to conduct studies on its proposed HIV drug. The researchers published their findings in *The Journal of the Medical Association*, showing that the drug was no more effective than a placebo in reducing AIDS or mortality. A sugar pill is as good as the drug. The company's response was not to try to develop drugs that would be effective—no, the response was to sue UCSF for damages and withhold data and blood samples from the researchers! (The suit has been settled.) According to Dr. Drummond Remune, a medical professor at UCSF not involved in the study, drug companies try to withhold data "for commercial reasons only." Dr. Remune said: "We are trying to get across to companies that if they are going to pay for research, they have to live with the results. It is just as important to know that something doesn't work as that it does" (from Guterman & Van Der Werf, 2001, p. A29). But if the doctors and the public learn that something does not work, then profits decrease. Thus the companies try to withhold data and sue researchers for being objective and honest.

Drugs are dangerous. Up to 100,000 people die each year because of medical mistakes, but that many people *several times over die from drug complications*. Pharmacologist Joe Graedon and medical anthropologist Teresa Graedon, Ph.D., report: "Physicians, nurses and pharmacists are not required to disclose drug complications. If anything, there is a disincentive to acknowledge problems because of a fear of legal action. . . . Experts estimate that 2 million people are hospitalized because of their medicines, but only 33,500 cases are reported" (Graedon & Graedon, 2000a, p. A4).

Despite these dangers, drugs are increasingly pushed, not only on adults but on children, pets, and even on children's fictional characters! The *Canadian Medical Association Journal* published a report recommending medication for Winnie the Pooh and his friends (Shea,

Gordon, Hawkins, Kawchuk, & Smith, 2000). Although the report was supposedly tongue in cheek, the recommendation is seriously sobering: Drug them all! "Pooh needs intervention," the authors state. Do they recommend assertiveness training, role playing, or other skill-building interventions? No. "We feel drugs are in order" (Shea et al., 2000, p. 1557). Ritalin, an amphetamine-like drug, is recommended for Pooh. Not only is Pooh supposedly suffering from ADHD, but like all good storybook bears, because Pooh thinks about honey, he supposedly suffers from OCD too. The donkey Eeyore, is said to need an antidepressant such as fluoxetine (e.g., Prozac) and Piglet on antianxiety narcotic medication. Reflecting the ignorance of the drug approach, the authors cannot agree on how to drug Tigger the tiger—some want stimulant medication, Ritalin or other amphetamines, while others argue for a psychiatric sedative. The article is sobering, and revealing, because all of the authors are physicians specializing in pediatrics or neurology. The authors ignore behavioral therapy and agree that medication is necessary, but they argue for medications that have the opposite effects for the same problem! That is like looking for solutions to pollution at the center of the earth or in outer space but ignoring what goes on the earth's surface. Equally troublesome is the implication that individuality is not valued—all should be drugged until all are average.

Why drug a character such as Tigger, who is happy, curious, and full of childlike energy and wonder? Because he is not *average*? If your child is happy, curious, and full of childlike energy and wonder, should he or she be drugged because of not being *average*? So what if Pooh is more mild mannered than average, and so what if he likes honey? Is Pooh not a warm, affectionate, giggly companion to his human friend Christopher Robin? Should we drug children who are more mild mannered and affectionate than average or who have acute interests? Apparently anything that is not "average" has become a disorder requiring medication. Is individuality a disorder now? The very meaning of average means that 50% will be below and 50% above; 50% of people will be more active than others, and 50% will be less active; 50% will be able to concentrate longer, and 50% will concentrate less; 50% will get more nervous when speaking in public, and so on. Do we drug everybody into bland sameness? Of course, when a person is so far from average on a *behavioral* characteristic that it causes personal distress or an inability to function at work, school, or socially, then the behavior should be addressed. That does not mean, however, that the individual should be drugged. Yet drugging ourselves into bland sameness is exactly what Americans are doing.

The "diagnostic criteria" of mental disorders are so (purposefully?) vague that virtually every human has some sort of "mental disorder," or at least suffers from several symptoms, thus every individual in the world is a good candidate for one drug "treatment" or another. For example, the criteria for ADHD include: "Often fidgets with hands or feet or squirms in seat. Often talks excessively. Often blurts out answers before questions have been completed. Often has difficulty waiting in turn." What *normal, healthy* child does *not* do these things? My youngest brother now holds a Ph.D. in quantitative psychology from the University of North Carolina. He was a double major (math and psychology) at Kenyon College. He has worked as a statistical consultant on several top research and business projects. However, as a child, during dinner he did not squirm in his seat; he simply refused to sit in his seat—*period*. He ate meals standing up, *next* to his seat, not in it. Should my parents have drugged him so that he would sit in his seat without squirming, or should they have allowed his atypical, nonaverage standing-while-eating behavior? Drugs could have suppressed his standing during meals, but what else would they have suppressed?

A pamphlet promoting the drug Paxil for "social anxiety disorder" states that "some of the signs and symptoms include": 'The anxiety-provoking social situation may cause physical symptoms like blushing, sweating, shaking, trembling, tense muscles, shaky voice, dry mouth or a pounding heart'" (GlaxoSmithKline, 2001). What completely *normal* person has *not* experienced these things before and during social situations—before or during a meeting with the boss, clients, student body, or faculty, or even asking a date to the prom. If one did *not* experience any "blushing, sweating, shaking, trembling, tense muscles, shaky voice, dry mouth or a pounding heart," then *that would be abnormal*! Psychiatry and the drug companies are trying to convince the world that normal, albeit sometimes uncomfortable, but normal nevertheless, behaviors and feelings are abnormal and require medication.

We have been led down a slippery slope of labels. What used to be called appropriately and simply a behavioral problem or difficulty came to be a labeled a "behavioral disorder." "Disorders" are not very different from, or a result of, "diseases." Almost overnight, simple behavior problems became "brain diseases." Americans have been long conditioned to believe that the best way to treat a disease is with drugs, so that is what we are now doing for problem behavior.

SHAME

"Paxil, Prozac, Ritalin. . . . Are These Drugs Safe for Kids?" asks the cover of the March 6, 2000, *U.S. News & World Report.* In some cases the answer is "we don't know if the drugs are safe for children, but we medicate millions of children anyway," and in other cases the answer is "no, the drugs are not safe, but we medicate millions of children anyway." (We want them to act "average" after all.) Americans are drugging their children with psychiatric drugs as soon as they learn to talk and walk! The *U.S. News*' cover story, "The Perils of Pills: The Psychiatric Medication of Children Is Dangerously Haphazard," was in part a response to findings reported in the *Journal of the American Medical Association* (Zito, Safer, dosReis, Gardner, Boles, & Lynch (2000, pp. 1025–1030), "that the number of 2-to-4-year-old children on Ritalin, antidepressants, and other psychoactive drugs increased dramatically from 1991 through 1995. Startling as it is, the news about toddlers merely underscores the rise in the use of powerful psychiatric drugs in kids of all ages—despite the fact that these drugs are largely untested for use in the young" (Shute, Locy, & Pasternak, March 6, 2000, p. 45). Furthermore, the reporters continue, "The treatment children get is often dangerously haphazard. Some are medicated, with no follow-up" (p. 45). This program of treatment often causes more problems than it solves, especially when a poor diagnosis results in putting a child on medication that only compounds the problem: For example, a girl is given no counseling for her father's death but instead is put on the very same drug her father was on when he committed suicide. The drug's listed side effects include "paranoid reactions, antisocial behavior, trouble concentrating, and hostility." A 7-year-old girl, later diagnosed with bipolar disorder, was put on the amphetamine-like Ritalin (a very inappropriate drug for bipolar disorder) and took a butcher knife to her sister. A depressed 16-year-old who was given Paxil and told there was no need to visit again for 3 weeks stabs his grandmother to death 61 times (Shute et al., 2000).

Drugging children, especially babies, for nonaverage behavior is particularly troubling, for two reasons. First, because many of the drugs have not been tested on youngsters, it is simply not known what effects drugging them will have—in the short term or in the long run. But, second, it is known that children are not simply small adults. Animal studies repeatedly reveal that many of the medications given for behavioral problems

permanently change (damage) the developing nervous system. "Almost nothing is known about how antidepressants and other psychoactive drugs affect a child's developing brain" (Shute et al., 2000, p. 47).