When are patients going to be told the truth about their psychiatric medications?

Among the countless mentally unwell patients whom I currently manage, I have one case that weighs heavily on my mind. The patient is a very pleasant 25-year old male* with pronounced tardive dystonia. During his first year of college (sometime in 2004), my patient began to withdraw from life, slowly losing contact with his friends and family. He also became agitated, requiring little sleep, and his thoughts and therefore his behaviours became increasingly more bizarre to his fellow students and diminishing pool of friends. He was eventually admitted to a nearby hospital and was given a diagnosis of schizoaffective disorder. He was prescribed two mg daily of risperidone (Risperdal) to manage both the psychotic symptoms and agitation. Within about ten days his condition stabilized and he was discharged back into the community with a referral to an outpatient psychiatrist and instructions to attend an outpatient programme for mental health patients.

Within several weeks of taking risperidone, he developed frequent episodes of facial grimacing and painful upper body contractures, characterized by having his shoulders being temporarily fixed into a shrugged position with concomitant tensing of the neck muscles. At the present time, the facial grimacing (tardive dyskinesia) has lessened, but his painful upper body contractures (tardive dystonia) involving the upper trapezius and anterior cervical muscles, occur constantly. The patient has these dystonic episodes numerous times throughout the day. They have become so bad that he is now getting unwanted attention from his coworkers and clients, which has become very distressing and embarrassing to him.

When this patient has questioned the value of his medication with several psychiatrists, each one has told him that the medication is necessary for stability but not much else. This is alarming but not so surprising. This patient's unfortunate reality reminds me of a very insightful passage from orthomolecular pioneer, Dr. Richard Kunin, in his article discussing the value of manganese and niacin for drug-induced dyskinesias:

"To my amazement the personnel could not seem to comprehend the disorder or empathize with the incredible suffering of the patient. Imagine the alienation such patients experience in relation to their peers, who can only interpret these indescribable movements as manifestations of madness. But the unkindest cut of all is to find that this disorder is commonly diagnosed as anxiety or hysteria by physicians and psychiatrists."[1]

The time has come for psychiatrists to discuss honestly with their patients all the potential risks and expected benefits from the medications they prescribe. There is an emerging body of literature that advocates a drug-centered model of drug action, as opposed to the outdated disease-centered model that espouses psychiatric medications as correcting some known and well validated disease process.[2] In the drug-centered model, it is recommended that psychiatrists inform their patients that psychiatric drugs are psychoactive, and "…induce complex, varied, often unpredictable physical and mental states that patients typically experience as global, rather than distinct therapeutic effects and side effects."[2] Patients should be told that these drug-induced altered states might be useful, for some altered states might suppress unwanted manifestations of mental disorders; and that these altered states might be harmful, for some altered states might induce unwanted or even unexpected physical and/or mental manifestations.

While I am strongly in favour of the immediate stability induced by psychiatric drugs during acute crises and/or life-threatening situations, I am more in favour of their gradual discontinuation once the acute crises have passed. Patients should be told that the majority of psychotropic medications produce a vast array of global psychoactive effects (i.e., sedation, psychomotor slowing, activation, and altered sense perception), which are often associated with negative outcomes.[3] The ideal is to immediately place all patients on orthomolecular treatment dur-

ing the acute period, so that once psychiatric medication is withdrawn, orthomolecular treatments can ensure ongoing stability, and hopefully a better long-term prognosis.

Unlike psychiatric medications, orthomolecular treatments are not associated with negative global psychoactive effects, and support rather than alter the proper functioning of the brain by supplying it with naturally-occurring substances it has been designed to require. Psychiatric medications are not normally found in the human body, and cannot correct for genetic defects (i.e., defective enzyme/coenzyme reactions), nor compensate for increased individual needs of specific orthomolecules, nor can they offset deficiencies of orthomolecules within the cerebrospinal fluid or other tissues of the body. To further illustrate my concerns, I offer an excerpt from Breggin's book, *Brain Disabling Treatments in Psychiatry:*

"The brain does not welcome psychiatric medications as nutrients. Instead, the brain reacts against them as toxic agents and attempts to overcome their disruptive impact. For example, when Prozac induces an excess of serotonin in the synaptic cleft, the brain compensates by reducing the output of serotonin at the nerve endings, by reducing the number of receptors in the synapse that can receive the serotonin, and by increasing the capacity of the transport system to remove serotonin from the synapse. Similarly, when antipsychotic drugs such as Risperdal, Zyprexa, or Haldol reduce reactivity in the dopaminergic system, the brain compensates, producing hyperactivity in the same system by increasing the number and sensitivity of dopamine receptors. All of these compensatory reactions create new abnormalities in brain function, sometimes causing irreversible disorders, such as antipsychotic drug-induced tardive dyskinesia."[4]

My clinical experience has revealed that most patients are not educated about the dangerous and often life-changing effects that might result from taking psychiatric medications. Patients are usually told that there are no viable options, other than standard psychiatric care, for their mental health issues. This problem is most evident in the treatment of schizophrenia. In this issue, we have a 'tour de force' article from scientist extraordinaire, Dr. Christine Miller, who has written an exquisitely up-to-date, comprehensive, and progressive article on genes and nutrition interactions as they pertain to schizophrenia. From reading her article, one can easily feel her passionate commitment to researching the biochemical minutiae of schizophrenia with the hope of facilitating a better understanding of, and perhaps new alternative (i.e., orthomolecular) treatment solutions to, the status quo. Her sincere commitment to schizophrenia is very apparent in the concluding paragraph of her article in which she mentions with sanguinity "…there is ample reason to pursue nutritional therapies in schizophrenia" juxtaposed with her concerns about current psychiatric options since "…neuroleptics have potent side effects that prohibit even a near-normal level of function."

Dr. Miller's article champions a greater optimism about the future of orthomolecular medicine, a future where patients' lives are enriched and not harmed by psychiatric treatments, because the prescribed treatments are "orthomolecular," and are thus safe and life affirming.

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*All identifying information has been changed to protect the confidentiality of this patient.

References

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