Correspondence

Evidence Based Medicine/Psychiatry vs Defamation Based Medicine/Psychiatry

Evidence Based Medicine/Psychiatry: Based on truth, sane internationally accepted definitions and facts. It is altruistic, benevolent, wishes the best for the patient or optimal treatment.

Defamation Based Medicine/Psychiatry: Not based on truth or facts. Based on false, misleading, irrational, defamatory definitions. It is selfish (vested interest based), malevolent and does not wish the best for the patient or optimal treatment. It can even mean or result in the withholding of essential, correct or beneficial treatment and thus wishes the patient malice or harm. The worst or most serious type of defamation based medicine/psychiatry is "criminal defamation based medicine/psychiatry."

To explain : When a person or persons have a scientifically correct definition in front of them to copy and they are not able to copy it correctly and get it wrong and leave out key words affecting its meaning, or leave out the essential second half of a definition which explains its meaning or scientific integrity, or alters or tampers with the definition to now mean the absolute opposite meaning to that originally intended, or quotes a conclusion and leaves key words out without dots – then the following has to be considered.

The person (1) can't read, is dyslexic, has impaired vision or is blind; (2) is an ignoramus or is mentally retarded or stupid or very foolish; (3) suffers from 'haematomentia' or 'bloody mindedness' or is blinded by bias; (4) is sick or ill and is in need of treatment.

The person can't copy what is in front of them if mentally retarded or brain damaged or has an acute or chronic brain syndrome. If the person gets the definition or conclusion wrong deliberately and repeatedly then what sort of illness or behaviour is this? This abnormal behaviour then comes under the personality disorders, sociopathy and psychopathy, for example, from the *Diagnostic and Statistical Manual, (DSM–IV)* 301.7 Antisocial Personality Disorder. The person is prone to tell lies, willfully/deliberately mislead and tell untruths. They tend to wish harm and malice. They are selfish and not altruistic. They know a document contains false/highly defamatory claims but condone it. This means they condone a document that is false, misleading, defamatory, invalid, inadmissible and thus illegal. This then means they condone negligence and incompetence. This then means they condone corruption or are acting in a corrupt way. If the person also condones corruption this means they are acting in a criminal way and the treatment may have to be court action/jail unless the person changes his/her ways and to stop their continuing harm to patients due to deliberate misinformation.

In future, when an authority repeatedly misrepresents an evidence based medicine/psychiatry definition and gets it wrong, they should be asked which of the above applies to them for getting it wrong?

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Case Reports from Finland

Case 1. Hypomania

This young man, born 1981, came to me the first time in the fall of 2003. He suffered from hay fever, atopic eczema and lactose intolerance. He has been studying media technics. A cousin has been depressed.

In 2001 he had an attack of hyper-ventilation and later panic episodes. He was medicated with Seroxat for a year and felt somewhat better. In March 2003 he suffered another panic attack and after that his body felt weak he became very fearful and suffered insomnia. Eventually he became hypomanic and got severely aggressive against his mother. He was brought to a mental hospital, where he spent some weeks. He was diagnosed with hypomania

and given the medication Risperdal 1mg and Seroquel 25 mg.

On the first visit the patient was calm and quiet, not psychotic, but it was difficult to talk to him. I ordered some laboratory tests and started him on vitamins, minerals and EFA including nicotinamide 1g 3 times a day and folic acid 5 mg a day. I suggested he leave out of his diet sugar, milk and coffee and as far as possible, processed food.

When he came the second time one month later the laboratory tests showed a very low fasting serum-folate on 4.4 nmol/L and a very high fasting plasma-homocysteine on 45 μmol/L. I increased the dose of folic acid to 15 mg a day but continued B_3 as before with B_6, B_{12} and zinc, as well.

His mother called me in March 2004. He was very much better and was back at school again. Interestingly the homocysteine came down to 13 μmol/L in spite of the 3 g of B_3. I saw him again in August 2004. Seroquel discontinued and only Risperdal and the nutrients were left. The school went very well and the mother reported that her son was very much better. He still did not have complete insight of his situation and was therefore not motivated enough, so there is some risk he will stop the medication and the vitamins. In that case a relapse is very probable and perhaps the motivation will then get stronger.

Case 2. Drug Problems and Psychosis

This young man, 28 years, came to see me the first time in the fall of 2003. He was silent, fumbling and intense. He has had drug problems for over 10 years and has taken "everything except for crack." In 2000 he went through a psychosis and locked himself up in a little, lonely cottage in the country side. He then spent some time in a mental hospital and was medicated with Zyprexa and Paroxetin. He said he has experienced "ecstasy as the darkest night of the soul."

As a child the patient suffered bronchial asthma, many episodes of pneumonia and other respiratory infections, fish allergies and allergies reactions to furred animals. He is intolerant to lactose.

He is very interested in spiritual issues and in the similarities of different religions and he is very musical. He had taken a reiki healing education and had a lot of help from a healer. He has been on the sick-list since 2000.

I started him on nicotinamide 1g tid; vitamin C 1g tid, a B-complex with B_6 250 mg and folic acid 5 mg, plus selenium, zinc, magnesium, calcium, vitamin D and essential fatty acids (EPA, DHA and GLA).

One month later he was getting better and in the spring of 2004 he said he "never felt better in his entire life", he was beaming with joy. In the fall of 2004 he had a girl friend, had a job and everything was fine. He was very motivated to continue his vitamins and to try to live healthily and no longer took any medication.

Case 3. Schizophrenia

A chronic schizophrenic female patient, 43 years, not married, was on sick pension for 20 years. She has an identical twin sister, who is "healthy but very nervous".

She had her first psychosis at the age of 17. She heard voices and was paranoid. Since then she has been in and out of hospitals. She worked a little in her early twenties but after that no more.

The patient always came with her mother. The first time, in the early winter of 2004, she was very silent and depressed. She suffered many side effects from Zyprexa 25 mg. Her mouth was dry, she suffered muscle tension and constipation. I started her on B_3 (nicotinamide) 1g tid; vitamin C 1g tid; B complex with B_6 250 mg; selenium, magnesium, manganese, zinc and essential fatty acids (EPA, DHA and GLA). I advised her to read books discussing these nutrients and advised her to stop sugar, coffee and processed food .

Laboratory tests indicated she was low in blood magnesium, zinc and selenium as

well as GLA. She had been taking EPA and B complex before coming to me the first time. One month later she felt much stronger in her body, was able to do her own house work and in working therapy it was reported "She is like a new person" The mother was happy and found her daughter more "with the feet on the earth".

She comes to me every three months and continues to make steady progress. She speaks vividly, smiles and laughs. She takes initiative even to call me. In the fall of 2004 Zyprexa was reduced to 20 mg a day and her psychotherapist said she needs to come only once a month. On my advice she had her mercury (silver) amalgam fillings removed by an experienced bio-dentist in order to get rid of the principal mercury source in humans and when I saw her in December 2004 she was cheerful and happy. Her muscles are much stronger, she goes to gym twice a week, and goes to traditional dances with her sister every Saturday night. Her sense of humour has returned, she behaves tenderly with her happy mother, pats her on her shoulder, laughs, asks a lot of questions and starts to make plans for the future. We plan to reduce Zyprexa gradually.

Case 4. Cancerophobia

Maria came to me the first time at the end of May 2004. She is 28 years old, married, has 2 children, $1^1/_2$ and 4 years, studies to be a nurse. She suffers from very difficult cancerophobia.

Maria has always been a sensitive person, a little anxious and careful, but cheerful, too. A grandmother, who was "strange", died in age of 20 from tuberculosis. In January 2004 they started to study cancers and tumors at school and Maria soon developed a very difficult cancerophobia. She started to dream about tumors all over her body, she got more and more depressed and eventually the situation was nearly absurd. She could not think about anything else, she visited doctor after doctor in order to get real investigations done and actually went through a lot of them, she asked her husband to examine her whole body for tumors many times a day and her small children got nervous and anxious, too. A doctor started her on citalopram, but it did not help. When she came to me she was really ill and later she said she thinks she would have ended in a mental hospital.

In our first discussion I recommended she stop asking her husband to examine her. She asked me to be allowed to come to me once a week for discussions and body examinations, to which I agreed. I started her on B_3, B complex with 250 mg B_6 and 5 mg folic acid, vitamin C, vitamin E, selenium, zinc, magnesium, calcium, vitamin D, EFAs and melatonin at night. I also give her recommendations with respect to diet and taught her some psychological techniques to overcome sudden feelings of fear.

Maria is a very intelligent young woman and it is easy and good to work with her. She soon started to get better and felt safe as she knew she has an appointment almost every week with me. The first real "aha" experience came when in July. She was taking 1g B_3 twice a day, and I suggested she increase the dose to 1 g tid. The next week she was excited, the higher dose B_3 had an immediate and very dramatic impact on her mental situation. She was now very much better and felt mentally stronger than ever before. She was cheerful and happy and there were many days where she did not even think about tumors. Her relationship to her husband was blossoming and her children were happy and calm.

During the autumn months Maria continued to progress although there was sorrow in the family, a grandfather was dying from lung cancer. When she got gastroenteritis and could not take her vitamins for a couple of days she became temporarily worse but recovered quickly again. Now she does not even think about getting examined for tumors but she still has a little written list with cancer questions every time she comes to me. She gets new "aha"

experiences. When she stops the birth control medication, she gets better. When she stops sugar she gets better, when she starts to eat healthier and more regularly and exercises she gets a little better again.

By the end of 2004 Maria sees me once a month, and very seldom calls. There were many days she does not even think about her tumor obsessions, she is calm, humorous and can laugh at herself. She decided not to continue nursing studies, but was now happily working in her mothers shop. Last time I saw her she was pregnant and happy and planning with her husband to start to build their own house after the baby is born. She now dreams vivid and beautiful dreams.

–Karin Munsterhjelm-Ahumada, M.D.
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AIDS in Finland

Thank you for passing on Dr Karin Munsterhjelm's observation that Finland has a lower rate of HIV infection than neighbouring countries.[1] HivNet Nordic's website[2] displays the number of new HIV cases diagnosed each year, during the period 1980 to 2003, in Denmark, Finland, Iceland, Norway and Sweden. From these data, it is clear that Dr. Munsterhjelm's observation is correct. Finland has had a far lower HIV infection rate than other Nordic countries. To illustrate, if you simply divide the total number of HIV/AIDS cases by the populations of the countries in the Nordic region, an interesting phenomenon is obvious. Since 1980, roughly 0.6%-0.7% of the populations of Denmark, Iceland, Norway and Sweden have been diagnosed as being HIV-positive. In contrast, the figure is only 0.3% for Finland. That is, the rate of HIV infection in Finland for the past 24 years has been only about 50% of that of the rest of the Nordic region, all of which, for geological reasons, is selenium deficient. Even more interesting, in 1984, Finland began supplementing all its agricultural fertilizers with sodium selenite.[3] Although the early figures were very low, for the period 1980 to 1984, the annual HIV infection rate for Norway and Finland was running about the same. However, in 1985 (the year after selenium fertilizer supplementation began in Finland), there were only 38 new HIV cases identified in Finland compared to 214 in Norway. There is further evidence, from countries to the east of the Baltic Sea, that low dietary selenium increases the risk of HIV infection. Estonia, for example, is separated from Finland only by the narrow Gulf of Finland. The soils of Estonia are also naturally very selenium deficient[4] and this country does not add this trace element to its fertilizers. The current HIV-prevalence rate amongst adults 15 to 49 years of age is 1.1%,[5] eleven times the rate in Finland. Adjacent Latvia, another selenium deficient neighbour[6] has an adult HIV-prevalence rate of 0.6%, six times that of Finland.[7] In contrast, two countries to the south, Lithuania and Poland, both of which have much more adequate dietary selenium levels[8-9] have adult HIV prevalence rates of some 0.1%, that is more or less the same as Finland's.[10-12] In summary, all Nordic countries except Finland and that country's eastern neighbours that have naturally selenium deficient soils have experienced a relatively high infection rate for HIV. This is not true of Lithuania and Poland where either soil selenium levels are naturally more adequate, or in the case of Finland where they are deliberately raised by adding this trace element to fertilizers. While these interesting geographical comparisons are not "scientific proof" that, as this author has been arguing for several years,[13-15] selenium protects against HIV infection, they are certainly very compatible with it. Indeed, the evidence presented here suggests that, by mandating the addition of selenium to its fertilizers in 1984, the government of Finland has probably reduced that country's HIV-prevalence rate by at least 50% and possibly far more.

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