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MEDICALIZATION AND PHARMACRACY STRESS

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This is the first of a series of Newsletters dealing with a significant but largely unappreciated source of psychosocial stress that has serious health consequences. Medicalization has been defined as: "A process or a tendency whereby the phenomena belonging to other fields like education, law, religion, etc. have been redefined as medical phenomena." Pharmacracy refers to the threat to human liberty resulting from modern medicine due to governmental policies and regulations that are influenced and often dictated by powerful pharmaceutical interests. Medicalization and pharmacracy are closely related. Each contributes to the other, both are driven by similar forces for financial gains, and have corrupted the practice of medicine by trying to convince healthy people into thinking that they are sick, as well as causing illness, instead of preventing or treating it.

Psychiatry is a prime example of progressive medicalization as illustrated by a review of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). This list of approved American Psychiatric Association definitions has become the bible for diagnosing mental and emotional illnesses. DSM-I, published in 1952, was a 130-page manual listing 106 mental conditions. DSM-II, its 1968 update, had 4 more pages and a total of 182 different diagnoses.

Also Included In This Issue

Both placed an emphasis on the need to distinguish between a neurosis, such as anxiety, in which patients were generally in touch with reality, as opposed to a psychosis, where they were disconnected due to delusions or hallucinations.

Critics complained there were often no clear boundaries between normal and abnormal, that symptoms for disorders were not detailed as they were for physical diseases, and disagreed about the criteria used for certain classifications. They and others were determined to prove that psychiatry was based on science, despite the fact that diagnoses were usually subjective assessments. These could be based on numerous factors, such as past experience with similar patients, training that emphasized very different theories and approaches, as well as varied views of mental illness in certain countries because of ingrained sociocultural influences and traditions.

It is fairly quick and easy to accurately diagnose tuberculosis, anemia, or a heart attack, because of abnormalities that can be detected with x-rays, laboratory tests or an electrocardiogram that all doctors accept. The same holds true for most other medical disorders. In contrast, there are no tests, imaging procedures or other objective criteria that can be used to diagnose mental disease, much less assess its severity or prognosis. There was considerable controversy as to how DSM-II could be revised in an attempt to conform to mainstream medicine. Some insisted that the term "neurosis" should be deleted, that some diseases should be referred to as "disorders" and that numerous new "disorders" should be included. When DSM-III finally appeared in 1980, its 494 pages now listed 256 diagnoses grouped by categories and subcategories in a numerical decimal system similar to the Dewey classification used by libraries. It was heralded as a "revolution" and "transformation" in psychiatric diagnosis by proponents, but not everyone agreed. Because of continued bickering over diagnoses like "ego-dystonic homosexuality", DSM-III-R, a 1987 567-page revision deleted this and replaced it with "sexual disorder not otherwise specified" that might include "persistent and marked distress about one's sexual orientation". Other disorders were added, for a total of 292 diagnoses. DSM-IV was published in 1994 and listed 297 disorders in its 886 pages. Clinical significance criteria for almost half of the entries were added that now required symptoms to cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning". This was also controversial, and Gay Rights groups and especially married gays protested being labeled as having a mental disorder. DSM-IV-TR, a 1,000 page "Text Revision", was published in 2000 to provide further information on this and other sensitive issues.

Do we really have close to 200 more mental diseases now than 50 years ago? Have any of these repeated DSM revisions made psychiatric diagnosis more scientific? Has anything been accomplished other than to increase the profits for pharmaceutical companies by promoting sales of psychotropic drugs? It is important to recognize that **at least half of DSM authors have or have had strong financial ties with these companies and that the decision as to which drug to use depends on how the**

disorder is worded. Some of these are hard to believe. If coffee keeps you awake at night, you suffer from Caffeine-Induced Sleep Disorder (292.89) rather than poor judgment in having some java shortly before retiring. And if you continue to toss and turn because you are concerned about being shy, you may be among the growing victims of Social Phobia (300.23). If you are worried about your place in the cosmos or spiritual issues, you've got Religious or Spiritual Problems (V62.89 or Z71.8).

Normal age related memory loss or diminished sexual activity are now disorders that allegedly require drugs. Bob Dole made erectile dysfunction or E.D. household terms and Viagra the solution. It's a lot more palatable and acceptable to be suffering from E.D. than to be impotent, which has the connotation of being crippled or disabled. We also have Levitra and Cialis, with new drugs like Uprima and Snafi waiting for approval and a chance to get a share of this multibillion-dollar market, that may soon extend to women. Despite objections, Medicare and Medicaid now pay for these pills, further legitimizing E.D. as a disease. Suggestive TV ads for E.D. drugs appear on prime time shows that feature movies like "Miracle on 34th Street" that children watch. Men can also obtain testosterone cream that works well if a doctor determines that it's "right for you." According to a *JAMA* ad, "Sexual enjoyment and satisfaction with erection duration were improved vs. baseline, **but these improvements were not significant compared to placebo**." The ad shows a happy couple dancing, a content couple riding a motorcycle, and two pictures of men swinging golf clubs (alone) and smiling. And if you are "ready" and your significant other isn't, he/she may be suffering from Hypoactive Sexual Desire Disorder (302.71), Sexual Dysfunction not specified (302.70) or Sexual Aversion Disorder (302.79). Women may also suffer from Female Sexual Arousal Disorder (302.72 Female Orgasmic Disorder (302.73), and dyspareunia or painful intercourse (302.76). However, men can be troubled by Male Erectile Disorder (302.72), Premature Ejaculation (302.72) and Male Orgasmic Disorder (302.74). Other sexual problems that can affect both men and women include, Voyeurism (302.82), Sexual Masochism (302.83), Sexual Sadism (302.84) and Gender Identity (302.85).

Impulse Disorders And Compulsive Shopping

DSM-1V has numerous diagnoses that refer to exaggerated or aberrant behaviors, and there are medications for most of them. There are so many disorders that you could easily create your own, especially if you had a pill for it. I was reminded of this by a recent study of compulsive shoppers. According to one psychiatrist who has studied the problem, these are mostly women in their thirties who organize their daily schedules around shopping expeditions at various stores ranging from consignment, antique shops and boutiques to larger clothing and department stores. They prefer shopping

alone and tend to purchase personal items like clothes, shoes, compact disks, jewelry, makeup, or various collectibles. These items are rarely needed and accumulate at home unused, and often still wrapped. Some shoppers return things, give them to friends, or sell them. Even though this behavior causes financial and marital problems, attempts to stop are unsuccessful. The shopping experience is arousing and has been described as "a total sensory experience" that may be intensified by various colors, sounds, lighting and smells. Some say they feel good, "high" and even powerful during buying sprees. Others explain that shopping relieves their depressed feelings, and for a few, it can be sexually arousing. Surveys suggest that 1-6% of women may have some form of this problem.

According to the study, which was published in a prestigious peer reviewed journal, researchers followed 24 compulsive shoppers for four months. One had bought more than 2000 wrenches and another owned 55 cameras. All were treated with the antidepressant Celexa (citalopram) for seven weeks, followed by either the drug or a placebo for an additional nine weeks. All of the patients who took Celexa for the entire course of the study reported that they had lost interest in shopping. Some said they couldn't believe they went shopping and didn't buy anything. In contrast, five of the eight patients in the placebo group had a relapse after stopping the drug. It is not clear why Celexa was effective but it was suggested that it might boost brain serotonin levels. However, this has been largely discredited as the explanation for why this class of antidepressants works, since drugs that do not affect serotonin, and even placebos are just as effective in clinical trials. Celexa also has side effects such as drowsiness and loss of sexual desire. Some authorities also question the wisdom of giving antidepressants to treat compulsive behavior or problems like alcohol dependency and substance abuse. They point out that this simply creates another addiction, similar to what occurs when methadone is substituted for heroin.

The study received widespread media coverage, and so much attention was devoted to compulsive shopping disorder, that the American Psychiatric Association was forced to issue the following press release:

> There have been a number of erroneous reports in the media indicating that the American Psychiatric Association is planning to add "compulsive shopping disorder" to the list of approved mental disorders. We would like to correct this misinformation.
>
> At this time, the American Psychiatric Association (APA) has no plans to add compulsive shopping to the list of mental disorders in the next edition of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), due for publication in 2010. In addition, APA is not altering the current edition,

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR), to include compulsive shopping as a disorder.

It does lists five "**Impulsive Control Disorders**" in which the individual cannot resist doing certain actions that are harmful to themselves or others:

1. **Intermittent Explosive Disorder** – individuals who are prone to explosive outbursts when subjected to stress.
2. **Kleptomania** – inability to resist the impulse to steal objects that are not needed for personal use or are stolen for their monetary value.
3. **Pyromania** - purposefully and recurrently starting fires for the pleasure derived from the fire itself rather than for monetary gain or social protest.
4. **Pathological Gambling** – a preoccupation with wagering in which the amount of the bet increases in order to create more excitement.
5. **Trichotillomania** - an increased state of tension prior to pulling out one's hair and a feeling of relief after doing this. Compulsive or pathological skin picking of lesions or normal skin and nail biting are similar but not recognized.

Antidepressants like Celexa are frequently used to treat these disorders, even though there are no scientific studies demonstrating a mechanism of action to explain their alleged benefits. In addition, this is an off label use, since antidepressants are not indicated for impulse disorders. However, once a drug is approved for any disorder, physicians are free to use it for any condition or complaint where it might be beneficial. Pharmaceutical companies have been quick to take advantage of this by publicizing studies, and especially anecdotal reports and celebrity testimonials, about some product that patients then ask their doctor to prescribe.

"Suffer The Little Children" Now Takes On A New Meaning

Children and teenagers are major targets for turning frequent and fairly normal behaviors into what appears to be a significant disorder requiring medication. If youngsters tend to argue with adults, lose their temper easily or deliberately annoy people, the problem may be Oppositional Defiant Disorder (313.81), although this may be difficult to distinguish from Conduct Disorder (312.8) or Disruptive Behavior Disorder (312.9) If they have trouble getting along with a brother or sister, they may have a Sibling Relational Problem (V61.8) and, if you and your spouse often argue about how to handle your unruly child, you could have a Partner Relational Problem (V61.1). Teenagers with problems doing math homework might be suffering from Mathematics Disorder (315.1), which should not be confused with Academic Problem Disorder (V62.3). Adolescents uncertain about values, loyalties, what career to pursue, or their goals in life, may be dealing with Identity Problem (313.82), which was downgraded from a "disorder" in

DSM-III to a mere "problem" in DSM-IV. Drug companies try to reassure and convince parents that they have something to relieve most of these.

A much more serious problem is the explosive rise in psychotropic drug prescriptions for children because of what appears to be an epidemic of bipolar disease and ADHD (attention deficit hyperactivity disorder). Both of these are new names for old disorders that were created to increase the sales of relatively obscure drugs to a gullible population. While there is little doubt that this deceptive strategy has been a marketing triumph, it has had disastrous health consequences. Bipolar disease has replaced manic-depressive psychosis; a term coined by the German psychiatrist Emil Kraepelin in 1902. Kraepelin noted that these patients had recurrent episodes of hyperactivity or depression during which they could not function properly, followed by intervals during which they had few or no symptoms. The disorder usually started in the twenties, and, as with depression, was seen much more frequently in women, and could disappear spontaneously. It was rare or non-existent in children. DSM-I referred to this as "manic depressive reaction" largely because of the influence of Adolph Meyer, the first Chairman of the Department of Psychiatry at Johns Hopkins, who viewed this and other mental diseases as a reaction of biogenetic factors to psychological and social stresses. The DSM-II termed the condition "manic-depressive illness" because of the need to better differentiate abnormal from normal and put psychiatric diagnosis on the same scientific footing as that used for medical disorders. Bipolar dsease replaced this in the 1980 DSM-III, which also referred to a possible pediatric form that might develop in children with Attention Deficit Disorder. The definition of bipolar disease was changed in the revision DSM-IIIR and again in DSM-IV. There are now several types of bipolar disease, for which there are presumably different types of drugs, and although it is now rarely used, many feel that manic-depressive disease is a more descriptive term.

Bipolar disease took off in the 1990's, when Abbott Laboratories introduced Depakote. Depakon, sodium valproate, an anticonvulsant that was available for decades, had been shown to be helpful in manic-depressive patients. But it was not approved for that diagnosis. Abbott reformulated it as semi-sodium valproate, which it claimed formed a more stable solution, and was able to get a patent on the new compound. In 1995, this was introduced as Depakote for the treatment of mania, since it had more sedative side effects than its predecessor. It was later approved for this based on clinical trials showing benefits in patients with acute manic states. Any sedative agent would have produced the same results but no company had chosen to do this, since manic states were fairly rare and adequately controlled by lithium and other agents.

However, **Depakote was advertised as a "mood stabilizer" rather than a treatment for manic-depressive disorder, which would have been illegal since there were no studies to support this. In addition, mood stabilizer was a term with no precise clinical or neuroscientific meaning** so it was not subject to legal sanction. Other companies that made antipsychotic drugs like Zyprexa, Risperdal and Seroquel quickly began to call them mood stabilizers. Prior to 1995, there were no articles on this in the medical literature and now there are over a hundred a year. As Healy and Le Noury note in a recent paper, "Pediatric bipolar disorder: An object of study in the creation of an illness", this combination of "rebranding" a disorder (from manic-depression to bipolar) and a new class of drugs ("mood stabilizers" from sodium valproate) is unprecedented within psychiatry."

The article also explains how pharmaceutical manufacturers of psychotropic drugs have created the current epidemic of bipolar disease in children by a massive, multipronged marketing campaign approach that included the following tactics:

1. Using industry-supported focus groups of academic psychiatrists, called opinion leaders, and family "support" groups as big lobbyists for their drugs.
2. Discussing bipolar writers, poets, playwrights, artists, composers and other celebrities. Few of the major 19th and 20th Century artists listed were diagnosed as having manic-depressive illness.
3. Using diaries and company website questionnaires to document any variations in mood (suggesting that this establishes the existence of a pathologic disorder) and constructing questionnaires designed to over diagnose bipolar disease.
4. Emphasizing "risks" such as suicide, alcoholism, divorce, and career failure, as if they are inherent and major features of bipolar disorder, and portraying it as a lifelong disease that requires continual drug therapy.
5. Control over academia and prominent child psychiatrists who lend their names to company written articles in prestigious journals, make presentations at professional meetings to report on company studies, and help deliver propaganda to practicing pediatricians and physicians.
6. A barrage of direct to consumer TV and other advertising that hype the benefits of drugs and minimize their dangerous side effects.

Bear in mind that these medications have not been approved for use in children, much less bipolar disease, and are frequently given in combination cocktails that include other drugs, even though their interactions have not been studied, some are contraindicated, or are needed to reduce serious side effects.

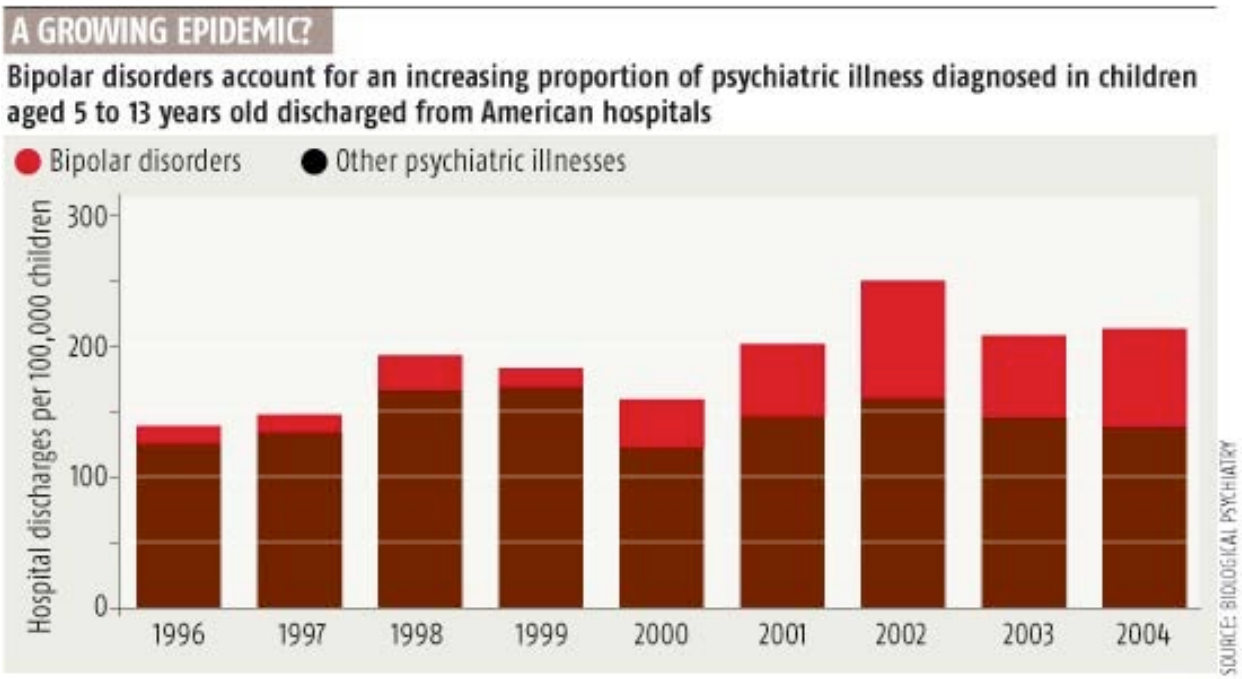
Let's look at some of the tragic results of this reckless approach.

Rebecca Riley – dead at age 4 from drug toxicity

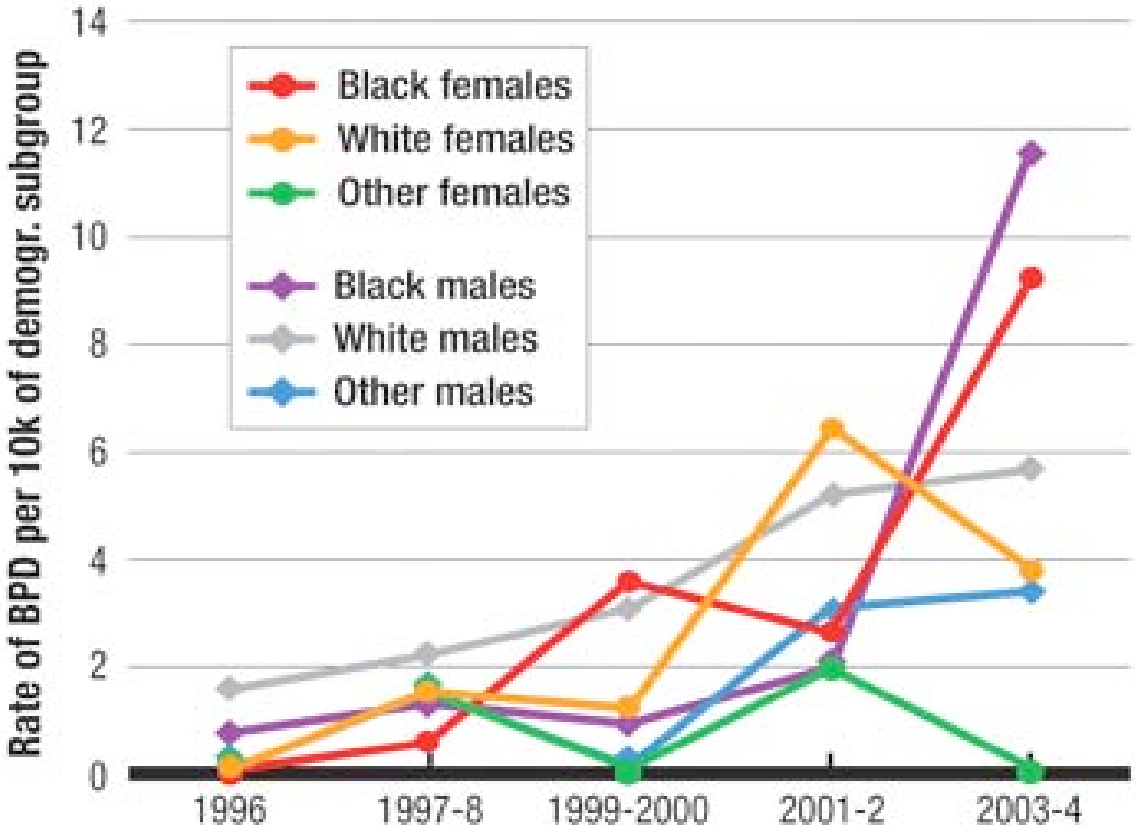
Rebecca Riley was diagnosed as having bipolar disease by a Tufts-New England Medical Center psychiatrist when she was 28 months old. She was placed on a cocktail of Seroquel – an antipsychotic, Depakote – a mood stabilizer, and clonidine – an antihypertensive drug occasionally used to help hyperactive children sleep. She died last year on the floor of her parents' bedroom at the age of four from "multi-drug toxicity." Rebecca's parents have been charged with murder for poisoning her with these drugs and the role of her psychiatrist is currently being investigated by the Massachusetts Board of Registration in Medicine.

Rebecca's case is not unusual. Heather Norris in Texas was diagnosed as being bipolar shortly after turning two. But child psychiatrist Dr. Dimitri Papolos, co-author of *The Bipolar Child*, believes that waiting until 2 is much too long to diagnose bipolar disorder and treatment may be indicated for some infants. This is based on interviews for the book in which many of the mothers remembered their baby's excessive hard kicking, and rolling around in the uterus, and keeping them awake with screaming after they were born. Others said that a sonogram technician or their obstetrician told them it was difficult to get a picture of the baby's face or to sample the amniotic fluid because of constant, unpredictable activity. A Duke psychiatrist told BBC news in 1995 that " One in ten children aged two to five had obvious signs or symptoms of psychiatric illnesses such as ADHD, anxiety or depression, suggesting that such conditions begin very early in life, perhaps even in the womb. Screening and treating these disorders in babies and infants is the way forward –waiting until childhood or adulthood is too late."

Another physician is recruiting patients for an FDA funded study for treating 60 bipolar children aged 3-7 with valproate and Risperdal. Risperdal was recently approved for autism in children and Zyprexa for teenagers, despite their known side effects and the FDA's admission that "We have not systematically looked at the data for children." One survey revealed that over 90 percent of children referred to a pediatric psychiatrist were prescribed a psychoactive drug. In 1996, 13 out of every 100,000 children in the US were diagnosed as having bipolar disorder. In 2004, the figure was 73 in 100,000, **a more than fivefold rise**. **Among children diagnosed with a psychiatric condition in 1996, 1 in 10 had bipolar disorder. By 2004, this had quadrupled, as shown below.**

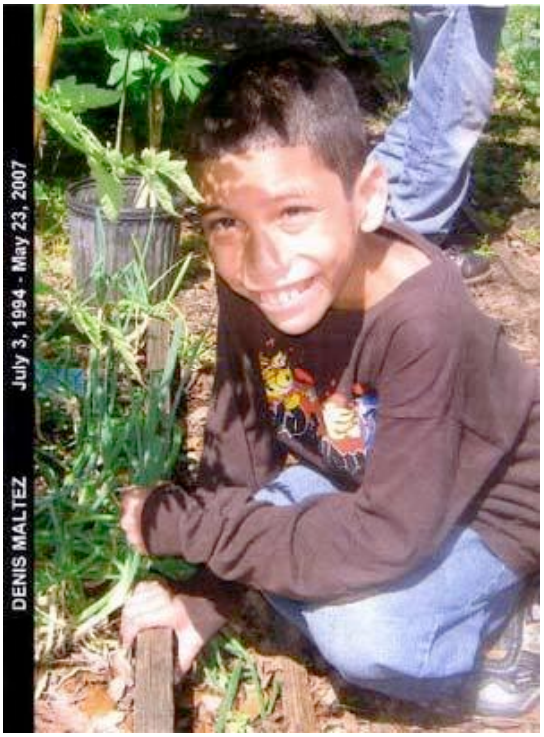


Hospitalization for bipolar disease increased 439% in children and 296% in adolescents during this period. As noted below, this rise was especially steep in black children from 2002 to 2004, possibly due to increased Medicaid coverage.



In many parts of the country, there is a preponderance of minority groups on Medicaid. Six months ago, it was reported, "In the past seven years, the number of Florida children prescribed such drugs has increased some 250 percent. Last year, more than 18,000 children on Medicaid were given prescriptions for antipsychotic drugs, even for some as young as 3 years old. Last year, 1,100 Medicaid children under 6 were prescribed antipsychotics, a practice so risky that state regulators say it should be used only in extreme cases. These numbers are just for children on fee-for-service Medicaid, generally the poor and disabled. Thousands more kids on private insurance are also on antipsychotics." **One 12 year-old was taking 16 psychotropic drugs at the same time.**

Children who wind up in foster care because of unsafe households due to drug use and violence also tend to be from minority groups. Almost all of these unfortunate kids have emotional problems and symptoms resulting from the stresses they have been subjected to. Superimposed on this, is the added stress of being incarcerated in a strange new environment. They are particularly likely to be overmedicated with psychotropic drugs so that they can be managed more easily. There are hundreds of horror stories about the disastrous damage, as well as several deaths due to this practice, which is also not uncommon to reduce complaints in elderly nursing home patients. Dennis Maltez, who recently died while he was in foster care is one example.



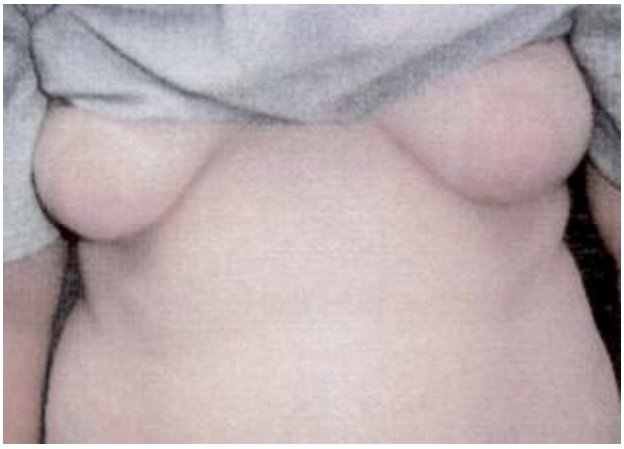
Dennis Maltez, dead at age 12

By the time he was 12 years old, Dennis Maltez had been diagnosed as having mental disorders ranging from autism and mental retardation, to depression, and schizophrenia. He was living in a group home for disabled children in Miami that had been cited for "letting kids go hungry, supervising them so poorly that they routinely attacked each other and medicating several of them so 'irresponsibly' that they trembled, slept a lot and drooled." Dennis had been receiving multiple medications and had to be hospitalized in January 2007 because of severe side effects. Following discharge, he was placed on Zyprex, Seroquel and Depakote but stopped breathing on May 23, after a staffer restrained him in a group-home van that was transporting him and others to a Miami flea market for a haircut. The exact cause of death was not specified but was considered to be related to his drug cocktail. After investigation, the group home and several others in the chain were permanently shut down.

The newspaper account also described a 9 year-old Florida girl taking 2 antipsychotics and 2 antidepressants, who committed suicide in a violent manner. Records of two boys aged 14 and 15, who were also on multiple similar medications, revealed that **both had been prescribed 28 psychotropic drugs over the past three years.**

Similar problems abound all over the country. In Tennessee, Medicaid antipsychotic prescriptions for children doubled from 1996 to 2001. In Texas, they represent 76% of prescriptions for foster children and increased 500% for all children from 1966 to 2000, despite the fact that 43% had no history or current evidence of psychosis. In 2005, nationwide Medicaid programs purchased 75% of all antipsychotic drugs and off label prescriptions for children and adolescents had jumped more than 80% since 2001. A few weeks ago, the *Rochester Democrat and Chronicle* interviewed families of some local foster children on medications, local and national experts, analyzed data from county, state and federal agencies and reviewed public records of Monroe County Family Court cases in which the prescription of these drugs has been an issue. Their survey revealed that in 2002, about a third of the county's foster care population, 327 children, were prescribed one or more common psychotropic drugs. By the end of 2006, the number had increased about 40 percent to 457 foster children, or almost half of the county foster care population. In the five years from 2002 through 2006, Medicaid expenditures for common psychotropic medications for Monroe County foster children nearly doubled - an increase almost four times the statewide rate. They are also on the rise at residential foster care treatment centers. At the nonprofit Hillside Children's Center, for instance, 55 percent of the foster children are prescribed one or more psychotropic drugs. Very young children are also receiving them, including a **1-year-old foster child who is taking Risperdal, and two 4-year-old foster children who are on Depakote**.

These and similar drugs can also cause numerous other complications



Gynecomastia in a 13-year old boy on Risperdal

Sean was prescribed Risperdal when he was 9 and developed breasts so large that they had to be surgically removed four years later. Risperdal causes increased production of prolactin, which stimulates the growth of breast tissue in males under the age of 18. Risperdal can also cause Neuroleptic Malignant Syndrome and tardive dyskinesia. Zyprexa and similar drugs frequently cause weight gain of 100 pounds or more that lead to diabetes, insulin resistance and metabolic syndrome.

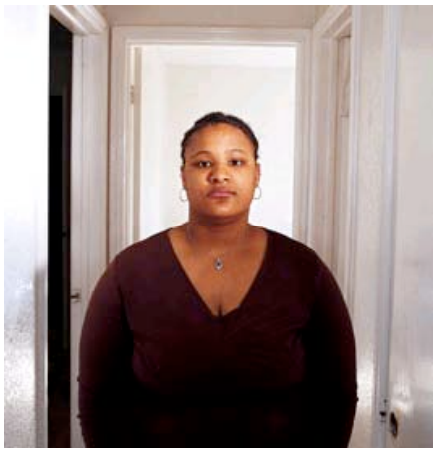
The Power Of Pharmacracy In Texas

Aliah Gleason is an eighth grade student in Pflugerville, Texas, a suburb of Austin. She was an above average student in the seventh grade but tended to be outspoken. Her parents considered her to be a bright but spirited girl who liked to clown around but her teachers claimed she suffered from "oppositional disorder," and placed her in a special educational program. University of Texas psychologists who subsequently administered a mental health screening test for all sixth and seventh-grade students, sent her parents a form letter stating "You will be glad to know your daughter did not report experiencing a significant level of distress." Not long after, they got a very different phone call telling them Aliah had scored high on a suicide rating scale and needed further evaluation. The Gleasons reluctantly agreed to have Aliah see a consulting psychiatrist, who concluded that Aliah was suicidal but did not hospitalize her, referring her instead to an emergency clinic for further evaluation. Six weeks later, a child-protection worker went to Aliah's school, interviewed her, then summoned her father to the school and told him to immediately take Aliah to Austin State Hospital, a state mental facility. He refused, and after a heated conversation, she placed Aliah in emergency custody and had a police officer drive her to the hospital.

According to one newspaper, "**The Gleasons were not allowed to see or even speak to their daughter for the next five months,** and Aliah would spend a total of nine months in a state psychiatric hospital and residential treatment facilities. While in the hospital, she was placed in restraints more than 26 times and medicated—against her will and without her parents' consent—with at least 12 different psychiatric drugs, many of them simultaneously. On her second day at the state hospital, Aliah said she was told to take a pill to "help my mood swings." She refused and hid under her bed. She says staff members pulled her out by her legs, then told her if she took her medication, she'd be able to go home sooner. She took it. On another occasion, she "cheeked" a pill and later tossed it into the garbage. She says that after staff members found it, five of them came to her room, one holding a needle. "I started struggling, and they held my head down and shot me in the butt," she says. "Then they left and I lay in my bed crying."

What, if anything, was wrong with Aliah remains cloudy. Court documents and medical records indicate that she would say she was suicidal or that her father beat her, and then she would recant. (Her attorney attributes such statements to the high dosages of psychotropic drugs she was forcibly put on.) Her clinical diagnosis was just as changeable. During two months at Austin State Hospital, Aliah was diagnosed with "depressive disorder not otherwise specified," "mood disorder not otherwise specified with psychotic features," and "major depression with psychotic features." In addition to the

antidepressants Zoloft, Celexa, Lexapro, and Desyrel, as well as Ativan, an antianxiety drug, Aliah was given two newer drugs known as "atypical antipsychotics", Geodon and Abilify, plus Haldol, an older one. She was also given the anticonvulsants Trileptal and Depakote—though she was not suffering from a seizure disorder—and Cogentin, an anti-Parkinson's drug.



Aliah Gleason at the age of 13

At the time she was discharged from a State mental hospital to a residential facility, Aliah was taking 4 SSRI antidepressants, 2 "atypical" neuroleptics, 2 anticonvulsants, an anti-anxiety drug, an older neuroleptic and a drug used to treat Parkinsonian side effects of the medications. Risperdal, another "atypical" antipsychotic was later added to her psychotropic cocktail. Her parents had never agreed to nor were they ever even notified of any of the above. In addition to gaining a large amount of weight and now looking much older than 13, their daughter had been transformed from an active, lively girl to a lifeless zombie.

The pathetic part of this story is that all of this was made possible by the Texas Medication Algorithm Project (TMAP) introduced in 1995 under Governor George Bush. This collusive, contrived and corrupt program instigated by drug companies, University of Texas psychiatrists, state mental health and correction officials, mandates prescribing the most expensive psychotropic drugs as first line treatment, regardless of their side effects. A doctor cannot choose a generic drug until at least two and often three drugs on the list have failed and must also write down the reasons and assume liability for deviating from the TMAP list. Just as corrupt and devious is the use of the TeenScreen questionnaire to diagnose mental disease. This was also developed under the auspices of drug companies to promote sales because of its **84% false-positive rate of identifying healthy children as having "mental problems."** In one study, almost 50% of those screened were found to be mentally ill and "were referred for intervention of some kind." **Although they have no scientific validity, President Bush wants TeenScreen and TMAP to be mandatory in all 50 states.** Stay tuned for more details on this and other stressful pharmacracy fiascos.

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