

## Psychiatric Drugs as Agents of Trauma by Charles L. Whitfield, MD

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# Psychiatric drugs as agents of Trauma

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**Abstract.** Drawing on the work of numerous psychiatrists and psychopharmacologists and my own observations, I describe how most common psychiatric drugs are not only toxic but can be chronically traumatic, which I define in some detail throughout this paper. In addition to observing this occurrence among numerous of my patients over the past 20 years, I surveyed 9 mental health clinicians who had taken antidepressant drugs long-term. Of these 9, 7 (77%) experienced bothersome toxic drug effects and 2 (22%) had become clearly worse than they were before they had started the drugs. Based on others' and my observations I describe the genesis of this worsened condition which I call the *Drug Stress Trauma Syndrome*.

These drug effects can be and are often so detrimental to the quality of life among a distinct but significant minority of patients that they can no longer be considered trivial or unimportant. Instead, they are so disruptive to many patients' quality of life that their effect becomes traumatic, and are thereby agents of trauma. These observations and preliminary data may encourage others to look into this matter in more depth.

## 1. Introduction

Depending on how we look at it, trauma can be simple, complex, or somewhere in between. In its simpler form it is any serious injury to the body, often resulting from an accident or violence and sometimes from a drug or medical procedure. Beyond the body, psychological trauma often results from an event that causes great distress or an emotional wound leading to psychological injury [18, 28, 52], and which may also result from a drug or medical procedure. Psychological trauma often accompanies physical trauma. Trauma can result from natural disasters such as earthquakes, fires, floods, hurricanes and severe storms that often cause death, injury, and property damage. These are usually single events that involve fewer of the confounding and complicating variables present in so many other kinds such as combat trauma and child maltreatment and neglect, including physical, sexual, or emotional abuse, bullying, domestic violence, or the witnessing of any of these [12, 13, 39–41, 49].

Any of these traumas may lead to one of the three main variants of posttraumatic stress disorder (PTSD) [11, 45, 50], including classical, complex and sub-variant PTSD, summarized in Table 1. In this article I add a fourth kind by describing how psychiatric drugs can act as traumatizing agents and make patients worse, which I call the Drug Stress Trauma Syndrome (DSTS), described below. After taking one, and usually more psychiatric drugs over time, many people end up feeling more distressed. They may experience a worse quality of life than they did before they started taking the drugs [6, 7, 21, 25, 26,

Table 1  
Variants of PTSD

PTSD variant	Characteristics and description
PTSD Sub-variant	Little or no memory of trauma experiences or history. Often fulfill less <i>DSM</i> diagnostic criteria than required for classical PTSD, yet patient usually has one or more trauma spectrum disorders and other trauma effects.
Classical PTSD	Memory/awareness for enough trauma effects to fulfill <i>DSM</i> criteria for PTSD categories A – F
Complex PTSD	Extreme variant after repeated severe trauma, especially during childhood. Commonly experience increased <i>dissociation</i> , marked <i>relationship difficulties</i> , <i>re-victimization</i> , <i>somatization</i> , extreme <i>disrupted feelings and emotions</i> , and a <i>lost sense of self and meaning</i> .
Drug Stress Trauma Syndrome (DSTS)	An unknown minority % may have DSTS without having another PTSD variant. Needs data gathering. Many usually have another variant of PTSD <i>plus</i> DSTS.

33, 35, 46, 47, 49–51]. First, it will be useful to describe and contrast the drugs in context with common illegal drugs according to their risk and toxicity.

## 2. Illegal drug toxicity

Illegal drugs often have toxic effects on our body and mind [24, 31, 38]. There are also legal *system* consequences for simple possession and use in most countries. Having worked in the field of addiction medicine since 1974 and psychiatry since 1980, I rank *illegal* drugs in order of the *most toxic* and dangerous: 1) phencyclidine (PCP, “Angel Dust”) is number one. In decreasing order of toxicity, I rank 2) amphetamines, including methamphetamine, as second. Then 3) cocaine, another stimulant, and not much different than amphetamines, but with a detrimentally short half-life. Fourth, is 4) heroin, a painkiller like morphine and the other opiates – all with several toxic effects. Next are 5) psychedelic drugs (erroneously called “hallucinogens”). And finally, 6) cannabis (marijuana) is probably the most used illegal drug today, with the toxic effects of over-sedation or “dumbing down” (which most *legal* and illegal psychoactive drugs also commonly cause), lung irritation and damage, dependence/addiction and withdrawal symptoms. Like *all these drugs* their *illegality*, *way of use* (ingesting, snorting, smoking or injecting), and *lifestyle* add more to their toxicity.

As toxic as these six kinds of drugs are, and not to discount their dangers, to keep it in perspective, in the USA the *legal* drugs alcohol and nicotine *disable* and *kill 25 times more* people (about 500,000 yearly deaths) than all of these illegal drugs *combined* [36].

## 3. Legal drug toxicity: How might psychiatric drugs make you worse?

Just because a drug may be legal, i.e., approved by the FDA or the equivalent worldwide and readily available from the medical and psychiatric system (physicians, nurses, pharmacists and the like) does not make them any less toxic than the illegal drugs listed above. In fact, some of the legal psych drugs are as or *more* toxic [1, 6, 7, 26, 33–35, 44, 49–51]. Psychiatrist and psycho-pharmacologist Peter Breggin wrote in 2008 [6, 7], “People commonly use alcohol, marijuana and other non-prescription drugs to dull their feelings. Usually they do not fool themselves into believing they are somehow improving the function of their minds and brains. Yet when people take psychiatric drugs, they almost always do so

without realizing that the drugs ‘work’ by *disrupting brain function*, that the drugs cause withdrawal effects, and that they frequently result in dangerous and destructive mental reactions and behaviors” (my italics).

In 1999 describing the course of events following *chronic psychoactive drug-taking* Hollister reviewed Shuster’s classic 1961 formulation [23, 42]: 1) the drug perturbs the normal homeostasis of an organ system by virtue of effects on enzymes, neurotransmitters, receptors or second messengers. 2) To compensate, the body responds by increasing the amounts of each. When this occurs the patient may become tolerant to the drug. 3) To maintain the desired effects of the drug, the dose is increased to overcome the body’s compensatory reactions. However, increasing doses result in renewed attempts at compensation. 4) Several cycles of this sort may ensue. 5) When a drug is withdrawn, the overcompensated mechanisms are now unopposed, resulting in a withdrawal reaction, generally characterized by symptoms and signs opposite to those usually produced by the drug (physical dependence) [23, 42].

Hollister wrote: “This schema was first introduced to explain the sequence of drug-taking of drugs of abuse, which also involve ‘psychic [psychological/neurological] dependence’. However, it may be extended to a variety of drugs. . . It has been long recognized that withdrawal syndromes vary among classes of drug. In 1964, the World Health Organization classified withdrawal syndromes in that fashion: Barbiturate-alcohol type, opiate type and stimulant type. *This classification still applies and might be modified now to include other drugs not usually abused, but which alter central nervous system function, such as antidepressants and antipsychotics, where discontinuation syndromes were unanticipated and more subtle and psychic dependence was not [suspected to be] present. We may conclude that any drug which disturbs normal physiology, biochemistry or gene expression may set the stage for such a reaction”* (my italics) [23].

Also in 1999 psychiatrist and psycho-pharmacologist David Healy and Richard Tranter described reactions to taking psychiatric drugs, including their withdrawal, as *pharmacological stress diathesis syndromes* [22]. They said, “Recent descriptions of discontinuation syndromes following treatment with antidepressants and antipsychotics, in some cases long lasting, challenge both public and scientific models of addiction and drug dependence. Antipsychotic and antidepressant drug dependencies point to a need to identify predisposing constitutional and personality factors in the patient, pharmacological *risk factors in the drug* and aspects of *therapeutic style* that may contribute to the development of *stress syndromes*. The stress syndromes following antipsychotics also point to the *probable* existence of a *range of syndromes* emerging within treatment. The characteristics of these need to be established” (my italics). Similarly, psycho-pharmacologist Ross Baldessarini and AC Vignera have called these psychiatric drug effects *pharmacologic stress, iatrogenic pharmacologic stress, and drug discontinuation-associated stress* [2, 3, 4].

Ranking the psych drugs in decreasing order as I did above for the illegal drugs, first are 1) the antipsychotic drugs, which are generally so disabling and toxic that they have been shown to cause early death [6, 7, 46, 47]. Second are 2) the antidepressant drugs, which share many toxic effects with the antipsychotics and often *cause* an increase in suicidal thoughts and completed suicides, as well as homicides, when compared with placebos [6, 7, 19]. Next are 3) the stimulants of the methylphenidate (Ritalin) and amphetamine type (which are nearly all amphetamines of one sort or another). Then 4) the benzodiazepine sedatives (“benzos”) whose main toxicities are over-sedation and emotional numbness (similar to the antipsychotics and antidepressants) and probably having the most painful withdrawal syndrome of all legal and illegal drugs for most people. Next, 5) the anti-convulsants, cleverly called “mood stabilizers” for marketing purposes, although they have little to do with mood and they commonly cause numerous toxic effects and an often painful withdrawal [6, 34]. I summarize major risks and

Table 2  
Some characteristics of illegal and legal psychoactive drugs

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*Illegal drugs*

- Overdose from toxic effects on body & mind
- Organ damage from chronic use
- “Dumbing-down” effect on mental & social function & self esteem
- Legal system consequences
- Most-toxic-drug rank: Phencyclidine (PCP), amphetamines, cocaine, heroin, psychedelics, cannabis
- The legal drugs alcohol & nicotine disable & kill 25X more people than *all these* illegal drugs *combined*

*Legal drugs* – have similar and often more toxic effects

- Organ damage from chronic use (e.g., as obesity, diabetes; fetal & brain/nerve damage, dementia, depression, anxiety, tremor)
  - “Dumbing-down” effect on mental & social function & self esteem
  - Forced drugging by hospital, court & state system
  - Withdrawal common & bothersome; often harmful to self & others; usually *misdiagnosed*
  - Akathisia ± withdrawal akathisia → suicide & homicide
  - Violence is common with both legal & illegal psych drugs
  - “Mental illness” labeling → fear & shame, discrimination, isolation
- 

toxicities of both the illegal and legal psychoactive drugs in Table 2. Here follows a selection of references for a more detailed summary of these drug effects [6, 8, 19, 20, 26, 33, 46–51].

#### 4. Drug stress trauma syndrome

I have seen countless patients over the past 20 years who came to me currently taking – or having taken in the past – from five to twenty psych drugs, none of which had helped them significantly long-term with their original complaints. Many of these people had gotten worse. I began to notice a pattern wherein a vicious cycle unfolded among a distinct minority of them. I observed that taking many of these drugs was often unpleasant, usually did not work well, and had become detrimental to their mental, relationship and behavioral health. They were worse than they were before they started the drugs. Here is how I have seen the Drug Stress Trauma Syndrome usually to come about.

#### 5. Genesis of DSTS

The person enters the health care system with one or more psychological or psychiatric symptoms or signs, from bothersome fear, anxiety, to sadness, low energy, to a behavior or relationship problem, or the like. The intake clinician usually does not carefully look for the three most common causes of these symptoms—a recent significant loss, a history of repeated trauma/PTSD and alcohol or other drug dependence. Instead, after a brief (influenced by health insurance or government treatment time limitations) and a cursory evaluation (influenced by the clinician’s training and skills), and usually with no physical or laboratory examination, a psychiatric diagnosis is made. This diagnosis may be in error, such as “depression”, an “anxiety disorder”, “bipolar disorder”, “ADHD”, a “psychosis”, or the like [27, 54]. Zur et al. argued: The DSM is more a political document than a scientific one. Decisions



Fig. 1. Drug Stress Trauma Syndrome components.

regarding inclusion or exclusion of disorders are made by majority vote rather than by indisputable scientific data.

But it satisfies several key people: The health insurance or other authorities' requirements, the clinician, the drug industry, and/or any number of authority figures (boss, court, probation officer, teachers or other school administration, parents or other family members) and, at least temporarily, the patient.

Not addressing that the patient's symptoms and/or signs may instead be grief-related [43, 49], trauma effects [18, 28] or due to an alcohol or other drug problem [31, 38, 50], a shortcut of one or more psychiatric drugs is prescribed. The clinician usually gives the patient little or no warning about drug toxicity or drug withdrawal [15], and offers them no counseling or psychotherapy (which would likely have been more appropriate) [6, 7]. Perhaps unknowingly acting in their favor long term, up to 25% of patients do not get the prescription filled. But for those who start taking the drug(s), the first toxic effect of "medication spellbinding", chemical dissociation or numbing occurs, even though the patient may not be fully aware of it [6]. An unaware observer—trying to be objective—may conclude something like, "So far, so good".

Sooner or later, the patient either stops taking or forgets to take the drug, and for most psychiatric drugs, one of the most common toxic effects begins to occur—drug *withdrawal symptoms*. If the withdrawal symptoms are bothersome enough, the patient usually contacts their prescribing clinician or physician who should – but usually does not – recognize them as being in drug withdrawal. Instead, they tend to misinterpret the symptoms as a re-emergence or worsening of the patient's original possible misdiagnosis' symptoms or signs [53]. With this misinterpretation, or second misdiagnosis, they commonly then prescribe a higher drug dose—or a different or stronger drug. They usually give the patient no education or insight on withdrawal symptoms, and again, no serious yet appropriate psychotherapy or counseling [6, 7, 33, 48–51].

Table 3  
Drug Stress Trauma Syndrome (DSTS) Genesis by stages of system-induced psychiatric/psychological illness

Actions	Dynamics
First "Diagnosis"	<ul style="list-style-type: none"> <li>• With no PTSD or Alc &amp; Drug (Chemical Dependence) assessment, wrong diagnosis is made. e.g., "Depression", "Anxiety Disorder", "Bipolar Disorder", "psychosis", "ADHD, etc.</li> </ul>
First "Treatment"	<ul style="list-style-type: none"> <li>• Not addressing trauma or A&amp;D effects</li> <li>• Psychiatric drug(s) are then given inappropriately</li> <li>• No warning to patient of toxicity, incl. drug withdrawal</li> <li>• No psychotherapy or counseling → "Medication spellbinding" *</li> </ul>
Patient eventually <i>stops or forgets</i> to take drug(s)	
Withdrawal not diagnosed	<ul style="list-style-type: none"> <li>• Misinterpret drug withdrawal symptoms/effects as</li> <li>• "Re-emergence/worsening" of original misdiagnosed symptoms or signs (see tables) or as</li> <li>• Another psychiatric disorder</li> </ul>
Withdrawal mistreated	<ul style="list-style-type: none"> <li>• Mis-prescribes</li> <li>• Higher drug dose or</li> <li>• Different or stronger drug</li> </ul>
Deterioration	<ul style="list-style-type: none"> <li>• No education on withdrawal symptoms</li> <li>• No psychotherapy or counseling</li> <li>→ <i>The Vicious Cycle Continues</i></li> <li>• Person becomes progressively more dysfunctional ± Physically ill, hospitalizations, arrests, family dysfunction/breaks, increased medical costs &amp; DSTS</li> </ul>

\* Medication Spellbinding = the capacity of psychoactive drugs to blunt the patient's appreciation of drug-induced mental dysfunction and, at times, to encourage a misperception that they are doing better than ever when they are actually doing worse than ever [6, 7].

The now-vicious cycle continues. Over time, the patient may become progressively more dysfunctional in their personal life, job, relationships, finances and/or with the legal system. As part of the DSTS, they often become physically ill, with one or more rushed and expensive emergency department visits, medical or psychiatric hospitalizations, violence, arrests, family dysfunction, relationship breakups, increasing medical costs and mounting debt. Eventually, similar to people with advanced alcohol or drug dependence, they may hit a "bottom".

This phenomenon, process and iatrogenically- and pharmacologically-induced condition is what I have come to call the Drug Stress Trauma Syndrome (Table 3). Using definitions of each of its four terms, I show a simpler summary that explains why I chose its terminology of DSTS in Table 4.

Table 4  
Drug Stress Trauma Syndrome (DSTS) summary

Drug—most psychiatric drugs
Stress—the effects of taking & stopping the drug are not only stressful, but distressing & often disruptive to pts quality of life
Trauma—repeated distress & disruption to quality of life by the drug effects can be & often are traumatic
Syndrome—it has a recognizable pattern of symptoms & signs

For a further definition of "syndrome" [wikipedia.org/wiki/Syndrome](http://wikipedia.org/wiki/Syndrome)

## 6. How common is DSTS? preliminary data

I don't have a reliable answer to this question. I estimate that DSTS is somewhere between rare and to a degree common. From my clinical experience, it may occur in at least a distinct minority of 20% or more of people who take psychiatric drugs long-term. We need observation, research and data-gathering for more reliable figures. For example, in April 2008 I surveyed 24 *clinicians* (social workers, nurses, therapists and counselors; 22 women and 2 men) at a one-day workshop that I gave on trauma and recovery to a total of 65 people. Of these 24 people, 9 (37.5%; 8 women and 1 man) had taken antidepressant drugs, 6 (2/3) of whom had been prescribed and taken *more than one* ADP drug. Seven of the 9 (77%) said they had felt bothersome toxic effects of the drug(s), 4 (44%) had thus far experienced a disruptive or bothersome withdrawal syndrome, and 2 (22% of the 9) said they had clearly become worse long-term than before they began taking the ADPs.

I did not ask them about their taking other psychiatric drugs. I believe that for their use of antipsychotic drugs, stimulants and benzodiazepines the percentage occurrence of DSTS may be more than 22%, and for "mood stabilizers", aka anticonvulsants, and lithium probably less. I discuss and raise several questions regarding these small and preliminary data after the next section.

## 7. Characteristic of DSTS

1. The first characteristic of DSTS is the *vicious cycle* described above and in Table 3. This vicious cycle contains the stressors and resulting distress described among most of the other characteristics below.
2. Distress from the *toxic effects of the drug(s)*. While these are many and varied, they frequently include several of the following: Spellbinding, confusion, difficulty thinking and focusing, insomnia, metabolic – endocrine system disruption, weight gain, diabetes, easy irritability, relationship disruption, drug seeking, depression, akathisia, suicidality, various aches and pains, inability to work, and more [1, 6, 7, 21, 26, 33, 37, 44, 46–51]. These are commonly misinterpreted as being a return of the original symptoms and diagnosis.
3. *Withdrawal effects*. These withdrawal effects can be identical to the toxic effects of the drugs *and* to some of the person's original symptoms, making the differential diagnosis difficult.
4. *Emotional "roller coaster" effects*. The person may be (seemingly, on the surface) relatively peaceful, content, or numb for hours or longer, only to be followed by varying degrees of emotional and behavioral distress, sometimes markedly so. This experience will often be exaggerated by either missing a dose (usually withdrawal) or an upper-downer cycle when the person uses alternating uppers or stimulants (such as caffeine, amphetamines, or Ritalin/stimulant-type drugs to wake up, then later, sedatives to try to sleep) [26].
5. *Disrupted sleep*, which tends to lead to a painful state of chronic sleep deprivation. A stressor in itself, this sleep deprivation can then aggravate their acute and chronic stress state. This disrupted sleep is often also aggravated by the upper-downer cycle described above [26].
6. *Treatment failure*. The drug or drugs commonly do not consistently help the person's original symptoms [6, 7, 21, 25, 26, 34, 35, 37]. I have seen countless patients who came to me complaining that even after trying numerous and different psychiatric drugs, that they are either no better, or commonly that they are worse. For example, I regularly see "depressed" people who have tried a string of antidepressants [such as Prozac (fluoxetine), Paxil (paroxetine), Zoloft (sertraline), Well-



butrin (bupropion), Effexor (venlafaxine), Celexa (citalopram), Lexapro (escitalopram), Cymbalta, (duloxetine), Pristiq (desvenlafaxine)], and they are no better – or often are worse. Some of them have also been tried on the more toxic antipsychotics, also with no help, and many have additionally been prescribed anti-convulsants (“mood stabilizers”), lithium and benzodiazepines – all to little or no avail. These repeated treatment failures have contributed to their loss of hope that they can ever get better [6, 7, 22, 26, 33, 46–51].

As an example, David Healy and colleagues reported the first results of an epidemiological study in North Wales on a population that has been stable for over 100 years regarding their numbers, age, cohorts, ethnic mix and rurality. It showed that since the introduction of the modern psychiatric drugs in psychiatry that there has been a *fifteen*-fold increase in the rate of admissions to psychiatric inpatient hospitals, and a *three*-fold increase in the rate of forced psychiatric hospital admissions. It also showed that people with bipolar disorders have relapsed sooner and more often. This is a remarkable study. Overall, patients with all psychiatric conditions now appear to spend a greater amount of time in a psychiatric hospital than they would have fifty or 100 years ago. These conditions have worsened to these degrees despite the availability of supposedly effective and claimed prophylactic drug treatments. These findings are incompatible with drug treatments’ being effective in practice for a majority of the patients [21].

7. Relative *non-support* from psychiatrists, other physicians and clinicians for using non-drug healing and recovery aids. Most of my patients have told me of having had this experience with other physicians, and I have seen it repeatedly over time in most dimensions of psychiatry from discussions with colleagues to psychiatry education events [5, 15, 32].
8. *Stigma, shame* and *confusion* from all of the above, including having been first labeled with a mental illness, promised improvement, and then not getting better with all these “state of the art” psych drugs that they see advertised on TV, in magazines, and elsewhere [5, 6, 7, 46, 47]. These painful feelings may aggravate the above stress responses.
9. The *presence* of DSTS then reactivates and often worsens any underlying PTSD, alcoholism, other chemical dependence, or other problems in their life. The original failure to address and treat the underlying trauma and its effects is a major factor in the genesis of PTSD. Most of the patients that I found to have the features of DSTS also had an underlying PTSD. So, rather than psychiatric drugs helping them, a fair percentage of patients with PTSD who are treated with the drugs appear to have been made worse. Instead of helping their PTSD this iatrogenic and drug-mediated worsening is likely relatively common among the multi-millions of people who are treated with psychiatric drugs today.

## 8. Healing from DSTS

10. *Complex features.* This painful syndrome is not usually easy to recognize and diagnose. It usually cannot be readily seen in a 5 to 15 minute medication follow-up check by a physician – which is the usual time approved by the health insurance industry, aka “managed care”. If government-run medicine takes hold in the USA, it will get worse. It takes enough time to recognize the many dimensions of DSTS, which usually requires the taking of a careful and thorough initial history from the patient. Then it will likely take a number of follow-up visits and psychotherapy sessions, coordinated with a physician with expertise in treating PTSD and helping people slowly detoxify from psychiatric drugs. Many affected patients won’t be able to recognize that it is the drugs that are making them worse due to their lack of knowledge and the spellbinding effects of the drugs.

For the person who has DSTS or similar symptoms, negotiating their recovery may seem like trying to walk through a mind field. They usually have to deal with multiple people: Clinicians, health insurance and payers, family (some of whom may want them to stay “mentally ill”), friends, community, and other authority figures. Navigating all these requires a self-commitment and focus on recovery, with ongoing patience and persistence. Some several thousand traumatized and damaged patients and their families have brought successful lawsuits against the drug makers, especially for drug-caused completed suicides, diabetes, birth defects and addictions [29].

Based on my long experience assisting many patients with it, to help someone heal from DSTS the clinician usually has to first realize that the patient may have it. The patient may also eventually have to self-diagnose it. The clinician then helps them gradually (over months or longer) decrease the dose of the psychiatric drugs and eventually stop taking them. If appropriate, they may also consider referring the patient to a psychotherapist or counselor who knows how to assist with trauma recovery and if indicated, alcohol and other drug dependence recovery [14, 16, 17, 30]. The patient learns to tolerate the emotional and physical pain of withdrawal from the drugs and grieving any trauma effects. They will need to get the right nutrition, attend any appropriate self-help meetings such as AA, NA, ACA, CoDA, EA, or AlAnon, all while being patient and persistent over months and sometimes years. This is similar to the recovery approach that I have outlined in my other books, including especially *My Recovery* [48]. For more details, see Chapter 15 in Breggin’s *Brain Disabling Treatments in Psychiatry* [6] and Chapter 12 on Stopping Psychiatric Drugs in my book *You May Not be Mentally Ill* [51].

## 9. Questions and discussion

DSTS has several unknowns and questions. These include: 1) How often does it occur? 2) What is the relationship of DSTS’s occurrence to the patient who has a prior history of repeated other kinds of trauma? And how might that affect its occurrence? Thus, 3) How common is DSTS among people with prior PTSD?

Figure 2 shows a 2-by-2 chart or two-dimensional model of psychiatric drug exposure and prior repeated trauma as factors in the genesis of DSTS that explores their relationship in 4 possible quadrants. As shown in both upper quadrants, the more prior repeated trauma in a patient will be more likely associated with increased symptoms and signs of mental illness as I summarize in Table 5 and in *The Truth about Depression* [49] and *The Truth about Mental Illness* [50]. Likewise, the more people with these symptoms and signs come to clinicians with them, given today’s worldview about mental health, the more likely they will be prescribed psychiatric drugs. Given a premise of this article, those who get the most psychiatric drugs for the longest time will be the most likely to develop DSTS. By contrast, those in the left lower quadrant will be the least likely to develop DSTS because of their lower exposure to *both* repeated trauma and long-term psychiatric drug use. Finally, in the right lower quadrant of the figure my best medical estimation is that we will need more research and data on those in this category due to the small amount of preliminary data above.

Also 4) How does the distress and trauma of experiencing DSTS affect the PTSD after their trauma in that this may now be their *fourth* trauma? Their 1st original trauma was that which caused the PTSD. The 2nd occurred when the trauma survivor tried to tell their experience of the trauma to those they thought were supposed to be protecting them, but it was invalidated or rejected by their parents, parent figures or clinicians. The 3rd trauma was having been labeled as being “mentally ill” when instead they were grieving a significant loss, had PTSD or complex PTSD, or an active addiction. The 4th trauma is their now experiencing the distress of DSTS, including their confusion about the nature and unanswered fact that the psychiatric drugs have not only *not helped* them, but made them worse in the form of DSTS.

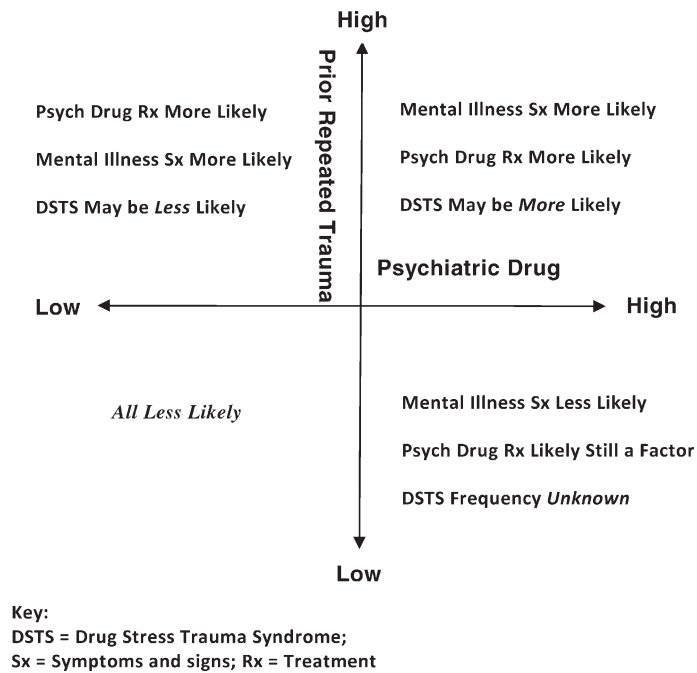


Fig. 2. Two-dimensional model of psychiatric drug exposure and prior repeated trauma as factors in genesis of DSTS.

Table 5  
Number of studies that document a significant link between repeated childhood trauma and mental illness

Clinical area	Clinical	Community	Prospective	Index/Meta Analysis/LitRev	Strength of Data/Total
Depression	96	70	22	21/*	Overwhelming/327
Suicidality	22	(both)		7	Strong/29
Alcohol/Drug Probs (SA/CD)	90		21	42 Index, 11 M-A/LitRev	Powerful/153
Eating Disorders				43 Index, 7 Lit	
PTSD	54	21	10	0/6	Strong/85
Anxiety Disorder	35	38	12	15/2	Very Strong/100
Personality Disorders	35			36/1	Very Strong/76
Psychosis	67		4 (& 2 strong family studies)	37 Index, 8 Lit Reviews	Very Strong/110
ADHD	15		15	4/3	Strong/77
Aggression & Violence	40		16	10	Strong/66
Low Self-Esteem	17	10	4	Only 1 of 31 didn't find it	Strong/31
Dissociative Disorders	30	16	3	11/2	Strong/57
Nicotine	10		1		Suggestive to Firm/11
Somatization	38		11	16	Strong/65
Revictimization	38		1	4	Firm to Strong/38

\*Plus Bi-Polar (13), Suicidality (29), and 51 newer-found studies on depression.

Problems of denial by physicians and other helping professionals regarding this finding are likely, such as: 1) the possible causal relationship between trauma and subsequent mental illness and 2) the possibility of the reality of DSTS among their patients who not only don't get better but get worse on psychiatric drugs. My experience is that based on their mindset, most physicians and other helping professionals deny the first and will likely deny the second, promoting more toxic drug exposure.

## 10. Trauma as a cause of mental illness

Does childhood trauma cause mental illness? If we had only a few studies that looked at a small number of research subjects which showed a link between childhood trauma and a particular mental disorder, the answer would be "No". But we have the opposite [9, 10, 12].

While many clinicians suspected it for decades, before 1980 we didn't have enough data to prove a significant link between repeated childhood trauma and subsequent mental illness. Now we do. The data are clear, and for most disorders, strong. We have accumulated the data mostly since the early 1980s. Today in 2010, we have hundreds of published data based and peer-reviewed reports conducted on well over 200,000 trauma survivors and their controls (Table 5).

What makes this evidence so strong is that the authors of these reports didn't focus on a limited population using a limited method of evaluation. Instead, we have 1) *a large number of studies* (well over 300), 2) that used *a large number* of research *subjects* (well over 200,000 people). These studies were conducted by 3) multiple and independent researchers who were 4) from *different countries*, and who 5) used several *different study designs* and methods (e.g., retrospective, prospective, index cases and meta-analysis) on 6) *diverse samples* of people (e.g., clinical, community and some forensic groups). Most of these also controlled for other possible influences, which academics call confounding variables. While they sometimes used inappropriate control groups (such as other psychiatric inpatients or outpatients instead of non-mentally disordered people), which appeared to underestimate the strength of the trauma-disorder link, they still found a significant relationship between trauma and subsequent mental illness. Had they all used healthy controls, the link would have been even stronger. Furthermore, the trauma-disorder link was 7) *replicated* by nearly every one of these over 300 peer-reviewed studies. The characteristics of this large number of scientifically conducted and published studies fulfill all of the criteria for quality research reports (as summarized in Table 4.2 on page 37 of *The Truth About Depression* [49]), including 8) highly meaningful *odds ratio* results and 9) a *graded response* pattern reported in all of the studies that looked for it.

For depression (now 327 studies – I found 51 more since I published *The Truth About Depression* [49]) and alcoholism and other drug dependence (153 studies), the link with trauma is powerful. For others, such as anxiety disorders, PTSD, eating disorders, psychoses and some personality disorders, the evidence is very strong. For still others, such as behavior problems, including ADHD in children and ADD in adults, and violence, and the occurrence of revictimization and somatization (which are not mental disorders, but happen commonly with them), it is strong.

## 11. Conclusion

These effects of psychiatric drugs are so common and detrimental to the patient that they can no longer safely or accurately be called "side effects". Instead, they are more appropriately called toxic effects. To recognize and make the diagnosis of DSTS when it exists will take an open minded and aware

clinician who has a high index of suspicion for the possibility of its presence. It will take a clinician who can transcend their indoctrination by the drug industry and its influences that psychiatric drugs are as safe and effective as they have advertised and promoted. These drugs' effects can be and are often so detrimental to the quality of life of so many patients that they can no longer be considered trivial or unimportant [1, 6, 7, 19, 25, 26, 33–35, 37, 47–51]. Instead, they are so disruptive to many patients' quality of life that their effect becomes traumatic, and are thereby agents of trauma.

I hope that this article and its observations and preliminary data will encourage others to look into this matter in more depth.

## References

- [1] J.K. Aronson (ed.), *Meyler's Side Effects of Drugs: The International Encyclopedia of Adverse Drug Reactions and Interactions* (15th edition), Elsevier Science, 2006.
- [2] R.J. Baldessarini, Chapters 18&19. Drugs and the treatment of psychiatric disorders, (pp. 399–459), in: Goodman and Gilman's *The Pharmacologic Basis of Therapeutics*, J.G. Hardman and L.E. Limbird (eds), 9th ed., McGraw Hill, NY, 1996.
- [3] R.J. Baldessarini and A.C. Viguera, Neuroleptic withdrawal in schizophrenic patients, *Arch Gen Psychiatry* **52**(3) (1995), 189–192.
- [4] R.J. Baldessarini, A.C. Viguera and L. Tondo, Discontinuing psychotropic agents, *J Psychopharmacol* **13**(3) (1999), 292–293; discussion 299.
- [5] C. Barber, *Comfortably Numb: How Psychiatry is Medicating a Nation*, Pantheon Books, NY, 2008.
- [6] P.R. Breggin, *Brain-Disabling Treatments in Psychiatry: Drugs, electroshock, and the psychopharmaceutical complex*, 2nd edition, Springer Publishing, NY, 2008a.
- [7] P.R. Breggin, *Medication Madness: A Psychiatrist Exposes the Dangers of Mood-Altering Medications*, St Martin's Press, NY, 2008b.
- [8] J.D. Bremner, *Before You Take That Pill: Why the Drug Industry May be Bad for Your Health*, Avery, 2008.
- [9] J.D. Bremner, Does stress damage the brain? Understanding trauma based disorders from a neurological perspective, Norton, NY, 2002.
- [10] J.D. Bremner, C.L. Whitfield, R. Anda, R. Lanius, C. Schmahl and E. Vermetten (In submission), A new look at trauma-related, or trauma spectrum psychiatric disorders.
- [11] C. Courtois, J.D. Ford, B.A. van der Kolk and J. Herman, *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide*, Guilford, NY, 2009.
- [12] B. Everett and R. Gallop, *The Link Between Childhood Trauma and Mental Illness*, Sage Publications, London, 2001.
- [13] V.J. Felitti, R.F. Anda, D. Nordenberg, D.F. Williamson, A.M. Spitz, V. Edwards, M.P. Koss and J.S. Marks, Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults, *American Journal of Preventive Medicine* **14** (1998), 245–258.
- [14] J. Glenmullen, *The Antidepressant Solution: A Step-by-Step Guide to Safely Overcoming Antidepressant Withdrawal, Dependence, and "Addiction"*, Free Press, NY, 2006.
- [15] J.G. Gottstein, Psychiatrists' failure to inform: Is there substantial financial exposure? *Ethical Human Psychology and Psychiatry* **9** (2007), 117–125.
- [16] C. Hall, C. Bergman, J. McNamara and J. Sorensen, *Harm Reduction Guide to Coming Off Psychiatric Drugs*, The Icarus Project and Freedom Center, NY and Boston, 2007.
- [17] J. Harper, *How to Get Off Psychiatric Drugs Safely*, CreateSpace, TheRoadBack.org, 2005. [http://www.amazon.com/How-Get-Psychiatric-Drugs-Safely/dp/1441455949/ref=sr\\_1\\_7?ie=UTF8&s=books&qid=1259165825&sr=1-7](http://www.amazon.com/How-Get-Psychiatric-Drugs-Safely/dp/1441455949/ref=sr_1_7?ie=UTF8&s=books&qid=1259165825&sr=1-7)
- [18] J.L. Herman, *Trauma and Recovery*, 2nd edition, Basic Books, NY, 1997.
- [19] D. Healy, *Let Them Eat Prozac: The Unhealthy Relationship Between the Pharmaceutical Industry and Depression*, New York University Press, 2004.
- [20] D. Healy, *Mania: A Short History of Bipolar Disorder*, Johns Hopkins University Press, 2008.
- [21] D. Healy, M. Savage, P. Michael, M. Harris, D. Cattell, M. Carter, T. McMonagle, N. Sohler and E. Susser, Psychiatric service utilisation: 1896 & 1996 compared, *Psychological Medicine* **31** (2001), 779–790.
- [22] D. Healy and R. Tranter, Pharmacological stress diathesis syndromes, *J Psychopharmacol* **13** (1999), 287–290.
- [23] L.E. Hollister, Pharmacological stress diathesis syndromes, commentary, *J Psychopharmacol* **13** (1999), 293–294.
- [24] D. Inaba and W.E. Cohen, *Uppers, Downers, All Arounders*, CNS Productions, 2007.

- [25] G.E. Jackson, *Reconsidering Psychiatric Drugs*, Author House, Bloomington, IN, 2005.
- [26] G.E. Jackson, *Drug-Induced Dementia: A Perfect Crime*, Author House, Bloomington, IN, 2009.
- [27] H. Kutchins and S. Kirk, *Making us crazy: DSM the Psychiatric Bible and the Creation of Mental Disorders*, The Free Press, New York, 1997.
- [28] R.A. Lanius, E. Vermetten and C. Pain, *The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic*, Cambridge University Press, 2010.
- [29] Legal summary cites 2010 selected: Paxil ref: <http://www.businessweek.com/news/2010-07-20/glaxo-said-to-have-paid-1-billion-over-paxil-suits.html>, Seroquel refs: Ref 1) <http://www.businessweek.com/news/2010-02-05/astrazeneca-facing-26-000-lawsuits-over-seroquel-update2-.html>, Ref. 2) <http://www.bloomberg.com/news/2010-07-30/astrazeneca-says-almost-4-000-seroquel-claims-settled-through-mediation.html>, Neurontin: <http://www.businessweek.com/news/2010-04-01/pfizer-said-to-settle-neurontin-suicide-lawsuit-for-400-000.html>, Zyprexa: <http://query.nytimes.com/gst/fullpage.html?res=9f00e5db1430f936a35752c0a9619c8b63>
- [30] P. Lehmann, *Coming Off Psychiatric Drugs: Successful Withdrawal from Neuroleptics, Antidepressants, Lithium, Carbamazepine and Tranquillizers*, Peter Lehmann Publishing, Germany, 2005.
- [31] J.H. Lowinson, P. Ruiz, R.B. Millman and J.G. Langrod, *Substance Abuse: A Comprehensive Textbook*, 4th ed., Lippincott Williams & Wilkins, Baltimore, 2004.
- [32] R. Moynihan and A. Cassels, *Selling Sickness: How the World's Biggest Pharmaceutical Companies are Turning us all into Patients*, Nation Books, NY, 2006.
- [33] J. Moncrieff, *A Straight Talking Introduction to Psychiatric Drugs*, PCCS Books, Ross-on-Wye, UK, 2009.
- [34] J. Moncrieff, *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment*, Palgrave/MacMillan, UK & NY, 2008.
- [35] J. Moncrieff, Why is it so difficult to stop psychiatric drug treatment? It may be nothing to do with the original problem, *Med Hypotheses* **67** (2006), 517–523.
- [36] NIDA National Institute on Drug Abuse 2010, [www.drugabuse.gov/infofacts/tobacco.html](http://www.drugabuse.gov/infofacts/tobacco.html).
- [37] J. Paris, *The Use and Misuse of Psychiatric Drugs: An Evidence-Based Critique*, Wiley, Somerset, NJ, 2010.
- [38] R.K. Ries, S.C. Miller, D.A. Fiellin and R. Saitz ed., *Principles of Addiction Medicine*, 4th edn, Lippincott Williams & Wilkins, Baltimore, 2009.
- [39] B. Rothschild, *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment*, W.W. Norton & Company, New York, 2000.
- [40] R.C. Scaer, *The Body Bears the Burden: Trauma, Dissociation, Disease*, Haworth Medical Press, N.Y, 2002.
- [41] R.C. Scaer, *The Trauma Spectrum: Hidden Wounds and Human Resiliency*, Norton, New York, 2005.
- [42] L. Shuster, Repression and de-repression of synthesis as a possible explanation of some aspects of drug action, *Nature* **189** (1961), 314–315.
- [43] B.G. Simos, *A Time to Grieve: Loss as a Universal Human Experience*, Family Services Association of America, NY, 1979.
- [44] C.J. Van Boxtel, B. Santoso and I.R. Edwards, eds, *Drug Benefits and Risks: International Textbook of Clinical Pharmacology (2nd edition)*, IOS Press, Amsterdam, 2008.
- [45] B.A. Van Der Kolk, A.C. McFarlane and L. Weisaeth, eds, *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*, Guilford Press, New York, 1996.
- [46] R. Whitaker, *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*, Crown Publishers, NY, 2010.
- [47] R. Whitaker, *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*, 2nd edn, Basic Books, 2010.
- [48] C.L. Whitfield, *My Recovery: A Personal Plan for Healing*, Health Communications, Inc., Deerfield Beach, FL, 2004b.
- [49] C.L. Whitfield, *The Truth about Depression: Choices for Healing*, Health Communications, Inc., Deerfield Beach, FL, 2003.
- [50] C.L. Whitfield, *The Truth about Mental Illness: Choices for Healing*, Health Communications, Inc., Deerfield Beach, FL, 2004a.
- [51] C.L. Whitfield, *You May Not be Mentally Ill*, Muse House Press, Atlanta, 2010.
- [52] R. Yehuda, ed., *Psychological Trauma*, American Psychiatric Publishing, Inc., Washington, DC, 1998.
- [53] A.H. Young and A. Currie, Physicians' knowledge of antidepressant withdrawal effects: A survey, *J Clin Psychiatry* **7**(58 Suppl) (1997), 28–30.
- [54] O. Zur and N. Nordmarken, DSM: Diagnosing for Money and Power: Summary of the Critique of the DSM. Online publication by Zur Institute. Retrieved 23 Aug 2010, <http://www.zurinstitute.com/dsmcritique.html>, 2007.