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Are Psychiatrists Betraying Their Patients?

When doctors give us psychiatric drugs, are they giving us an unhealthy quick fix--and making a bundle off of it? Prominent psychiatrists debate this explosive issue.

PSYCHIATRIST LOREN MOSHER RECENTLY RESIGNED IN DISGUST from the American Psychiatric Association, claiming that some of his colleagues are too quick to hand out drugs in what he terms an "unholy alliance" between psychiatrists and drug companies. A substantial number of cases of misdiagnosis and fraud support his view that patient care may be in jeopardy.

*But not everyone agrees. Frederick Goodwin, M.D., host of radio's *The Infinite Mind* and a former director of the National Institute of Mental Health, counters that volumes of research and thousands of real-life stories long ago confirmed the value of prescription drugs for psychological problems. And he has the establishment behind him. Providing testimony are the American Psychiatric Association, the principal professional association of psychiatrists in the country; the National Institute of Mental Health, the federal government's policy and research organization; and the National Alliance for the Mentally Ill, the nation's largest advocacy group for the mentally ill.*

Loren R. Mosher, MD:
"I Want No Part of It Anymore"

RESPONSES FROM:
Frederick K. Goodwin, MD
The American Psychiatric Association
The National Institute of Mental Health
The National Association for the Mentally Ill

"I Want No Part of It Anymore"

Loren R. Mosher, M.D.

Dr. Mosher is the director of Soteria Associates, San Diego, and a Clinical Professor of Psychiatry, School of Medicine, University of California at San Diego, California.

The trouble began in the late 1970s when I conducted a controversial study: I opened a program -- Soteria House -- where newly diagnosed schizophrenic patients lived medication-free with a young, nonprofessional staff trained to listen to and understand them and provide companionship. The idea was that schizophrenia can often be overcome with the help of meaningful relationships, rather than with drugs, and that such treatment would eventually lead to unquestionably healthier lives.

The experiment worked better than expected. Over the initial six weeks, patients recovered as quickly as those treated with medication in hospitals.

The results of the study were published in scores of psychiatric journals, nursing journals and books, but the project lost its funding and the facility was closed. Amid the storm of controversy that followed, control of the research project was taken out of my hands. I also faced an investigation into my behavior as chief of the National Institute of Mental Health's Center for Studies of Schizophrenia and was excluded from prestigious academic events. By 1980, I was removed from my post altogether. All of this occurred because of my strong stand against the overuse of medication and disregard for drug-free, psychological interventions to treat psychological disorders.

I soon found a less politically sensitive position at the Uniformed Services University of the Health Sciences in Maryland. Eight years later, I re-entered the political arena as the head of the public mental health system in Montgomery County, Md., but not without a fight from friends of the drug industry. The Maryland Psychiatric Society asked that a state pharmacy committee review my credentials and prescribing practices to make sure that Montgomery County patients would receive proper---read: drug---treatments. In addition, a pro-drug family advocacy organization arranged for more than 250 furious letters to be sent to the elected county executive who had hired me. Fortunately, my employers were not drugindustry-dominated, so I kept my position.

Why does the world of psychiatry find me so threatening? Because drug companies pour millions of dollars into the pockets of psychiatrists around the country, making them reluctant to recognize that drugs may not always be in the best interest of their patients. They are too busy enjoying drug company perks: consultant gigs, research grants, fine wine and fancy meals

Pharmaceutical companies pay through the nose to get their message across to psychiatrists across the country. They finance symposia at the two predominant annual psychiatric conventions, offer yummy treats and music to conventioners, and pay \$1,000-\$2,000 per speaker

to hock their wares. It is estimated that, in total, drug companies spend an average of \$10,000 per physician, per year, on *education*.

And, of course, the doctors-for-hire tell only half the story. How widely is it known, for example, that Prozac and its successor antidepressants cause sexual dysfunction in as many as 70% of people taking them?

What's even scarier is the greed that is directing a good deal of drug testing today. It is estimated that drug manufacturers have, on average, 12 years to recoup costs and make profits on a given medication before a generic form can be made. So pressure to test new drugs mounts. In the field of psychiatric drug testing, organizations make a profit of as much as \$40,000 for every patient who successfully completes a trial. And university psychiatry departments, private research clinics and some individual doctors live on this money.

The good news is that the press is catching on. *The New York News*, *Milwaukee Journal Sentinel* and *New York Post* have recently run articles or series on how pharmaceutical companies use cash incentives to encourage doctors to prescribe their drugs.

This spring, the *New York Post* revealed that Columbia University has been cashing in. Its Office of Clinical Trials generates about \$10 million a year testing new medications--much of which is granted to the Columbia Psychiatric Institute for implementing these tests. The director of the institute was being paid \$140,000 a year by various drug companies to tour the country promoting their drugs. He also received payments of nearly \$12,000 from a drug manufacturer to head up a study on panic disorders. How could he rate these drugs fairly when his livelihood was dependent on the success of the drug manufacturer? The director resigned in the aftermath of the article's publication.

At least one drug company, WyethAyerst Research, has spoken out against offering cash bonuses and other incentives to researchers. But company representatives admit it's difficult to stay competitive when other groups so eagerly violate ethical concerns.

The APA Connection

The American Psychiatric Association representing the majority of psychiatrists in America, with about 40,000 members--is also unduly influenced by pharmaceutical dollars. The Association:

- receives substantial rent from drug companies for huge symposia spaces at national conventions.
- derives an enormous percentage of its income from drug companies--30% of its total budget is from drug company advertising in its many publications.
- accepts a large number of unrestricted educational grants from drug companies.

This relationship is dangerous because researchers and psychiatrists then feel indebted to the drug companies, remain biased in favor of drug cures, downplay side effects and seldom try other types of interventions. And they know they have the unspoken blessing of the APA to do so.

Collectively, these practices aggressively promote reliance on prescription drug use--so much so that many people think drugs should be forced on those who refuse to take them. The APA supports the National Alliance for the Mentally Ill, which believes that mentally ill patients

should be coerced to take medication. I am appalled by this level of social control. Mentally ill people should be given a choice to have their illness treated in alternative ways.

Over the last decade, I have written a number of letters bringing my concerns to the APAs attention but have received no response. The association claims that what it's doing is in the "best interest of patients," but its strong ties to the drug industry suggest otherwise.

Recently, it was dues-paying time for the APA, and I sat there looking at the form. I thought about the unholy alliance between the association and the drug industry. I thought about how consumers are being affected by this alliance, about the overuse of medication, about side effects and about alternative treatments. I thought about how irresponsibly some of my colleagues are acting toward the general public and the mentally ill. And I realized, I want no part of it anymore.

The Other Side:

"Safe and Effective Drugs Have Improved the Lives of Millions"

A Response by Frederick K. Goodwin, M.D.

Dr Goodwin is a professor of psychiatry at the George Washington University Medical Center and former director of the National Institute of Mental Health.

Dr. Mosher has seized onto the recent press interest in the relationship between the pharmaceutical industry and biomedical professionals as an opportunity to re-open a 25-year-old argument--one that has long been settled by a mass of scientific evidence and by the testimony of hundreds of thousands of their families and their caregivers. The availability of safe and effective psychoactive drugs has dramatically improved the lives of millions of individuals with major mental disorders such as schizophrenia, bipolar illness, clinical depression, obsessive-compulsive disorder and panic disorder. Dr. Mosher has

While Mosher apparently still sees the issue as a choice between medications and psychological treatment (he says, "Schizophrenia, can often be overcome with the help of meaningful relationships rather than with drugs"), the overwhelming majority of mental health professionals now know that for the seriously mentally ill effective medication makes it possible for psychosocial interventions to work. And work they do. Many well-controlled studies have shown that psychosocial treatments combined with medication can produce substantially better results than medication alone.

It is now so well-established that illnesses such as schizophrenia and bipolar disorder generally require medication, that many countries no longer allow a placebo group in clinical trials with

these disorders. Incidentally, Mosher's 1970s "study" purporting to compare "meaningful relationships" with medication was no such thing. A true scientific inquiry would have required a single pool of patients randomly assigned to either psychotherapy or drug groups. The report was simply an interesting description of their experience with a group of patients who, at least in the short run, did not seem to require medication.

Mosher would have us believe that the very broad consensus about the importance of medications is somehow the result of drug company money.

Tell that to the parents of a schizophrenic son who, following treatment with a new, atypical neuroleptic drug, is able to hold a job for the first time, to form meaningful relationships, in short, to reconnect to life.

Tell that to the patients who run the National Depressive and Manic-Depressive Association, for whom medication, often combined with psychotherapy, has made the difference between a shadow-like existence on the margins of life and the high-level functioning necessary to sustain a successful organization.

Tell that to the thousands of social workers, psychologists and psychiatrists who work with the seriously mentally ill every day and who know from their own experience that without medications, their patients could not engage with them in the difficult psychological work of recovery.

Don't forget that before the psychopharmacology revolution, our state hospitals were filled with hundreds of thousands of individuals trapped in their psychosis, the victims of what modern research has clearly shown to be brain disorders. Today only the tiniest fraction of the mentally ill still require involuntary hospitalization. Why? Primarily because of modern medications. Throughout the long history of psychiatry and psychology during the pre-drug era, countless heroic efforts to treat severe mental illness with psychotherapy alone ended in frustration, a frustration keenly felt by patients, families and caregivers alike.

Mosher suggests that the pharmaceutical industry is a monolithic force. In reality, a variety of drug companies compete with one another for market share, and clinicians seem to be able to sift through competing claims and counterclaims.

While our ability to treat these disorders has improved dramatically over the last 30 years, there is still much to be done. The development Of novel drugs will continue to be essential to improving treatment options. Pharmaceutical innovation depends on lively competition in the industry, adequate capitalization of what is a high-risk business and, most importantly, a close working relationship between industry, government and academia. The procedures and safeguards needed to ensure the integrity of this process require continued discussion. But it needs to be conducted seriously.

See Appendix: Letter from Mosher to Goodwin correcting errors in the above article (page 8-9, below). Goodwin has not responded.

A Response by the American Psychiatric Association:

"We Advocate For the Patient and For Quality Treatment"

James Thompson, M.D., is the deputy medical director of the Office of Education at the American Psychiatric Association.

Dr Mosher raises an issue of great concern for all of medicine: the commercial influence on medical education.

The APA supports the rigorous stands taken by both the American Medical Association and the Accreditation Council for Continuing Medical Education (ACCME) in this area, and has instituted a careful review and monitoring process, ensuring that sessions supported by the pharmaceutical industry at our meetings present solid scientific information in an unbiased manner

We control all aspects of this process: We choose the topics and the speakers, and we control the logistics and evaluation.

These sponsored sessions represent only a small percentage of the program and are routinely well-attended and highly rated for scientific content and lack of bias. Companies are charged a fee (though not "rent," as the writer indicates), much of which covers the cost of reviewing and monitoring the presentations.

No advertising is permitted and the company's name is mentioned as required by the ACCME guidelines. It would be pointless to exclude industry from our meetings altogether because this would empower them; they would set up independent symposia at the time and location of our meetings, but outside of our control.

In addition, throughout APA programs and publications, nonpharmaceutical treatments for mental disorders are explored, emphasized and, in many cases, recommended.

A major APA commission focuses on the application and efficacy of psychotherapy. Our practice guidelines -- prepared with no commercial support whatsoever -- include recommendations on psychotherapy and other nonmedication-based treatments, and we continue to recommend psychotherapy training for residents. As with any medical specialty, our members have varying attitudes about treatment modalities, but the APA supports the use of a wide variety of therapeutic options geared toward the needs of the particular patient and continues, above all, to advocate for the patient and quality treatment.

A Response by the National Institute of Mental Health:

"The Time for Helplessness And Bitterness Is Past"

Steven E. Hyman, M.D., is the director of the National Institute of Mental Health.

It would be tragic if Dr Mosher's personal history prevented anyone with mental illness from obtaining effective treatment. In the years since Mosher has been active in research, a revolution has occurred. In place of medications with questionable efficacy and major negative side effects, or unproven and expensive psychotherapies, we now have a variety of safe and effective medications and psychotherapies for mental illnesses.

The National Institute of Mental Health, with public funds, has overseen this quiet revolution and has funded its own studies to make sure that the new mood stabilizers, antidepressants and antipsychotics work for Americans with mental illness. While much remains to be done, the time for helplessness and bitterness is past.

A Response by the National Alliance for the Mentally Ill:

"All People Should Have The Right to Make Their Own Decisions"

William Emmet is the chief operating officer of the National Alliance for the Mentally Ill.

For the record, the National Alliance for the Mentally Ill (NAMI) focuses primarily on ensuring access to adequate, appropriate treatment within the American health care system. As a matter of Policy, it does not endorse any particular treatment or services for brain disorders. NAMI believes that all people should have the right to make their own decisions about medical treatment, but is aware that some individuals with brain disorders such as schizophrenia and bipolar disorder may at times, due to their illness, lack insight or good judgment about their need for medical treatment. Involuntary treatment of any kind should be used only as a last resort and only when it is believed to be in the best interest of the individual, following a court hearing in which due process has been provided. Outpatient treatment also should be considered the most beneficial, least restrictive and least costly treatment alternative

Appendix:

Letter Mosher to Goodwin

September 7th, 1999, from Loren R. Mosher, MD, to Frederick K. Goodwin, MD.

Dear Fred:

Thank you for taking the time to write a rebuttal to my article in the Sept./Oct. issue of Psychology Today. The content of your response was, of course, completely predictable. I have no quarrel with the free expression of differing points of view. Unfortunately, however, it contains four errors of fact that I cannot let you purvey to an unsuspecting readership without correction

1. In the second paragraph you assert that I am arguing, in general, that it is "a choice between medications and psychological treatment" and then go on to cite my description of the methods used in the Soteria Project in support of this false dichotomization. As is clear from the next paragraph you have no understanding of the nature of that experiment. My position about medications has been very consistent over many years: They do "work", but at what price in terms of unwanted effects and serious short and long term toxicities? They have also had the effect of relegating all psychosocial treatments for disturbed and disturbing persons to an adjunctive role. This is good to be sure psychiatrists maintain their power but at the same time it prevents us from learning what a pure psychological treatment can do.

2. The third paragraph reveals either a remarkable level of ignorance or arrogance. Had you exercised the intellectual integrity I expect from someone of your stature you would have read at least one of the 38 publications from the Soteria Project. Had you done so you would know that it was an NIMH funded two year follow-up, random assignment, treatment study of persons newly identified as having schizophrenia -- not "simply an interesting description". I know that scientific invalidation is a commonly used technique for disregarding results that are not in keeping with the prevailing zeitgeist. This is a blatant use of it.

3. In the fourth paragraph on page 42 you assert that the neuroleptics were responsible for the emptying out of mental hospitals. Again, a modicum of scholarship on your part would reality test this not uncommon delusion among biopsychiatrists like yourself. It has been shown time and time again that it is administrative policy that controls the census of mental hospitals. To edify you just a bit: In the US most deinstitutionalization occurred after 1972, as a consequence of the availability of SSI, long after the anti-psychotic drugs were used universally in state hospitals.

4. In the same paragraph you say that because of these medications "only the tiniest fraction of the mentally ill require involuntary hospitalization". This may be true in the ivory tower where you work but out in the trenches it just doesn't wash. For example: In

the San Diego public system 65% of adults and 85% of youth are admitted to hospital involuntarily. I do not believe this county is an aberration certainly not in California. This may constitute a tiny fraction to you but maybe you and I took different statistics courses.

Because you and I have been colleagues for so long it saddens me that you no longer seem to be concerned about truth. It also frightens me because of your power and prestige. Who are relatively powerless patients to trust? It appears you are a good example of the kind of psychiatrist that embodies what the APA stands for -- and resulted in my resignation. Since your Psychology Today response contains so many examples of your ignorance I must presume you have not read my original letter of resignation from APA. I am enclosing a copy FYI.

Sincerely,

Loren R. Mosher M.D.
Director, Soteria Associates
Clinical Professor of Psychiatry, UCSD
Adjunct Professor of Psychiatry, USUHS

Cc: Dr. Hyman

P.S. What is your annual income from various drug company fees, lectureships, honoraria and consultations?
