Editorial

Should Tranquilizers Be Used Preventively for Schizophrenia?

The Globe and Mail, August 31, 1999, reprinted a report from the Wall Street Journal prepared by Elyse Tanouye with the headline "Schizophrenia. A Bold New Therapy for the Madness that Ruins Families." I began to read this report with great interest thinking that perhaps there was something very bold, innovative and even therapeutic for this difficult disease. It turns out that what is being proposed is neither new, nor bold and certainly will not be therapeutic. The Yale Psychiatric Institute's Prime Research Clinic in New Haven proposes that young patients with an increased risk for schizophrenia may benefit from a promising but highly unorthodox experimental treatment. They hope that giving anti-psychotic drugs along with conventional talk therapy can interrupt the biological processes. They hope they can prevent the development of schizophrenia.

Is it New, Is it Bold?

Anyone who has studied modern psychiatry and the treatment of mental illnesses knows that psychiatrists are very reluctant to diagnose schizophrenia early and they most often are labeled with other diagnostic terms such as bipolar (if they are depressed and most of them are) or borderline personality disorder (if they show antisocial characteristics). These misdiagnosed patients have for many years been given these powerful antipsychotic drugs. There is therefore nothing new about the idea of giving these drugs to pre-schizophrenic teenagers. It is happening all the time. What may be news is that these patients will receive an entirely new label, pre-psychotic schizophrenia. Perhaps the Wall Street Journal thinks of this experiment as bold. I would be surprised if they were told this is the case by the investigators who will run these trials. Of course the experiment will test the latest drug, olanzapine, against placebo, the double blind method, the fool's-gold standard of modern psychiatry.

Will it Work?

If one wants to prevent the development of schizophrenia this procedure may work but if one wants to help these patients become normal it will not for these drugs merely convert one psychosis, schizophrenia, into another the tranquilizer psychosis. They may not become schizophrenic because the tranquilizer psychosis will overwhelm them and, to a degree, hide the natural schizophrenia.

Antipsychotic drugs were introduced to psychiatry early in the 1950s by Dr. H. Laborit, a surgeon in France, because he wanted a substance that reduced the presurgical anxiety of his patients. He learned about the antihistamines shortly after they were first synthesized in 1947 by Dr D. Bovet, an Italian Nobel Laureate chemist. One of these, chlorpromazine (thorazine in the US), had extraordinary properties of relaxing patients without putting them into a deep sleep. Tested on psychiatric patients it dramatically decreased the intensity and frequency of psychotic symptoms. In one early therapeutic trial in a mental hospital in the US, the ward noise level was used as the measure of response. Within a few weeks of placing the patients on this drug there was a remarkable decrease in noise level.

Psychiatrists were very impressed and a world-wide feeling of over-confidence developed, that at last we had the solution to schizophrenia. There were serious side effects, such as tardive dyskinesia, which for a long time were ignored and even denied, but eventually accepted since every medical student knows that if a drug has no side effects it is not a drug, that is it has no activity. We put up with the side effects. The side effects of electro convulsive therapy and insulin coma were much worse. The beneficial effect of chlorpromazine and other drugs which rapidly followed out-weighed the toxic side effects.

But not everyone agreed that we had a panacea. Orthomolecular psychiatrists were more impressed with the slow but gradual and

sure response to megavitamin therapy which did not cause the same side effects, was remarkably free of them in fact. Dr Meyer Gross, an eminent psychiatrist in England said that the drugs changed one psychosis into another. He was very prescient.

New Drugs, New Side-Effects

The combination of this rapid, apparently curative effect of the drugs, with the constant push by the drug companies, quickly brought these drugs to the foreground until today they are considered the only treatment for schizophrenia and other psychoses. The drug companies excelled at competing with each other and producing ever more new drugs. Each one came with the usual fanfare that they were more effective and less toxic. Currently we have a half dozen antipsychotics, supposedly much more effective and much less toxic than their predecessors. I am not convinced this is true, from my experience with these drugs over the past four years. The side effects are somewhat different. Olanzapine, for example, very often causes major weight gain.

Recently, a young schizophrenic woman came to see me. She had been on thioridazine and was doing quite well. I added the orthomolecular program and she further improved. However the psychiatrist she had been seeing regularly started a study on olanzapine and persuaded her to switch to 15 mg daily. He made her promise that she would not stop the medication for two years. According to her father she became less psychotic but according to the patient the price was so great it was not worth it. She had gained 50 pounds. At age 19 this was a terrible blow to her self esteem and to her future social growth. She begged her psychiatrist to switch back to thioridazine but he would not, dismissing her concern with the blunt uncaring and insensitive statement, "It is better to be fat and normal, than thin and psychotic." She was improving on the orthomolecular program anyway but as far as she was concerned she had been better off lean and good looking even if she was a bit more psychotic. It was clear to me her psychiatrist was more interested in the drug study he was doing than he was in her overall welfare. She decided, and her parents agreed, that she would drop out of the study and probably not see that psychiatrist anymore. I persuaded her to try a lower dose and wait for two weeks until she had a chance to talk it over with him.

The Tranquilizer Psychosis

I have not seen any studies discussing the most toxic effect of drugs, compared to which tardive dysksinesia is minor. This is that tranquilizers create a tranquilizer psychosis. It is not surprising that this is totally ignored. The first psychiatrist to point out that tardive dyskinesia was caused by tranquilizers was ostracized for several years after his first report appeared. The drug companies certainly will not find it advantageous to refer to this major problem induced by their favorite drugs, and psychiatrists who have been nurtured and raised on the idea that these are the only drugs will find it very difficult to ever change their point of view.

If you do not believe that tranquilizers cause a psychosis, start taking 15 mg of olanzapine today and stay on it for a few months and see what happens to you. Ask your family what they think of your condition, i.e. if you are still working. The tranquilizer psychosis is a mixture of the original psychosis under partial control combined with the toxic effect of these drugs. **Table 1.** (p. 125) shows the similarities and differences between the natural psychosis and the tranquilizer psychosis.

Tranquilizers thus convert, as Meyer Gross remarked so many years ago, a natural psychosis to an iatrogenic psychosis, the tranquilizer psychosis. They convert hot into cool symptoms which are much more tolerable and allow the patient to be cared for at home, to be discharged from hospi-

Table 1. Similarities and differences between the natural psychosis and the tranquilizer psychosis.

Symptoms/signs	Schizophrenia	Tranquilizer Psychosis
Perception	Voices Visions Illusions	Same, but to a lesser extent
Thought Disorder		
Content	Paranoid Delusional Ideas of reference	Not as intense
Process	Blocking, Memory Concentration Not able to learn	Not as intense Same or worse Same or worse Same or worse
Mood	Depression Agitation Anxiety Apathy, disinterest	Same Less Less Less
Behavior	Hot*	Cool**
Physical Toxicity	None	Tardive dyskinesia Nausea, Weight gain Impotence

* I define Hot symptoms as those which direct the attention of relatives and friends to the changes in the patient. These are extreme changes in personality and behaviour. Thus if a patient responds to paranoid delusions, is severely agitated, depressed or suicidal, or behaves in a bizarre manner, these are Hot symptoms which quickly segregate the patients from normal peers.

** Cool symptoms do not arouse the same degree of attention even though they are just as disabling. They include hallucinations the patient does not divulge to anyone, thought disorder that is hidden, moderate depession, apathy or disinterest.

Many years ago a chronic schizophrenic man was admitted to the psychiatric hospital as an emergency. For a long time he had sat quietly in the kitchen in his home not talking to anyone and not interacting. This behaviour was tolerable. But suddenly he began hopping on one foot and would not stop. Within a few days he was in hospital. The hot symptoms were intolerable and drove him into treatment.

tals too soon, and to make available the city streets for their care and shelter. But the objective of therapy should be to cure the patient in the sense that one cures diabetes. It is to remove symptoms and signs, to make it possible for patient and family to get along reasonably well, to permit the patient to get on in the community properly housed and reasonably comfortable, and to pay income tax. I estimate that fewer than 10% of all schizophrenics treated in North America ever achieve this state of well being with or without tranquilizers when this is the only treatment.

Tranquilizers do initiate the recovery process in schizophrenic patients and this produces the illusion that they will eventually lead to a recovery. However, as the recovery process continues, that person's biochemistry becomes more normal and then begins to respond to the drug as if they were normal i.e. they become sick. Tranquilizers make normal people sick. This was established in communist Russia under the old regime when dissidents were placed on thorazine. They became psychotic with the tranquilizer psychosis. The Yale group will observe but not recognize the same phenomon.

This then is the dilemma. How can one benefit from the moderate improvement induced by the drugs and at the same time prevent them from becoming psychotic from the drug? The usual way is to withdraw the drug, but in most cases the original psychosis recurs and this process is repeated over and over. Or one can very slowly decrease the amount of drug, but in most cases the same disease recurs. There is no escape because when the drug dose is so small that the side effects are gone, its therapeutic effect is also gone.

Orthomolecular Psychiatry

Orthomolecular psychiatry does provide a third pathway, a pathway toward health. Nutrients have no side effect in the recommended doses. They gradually start the process of real recovery in most cases but they do so slowly. It takes a least two months before they kick in. But once they are effective the disease seldom recurs as long as the nutrients are taken. This means that one can combine the therapeutic effect of nutrients, which is slow but enduring, with the rapid therapeutic effect of the drugs, and as the patients begin to recover the amount of drug is slowly decreased until the dose is nil or so close to it that there are no side effects. I have several patients on haldol 1 mg daily and they remain well on this dose. Xenobiotic psychiatrists provide the schizophrenic patients with two choices, remain psychotic without drugs, become psychotic with drugs. It is not surprising so many patients have to be forced by legal sanction or by parenteral administration to take drugs.

If the tranquilizer drugs are not withdrawn as the patients begin to recover on orthomolecular therapy there will be no response or no apparent response. There may have been a response of the original schizophrenic state but this will be masked by the tranquilizer psychosis. If, therefore, double blind studies are conducted by investigators not aware of these facts, they will maintain the same dose throughout the study and will see little change with or without the orthomolecular therapy. Nutrients do not reverse or cure tranquilizer psychosis. It is vital that the amount of drugs be reduced as recovery begins, for only then will the investigator see the real effect of the treatment and only then will patients and their families observe the real recovery which has occurred.

The six prospective double blind placebo controlled trials we conducted in Saskatchewan between 1952 and 1960 did not include drugs in our treatment protocal. The results are described in my recent book, *Vitamin B_3 and Schizophrenia: Discovery, Recovery, Controversy,* (Quarry Press, Kingston, ON, 1999). We were fortunate not to have included them since it now appears very likely that had we done so there would have been much less differentiation between placebo and active treatment. The tranquilizers would have washed out some of the difference and would have prevented some of the good recoveries we saw. In those early years of tranquilizer use their pernicious role in preventing full recovery was not understood.

A study at the Massachusetts Mental Health center compared two cohorts of patients treated between 1945 and 1949 before tranquilizers were introduced, against a cohort betweeen 1955 and 1959

after these drugs were in use. The earlier cohort was better off since more of them were employed and fewer were dependent on welfare.

Orthomolecular therapy combines the best of nutritional modification, supplementation of a few nutrients, along with the best of modern drug therapy. The drugs are rapidly effective in initiating the recovery process, and the nutrient program is slow but steady and enduring. As treatment proceeds and the patients show clear evidence of recovering the drugs are slowly withdrawn. With this combination, the psychosis remains under control and the tranquilizer psychosis is not allowed to develop. If the drugs are not withdrawn the tranquilizer psychosis will develop and this will not be prevented or ameliorated by the nutritional therapy. Vitamin B_3 does not cure the tranquilizer psychosis.

Many years ago I hoped that one day we would have a drug specific against schizophrenia which would treat as well as insulin injections do against diabetes mellitus. More recently I concluded that there would never be any synthetic drug that would cure these patients, reasoning that since the problem is some metabolic fault how can any compound which fits nowhere in the scheme of biochemical reactions in the body and which can only interfere ever be found to be curative.

Now I will modify my belief. I believe that although the odds are long against, a compound will be found, but it will have to be so close to a natural or orthomolecular compound that it suppresses only the set of reactions which cause schizophrenia, or restores the set of reactions that allows all the other reactions to become normal. It will have to be a minor variation of a natural compound which can be transformed into a natural compound in the body. It will be an orthomolecular compound.

When one looks at the enormously intricate pattern of reactions involving amino acids, and essential fatty acids and all their precursors and derivatives, it is unlikely that in our lifetime such compounds will be formed. We will see a succession of ever more powerful drugs which will suppress some of the symptoms and as usual the price will be that they will not recover. There will always be an enormous price to pay and it will be paid by the patients and their families, not by the psychiatrists who prescribe them and the drug companies who provide them.

This Yale experiment, so "bold" and "new," simply consists of an attempt to prevent the real psychosis from emerging by inducing in them a tranquilizer psychosis. The author of this report does raise the question that the majority of pre-schizophrenic patients may not be schizophrenic at all. We will therefore have a most interesting study in which non psychotic young people will be made psychotic using olanzapine. I will follow this study with great interest but I doubt it will ever see the light of day. Perhaps we should place every teenager, male and female on olanzapine and in this way ensure that no one will develop schizophrenia because they will all have the tranquilizer psychosis.

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