Child Psychiatry: Does Modern Psychiatry Treat or Abuse?

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"It may actually be the case that children were safer before child psychiatry"
–M. McKay (2007)

Introduction

Jay, six years old, was forced into the modern psychiatric system from which he was rescued 3 years later by Dr Marty McKay and from Child Welfare by a court order. By then he had seen 60 physicians, diagnosed with dozens of diagnoses including mental retardation. ADHD, Tourette Syndrome, Oppositional Defiant Disorder, Obsessive-Compulsive Disorder, Conduct Disorder and the current favorite Childhood Onset Bipolar Mood Disorder. He was treated with toxic drugs and combinations with no evidence they were therapeutic. Toward the end of his treatment program he was on Ritalln, Divalproic Acid and Seroquel. He was saved by the relentless effort of Dr M. McKay who insisted the Hospital for Sick Children take him under care away from his psychiatrist. It took ten months to get him off the drugs. He had stopped growing. Since then he has regained his health. The long term effect of this massive long term toxic drugging is not known.

Rebecca Riley was not so lucky. She died from an overdose of two of the drugs prescribed for Jay. Under the heading "What Killed Rebecca Riley" this tragic event was featured on CBS, Sixty Minutes, on September 30, 2007. Rebecca was the youngest child in a dysfunctional family. Her two older siblings were already on massive drug medication. At age 2.5 years she was diagnosed ADHD and bipolar. She was prescribed Seroquel, a favorite antipsychotic for adult schizophrenic patients, Depakote, an anticonvulsant for adults, and Clonidin, a drug for lowering blood pressure. December 13, 2006, she was found dead lying on the floor near her mother's bed, from an overdose of drugs. Her parents are charged with murder and are in jail waiting trial. December 12 she appeared to have a cold. Her mother gave her some Tylenol and some more Clonidine because she did not go to sleep. Then she laid her down beside her on the floor and fell asleep. When her mother woke up, Rebecca was dead,

The publicity given to Rebecca's death spurred Massachusetts into the beginning of regulatory action. Allen[1] reported "Although cases like the overdose of Rebecca Riley are rare, the prescription of psychiatric drugs to young children is not. Doctors last year prescribed Clonidine–a drug sometimes used to treat hyperactivity that was found in lethal quantities in the Hull girl's bloodstream–to 955 children under age 7 in MassHealth. Doctors also prescribed antipsychotic drugs, which raise the risk of diabetes and obesity, to 536 children under age 7. The largest provider of mental health services for MassHealth–Massachusetts Behavioral Health–identified 35 preschoolers in the first three months of the system who were taking three psychiatric medications or one antipsychotic drug."

Diagnosis

The North American psychiatric profession is enamored with the DSM system of diagnosing. This system is not as popular in other areas of the world, especially Australia, but doubts are developing even in North America. *The Canadian Journal of Psychiatry* featured a debate about the utility of the DSM classification of

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depression. Parker[2] concluded that DSM lacks explanatory power and compromises research and clinical practice. He is convinced that it does not indicate what might be causes and has no value in determining what treatment should be used. He could also have added that it is also not reliable in that several independent psychiatrists examining the same individual will come to several different diagnostic conclusions. It is not reliable it is not valid. Why are we still stuck with it? Goldney,[3] defending the DSM gave a rather weak defense and hoped that it might one day be useful but did not answer the Parker charges.

In 1952 I visited Dr. Nathan Kline, Director Research of one of the New York Mental Hospitals. He was very taken with the new computers being developed. During this visit he described in detail how nosology would solve our problems. He hoped that his hospital would have the major computer which would be the diagnostic computer for the United States. I did not think much of his ideas but they must have had a major impact. I believe that the DSM is faithfully following them. The main result is nothing except for the very hefty DSM-IV. The treatment is not scientific, and has made no serious attempt to become scientific.

Pre-scientific medicine faced similar problems. It had to be descriptive since there were no laboratory or other accurate diagnostic tests available. Pain in the chest, worse on breathing and fever suggests something wrong in the chest maybe the lungs. Pneumonia was a high risk of death disease and was called the friend of the senile aged because it was a common cause of death. Before antibiotics became available one of the standard treatment was mustard plaster. Today we know there are many causes of pneumonia, that this condition is a syndrome and the real cause must be treated. Tests will determine if it is cancer, or a bacteria or asbestos or a fungus and then appropriate treatment is given.

Modern psychiatry is in the mustard plaster stage of scientific diagnosis. This is understandable if the tests are not available but is unforgivable when available tests are not used. It would be like using mustard plasters because one did not believe in the physical and laboratory tests that are available for pneumonia. Psychiatrists over 100 years ago did use tests when they became available. Around 1900 a text book of psychiatry discussed differential diagnosis of psychosis included pellagra (vitamin B_3 deficiency) scurvy (vitamin C deficiency) syphilis of the brain and dementia praecox which later was renamed schizophrenia. The two vitamin deficiency syndromes were removed from psychiatry and came under proper care by public health and other doctors. The addition of small amounts of niacinamide to flour almost eradicated pellagra. This was one of the greatest public mental health measures ever and did more to decrease the incidence and prevalence of psychosis than all of psychiatry has done. General paresis of the insane (syphilis), was diagnosed by a blood test and disappeared from psychiatry. Dementia praecox also disappeared by being renamed schizophrenia.

There was little further progress until orthomolecular psychiatry developed.

In 1960 my research group in Saskatchewan discovered the mauve factor and used this as a way of characterizing a condition we called Malvaria and later Carl Pfeiffer renamed it pyroluria.[4] These patients came from several diagnostic groups including schizophrenic who excreted too much of this factor into their urine. Pfeiffer eventually described a large number of different syndromes of schizophrenia. Each requires a rather different program. For if the disease is present due to a deficiency or a need for a lot of niacin it will not respond to any other vitamin

or treatment. Drugs are not specific and swamp the whole biochemical machinery of the body and affect everything. They can not be expected to be curative in the way discovering the cause and treating it is. I am sure that when the real cause of the clinical depressions usually seen by psychiatrists is discovered the profession will be totally surprised by the number of patients they had diagnosed as depression who have a nutritional cause and who respond to appropriate orthomolecular treatment. For example very few psychiatrists know that chronic food allergies can cause depression and that when these foods are removed the depression is gone. This is specific treatment and will one day be accepted by physicians who come from a different field of practice and who will know how to diagnose and treat. In the same way psychiatrists will lose their practices to doctors more willing to be scientific.

Of the forty or more different attention deficit disorders in children the main treatment is Ritalin no matter which of the forty labels is attached to the child. A child may be seen by ten different psychiatrists and given ten different diagnoses and numbers and leave the office with the same prescription. This means in fact that psychiatrists are no longer necessary since the diagnostician, and the diagnosis and the number are irrelevant. Any parent any time they are unhappy about their child's behavior would simply buy some Ritalin product over the counter.

Colleen Clements,[5] associate professor of psychiatry, University of Rochester is a medical ethicist who writes a column for the *Medical Post*. She is very concerned about the pervasive use of Ritalin and other stimulants for the treatment of children, usually diagnosed one of the ADHD disorders. She points out (1) ADHD is a classification with dubious scientific basis; (2) There are no well established norms against which to judge the behavior of these children; (3) Long term treatment with these drugs interferes with normal development and that society appears to benefit more than the child does from his treatment and; (4) The condition that a serious deviation must be present before treatment is started is ignored. Children are put in an illness category, which is degrading of their normality and worth. In a following issue she makes her points more dramatically. Drug prescriptions to children and adolescents increased from 275 per 100,000 in 1993-1995 to 1,438 per 100,000 in 2002. This is a five fold increase; forty percent were on another drug as well.

Between 1950, when I first became interested in psychiatry, and 1965 the older diagnoses were used. Various degrees of retardation were diagnosed based primarily on the IQ test. A very few schizophrenic children were recognized using adult criteria but these were remarkably accurate in predicting future psychoses. Dr. Loretta Bender was one of the best predictors. In one paper she reported the outcome of a number of childhood schizophrenic patients she had examined before the age of ten and who were re examined about seven years later. Half of them were adult patients in mental hospitals and the other half were psychopathic teens on the streets of New York.

Infantile Autism was so rare most doctors never saw any cases. It had been only recently described. Downs syndrome was diagnosed on physical appearance until the genetic test became available. A few hyperactive children were recognized. They were called minimally brain damaged. But this was very unpopular with their parents who heard only the word brain damage and not the word minimally. After 1960 psychiatry has been sensitive to public opinion re diagnosing. Minimally brain damage was dropped and replaced by hyperactivity.

From 1965 to today the diagnoses

have been completely changed. The APA Diagnostic Manual introduced the ADD system listing about forty different categories with their own diagnostic number. There was an explosion of diagnostic categories. All were descriptive. None had any real meaning.

The official diagnostic Bible of the American Psychiatric Association is DSM now in its fourth edition, 1994. It contains several hundred different diagnostic categories each with its own official number. I started in psychiatry in 1950. We had to consider only several dozen different diagnoses. It was simple. The explosion of diagnostic categories now listed in Number IV is fantastic. I cannot think of any other branch of medicine where the number of diseases (diagnoses) has increased by geometric progression. Does that mean that we have all developed all these new diseases, as the DSM IV would have us believe? And if this is true what will be the final count in edition V, expected to appear in 2011?

The problem is that psychiatric diagnosis contrary to all diagnosis in medicine is not scientific. It is descriptive, legal and moral. There are many variations in the way people behave and think and there is no limit to the number of descriptive diagnostic categories. I fully expect that one day the DSM will be thicker than the telephone books of large cities. There must be a reason and one is conflict of interest. A flagrant example of conflict of interest is reported by Cosgrove et al.[6] She and her colleagues examined the financial relationship between DSM-IV panel members and Big Pharma. Out of 170 panel members 56% had one or more financial associations with Big Pharma. All the members of the panel on Mood Disorder and Schizophrenia had these ties. They recommended full disclosure. If a company has a drug released for treatment of schizophrenia it will pay them handsomely if the criteria for this condition are so relaxed, so altered that many patients not previously diagnosed schizophrenia will become so under the new guidelines.

If diagnosis were scientific this would play little role but since the diagnosis is more psychological and political it does play a major role. At one time being gay was listed as one of the diseases in the APA manual. I keep using the word diagnosis when the APA uses the word disorder. Most people see no difference. This was quickly changed when so many of the members of the profession were gay. Two new diseases are (1) social phobia and (2) premenstrual dysphonic disorder. Psychiatric diagnosis is not causal nor does it indicate what treatment should be used.

Gerstel's report[7] should be read. It is very critical and biting in its attack on APA diagnoses. She lists the following new diagnostic categories using the term problem. I will use the psychiatric term "disorder."

Self delusion disorder–you think you are normal and healthy.
Sibling relationship rivalry disorder–if you have problems with your siblings.
Partner relationship disorder–Guess what this means.
Phase of life disorder–concern about getting married or divorced.
Non compliance disorder–refuses to deal with your problems.
Intermittent explosive disorder–road rage or getting mad at your spouse.

I do not know the numbers for these new mental illnesses. I suspect that pretty soon any person who believes that orthomolecular psychiatry can be helpful will be labeled as suffering from a vitamin delusional disorder. I must be pretty sick but again I do not know what my number is. Several decades ago a psychiatrist in Los Angeles testified in court that his patient was delusional because she believed that

vitamin B_3 might help her.

It is clear from Gerstel's account that psychiatry knows that this is a profitable semantic game. It is not stupid. Thus Dr. M. First, director of the project to review DSM-IV, expects fewer new categories will be added because "they're hard to get rid of. It's disruptive to eliminate a disorder people have been using." This statement gives the game away. Because real diseases can not be gotten rid of so easily simply by deleting them from the diagnoses manuals. If they can be added and later deleted simply by a popular vote or by popular pressure, are they really disorders or are they sophistical ways of describing behavior which might better be used in novels and public discourse and not tied to diseases where they do harm to victims of these diagnoses? But there is a glimmer of hope. First and Zimmerman[8] indicate that in the new DSM-V some laboratory tests may be included in the diagnosis.

Children and Bipolar

The latest mass trend is to diagnose children as bipolar. Today in the United States there are one million children on toxic adult drugs for their bi polar disorder. They are diagnosed as early as age 3. Duffy[9] in a very recent review concludes that as currently diagnosed, bipolar disorder does not manifest as such typically until at least adolescence. The title of her paper is a question "Does Bipolar Disorder Exist in Children? A Selected Review". After reviewing 41 published reports she concludes that it does not. She writes "Chronic fluctuating abnormalities of mood, over activity and cognition and conduct disturbances have been described in very young children. Whether this syndrome represents an early variant of BD or some other psychiatric disturbance is at this time unknown and requires further research".

In a recent report Madsen et al[10] found a significant association between the amount of tranquilizers taken over years in grams and cerebral cortex atrophy. The estimated risk of atrophy increases by 6.4% for each additional 10 grams of tranquilizer drug (in chlorpromazine equivalents). Gur et al[11] reported that tranquilizers increased sub cortical volumes in schizophrenic patients. These changes were not present in patients not on this medication. They suggested these changes were in response to receptor blockade and could decrease the effect of treatment. In other words these drugs damage the brain and decrease the odds these patients can ever recover. Are we preparing the ground for the next major pandemic of illness with millions of chronic schizophrenic patients becoming more and more brain damaged as they are forced to remain on their tranquilizers? And when it is fully upon us what are we going to do about it?

At age two children's brains start to develop rapidly and reach adult weight by age five. Between age two and five the brain triples in weight and this is the period when children are more impulse than control. They have to learn ways of dealing with others and with aggression so that they will become good members of society, How can the developing brain deal with these if inhibited with toxic drugs. It is well known that children are much more sensitive to drugs, even to the additives that are present in our food.

Forty years ago Dr. Ben Feingold, a well-known and respected allergist, reported that these additives made some children develop these problems. His work was totally rejected except by parents of the children who found their children became better when these additives were removed. A panel of the United States National Institutes of Health determined in 1982 that there was no scientific evidence to support these claims. The majority of clinical studies done at that time including some that were controlled, all showed that Feingold was wrong. The paradigm at that time opposed his conclusions. The paradigm is

now changing and the recent studies, also controlled, show that Feingold was right.[12] As the paradigm changes it becomes easier to insinuate these out-of-the box studies and to get them accepted. Most people do not realize that to the medical professions scientific means it has been accepted by the paradigm. If it is outside the paradigm it is not scientific.

Allowing these children to be diagnosed bipolar on vague behavioral changes that are simply a learning process is like giving a licence to kill, if not the child, then its mental growth and development

ADD and Ritalin

As the diagnostic term hyperactivity became more popular the use of stimulant drugs also increased beginning with the amphetamines (speed), and later ritalin which has evolved into different names and different formulations for the same drug. Even caffeine has been used. These stimulants had what was called a paradoxical effect on these active children. It relaxed them. Given to adults they were stimulants and were used to treat conditions with excessive sleepiness and to control excess sedation of the anticonvulsants. They were very effective and needed no double blinds to show that they did something. Children who were out of control would quickly settle down. This was great for schools who could not deal with too many hyperactive children in the classes. The drugs would be given in the morning which would keep them more or less down until they came home when the effect of the drug was gone and their hyperactivity once more exerted itself. Teachers appreciated these drugs more than did their parents. Adults were given barbiturates to help them sleep and amphetamines in the morning to waken them up. They were widely abused. One of my patients became addicted to amphetamines given to him when young to keep his weight down and later became schizophrenic. A few children not liking the side effects of these drugs would not swallow them, and sell them to their older school chums. It is called kiddy coke. But over the past two decades they have been replaced by ritalin. Diagnosing them with one or more of the forty APA's ADDs gave the doctor permission to give them any combination of ritalin and other drugs.

Health Canada warns, (*Times Colonist*, Victoria, May 27, 2006), that ADHD drugs can be deadly, even for youngsters. It should have said especially for youngsters whose lives may be destroyed by these drugs: Adderall XR, Concerta, Dexedrine, Ritalin and Ritalin SR, Strattera, Attenade and Biphenin. The potential market is immense and explains why so many different names are used for almost the same drugs for these children. Health Canada warns that they may cause heart disease and even death but does not mention many other very serious side effects such as loss of appetite, suppression of growth and the consequences on personality by long term drug use and later addictions but some doctors are not convinced as they see more benefit than risk. This is a logical point of view if one does not know that there are much better alternatives to these drugs which are effective and do not cause any of the side effects listed.

The Ritalin advocates have new ammunition in their major attempt to retain this drug for the treatment of children, NIMH, which sponsored what it calls "The first long-term, large-scale study designed to determine the safety and effectiveness of treating preschoolers who have attention Deficit/hyperactivity disorder (ADHD) with methylphenidate (Ritalin)". Not surprisingly they found it safe and effective when used in low doses for pre schoolers, ages 3 to 5. The study found that children in this age range are more sensitive than older children to the medication's side effects and therefore should be closely monitored

Lets tease out the relevant data from this carefully worded document designed to support their conclusions

1. The study ran for 70 weeks. This may be a long time in contrast to the usual few months drug studies but is very short term in respect to these children growing into their mid teens. Malnutrition may not show its worst toxic side effects for up to 20 years. To call this a long term study is surely a major stretch. They also called it a large scale study but only 303 children were included. The term large scale is unwarranted even if that sample size was probably adequate. The description "long term" and "large scale" are used to soothe the public

2. Safety. Adverse effects are worse than with older children.

3. The medication slowed their growth rates. Over the 70 weeks of the study they grew one half inch less than the expected rates. However, a five-year follow-up study is underway to track the children's physical, cognitive, and behavioral development. Suppose we estimate what would happen if these children remained on trial for ten years, into their teens which is not that uncommon. This is difficult as growth is not linear with respect to age but we can estimate that on the average they would be 5 inches shorter and weigh 30 pounds less. How many teen agers would appreciate having their height and weight cut down that much? Height has economic and competitive advantages for both men and women. I know of no teenagers who would be happy if they knew that was going to occur. I am sure they would be even more reluctant to take the drugs and more eager to sell it to their friends as kiddie coke.

4. Eleven percent had to drop out of the study as a result of intolerable side effects. For example, while some children lost weight, weight loss of 10% or more of the child's baseline weight was considered a severe enough side effect for the investigators to discontinue the medication. Other side effects included insomnia, loss of appetite, mood disturbances such as feeling nervous or worried, and skin-picking behaviors. Can a treatment which makes one out of ten worse really be considered safe and effective?

Antipsychotics

I consider psychiatric drugs essential evils with major emphasis on the evil. They are essential for many patients but evil when used in large doses and for ever. They are less evil when used in much smaller doses and for shorter periods and if combined with orthomolecular psychiatric methods. They should be used like crutches and thrown away when they are no longer needed. Much more attention must given to the toxic side effects of the drugs. One of the major toxic long term side effects is that it is almost impossible to ever fully get well when on the medication. The natural recovery rate when patients are given proper shelter, good food and treated with civility and respect it is around forty percent. When treated by modern psychiatry it drops down to about ten percent. After over fifty years of research, mostly drug research, and billions spent on this research psychiatry has decreased the recovery rate over that achieved by the moral treatment of the insane sponsored by the Quakers from 40% to 10%. In the field of cancer has there been little improvement but it has not gotten worse than it was 150 years ago.

In Sweden government legislation enforces the "substitution principle"[12] This means that if a safer alternative is available for any toxic chemical added to the environment, food, etc., there is a legal obligation to use the safer compound. This is a very enlightened policy, not used in the North America. It should be enforced in all forms of chemotherapy including antipsychotic medication to replace drugs that are dangerous and for which there are

safer alternatives. I consider treating with psychiatric drugs palliative chemotherapy for psychiatric conditions and about as effective as is chemotherapy for cancer. And in the same way that chemotherapy for cancer leaves patients very sick so treatment with antipsychotics causes the tranquilizer psychosis which is often confused with the original psychosis.

Side effects, usually involuntary movements, can be permanent and are hence evidence of brain damage. A report in 1985 in the Mental and Physical Disability Law Reporter indicates courts in the United States have finally begun to consider involuntary administration of the so-called major tranquilizer/antipsychotic/neuroleptic drugs to involve First Amendment rights because antipsychotic drugs have the capacity to severely and even permanently affect an individual's ability to think and communicate. In *Molecules of the Mind: The Brave New Science of Molecular Psychology,* Professor Jon Franklin[14] observed: "This era coincided with an increasing awareness that the neuroleptics not only did not cure schizophrenia, they actually caused damage to the brain. In severe cases, brain damage from neuroleptic drugs is evidenced by abnormal body movements called tardive dyskinesia. However, tardive dyskinesia is only the tip of the iceberg of neuroleptic caused brain damage. Higher mental functions are more vulnerable and are impaired before the elementary functions of the brain such as motor control."

Orthomolecular Treatment

By 1960 I had been using large doses of vitamin B_3 for seven years for treating schizophrenia, hypercholesterolemia, for decreasing the ravages of senility and for other conditions and I am still learning about this remarkable vitamin called a wonder drug by my friend Dr. Lars Carlson, Karolinska Institute in Sweden. What I have learned is described in the book Harold Foster and I wrote about niacin[15].

But in 1960 I had very little experience with its beneficial effects in helping children with learning and behavioural disorders. These are usually correlated as it is rare that a child will suffer from one set of these symptoms and not the other. My conclusions have been recorded in dozens of publications in *Journal of Orthomolecular Medicine* and in several books and there has been massive corroboration by physicians who used the treatment I had described.[16] If this treatment is as good as I have seen and described why is not every child getting the benefit? Why is psychiatry loading these children with heavy doses of ritalin and atypical anti psychotic drugs? Why did Jay and his family have to suffer so much. Why did it take the intense dedication of Dr Marty McKay to save Jay's life and allow him to become a functioning human being. Why did the Ontario College of Physicians and Surgeons find that the psychiatrist who treated J was not to be censured?

In 1999[17] I described 110 brief case histories of children under the age of fourteen I had treated with orthomolecular methods. It is obvious that many of them would today, if seen by a child psychiatrist, would be diagnosed with one or more of the ADDs and bipolar. They would have been treated with anti psychotic drugs and none would have recovered. The first three children I treated in 1960 recovered. No double blinds were needed.

In 1960 a physician called me from the United States. He was crying as he told me about his son, age 12, who was in hospital. He had just been advised that there was no treatment, no hope and that he should lock him up in a California state mental hospital and forget about him. That was very common advice. I advised his father that he should obtain some niacin and take it to the hospital to discuss with his son's psychiatrist. I did not think that any knowledgeable doctor would be afraid of

a vitamin. This was a failure as the psychiatrist became very angry, denounced the use of niacin saying that they had tested it and that it would fry his brains. Both statements were equally not true. I have been on niacin for over fifty years and so far my brain appears not to have been fried. Father then began to visit his son daily and while there, he fed him jam sandwiches made up of a slice of bread, a layer of jam, niacin powder, another layer of jam and a slice of bread. Three months later he wanted to go home. He completed grade 12 in the top 5% in the USA. Later, he studied medicine and became a research psychiatrist. He spent one summer working in Linus Pauling's laboratory.

In the same year, a female age 7 was equally disturbed and was labeled retarded, a term no longer favored. Her mother was schizophrenic. She was being prepared in New York City for schooling for the retarded. She was started on niacinamide 1 gram three time daily. She did not improve for two years but in her third year began to improve. She became normal, graduated on the Dean's list at University, became a teacher, married and recently retired. A few pennies worth of a single vitamin allowed this bright young girl to live a normal and productive life. This case illustrates the futility of psychiatric diagnosis.

Starting in 1960 I have treated well over 2,000 patients under the age of fourteen.[17] There were very few failures and when they did occur it was often because the parents were not able to supervise their children's program effectively. Often one or both parents are also ill and should be treated. Schizophrenic children respond very well. In 1960 a young couple with 4 children were expelled from the city in which they were living because both parents were so psychotic the city could not deal with them and threatening to commit them to the closest mental hospital. They fled to Saskatoon. Came under my care, and were given orthomolecular treatment. The father was well in a few months and has been well since and working full time. The mother went to university, received an MA and is now a senior administrator. Of their four children three developed of behavioral problems. Dairy products were eliminated, they were given vitamins and today the entire family is normal.

The treatment theory and practice is based on the modern paradigm about the use of vitamins as treatment and not only to prevent a few deficiency disease such as pellagra, scurvy, rickets. The treatment is more complex than just handing out a few vitamin pills. That is how it started but it became clear that the whole field of nutrition is involved, That is why in my books on children I gave so much space to nutrition. This I will not repeat.

The first element is to correct the diet of the patients. Too many consume huge amounts of food artifacts such as the sugars, free fats and products made from refined flour. This food is tasty, cheap and heavily advertised. This has been ignored for decades by government but at last the evidence has become so persuasive that attempts are being made to cut down eating of these artifacts. Just as important is to eliminate foods to which the patient is allergic. This has been totally ignored by medicine except by a few clinical ecologists who are also ignored. If the patient is sick because they are eating large amounts of milk to which they are allergic they will not recover until that has been corrected. The child can eat all good foods.

After the patients and their parents are instructed with respect to what to eat and when (i.e. to have three meals each day), they are started on the appropriate vitamins For children with behavioral and/or learning disorders the two B vitamins B_3 and B_6 are the most important. When I first began to treat with vitamins I used only B_3 but later it became clear that

B_6 also played a role especially for autistic children. Vitamin C is needed as no one ever gets enough from food. Vitamin D is needed especially in northern countries where ultraviolet light is rare most of the year, And since it is rare for any person to have only one deficiency it is good to add a multi B- complex preparation. The most important minerals are zinc when there is evidence of a deficiency which is common when dairy products are consumed by allergic children and selenium in areas deficient like the west coast of North America.

Perhaps a more detailed description may be more persuasive.. Ben was my first child to receive orthomolecular treatment. Being the first he, his family and his response remain fresh in my mind. I will repeat what I wrote in *Healing Children's Attention and Behavior Disorders*. If a picture is worth a thousand words perhaps one good anecdote is worth dozens of brief case histories.

The Case of Ben

One evening, early in 1962, my friend George called to say he was very worried bout his youngest son, Ben. Nine years old, Ben had become a behavioral problem with a learning disability. Today he would be diagnosed as suffering from ADD (Attention Deficit Disorder) or one of its many variants. Progress at school was so slow his teachers began to prepare his parents to have him go to a school for slow learners, perhaps even to a school for the mentally retarded. But before anyone was aware that Ben had such a problem, he had tested 120 on an IQ (intelligence quotient) test. To his father, a public administrator, and his mother, a teacher, this was not only perplexing but very disturbing. I asked George to bring Ben to my office on the fifth floor of the University Hospital, now Royal University Hospital, in Saskatoon. At the time, I was Director of Psychiatric Research, Psychiatric Services Branch, Department of Public Health, Saskatchewan, and Associate Professor of Psychiatry at the Medical School.

I was not very keen on seeing Ben since I had little experience in treating children. The few children I had seen in the previous ten years were all considered either slow learners or had various degrees of severe retardation and no treatment was available for them. The 1960 view of these children was that they were primarily failures of the educational system and required special pedagogic skills and programs in order to deal with the problem. None of these special educational efforts was very effective. This was why the hospitals for the retarded were not called hospitals but rather training schools. We had one in Moose Jaw and a second one was created later on in Prince Albert after the building was closed as a special hospital for treating patients with tuberculosis. These hospitals (training schools) had more teachers and psychologists than physicians on their staff compared to mental hospitals housing schizophrenics and "real" mentally sick patients. To perpetuate this idea some American hospitals for these children called themselves "campuses:"

The modern type of hyperactive learning disordered child was extremely rare in 1960. This was also the view of celebrated pediatrician and children's health advocate Dr. Benjamin Spock. I met Dr. Spock just before we were both to appear on a TV program in Toronto in the mid 1960s and I asked him whether he had seen many "hyperactive" children when he was still practicing. He asked me to describe what I meant by hyperactive and later said that he could not recall having seen any children with this problem. But George was so disturbed I set aside my worry about making a proper assessment of Ben.

Ben came into my office with his

father. He was a good looking boy, appeared healthy, with none of the physical stigmata of the seriously retarded children seen in old psychiatric textbooks. He did not know why he had been brought to see me, and he denied having any problems or symptoms. His father gave me his developmental history. He was walking by 14 months and speaking by 20 months. Both parents considered him an ideal child until he entered Grade one when he was 7 years old. By the end of 1960, his mother noticed a change in behavior. He became more anxious, could not fall asleep at night, and if he did sleep, woke up frequently during the night. School became harder for Ben. When the family moved to a different part of the city and he was moved to a different school, he had even more problems. His teachers were worried about his erratic performance at school and told his parents he was in a "shell:" Reading and spelling were very poor. He finished Grade 3 with a D average in spite of extensive tutoring and drilling at home by his mother.

In July 1961 he was examined by a mental health clinic specializing in treating children. Ben's mother told them he had a very poor memory, reversed letters, and had no knowledge of phonics. His eyes skipped back and forth so much she tried to keep him focused by using a ruler under the lines. His teachers reported he was not working up to his best ability, spent a lot of time day-dreaming, wasting time, and therefore falling behind. His marks were very low. He did not complete his assignments and did not bother to write his exams, nor could he be motivated. At home Ben was negative to his father, missed a lot of school, and often would come home after school hours not having gone to school that day. The clinic blamed the move to a new school and sibling rivalry with his brother, a year and a half older. They recommended remedial reading, which proved to be ineffective.

After my examination, I was puzzled. Nothing appeared which could explain the deterioration of this child to his present state. I arranged to analyze his urine for the "mauve factor:" This was a substance which my research group had discovered in the urine of a majority of schizophrenic patients we treated, but it was also found in a smaller number of patients with other diagnoses. Over the previous few years, I had found that any patient with this substance in their urine more closely resembled schizophrenia than they did other diagnostic groups and that they responded very well to large doses of vitamin B_3 (niacin or niacinamide). We called it the mauve factor and later identified it as kryptopyrrole (KP).

The next day we found large quantities of KP in Ben's urine. I started Ben on niacinamide, 1 gram three times each day after meals. His parents continued this regimen for several months. George called me again that fall and told me that Ben was normal. He had been given remedial reading for two months by the clinic, who then pronounced him well, but he had shown no progress whatever before starting on the vitamin. He had spent the summer happily getting caught up with his reading.

One of his teachers prepared a report on Ben which she sent to me in 1973. George had advised her that Ben had done so badly in previous classes that he was called "stupid" in school and had responded by not answering any questions during class. But to her surprise she found him active in group discussions and volunteering answers. Here is what she wrote: "The first thing that his parents noticed in Ben's improvement after he showed an improvement in his health was his desire to go to school. Ben started to do his assignments, but at first he found the excuse of hunting for his books and pencils in his desk to delay him in starting his assignments promptly." The teacher

started keeping his books on her desk for some time, but midway through the term Ben took the initiative to get his books out promptly and began his assignments. Previous to vitamin therapy, Ben had no desire to take down all the notes given in the allotted time. When anything was dictated, Ben would have hard time keeping up. Then he would become very tense and, so to speak, "fold up" This would happen in some exams, especially in Spelling and Arithmetic, which he was slow doing, and then he would run out of time.

These problems soon began to disappear. Many other improvements were noted physically, socially, emotionally and educationally. Ben at the beginning of the term would pride himself with the fact his mother was also a teacher. Later on in the term, Ben also started to mention his father and brother. "Ben is no longer shy," his teacher reported. "He is a sparkling personality; not afraid to speak up. He has started to take an interest in sports, in which he excels and which should be encouraged. He now gets along well with the children at school and at camp. He will assume leadership and organization duties. Ben now can read with eye-reversal not noticeable in reading and seldom in writing. Ben would go up on the stage to sing, say a speech, and read the morning scripture to the whole student body and the staff. All of the these things he did well with little nervousness and tension noticeable. Ben also reads books without being told and enjoys reading them."

In 1966 Ben had completed Grade 7 with a low A average. In Grade 9 he went to a track meet, participated in extra curricular activities, and worked as stage manager for a school play. He was so busy he finished his scholastic year with a C average. Nevertheless, his parents were delighted with his state of normality.

In 1970 his mother wanted me to see him again. Ben had not taken niacinamide for two years, and she was worried that he might relapse. Ben had forgotten he had ever seen me and did not understand why he should take vitamin pills. I explained the situation to him, and he agreed he would start again and keep taking vitamin niacinamide until age 18. Later Ben married. He is raising a family and has a responsible permanent job. He meets my criteria for recovery: he is free of symptoms and signs of illness, he gets on well with his family and with the community, he is employed and pays taxes.

Although Ben was one of the first children I tested for mauve factor (KP) and advised to take large doses of niacinamide, he is an excellent example of what can be done for these children with so-called learning disabilities and behavioral disorders if they are examined, diagnosed, and treated with the correct, orthomolecular approach. Ben's treatment and response to a vitamin in large doses is a prototype of what can be achieved through diet and nutrient supplements, not only for "ill" children like Ben, but also for "healthy" children.

Discussion.

I still marvel at the fact that a disease which was very seldom diagnosed in children a few years ago is found in millions of children down to the age of two to such a degree that they are given antipsychotic drugs. This may be due to the Cascade phenomenon. Tierney[18] writes "Cascades are especially common in medicine." This phenomenon leads to widespread errors, mistaken consensus agreements. Tierney continues, "Doctors take their cues from others, leading them to over diagnose some faddish ailment (called bandwagon diseases) and over-prescribe certain treatment (like the tonsillectomies once popular for children). Unable to keep up with the volume of research, doctors look for guidance from an expert–or at least some who sounds confident."

In his book *Good Calories, Bad*

Calories[19] Gary Taubes presents massive evidence that the current idea about the relation between heart disease and fats in food is a severe case of mistaken consensus. The cascade effect led the medical world into a false hypothesis which has driven food guides for decades and which has not decreased heart disease as it was confidently predicted it would.

The idea that bipolar is so common originated at Harvard University with Dr. J. Biederman, Head of Child Psychopharmacology at Massachusetts General Hospital. In a CBS program he defined it more broadly so that more children could be diagnosed. He was very confident. Here we have the needed elements for a Cascade to start–the opinion by a respected scientist attached to Harvard. How many psychiatrists would stand up against a scientist from a distinguished university? The idea was also very attractive and helpful to Big Pharma which found an enormous new market for these drugs. A controlled study is now underway at Massachusetts General Hospital to test the effect of these drugs on children between ages 4 to 8 with bipolar psychosis, double blind of course. I find it bizarre that a diagnostic system which has never been validated and which is as useless and harmful as the DSM can have been accepted so quickly by the profession and that a treatment, for which there is no evidence that it works for children and has not been released for this purpose, can have become so popular in a very few years whereas orthomolecular treatment which has been developing over decades and which has been corroborated every time it has been used is hardly known. Of course the massive sweep of bad ideas is not unique to psychiatry. This phenomenon is described by Devra Davis[20] in the war against cancer as well as by Taube in his description of the war against the real cause of the pandemic of the metabolic disease.

Conclusion

Psychiatric diagnosis as described in DSM IV is not scientific, nor useful, either for treatment or prognosis and should be abandoned. It should be replaced by etiologic diagnosis, such as allergies, vitamin and mineral deficiency and dependency. Present diagnosis is harmful to children. It is a licence to kill. Palliative toxic psychiatric chemotherapy should follow the "substitution principle" mandated in Sweden for toxic environmental chemicals.

The adoption of these two policies would eliminate a large number of harmful conditions including brain damage, suicide, diabetes, abnormal blood lipid levels and associated cardiovascular disease. On a social level it would eliminate much pain, hardship, family disruption and chronic invalidism.

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