



ELDERLY ABUSE

Cruel Mental Health Programs

Report and recommendations
on psychiatry abusing
seniors

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IMPORTANT NOTICE

For the Reader

The psychiatric profession purports to be the sole arbiter on the subject of mental health and “diseases” of the mind. The facts, however, demonstrate otherwise:

1. PSYCHIATRIC “DISORDERS” ARE NOT MEDICAL DISEASES. In medicine, strict criteria exist for calling a condition a disease: a predictable group of symptoms and the cause of the symptoms or an understanding of their physiology (function) must be proven and established. Chills and fever are symptoms. Malaria and typhoid are diseases. Diseases are proven to exist by objective evidence and physical tests. Yet, no mental “diseases” have ever been proven to medically exist.

2. PSYCHIATRISTS DEAL EXCLUSIVELY WITH MENTAL “DISORDERS,” NOT PROVEN DISEASES. While mainstream physical medicine treats diseases, psychiatry can only deal with “disorders.” In the absence of a known cause or physiology, a group of symptoms seen in many different patients is called a *disorder* or *syndrome*. Harvard Medical School’s Joseph Glenmullen, M.D., says that in psychiatry, “all of its diagnoses are merely syndromes [or disorders], clusters of symptoms presumed to be related, not diseases.” As Dr. Thomas Szasz, professor of psychiatry emeritus, observes, “There is no blood or other biological test to ascertain the presence or absence of a mental illness, as there is for most bodily diseases.”

3. PSYCHIATRY HAS NEVER ESTABLISHED THE CAUSE OF ANY “MENTAL DISORDERS.” Leading psychiatric agencies such as the World Psychiatric Association and the U.S. National Institute of Mental Health admit that psychiatrists do not

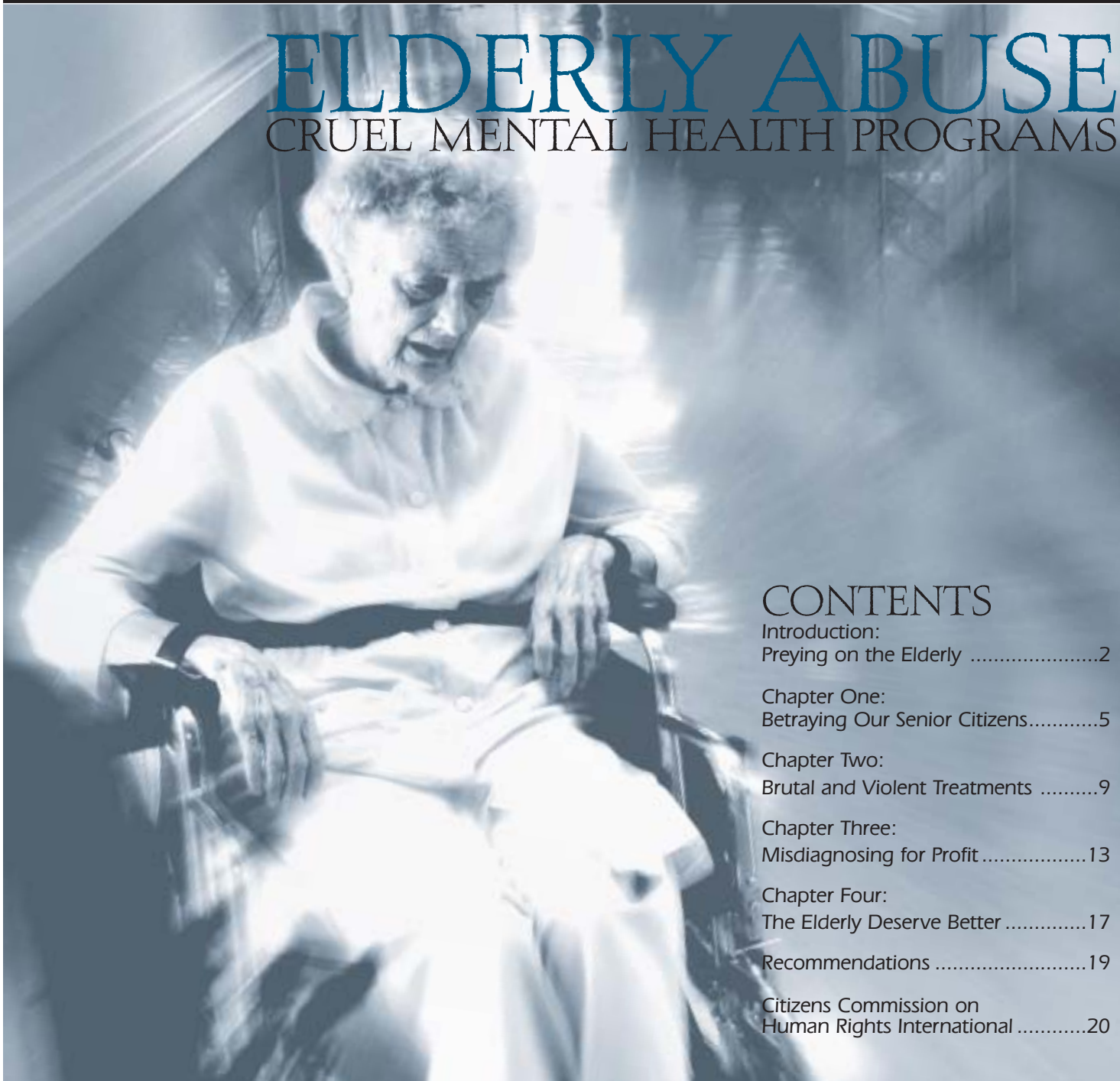
know the causes or cures for any mental disorder or what their “treatments” specifically do to the patient. They have only theories and conflicting opinions about their diagnoses and methods, and are lacking any scientific basis for these. As a past president of the World Psychiatric Association stated, “The time when psychiatrists considered that they could cure the mentally ill is gone. In the future, the mentally ill have to learn to live with their illness.”

4. THE THEORY THAT MENTAL DISORDERS DERIVE FROM A “CHEMICAL IMBALANCE” IN THE BRAIN IS UNPROVEN OPINION, NOT FACT. One prevailing psychiatric theory (key to psychotropic drug sales) is that mental disorders result from a chemical imbalance in the brain. As with its other theories, there is no biological or other evidence to prove this. Representative of a large group of medical and biochemistry experts, Elliot Valenstein, Ph.D., author of *Blaming the Brain* says: “[T]here are no tests available for assessing the chemical status of a living person’s brain.”

5. THE BRAIN IS NOT THE REAL CAUSE OF LIFE’S PROBLEMS. People do experience problems and upsets in life that may result in mental troubles, sometimes very serious. But to represent that these troubles are caused by incurable “brain diseases” that can only be alleviated with dangerous pills is dishonest, harmful and often deadly. Such drugs are often more potent than a narcotic and capable of driving one to violence or suicide. They mask the real cause of problems in life and debilitate the individual, so denying him or her the opportunity for real recovery and hope for the future.

ELDERLY ABUSE

CRUEL MENTAL HEALTH PROGRAMS



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ELDERLY ABUSE
Cruel Mental Health Programs



INTRODUCTION

Preying on the Elderly

In today's high-pressure world, tradition is too often replaced by more "modern" means of dealing with the demands of life. For example, while once heavily community-, church- and family-based, today the task of caring for our parents and grandparents routinely falls to organizations such as nursing homes or aged-care centers. There we trust that professionally trained staff will take care of our elders as we would.

Doubtless, 67-year-old Pierre Charbonneau's wife and family felt this way when he was rushed to a hospital suffering from a severe anxiety attack reportedly related to Alzheimer's disease. Displaying "acute agitation," Pierre was prescribed a tranquilizer. Ten days later he was transferred to a nursing home where the drug dosage was immediately doubled, and then tripled three days after that. Shortly after, his wife, Lucette, found him bent over in his wheelchair with his chin touching his chest, unable to walk and capable of swallowing only a few teaspoons of puréed food.

A pharmacist warned Lucette that her husband was possibly suffering irreversible nervous system damage caused by major tranquilizers. The family called the nursing home and requested that the drugs be stopped. It was too late. Mr. Charbonneau's tongue was permanently paralyzed, a doctor later explained, and he would never regain his ability to swallow. Nine days later, Mr. Charbonneau died. The cause of death was listed as a heart attack.¹

For those who contemplate how to arrange care for

much-loved and aging parents or grandparents, it is vital to know that this tragic story is not an exception in elder care today.

When Wilda Henry took her 83-year-old mother, Cecile, to a nursing home, "she walked in the place as good as you and I could." Within two weeks, after being prescribed the psychiatric drug Haldol, Cecile began babbling instead of talking, drooling constantly, shaking violently and was unable to control her bowels. The dose, it was later discovered, had been increased to 100 times the recommended amount. A medical doctor

determined that excessive use of Haldol had caused these symptoms as well as permanent liver damage.

The reality of nursing home and aged-care center life today is often far from the stylized image of communicative, interactive and interested elderly

residents living in an idyllic environment. By contrast, more often than not, the institutionalized elderly of today appear submissive, quiet, somehow vacant, a sort of lifelessness about them, perhaps blankly staring or deeply introspective and withdrawn. If not by drugs, these conditions can also be brought on by the use of electroconvulsive or shock treatment (ECT) or simply the threat of painful and demeaning restraints.

Rather than this being the failure of nursing hospital and aged care staff generally, this is the legacy of the widespread introduction of *psychiatric* treatment into the care of the elderly over the last few decades.

Consider the following facts about the "treatments" they receive:

"Rather than being cherished and respected, too often our senior citizens suffer the indignity of having their minds heartlessly nullified by psychiatric treatments."

— Jan Eastgate

■ Tranquilizers, also known as benzodiazepines, can be addictive after 14 days of use.²

■ In Canada, between 1995 and March 1996, 428,000 prescriptions for one particular, highly addictive tranquilizer were written, with more than 35% of these for patients 65 and older.

■ In Australia, a study found one third of elderly people were prescribed tranquilizers and another found that the elderly were prescribed psychoactive drugs in nursing homes because they were being “noisy,” “wanting to leave the nursing home” or were “pacing.”³

■ Data from coroners’ reports compiled by Britain’s Home Office showed benzodiazepines as a more frequently contributing factor to causes of unnatural death each year than cocaine, heroin, ecstasy, and all other *illegal* drugs.⁴

■ While nations wage a war on cocaine, heroin and other street drugs, roughly one in five seniors in the United States struggles with a different kind of substance abuse—prescribed psychoactive drugs.

In the United States, 65-year-olds receive 360% more shock treatment than 64-year-olds because at age 65 government insurance coverage for shock typically takes effect.

Such extensive abuse of the elderly is not the result of medical incompetence. In fact, medical literature clearly cautions against prescribing tranquilizers to the elderly because of the numerous dangerous side effects. Studies show ECT shortens the lives of elderly people significantly. Specific figures are not kept as causes of death are usually listed as heart attacks or other conditions.

The abuse is the result of psychiatry maneuvering itself into an authoritative position over aged care. From there, psychiatry has broadly perpetrated the tragic but lucrative hoax that aging is a mental disorder requiring *extensive* and *expensive* psychiatric services.



The end result is that, rather than being cherished and respected, too often our senior citizens suffer the extreme indignity of having their power of mind heartlessly nullified by psychiatric treatments or their lives simply brought to a tragic and premature end.

This publication is being presented to expose the harsh reality that such tragedies are repeated quietly and frequently in aged-care facilities all over the world. Such betrayal of the elderly and their loved ones must not be tolerated in a civilized society.

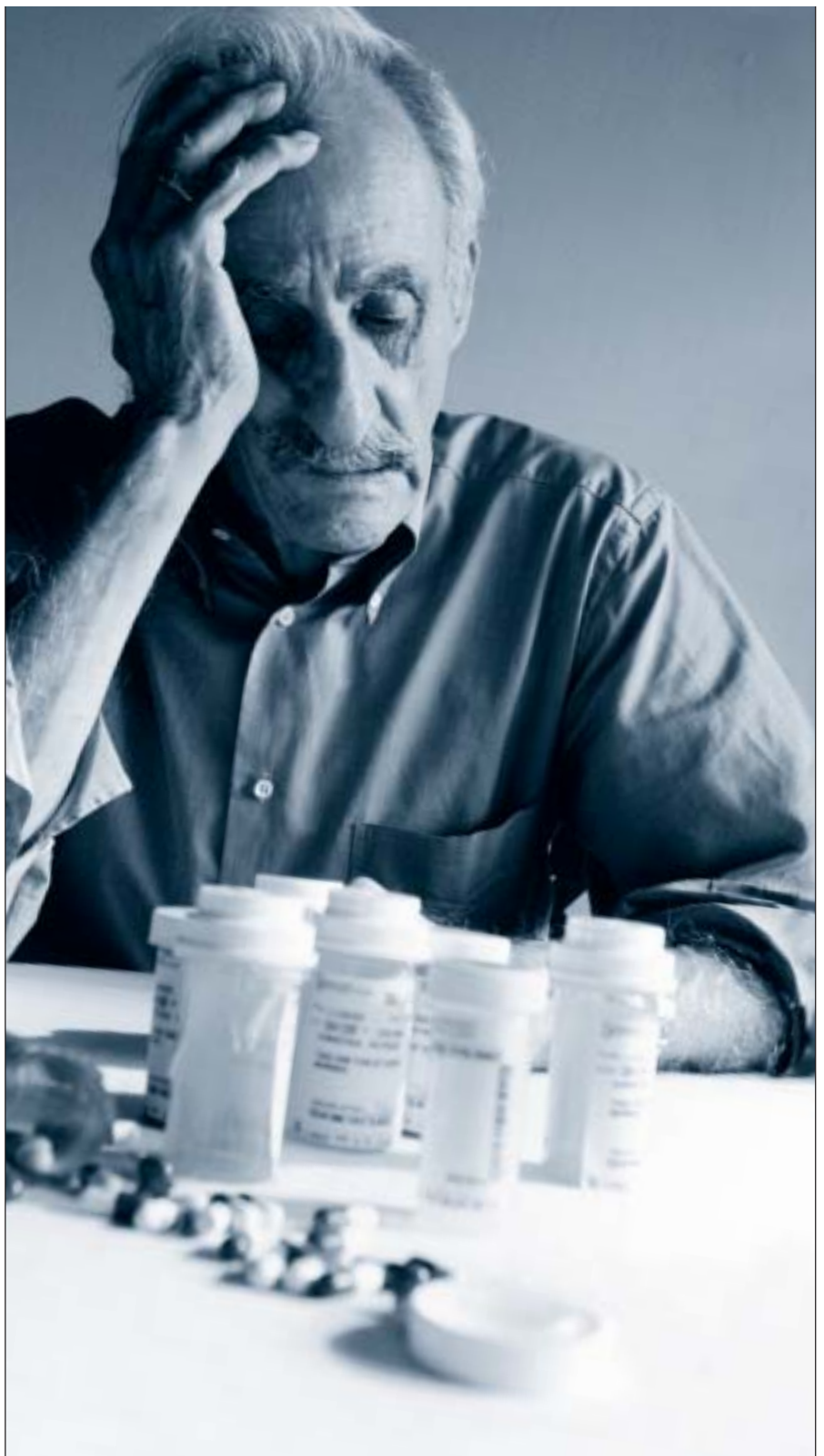
Sincerely,

A handwritten signature in dark ink, appearing to read "Jan Eastgate". The signature is fluid and cursive.

Jan Eastgate
President, Citizens Commission on
Human Rights International

IMPORTANT FACTS

- 1** One in five seniors in the United States suffers from abusively prescribed psychoactive drugs.
- 2** An Australian study found that the elderly were prescribed psychoactive drugs in nursing homes because they were being “noisy,” “wanting to leave the nursing home” or were “pacing.”
- 3** Medical literature clearly cautions against prescribing tranquilizers for the elderly because of the numerous dangerous drug side effects.
- 4** In Canada, between 1995 and March 1996, 428,000 prescriptions for one particular highly addictive tranquilizer were written, with more than 35% of these for patients 65 and older.





CHAPTER ONE

Betraying Our Senior Citizens

What is the sense of prescribing a senior citizen a tranquilizer that is more lethal and harder to withdraw from than heroin, one that leads to a 45% increase in the risk of having a car accident within seven days of taking it?⁵ Why give them an antidepressant that could increase the risk of their falling by 80%, or could cause them to become agitated or aggressive, or even suicidal?⁶

Common sense and decency dictate that the last thing a fragile, anxious or vulnerable elderly person needs is the additional physical and mental stress associated with heavy, addictive psychiatric drugs.

As Dr. Richard Lefroy, formerly of the Sir Charles Gardiner Hospital in Western Australia, warned his colleagues, “[Drugs] can alter older people’s ability to orient themselves and can reduce their reason. As a result people want to put them in institutions.” Lefroy further stated that some *medical* drugs affect the brain and upset the patient, who is then typically prescribed tranquilizers. Irrationality, belligerence or a “dopey” appearance often result.

Dr. Jerome Avorn, an associate professor of social medicine at Harvard University, bluntly explained: “Drugs do ... quiet them down. So does a lead pipe to the head.”⁷

Ninety-seven-year-old Mary Whelan, previously happy at her nursing home, was labeled with “dementia” and locked up in a Florida psychiatric hospital, despite her daughter’s objections. “She was so drugged that she could not keep her head up to eat her dinner. She just wanted to go to sleep. It broke my heart,” her daughter told a local newspaper.

In 2002, Dr. Eleonore Prochazka, a German pharmacist and toxicology expert, warned of the dangers of “using psychiatric drugs and other meth-

ods, which can lead to a destruction of the personality—even cause death.”

Thomas J. Moore, a senior fellow in health policy at the George Washington University Medical Center, reports that more than 100,000 people die every year in America from the adverse effects of prescription drugs. Moore warns: “In

The last thing a fragile, anxious or vulnerable elderly person needs is the additional physical and mental stress associated with heavy, addictive psychiatric drugs.

such a poorly managed, inherently dangerous system, consumers must pay far more attention to risks and benefits of the drugs they take. Can they recognize the adverse effects of the drugs they’re taking, especially the subtle ones like fatigue or mild depression? Is this one of the drugs where a small overdose is dangerous?”

However, these are hardly questions and responsibilities that should be shouldered by the elderly. Protection from such risks must be afforded them as an intrinsic part of aged-care systems.

PSYCHIATRIC DRUGS

Destroying Lives



Anyone who has pushed their way through the “clinical pharmacology” section of drug information packaging to read the list of “adverse reactions,” knows that “informed consent” is something of a misnomer. In the case of the elderly it is a cruel charade. For ease of reference, the following is a partial list of the side effects of psychiatric drugs routinely prescribed for seniors:

Minor Tranquilizers

Minor tranquilizers or benzodiazepines can cause lethargy, lightheadedness, confusion, nervousness, sexual problems, hallucinations, nightmares, severe depression, extreme restlessness, insomnia, nausea and muscle tremors. Epileptic seizures and death have resulted from suddenly stopping the use of minor tranquilizers. Thus,

it is important to cease taking these drugs only under proper medical supervision, even if the drugs have only been taken for a couple of weeks.

Major Tranquilizers

Major tranquilizers, also called antipsychotics, or “neuroleptics” (nerve-seizing), frequently cause difficulty in thinking, poor concentration, nightmares, emotional dullness, depression, despair and sexual dysfunction. Physically, they can cause *tardive dyskinesia*—sudden, uncontrollable, painful muscle cramps and spasms, writhing, squirming, twisting and grimacing movements, especially of the legs, face, mouth and tongue, drawing the face into a hideous scowl. They also induce *akathisia*, a severe restlessness that studies show can cause agitation and psychosis. A potentially fatal effect is “Neuroleptic Malignant Syndrome,” which includes

muscle rigidity, altered mental states, irregular pulse or blood pressure and cardiac problems. Moreover, silent coronary death “... may be one of the most serious threats of prolonged drug use,” according to William H. Philpott, M.D. and Dwight K. Kalita, Ph.D., in *Brain Allergies*.⁸

Antidepressants

Antidepressants (tricyclics) can cause sedation, drowsiness, lethargy, difficulty thinking, confusion, poor concentration, memory problems, nightmares, panic feelings and extreme restlessness; also delusions, manic reactions, delirium, seizures, fever, lowered white blood cell count (with risks of infection), liver damage, heart attacks, strokes, violence and suicidal ideation.

Selective Serotonin Reuptake Inhibitors

Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants can cause headaches, nausea, anxiety and agitation, insomnia and bizarre dreams, loss of appetite, impotence and confusion. It is estimated that between 10% and 25% of SSRI users



experience akathisia, often in conjunction with suicidal thoughts, hostility and violent behavior. Withdrawal syndromes are estimated to affect up to 50% of patients, depending on the particular SSRI drug. In 1998, Japanese researchers also reported in *Lancet*, the journal of the British Medical Association, that substantial amounts of these antidepressants can accumulate in the lungs and may be released in *toxic* levels when a second antidepressant is prescribed.

Newer Anti-Psychotics

One in every 145 patients who entered clinical trials for four atypical (new) antipsychotic drugs died, yet those deaths were never mentioned in the scientific literature.⁹ Thirty-six patients involved in the clinical trials committed suicide.¹⁰ Eighty-four patients experienced a “serious adverse event” of some type, which the Food and Drug Administration (FDA) defines as a life-threatening event, or one that requires hospitalization. Nine percent of the patients dropped out of the clinical trials because of adverse events, which was a similar rate to those treated with the older antipsychotics—therefore, there was no greater improvement over the older treatments, as originally touted.¹¹



IMPORTANT FACTS

1 Electroconvulsive Therapy (ECT or electroshock) involves the application of between 180 and 460 volts of electricity through the brain, causing a grand mal seizure and irreversible brain damage.

2 People 65 years of age and older comprise almost 50% of those getting electroshock today. ECT can shorten the lives of elderly people.

3 Women make up two thirds of all people shocked; elderly women are the primary target.

4 Of the estimated 300 people who die each year from ECT in America, approximately 250 are elderly patients.

5 In the U.S., 65-year-olds receive 360% more shock treatment than 64-year-olds because at age 65 Medicare (government insurance) coverage takes effect.





CHAPTER TWO

Brutal and Violent Treatments

Psychiatric drugging of the elderly is not the only legacy of psychiatric interference with care for our senior citizens. Indiscriminate use of violent restraints and Electroconvulsive Therapy (ECT or shock treatment) on the elderly is also responsible for needless suffering.

Jennifer Martin's 70-year-old mother started having headaches and nausea. She stopped eating and couldn't talk. A psychiatrist claimed the elderly woman was in shock from recent deaths in her family and that she needed ECT to bring her out of it. Less than 24 hours after the treatment, Jennifer's mother was dead. An autopsy revealed that her problem was not depression, but something wrong with her brain stem. "Shock treatment killed her," Jennifer said in 1997.

Although rarely referred to as shock treatment by psychiatrists, ECT involves the application of between 180 and 460 volts of electricity through the brain, causing a grand mal seizure and irreversible brain damage.

While psychiatrists openly admit they have no idea how ECT works, they have no hesitation in shocking people, including the elderly.

Dr. Nathaniel Lehrman, retired clinical director of Kingsboro State Mental Hospital, New York,

warned that elderly people can least stand the rigors of ECT. "This is gross mistreatment on a national scale," he stated.¹² Yet people 65 years of age and older comprise almost 50% of those getting electroshock today.

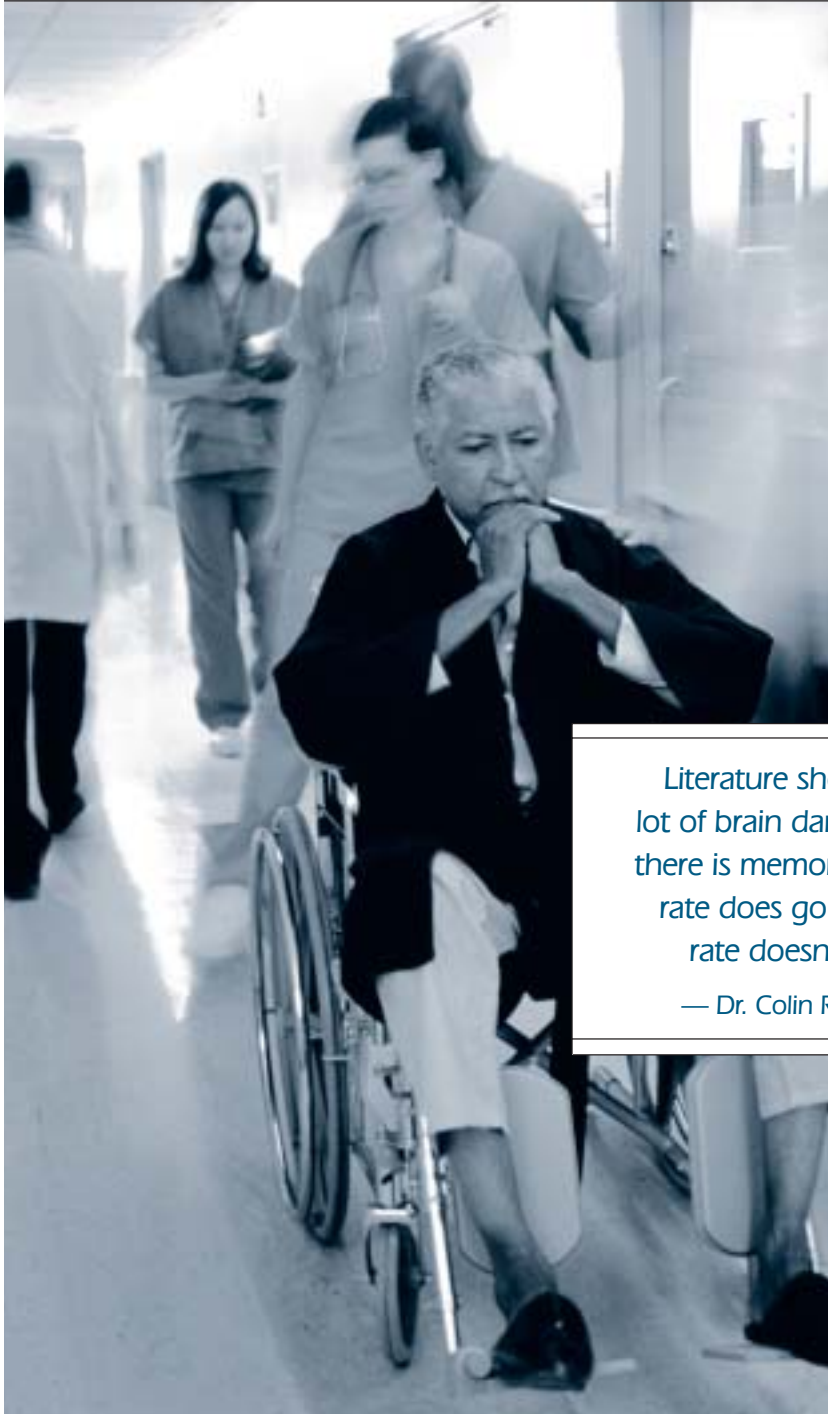
In 1991, psychologist Robert F. Morgan testified before a hearing into ECT that an elderly person's "depression" is often triggered or worsened by their fears of losing their memory and health, both of which electroshock is known to affect adversely.¹³

A survey of psychiatrists, psychotherapists and general practitioners by the Royal College of Psychiatrists in Britain confirmed memory loss as an effect of ECT. Of the 1,344 psychiatrists surveyed, 21% reported "long-term side effects and risks of brain damage, memory loss [and] intellectual impairment."¹⁴ General

practitioners said that 34% of patients whom they had seen months after receiving ECT " ... were poor or worse." Fifty psychotherapists were more candid about the effects of ECT; some of their comments were: "It can cause personality changes and memory impairment, making therapy more difficult" and " ... ECT, however it is dressed up in clinical terms, is inseparable from an assault. ..."¹⁵

A watchdog group in the United Kingdom called "ECT Anonymous" summed up the Royal

"This is gross mistreatment on a national scale."
— Dr. Nathaniel Lehrman, retired clinical director, Kingsboro State Mental Hospital, New York



Literature shows “there is a lot of brain damage [with ECT], there is memory loss, the death rate does go up, the suicide rate doesn’t go down.”

— Dr. Colin Ross, psychiatrist

College’s report as “a chilling catalogue of blundering incompetence.” Spokesperson for the group, Roy Barker, described ECT as: “An appointment with fate, a brief but vital juncture in your life, a few seconds, that, mishandled, can destroy the quality of your entire life.”¹⁶

In 2004, psychiatrist Harold A. Sackheim, a major proponent of ECT, when addressing the frequency with which patients complain of memory loss, stated, “As a field, we have more readily acknowledged the possibility of death due to ECT than the possibility of profound memory loss, despite the fact that adverse effects on cognition [consciousness] are by far ECT’s most common side effects.”¹⁷

Dr. Colin Ross, a Texas psychiatrist, candidly stated in 2004: “Nobody understands ... precisely how ECT does anything. But it’s known for scientific fact that what it does do is cause a drastic impairment in your EEG [recording of electrical activity in the brain].” Animal studies also reveal ECT causes microscopic hemorrhage [bleeding] and

brain shrinkage. “So there’s really no possibility of disputing that ECT causes damage to the brain. It’s just a question of how subtle or how coarse or gross is it and how long does it last?”¹⁸

Dr. Ross says that existing ECT literature shows “there is a lot of brain damage, there is

memory loss, the death rate does go up, the suicide rate doesn’t go down.”¹⁹

A 1993 study revealed that ECT shortens the lives of elderly people—that “Patients over 80 years old who receive ECT for major depression are at increased risk of death over the two years following treatment.”²⁰ A Canadian study reported in 1997 that when patients receiving ECT were 80 or older, 27% died within *one* year of the “treatment.”²¹



In the United States, 65-year-olds receive 360% more shock treatment than 64-year-olds. It is not coincidental that at age 65, Medicare (government insurance) coverage takes effect.²² The U.S. psychiatric industry alone today reaps an estimated \$5 billion a year from the administration of ECT. In addition, psychiatrists have an almost “malpractice-free” domain because any elderly patient complaints after ECT can easily be attributed to the patient’s senility.²³

Of the estimated 300 people who die each year from ECT in America, approximately 250 of them are elderly

patients. Yet, *USA Today* reported that doctors rarely report shock treatment on death certificates, even when the connection seems apparent, and when death certificate instructions clearly call for it.²⁴

Restraint Measures Cause Fatalities

While treatment is not supposed to kill a patient, this is what happens virtually every day in psychiatric facilities, especially through the use of violent restraints. For decades, horror stories have emerged of institutionalized patients dying while strapped to beds and chairs, others while pinned to floors by psychiatric nurses and aides. Family members are frequently told lies about the circumstances under which their loved one died.

In a statement for a 2002 California court case related to restraints, Ron Morrison, a registered psychiatric nurse, said that patients can become so exhausted fighting against restraint, they risk cardiac and respiratory collapse.²⁵

For decades, horror stories have emerged of institutionalized patients dying while strapped to beds and chairs.

Between 1994 and 1998 in Japan, scandal rocked the country after the discovery that private psychiatric hospitals were forcibly incarcerating and illegally restraining elderly patients. One male patient

developed a potentially fatal condition after being kept in restraints for five days. Seeing he was unable to breathe, staff diagnosed pneumonia. However, doctors at a medical hospital where he was transferred, discovered that he had developed blood clots from the restraints.²⁶

The use of restraints is not designed to aid the patient. A lawsuit in Denmark revealed that hospitals using restraints received additional funding for so “treating” those patients. Harvard psychiatrist Kenneth Clark reported that patients are *often provoked* in order to justify placing them in restraints. In the United States, too, patients in restraints yield higher insurance reimbursements—at least \$1,000 a day.²⁷ The more violent a patient becomes—or is made—the more money the psychiatrist makes.

This is the truth as to why thousands of patients each year are subjected to “four-point restraints,” often after being given *known* violence-inducing drugs without their consent.

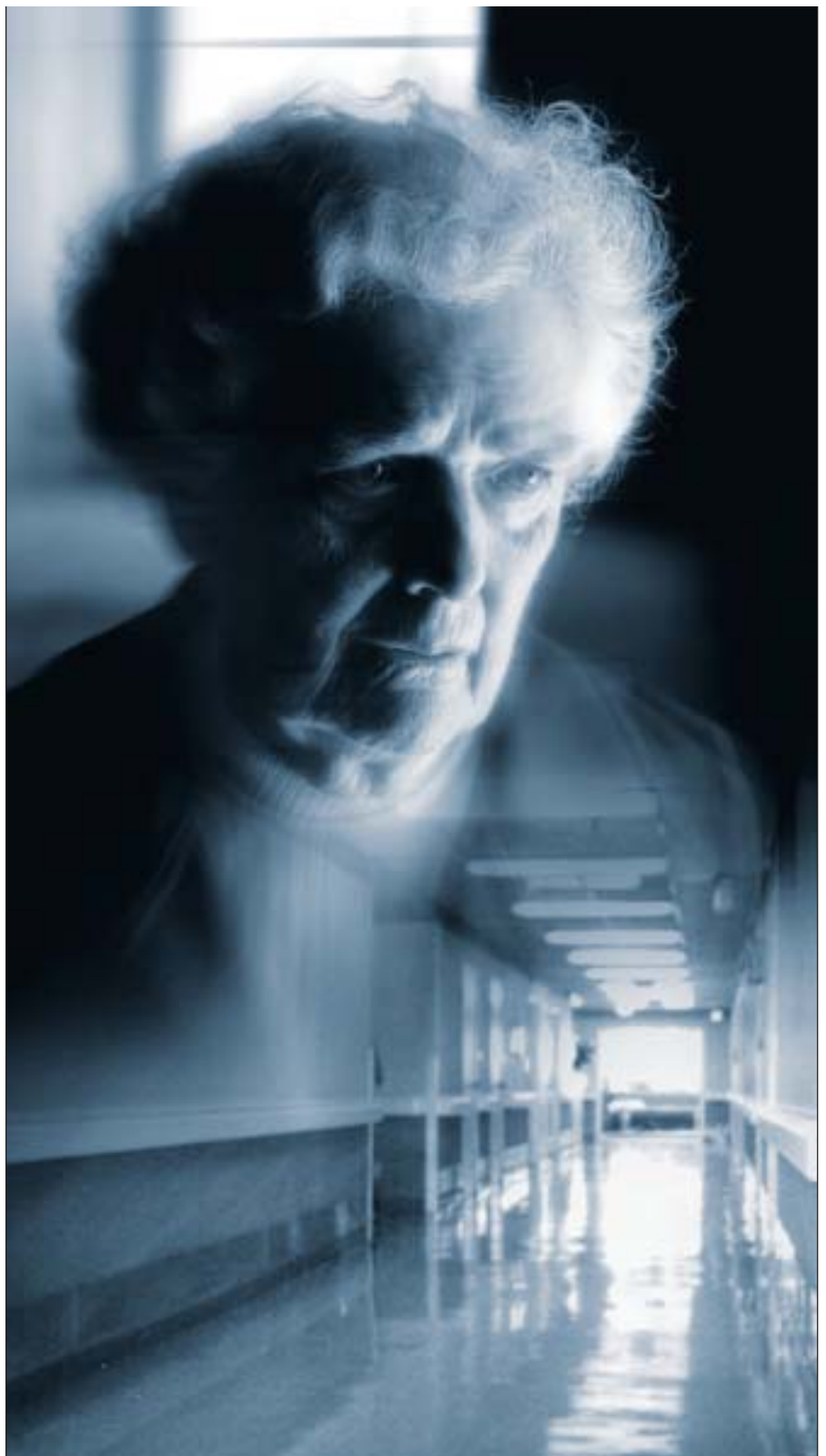
IMPORTANT FACTS

1 Through the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and the mental disorders section of the *International Classification of Diseases (ICD-10)*, psychiatry has fraudulently redefined old age as a “mental illness.”

2 In 1999, \$194 million was paid for psychiatric services in nursing homes in the United States.

3 Dementia and Alzheimer’s disease are very lucrative fields for psychiatry, even though they are physical illnesses and the proper domain of neurologists.

4 Medical experts on Alzheimer’s say that 99% of these cases don’t belong in psychiatric “care.”²⁸





CHAPTER THREE

Misdiagnosing for Profit

To psychiatrists old age is a “mental disorder,” a for-profit disease for which they have no cure, but for which they will happily supply endless prescriptions of psychoactive drugs or ECT. In 1999, \$194 million was paid for psychiatric services in nursing homes in the U.S. An additional \$1 billion was paid for treatment of the elderly in psychiatric hospitals.

In the United States, federal law provides an open door for psychiatry: each nursing home resident must have a “mental health evaluation.” This excludes testing for physical illnesses, determining nutritional deficiencies or other causes of distress.

On June 28, 2001, a nurse at the Rock Creek Center Psychiatric Hospital in Illinois, found a 53-year-old patient unresponsive 12 hours after he was drugged. Hours later the man died. A mandated autopsy revealed the man died of multiple sclerosis. On the admission form “MS” was clearly entered. However the multiple sclerosis was ignored by psychiatric staff. Officials of the facility later told investigators they believed “MS” stood for “mental status.”²⁹

In his book *Prescription for Nutritional Healing*, well-known medical/health columnist and broadcaster, Dr. James Balch, says, “Senility

occurs in old age but it is really not very common in the elderly. Many of those diagnosed as senile are actually suffering from the effects of drugs, depression, deafness, brain tumors, thyroid problems, or liver or kidney problems. Nervous disturbances, stroke and cerebral dysfunction are considered symptoms of the senility syndrome. Often, a nutritional deficiency is the cause.”³⁰

Dr. Sydney Walker III, in his book *A Dose of Sanity*, gave this example of how easy it is to misdiagnose the elderly: “ ... a 71-year-old man who had always been in good health, suddenly began exhibiting dramatic mental deterioration. His memory became very poor, he developed a shuffling gait, and he became apathetic and was unable to do simple chores such as bal-

ancing a checkbook. The man’s doctors gave him a ... ‘diagnosis’ of incurable dementia.” After further deterioration, his wife admitted him to a hospital where a urologist diagnosed prostate problems. “The prostate surgery—seemingly unrelated to the man’s senility—caused a remarkable change in his behavior. His confusion and despondency cleared, his memory became as good as ever, and his other symptoms of senility vanished completely.”

“Psychiatry’s answer to the basic problems of aging is to label them as ‘depression’ ... and, when the person complains or protests this indignity, this protest is further labeled as a mental illness, often ‘dementia.’”
— Dr. Roberto Cestari, M.D., Italy, 2004



Without the use of drugs or coercion, Italian physician Dr. Giorgio Antonucci salvaged the lives of hundreds of patients deemed incurable and condemned to live out their old age in institutions. He taught his patients living skills, organized concerts and field trips as part of their therapy. Subsequently many were discharged to live successful lives in the community.

In most cases, the elderly are merely suffering from physical problems related to their age. However, Dr. Roberto Cestari, M.D., from Italy, says: "Psychiatry's answer to the basic problems of aging is to label them as 'depression,' as a loss of mental faculties, or even a disease and, when the person complains or protests this indignity, their protest is further labeled as a mental illness, often 'dementia.'"

If an elderly person can't remember where their shoes are or whether they've paid the electricity bill that month, psychiatry claims that he or she is manifesting symptoms of dementia, sufficient grounds to be removed to a nursing home or psychiatric hospital.

Underlying this is an entire foundation of fraudulent "diagnostic" criteria, specifically the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and the mental diseases section of the *International Classification of Diseases (ICD-10)*. Through these devices, psychiatry has any mental impairment of the aged corralled as a "mental illness." The labels are then used to involuntarily commit the elderly to a psychiatric facility, take control of their finances, override their wishes regarding their business, property or health care needs and defraud their health insurance.

The list of physical illnesses that psychiatry has tacked "dementia" onto include:

- Dementia Due to Head Trauma
- Dementia Due to Parkinson's Disease
- Dementia Due to Huntington's Disease
- Dementia Due to HIV Disease³¹

And in case none of these fit, there's the catch-all category: "Dementia Due to ... [Indicate the General Medical Condition not listed above]."

Testifying before the Finance Committee of the U.S. Senate in 2001, Michael F. Mangano, Acting Inspector General of the Department of Health and Human Services (HHS), reported that the insurance company for a 95-year-old Alzheimer's patient was billed \$3,305 for 40 hypnotherapy sessions. Not surprisingly, the doctor's medical records reported that the patient was neither attentive nor cooperative. HHS determined the patient's treatment was "medically unnecessary" and "inappropriate."

Dementia and Alzheimer's disease are very lucrative fields for psychiatry, even though they are purely physical illnesses and the proper domain of neurologists. Medical experts on Alzheimer's say that 99% of these cases don't belong in psychiatric hands.³²

In the same way, psychiatrists do not belong in aged care.

A REPORT OF ABUSE

Caught in a Nightmare

Seventy-four-year-old William's nightmare began when his home care nurse asked a seemingly innocuous question: "Do you feel depressed?"

Considering that William had just been released from a general hospital for congestive heart failure, discharged with orders to use an oxygen tank at home, he felt it reasonable to admit that yes, his spirits were down a bit.

During the next few days, he would wish he had never spoken. The home care nurse began to ply him with odd questions: "Have you ever thought about suicide?" and, "If you were going to commit suicide, how would you do it?" He clearly told her he was definitely not considering suicide. For some reason, she didn't believe him.

Instead, she made a telephone call and within 10 minutes an attendant from a local psychiatric hospital arrived at William's home. He refused the attendant's invitation to return with him to a psychiatric hospital, insisting that he had no desire to kill himself. The attendant made a phone call.

The police arrived. After being unhooked from his oxygen tank, William was searched for weapons, then unceremoniously bundled into a police car, and driven to the medical hospital he had recently been discharged from.

Upon arrival, William explained to the physician on duty that there had been a misunder-

standing and that he had no intention of committing suicide. He was overruled and taken to a psychiatric facility where, without examination, he was admitted as "suicidal" and held against his will for 72 hours. During this period, a patient assaulted him,

knocking him out of his bed. A psychiatrist determined that this was evidence that William was "dangerous."

The prognosis? William needed to remain under psychiatric "care" for another 48 hours.

Fortunately for William, as it turned out, he began to experience a heart attack and was transferred back to the medical hospital. There it was determined he had suffered an angina attack. But as it was "only" angina, the doctors planned to send him back to the psychiatric facility.

A very anxious William managed to prevail upon his medical doctor to keep him—at

least until after the court hearing scheduled the next day to assess his competency.

Thankfully, in spite of the testimony of the psychiatrists, the judge agreed with William and a doctor that he was not in need of confinement and was not "crazy."

As for the aftermath of William's unsolicited and involuntary imprisonment, his Medicare insurance was billed \$4,000 for a four-day stay (even though he had only been kept for two days) and he himself was billed \$800 for the treatment of a "mental disorder" he never had.



IMPORTANT FACTS

1 In one study, 83% of people referred by clinics and social workers for psychiatric treatment had undiagnosed physical illnesses; in another, 42% of those diagnosed with “psychoses” were later found to be suffering from a medical illness.³³

2 There are many causes of mental distress. Researchers Richard Hall and Michel Popkin list 21 medical conditions that can cause anxiety, 12 that cause depression, and 56 that create mental disturbance in general.

3 The most common *medically induced* psychiatric symptoms are apathy, anxiety, visual hallucinations, mood and personality changes, dementia, depression, delusional thinking, sleep disorders (frequent or early morning awakening), poor concentration, tachycardia [rapid heartbeat], tremors and confusion.

4 Dr. Stanley Jacobson, Ph.D., says, “Oldness itself is reason to be sad if you dwell on it, and it is in any event a matter of life and death to contend with.”





CHAPTER FOUR

The Elderly Deserve Better

According to internationally renowned author and professor of psychiatry emeritus, Thomas Szasz, “Most elderly people can care for themselves, both economically and physically, at least for awhile However, with the relentless advance of age, these assets gradually erode. Unless the old person receives continuous stimulation and support through human contacts at work or in the family, he becomes idle and lonely, often ending up in a nursing home, drugged into mindless passivity. If he remains alert, he may become depressed and tell himself something like this: ‘No one needs me anymore. I am of no use to others. I cannot even take care of myself. I am worthless. I would be better off dead.’”³⁴

Dr. Stanley Jacobson, Ph.D., wrote that “depression” among the elderly is currently a “hot topic” in the world of mental health: “If the elderly are not sad but make too much of minor ailments, or imagine disease when none can be found, the experts say they are depressed and need professional help. And if the elderly are not sad or hypochondriacal but have problems relating to appetite, sleep or energy, the experts say they are *clinically* depressed and need professional help.”³⁵

Jacobson says the “experts” are wrong. “Oldness itself is reason to be sad if you dwell on it, and it is in any event a matter of life and death to contend with.”

“When all doctors are aware of the reactions of old people to drugs, specialists will be out of busi-

ness,” Australia’s Dr. Richard Lefroy said, adding that regular hospitals should be the primary center for care for the elderly, just as they are for everyone else, not nursing homes which are frequently run for profit and do not have acceptable standards, especially where they are based on a psychiatric model.

All psychiatric treatments amount to no less than a criminal assault on the mental health of the elderly. Our seniors deserve and need our protection from abuse.

The Need for Proper Medical Care

Medical studies have shown time and again that for many patients, what appear to be mental problems are actually caused by an undiagnosed physical illness or condition. This does not mean a “chemical imbalance” or a “brain-based

disease.” It does not mean that mental illness is physical. It does mean that ordinary medical problems can affect behavior and outlook.

■ Gary Oberg, M.D., past president of the American Academy of Environmental Medicine, says, “Toxins such as chemicals in food and tap water, carbon monoxide, diesel fumes, solvents, aerosol sprays and industrial chemicals can cause symptoms of brain dysfunction which may lead to an inaccurate diagnosis of Alzheimer’s or senile dementia.”³⁶

■ Former psychiatrist William H. Philpott, now a specialist in nutritional brain allergies, reported, “Symptoms resulting from B12 deficiencies range from

“When all doctors are aware of the reactions of old people to drugs, specialists will be out of business.”

— Dr. Richard Lefroy, Australia

poor concentration to stuporous depression, severe agitation and hallucinations. Evidence showed that certain nutrients could stop neurotic and psychotic reactions and that the results could be immediate.”³⁷

■ According to one mental health group, “When a person remains depressed despite normal efforts to remedy the problem, a physical source of the depression should be considered.” They list a number of possible physical sources, including: nutritional deficiencies, lack of exercise, thyroid problems, poor adrenal function, hormonal disorders, hypoglycemia, food allergies, reactions to heavy metals, sleep disturbances, infections, heart

problems, lung disease, diabetes, chronic pain, multiple sclerosis, Parkinson’s disease, stroke, liver disease, and even psychiatric drugs themselves.

■ Several diseases closely mimic the symptoms of so-called schizophrenia. Dr. A. A. Reid lists 21 conditions, beginning with an increasingly common one, “the temporary psychosis brought on by amphetamine drugs.” Dr. Reid explains that drug-induced psychosis is complete with delusions of persecution and hallucinations and “is often indistinguishable from an acute or paranoid-schizophrenic illness.”³⁸

■ In 1998, the Swedish Social Board cited several cases of disciplinary actions against psychiatrists, including one in which a patient was complaining of headaches, dizziness and staggering when he walked. The patient had complained of these symptoms to psychiatric personnel over a long period of time before a medical check-up revealed that he had a brain tumor.³⁹

Dr. Thomas Dorman, an internist and member of the Royal College of Physicians of the United Kingdom and of Canada advises, “... please remember that the majority of people suffer from organic disease. Clinicians should first of all remember that emotional stress associated with a chronic illness or a painful condition can alter the patient’s temperament. In my practice I have run across countless people with chronic back pain who were labeled neurotic. A typical statement from these poor

patients is, ‘I thought I really was going crazy.’” “Often,” he said, the problem may have been “simply an undiagnosed ligament problem in the back.”⁴⁰

Proper medical examination by non-psychiatric

diagnostic specialists is a vital preliminary step in mapping the road to recovery for any mentally disturbed individual. Therefore, funding should be directed to those mental health facilities that have a full complement of diagnostic equipment and competent medical (non-psychiatric) doctors. In this way, finding the underlying physical condition could eliminate more than 40% of psychiatric admissions.

The very least our senior citizens deserve is to be able to enjoy their golden years, safe in the knowledge that they won’t be taken from their homes, incarcerated in what amounts to prison conditions, drugged until they are senseless and, with electrodes strapped to their heads, brutally shocked. To render them inactive and mindless through powerful mind-altering drugs and ECT, both with horrendous and life-threatening side effects, is an unforgivable assault on our elderly.

Medical studies have shown time and again that for many patients, what appear to be mental problems are actually caused by an undiagnosed physical illness or condition.



RECOMMENDATIONS

Recommendations

- 1** If an elderly person in your environment is displaying symptoms of mental trauma or unusual behavior, ensure that he or she gets competent medical care from a non-psychiatric doctor. Insist upon a thorough physical examination to determine whether an underlying, undiagnosed physical problem is causing the condition.
- 2** Insist that any nursing home where an elderly person is to be admitted has a policy of respecting the resident's wishes not to undergo any form of psychiatric treatment, including psychoactive drugs. Sign a "Psychiatric Living Will" (available on CCHR's website) to prepare for this and give a copy to the nursing home staff.
- 3** Protect the elderly. There needs to be an increase in humane, rational and drug-free alternatives to psychiatry for the elderly; research into Alzheimer's disease and dementia should be limited to neurologists and medical doctors and taken out of the hands of psychiatry. ECT must be prohibited on the elderly.
- 4** File a complaint with the police about any mental health practitioner found to be using coercion, threats or malice to get people to "accept" psychiatric treatment or who hospitalizes an elderly patient against his or her will. Send a copy of the complaint to CCHR.
- 5** If you or a relative or friend have been falsely imprisoned in a psychiatric facility, assaulted, abused or damaged by a mental health practitioner, seek attorney advice about filing a civil suit against any offending psychiatrist and his or her hospital, associations and teaching institutions.
- 6** No person should ever be forced to undergo electric shock treatment, psychosurgery, coercive psychiatric treatment or the enforced administration of mind-altering drugs. Governments should outlaw such abuses.
- 7** Legal protections should be put in place to ensure that psychiatrists and psychologists are prohibited from violating the right of every person to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and in other relevant instruments.



Citizens Commission on Human Rights International

The Citizens Commission on Human Rights (CCHR) was established in 1969 by the Church of Scientology to investigate and expose psychiatric violations of human rights, and to clean up the field of mental healing. Today, it has more than 130 chapters in over 31 countries. Its board of advisors, called Commissioners, includes doctors, lawyers, educators, artists, business professionals, and civil and human rights representatives.

While it doesn't provide medical or legal advice, it works closely with and supports medical doctors and medical practice. A key CCHR focus is psychiatry's fraudulent use of subjective "diagnoses" that lack any scientific or medical merit, but which are used to reap financial benefits in the billions, mostly from the taxpayers or insurance carriers. Based on these false diagnoses, psychiatrists justify and prescribe life-damaging treatments, including mind-altering drugs, which mask a person's underlying difficulties and prevent his or her recovery.

CCHR's work aligns with the UN Universal Declaration of Human Rights, in particular the following precepts, which psychiatrists violate on a daily basis:

Article 3: Everyone has the right to life, liberty and security of person.

Article 5: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 7: All are equal before the law and are entitled without any discrimination to equal protection of the law.

Through psychiatrists' false diagnoses, stigmatizing labels, easy-seizure commitment laws, brutal, depersonalizing "treatments," thousands of individuals are harmed and denied their inherent human rights.

CCHR has inspired and caused many hundreds of reforms by testifying before legislative hearings and conducting public hearings into psychiatric abuse, as well as working with media, law enforcement and public officials the world over.



MISSION STATEMENT

THE CITIZENS COMMISSION ON HUMAN RIGHTS

investigates and exposes psychiatric violations of human rights. It works shoulder-to-shoulder with like-minded groups and individuals who share a common purpose to clean up the field of mental health. We shall continue to do so until psychiatry's abusive and coercive practices cease and human rights and dignity are returned to all.

Esperanza Santillan Castillo
Federal Legislator, Mexico

"It is important that CCHR becomes well known, primarily because the subject that they work on is very important—the mental *health* of human beings. If we have good mental health, we will have a surviving society and we'll have a higher quality of life."

Dr. Julian Whitaker M.D.
Director, Whitaker Wellness Institute,
California, Author of "Health & Healing"

"CCHR is the only nonprofit organization that is focused on the abuses of psychiatrists and the psychiatric profession. The reason it is so important, is that people do not realize how

unscientific the psychiatric profession is. Nor does anyone realize how dangerous this labeling and drugging of people has become. So the efforts of CCHR and the successes they have made is a cultural benefit of great magnitude."

Kelly O'Meara
Investigative Journalist, USA

"I can't imagine not having CCHR out there. I don't know of another organization that tries to bring awareness to this issue of psychiatric abuse in a very compassionate way. They care that people are being hurt. That's one of the things that drew me to CCHR. They're very compassionate people, it's so rare."

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CCHR's Commissioners act in an official capacity to assist CCHR in its work to reform the field of mental health and to secure rights for the mentally ill.

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Citizens Commission on Human Rights

RAISING PUBLIC AWARENESS

Education is a vital part of any initiative to reverse social decline. CCHR takes this responsibility very seriously. Through the broad dissemination of CCHR's Internet site, books, newsletters and other publications, more and more patients, families, professionals, lawmakers and countless others are

THE REAL CRISIS—*In Mental Health Today*
Report and recommendations on the lack of science and results within the mental health industry

MASSIVE FRAUD—*Psychiatry's Corrupt Industry*
Report and recommendations on a criminal mental health monopoly

PSYCHIATRIC HOAX—*The Subversion of Medicine*
Report and recommendations on psychiatry's destructive impact on healthcare

PSEUDOSCIENCE—*Psychiatry's False Diagnoses*
Report and recommendations on the unscientific fraud perpetrated by psychiatry

SCHIZOPHRENIA—*Psychiatry's For Profit 'Disease'*
Report and recommendations on psychiatric lies and false diagnosis

THE BRUTAL REALITY—*Harmful Psychiatric 'Treatments'*
Report and recommendations on the destructive practices of electroshock and psychosurgery

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Report and recommendations on widespread sex crimes against patients within the mental health system

DEADLY RESTRAINTS—*Psychiatry's 'Therapeutic' Assault*
Report and recommendations on the violent and dangerous use of restraints in mental health facilities

PSYCHIATRY—*Hooking Your World on Drugs*
Report and recommendations on psychiatry creating today's drug crisis

REHAB FRAUD—*Psychiatry's Drug Scam*
Report and recommendations on methadone and other disastrous psychiatric drug 'rehabilitation' programs

becoming educated on the truth about psychiatry, and that something effective can and should be done about it.

CCHR's publications—available in 15 languages—show the harmful impact of psychiatry on racism, education, women, justice, drug rehabilitation, morals, the elderly, religion, and many other areas. A list of these include:

CHILD DRUGGING—*Psychiatry Destroying Lives*
Report and recommendations on fraudulent psychiatric diagnosis and the enforced drugging of youth

HARMING YOUTH—*Psychiatry Destroys Young Minds*
Report and recommendations on harmful mental health assessments, evaluations and programs within our schools

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Report and recommendations on the failure of community mental health and other coercive psychiatric programs

HARMING ARTISTS—*Psychiatry Ruins Creativity*
Report and recommendations on psychiatry assaulting the arts

UNHOLY ASSAULT—*Psychiatry versus Religion*
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Report and recommendations on the role of psychiatry in international terrorism

CREATING RACISM—*Psychiatry's Betrayal*
Report and recommendations on psychiatry causing racial conflict and genocide

CITIZENS COMMISSION ON HUMAN RIGHTS
The International Mental Health Watchdog

WARNING: No one should stop taking any psychiatric drug without the advice and assistance of a competent, non-psychiatric, medical doctor.



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*“To psychiatrists old age
is a ‘mental disorder,’ a for-profit
‘disease’ for which they have no cure,
but for which they will happily
supply endless prescriptions of
psychoactive drugs or damaging
electroshock treatment.”*

*— Jan Eastgate, President,
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