Institute for Family Advocacy and Leadership Development

PO Box 502
Epping NSW 1710

305/16-18 Cambridge Street
Epping NSW 2121

Phone (02) 9869 0866
Facsimile: (02) 9869 0722
Email: familyadvocacy@family-advocacy.com

File number: 11359

Author:	Wolf Wolfensberger
Title:	Reply To Levitas, McCandleless, Elenewski and Sobel
Original Source:	SRV Journal Vol. 5 pages 39-41
Publication date:	2004
Publisher information:	Social Role Valorization Implementation Project

Abstract:
In an article in the February 1994 issue of *Mental Retardation*, Wolfensberger briefly remarked on the neurotoxic, and health-and life-destroying, effects of prescription psychoactive drugs. In the October 1994 issue, Levitas et al. strongly questioned that assertion, at least as long as the drugs are not used "indiscriminately," and questioned the publication of such controversial statements without documentation. In this article, Wolfensberger provides extensive elaboration, analysis, and documentation of his original assertion.

Keywords: drug therapies, social role valorization, intervention, health

Reply To Levitas, McCandleless, Elenewski and Sobel

Wolf Wolfensberger

Abstract

In an article in the February 1994 issue of *Mental Retardation*, Wolfensberger briefly remarked on the neurotoxic, and health-and life-destroying, effects of prescription psychoactive drugs. In the October 1994 issue, Levitas et al. strongly questioned that assertion, at least as long as the drugs are not used "indiscriminately," and questioned the publication of such controversial statements without documentation. In this article, Wolfensberger provides extensive elaboration, analysis, and documentation of his original assertion.

Introduction

Levitas, McCandleless, Elenewski and Sobel (1994) seem to have missed one overarching point. The article they critiqued (Wolfensberger, 1994) was in the nature of an opinion piece, albeit a major statement of a broad and high-level view by a person of some standing who has been in human services since 1955, and in the field of mental retardation since 1957. As that article made clear, it was the written and edited version of a plenary presentation at the 1992 New Orleans Convention of the American Association on Mental Retardation. Thus, it was also quite clear what the article was not: A detailed review of the literature on any of the sweeping or even outraging statements I made, including the ones on the drug issue that exercised Levitas et al. If all of the many assertions in that article had to be buttressed by a detailed review of the literature, a big book—or even series of books—would have been necessary. Furthermore, a critique such as that by Levitas et al. would delegitimize the publication of any high-level, summary, personal but informed interpretation of a field and a time. Other readers seem to have understood this, or else there might have been a flood of complaints about my many other "unsupported" statements.

As we shall see, the response by Levitas et al. relates intimately to my remarks on the nature of modernism, the bankruptcy of the formal human service system, and the perilous situation of retarded people.

Let it also be clearly noted that there are two distinct issues at stake. One is whether there is large-scale, seriously health-detrimental prescription mind drugging taking place. We can call this an issue of truth. The second issue

is the lack of evidentiary documentation in my February 1994 article, and possibly the extent and nature of such documentation that would be credible.

In order to answer Levitas et al.'s question of what drugs I am speaking about, I will use the term "psychiatric drugs" to refer to any drugs that are medically prescribed with the stated intent of altering feeling state, mental functioning or conduct for the better. Among prescribed drugs nowadays, this would subsume those to help people sleep, mood-control drugs, so-called tranquilizers, sedatives, so-called antidepressants or antipsychotics, drugs given against manias, anticonvulsants, alleged learning or intelligence enhancers, alleged enhancers of mentality of senile people, mental energizers or activators, stimulants, drugs given to control activity level or self-control, plus any drugs given in order to combat the adverse effects (often falsely labelled "side effects") of any of the above. On the borderline of psychiatric drugs (but not a significant focus of this article) are drugs prescribed to wean people from addiction or to suppress appetite, and any drugs in the above categories that are available over-the-counter but nonetheless prescribed for any of the above purposes.

Issues of epistemology

In regard to the issue of the toxicity of psychiatric drugs, and their role in deathmaking of service clients, a much higher level issue than what are the "research findings" is the larger question of what constitutes relevant evidence, because on the drug issue—as with a number of other issues related to human service these days—questions of epistemology play a decisive role, as I brought out in an earlier article in this journal (Wolfensberger, 1989). That this issue of what constitutes relevant evidence plays a large role in the Levitas et al. critique will be further brought out later.

When one raises a voice in regard to any currently controversial issue, or confronts people with unpleasant truths, one will commonly be asked—or even confrontationally challenged—what the "evidence" or "proof" is, and to produce it if it exists. In my own experience, I have even been challenged to present evidence of contemporary deathmaking of devalued people by someone whose very livelihood was derived by working in a service addressing abuse of the elderly. This revealed that even someone whose job would not exist were it not for the fact that elderly people are being subjected in large numbers to deathmaking can still fail to perceive the realities daily in front of them as constituting relevant evidence.

Such challenges raise the question of what the sources of knowledge are. In order to address this question, we need to reflect on truth, and how it is perceived and attained in general. Unfortunately, this is a massive topic, so here I will present only a few salient points.

1. Epistemology is the branch of philosophy that deals with how humans come to know anything (assuming they can know anything at all) and what knowledge is. The epistemology of science deals specifically with how scientific knowledge is acquired, which is a subset of knowledge more generally. After thousands of years of controversy, there is now a near-consensus among epistemologists that everything we consider knowledge involves neural processes which themselves involve the conversion of sensory inputs into chemical and electrical signals passed along from neuron to neuron. This means that we cannot know with certainty that whatever goes on in our nervous system has any correspondence to objective reality outside of us—one just acts as if it did, and

presumably, everybody else acts the same way. It is in this sense that all "knowledge," even of the scientific variety, can be said to reduce ultimately to assumptions, belief, faith, and therefore, "religion."

2. Epistemologists and philosophers of science have also established that nothing can ever be considered definitively proven in science, but that it may be possible (opinions disagree a bit here) to at least falsify false propositions by scientific methods. This is done by testing the co-called "null hypothesis," which can be simply stated as "two sets of data do not differ." One of several null hypotheses that might be relevant to the drug issue before us would be something like, "prescription psychiatric drugging is not harmful to the people taking the drugs," and then one would have to see if evidence can be marshalled to disprove this statement.

3. It is also well-known that whenever people's strongly-held or important beliefs are challenged, their definitions of what even constitutes relevant evidence are apt to become so flexible as to accommodate or refute any amount of any kind of evidence. This is particularly true where grave moral issues are at stake. In other words, even beliefs that are in the empirical realm—such as it is—begin to be treated as if they were religious tenets. Because knowledge is merely one special way of labelling what is ultimately a matter of faith, all evidence can be discredited if one has a mind to do so.

4. Truth and evidence are not to be equated with each other. Many truths can be apprehended (assuming any of them can be) through a process of intelligent observation that does not meet the criteria of what many people—especially in the social and psychological fields—understand or mean by the terms "research" and "research data." Conventional research, data, or "evidence" can help to get at the truth—but they can also obscure truth, which has often been the case where highly ideological issues pertaining to human nature and human services have been at stake. Consider only the "research studies" done by the social Darwinists and eugenicists. Thus, mountains of "evidence" on an issue may all support the opposite of the truth, and if one accepts such an available data base, one may actually become alienated from the truth. On the other hand, there are occasions when one can arrive at truth that is contrary to an available data base. All this means that it is possible for at least some people to know the truth on some issues without anything that would be considered admissible evidence in scientific research or in court.

5. Relatedly, in some fields—and especially the psycho-social ones—very distorted views prevail about the nature of "research." The "research" considered admissible by many people is actually only a modest component of a much broader empirical approach to truth. A good example of the latter is astronomy, where rigorous empirical processes are used, but little is done that is analogous to what vast sectors of the psycho-social sciences consider "research."

6. A big problem is that to most people, evidence means "hard data" and publicly available statistics (which is what they call "facts"). On many issues, such evidence of any consequence will be intrinsically hard to come by, especially if the issues have major moral dimensions and are actuel at the moment. The greater the moral issues at stake, and the greater the evils being committed, the harder it will be to get so-called "hard evidence" about what is going on. How far this can go may surprise some people. For instance, even though abortion is the most massive form of

deathmaking in both the US and Canada that is both direct and legal, both the American and the Canadian governments ceased collecting abortion statistics years ago. In fact, abortion is the only medical procedure on which no government statistics are collected. There are more statistics on treatment of hangnails—but please do not ask me to prove it! Similarly, some German institutions for the handicapped destroyed incriminating evidence about the "euthanasia" program practiced there under the Nazi regime, and to this day, there is debate as to whether as few as 70,000 or as many as 300,000 or more impaired people were killed. Entire populations can disappear without there being any hard evidence that they were exterminated, that there was a genocide, or that the peoples themselves ever even existed! The experience of the Armenians and the Gypsies comes close to this.

7. In addition, much has also been taught—even for millennia—about there being a moral dimension to human access to truth, especially in that certain negative moral states can become profound obstacles to one's apprehension of truth.

8. All of this should make clear that we must thus rid ourselves of any illusions that the transaction of grave evils can be verified by what most people would call "hard evidence"—especially not while the evil is still taking place, and sometimes not even afterwards.

9. Therefore, instead of talking and thinking about "getting the 'evidence' or "'facts'," one must think and speak in terms of ascertaining, apprehending, or discerning the truth. In order to do this, one must be open not only to "research evidence," but to experience and empiricism broadly. Many people also believe that there are intuitive or even spiritual avenues of insights into truth as well. At any rate, people who are able and willing to open their eyes to what is going on around them will perceive much truth even in the absence of "research evidence," or even where the "research evidence" is faulty. However, persons with a deep passion in their hearts for truth and justice (not merely for evidence), and who are willing to accept whatever truth is, are always few. The majority of people fail to be seekers of important truth because that always puts one at odds with powerful parties—usually the majority—and their social structures, and results in serious negative consequences to oneself.

   A logical corollary is that while grave evils are in progress, they will have to be identified by truth-seeking processes other than, or in addition to, the "scientific method." Thus, those who seek to know the truth need to abandon naive concepts of epistemology and of how to gain knowledge of the facts.

10. Moral action is often necessary even in the absence of "data" or "research," or in the presence of "data" and "research" that contradict the truth on which action is needed. To demand that moral action be postponed until there is conclusive or even "scientific" proof can be outright diabolical. No proof of that rigor (or of any conventional type) that the Holocaust was taking place in Europe was available to most people until after World War II, yet there existed people who were prepared to know the truth and act on it. Similarly, there was no "proof" in the public domain during the American Indochina War that certain massive and indiscriminate bombings were taking place. Indeed, those who acted on that knowledge by decrying such bombings were confronted by government denials (i.e., by what many people considered to be very powerful "disproof"). Moral action may be needed the most precisely on those

occasions where others are in the greatest confusion, and when truth is severely contested, denied, concealed, disguised, etc.

Isssues of truth about psychiatric drugs

I will now address psychiatric drugs specifically.

Body systems and mental functions vulnerable to psychiatric drugs

First, I want to expand on my statement (Wolfensberger, 1994) that psychiatric drugs are "destructive to every single bodily and mental system: neural, muscular, and circulatory systems; bones; teeth; ingestive/digestive/excretory systems; metabolism; eyes; skin; and immune, respiratory, and reproductive systems." I could have added, if space had permitted, that physical symptoms can include (but are not limited to) dry mouth, swollen lips, gums, and tongue; reduced control over throat muscles; stiff, painful muscles; tremors, twitches and other involuntary movements; pathologically high or low activity level; rigidity; frozen facies; skin rashes; skin sensitivity to light; fever; sweating; shivering; blurred vision; lenticular deposits; blood clots; bone marrow poisoning; bone fracture; fluid build-up; dehydration; urinary incontinence; dramatic weight gain; constipation; intestinal paralysis; decline in potency on the one hand, and priapism on the other; reduced resistance to infection; pulse irregularity; breathing irregularity; and teratogenesis. Mental and psychomotor symptoms can include, among others, reductions in alertness, wakefulness (even loss of consciousness), concentration, orientation, drive, libido, appetite, coordination, balance, and intelligence; and increases in anxiety, irritability, aggressiveness, insomnia, fatigue, tiredness, sleep, nightmares, confusion, dizziness, craving for sweets, drooling and appetite. Between them, psychiatric drugs affect all bodily systems, and have produced almost all imaginable aberrations of sensation, mentation, and psychomotor functioning. Many symptoms are classical signs of central nervous system dysfunction or damage, such as extrapyramidal effects. Many such drugs are also dependency-forming, and cannot be abruptly withdrawn without great trauma. What other drugs are there that produce as wide and as unpredictable a range of symptoms?

Despite all that I said about epistemology that affects the issue, there actually—believe it or not—still (or also) does exist plenty of hard evidence that psychiatric drugs have had a long history of devastating destructiveness on people's minds and bodies, such as in the above litany.

One such piece of evidence is that at least as early as 1958, Wardell, Rubin, and Ross (1958) warned that even at low dosage, tranquilizers could have "potentially fatal" effects.

Another basic piece of evidence long available is the very listing of adverse effects that—despite all the accompanying deceptiveness—the drug manufacturers themselves publish periodically. Anyone can look up this evidence (e.g., in the Physicians' Desk Reference issued annually by the Medical Economics Company), or its equivalent in other countries. However, this evidence must be considered only a minimal beginning, since things are always much worse than the manufacturers admit, as has become apparent through the decades since the 1950s. For instance, consider the drug chlorpromazine that is represented by the name Thorazine. It has been a mainstay of psychiatrists and others since the 1950s, especially in cases of psychosis. Yet as early as 1973, a manufacturer's ad (e.g., in the April 1973

American Journal of Psychiatry) listed 56 lines of adverse effects versus only 10 lines of promised benefits. Yet the adverse effects occur with much greater likelihood than the benefits. Since 1952, the ratio of promised benefits to adverse effects has become ever smaller. For instance, in a manufacturer's flyer on the "antipsychotic" drug Piportil, included inside a June 1994 journal, there were 2 lines on "indications" for prescribing the drug, 21 lines on "contraindications," 13 of "warnings," 83 on "precautions," and 115 on "adverse reactions," about half of the latter on the nervous system! The manufacturer's companion sheet for Modecate, a drug for "the management of the manifestations of schizophrenia," displayed a similar pattern.

Much more truthful—and even more devastating—evidence on prescription mind drugs than even that acknowledged in the pro-drug professional literature is found in publications and guidelines published by public advocacy and/or consumer groups. Examples are Edelson (1987), Griffith (1992), Long (1991), Medawar (1992), Stern (1991), and US Pharmacopeial Convention (1991), and those published by the Public Citizen Health Research Group (e.g., Wolfe, Fugate, Hulstrand, & Kamimoto, 1988; Wolfe & Hope, 1993). This group also publishes a periodical, *Health Letter*, that occasionally carries exposé-type (but informed, evidence-based and non-sensational) articles on these drugs.

Another major source of evidence is publications by victims of psychiatric drugs and psychiatry. One of the most informative such sources has been Dr. Caligari's Psychiatric Drugs by the Network Against Psychiatric Assault (1984; unfortunately now out of print). And what is one to make of the endless stream of horror stories told by past and present clients of psychiatry, most of which since the 1950s have included horror elements about drugging—often against their will and/or without their knowledge? A small sample of such first-hand heartbreaking stories includes Donaldson (1976), Gordon (1979), Gotkin and Gotkin (1992), and Millett (1990). A small sample of second-hand such stories (e.g., as told via interviews) includes Neary (1975), Sheehan (1982), Susko (1991, based on 35 interviews) and Weitz and Burstow (1988). Are these and many other such accounts all to be written off as the ravings of lunatics who failed to understand what was good for them and displaced their anger or craziness on their benefactors, or as constituting only a tiny minority of people who happened to be subjected to poorly competent treatment?

Yet further devastating evidence not only on the destructive effects of prescription mind drugs, but also the evil economics that motivate them, the evil politics that accompany them, and the deception that attends them, is found in certain major works that are almost of the genre of well-informed investigative journalism. Examples are Hughes and Brewin (1979), Schrag (1978), and Silverman (1976). Also along these lines, while mainline medicine and shrinkery does not admit how badly psychiatric drugs debilitate people, we learn from the generic press that the secret police in the former East Germany forced such drugs on some of its prisoners with the express purpose of "disintegrating" their personalities (Jackson, 1992). What does shrinkery in service to dictatorship know that shrinkery elsewhere refuses to know?

There are also works by dissident psychiatrists that contain a wealth of evidence not readily available from establishment or imperial psychiatry. Among these are the works of Breggin (e.g., 1983, 1991), not to mention the long history of dissident documentation in the works of Thomas Szasz. Breggin says that "most of the commonly used psychiatric drugs can eventually produce persistent and even permanent mental dysfunction. The so-called antipsychotic drugs . . . cause permanent neurological damage in most patients given

long-term treatment" (Gospodaruk, 1994). I consider this a conservative statement of the truth.

Another class of such evidence is in the vignette category (i.e., documentations of instances of one or a few cases but where many such vignettes come from many, and diverse, sources). Some of us are surprised that some such evidence actually became publicly available.

I have in my files uncounted such vignettes of deaths or serious health impairments in which psychiatric drugs played a significant or even decisive role. These vignettes are from newspapers, in-house agency periodicals, newsletters of advocacy organizations, and official investigations. The many state developmental disabilities and mental health protection and advocacy offices alone publish a steady stream of such documented vignettes. However, many of these data are not consolidated by any one party into a systematic reporting and accounting. But we can be certain of three things.

(a) These vignettes fall into my hands almost accidentally, and therefore, can only be a small sampling of what is going on.

(b) There is every reason to believe that not all drug-related deaths ever end up being reported as such, or reported in ways that make them visible to even casual collecting. Therefore, my vignette mountain is probably only the iceberg tip.

(c) Those who do not want to know that psychiatric drugs are deadly are extremely unlikely to collect—either casually or systematically—evidence that they are. The pro-drug people are not exactly quick and eager about bringing together the isolated reports of drug-related injuries and deaths into population statistics—though this would be a laudable instance of "research" and "evidence collection." As we shall see later, authorities with vested interests will often go to ludicrous degrees to deny the incriminating elements of such vignettes, and practice other forms of deception.

Apparently from all of the above source categories, one could also cite equivalent publications in languages other than English.

For those who consider much of the above evidence not "hard" enough, there are some very hard data on hospital emergency admissions related to mind drugs.

In only one 12-month period from mid-1976 to 1977, 54,000 people in the US alone sought emergency room treatment related to the use of just one psychiatric drug, Valium. This was more than for any other drug; heroin was only in fourth place. This does not even include emergency admissions for other psychiatric drugs during that same time, such as 9,300 in the US for Librium, and 6,100 for Thorazine. Of the Valium-related admissions, at least 900 ended in death (Price-Root, 1979). Since Valium is one of the less toxic drugs, but also one of the more widely prescribed ones, how much worse must be the impact of the "heavier" drugs, and how many more the deaths due to effects other than acute toxicity such as usually involved in the above cases with Valium.

Based on statistics gathered in 24 US cities between May 1976 and April 1977, the US National Institute of Drug Abuse estimated that there were 5,800 drug-related deaths in hospital emergency rooms from 16 of the more widely used psychiatric drugs (Chowka, 1979). This figure did not include drug-related deaths that did not occur in emergency rooms, nor such deaths that resulted from intentional overdoses, nor deaths that resulted from the less widely used drugs, nor abbreviations of life due to indirect, long-term, non-acute impacts on health. During the same period, there were only 1,700 emergency room deaths due to heroin and morphine!

The above statistics acquire special plausibility when viewed against the backdrop of the larger drug scene generally. There are estimates that as many as 17% of all hospital admissions are in response to adverse effects from all drugs combined (Buie, 1989).

Levitas et al. appear to want to rescue what they call "antimanics" from the bad reputation of the anti-psychotic drugs, but since they denied the awful effects of the latter, what is the point of this separation? However, to the degree that lithium is considered an "antimanic," a litany of its adverse effects is found (among others) in *Network Against Psychiatric Assault* (1984). Levitas et al. should take a good look at people who have been on this drug for a dozen years or more.

Thus, considering the litany of adverse effects and the pervasiveness of the impact of psychiatric drugs, plus considerations yet to be covered below, at least some of us conclude

(a) that they are toxins,

(b) that many of the toxic effects act on the nervous system, and

(c) that adverse effects on the mind include what have been falsely interpreted as therapeutic effects, such as when undesired affect is flattened and/or energy and activity is decreased.

Because of these facts, I have cautioned people for years never to refer to psychiatric drugs as "medication," but as "dope" (e.g., as in "prescribed shrink dope" and similar terms).

However, none of this is to deny that with the vastly exaggerated hopes that have been placed on mind drugs generally, there is bound to be a huge placebo effect—and as much on the people taking the drugs as on those giving them, or otherwise putting their hopes in them. These expectations are apt to elicit behaviors from people around the people on drugs that in turn elicit positive behaviors from the people on the drugs.

Further considerations on some of the mechanisms by which psychiatric drugs inflict damage or function in a deathmaking fashion

To understand how psychiatric drugs injure or kill, one must note three facts.

(a) People do not only get injured or made dead by the toxic effects of these drugs, but also by their other deleterious effects, including the non-neural effects set in motion by the neural ones. For instance, when elderly persons lose equilibrium because of the neurotoxic effect of such drugs, fall, break bones, and die from distantly-derived complications, it was not the neurotoxins that were the listable cause of death, but it was nonetheless the fault—so to speak—of the drugs and their neurotoxic effects, and of course probably also of the people who prescribed these drugs to such persons. Yet when elderly people die as a result of complications subsequent to bone fractures subsequent to being on psychiatric mind drugs, the death certificate is not even apt to mention the bone fracture, much less the role of the mind drug.

(b) Injury or death can be caused indirectly and over a period of time during which the role of the psychiatric drug becomes difficult to perceive—and easier to deny.

(c) Injuries and death related to psychiatric drugs can occur years after the person has been off such drugs.

It is not clear whether Levitas et al. have attempted to distinguish between direct and indirect damage of mind drugs, but if they did, the distinction is at best a distraction from the fact that damage occurs. Also, many

drugs—prescribed or otherwise—impact indirectly, be it therapeutically, destructively, or both.

One deathmaking mechanism is that in elderly people, psychiatric drugs debilitate both the body and mind, often permanently and eventually lethally. Even the drug industry admits that one-sixth of all hospital admissions in the US of people over age 70 are for the treatment of negative drug (both psychiatric and nonpsychiatric) reactions (Masterson & Cook, 1988). The US National Institute on Aging found that close to half the 200,000 Americans over age 65 who have hip fractures each year were on prescription psychiatric drugs, and that these were a major contributor to the hip fractures because of the mental debility that the drugs had induced (Staff, 1990d). Earlier reports (Staff, 1987) had noted the same thing. Receiving one of the more long-lasting tranquilizers increased the risk of hip fracture by 70%!

A whole series of studies (summarized by Sobsey, 1983) have found that handicapped children have all sorts of vitamin and mineral deficiencies in their diets, and that some of these deficiencies are due to the drugs these children are given. For instance, many anticonvulsants create an increased but unmet need for certain vitamins and minerals. Conversely, because psychiatric drugs often reduce bodily activity, they reduce caloric requirements, but they apparently also reduce the body's absorption of certain vitamins.

Another of many deathmaking mechanisms is the administration of psychiatric drugs in combination with all sorts of conditions of abusive or low-quality services that are far from atypical, and sometimes even normative. A few illustrative examples follow.

A 27-year old man at a psychiatric institution who was on 1,200 milligrams of Thorazine daily (an extremely high dose) one day became upset and began to take frequent drinks of water, which he continued to do during the next several days. He became comatose and died. He was found to have had acute water intoxication, either precipitated by, or interacting with, his high Thorazine levels.

A 34-year old "schizophrenic" woman had been given the powerful drugs Elavil and Haldol, and was given electroconvulsive shock treatments despite the fact that she had broken her ankle. Within two days, she was dead from an embolus that originated near her broken ankle.

A 40-year old depressed man in a psychiatric institution was found dead after having had a seizure. Even though an autopsy showed that his blood Haldol level was within the lethal range, and that it had presumedly precipitated the seizure, an inquiry concluded that there was "insufficient evidence to state whether his medication had caused or contributed to his death." (Note what I shall say later about cover-ups.)

These three cases all occurred close enough in time to be reported in the same issue of the newsletter of the New York State Quality of Care Commission (Staff, 1984b) which is supposed to monitor abuses in state-funded or operated mental facilities. This is just one single publication in which one finds an endless litany of such single or small-cluster cases, almost all of which tend to be treated as accidental preventable mishaps rather than as the fruit of systematic patterns and policies of social devaluation and professional politics.

Another deathmaking mechanism is to put people (often already enfeebled by years of patienthood and bad health) on high doses of psychiatric drugs—usually also multiple such drugs—and then to simultaneously restrain and isolate them, often in overheated areas (e.g., unventilated "side rooms"). Then we get death (possibly from heart failure) from one or more of the combination of stress, toxic drug effects, and body overheating, especially where the

drugs inhibit perspiration. My archives contain case after case of such vignettes, including many where simultaneous drugging and restraining followed altercations with staff.

Often, a death that was precipitated by drugs, or to which the drugs at least contributed, is listed as pneumonia or heart attack. But that the person has been on mind-destroying drugs for years, and therefore had lowered mental competency, had a weakened respiratory or circulatory system, and was given a dose of drugs and then locked in a hot "side room" with no air circulation so that the person finally had a heart attack—that may be the real scenario.

One well-known mechanism through which some of the psychiatric drugs kill is that they impair—sometimes permanently—sensation and muscle control in the throat; this may include suppression of the gag reflex (e.g., in order of date, Miller & Chinoy, 1967; Spitz & Fischer, 1973; Lapon, 1985). In consequence, people do not feel and report pain there, or are at vastly heightened risk of choking to death. (The reason drugs such as Thorazine are given against severe hiccups is probably because they interfere with normal nerve function in the throat.) Miller and Chinoy (1967) state that death from asphyxiation is ten times higher in institutionalized people who are on tranquilizers. Choking deaths, especially of elderly residents, as a result of drug action were also reported from a number of Texas institutions (Staff, 1981). This risk is further heightened by the fact that many of the lowly people who get put on these drugs do not get good and timely dental care, and may therefore swallow food that had been insufficiently chewed. What scientific publication may I cite for this happening even to specific people known to me or my acquaintances? Would Author (1994) serve? And if a drug paralyzes sensory and motor nerves, especially in the head or throat, one would have to invoke some pretty far-fetched mechanism in order to claim that it is not a neurotoxin.

One reason people on psychiatric drugs often suffer injury or death is that their mentality has been so impaired by these drugs that they cannot or will not report pain or other symptoms (e.g., Wendkos, 1979), advocate on their own behalf, or even fend for themselves. An example of the latter occurred when a fire broke out at an apartment project for the elderly in North Carolina, killing three and injuring 18 residents. The firefighters were hampered by the fact that so many residents were so drowsy from drugs that they could hardly be woken up ("Elderly flee high-rise," 1983).

A particularly diabolical form of deathmaking is the normative (not exceptional) practice of polypharmacy in general, and the related widespread practice of putting people on more than one psychiatric drug at a time—sometimes on three, four or more of them! In many cases, psychiatric drugs are given in order to combat the adverse effects of other psychiatric drugs—a bit like trying to drive the devil out through Beelzebul! Sometimes, anticonvulsants are given against convulsions caused by other psychiatric drugs.

Deception associated with psychiatric drugs

This brings us to one of the overarching statements one can make about psychiatric drugs, namely, from the first, these drugs have been surrounded by deception, falsehood, cover-ups and cheating—and still are.

One such deception is that psychiatric drugs have specific therapeutic effects on the mind and/or conduct. But as the above listing shows, they tend to have effects on all sorts of bodily systems, the brain and the mind being only one, and often not the primary or major one. Even the first tranquilizer, chlorpromazine (Thorazine), came about as a very minor molecular modification of an antihistamine, and was first named Largactil for the very reason

that it had a large number of actions (e.g., Silverman, 1976), including those typically sought from an antihistamine. Some of the tricyclic drugs deployed against depression happen to be effective against malaria (Bitonti et al., 1988). So which is the "main effect" or "therapeutic effect," and which the "side effect"? In this respect, psychiatric drugs function like most drugs, in that few affect only one organ or one function. For example, Rogain started out as a blood pressure drug with the apparent "side effect" of eliciting hair growth; now it is promoted primarily as a hair growth drug with "side effects" on blood pressure.

Another kind of systematic deception about psychiatric drugs—one of the biggest such deceptions—is that they are given for therapeutic purposes, when the real reasons are primarily those of management convenience and economy. An example is the drowsiness and loss of energy that has been a major effect of so many of these drugs. For instance, Baumeister, Todd and Sevin (1993) note that any suppression of disordered or maladaptive behaviors in retarded persons as a result of administering psychoactive drugs to them results from the fact that most such drugs tend to suppress behavior in general. This is what I meant when I stated in my article (Wolfensberger, 1994) that "therapeutic effects" derive from the toxic effects of the drugs.

Here is also a point where my earlier discussion of the issue of evidence becomes very relevant. For instance, I know of no published systematic analysis of the fact that modern hospital medicine has undergone an absurd paradigm shift of withdrawal from low-tech bedside care and environmental hygiene in favor of high-tech strategies (including pumping antibiotics into patients instead of keeping the premises immaculately clean), and that this withdrawal of bedside care has been accompanied by a strategy of reducing patient demand for bedside care by a steady increase in the use of sedatives and tranquilizers. The latter has been going on since at least the 1970s, and much of it clearly falls into the category of management convenience and cost containment. Drugging of hospital patients also serves the purpose of using a high-tech means to compensate for the surrender of the traditional low-tech strategy of giving hospital patients rest—something that has become almost impossible in the modern hospital environment with its constant noise, lights and interruptions. This drugging practice not only constitutes dangerous polypharmacy, and increases the risk of errors in drug dispensing generally, but is particularly devastating to elderly patients. The adverse consequences to them include falls, and—I believe—permanent mind diminishment in many instances.

However, even in all sorts of nonmedical service settings, management convenience is a major motive for drugging. It seems to me that honest people could only disbelieve this if they do not know what is going on in the service field.

Another common pattern of deception with psychiatric drugs is that on the one hand, the alleged benefits of new such drugs are euphorically and exaggeratedly trumpeted (remember the ad, "Whatever the Diagnosis—Librium"?), while the known or expectable adverse effects are denied, played down or kept hidden—often for decades.

One of innumerable related aspects of deceptive promotion is to market a drug with all sorts of claims even though the research done on it was grossly inadequate or deficient. For instance, even though barbiturates had been used against convulsions for a very long time, the effect of these drugs on the mentality of people who took them over long periods had never been established, though there had been strong indications that these drugs impair the intelligence of children who take them on a prolonged basis ("Worse than the disease,"

1990). As McNair noted (1973), diazepam, chlordiazepoxide and meprobamate had been researched for 20 years, but this research had been so poorly conducted as to permit no "meaningful inferences," and McNair applied the term "pseudoscience" to this situation. Hydergine was given for 30 years to elderly people to combat mental deterioration, and by 1989 had become the 11th most prescribed drug in the world, given to millions of helpless elders—until a controlled study was finally conducted, and found that the drug accelerated mental deterioration (Staff, 1990a). Why this should surprise people amazes me, since the drug is related to the ergot toxin that drives people mad.

Another related deception is that drugs are promoted even when there is research that belies the claims, but the research results are denied or covered up. For instance, Halcion has been promoted as a sleeping pill and against jet lag since Upjohn's halcyon days of 1982, and soon became the world's single most prescribed sleeping pill. That it had devastating impacts on people was already known in the late 1980s (e.g., Staff, 1990c), and just recently, it was reported (Cowley, 1994b; also CBS TV's "60 Minutes," 3 July 1994) that Upjohn had lied to the US Federal Drug Administration since at least 1982 about the drug's dangerous effects, had falsified data, and had been systematically discrediting not only adverse publications but also individuals associated with adverse information. (I feel kinship with such individuals!)

Equally recent (e.g., Stein & Baker, 1994) is a similar discovery that Eli Lilly began at least as early as 1988 to cover up the negative effects of Prozac that has recently been promoted as a virtual miracle drug against the mental ills of life. Prozac is being prescribed like lollipops to millions of people—five million in the US alone (Hirsch, 1994a) —and for "everything but hangnails" by physicians of all kinds, usually after spending less than three minutes discussing their patients' problems with them (Cowley, 1994a). Amazingly, despite even those adverse—and not exactly trivial—effects that appear rather soon in at least a third of the people who take Prozac, its explosive use has been promoted and accompanied by the interpretation that it has no adverse effects (e.g., Hirsch, 1994b), or the next best thing to it (e.g., Barondes, 1994; Newman, 1994). Yet 28,000 people have been reported to have had serious adverse experiences in connection with being on Prozac, and 170 were suing in US courts as of late 1993 (Stein & Baker, 1994).

I have mentioned the specific cases of Hydergine, Halcion and Prozac only because of their recency; one could mention zillions of such deceptions worldwide since the 1950s.

Often, the fact that a previously ballyhooed drug has serious adverse effects is only widely acknowledged when a new drug arrives that can then be ballyhooed as a superior alternative with fewer adverse effects. A good current example is the promotion of Depakote against mania, with the message—previously widely denied—that one-third of "patients" "cannot tolerate" lithium, or develop liver dysfunction, weight gain, severe acne, impaired memory and dulled intelligence from it (e.g., Azar, 1994, in an article headlined "New Manic Treatment is Major Breakthrough"!). Some people die from "lithium toxicity" (e.g., "Verdicts and settlements," 1985). If lithium was that awful all along, why did the shrink field play down its adverse effects until now, and interpret lithium as a miracle drug?

Relevant to several of the above patterns of deception is a "review of reviews" (something of a super-meta-analysis) of 56 years of studies of drugging of children with alleged "attention-deficit" (formerly often called by names such as hyperactivity) with "stimulants" (apparently mostly amphetamines) (Swanson et al., 1993). It found 341 reviews of such studies. Aside from finding that the research tended to

be so shoddy as to make interpretation difficult, the authors concluded (among other things) that stimulants do not result in long-term improvement in academic performance or social adjustment, or in the much ballyhooed "paradoxical response" benefit. On the other hand, a large placebo effect was reported, and "side effects" were observed in many children on these stimulants, though it seems to me that the issue of negative effects has been very poorly attended to in this corpus of studies. For instance, when a certain proportion of children begin to display tics, or others with tics show more or bigger tics, surely something bad is happening to the nervous system that must also be at work even in those children who are not reported to show tics, or worse tics.

As I was drafting this reply to Levitas et al., the June 1994 issue of *Mental Retardation* arrived, with an article (Kastner & Walsh, 1994) exposing the fact that an article published in the October 1993 issue of *Mental Retardation* (Lepler, Hodas & Cotter-Mack, 1993) which purported to document a program of reduction in "psychotropic drug use" for retarded people was fallacious, even if only from naiveté rather than intentional deception. Nonetheless, the overall impact of such false studies does result in deception of the receivers of such literature. But ironically, Kastner and Walsh (1994) were themselves not willing to believe that "psychotropic drugs" are unhealthy, despite the mountainous data base to that effect.

A very common pattern of deception is that not only are the long-term or indirect detrimental impacts of psychiatric drugs denied, but even their rather direct and immediate role in causing deaths is widely denied, whitewashed, or covered up, much as is the case with deaths from other untoward causes in human services.

For instance, an inmate at Hutchings Psychiatric Center in Syracuse was given two oral doses of Haldol, plus four intramuscular shots thereof—the last one 90 minutes before she died, which she did 14 hours after admission to the institution. Two state review bodies concluded that the drugs had nothing to do with her death ("Probe clears," 1987).

Between 1970 and 1978, 1737 residents of the Rockland Psychiatric Center in New York State died—an amazingly large number, amounting to 17.5 deaths per month, or more than one every other day. The Rockland County medical examiner and others concluded that prescription mind drugs were implicated in 30% of these deaths—which was vigorously denied by state authorities (Zugibe, 1980; see also Hughes & Brewin, 1979).

The major exception to the rare mention of psychiatric drugs on death certificates occurs when a person has used such drugs to commit suicide. Except for these cases, I would be surprised if psychiatric drugs were listed on more than a very few thousand death certificates a year in the US, but I would not be surprised if it was even only in the hundreds. This reality surely is a deception if these drugs played a role in significantly more deaths, and especially in the ca. 100,000 deaths that I have estimated.

Relevant to the entire institutionalized insanity and bankruptcy of shrinkery that is hidden behind much deception is a very ambitious World Health Organization study (Jablensky et al., 1992). It compared the experiences of "schizophrenia" in a sample of rich and poor countries from around the world. It found that in the rich countries, 91% of the "schizophrenics" spent time in psychiatric facilities over the course of two years, and 60% were put on "antipsychotic" drugs for at least 76% of these two years. The corresponding figures for the poor countries were 44% and 16%. Guess which group had the more positive outcomes? The poorer countries, including recovery rates that were 59% better! Not exactly a good recommendation either for psychiatry or "antipsychotic" drugs, and all the

more remarkable considering that the mainline ideology these days is that "schizophrenia" is one of the genetically more hard-wired disorders. No wonder one has heard so little about these findings in the shrink or public literature, even though they should be making headlines everywhere.

Hardly anything has been learned from all this deception, and especially not by those who had placed exaggerated hopes in these drugs or participated in the deception. After all, the same patterns are still operative.

One of the iron rules in the domain of moral wisdom is that violence—hence also deathmaking—is always attended by deception. And vice versa, the presence of a pattern of deception and falsehood is a strong sign that violence is either in progress, or imminent, or has already been committed in the recent past. However, I know of no scientific body of "research evidence" that has dealt with these important realities.

One implication is that when deception is rampant, it will be very difficult to get at the "facts." Even if one does, one may be deceived about their meaning, not to mention that many people will be so weak, scared or misled that they do not even want to know the truth. And yet, the truth is vastly easier to ascertain than the evidence that is concordant with, and expressive of, it.

Now in light of my earlier comments about what constitutes evidence and empiricism, consider that some people would only count as evidence or "fact" what was reported in a scientific journal (as by Baumeister et al., 1993). They would not equally credit the following statement by an institution worker reported in a newspaper as early as 1975: "You keep them busy or you zonk them out" (Wood, 1975). In other words, staff tend to do whatever it takes to keep clients docile and easy to manage, and if this means doping them with drugs, then so be it. Is evidence along these lines only credible after it has appeared in a scientific journal? Is it only evidence if it is reported in print? Would it not count if one had simply heard such a remark made often enough by different workers?

Further, even if I were to give such citations for every controversial statement I make, would those who take issue with such statements accept my sources? Would not the next step be to controvert the validity of the sources themselves? Thus, as I said, at a certain point it is no longer an issue of evidence, but of whether one is able and willing to perceive the truth.

The question of the number of dead victims

The sections above have already provided data relevant to the numbers issue. An example is the 5800 deaths from psychiatric drugs in one year, in just one of many categories involving only 16 such drugs, only in emergency rooms, and not involving suicide attempts (Chowka, 1979). Below follow additional considerations and documendations.

In estimating the total injury and deathmaking impact of prescribed mind drugs, one must consider

(a) how many people are on them,

(b) who they are,

(c) that some people are on multiple such drugs,

(d) how injurious the drugs are, and

(e) that with some drugs (e.g., Prolixin), even a single dose can be fatal.

Psychiatric drugs are by far the largest sellers of all prescription drugs, and many billions of doses of tranquilizers alone are administered annually just in the US. In some countries, the rates are even worse.

There are estimates that at any given time, ten million Americans are on some psychiatric drug that is given against what one might loosely call "mental troubles," thus not even counting the anticonvulsant drugs. Some people are on drugs for long periods of time, some of them for decades (such as many of the people in nursing homes and mental institutions). Some people who are on such drugs are weak to begin with, such as many of the elderly, and many are children. It is well known that with children, the toxic effects of virtually any drug will show up after a much shorter time than they do with adults, as is also evident in alcohol abuse by children and youths. Despite their vulnerability, millions of children have been put on drugs in the amphetamine family in order to control their unsocialized behaviors or improve their school work (i.e., compensate for poor upbringing or poor schooling) (e.g., Kohn, 1989; Toufexis, 1989), yet some authorities have speculated that even a single amphetamine dose may already be able to inflict a permanent change to the brain (Staff, 1984a). The amphetamines given to children are identical or related to the ones the US Air Force had been giving its fighter pilots, and that are believed to have impaired their mentality so much as to account for an entire series of (at least five) crashes (e.g., "Drugs: They don't belong," 1988). Also, amphetamines are known to have caused deaths among people who have used them as diet aids (e.g., "Body & Soul: Weight loss," 1990).

A huge proportion of the millions of children put on psychiatric drugs for being hyperactive are not even hyperactive at all (e.g., Toufexis, 1989), and hardly any should be on these drugs even if they were.

The percentage of elderly people on mind- or mood-altering drugs has been estimated to be as high as 50% (Masterson & Cook, 1978). Perhaps more plausible is one Michigan study that found 16% on "psychotropic drugs," with 25% being on four or more prescription drugs of all kinds (Seniors & Substance Abuse Task Force, 1978). Among nursing home residents, 65% may be on one psychiatric drug, and 20% on two or more—and almost all inappropriately so even according to the manufacturers' instructions (Buie, 1989). At the same time, elderly people are particularly apt to be greatly debilitated by psychiatric drugs (e.g., Breggin, 1983).

There are diagnoses given to millions of people that will result in near-certainty of psychiatric drugging, "schizophrenia" and "depression" being prime examples. In the case of "schizophrenia," this drugging is apt to be very long-term—perhaps life-long. The case of "depression" is ironic because it has become a craze syndrome apt to be "diagnosed" whenever someone is unhappy or finds life burdensome, which more and more people in today's crazy world do—and yet which has increasingly been interpreted as genetic.

There are entire service sectors that are notorious for extremely high psychiatric drugging rates. Almost everyone in a psychiatric "emergency" service is apt to be on such drugs, plus the majority of clients of psychiatric outpatient clinics. Institutions of all types (including those in mental retardation), as well as prisons, have high psychiatric drugging rates.

In prisons, the overriding reason is management convenience. In the foster care system, tranquilizing of children has been described as "routine" (McTaggart, 1981).

There are also locales where psychiatric drugging has become part of the mainstream human service culture. In some school systems, an amazingly large proportion of children are on such drugs (6% of elementary school children on amphetamines alone in one such system (Kohn, 1989)). During 1975-77, 44% of the non-institutionalized population of the Canadian province of Saskatchewan above age 30 was on prescribed "mood-altering" drugs, and 53% of the non-institutionalized population above age 60 was. Women received drugs up to

four times as often as men, and usually in larger doses (Harding, 1978). By 1980, at least 20% of the German population was taking "psychotropic drugs" on a long-term basis, including 6% of juveniles ("Eltern allzu sorglos," 1983). Currently, a quarter of the French population (presumably adults) is reported to be on Valium (Stanger & Mabry, 1994), and about 9% is dependent on drugs for a night's rest (Shearer, 1989). Is this evidence hard enough?

It is also well known that people get kept on drugs—sometimes for decades—even though they show no positive response (e.g., Kohn, 1989; Langee, 1990; New York State Commission on Quality of Care, 1986). Relatedly, a huge number of institutionalized people in recent decades have been put on, and kept on, drugs to combat those of their behaviors that were natural responses to the awful conditions of these institutions in the first place. A recurring research finding has been that when people move from institutions into more normal settings, their behaviors also become more normal.

In addition to the very selective but sickening evidence of the injuriousness of psychiatric drugs that I cited earlier, it is also relevant to the numbers issue that a third of "schizophrenics" on "medication" are said to display extrapyramidal symptoms (Staff, 1994). Facts like this, the data cited previously on admission to emergency medical services because of psychiatric drug effects, and other phenomena are equivalent to what in clinical research in medicine are called "markers" of yet more serious outcomes—in this case, death.

Similarly, between 1973 and 1976, a total of 1,285 residents of state-run residential facilities died in California alone. At least in part because of deception, the real causes of such deaths are unknowable. However, in light of the fact that drugs were acknowledged to be implicated in at least 120 of them (Staff, 1981), we are justified in assuming that the real number of deaths in which psychiatric drugs played a role must be considerably larger, and that the California situation is not an exception to the national one. (Recall the earlier mention of 1,737 deaths at Rockland Psychiatric Center. Zugibe said that choking deaths were occurring at "therapeutic dose" levels, not just overdoses, and that this was a problem all over the US [cited in Hughes & Brewin, 1979, pp. 175-176].)

My estimate of 100,000 life abbreviations in the US also no longer looks so high when one considers statistics on deaths caused by other drugs. For instance, a mere two deceptively-promoted drugs against arthritis were said in 1983 to have caused more than 10,000 deaths ("Arthritis drugs," 1983).

The plausibility of harm from drugs is also illuminated if one looks at the effects of nonprescription, legal, normative drugs such as caffeine, alcohol and nicotine. For instance, tobacco smoking has stabilized at about 26% of the US population, and the federal Centers for Disease Control and Prevention estimate that cigarette smoke alone significantly abbreviates the lives of over 400,000 people a year in the US (Farley, 1994; 434,000 in 1988 according to "Nevada tops nation," 1994). The probabilities of a 50-year-old smoker dying during the subsequent 17 years is almost triple that of a nonsmoker, according to the American Cancer Society ("In the news," 1994.) Yet smoking tobacco is vastly less toxic than most psychiatric drugs, and it does its harm almost exclusively via steady long-term use, while people can die or suffer irreversible damage in consequence of single or brief episodes of psychiatric drugging.

So my estimate of 100,000 life abbreviations a year in the US amounts to only one out of about every hundred people who received such drugs. But if it were only half that many, would that invalidate my argument—nay, the very facts themselves—that there is much

deadly use of these drugs going on, and that this is widely denied or covered up?

Levitas et al. seem to imply that the only deathmakings that count are the ones that are due to "indiscriminate" psychiatric drugging, which presumably includes incompetent or uncaring drugging. This argument is irrelevant to, or even distracting from, my thesis. Furthermore, there is overwhelming hard evidence that incompetence in the prescription and administration of such drugs is not only normative but outright inevitable. After all, the problems in the psychiatric drug field are in large part only a worse version of what has been going on in the larger context of medical drugs, which are commonly marketed with woefully inadequate or even fraudulent research (e.g., Palca, 1990; Roman, 1988; Staff, 1979; Sun, 1984), deceitfully promoted (e.g., Network Against Psychiatric Assault, 1984; Silverman, 1976), incompetently prescribed, and dispensed in an error-ridden fashion (e.g., Kehrer & Kehrer, 1985). A specific example of nonpsychiatric drugs widely employed without adequate research is the following. In the 1980s, cardiologists were so confident of two heart drugs that they put 200,000 people a year on them, but they resisted controlled studies because they considered it unethical to withhold the drugs from control subjects. When a controlled study was finally conducted, it soon had to be halted because it was found that the drugs tripled the death rate (Nowak, 1994)! In fact, so-called "clinical trials" in medicine generally normatively violate the rules of research, and in most cases in respect to very elementary—rather than sophisticated—criteria (e.g., Nowak, 1994). For instance, just in June 1994, we learned that on a $9 million national breast cancer research project, at least 11 participating institutions either falsified data, failed to enroll patients properly, or misplaced data ("Breast cancer research," 1994).

As to the rates of error or incompetency in the use of all prescription drugs, 33-50% are said to be used incorrectly, and to have caused 2.7 million hospital admissions annually in the US in the early 1980s. In hospitals, drugging errors generally are said to account for "hundreds of thousands of deaths"—but with very little attempt to collect systematic data (Staff, 1985).

Merely from studying the psychiatric drugging scene, one gets headaches, nausea, dizziness and trembling hands, especially as one learns the devastating reality that incompetent prescribing and administration are actually inevitable for at least five reasons. (a) The drug industry makes fabulous profits from drugs being massively prescribed and used (e.g., deMarco, 1982; Greenwald, 1989), and therefore advertises and promotes these drugs ruthlessly and often deceptively so as to maximize their use (e.g., Purvis, 1990; Staff, 1991). This militates strongly against "discriminate," let alone valid, use of drugs. After all, when drugs are promoted with invalid and even outright deceptive information, it is not even possible to employ such drugs competently. (b) Any physician may prescribe any drug with hardly any sanction, and there is therefore bound to be a high percentage of incompetent prescribing, considering how many physicians prescribe these drugs, and how many different kinds of psychiatric drugs there are. (c) The financial investments of so many physicians in drug firms (e.g., Staff, 1990b) also induces conflicts of interests that bias physicians toward prescribing when they should not. (d) Many people clamor for drugs from their physician, including for psychiatric drugs that they think will alleviate their suffering. (e) The way psychiatric drugs function is very poorly understood, what is known is not well taught, and the normative physician—even psychiatrist—functions largely on the basis of biased and incomplete information from the drug manufacturers and salespersons, and is virtually drug-illiterate (e.g., Staff, 1990b),

according to a former US Food and Drug Administration commissioner.

Here are just a few bits of hard evidence of the widespread incompetence in the prescription and administration of mind drugs.

In one survey, 29% of all adult psychiatric inmates in California's four state hospitals were found to be on Thorazine in excess of 800 milligrams a day, where 30 milligrams is considered a low but possibly effective dose (Network Against Psychiatric Assault, 1984). A number of studies have found that retarded people who do not have epilepsy are apt to be put on anticonvulsants anyway (e.g., Alvarez, 1989; Chadsey-Rusch & Sprague, 1989), sometimes on the assumption that those of their behaviors judged inappropriate by staff are linked to epilepsy. This irony is compounded by the fact that people put on anticonvulsants do not even get a dose large enough to be effective if—in fact—they are epileptic. Kaufman and Katz-Garris (1979) found that only one out of every 17 allegedly epileptic residents was receiving a sufficient drug dosage against seizures, but all were getting the negative effects that the drugs bring. And retarded persons without a seizure history are often put on anticonvulsants—and on larger doses of such anticonvulsants than non-retarded persons with seizure records (Kaufman & Katz-Garris, 1979). Triple irony is contained in the fact that Cole, Lopez, Epel, Singh and Cooperman (1985) found a high rate of vitamin deficiencies induced among retarded institution residents by anticonvulsants.

The New York State Commission on Quality of Care (1986) found that in five of the state's mental retardation institutions, psychoactive drugs were often virtually randomly prescribed, without rationales; and once again it was found that seizure medications were given to people who had shown no evidence of seizures.

A 1982 study found that people diagnosed as depressed were much more likely to be given tranquilizers designed for (other) psychoses and not recommended for depression than they were to receive "anti-depressants" (Holden, 1986).

Overall, and not just in regard to psychiatric drugs, errors of prescription, dispensing, and administration shoot up dramatically wherever devalued people are involved. In at least one 1982 study of nursing homes by Barker (cited in Kehrer & Kehrer, 1985) it was 59%. In nursing homes, almost all the psychiatric drugs given may be inappropriate even according to the manufacturers' instructions (e.g., Buie, 1989; see Buie also for the high rate of dispensing errors in nursing homes).

Thus, even if it were true that psychiatric drugs are only harmful when there is staff negligence or incompetence, the vast amount of staff negligence and incompetence, plus the devaluation (since mistakes skyrocket whenever devalued people are the clients) in human services would make one shudder to think what toll this must take on devalued clients.

According to Brown and Funk (1986), the single biggest iatrogenic disorder (i.e., caused by medical efforts) of our day turned out to be tardive dyskinesia. As of the date of that book, 25% of people on neuroleptic drugs had tardive dyskinesia.

One thing one can say overall is that many people who are depressed get put on drugs that give people depressions, many psychotic people get put on drugs that make them crazy, many people who do not have seizures get put on drugs that cause seizures, many stupid children get put on stupid-making drugs, many senile people get put on drugs that cause dementia, and many people with twitches get put on twitches-making drugs. Such evidence raises the question how much of what goes on is incompetence, and how much is evil. Even if only some of it were due to incompetence, it would mean that incompetence is the norm, and

if that is so, then defending the drugs and blaming any harm that may result from them on practitioner incompetence begins to sound alarmingly like the slogan of the pro-gun lobby: "Guns don't kill people, people do." Is the parallel here that "drugs don't kill people, physicians do"?

One could continue the kind of horror story documented here in regard to those drugs that are used for their mind effects that once were prescribed but are now available over the counter, such as some of the amphetamines and Phenergan (Staff, 1989).

Conclusion

As to further specifics on the devastating deathmaking way in which psychiatric drugs have been prescribed, one can only wonder (a) "how much evidence is enough," and (b) on what epistemology Levitas et al. have drawn.

For 30 years, what I call shrinkery denied that there was such a thing as what came to be called tardive dyskinesia (Brown & Funk, 1986). When it could no longer be denied, the extent of its destructiveness was belittled (e.g., Roman, 1988, p. 52). And now Levitas et al. tell us once again, or still, that "even in excess dosages, none" (of the psychoactive drugs) "is directly toxic to nerve cells." Levitas et al. seem to have read—or ideologically embraced—the top-down line of the imperial powers, the privileged professions, the drug industry, imperial medicine, psychiatry, the publicly supported formal service system. They appear oblivious to, or unbelieving of, the bottom-up realities experienced by lowly devalued or oppressed people (e.g., see Wolfensberger (1989) for a discussion of this epistemology clash), to say nothing of hard evidence contrary to the top-down party line. They may not know—or want to know—that people in vast numbers have been put on these drugs primarily because their devalued identities and resultant life realities have been interpreted as clinical mental conditions (e.g., McKnight, 1980, 1985).

If Levitas et al. have never read the extensive earlier literature on the magnitude of the prescription psychiatric drugging of retarded people specifically, then they may consider the very recent statement by Sobsey (1994) that probably a majority of retarded people are receiving "psychoactive" drugs (pp. 136-137). Sobsey has plenty of other bad things to say about these drugs, including evidence that the rate of death due to obstruction of the airways is very high among institutionalized retarded people. For instance, consider this astounding statistic: The rate of death by asphyxiation among retarded people increased by 2,400% between 1955 and 1980, and a large proportion of these deaths was found to be a result of impaired swallowing reflexes due to tranquilizing drugs (Carter & Jancar, 1984, cited in Sobsey, 1994).

Levitas et al. speak of reversible toxic effects of mind drugs, but fail to acknowledge the decades of controversy about the reversibility of all sorts of effects of the material methods used by psychiatry that are obviously detrimental in the short run, including electroconvulsive shock. It is my guess—widely shared, however—that any material impact on the brain that results in acute mental symptoms of some significance probably leaves the brain permanently diminished, even if (a) the acute mental symptoms disappear, and (b) material diminishment to the brain cannot be ascertained by current means. If a single episode of alcohol intoxication destroys many brain cells—as is universally asserted—then why should one expect less from mind drugs that require prescriptions but also have acute negative effects on the nervous system? However, the fact that the long-term detrimental effects suffered from electroconvulsive shock by so

many victims of psychiatry continues to be denied in the mainstream of the mind professions is merely one aspect of the systematic denial by these professions of their destructive and deceptive practices in general, and over centuries.

Considering how psychiatric drugs have been used, it is my informed guess that with the exception of anticonvulsive drugs, perhaps somewhere around 1% of current prescription psychiatric drugging is warranted—but even if it were 10%, or even 50%, the current pattern is a deadly one.

We are now in a better position to return to some of the reasons why the use of prescription mind drugs has been surrounded by deception.

1. These drugs are a major tool of violence by the drug industry and the mental professions, especially against society's devalued people, and like any violence, this is drenched in deception.
2. Without reliance on these drugs, the moral, ideological, and competency bankruptcy of psychiatry would be obvious, since psychiatry has so little else to offer that is either (a) valid, or (b) unique to itself and not also offered by other professions, as in the case of office-based talk strategies (counseling, so-called psychotherapy, etc.)—a practice that is itself "scandalous," as Doerner (1981) put it.

How much the use of mind drugs is part of a turf battle is evident in the unrelenting warfare of psychiatry on behalf of involuntary drugging (i.e., warfare against all efforts to require the voluntary consent of the "patient" or his/her surrogate). Are Levitas et al. aware of this battle? Do they need literature citations on it? Would they believe it if such citations were given? Would they see it as evidence relevant to the topic at issue? Surely, human service people who would go to court to force electroconvulsive shock on an 80-year-old woman because she is unhappy about living in a nursing home (e.g., Gougis, 1994) would not stop at all sorts of drugging atrocities.

Even aside from the turf battle, one has to consider the quality of mental services generally of which psychiatric drugging is only a small part, and report after report on this topic is an indictment of that service system. What the mental people do to children alone is so awful that Armstrong (1993), in yet another exposé of the child shrink service system, selected as the title of his book, *And they call it help*.

It is also relevant to note that the response by Levitas et al. relates intimately to the critique of what I called modernism in my 1994 article, in that they evidence a faith of religious proportion in the second form of materialism that I sketched (Wolfensberger, 1994, p.20) (i.e., the one that sees human mastery over the material domain as the hope for victory over human afflictions and imperfections)—in this case, those of the heart, mind and soul. Evidence that such hopes are an idolatrous faith is often received with denial of the evidence.

Earlier, I mentioned that the issue of truth about drugs is separate from the one of actually citing evidentiary references. This issue is also highly relevant to Levitas et al.'s bringing in questions about Tegretol. They mention that Tegretol is used both as an anticonvulsant and an "antimanic," and they do so in a fashion that most readers would interpret to be depreciatory of my thesis. Yet regardless with what intent Tegretol is prescribed, it comes recommended (even by its manufacturer) with extreme caution because of its "not uncommon" multiple adverse—and potentially deadly—effects. Surely, Levitas et al. know this, and they also know that dead is dead, so what is going on here? What are they trying to do?

In light of the fact that the downtown streets of our cities, the neighborhoods into which "mental patients" get dumped, and the neighborhoods of psychiatric facilities all teem

with people with symptoms of tardive dyskinesia so severe as to be apparent even to casual passers-by, the statement by Levitas et al. that "even in excess of therapeutic dosage, none ("psychoactive drugs") is directly toxic to nerve cells" leaves one incredulous, and at a loss what to say or do. What do "data" or "research evidence" matter after such an assertion?

I admit to having written my reply to Levitas et al. in a state of irritation because it required me to devote precious time to write about the obvious—and in response to people with lots of relevant standing, institutional affiliations, and job titles to do the called-for documentation themselves. For none of the documentation contained in this article did I have to take recourse to a computer or search a library, except in order to complete the correct citation for about a dozen items among all those that I already possessed, and to double-check the data from one source. All the data I cited were already in my office archives and thus constitute a minimal rather than systematic documentation. Yet I am neither a specialist on drugs nor in the medical field, while all four authors of the Levitas et al. critique are at least the latter. I have labored to prove the point—which I think I did—yet it is people like themselves who have the technical background, the resources, and presumably much ongoing clinical involvement who should be doing this. I expect that the next time they question one of my assertions that is in the empirical realm and in a publication that by its very nature is not intended to be documentary in nature, they do the documentation work rather than making what they accused me of, and presumably any similar critique of the prescription mind drug scene, namely, invalid claims and concoction of "unsupported theories."

I also hope that even if Levitas et al. are unconvinced and perhaps even unconvincable, at least many other readers will have learned that we are, in fact, dealing with an epistemological issue that is obscured precisely because it involves both sensitive turf issues, and one of the gravest of all moral issues: Deathmaking, and especially deathmaking of devalued people.

References

Alvarez, N. (1989). Discontinuance of antiepileptic medications in patients with developmental disability and diagnosis of epilepsy. *American Journal on Mental Retardation, 93*(6), 593-599.

Armstrong, L. (1993). *And they call it help: The psychiatric policing of America's children*. New York: Addison-Wesley.

Arthritis drugs lethal, says MD. (1983, December 29). *Syracuse Herald Journal*, p. A4.

Azar, B. (1994). New mania treatment is a major breakthrough. *APA Monitor (American Psychological Association), 25*(5), 28.

Barondes, S. H. (1994). Perspectives: Thinking about Prozac. *Science, 263*, 1102-1103.

Baumeister, A. A., Todd, M.E., & Sevin, J. A. (1993). Efficacy and specificity of pharmacological therapies for behavioral disorders in persons with mental retardation. *Clinical Neuropharmacology, 16*(4), 271-294.

Bitonti, A. J., Sjoerdsma, A., McCann, P. P., Kyle, D. E., Oduola, A. M. J., Rossan, R. N., Milhouse, W. K., & Davidson, D. E. (1988). Reversal of chloroquine resistance in malaria parasite plasmodium falciparum by desipramine. *Science, 242*, 1301-1303.

Body and soul: Weight loss. (1990, November 18). *National Catholic Register*, p.3.

Breast cancer research project riddled with problems, officials say. (1994, June 16). *The Post Standard*, p.A7.

Brown, P., & Funk, S. C. (1986). Tardive dyskinesia: Barriers to the professional recognition of an iatrogenic disease. *Journal of Health & Social Behavior, 27*, 116-132.

Breggin, P. R. (1983). *Psychiatric drugs: Hazards to the brain*. New York: Springer.

Breggin, P. R. (1991). *Toxic psychiatry: Why therapy, empathy, and love must replace the drugs, electroshock, and biochemical theories of the "new psychiatry."* New York: St. Martin's Press.

Buie, J. (1989, April). Elderly over-drugged, abandoned, panel says. *APA Monitor, 20*(4), 26.

Carter, G. & Jancar, J. (1984). Sudden deaths in the mentally handicapped. *Psychological Medicine, 14*, 691-695.

Chadsey-Rusch, J., & Sprague, R. L. (1989). Maladaptive behaviors associated with neuroleptic drug maintenance. *American Journal on Mental Retardation, 93*(6), 607-617.

Chowka, P. B. (1979, March). The organized druggging of America. *East West Journal*, p. 34.

Cole, H. S., Lopez, R., Epel, R., Singh, B. K., & Cooperman, J. M. (1985). Nutritional deficiencies in institutionalized mentally retarded and physically disabled individuals. *American Journal of Mental Deficiency, 89*(5), 552-555.

Cowley, G. (1994a, February 7). The culture of Prozac: How a treatment for depression became as familiar as Kleenex and as socially acceptable as spring water. *Newsweek*, pp. 41-42.

Cowley, G. (1994b, May 2). Halcion: A damaging report. *Newsweek,* p. 6.

DeMarco, D. (1982). *The anesthetic society*. Front Royal, VA: Christendom Press.

Doerner, K. (1981). *Madmen and the bourgeoisie: A social history of insanity and psychiatry* (J. Neugroschel & J. Steinberg, Trans.). Oxford: Basil Blackwell.

Donaldson, K. (1976). *Insanity inside out*. New York: Crown.

Drugs: They don't belong in cockpits of American jet fighters. (1988, July 29). *Syracuse Herald Journal*, p. A6.

Edelson, E. (1987). *The ABCs of prescription drugs*. Garden City, NY: Ivy Press (Doubleday).

Elderly flee high-rise fire that kills 3. (1983, February 16). *Syracuse Herald Journal*, p. A3.

Eltern allzu sorglos: Nimm doch mal Valium. (1983, October 29). *Amerika Woche*.

Farley, C. J. (1994, April 18). The butt stops here: Threatening to snuff out smoking for good, the crusade against tobacco shifts into higher gear. *Time, 143*(16), 58-64

Gordon, B. (1979). *I'm dancing as fast as I can.* New York: Harper & Row.

Gospodaruk, V. (1994, Spring). Toxic Psychiatry by Dr. Peter Breggin. *Asylum*, p. 39.

Gotkin, J., & Gotkin, P. (1992). *Too much anger, too many tears: A personal triumph over psychiatry*. New York: Harper Collins.

Gougis, M. (1994, January 2). 80-year-old woman fights recommended shock therapy. *Indianapolis Star*.

Greenwald, J. (1989, May 8). Just what the doctor ordered: The maker of Valium splits the world's priciest stock. *Time, 133*(19), 68.

Griffith, H. W. (1992). *Complete guide to prescription and non-prescription drugs.* New York: The Body Press.

Harding, J. (1978). *A socio-demographic profile of people prescribed mood-modifiers in Saskatchewan. Final Report*. Saskatoon, Saskatchewan: Alcoholism Commission of Saskatchewan, Research Division.

Hirsch, M. (1994a, March 11). The Prozac paradox. *Syracuse Herald Journal*, pp. C1, C3.

Hirsch, M. (1994b, March 11). Safer antidepressants coming. *Syracuse Herald Journal*, p. C3.

Holden, C. (1986). Depression research advances, treatment lags. *Science, 233*, 723-726.

Hughes, R., & Brewin, R. (1979). *The tranquilizing of America: Pill popping and the American way of life.* New York: Warner Books (Harcourt Brace Jovanovich).

In the news. (1994, April 5). *Syracuse Herald Journal*, p. A2.

Jablensky, A., Sartorius, N., Ernberg, G., Anker, M., Korten, A., Cooper, J. E., Day, R., & Bertelsen, A. (1992). Schizophrenia: Manifestations, incidence and course in different cultures: A World Health Organization ten-country study. *Psychological Medicine, 22*(4), Monograph Supplement 20, 1-97. (Whole issue)

Jackson, J. O. (1992, February 3). Fear and betrayal in the Stasi state. *Time, 139*(6), 32-33.

Kastner, T. A., & Walsh, K. (1994). Exchange of views on psychotropic drug use in community settings. *Mental Retardation, 32*(3), 243-245.

Kaufman, K. R., & Katz-Garris, L. (1979). Epilepsy, mental retardation, and anticonvulsant therapy. *American Journal of Mental Deficiency, 84*(3), 256-259.

Kehrer, D., & Kehrer, J. (1985, May 5). What you must know about prescription drugs. *Parade*, pp. 15-16.

Kohn, A. (1989). Suffer the restless children. *Atlantic Monthly, 264*(5), 90-100.

Langee, H. R. (1990). Retrospective study of lithium use for institutionalized mentally retarded individuals with behavior disorders. *American Journal on Mental Retardation, 94*(4), 448-452.

Lapon, L. (1985). *Mass murderers in white coats: Psychiatric genocide in Nazi Germany and the United States.* Springfield, MA: Psychiatric Genocide Research Institute.

Lepler, S., Hodas, A., & Cotter-Mack, A. (1993). Implementation of an interdisciplinary psychotropic drug review process for community-based facilities. *Mental Retardation, 31*(5), 307-315.

Levitas, A., McCandleless, G., Elenewski, E., & Sobel, B. (1994). Commentary on Wolfensberger. [Letter to the editor]. *Mental Retardation, 32*(5), 366.

Long, J. W. (1991). *The essential guide to prescription drugs.* New York: Harper Collins.

Masterson, M., & Cook, C. (1988, July 25). Drugging the elderly, Part 1: They're killing our grandmothers. Doctors and lawmakers aren't aware of the nation's No. 2 drug problem. *Syracuse Herald Journal*, pp. A1, A4.

McKnight, J. L. (1980). A nation of clients? *Public Welfare, 38*(4), 15-19.

McKnight, J. L. (1985). John Deere and the bereavement counselor. *Institutions, Etc., 8*(2), 17-23.

McNair, D. M. (1973, November). Antianxiety drugs and human performance. *Archives of General Psychiatry, 29*, 611-617.

Medawar, C. (1992). *Power and dependency: Social Audit on the safety of medicines*. London, England: Social Audit Ltd.

McTaggart, L. (1981, August 16). Chemical babysitters. *Parade,* pp. 10-13.

Miller, J. J., & Chinoy, M. (1967). Unpublished paper presented at *123rd Annual Meeting of the American Psychiatric Association*, Detroit, MI.

Millett, K. (1990). *The loony-bin trip*. New York: Touchstone Books (Simon & Schuster).

Neary, J. (1975). *Whom the gods destroy: An account of a journey through madness.* New York: Atheneum.

Network Against Psychiatric Assault. (1984). *Dr. Caligari's psychiatric drugs.* (3rd ed.). Berkeley, CA: Author.

Nevada tops nation in smoking deaths. (1994, June 27). *Syracuse Herald Journal*, p. A8.

Newman, R. (1994). Prozac: Panacea? Psychological steroid? *APA Monitor, 25*(4), 34.

New York State Commission on Quality of Care. (1986). *Medication practices in New York State developmental centers: A post-Willowbrook report on practices at five developmental centers*. Albany, NY: Author.

Nowak, R. (1994). Problems in clinical trials go far beyond misconduct. *Science, 264*, 1538-1541.

Palca, J. (1990, April 20). Scientific misconduct cases revealed. *Science,* 248, 297.

Price-Root, S. (1979, September 10). An epidemic of tranquilizer abuse. *San Francisco Chronicle*.

Probe clears Hutchings in death. (1987, June 26). *Associated Press in Syracuse Herald Journal*, p. B2.

Purvis, A. (1990, May 28). Just what the patient ordered: Prescription drug ads make doctors edgy and consumers curious. *Time, 135*(22), 42.

Roman, M. B. (1988). When good scientists turn bad. *Discover, 9*(4), 50-58.

Schrag, P. (1978). *Mind control*. New York: Praeger.

Seniors and Substance Abuse Task Force. (1978). *Substance abuse among Michigan's senior citizens: Current issues and future directions*. Lansing, MI: Michigan Office of Services to the Aging.

Shearer, L. (1989, April 23). Pill-popping in France. *Parade*, p. 16.

Sheehan, S. (1982). *Is there no place on earth for me?* New York: Houghton Mifflin.

Silverman, M. (1976). *The drugging of the Americas: How multinational drug companies say one thing about their products to physicians in the United States, and another thing to physicians in Latin America.* Berkeley, CA: University of California Press.

Sobsey, D. (1994). *Violence and abuse in the lives of people with disabilities: The end of silent acceptance?* Baltimore, MD: Paul H. Brookes.

Sobsey, R. J. (1983, Winter). Nutrition of children with severely handicapping conditions. *TASH (The Association for the Severely Handicapped) Journal, 8*, 14-17.

Spitz, W., & Fischer, R. S. (Eds.). (1973). *Medicolegal investigations of death*. Springfield, IL: Charles C. Thomas.

Staff. (1979, November 2). Headache for Bristol-Meyers. *Science*, 206.

Staff. (1981). Mental hospital deaths: "Incompetent or negligent actions by physician and nursing staff members." *Institutions, Etc., 4*(1), 6-7.

Staff. (1984a). First amphetamine may alter brain. *APA Monitor, 15*(3), 16.

Staff. (1984b, January-February). Medical Review Board notes: Acute water intoxication. *Quality of Care*, p. 3.

Staff. (1985). Health care action: March. *AARP News Bulletin, 26*(3), 4.

Staff. (1987, May). Prescription drugs blamed for falls and fractures. *Health Letter, 3*(5), 4.

Staff. (1989, September). Drug alerts: Phenergan (promethazine)—do not use. *Health Letter, 5*(9), 9-10.

Staff. (1990a, December). Drug alert: Hydergine may hurt what it's supposed to help. *Health Letter, 6*(12), 8.

Staff. (1990b, May). Generic drugs: Still safe? *Consumer Reports, 55*(5), 310-313.

Staff. (1990c, January). The Halcion story: What you need to know (but the FDA won't tell you). *Health Letter, 6*(1), 1-3, 8.

Staff. (1990d, March). Study ties falls to tranquilizers. *AARP News Bulletin, 31*(3), 14.

Staff. (1991, October). Outrage of the month: The AMA helps to worsen the image of doctors. *Health Letter, 7*(10), 12.

Staff. (1994, July). Breakthroughs: Medicine: A refuge from delusion. *Discover*, p. 22.

Stanger, T., & Mabry, M. (1994, June 20). Liberté, égalité, médiocrité. *Newsweek*, p. 50.

Stein, M., & Baker, P. (1994, Spring). Newsround: Prozac drug trial flawed. *Asylum,* p. 6.

Stern, E. L. (1991). *Prescription drugs and their side effects*. New York: Perigee Books (Putnam).

Sun, M. (1984). Panel says Depo-Provera not proved safe. *Science, 226,* 950-951.

Susko, M. A. (Ed.). (1991). *Cry of the invisible: Writings from the homeless and survivors of psychiatric hospitals*. Baltimore, MD: Conservatory Press.

Swanson, J. M., McBurnett, K., Wigal, T., Pfiffner, L. J., Lerner, M. A., Williams, L., Christian,

D. L., Tamm, L., Willcutt, E., Crowley, K., Clevenger, W., Khouzam, N., Woo, C., Crinella, F. M., & Fisher, T. D. (1993). Effect of stimulant medication on children with attention deficit disorder: A "review of reviews." *Exceptional Children, 60*(2), 154-162.

Toufexis, A. (1989, January 16). Worries about overactive kids: Are too many youngsters being misdiagnosed and medicated? *Time, 133*(3), 65.

US Pharmacopeial Convention. (1991). *The complete drug reference.* Yonkers, NY: Consumer Reports Books.

Verdicts and Settlements. (1985, Spring). *The Advocate,* pp. 4-6.

Wardell, D., Rubin, H., & Ross, R. (1958). The use of reserpine and chlorpromazine in disturbed mentally deficient patients. *American Journal of Mental Deficiency, 63*, 330-334.

Weitz, D., & Burstow, B. (Eds.) (1988). *Shrink resistant: The struggle against psychiatry in Canada*. Seattle, WA: Left Bank.

Wendkos, M. H. (1979). *Sudden death and psychiatric illness*. New York: SP Medical & Scientific Books.

Wolfe, S. M., Fugate, L., Hulstrand, E. P., & Kamimoto, L. E. (1988). *Worst pills best pills: The older adult's guide to avoiding drug-induced death or illness. 104 pills older adults should not use. 183 safer alternatives.* Washington, DC: Public Citizen Health Research Group.

Wolfe, S. M., & Hope, R.-E. (Eds.). (1993). *Worst pills best pills II: The older adult's guide to avoiding drug-induced death or illness. 119 pills you should not use. 245 safer alternatives*. Washington, DC: Public Citizen Publications.

Wolfensberger, W. (1989). Bill F.: Signs of the times read from the life of one mentally retarded man. *Mental Retardation, 27*(6), 369-373.

Wolfensberger, W. (1994). A personal interpretation of the mental retardation scene in light of the "signs of the times." *Mental Retardation, 32*(1), 19-33.

Wood, J. G. (1975, October 21). "You keep him busy or zonk him out," says director of a retarded ward. *Boston Globe*.

Worse than the disease. (1990, February 19). *Time, 135*(8), 74.

Zugibe, F. T. (1980). *Sudden death related to the use of psychotropic drugs. Legal Medicine, 1980.* Philadelphia, PA: W. B. Saunders.

srv-vrs-srv-vrs-srv-vrs

Wolf Wolfensberger, PH.D., is the Director of the Training Institute for Human Service Planning, Leadership and Change Agentry at Syracuse University .

The citation for this article is:

Wolfensberger, W. (2004). Reply To Levitas, McCandleless, Elenewski and Sobel. *SRV-VRS: The International Social Role Valorization Journal, 5*(1&2), 42-66.