

## THE “CHEMICAL IMBALANCE” LIE DOOMS INFORMED CONSENT

### **Testimony of Fred A. Baughman Jr., MD, to the March 23, 2006 [FDA] meeting of the Psychopharmacologic Drugs Advisory Committee Testimony**

The fact of the matter is that there is no such disease (objective abnormality = disease) as ADHD. It is a contrived, faux disease--an illusion. This being the case, children said to have it are normal/disease-free and giving them ADHD drugs, or any psychiatric drugs, is not treatment, but poisoning.

“Once Ritalin or any psychiatric drug courses through their body, they are, for the first time, physically, neurologically, biologically, abnormal.” [1]

In medicine, diagnosis must be complete before, logical, scientific, treatment can be planned and informed consent can be elicited. First of all, diagnosis requires an answer to the question: Is there an objective abnormality—yes or no? If “yes” further examinations and tests are performed to determine which disease is present. If there is a macroscopic (gross), microscopic or chemical abnormality, evident in life, or at autopsy, at death, --a disease is present. Because there are no objective abnormalities in psychiatry there is no such thing as a psychiatric disorder/disease/chemical imbalance.

Psychiatric drugs were first marketed in the fifties. Psychiatry and Big Pharma “married” and gave birth to the marketplace strategy of the “big lie” by which they would call all things emotional and psychological “chemical imbalances” of the brain, needing “chemical balancers”—pills.

On September 29, 1970, Representative Cornelius Gallagher of New Jersey launched the Congressional hearing, Federal Involvement in the Use of Behavior Modification Drugs on Grammar School Children: Behavior Modification Drugs in School Children, saying: “I have received letters critical of minimal brain dysfunction, one of thirty-eight names attached to this condition.”

But, the “chemical imbalance” strategy was clearly in place. Dr. Ronald Lipman, Chief of the Clinical Studies Section, FDA, testified: “...hyperkinesis is a medical syndrome. It should be properly diagnosed by a medical doctor.”

In 1948, 'neuropsychiatry' was divided into 'neurology,' dealing with physical abnormalities/diseases and 'psychiatry,' dealing with emotions and behaviors [2].

In the DSM-III of 1980 it was ADD; in the DSM-III-R of 1987, ADHD; in the DSM-IV of 1994, it was ADHD of another sort.

On December 22, 1994, Paul Leber, MD, Director, Division of Neuropharmacological Drug Products of the FDA, wrote to me: "... no distinct pathophysiology for the disorder (ADHD) has been delineated."

On May, 13, 1998, F. Xavier Castellanos of the NIMH wrote to me: "... we have not yet met the burden of demonstrating the specific pathophysiology that we believe underlies this

condition.”

At the November 16-18, 1998 Consensus Conference, William B Carey [3], speaking on the subject: “Is ADHD a Valid Disorder?” concluded: “What is...described as ADHD in the United States appears to be a set of normal behavioral variations...”

James M. Swanson and F. Xavier Castellanos [4] reviewed the structural/anatomic MRI research [5-18] concluding: “... ADHD subjects have on-average 10% brain atrophy.”

From a floor microphone I (Baughman) challenged Swanson: “Why didn’t you mention that virtually all of the ADHD subjects were on stimulant therapy and that this is the likely cause of their brain atrophy?”

With their main line of evidence shown to be a lie, the Consensus Conference Panel confessed: “...we do not have an independent, valid test for ADHD...there are no data to indicate that ADHD is a brain malfunction.”

Palco of NPR observed: “ADHD is like the Supreme Court’s definition of pornography: ‘You know it when you see it.’”

On October 9, 2002, Castellanos, et al [19], published the one-and-only MRI study of an ADHD-untreated group. Inexplicably, they failed to use matched controls, voiding the study. ADHD remained without validation as a disease while the ADHD drugs—methylphenidates and amphetamines remained the probable cause of the “on-average, 10 percent” brain atrophy.

In 2002, Weinberger [20] of the NIMH claimed “major psychiatric diseases”...are associated with “subtle but objectively characterizable changes.” However, he could not reference a single proof.

In 2002, the Advertisement Commission of Holland determined that Brain Foundation-Holland claim that ADHD is an inborn brain dysfunction “...gives a wrong and misleading representation and enjoined them to stop.

In 2003, Ireland prohibited GSK (GlaxoSmithKline) from claiming on it’s Paxil/paroxetine leaflet: "(it) works by bringing serotonin levels back to normal."

While the FDA’s Goodman [21], acknowledged that claims that SSRIs correct a serotonin imbalance go "too far," he had the temerity to suggest: "this is reasonable shorthand for expressing that this is a chemically or brain-based problem.”

Saying any psychiatric diagnosis “... is a brain-based problem and that the medications are normalizing function,” is an anti-scientific, pro-drug, lie—one that reflects FDA and government policy generally.”

There is nothing more despicable than a physician who knowingly tells normal patients that they are “sick,” “ill,” or “diseased,” for profit. Yet this has become standard practice throughout medicine, and at the Food and Drug Administration (FDA), American

Psychiatric Association (APA), American Medical Association (AMA), American Academy of Child and Adolescent Psychiatry (AACAP), American Academy of Pediatrics (AAP), American Academy of Neurology (AAN), Child Neurology Society (CNS), American Academy of Family Practice (AAFP), and countless other organizations.

All health care agents and agencies, and all manufacturers of drugs must cease their representations of psychological/psychiatric diagnoses as diseases/ “chemical imbalances.” The right to informed consent--universally abrogated by such lies--must be restored to US medicine.

You — at the FDA mandate the medical treatment of ADHD. Where is the proof (1) that ADHD is a disease? Give us that reference, that citation. Right now please. Give us the reference-citation to the examination or test that demonstrates (2) an objective abnormality child-by-child. The members of the panel provided me with no such references/citations either at the time of my request or at any time before, during, or after the day-long conference.

### References

1. Baughman FA, Treatment of Attention-Deficit/Hyperactivity Disorder, JAMA, 1999;281; 1490.
2. Cohen MM, editor. American Academy of Neurology: The first 50 years, 1948–1998 p 1-8. (1998). St. Paul (Minnesota): American Academy of Neurology.
3. Carey WB, NIH Consensus Conference on ADHD, November 16-18, 1998.
4. Swanson J, Castellanos FX, Biological Bases of Attention Deficit Hyperactivity Disorder, NIH Consensus Development Conference on ADHD (p 37-42, program and abstracts), November 16-18, 1998, National Institutes of Health, Bethesda, MD
5. Hynd GW, Semrud-Clikeman M, Lorys AR, et al., Brain morphology in developmental dyslexia and attention deficit disorder/hyperactivity. Arch Neurol, 1990;47:919-926.
6. Hynd GW, Semrud-Clikeman M, Lorys AR, et al., Corpus callosum morphology in attention-deficit hyperactivity disorder: morphometric analysis of MRI., J Learn Disabil.1991;24:141-146.
7. Hynd GW, Hern KL, Novey ES, et al., Attention deficit hyperactivity disorder and asymmetry of the caudate nucleus, J Child Neurol. 1993;8:339-347.
8. Giedd JN, Castellanos FX, Casey BJ, et al., Quantitative morphology of the corpus callosum in attention deficit hyperactivity disorder, Am J Psychiatry, 1994;151:665-669.
9. Castellanos FX, Giedd JN, Eckburg P, et al., Quantitative morphology of the caudate nucleus in attention deficit hyperactivity disorder, Am J Psychiatry, 1994;151:1791-1796.

10. Semrud-Clikeman M, Filipek PA, Biederman J, et al., Attention-deficit hyperactivity disorder: magnetic resonance imaging morphometric analysis of the corpus callosum, *J Am Acad Child Adolesc Psychiatry*, 1994;33:875-881.
11. Baumgardner TL, Singer HS, Denckla MB, et al., Corpus callosum morphology in children with Tourette syndrome and attention deficit hyperactivity disorder, *Neurology*, 1996;47:477-482.
12. Aylward EH, Reiss AL, Reader MJ, et al., Basal ganglia volumes in children with attention-deficit hyperactivity disorder, *J Child Neurol*, 1996;11:112-115.295.
13. Castellanos FX, Giedd JN, Marsh WL, et al., Quantitative brain magnetic resonance imaging in attention-deficit/hyperactivity disorder, *Arch Gen Psychiatry*, 1996;53:607-616
14. Filipek PA, Semrud-Clikeman M, Steingard RJ, et al, Volumetric MRI analysis comparing attention-deficit hyperactivity disorder and normal controls, *Neurology*, 1997;48:589-601.
15. Casey BJ, Castellanos FX, Giedd JN, et al., Implication of right frontostriatal circuitry in response inhibition and attention-deficit/hyperactivity disorder, *J Am Acad Child Adolesc Psychiatry*, 1997;36:374-383.
16. Mataro M, et al., *Archives of Neurology*, 54 (1997):963-68
17. Berquin PC, Giedd JN, Jacobsen LK, et al., The cerebellum in attention-deficit/hyperactivity disorder: a morphometric study, *Neurology*, 1998;50:1087-1093.
18. Mostofsky SH, Reiss AL, Lockhart P, Denckla MB., Evaluation of cerebellar size in attention-deficit hyperactivity disorder, *J Child Neurol*, 1998;13:434-439.
19. Final statement of the Panel of the Consensus Panel, November 18, 1998.
20. Developmental Trajectories of Brain Volume Abnormalities in Children and Adolescents With Attention- Deficit/Hyperactivity Disorder, F. Xavier Castellanos, Patti P. Lee, MD; Wendy Sharp, MSW; Neal O. Jeffries, PhD; Deanna K. Greenstein, PhD; Liv S. Clasen, PhD; Jonathan D. Blumenthal, MA; Regina S. James, MD; Christen L. Ebens, BA; James M. Walter, MA; Alex Zijdenbos, PhD; Alan C. Evans, PhD; Jay N. Giedd, MD; Judith L. Rapoport, MD *JAMA*, 2002;288:1740-1748 .
21. Wayne K. Goodman, MD Chair of the US Food and Drug Administration (FDA) Psychopharmacologic Drugs Advisory Committee, quoted in *Canadian Medical Association Journal*, March 14, 2006. SSRI ads questioned. Colin Meek. Wester Ross, Scotland