Psychiatry in the Hot Seat: The Joseph Biederman Depostion

Highlights and Commentary

What follows is some highlights from the sworn evidence of psychiatrist Joseph Biederman taken on February 26, 2009 as part of the many lawsuits filed against giant pharmaceutical company Johnson&Johnson and its subsiduaries. It had been earlier revealed in an investigation by Senator Grassley of Iowa in the US that Biederman had failed to report, on mandatory conflict of interest forms, at least $1.4 million that he received from drug companies financing his 'research' and talks about their products.

In late 2013 the **US Department of Justice** reported that as a result of actions brought against Johnson&Johnson and its subsiduaries the Big Pharma giant will pay $482 million in **criminal** fines and forfeitures as well as 1.72 billion in civil settlements to federal and state governments. Allegations included illegal off-label marketing and kickbacks to doctors and pharmacists. Among the targets were small children, the elderly and the mentally disabled.

The interrogator (**Q**) below is Fletch Trammell, Counsel for the Plaintiff, and the witness (**A**) is psychiatrist Joseph Biederman. Counsel for Biederman is Peter Spivack, and Counsel for Johnson&Johnson is Jeffrey Peck. Interjected throughout the interrogations are objections from both counsels for the defence. The blue text is my own further commentary. Each section is followed by the page reference from the deposition document. You can download that in its entirety here.

(**Q**) Fletch Trammel, Counsel for the Plaintiff

(**A**) Joseph Biederman, Psychiatrist

Q. So when you were six months old you left Prague for Argentina. Right?
A. Right.
Q. Went to all your grade school and high school in Argentina?
A. Correct.
Q. Passed an entrance exam and went to medical school?
A. Yes.
Q. And how old were you at that point?
A. I was 16.
Q. And how old were you when you got out of medical school?
A. 22.
Q. What did you do after that?
A. I did my internship in Hadassah Medical Center, Hebrew University, Jerusalem.
Q. Why did you go to Jerusalem?

A. Because I wanted to.
Q. Why did you want to?
A. Because I felt like it.
Q. And why did you feel like it?
A. That was my choice.
Q. What was of interest to you in Jerusalem?
A. I like their medical training and I wanted to have that experience.
Q. Did you apply to any other internship programs?
A. No.
Q. Just the Hadassah University in Jerusalem?
A. Yes.
Q. What did you do after your internship?
A. I did my residency in psychiatry
Q. Immediately after?
A. Immediately after.
Q. Stayed in Jerusalem?
A. Yes.
Q. And after that?
A. After that, I came to Boston to train in child psychiatry.
Q. You weren't a research fellow at the Jerusalem Medical Health Center?
A. Yes, that was part of the residency.
Q. Then you came to Boston to do your clinical training?
A. I came to Boston to train in child psychiatry.
[pp. 37-38]

Q. Can you think of a manufacturer that makes a drug that you use in your practice with which you don't have a professional relationship of any kind?
A. I cannot tell you. There are multiple drugs, I don't have a relationship with every manufacturer of every drug that is produced in this country or in the world. [Probably not through lack of trying however. In any case Trammell's question remains unanswered....]
Q. But you do have a professional relationship with dozens of drug manufacturers, right?
A. Yes, I do. I have a professional relationship with dozens of manufacturers. But my relationships are on the basis of advancing the knowledge and advancing clinical care. [If you say so, Biederman....]
MR TRAMMELL: Object as non-responsive
BY MR TRAMMELL:
Q. In the course of carrying out these relationships with all these drug manufacturers, does the relationship always involve them giving you money?
A. Most of the time.
[p. 56]

Q. What is the nature of Senator Grassley's investigation of you?
A. Senator Grassley read, there was an article in The Boston Globe about a little girl in town that the parents are accused of first degree murder. In fact, you may have seen it. The accusation has been upgraded from second-degree to first-degree murder. But because the child was diagnosed with bipolar illness, it captured the imagination of the media and there was an article in 'The Boston Globe' that talked about the diagnosis and how controversial that is and particularly as it pertains to preschoolers. [Textbook inability of a psychopath to

take responsibility for his actions while seeing himself always as the victim. Biederman conveniently neglects to mention that 'the child' died as a result of an overdose of psychiatric drugs administered by the parents, and prescribed by a doctor contrary to FDA recommendations, but exactly according to the recommendations of drug company sales reps and drug company financed psychiatrists, most notably, Biederman. In fact it was widely and accurately reported at the time that Biederman had spearheaded a forty-fold increase in diagnoses of children for 'pediatric bipolar', one of the fictional conditions for which Rebecca Riley was being poisoned. (Actually Rebecca is only one of many children who have died or been grossly deformed or brain damaged as a result of poisoning by psychiatric drugs prescribed since the Biederman-led boom in such prescriptions for children, even when prescribed doses *were not exceeded*.) But of course its not Biederman's fault, the fault lies only with the parents.....] And in the article, the reporter got sent my standard disclosure forms, so he wrote that I have extensive relationship with fifteen or so pharmaceutical companies, So Senator Grassley wrote a letter to the institution, to Harvard and Mass, General, asking for details. And that has been the cascade of events.
Q. So Senator Grassley became interested in you because of these people who were accused of killing their kid?
A. Senator Grassley claims to be interested in issues of conflict of interest and is interested in making sure that the universities have tight conflict-of-interest rules. I have no dispute with that. [Biederman may not dispute Grassley's interest in conflict-of-interest rules but apparently has no problem breaking them to the tune of over one million. He conveniently fails to mention to Trammell that 7 months prior to the deposition, Senator Grassley's Congressional investigation revealed that Biederman had failed to report to Harvard University at least *$1.4 million* in outside income from Johnson & Johnson and other makers of antipsychotic medicines. (Click here for more.) Biederman was later penalized by Harvard Medical School and the Massachusetts General Hospital as a direct result of the Grassley investigation. Of course, the lightness of the penalty was in itself a crime.]
[p. 63]

Q. Did Janssen ever refuse to pursue one of your proposals for studying Risperdal in kids? [Note: Janssen is the subsidiary of Johnson&Johnson responsible for the marketing and manufacture of the drug 'Risperdal' that both J&J and Biederman wanted to give to children, contrary to FDA recommendations, for the fictional disorder 'pediatric bipolar'.]
A. Pharmaceutical companies, they get a lot of proposals and most of them are refused.
Q. Did Janssen ever -- Objection, nonresponsive. Did Janssen ever refuse to fund one of your research proposals for using Risperdal in kids?
MR. PECK: Objection to form.
A. I don't remember. I think that my first proposal was denied, so I guess that the answer is that they refused.
Q. So the first proposal you sent to them, they refused to fund the study?
A. Yes.
Q. Did that bother you?
A. Proposals are submitted to do a study. If the study is not done, it's disappointment.
Q. But it didn't bother you, did it?
A. Could you define bother?
Q. Sure. Were you upset?
A. I don't think I was upset. I was disappointed.
Q. So not upset, just disappointed, right?

A. This happens a long time ago. I cannot recall my response, but I think that disappointment is a more accurate description.
Q. In any event, you send out a lot of proposals, some of them are accepted and some of them are denied, right?
A. Correct.
Q. Janssen happened to deny your first proposal. Right?
A. I think so.
Q. And did that affect your prescribing practices of Risperdal?
A. Not at all.
Q. Did it affect your professional relationship with Janssen?
A. Not at all.
Q. How long was it between the time that they rejected your first proposal to any suggestion on either side that you would do more research?
A. I don't remember. We got funding to do a study of risperidone in I believe 2002.
Q. Did you ever try to get back at Janssen for denying your request to do a study?
A. No.
[Biederman is almost certainly lying. As we shall see.....]
Q. I'm on 4. Handing you Biederman Exhibit 4, Doctor, what I want you to do is look at the e-mail that is the third e-mail on the first page from John Bruins, who is the Janssen medical science liaison, to a bunch of people at Janssen. Do you see that?
A. Could you point out what you want me to--?
Q. It's this one right here.
A. This e-mail?
Q. Yes.
A. Okay.
Q. You see that?
A. Yes.
[pp. 83-86]

Q. [Still on Exhibit 4 – Janssen internal email] If you go down and look at the second bullet point here, it says "Three or four years ago Janssen HO, which I assume means home office, but maybe you know better," requested that he [Biederman] put together a study to evaluate Risperdal in the child and adolescent population. He submitted a thorough and lengthy proposal which amounted to approximately $280,000. We dragged our heels on his request, which we made, for over a year. He finally received a standard ding letter. By the time I found out about it a week later I went to see him, his secretary advised me of his fury. The sales representative who called on him and I took an hour of verbal beating. I have never seen someone so angry". Did I read that reasonably correctly?
A. Yes. This is what the e-mail says.
Q. Right. Does this refresh your recollection that Janssen requested that you put together a study proposal which you then submitted to them?
A. The way that I recall it happened, it was that I sent a letter; they responded -- that I'm interested to do a study. They responded that they wanted a detailed proposal and a budget. But the initiative was from me to them, so the budget - they requested to follow up with a detailed proposal and a budget.
Q. And they denied that proposal?
A. Yes.
Q. And you were furious, right?

A. I don't recall being furious. I was disappointed.
Q. Do you understand the difference between furious and disappointed?
A. Maybe you can explain to me.
Q. Well, do you understand the difference?
A. I am telling you that I have no idea what he's talking about.
[pp.86-88]

Q. The next bullet point [still on Exhibit 4] says "Dr Biederman is the head of adolescent psych at MGH. Since that time our business became non-existent within his area of control." Do you have any idea what that's referring to?
A. No.
Q. "He now has enough projects with Lilly [Janssen's chief competitor] to keep his entire group busy for years". Do you see that?
A. Yes.
[Bruin's observations suggest that Biederman's recommendations regarding the use of any particular drug company's products for so-called 'psychiatric disorders' were based on business considerations and not scientific or clinical ones. Keep in mind that the products offered by the companies were not identical, with each company having an exclusive patent for their own offering.]
[p. 94]

Q. And the truth is, Doctor, that after Janssen asked you for a proposal and you took your time, your valuable time to create this proposal and send it to them and they had not enough courtesy to give you what you considered to be a reasonable explanation of their decision, you decided that you were going to show them and your business was going to be non-existent with them for the future, right?
MR. SPIVACK: Objection, asked and answered, argumentative, no foundation.
A. I have no idea what you are asking.
[p. 95]

Q. Now, the truth is you wanted to show Janssen you weren't somebody to jerk around and if they were going to deny your research proposals after they requested that you make the proposal, you were going to show them how powerful a national figure you are by ending your business with them.
MR. SPIVACK: Objection, argumentative, no foundation, calls for speculation, asked and answered.
A. I am actually not sure what is your question. Maybe you can do one question at a time, not a multi-layered one.
Q. I'll object as non-responsive. And just answer my question the best you can.
A. I submit – I am a scientist. [If you say so, doc....The fact is that this self-important psychopath was using the pseudo-scientific fraud that calls itself psychiatry to pursue self-aggrandising policies and pipe-dreams that have resulted in the (still ongoing) poisoning of millions of children world-wide. More on this below.] I submit applications all the time to various sources; foundations, pharmaceuticals, the Government. The most common state of affairs is rejection. Okay? So what happened with Janssen is a matter of fact of life in academia. Submit a proposal, they don't want it, that's part of life.
Q. Well, the truth is it's one thing to deny other people's requests for proposals. It's another thing to deny yours, because you're a powerful national figure in child psychiatry and you

had the impression that they were jerking you around by denying your request for research funding, right?
MR. PECK: Object to form.
MR SPIVACK: Objection.
A. This is Mr. Bruins' state of mind and interpretation of the reality. I submit applications all the time and to all kind of foundation, and rejection is a very common state of affairs.
Q. How could Mr Bruins be so mistaken?
SPIVACK: Objection, no foundation.
A. I have no idea.
Q. Did you find him to be a person who was not truthful?
A. No.
Q. He was always honest with you, wasn't he?
A. I do not -- My interactions were strictly professional. I have no basis to think one way or another.
[pp. 97-99]

Q. One of the things you wanted to study was the efficacy of Risperdal in preschoolers, right?
A. Yes.
Q. And how old are preschool kids?
A. Could you repeat the question?
Q. How old are preschool kids?
A. Four to six.
Q. And what age range was Risperdal approved for at that time?
A. It was approved, to my recollection, for individuals older than I8.
[pp. 114-115]

Q. Do you have any idea how much money either you personally or the center [Biederman's research centre] has received from Janssen over the course of your relationship?
A. I never totalled it.
Q. Is it just too much to count or you just don't know?
MR. PECK: Object to form.
A. No, I do not know.
Q. Is it millions of dollars?
A. From Janssen?
Q. Mm-hmm.
A. Well, the center alone had 2 million.
Q. Okay. But all in, it's millions of dollars. Right?
A. I would not say millions of dollars. That was the most substantial amount of funding that we received.
Q. You don't know whether you got over a million dollars from Janssen?
MR PECK: Object to form.
A. No.
[Biederman knows all too well that an investigation by US Senator Grassley only 7 months prior to the deposition revealed that Biederman had received personally at least *$1.4 million* in outside income from Johnson & Johnson and other makers of anti-psychotic medicines. Trammell, who also knows of the Grassley investigation, unwittingly gives Biederman an escape route by asking specifically of his income from Janssen (Johnson&Johnson), which

may have been under a million dollars (but not by much!). Trammell's next question ought to have been, “Did you receive a total of over a million dollars from various makers of anti-psychotic medications including Janssen, of which the latter was by far the greatest contributor.” That one, Biederman could not have dodged.]
[pp.119-120]

Q. Okay. If you go to the third page [of Johnson&Johnson's 2002 annual report for Biederman's research centre, which J&J funded], which has a heading that says Executive Summary, go to the second paragraph; it says “An essential feature of the center is its ability to conduct research satisfying three criteria: A. it will lead to findings that improve the psychiatric care of children [“psychiatric care” is a contradiction in terms]; B. it will meet high levels of scientific quality [psychiatry is not science at all as we shall see below]; and C. it will move forward the commercial goals of J&J" [Bingo!]. Did I read that right?
A. Yes.
Q. So there may have been multiple purposes for the center. One of the essential purposes was that it move forward the commercial goals of J&J. Right?
[pp.135-136]

Q. The next sentence says "We strongly believe that the center's systematic scientific inquiry will enhance the clinical and research foundation of child psychiatry and lead to the safer, more appropriate and more widespread use of medications in general. [“widespread” being the only real consideration of J&J at the time, truth be told] Did I read that right?
A. "In children."
Q. In children, right.
A. Yes.
Q. Did I read that correctly?
A. Yes.
Q. So what they're saying here is that because of the work that you do at the center, there'll be more Risperdal used. Right?
MR. PECK: Object to form.
A. We believed that if the medicines -- if the disease is found to be morbid and disabling, if the medicines like risperidone are found to be safe and effective, clinicians will be more able to deploy them for the right patients with better knowledge about the spectrum of effects and adverse effects. This is what we meant. [Again Biederman is deliberately misleading the court. He knows very well that the terms “disease” and “morbid” are not applicable to *any* psychiatric disorder , including the ill-conceived 'pediatric bipolar' from which both he and Johnson&Johnson profited enormously:

“No behaviour or misbehaviour is a disease or can be a disease. That's not what diseases are. Diseases are malfunctions of the human body, of the heart, the liver, the kidney, the brain. Typhoid fever is a disease. Spring fever is not a disease; it is a figure of speech, a metaphoric disease. All mental diseases are metaphoric diseases, misrepresented as real diseases and mistaken for real diseases.” - Thomas Szasz, Professor of Psychiatry Emeritus

(More on the invalidity of psychiatric disorders below.)

Nonetheless Biederman uses the terms “morbid” and “disease” (elsewhere in the deposition he adds the adjective “serious”) in an attempt to justify to the jury the use in children of a

powerful (and ultra-toxic) psychiatric drug approved at the time only for a rare and serious so-called psychiatric disorder, and only in adults. Johnson&Johnson showed how much confidence they had that the jury was going to buy that nonsense when in 2012 they agreed to settle out of court to the tune of over 2 billion.....]
[p. 136]

Q. The next paragraph, "Equally important to effective use of medications is the demonstration of the validity of disorders" Did I read that right?
A. Yes.
Q. What does that mean, the validity of disorders.
A. The meaning is not all temper tantrums are bipolar illness. Not all lack of concentration is ADHD. So when we describe a condition, we need to do our best to make sure that this condition is valid. [Biederman conveniently neglects to mention that no psychiatric disorder including bipolar and ADHD, either in children or adults, has ever been shown to be 'valid' according to sound scientific standards, the criteria for which he lists below. Keep in mind that there is no way he could have been simply ignorant of the fact. It is common knowledge among psychiatrists. Consider the following statement from Thomas Insel, Director of the National Institute of Mental Health in the US:
"While DSM has been described as a 'Bible' for the field, it is, at best, a dictionary.... The weakness is its lack of validity. Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of fever." [emphasis mine]]
Q. So you and Janssen were inventing disorders?
MR PECK: Objection, form.
A. Absolutely not. [if you say so doc.....]
Q. Is there something wrong with that, inventing disorders?
A. Inventing disorders? Of course, the way that you say it and the choice of words has some pejorative conspiratorial component. [Exactly. Notice the standard resort to terms like 'conspiracy' when confronted with the truth. This is a common method of distraction – Jews are particularly fond of it. The intention is to mentally tie any accusation to ideas of insubstantial speculation and mental imbalance invoked by the trigger word 'conspiracy'. The method has proven to be extraordinarily effective for a long time especially with mainstream media hypnotised masses. Trammell simply ignores it.]
Q. You mean pejorative, you mean it has a bad connotation?
A. Yes.
Q. Why is it bad to be creating diseases or creating disorders or creating categories of disorders?
A. The diseases are not created. The conditions that we see in front of us are reconceptualized. [He means 'recapitalized'.] In other words, the child that was called before mentally retarded today may be called autism spectrum. [And hey, why not 'reconceptualize' 'naughty' and 'answers back' and 'nuisance' and 'troublesome' and 'difficult' while we're at it? Let's call them something clinical-sounding like 'conduct disorder' maybe...... (more below)] So as we understand more these problems, we conceptualize in a different way. Schizophrenia and bipolar illness were not considered separate entities in the past, so as progress and knowledge develop, clinicians and scientists understood that they are separate entities that required different treatment. [Why sell one drug when you can sell two? And

what kind of 'knowledge' or 'advancement' is it, that is based entirely on vague and subjective reports of patient symptomatology and scientifically invalid *ideology*, not science? Unless of course Biederman is referring to the advancement of drug company interests, and his own power base and inflated sense of his own importance.....]

Q. That was an advancement, right, to make that distinction, wasn't it?

A. It's an advancement to know what we have in front of us.

Q. So what's wrong with what y'all were doing here, inventing disorders?

MR PECK: Object to form.

MR SPIVACK: Objection, misstates the witness's testimony, misstates the document.

A. I did not invent any condition.

Q. Well, you certainly created the belief in the medical community that things that weren't thought of as psychiatric disorders in the past were actually psychiatric disorders, didn't you?

A. No. [It was widely reported at the time that Biederman had spearheaded a 40 fold increase in 'bipolar disorder' diagnosis among children. Is Biederman suggesting that all of these newly diagnosed children had been previously diagnosed with some other psychiatric disorder? Consider the following observation from a less mendacious and prevaricative member of his profession:

"Virtually anyone at any given time can meet the criteria for bipolar disorder or ADHD. Anyone. And the problem is everyone diagnosed with even one of these 'illnesses' triggers the pill dispenser." - Dr. Stefan Kruszewski, Psychiatrist

The fact is that the psychiatric diagnostic manual has been for decades now so absurdly inclusive of any type of human behaviour imaginable that the only question that remains for a psychiatrist is if and which drug to prescribe.]

MR SPIVACK: Objection, calls for speculation.

A. I described that the children that were going under different names that were disturbed, some of these children may have a condition that is called bipolar illness. Not one of these children, I did not grab anybody from their basement and brought them to the clinic. [No, that isn't necessary, there is never a shortage of gullible and/or lazy parents falsely guided or willingly misled by bought out opinion leaders who will happily provide the Biederman's of this world with their unfortunate guinea pigs...] So these children existed but they were conceptually seen differently. They had other diagnoses, like conduct disorder, for instance. [Conduct disorder? Oh, I get it doc, that used to be called just plain old bad behaviour. Certainly the 'reconceptualization' of bad behaviour in children as a 'disease' requiring a highly lucrative drug to treat it is a completely different way of looking at things. (I mean, why spank your children when you can poison them?) Oh, and 'different' is the only non-'pejorative' adjective I can think to ascribe to it......]

Q. So you're trying to say you weren't preying on kids?

MR SPIVACK: Objection, argumentative, misstates the testimony.

MR PECK: Objection.

BY MR TRAMMELL:

Q. Is that what you're trying to say?

MR. PECK: Object to form.

A. Are you seriously asking me this?

Q. Yes.

A. I'm preying on children?

Q. Are you trying to say that you weren't doing that?
A. No, I never preyed on anybody. [If you say so creep....]
[pp.137-140]

Q. Now, in order to demonstrate, what kinds of science would need to be generated to demonstrate the validity of pediatric bipolar disorder?
A. We conceptually thought to do neuroimaging to see if the neuro-anatomy of the brain is different in people that have bipolar illness and ADHD using different imaging technologies. Our genetic research was interested in trying to identify genes that are associated with one or the other.
Q. So the work you wanted to do to demonstrate the validity of pediatric bipolar disorder was neuroimaging and genetic research? [Let's call a witness regarding this from among psychiatry's own ranks, Harvard Medical School psychiatrist, Dr. Joseph Glenmullen:
"[While there has been] *no shortage of alleged biochemical explanations for psychiatric condition....not one has been proven. Quite the contrary. In every instance where such an imbalance was thought to have been found, it was later proven false."*

"No claim for a gene for a psychiatric condition has stood the test of time, in spite of popular misinformation."]
A. And associated. We also were interested in examining the course of the illness, to examine clinical correlates. We examined familiality of ADHD and bipolar illness. These are things that we did.
Q. And did that work demonstrate the validity of pediatric bipolar disorder? [Watch now as Biederman shrewdly evades this crucial question on which he knows the whole Psychiatry fraud is based. Amazingly an otherwise usually sharp Trammell let's this one get past him......]
A. Well, the classic understanding of validity rests on a disease that has a unique set of clinical features, that has a unique course, biological correlates such as neuroimaging, genetic and familiality and the therapeutic responsiveness to different treatments. [No psychiatric disorder has *any* biologic correlates, not in brain structure, not in genetics, not in familiality, despite decades of asses like Biederman trying to find one. So while Biederman somewhat unnecessarily provides Trammell here with the *criteria* for validity, he is careful to avoid answering the question he was asked. His evasiveness is understandable when you consider the fact that, of course, his work did *not* demonstrate the validity of pediatric bipolar disorder. (See the Director of the NIMH's stement above.)]
Q. It says validity of disorders. That's a plural. Do you know what other disorders it's talking about?
A. ADHD and bipolar illness.
Q. At this point was ADHD a valid disorder?
A. ADHD in children was a valid diagnosis but still under attack. ADHD in adults was emerging. [Again evasion! Trammell did not ask Biederman if ADHD was a valid *diagnosis*, but rather if it was a valid 'disorder'. Biederman seeks to avoid the question with a subtle shift in semantics. He gives a meaningless answer: "valid diagnosis, but still under attack", what does that mean? Validity is validity; true, objective validity cannot be "attacked". On the other hand, ideology can be. In any case let's allow the US National Institutes of Health itself to answer the question Biederman was so careful to avoid answering:

“We do not have an independent, valid test for ADHD, and there are no data to indicate ADHD is due to a brain malfunction.” - Final statement of the panel from the National Institutes of Health Consensus Conference on ADHD.]
[pp.142-143]

Q. This is 10. 10 is a case report published in the Journal of Child and Adolescent Psychopharmacology, November 4, 2001. You and Louise Glassner Cohen are the authors, right?
A. Correct.
Q. What is a case report?
A. It's a group of children that have very elevated levels of prolactin that we treated with a selective D2 agonist called cabergoline.
Q. Why were you studying this? Why did you write this case report?
A. Because I was concerned about elevation of prolactin, particularly very high elevations that these children had, and I was looking for ways to normalize them. [Despite Biederman's attempts throughout his deposition to downplay the prolactin issue, what he actually knew about the study known as 'RS-INT-41' and the fraudulent and now infamous 'Findling article' that was Janssen's response to it, remains unexplored by legal avenues. In short the RS-INT-41 study showed as far back as 2000 a correlation between elevated levels of prolactin in boys taking Risperdal, and a condition known as 'gynecomastia' - the growing of large, unsightly female breasts. This was significant because the taking of risperidone (the active constituent of Risperdal) had been shown to raise prolactin levels. The study also found that the percentage of boys developing gynecomastia when taking Risperdal was far in excess of the indication on its label which at that time listed the side-effect as 'rare'. Rare, in clinical terms, means less than a tenth of a percent. In fact the RS-INT-41 data had indicated a figure at least fifty times the figure (0.8%) arrived at in an article that Janssen paid thousands of dollars to have published in medical journals targeted at the medical community, and which claimed to be a scientific analysis of the RS-INT-41 data. (It has since been cited over a hundred times in the medical literature.) The same article conveniently omitted the data showing the relationship between prolactin levels and gynecomastia and falsely claimed that no evidence for such a relationship had been found.

Consider the following time-line:

1. A long term open trial for the safety and efficacy of Risperdal known as 'RS-INT-41' ends in May 2000 and shows that an average of at least 4.5% of boys taking Risperdal developed gynecomastia. (One long term trial analysed by Janssen scientists later in the year gave a figure as high as 12.5%.)
2. Same study shows that 98% of the boys who had been taking Risperdal for eight to 12 weeks and who had elevated prolactin levels (a condition known as hyperprolactinemia), also developed gynecomastia, thus putting a direct causal link between riperidone-induced hyperprolactinemia and gynecomastia beyond any reasonable doubt.
3. In August 2000 Excerpt Media, a data-for-sale outfit specialising in skewing/misrepresenting data in medical journals for highest bidder drug corporations, recruits child psychiatrist Dr. Findling as 'lead author' for a pre-written article in which the gynecomastia data from RIS-INT-41 is watered down with two shorter term, and thus less reliable studies (gynecomastia generally only develops after at least eight weeks), and then further deliberately and fraudulently misrepresented using an arithmetical sleight of hand

that would fool only those who didn't bother to read beyond the introductory abstract (unfortunately this includes almost all so-called 'physicians'). Briefly, all boys over 10 years and all *girls* were counted in the denominator of the boys with gynecomastia to boys without gynecomatia ratio, while all boys with gynecomastia over 10 years were *taken out* of the numerator.
Other statistics showing a clear correlation between levels of prolactin and incidences of gynecomastia are left out of the final draft of the Findling article which concludes falsely that no such correlation was found.
4. Just a few months later in early 2001 Biederman co-authors a paper proposing the possible efficacy of a compound called 'cabergoline' "for the treatment of risperidone-induced hyperprolactinemia in youth".

Now if Biederman really believed both the Risperdal label's claim about gynecomastia being a 'rare' side effect (Biederman had been busy for some time aggressively advocating the use of Risperdal while being on Janssen's payroll), and Janssen's claim that no evidence for a hyperprolactinemia-gynecomastia causal link had been found, then why did he feel the need for the cabergoline study? There were many other 'rare' side effects listed on the Risperdal label even more serious, why focus in on that one in particular? *Unless of course he knew that the prolactin problem was much more serious than the Risperdal label and Janssen were telling physicians and the gullible public at the time.*
Interestingly the man in charge of Risperdal sales at the time, infamous white collar criminal Alex Gorsky, cited caybergoline as the best solution for risperidone-induced hyperprolactinemia in his own court deposition of 2012. Funny that.
(By the way, J&J is still being sued left, right and centre by parents with disfigured sons to this day, as Gorsky, now J&J's CEO, is well aware of. There are literally thousands of cases presently in the works.)
One thing is certain, about a year after Biederman's caybergoline study Johnson & Johnson had deposited the first $500,000 of what would be $2 million into an account set up for Biederman's revolting centre for chemical experimentation on small children - a centre that had as one of it's chief reasons for existence (as listed on its executive summary), to "move forward the commercial goals of J&J." This goal it handled skilfully, while its chief 'scientific' goal, namely to find a biomarker or genetic origin for the fictional disorder 'pediatric bipolar' *failed completely*. Idiot.]
[p. 208]

Q. How does a doctor who reads your paper or hears your talk know how much irritability is enough when they're making subjective judgements about kids who are acting up?
A. All the diagnostic criteria are subjective. People that treat children know what I'm talking about because these children come to our offices with desperate parents that do not know what to do with them.
Q. Did Janssen ever tell you the true opportunity in bipolar disorder in kids is that the meaning of these diagnostic criteria is so vague, it's so hard to understand what would qualify as bipolar disorder, that we can convince doctors who are just confused and dealing with frustrated parents to use Risperdal where they probably shouldn't?
MK PECK: Object to form, foundation
BY MR TRAMMELL:
Q. Did anybody ever tell you that?
A. No

Q. Anybody ever say that to you, "That's our plan here with Risperdal"?
A. Not at all.
[pp.233-234]

Q. Isn't it consistent with children's normal conduct to be irritable?
A. No. [Idiotic answer.]
Q. It isn't?
A. No.
Q. Do you have any children?
A. Yes.
Q. Were you around when they were young?
A. Where do you think I was?
Q. I don't know.
A. Okay. Of course I was around.
Q. Were you around?
A. Yes.
Q. Were you ever in the house when they would act up?
A. I am a child psychiatrist I find it offensive that you will think that I would not know the difference between a temper tantrum and this condition.
Q. But maybe you can educate me and the jury.
A. I would be happy to.
[Let's see how this self important ass fares.....]
Q. Were you around when the kids would cry for no reason?
A. Yes.
Q. Were you around when they would yell and scream at each other?
A. This is not what I am talking here.
Q. Were you around when that stuff happened?
A. Yeah.
Q. And which anti-psychotic drug did you treat them with?
A. The problems that families consult with me are extraordinarily debilitating, severe and devastating, Many of these children require institutionalization or placement outside the home, I am not talking about normal occurrence of everyday living.
Q. So, in other words, when your kids were irritable or crying, they weren't anti-psychotic, but when other people's kids are irritable and crying, they are?
A. The problems --
MR SPIVACK: Objection, argumentative, misstates the testimony,
A. The problems that I consult on and treat are orders of magnitude different than normal childhood experiences.
Q. But the differences in magnitude and judging those differences is entirely subjective, isn't it?
A. All psychiatric diagnoses are subjective in children and in adults.
Q. And doesn't that create a tremendous amount of danger of misdiagnosis? [Emphasis mine. Actually the issue is not so much misdiagnosis as *meaningless* diagnosis.]
A. I think that subjectivity requires more clinical training than when you have objective parameters that anybody can determine. So there is training to be able to secure that the diagnosis is actually accurate, and that is what doctors are trained to do for many years.
[You'll see this standard first line of defence of psychiatrists, or rather, more accurately, 'evasion tactic', crop up routinely in what follows. i.e. 'don't worry about it, trust us, we're

the experts'......you may also have noted that he still hasn't made a credible distinction between ordinary irritability and his criterion of 'irritability' for 'bipolar disorder'.]

Q. Right Psychiatrists?

A. Psychiatrists, yes

Q. So the dangers of misdiagnosis are less in psychiatrists than they are in non-psychiatrists?

A. Not only psychiatrists, depending on what we are talking about. There is a discipline within pediatrics that is called behavioral pediatrics that you have a reasonable amount of mental health training. And as I explained to you before, there is a capacity problem in our field that there are not enough trained child psychiatrists to evaluate and treat all the children that require assessment and treatment.

[Actually it doesn't matter, psychiatrist or no, the diagnosis can only ever be as good as the diagnostic criteria on which it is based, and these are demonstrably absurd, as we shall see.....]

Q. Does that mean that children should get substandard care just because there aren't enough doctors?

A. No. I am only stating the reality, that there are not enough child psychiatrists in the world, in this country, to attend to the many children that require care. It's not something that I developed; it's a reality of our society.

Q. And so children get substandard care?

MR SPIVACK: Objection, argumentative, misstates the testimony, asked and answered,

MR TRAMMELL: What about speculation?

MR SPIVACK: Are you objecting to your own question?

[pp.235-238]

Q. What is distractibility as a criteria for bipolar disorder?

A. Distractibility refers to a situation in which the person does not stick to the task at hand and is attracted to extraneous activities like being more interested in what's going on in the next room instead of doing their activities.

Q. So distractibility in kids, is that like when you're trying to get their attention when they're watching their favorite TV show and they won't pay any attention to you?

A. No. Distractibility is a serious problem that occurs in many psychiatric units, including ADHD, where the child cannot stay on task. That includes school work or activities that require sustained attention.....

Q. Is that like when you tell your kid to go clean their room and they stop cleaning their room and start playing with their toys?

A. No. Distractibility refers to the inability to stay on task. [Isn't that what Trammel just described??] So usually for children, the inability to stay on task is around school work.

Q. I'm giving you examples of not staying on task and you're telling me that those are not criteria for bipolar disorder. How is anybody supposed to know that from the word distractibility?

A. That's the reason that you have training and you go to medical school and you go to residency for many years and you see a million people and then you understand the difference. [i.e. don't worry about it, trust us, we're the experts.....] If I ask you to evaluate the site of somebody's prostate, you will also not know, There are many things that you do not know, not only this. [misleading: the location of one's prostrate is entirely objective, psychiatric diagnosis entirely subjective.]

Q. That's certainly true.
MR SPIVACK: So stipulated.
BY MR TRAMMELL:
Q. So if a doctor goes to medical school, goes through a residency and sees millions of people, he understands what distractibility means.
A. Yes.
Q. -- in the context of pediatric bipolar disorder?
A. In the context of any. Distractibility is one item; it occurs in other conditions. If you have an attack of asthma, you also will be distractible. If you are febrile with influenza, you may not be able to concentrate, So distractibility is one. That's the reason that there are many symptoms, not just one.
Q. Right. But it is the most common symptom?
A. No, it's not the most common.
[actually it *is* the most common, according to Biederman's own study, as we will see below]
Q. Okay, we'll get to that in a minute. And just so we're all clear, this is the type of talk you would give when you were hired by Janssen to give talks, right?
A. This is the type of talk -
MR PECK: Object to form
A. -- that I give when I talk on pediatric bipolar illness
Q. Including when Janssen hires you, right?
A. This is a talk that I give when I talk about pediatric bipolar iIlness; I define the illness, by the way, these are not my definitions; this is something that is accepted in our nosology for children and adults.
[By 'nosology' Biederman means the utterly bogus DSM (diagnostic and statistical manual) whose 'disorders' are included on the basis of a *vote* by select members of the utterly corrupt American Psychiatric Association.]
Q. But you talk about this subject matter when you give talks that Janssen has paid you to give, right?
A. This is the talk that I give when I talk about pediatric mania with or without Janssen.
Q. Okay, but with Janssen, right?
A. Sometimes with Janssen.
Q. Now, can you give me an example of distractibility that would satisfy the criteria for bipolar disorder?
A. I gave you those examples.
Q. Well, give me--
A. It is a person that is unable to stay on task when required to do so. So in childhood, usually it's around school tasks. The person cannot engage in homework or cannot pay attention to the school activities deployed by the teacher.
Q. So a kid that doesn't do his homework satisfies one of the criteria for bipolar disorder?
A. No. The child that is unable to do the homework all the time, not once. Okay?
Q. So a kid who repeatedly fails to do his homework satisfies one of the criteria for bipolar disorder?
A. If he is persistent and it's there all the time, that's one of the criteria, yes.
Q. What does "all the time" mean? What does 'persistent' mean?
A. Well, persistent is more often than not; it's lasting weeks, not minutes.
Q. Number 2, increased activity or psychomotor agitation, is that the same thing as hyperactivity?
A. No, psychomotor agitation is a state of acute restlessness, has the feel of somebody that

cannot stop moving, like a caged animal.
Q. What is increased activity?
A. Increased activity is somebody that is engaging in more activities than usual in the sense of doing projects that they had not been interested or able to do before, that they are trying to do activities outside their abilities, things of that type.
Q. Do you ever have increased activity at the same time as distractibility?
A. Increased activity refers as a choice of activities that people engage. For example, a person may decide to do a wide range of activities way beyond the time of the day. Has nothing to do with distractibility.
Q. So how about a kid that doesn't want to do his homework for a whole semester and just wants to play video games or just wants to play the piano? Has he met two criteria?
A. No, because the psychomotor agitation is a very severe state that the person cannot stop moving and it's a frantic state of going from door to door or room to room or wall to wall. It has the feeling, as I said before, of a caged animal.
Q. I understand. And you're trying to evade me, but there's an "or" there.
MR SPIVACK: Objection, argumentative
BY MR TRAMMELL:
Q. It says "increased activity or psychomotor agitation".
A. Yeah I did not invent the criteria.
Q. I understand. So increased activity is -- Well, we've talked about that. So a kid that doesn't do his homework for a semester and that just wants to play the piano all the time or draw pictures, has he met two criteria?
A. Not doing the homework -- No. I'm not sure where you're going with this. [that means he doesn't *like* where Trammell is going with this.] But not being able to attend to task or being distractible is different than refusing to do your homework. [okay got that doc, but *how*??]
Q. Well, that was the example you gave.
A. You asked me for an example, I gave an example.
Q. Okay. So if –
A. But not doing your homework would be somebody that is just oppositional or unable to do the homework. Distractibility is a clinical phenomenon in which a person can't attend to task and looks to other areas for interest. [the use of the label 'clinical' is another attempt to avoid the question but Trammell isn't buying it...]
Q. How do you tell the difference?
A. This is the reason that you go to school. [i.e. don't worry about it, trust us, we're the experts.]
Q. So it's just doctors in their subjective judgment are supposed to decide?
A. Yes.
Q. "Grandiosity or inflated self-esteem" is that like little girls that say they're princesses? Is that what that means?
A. No.
Q. What does that mean?
A. It means like thinking that you are Superman and you can fly, so you go to the window and trying to fly.
Q. So a little boy who puts on his Superman costume and runs around the house is grandiose?
A. No. A little boy that puts the costume on, opens a window and try to jump is.
Q. So it has to be some sort of suicidal action?
A. No, has to be something out of the ordinary.

Q. Well, isn't everybody that jumps out of the window out of the ordinary, I mean?
A. No. This is not a suicidal act when children feel that they have flying abilities of Superman and that's the reason they want to fly out the window, not because they want to kill themselves.
Q. How do you distinguish between the detachment from reality in a small child who wears the Superman cape versus the small child that thinks he can fly?
A. Usually by the intensity and the bizarreness of the problem. So children have active fantasies; usually they don't act on those fantasies
Q. So even if a kid thinks he can fly, it's not grandiosity unless he jumps out the window?
A. The children that play Superman or house or firefighters don't act on those fantasies. If a child goes to join a fire-fighter brigade, it's a little bit different than playing house.
Q. But it is impossible for you to draw a line or ---
A. Not for me or even for you.
Q. Well, why don't you tell me how you draw the line.
A. That is part of the training that physicians go through by.... as I said before, a physician that is trained to listen to murmurs of the heart can distinguish if it's your upper valve or right valve is affected and so on and so forth, So it's all part of training. [i.e. don't worry about it, trust us, we're the experts. Always we come back to the same defence. Notice again the recurring misleading tactic: murmurs of the heart, and the location and condition of heart valves are all *objective* phenomena. Psychiatric diagnosis on the other hand is not objective at all, as Biederman has himself conceded above. He is therefore deliberately likening the subjective to the objective here in order to falsely give the former the same aura of credibility as the latter – a credibility it does not in reality have per se. But Trammel, unlike many gullible parents/patients unfortunately, is on to him......]
Q. You see, it's not an answer to say “I'm a doctor and you're not”, because you can't explain it. Can you explain where you draw the line without saying "I'm a doctor"?
A. Usually by the severity and the disability associated with the symptom. The patients that come to see me come to see me; I am not going to recruit them. Okay? So a patient is in my office because there are certain symptoms that the patient is suffering from that the family is asking for help. And I'm not going to somebody's house and taking a child that dresses as Superman and tell him you need to be treated. [No, but a parent might under the false guidance of other compromised 'opinion leaders' like Biederman.]
MR. TRAMMELL: I'll object as non-responsive.
BY MR TRAMMELL:
Q. It is a perfectly appropriate answer for you to say “I can't draw the line, I have no idea!”
A. No, that's not true. I have an idea.
Q. Okay. Well, tell me where you draw the line.
A. The idea is if the symptoms are disabling, persistent, associated with distress and disability, those symptoms are abnormal.
Q. Give me an explicit example of where you can draw the line in all cases.
A. You never draw the line in all cases; you draw the line in individual cases. So if somebody engages in an activity that is totally out of their purview, they want to do something that they have no skills of any kind and they think that they have and they actually engage in those activities. So those are things that are not necessarily just regular play of children.
Q. Do you understand that doctors hearing this who aren't trained in psychiatry [or even those that are, if the vagueness of the diagnostic criteria is anything to go by] might get the misimpression that that means things that don't rise to the level of psychotic grandiosity or

bipolar grandiosity? Do you understand that they might get that misimpression?
[Trammell should have asked him to define 'psychotic'. That's always good for a laugh at psychiatrists.....]
MR SPIVACK: Objection, no foundation.
A. I do not know what doctors understand. But the kind of things that I am talking about, a doctor hearing of the behaviors that I am describing will not see that as normative behavior.
[Oh, yes, that magical diagnostic ability of 'doctors' that defies meaningful definition again.......]
Q. "Flight of ideas or racing thoughts" what does that mean?
A. That the thoughts are flooding your head; that the child has ideas that are changing very rapidly in his or her head.
Q. How about, can you give me an example of that?
A. Well, ideas, I don't know what example to give. A person that is talking about three or four subjects at a rapid clip. The patients sometimes complain that the head is flooded with thoughts and ideas and they cannot stop it.
Q. So the patient, the kid, has to come in and say "My head is flooded with racing thoughts"?
A. No. The children will say "I have ideas that I cannot stop" and "My brain is racing" is what children say. The parents complain that the child talks about five subjects at the same time.
Q. So when a kid talks about multiple subjects at the same time, they meet one of the criteria for bipolar disorder?
A. If it's disabling and severe and does not make any sense, yes.
Q. Next is "Activities with painful consequences". Now, isn't that so vague that it's absurd? I mean, that is a useless criteria, isn't it? Because kids hurt themselves all the time.
MR SPIVACK: Objection, argumentative.
A. I think that you should write a letter to American Psychiatric Association. I did not invent these criteria. [No, but he makes a whole lot of money and bases his considerably inflated sense of his own importance upon them....] This usually reflects things like buying sprees, reflects things like engaging in extramarital affairs. Those are the things. So going on drinking binges beyond recognition or traveling across the world without having money to travel across the world, these are the things that this is alluding to.
Q. How would this manifest in a kid?
A. In kids it will manifest as doing like I told you before. A patient of mine, for example, went through the ducts of the air-conditioning to watch, a seven-year-old, to watch his mother undress in the shower, for example. Or downloading pornography or touching the genitalia of a classmate, or touching the breast of their teacher if he's a boy.
Q. That's what activities with painful consequences mean?
A. These are the childhood -- You asked me about the childhood equivalent. In adults is hypersexuality, is buying sprees, is inappropriate behavior. These are not just little things that people do. [Of course there could not possibly be a much simpler explanation for hyper-sexuality, buying sprees and escapist behaviour, like for example, a world in which children (and adults) are bombarded continually with sexual imagery, escapist fantasy, and incentives to buy, buy, buy from all directions, by mass media and Hollywood content and consumer advertising, all for the express and overt purpose of psychological manipulation and behaviour modification. I mean that explanation would call for decidedly *unprofitable* solutions, wouldn't it.......?]
Q. Aren't there things that kids do that would be extraordinary for adults but are just part of

normal childhood behavior?
A. No. [another idiotic and childishly contentious answer.]
Q. No?
A. I think that the children that engage in these activities do things that other children of the same age don't.
Q. Children are just little adults and they act the exact same way?
A. No. They have equivalent abnormal behaviors. A child may not have a credit card but may be insisting on buying things all the time, for example.
Q. But it is extraordinary for an adult to cry for no reason. It's not extraordinary for a kid, is it?
A. Children cry for reasons.
Q. Well, to cry for non-apparent reasons.
A. No, children cry for a reason [Trammell conceded this]: when they are frustrated, when they're sad, when they're reprimanded. Adults with depression sometimes cry continuously.
Q. Okay, well, how about this? And this doesn't seem to be a controversial point and I can't imagine why you're disputing it. But my son wears a Superman costume sometimes and he's four. That would be an extraordinary thing for me to do, wouldn't it?
A. No, you can dress as Superman on Halloween. [another idiotic and childishly contentious answer.]
Q. And this may be funny to you but it's not funny to me. And just so we're clear you're saying that there are no distinctions between the types of extraordinary behavior that kids engage in versus adults, and so I just want the jury to understand exactly what you're telling doctors are the diagnostic criteria for treating these kids for bipolar disorder.
MR. SPIVACK: Objection, misstates the testimony, argumentative.
A. The symptoms that children have in content may not be different but they have developmental variability because they are children. And as I said before, a child may not have a credit card but has other manifestation of excessive buying.
Q. If you'll go to, the last three numbers are 895.
A. Say again?
Q. The last three numbers on the side are 895.
A. Mm-hmm.
Q. Says Frequency of Bipolar Symptoms. It references a Wozniak and Biederman study, which I assume is you? You're Biederman?
A. Yes, I'm Biederman.
Q. It says 97 percent of-- Well, I assume what this means, and you can tell me if I'm wrong, is that in the kids who met the diagnostic criteria for a pediatric bipolar disorder, 97 of them satisfied the D criteria?
A. 97 percent had distractibility, yes.
Q. 97 percent, okay. Was that the most common characteristic?
A. One of the most common ones, yes
Q. And, again, it's tied with increased activity. Right?
A. 97 percent also had increased activity.
Q. And those are the two highest, aren't they?
A. Increased activity is one, yes.
Q. And the third highest is irritability, right?
A. Yes.
Q. So the distracted, irritable child with increased activity is the most common bipolar child. [And most conveniently for criminal drug companies (such as Johnson&Johnson) who were

looking to expand the off label use of their drug into the children market and who were therefore financing this creep to the tune of $1.6 million, this criteria apparently includes just about *all* children.....]
[pp.240-255]

Q. Let me ask you this: How many studies did Janssen pay you to do on Risperdal?
MR SPIVACK: Objection, form, argumentative
A. To my recollection, we did two studies. One was an open label study of risperidone [an open label study means testing the efficacy of a drug without comparison to a placebo control group. A placebo is an inert pill made to look the same as the tested drug. Quite apart from the entirely ideological nature of the so-called 'efficacy' of a psychiatric drug, a study done without a placebo is generally biased in favour of the tested drug because it has no way of eliminating the placebo effect from the overall results. (the placebo effect is the tendency of a certain percentage of people in any sample group to meet predefined conditions even when given an inert pill.)] and we did an imaging study using a technology that is called spectroscopy that is based on MRI [magnetic resonance imaging] to examine the effect of risperidone on the brain.
[The effect of risperidone (a so-called 'antipsychotic' and the active constituent of 'Risperdal') on the brain is to alter its structure, chiefly levels of dopamine and serotonin. Anti-depressants also affect serotonin levels in the brain. This change to brain structure is otherwise known as brain damage. I mention this in order to explain an important methodology in the ongoing Psychiatry fraud. Patients diagnosed with 'depression' or 'schizophrenia' who had been taking anti-depressants and anti-psychotics respectively for some time were shown, as would be expected, to have abnormal dopamine/serotonin levels with imaging technology such as that described above by Biederman. Despite the fact that it was well-known that psychiatric drugs actually *cause* such alterations in brain structure, such tests are often fraudulently alluded to as evidence of brain disorder correlating with ideologically defined psychiatric 'disorders'. Psychiatrist Peter Breggin explains:

"Despite more than two hundred years of intensive research, no commonly diagnosed psychiatric disorders have proven to be either genetic or biological in origin, including schizophrenia, major depression, manic-depressive disorder, the various anxiety disorders, and childhood disorders such as attention-deficit hyperactivity. At present there are no known biochemical imbalances in the brain of typical psychiatric patients—until they are given psychiatric drugs."

When later, other more honest investigators insisted that only those people diagnosed with 'depression' and 'schizophrenia' *who had never taken any psychiatric drugs* have their brains imaged, dozens of tests exposed the fraud: the fact is that there has never been any brain imaged of anyone diagnosed with 'bipolar', 'schizophrenia' or any psychiatric (non-neurological) disorder, *and who has not taken any psychiatric drugs*, that has shown *any variance at all* from normal brain structure.]
Q. How many papers have you written since you began your consulting relationship with Janssen about Risperdal?
A. I have written papers before any consulting relationship with Janssen - I believe that I have written somewhere like nine papers of the fifty or sixty that have been written on risperidone in children.
Q. So nine papers plus the two studies that you did?

A. No, that includes the studies.
Q Okay, includes the results of those studies?
A. (Witness nodded.)
Q. In any of those nine papers, did you determine that Risperdal wasn't safe or effective to treat the disease you were studying?
A. In the papers I described what I saw. I reported in detail what were the rate of response and I detailed all the side effects that we noted. [in case you are wondering, the answer to Trammell's question is no...]
Q. In all of those studies Risperdal was effective at treating whatever you were studying, right?
A. Was effective in about 60 to 70 percent of the children that received treatment with risperidone.
Q. In any study where you compared Risperdal to another drug, Risperdal was more effective, right?
A. No. Abilify was more effective than risperidone.
Q. When was that? When did that paper come out?
A. I think 2007 or-
[This creep knows exactly when he wrote the paper – the exact year that the patent for Risperdal was due to expire, making it drastically less profitable as a result. Abilify on the other hand had another eight lucrative years to go, expiring in May 2015.]
Q. After the center closed?
A. The center closed in 2005. Abilify came around that time, so I think it's an issue. I cannot study medicines that are not available to me, so I tried to study each of the atypical neuroleptics as they came to market.
Q. And in 2007 when you wrote the paper where Abilify beat Risperdal, did you have a consulting relationship with Bristol-Myers Squibb, who makes Abilify?
A. I had funding, relatively modest funding from Bristol-Myers Squibb. Parenthetically I not only studied the atypical neuroleptics, I studied carbamazine as well.
Q. So in the study Bristol-Myers Squibb funded, their drug beat Risperdal, right?
A. It was not a head-to-head comparison. Using the same protocol that we used to treat children with risperidone, we noted that the rate of response was about 80 or 90 percent compared with 60 to 70 percent. We did not do a head-to-head comparison.
Q. But the rate of response for Abilify was 20 higher than for Risperdal, right?
A. Yes.
Q. And that was a study that was funded by Abilify's manufacturer. Right?
A. Correct [pp.273-275]

Q. Do you think you could diagnose an infant under the right circumstances that was brought to you as bipolar?
MR. SPIVACK: Same objection.
A. I don't think so.
Q. You can't do it?
A. It's not that I cannot do it. There are several obstacles. One is that children don't have -- Infants don't have a large repertoire of symptoms. They cannot run around, they cannot express their emotions. They can cry. So I think that it would be very difficult to make a diagnosis in the absence of some of the descriptions that you went through with me before. The other component is that usually infants with dysregulated mood and difficulties go to a subspecialty within child psychiatry that is called infant psychiatry, so they will not have

access to clinicians like myself that tend to see children a little bit older than infants.
Q. If those obstacles were alleviated, could you diagnose bipolar disorder in an infant?
A. With the armamentarium of today, without additional information, it would be very, difficult to make a diagnosis in an infant.
Q. What additional information would you need?
A. Well, if there are biomarkers, for example, if our imaging technology or our genetic technology will alert us to a particular mutation that aggregates in children with bipolar illness, so a child that is expressing very abnormal behaviors in infancy with that mutation, the suspicion would be higher.
Q. So if you were able to use the techniques you just mentioned, could you diagnose an infant with bipolar disorder?
A. Again, it's a totally speculative. What I am telling you, when the imaging technology, biomarkers, genetic research will be advanced, the field will be able to make younger and younger diagnosis. You will be able to know that you are going to end up demented when you are an infant. We can say today that Huntington's disease is going to affect you when you are 50 at birth.
[Here Biederman sums up the sad basis of the ongoing Psychiatry fraud: the fact is that despite half a million dollars a year for four years from criminal corporation Johnson&Johnson to search for a 'biomarker' for his fictional disorder 'pediatric bipolar' (including highly sophisticated MRI brain imaging technology and genetic research facilities) Biederman came up with nothing. (Actually this wild goose chase has been going on now for hundreds of years.) Though that didn't stop this infernal idiot from advocating the use of brain structure-altering drugs to treat so-called 'diseases' without any demonstrable bio-markers, and whose so-called 'efficacy' is entirely an ideological decision.
The fruitless search for a biomarker for any of hundreds of ill-conceived psychiatric disorders has been for decades the chief thorn in the side of psychiatrists seeking an ever-elusive equal status with real medicine for their psychiatric enterprise. Naturally, to admit simply that no such biomarker exists is to admit the essential baselessness (and perhaps more significantly, the drastically reduced *profitability*) of their enterprise, and to admit further that they are nothing more than glorified quacks. Therefore, as one might guess, such honesty has not traditionally been the route favoured by psychiatrists like Biederman. They prefer to insist (and maybe even believe) that they simply haven't found the elusive 'biomarkers' yet. This of course does not stop them from prescribing toxic psychiatric drugs to unwitting and gullible 'patients' in the meantime, as if the non-existent biomarkers had *already been found*. I mean, why let the facts get in the way of their greed and their self-aggrandising delusions, or their insistence that we all adopt their spiritually bankrupt ideas about what constitutes a 'healthy' mind?
Note that Biederman's analogy of Huntingdon disease is yet another carefully chosen and misleading one. Huntingdon's disease is a genuine neurological disorder with visibly demonstrable brain structure anomalies. As such it has nothing in common with any of the so-called psychiatric disorders in psychiatry's diagnostic manual.
The fact is that this clown, Biederman, was hoping to make a name for himself finding a biomarker for what remains essentially an ideological fantasy: that mental disorder is *brain* disorder. And he failed. Nonetheless millions of people (children and the elderly included) all over the world have been, and continue to be, poisoned as a result of the criminal stupidity and conceit of psychiatrists like Biederman who together conspire to create the false impression that the ever barren search of psychiatry for scientific legitimacy has in fact been realized.

“All psychiatrists have in common that when they are caught on camera or on microphone, they cower and admit that there are no such things as chemical imbalances/diseases, or examinations or tests for them. What they do in practice, lying in every instance, abrogating [revoking] the informed consent right of every patient and poisoning them in the name of ‘treatment’ is nothing short of criminal.” — Pediatric Neurologist, Dr. Fred Baughman Jr.,]

Q. I should have asked you this first. Is it possible to diagnose an infant with bipolar disorder?
A. Today we have -- No, we don't have adequate tools to make the diagnosis in an infant.
[The fact is that psychiatrists do not have adequate tools to diagnose *anybody with any of their ill-conceived disorders*, not just infants with bipolar. Instead they must resort to absurd diagnostic 'techniques' that are entirely subjective and entirely open to multi-interpretation and misinterpretation, as we have seen above. The only thing that presently protects infants from psychiatric atrocity is the fact that they have not yet learned to talk. The psychiatrist must have first a little rope.......]
[pp. 303-305]