

## **Antipsychotics Harm Schizophrenia.**

Psychiatrists diagnose schizophrenia patients have psychosis. This means a patient has delusions and hallucinations which may cause them to hurt themselves or others. People with psychosis do not harm themselves or others any more than the general population does.

People can recover from psychosis without using antipsychotics or when they are kept on antipsychotics for only a short period of time. People who have experienced psychosis and have not taken or stop taking antipsychotics experience less subsequent episodes of psychosis over their life when compared to people who are kept on antipsychotics continuously. [1] [2] [3]

In the 1950s doctors observed that hospital patients would appear calm after administering major tranquilizers to them so psychiatrists thought it was a good idea to give major tranquilizers to patients in mental hospitals who were thought of as disruptive. Sedating mental patients was hailed a success and also resulted in psychiatrists announcing that they have discovered major tranquilizers stop schizophrenia patients' symptoms.

Patients whose schizophrenia symptoms do not reduce when medicated with major tranquilizers get diagnosed as being drug resistant or treatment-resistant and are prescribed larger doses. It is common for these patients to be tranquilized into symptom submission until they drool and shuffle. When doses are too high patients become paralytic. Clinicians have diagnosed this as the patient is deteriorating due to the progression of their mental illness. Sometimes even higher doses are prescribed to treat patients declining health.

A number of patients feel sick when they take major tranquilizers and many will inform medical staff of this and attempt to have their medication stopped or at least reduced. Psychiatrists have decided that refusing medication is bad behavior and these patients are behaving inappropriately because they are psychotic. Psychiatrists diagnose these patients as having schizophrenia symptoms which are more serious than what was first thought and in response psychiatrists will increase patients' medication. Psychiatrists' attitudes to schizophrenia patients who have bad drug reactions when they take antipsychotics are summed up in words such as non-compliant, uncooperative, dysphoric response and anosognosia.

Patients in hospitals used major tranquilizers for short periods however schizophrenia patients were being given much higher doses year after year. The outcome was that schizophrenia patients were becoming ill and many were dying. It was obvious that major tranquilizers were causing this. Instead of stopping the prescribing of major tranquilizers to schizophrenia patients in the 1970s it was decided that changing the name of major tranquilizers to antipsychotics would solve the problem.

Drugs known to be directly responsible for schizophrenia patients becoming sick and passing away were called "first-generation antipsychotics" or "typical antipsychotics". New drugs were developed using different chemicals. The new drugs were called "second-generation antipsychotics" or "atypical antipsychotics". The atypical antipsychotics caused exactly the same types of injuries and deaths as the typical antipsychotics. It was decided by drug manufacturers and psychiatrists that it is reasonable for schizophrenia patients to be exposed to the now well understood ill-effects of antipsychotics.

Today it is common for clinicians and drug manufacturers to insist that the injuries caused by antipsychotics are in fact symptoms of psychosis, genetics, life-style choices, aging and

disease. The harms antipsychotics cause are as invisible to clinicians and drug manufacturers as all the schizophrenia patients made sick and killed by antipsychotics.

For over 65 years schizophrenia patients have been recommended, coerced and forced to use antipsychotics. Schizophrenia patients die on average 25 years earlier than the general population. [4] This is primarily because antipsychotics are slow poisons particularly when doses are high. Repeated doses result in injures and continued use causes death. Physical health, age, dose size and length of time on medication will influence how soon death occurs. For example a person who starts using antipsychotics when they are young and healthy might live 1 - 3 decades but an elderly person might die within a few months or years from commencing medication. Elderly people who take atypical antipsychotics for dementia related psychosis are at increased risk of death compared to placebo.

In 2005, studies using monkeys reveal when healthy animals are exposed to antipsychotics for 17 to 27 months, they lose an average of 8-11% of their brain volume. Researchers tested Haldol [brand name for the typical antipsychotic haloperidol] and Zyprexa [brand name for the atypical antipsychotic olanzapine]. [5]

In America now antipsychotics are prescribed to over 1% of youth under age 18 and children as young as 5. [6] In 2018 Australian investigators published that antipsychotics may cause brain atrophy in children. Psychiatrists have challenged this by insisting psychosis itself is responsible for brain atrophy and medications may protect the brain by reducing symptoms. [7] The populations of schizophrenia patients who have never been exposed to antipsychotics do not have brain atrophy.

Serotonin and dopamine communication increases greatly when people have good and pleasurable feelings and experiences. There are over 60 varieties of chemical messages or neurotransmitters in the human brain. Dopamine and serotonin are two neurotransmitters. Neurotransmitters communicate messages from neuron to neuron, across different parts of the brain and between the brain and the rest of the body. The brain contains billions of neurons.

Neurons have approximately 6 to 8 receptors on them. When a neuron receives neurotransmitters from another neuron each of its receptors bind with individual neurotransmitters. If there is sufficient neurotransmitter-receptor binding the neuron will fire an electric impulse which will cause its own neurotransmitters to be released to the next neuron. This is how the brain communicates.

Antipsychotics are a "receptor antagonist" meaning they bind to and block receptors so they can no longer receive neurotransmitters. Blocked receptors sedate patients by switching off communication pathways in the brain so the brain is working at reduced capacity. In other words antipsychotics are chemical lobotomies. There are 5 types of dopamine receptors and there are 15 types of serotonin receptors. Antipsychotic drugs randomly target receptor types never identified as causing or contributing towards the existence or symptoms of any mental disorders.

In order to correct the situation of receptors not working neurons will grow new receptors to replace their blocked receptors. This means the brain has the ability to recover from having its receptors blocked. If an antipsychotic drug dose is at too high or administered for too long periods of time neurons will need to grow so many replacement receptors thus they become deformed and resemble cancerous growths. The communication pathways that consist of such neurons over time become permanently damaged and will no longer work even after medication is stopped. This is a permanent lobotomy and to keep consuming antipsychotics does nothing accept further damage. Permanently dysfunctional dopamine communication pathways result in movement disorders (tardive dyskinesia), psychotic symptoms (tardive psychosis) and global cognitive decline (tardive dementia). [8] It is reasonable to prescribe antipsychotics for up to 3 months unless a patient requests otherwise. It is also recommended that patients who have no

schizophrenia symptoms after using antipsychotics for 12 months should be weaned off medication because the majority of these patients will not have psychosis. [9]

Antipsychotics are addictive<sup>1</sup> and stopping cold-turkey usually results in the patient developing withdrawal psychosis (this involves a surge of unusual thoughts, emotions and behaviors). The correct method for antipsychotic drug withdrawal is a slow tapering of doses over time. How long depends on what amount of medication the patient was on in the first place. Almost all patients who are slowly weaned off their meds do not develop withdrawal psychosis. It is recommended that patients should only stop taking antipsychotics under medical supervision it is almost impossible to find a clinician who will do this.

Almost all clinicians believe antipsychotics are not addictive thus patients who have the opportunity to stop taking antipsychotics are taken straight off their medication and it is common for them to develop withdrawal psychosis. These clinicians believe that when antipsychotic medication stops, psychosis manifests in the patient, so antipsychotics stop psychosis therefore patients must continue taking antipsychotics for the rest of their life.

I was very depressed after a relationship breakup, not having a job and moving in with my parents. Mum seeking help found it in the form of getting me committed. I had no contact with a psychiatrist but daily I was given 20 milligrams of Zypine [olanzapine]. I never was told the name of the psychiatrist who diagnosed me with schizophrenia. After almost 3 weeks as an involuntary patient a nurse told me I had schizophrenia and then she said nothing else.

Once off methadone for a few months I found 10 mg in the morning and 10 mg in the evening of Zypine made me feel too tired and unmotivated, and I gained a lot of weight so I stopped taking it and I felt great. I told Mum but she was told when patients stop taking medication schizophrenia symptoms return. She got me help again and I was committed for a second time. The police apprehended, handcuffed and drove me to a hospital where I was physically restrained and injected with 150 mg Invega. About 10 days later I laid eyes on a psychiatrist at a legal proceeding known as a Mental Health Inquiry where he recommended I am detained as an involuntary patient for 2 more weeks.

My release from a mental hospital was on the condition that I complete a Community Treatment Order (CTO) at the local Community Centre to police my taking 150 mg of Invega by injection every month. After a year a psychiatrist gradually reduced my dose and I got down to 50 mg then she left and was not replaced. After being on a CTO for almost 3 years I was released into the care of a local doctor who was writing my Invega prescriptions.

I found one psychiatrist who automatically bulk-billed Medicare and he was the same psychiatrist I had at my last Mental Health Inquiry. I questioned why I was diagnosed with schizophrenia he answered - no job.

I asked the psychiatrist to reduce my dose to 25 mg he said no. Another time I asked him to take me off antipsychotics all together he laughed at me like I was being funny. On another visit in desperation I asked if he could put me back on Zypine in the hope that this might lead to reducing my dose but he said this would be impossible and then he told me I could see another psychiatrist if I didn't like it.

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<sup>1</sup> Antipsychotics withdrawal symptoms include: abnormal skin sensations, aching muscles, anxiety, diarrhea, dizziness and vertigo, feeling too hot or too cold, feeling withdrawn socially, headaches, loss of appetite, mood disturbances, nausea (feeling sick), neuroleptic malignant syndrome, restlessness, agitation and irritability, runny nose, shaking, insomnia, sweating, tardive dyskinesia, tardive psychosis and vomiting.

Drug manufacturers' consumer information offers no science behind why schizophrenia patients must all use antipsychotics to manage symptoms. (1) Zypine: "this medication helps by correcting imbalances in the brain which may cause mental illness." (2) Invega: "The mechanism of action of paliperidone, as with other drugs having efficacy in schizophrenia is unknown, but it has been proposed that the drugs therapeutic activity in schizophrenia is mediated through a combination of central dopamine Type 2 (D<sub>2</sub>) and serotonin Type 2 (5HT<sub>2A</sub>) receptor antagonism."

Antipsychotics users do not pass out on high doses like people do on opiates so clinicians believe that high doses are not harmful. On high doses patients can't think, are tired, feel unmotivated, live like invalids and have an insatiable hunger as if the body craves food as an antidote to an overwhelming feeling of fatigue. Denying people with psychiatric disorders the right to refuse medical treatment exposes them to medical treatment which causes them more harm.

Overdosing patients robs them of the will to live. The suicide rate for schizophrenia patients who use antipsychotics is higher than the general population.

**Adverse reactions to antipsychotics:** (1) Aggression; (2) Agitation; (3) Anemia; (4) Apathy; (5) Blood clotting disorders including deep vein thrombosis and blood clot in the lung - can be fatal; (6) Blurred vision; (7) Brain atrophy; (8) Brain damage; (9) Cardiovascular and pulmonary disease; (10) Cognitive and motor impairment; (11) Dead brain cells; (12) Decreased life expectancy; (13) Dementia; (14) Degeneration of the retina; (15) Drowsiness; (16) Dry eye; (17) Dry mouth - makes teeth rot; (18) Dysphoria - is a state of mental discomfort or suffering. Feel depressed and awful. It's also a state of unease, dissatisfaction, restlessness, anxiety and misery; (19) Dysphoric mood expressed by patients as sadness, heaviness, numbness or sometimes irritability and mood swings. Sufferers often report a loss of interest or pleasure in their usual activities, difficulty concentrating, or loss of energy and motivation; (20) Dysphoric response refers to those patients who habitually complain about the drug effect. They feel "miserable" on the drug, and continually plead to have the drug stopped or dosage reduced; (21) Tardive Dystonia or muscle dystonias is prolonged abnormal contractions of muscle groups such as spasm of neck muscles progressing to tightness of the throat, swallowing difficulty, difficulty breathing and/or protrusion of the tongue - very painful; (22) Exhaustion or fatigue; (23) Extrapyramidal Symptoms (EPS) or drug induced movement disorders include: (A) muscular spasms, tremors, skeletal muscular rigidity, shuffling, stooped posture, involuntary muscle movements in the lower face and distal extremities; (B) Parkinsonism, symptoms are: muscles become stiff and weak, face may lose its animation, fine movement might be difficult, may develop a slow tremor especially in the hands, fingers may move as if they were rolling a small object between them, when walking may lean forward, take small steps and find it difficult to start and stop, and mouth may hang open and may dribble; (C) Akathisia or Tardive Akathisia: the presentation of akathisia is variable and comprises subjective complaints of restlessness - that can be present as tension, nervousness, or anxiety, or distress - and an overwhelming urge to move such as pacing, swinging of the legs while seated, rocking from foot to foot; (24) Fall in blood pressure; (25) Glaucoma (gradual loss of sight); (26) Headache; (27) High blood pressure; (28) Hypersensitivity reactions such as allergic reaction and anaphylactic reactions; (29) Impairment of learning and memory; (30) Increased appetite; (31) Increased prolactin is a sex hormone that causes breasts to produce milk; (32) Increased risk of death compared to placebo in elderly patients; (33) Increased sensitivity to sunlight; (34) Insomnia; (35) Interference with calcium metabolism and bone structure - osteoporosis ; (36) Life threatening intestinal disorders;

(37) Long QT syndrome - the heart takes longer than normal to recharge between beats and the heart rhythm is irregular - this can be fatal; (38) Lose the will to live; (39) Loss of movement or difficult to move and muscles may feel very weak; (40) Low white blood cell count: more likely to catch infections and less able to fight them - can be fatal; (41) Malaise; (42) Metabolic Syndrome - is a medical term for the following symptoms: weight gain and obesity, high blood sugar, diabetes, high blood pressure, high cholesterol. Metabolic syndrome increases risk of getting diabetes, stroke, heart disease and cardiovascular disease; (43) Mood disorders; anxiety and depression (44) Nausea; (45) Neuroleptic Malignant Syndrome (NMS) develops in 24 - 72 hours affects the nervous system. Results in death in up to 30% of cases. Symptoms are: sweating or fever, high temperature, tremors, rigidity or loss of movement, difficulty speaking and swallowing, rapid heartbeat and breathing and changes in blood pressure, and changes in consciousness, from lethargy and confusion to stupor or coma and acute renal failure. Symptoms may last for days or weeks after coming off antipsychotics. People who get NMS tend to get it again if antipsychotics resume. NMS can occur when starting medication, or after dose increases and after being on a steady standard dose for many years or when withdrawing from antipsychotics; (46) Over the long term antipsychotics may cause dopaminergic pathways in the brain to become permanently dysfunctional and may lead to: (A) movement disorders (tardive dyskinesia) (B) severe psychotic symptoms (tardive psychosis) (C) global cognitive decline (tardive dementia); (47) Pain in muscles; (48) Pancreas, kidney, liver and abdominal damage - each can be fatal; (49) Physical inactivity and deterioration; (50) Problems with regulating body temperature - too high or too low; (51) Rapid heartbeat; (52) Reduced ability for physical activity; (53) Reduced brain activity; (54) Seizures; (55) Sexual dysfunctions: decreased libido, spontaneous ejaculation, persistent and painful erection of the penis, impotence, sterile sperm, enlargement of man's breasts and an abnormal absence of menstruation; (56) Sleepiness/tired; (57) Socially withdrawn and detached from those around you; (58) Spontaneous flow of milk from the breast not associated with childbirth or nursing; (59) Stroke; (60) Suicidal feelings and behavior; (61) Tardive Dyskinesia (TD) is a syndrome of potentially irreversible involuntary muscle movements, including diminished voluntary movements and movements similar to tics or jerky involuntary movements affecting especially the shoulders, hips and face. TD is a painful disease. TD is also a common drug withdrawal symptom; (62) Tardive Psychosis (TP) is new psychotic symptoms which arise after taking antipsychotics for a while, and which are caused by the medication not the original illness returning. TP is also a common drug withdrawal symptom; (63) Thrombotic thrombocytopenic purpura (TTP) is a blood disorder in which blood clots form in small blood vessels throughout the body; (64) Vomiting.

[1] <https://www.madinamerica.com/2013/03/do-antipsychotics-worsen-long-term-schizophrenia-outcomes-martin-harrow-explores-the-question/>

[2] YouTube. Video: "Take These Broken Wings -- Healing from Schizophrenia, Cure without Medication" (FULL FILM). Subscribe: Daniel Mackler.

[3] <https://www.madinamerica.com/2017/04/new-study-explores-long-term-outcomes-antipsychotics-drugs/>

[4] <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2466831>

[5] [www.breggin.com/td-resources/Dorph-Petersen2005-monkey-brain-damage-pdf](http://www.breggin.com/td-resources/Dorph-Petersen2005-monkey-brain-damage-pdf)

[6] <https://www.madinamerica.com/antipsychotics-pediatric-use/>

[7] <https://www.madinamerica.com/2018/11/researchers-warn-brain-atrophy-children-prescribed-antipsychotics/>

[8] [breggin.com/antipsychotic-drugs-and-tardive-dyskinesia-resources-center/scientific-literature/](http://breggin.com/antipsychotic-drugs-and-tardive-dyskinesia-resources-center/scientific-literature/)

[9] YouTube. Video: "How to CURE Schizophrenia." Subscribe: Zorkmid123.

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## **Mental Humour.**

I object to screening 0 - 3 year olds for mental illness or emerging mental illness. This is blatant recruiting to make more consumers of psychiatric drugs.

Will parents who refuse for their 3 year old to take antipsychotics lose custody of their child?

There are adults who cannot get a prescription for speed (or ADHD drugs) but a hyperactive 2 year old can?

Antidepressants cause depression, anxiety and suicide in some patients how does a 1 year old say this drug makes me want to die?

Irregular feeding patterns, difficulty sleeping, whining, crying, calling for absent parent, temper tantrums, shyness and hyperactivity are not symptoms of psychiatric disorders or emerging mental illness. These behaviors are all normal for 0 - 3 year olds.

Zoloft antidepressants for the newborn with irregular feeding patterns

Prozac antidepressants for the 1 year old that was whining and crying

ADHD drugs for the 2 year old that was hyperactive

Zypine antipsychotics for the 3 year old that calls for absent parent

Electricity brain stimulating device for the 4 year old that has temper tantrums

Lithium mood stabilizer for the 5 year old that is shy and has difficulty sleeping.

If you don't have a mental illness a psychiatrist can give you one.

You need to have a very low opinion of someone to think that giving them a lobotomy will help them. Antipsychotics work by cutting off parts of the brain from working so the brain can no longer do the things it needs to do.

Victims are being held hostage by psychiatrists as schizophrenia patients who must live as antipsychotics consumers.

Antipsychotics lobotomy for all the mental patients in the asylums of the 1950's.

Antipsychotics lobotomy for all schizophrenia patients since the 1950's.

Antipsychotics lobotomy for Mr. and Mrs. Normal to treat their anxiety in the 21st century.

Antipsychotics lobotomy for all the children who do not live up to expectations.

Anxiety, depression or schizophrenia it's all the same thing the only difference is respectable people don't have schizophrenia said one psychiatrist to another.

Just because someone says something is good for you do not make it so. It's good you have been diagnosed with schizophrenia because now you there is a medication you can take. It's good medication it will make you well say the psychiatrist, doctor and nurse. It doesn't take long for you to find out how wrong they all are.

How do antipsychotics work? They make your mouth dry and your eyes feel like there's sand in them and everything appears too bright. They make your vision blurry and your sight deteriorates.

## Mental Humour.

They make you feel like your body is overheating one minute and the next you cannot get warm enough. They make you feel like you're always starving hungry. They give you a grey complexion and rashes of red spots all over your body. They give you blood clots and varicose veins. They make you overweight; give you high sugar, diabetes and high cholesterol. They make it hard for you to think; you cannot learn new things or remember what you did a minute before because your mind is basically blank. Antipsychotics make you anxious, depressed and suicidal. They make you psychotic. They make parts of your body tremble uncontrollably. They make your muscles feel like stone which is unbearable agony. They make your blood pressure go too high so it feels like your head is going to explode. They make your blood pressure go too low so you feel faint. They make you get osteoporosis and make your teeth rot. They make you get Parkinson's disease. They make you unmotivated and fatigued. And if Antipsychotics don't kill you first they give you dementia.

Some people see the disease schizophrenia as a hallucination, conjured out of delusions which have for over a century been complimented with faulty scientific perceptions and disordered medical thinking. The symptoms of schizophrenia appear to make psychiatrists so paranoid they become unmotivated and have trouble thinking thus they interpret abnormally which has led to their faulty perception that antipsychotics are the bee's knees for the management of schizophrenia.

I can see you're psychotic I have the vision of a psychiatrist.

Manufacturers of antipsychotic drugs and psychiatrists toasting to a job well done as the number of their schizophrenia detainees keeps on rising. It is estimated 51 million people have schizophrenia in the world.

Psychiatric drug manufacturers are laughing all the way to the bank.

Psychiatrists are giggling living their life-styles of the rich and famous.

Mental health care workers are grinning they can afford to pay their bills.

And mental patients are crying and dying because they are at the bottom of the food chain.

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## How Psychiatric Drugs Work.

Psychiatric drugs alter chemical activity in the brain which will either decrease or increase how much communication takes place in the brain. This communication is processed and interpreted into instructions for how the brain will operate the body. These instructions result in the body working differently to what it normally would be. How the body is working affects how a person feels. Psychoactive drugs can change how a person feels by changing how the body works. When a person feels differently their mood changes and this is how psychiatric drugs can work to stop some patients' mental disorder symptoms.

Mind altering drugs each have the ability to change a patient's mood by making their body feel sedated or stimulated. This can give instant emotional relief so a person might become calm, relaxed, happy, optimistic or excited. It is common for people to use mind altering drugs to improve on how they are feeling or to psychologically adapt to their environment.

Psychoactive drugs do not directly alter a person's mood so there is no guarantee that how a drug is operating a person's body will improve how they are feeling. A drug that works for some people will also not work for other people and will in fact make some people feel sick. Because a drug does not suit all people the people it does work for should not be denied access. The range of psychiatric drugs that are available means finding a drug that will work to improve how a person is feeling is possible for almost everyone.

A psychiatric drug will affect patients so they will fit into one of the three following categories: (1) Patients who enjoy how a drug makes them feel they can become positive and this change in mood can result in patients psychiatric disorder symptoms stopping. (2) When a patient feels unwell due to how a drug has altered how their body is working they get distressed. This may or may not stop them from showing psychiatric disorder symptoms but they are having a bad drug experience which can be far worse than the disorder they are being treated for. If medication is not stopped patients may become depressed, anxious, suicidal, violent or aggressive. (3) If a patient physically feels little or nothing when they take a drug it means for them this drug has no mind altering effect however the drug is altering chemical activity in the brain so clinicians need to evaluate if these patients health is improving or deteriorating over time. The medication may be working only as a placebo for some patients.

It is appropriate to prescribe psychiatric medications firstly according to how a patient is feeling and secondly according to the type of mental disorder they have been diagnosed with. **A drug should not be allocated as the only medication that all people with a particular type of mental disorder must use because some people will not respond well to the drug thus their health will deteriorate if medication continues.** For example some people with: (1) schizophrenia find increasing dopamine, norepinephrine and serotonin improves mental health (and reducing dopamine and serotonin deteriorates mental health), (2) depression find increasing dopamine and norepinephrine improves mental health (and increasing serotonin deteriorates mental health) and (3) ADHD find reducing dopamine and serotonin improves mental health (and increasing dopamine and serotonin deteriorates mental health).

People who have depression are prescribed antidepressants and this treatment works for some patients under the assumption that the theory of not enough serotonin in the brain causes depression is correct. Some patients who use antidepressants get more depressed, anxious and suicidal. Ignoring this is harmful to patients. They should be given access to trying other psychiatric drugs not be put on higher doses of antidepressants.

Many schizophrenia patients object to using antipsychotics because antipsychotics make them feel unwell. Psychiatrists have constructed a narrative for patients saying they are psychotic and that is why they are objecting to medication so their drug dose is increased. The dose for

almost all patients who do not complain that antipsychotics make them feel unwell is up to 20 milligrams while patients who feel unwell when using antipsychotics can find themselves being prescribed up to 150 mg. It has been noted by psychiatrists that patients who are placed on high doses after objecting to medication tend to share the following characteristics; non adherence to treatment, higher relapse rates, increased number of involuntary treatments, poorer psychosocial functioning, aggression and a poorer course of illness. A long time ago if psychiatrists listened to schizophrenia patients the way psychiatrists expect schizophrenia patients to listen to them they would learn that antipsychotics are not appropriate treatment for all schizophrenia patients. In summary one psychiatric drug to treat everyone who has a particular mental disorder is not the correct medical approach to treating psychiatric disorders.

Any psychiatric drug is able to treat any psychiatric disorder when it is compatible to a patient. It is unreasonable to deny people access to the healing powers of any psychiatric drug because they do or do not have a particular mental disorder. Recreational drug users enjoy psychoactive drugs because they make them feel better generally speaking they are excluded from access to psychiatric medications. Recreational drug users are often called drug addicts and it is common for them to get diagnosed as having a substance abuse problem so they cannot get prescriptions for certain drugs that work for them.

Clinicians make an educated guess about what is the best size dose to begin a patient on and use patient feedback to diagnose if a dose is too high or too low because patients are in the best position to tell how a medication is affecting them. Under dose patients and medication acts as a placebo. Overdosing patients can inebriate, disable and injure. If the doses are too high or a patient's drug tolerance is low patients can become aggressive, manic, docile or submissive. People have different tolerance levels to different drugs. An average standard size dose will not suit all patients. A dose must not be determined only by the severity of symptoms.

Psychiatric drugs only have the potential to be therapeutic if a patient likes how the drug affects them. Each patient needs to have access to experiment with trying different types of psychiatric drugs in order to find out which drugs work best for them. A drug must be tailored to a patient based on the patient's feedback to the clinician about how their drug experience is working for them.

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## Psychiatric Drugs and Drug Addiction

A patient will become addicted to a psychoactive drug after using it for 3 to 7 days in a row. When a patient begins taking a mind altering drug the drug will increase or decrease communication in the brain. This means a different set of instructions being communicated than what the brain would otherwise have done. The brain responds to instructions that are different from what it intended as something it must stop. The brain does this by adjusting its own neurotransmitter or receptor supply to factor in with the neurotransmitter or receptor activity of the drug so that together the brain and the drug cause neurotransmitter communication in the brain to work as the brain wants it to work. The brain is now dependent on the drug to work the way it wants to work because now it is relying on the drug's chemical activity to perform exactly as it did prior to medication and this means the patient is now addicted to their medication.

The brain restores its chemical activity so it resumes working the same as it was prior to medication. The medication stops causing abnormal neurotransmitter or receptor activity and now the drug's euphoria usually stops and for some people it is replaced with a general sense of wellbeing. During addiction the mundane chemical presence and activity of a psychiatric drug can influence some patients to feel calm, positive or optimistic.

On the other hand there will be patients who once they become drug dependent the drug no longer gives them a sense of wellbeing because only the drug's euphoria associated with when one initially begins using a drug has a therapeutic effect for them so the medication stops working. These patients may do well by rotating between two or more types of psychiatric drugs or they may benefit from having their dose varied over a three day cycle. For example: day one - dose strength 5 = euphoria; day two - dose strength 4 = feeling of wellbeing; day three - dose strength 3 = feeling of wellbeing; day four - dose strength 5 = euphoria; and so on. If a person must experience ongoing euphoria for wellbeing by having varying doses, or just a constant feeling of wellbeing by maintaining on the same dose every day - depends on which method works best for each person.

When a patient is addicted to a psychiatric drug they will have drug withdrawal symptoms if the drug is stopped suddenly. The exception is when a patient switches straight from one psychoactive drug to another psychoactive drug then as a rule there are no withdrawal symptoms. This shows that the neurotransmitter communication mind altering drugs orchestrate in the brain completely control how the body works when patients begin medication.

The correct method for drug withdrawal from psychiatric drugs is a slow tapering of doses over time. How long depends on what amount of medication the patient was on in the first place. Patients who are slowly weaned off their meds will find their drug withdrawal symptoms are more manageable. Clinicians recommend patients should stop taking some types of psychiatric drugs under medical supervision however it is virtually impossible to find a psychiatrist or doctor who will do this. A patient who has been on a drug for a period of time and is enjoying good mental health and decides they want to stop using should be encouraged and supported by clinicians.