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THE FILM

When profit-driven medicine meets human beings in distress.

OFFICIAL SELECTION COURAGE FILM FESTIVAL 2020

THE VIRTUAL REEL RECOVERY FILM FESTIVAL 2020 OFFICIAL SELECTION

PERISCOPE MOVING PICTURES

LOCATION SOUND BY ALAN BARKER MUSIC BY NATHAN HALPERN EDITED BY DAVID DAWKINS DIRECTOR OF PHOTOGRAPHY JOAN CHURCHILL

PRODUCED BY MUFFIE MEYER PRODUCED & DIRECTED BY LYNN CUNNINGHAM AND WENDY RACTLIFFE

medicatingnormal.com

MEDICATING NORMAL: DISCUSSION GUIDE FOR 76-MINUTE VERSION

Note: When navigating the DVD, use the chapter numbers only. When streaming the film, use these streaming times.

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Chapter 3	Over-Medication for Life's Stressors	19:25
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WARNING: This film is controversial.
It contains important information that you may not have heard before.
Its intent is to counteract the prevailing view that psychoactive drugs are the answer to all mental suffering. These drugs can relieve symptoms, and there are good psychiatrists who do not over-prescribe them. However, for a significant segment of the population, these drugs can cause serious harm. It is very important to become informed about the pros and cons of psychotropic drugs before taking or stopping them.

CHAPTER 1: PBS SPONSOR MESSAGES (~00:00)

Medicating Normal premiered on public television in January 2022. In its 3-year PBS run, the film is anticipated to reach millions of viewers. A special thank you to the film's PBS sponsors whose messages play at the beginning and end of the film for viewers.

To visit the sponsor's websites and learn more about the valuable resources they provide, click on their respective logos below:

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CHAPTER 2: INTRO AND WHAT LED FIVE PEOPLE TO MEDICATION (~01:01)

In today's society, much of human suffering - grief, sadness, distractibility, sleeplessness, trauma, etc. - is often seen as an "illness" needing a "quick fix" or a pill.

- What is normal? What would you consider a "normal" reaction to war, trauma, loss, academic pressure, job or marriage dissatisfaction? Consider a normal reaction versus an abnormal reaction to the above life's circumstances.
- What is mental illness and what is mental health? Who determines what is normal and what is abnormal?[1]
- What are some reasons people seek out psychiatrists and psychologists as authorities to help them? Who influences where we, as a society, seek out help with life's struggles?
- At the beginning of the film, it says, "1 in 5 Americans take prescribed psychiatric medications daily." Talk about why this is occurring - what could be the underlying reasons for this?

CHAPTER 3: OVER-MEDICATION FOR LIFE'S STRESSORS (~19:25)

Marketers of all kinds have conflated being "normal" with being "comfortable," and pain as something that needs to be medicated. The DSM-5, the bible of psychiatry, defines and categorizes *symptoms of distress* that are then used to provide a diagnosis. A prescribed medication requires a diagnosis.

- How does the DSM-5 and its 157-listed disorders influence the way we see ourselves and others?
- There are many legitimate reasons people experience mental health "symptoms." For example, severe life stressors such as grief, a breakup, academic overload, trauma, or in current times- the pandemic. How does a clinician differentiate between a normal reaction to a life stressor versus a mental illness? The textbook answer is that when a person's distress begins to interfere with their lives, functioning, and productivity, this equals mental illness needing medication. Discuss what is wrong with this narrative. [Hint: Should a bullied student presenting with anxiety and depression, who refuses school, be medicated?]
- How can a professional encourage a patient to recognize and communicate their feelings and take action to alleviate stressors?
- When, how and by whom should individuals be taught the life skills of self-regulation, problem-solving, safety, boundaries, communication, and other mechanisms to help people cope with life's stressors?

CHAPTER 4: DEBUNKING THE CHEMICAL IMBALANCE THEORY OF MENTAL ILLNESS (~22:35)

An examination of the origins of the "chemical imbalance" theory, this chapter explores the now debunked theory that a single chemical can rebalance a chemically imbalanced brain. Psychiatry, marketers, mainstream media, and average Americans still buy into the idea that there is a "pill for every ill."

- How much do we actually know about the brain and whether or not certain levels of neurotransmitters cause mental illness?[2]
- Why do you think the chemical imbalance theory persists? Why do you think our medical profession still relies on the rationale of the chemical imbalance theory even though it has been disproven?[3]
- How can we think about human distress outside of the disease model?[4] Talk about some of the things that can affect mood, behavior and well-being. Consider things that are not commonly thought of as emotional stressors. [Hint: diet, exercise, sleep, socioeconomic stressors, sense of purpose, symptoms stemming from physical disease - thyroid, MS, brain tumors, Parkinson's, etc.]
- Could prescribed medications—psychiatric or otherwise—cause a sort of "chemical imbalance" of their own?[5]

CHAPTER 5: POLYPHARMACY: NEW SYMPTOMS LEAD TO MORE DRUGS (~26:30)

Polypharmacy occurs when a person is prescribed multiple medications at the same time. Often, medications are not studied in combination or in the long term. When a side effect occurs, often another medication is given to alleviate the side effect. Other times, side effects (like mania or sleeplessness) are misidentified as new disorders for which more medications are given–this is referred to as a prescription cascade. Patients may be prescribed cocktails of drugs, resulting in increased healthcare utilization, and risk for disability and serious adverse outcomes.

- What are the risks and costs of polypharmacy? Consider also vulnerable populations.
- How can patients learn about the drugs they are taking, including their side effects? What is health literacy? What should basic health literacy consist of? How do we teach patients and providers to acquire and maintain basic health literacy? Address the fact that people with lower socioeconomic status may have little to no basic health literacy or self-advocacy skills, and therefore may need more time with healthcare providers.
- What are some of the reasons that drugs cease to be effective? [Hint: tolerance, adverse reactions over time, drug interactions]
- Discuss how side effects are often mistaken for new illnesses leading to more prescriptions and potentially even more adverse events.
- Where can a person find trustworthy information about medications? For example: pharmacists, doctors, Drugs.com/Drugs Interactions Checker, RxISK.org, Cochrane Database, Therapeutics Initiative, Physician's Desk Reference (PDR), etc. How can a person determine whether a source is trustworthy?

CHAPTER 6: MEDICATIONS CAN PROVIDE HELP BUT ALSO CAUSE HARM (~34:01)

Psychiatric medications can help many people, particularly in the short term. For some they are life-saving, for others they are life-threatening. They can and do serve a purpose, i.e., in an acute crisis, to get through an uncertain time, or occasionally to get sleep. However, even when medications initially help, our biology and environments are constantly changing; and medications can unpredictably shift to becoming counterproductive or even harmful.

- When and in what settings can psychiatric medication help?
- What do we mean when we say that psychiatric drugs "work?" Talk about some of the coexisting pros and cons of how medications affect people? Consider antidepressants and benzodiazepines as examples.
- Since no one can adequately predict who will be harmed by medication, talk about how you - if you were a prescriber - might grapple with this question.
- What are things that can impact a drug's effectiveness? [HINT: the placebo effect[6], hormones, diet, age, interaction with other drugs or alcohol, beliefs about how drugs work, beliefs about the cause of symptoms, and beliefs about a drug's efficacy.]
- Drugs are frequently prescribed for much longer periods of time and for greater frequency than recommended (on the packaging insert, for example). What would it look like if health care providers had a plan for discontinuation in place? Talk about the consequences of not having an exit plan.

CHAPTER 7: PHYSIOLOGICAL DEPENDENCE & WITHDRAWAL (~35:51)

Physiological dependence and withdrawal are realities not often acknowledged or identified in clinical practice. Withdrawal symptoms can range from mild to severe and life-threatening. Some patients can discontinue their psychiatric medication without any immediate withdrawal effect, while others have symptoms that can last for months to years (protracted). These symptoms range in severity from dizziness and brain zaps to extreme irritability, akathisia, suicidal urges and more.[7,8]

There are different ways that a patient can experience withdrawal symptoms:

- Tolerance is when the original dose of drug has progressively less of the desired therapeutic effect and a higher dose is required to obtain it. Tolerance withdrawal means that "withdrawal symptoms" can occur even in the continued presence of the drug.
- During a planned taper, uncomfortable and even life-threatening withdrawal symptoms can occur, which usually means the taper is too fast.
- Abrupt discontinuation (going "cold turkey") can be very dangerous and is ill advised. It can bring on extremely uncomfortable and life-threatening symptoms (seizures, for example). These symptoms may not show up immediately - they can even occur weeks or months after discontinuation.

CHAPTER 7 CONTINUED...

Withdrawal symptoms can occur even after taking a "low dose" of a medicine and/or for a short period of time. Often, online peer support groups provide guidance and are the only refuge for patients struggling to come off their prescribed drugs. Healing from the neurological damage that some people experience requires enormous support.

- All classes of psychiatric drugs can cause physiological or psychological symptoms during withdrawal. The severity of the symptoms and their presentation vary widely. How can or should this fact impact how they are prescribed?
- Are there adequate systems in place for patients who wish to come off of their psychiatric drugs and, if not, what new systems could be developed? What kinds of tools could help healthcare providers wanting to assist those patients?
- How can professionals identify whether or not a patient's physiological and emotional presentation could be related to adverse effects of the medications they are taking, physiological dependence and/or withdrawal?
- It is very hard to tell the difference between symptoms of tolerance, withdrawal, and/or relapse of the original condition. Determining which one is occurring can inform the patient's treatment plan and referral. What are some questions you could ask the patient to help determine the root cause to inform next steps?

Note: Twelve step programs are designed to address the behaviors of addiction (i.e., compulsive use of drugs) and help people maintain their sobriety once off drugs; they do not help people taper prescribed drugs. Rehab and detox programs tend to take people off psychiatric drugs much too quickly and prescribe other psychiatric drugs to alleviate symptoms of withdrawal.[9]

CHAPTER 8: SAFE TAPERING (~40:20)

Prescribers have vastly different strategies for tapering as there are currently no universal protocols for deprescribing. However, all clinicians should strive for patient-centered, symptom-based tapers with as much professional, peer, and/or family support as possible.

- What kind of support do you think a person may need while undergoing a planned taper and withdrawal? What can a professional do to support the process? (Consider low socioeconomic status clients who cannot afford co-pays for therapy or alternative treatments.)
- Often patients are discouraged from using the internet to investigate their symptoms or for additional information. Discuss the pros and cons of online, peer-run support groups for people tapering and healing from physiological dependence and withdrawal.[10,11]
- Given that people have to taper at unique rates due to tolerability and circumstance, how does a healthcare professional provide a patient-centered, symptom-based taper? What would this look like?

CHAPTER 9: SUICIDE, LIVES INTERRUPTED & US MILITARY VETERANS

(~43:50)

In today's society, much attention is paid to the rising number of suicides, particularly among our military. The contributing role that medication plays is not widely acknowledged. Black box warnings for suicide are there because of overwhelming evidence. It is imperative that patients and healthcare providers pay closer attention to them. Psychiatric medications can lead to suicidal ideation, and also to dis-inhibited behaviors such as violence, gambling and reckless sexual impulses.

- How does a patient distinguish suicidal ideation that is caused by a drug versus originating from the distress itself? How does a clinician tell the difference? What should the treatment be if found to be caused by a drug?
- When servicemembers come home from war, they go through the disability process and receive monetary support, which often includes multiple medications. Does long-term psychiatric treatment convert capable and combat-tested veterans into chronically mentally ill patients and thereby disincentivize real healing? Does anyone consider that psychiatric treatment itself, could be causing disability and contributing to high suicide rates in the veteran community?
- After WWII, most of our military journeyed home on ships for many weeks before re-entering civilian life allowing them to share "war stories" with fellow servicemembers. Today, veterans return home with no time to decompress or talk through their traumatic experiences. How are our current systems of care failing our veterans and how can we support their transitions back home?

CHAPTER 9 CONTINUED...

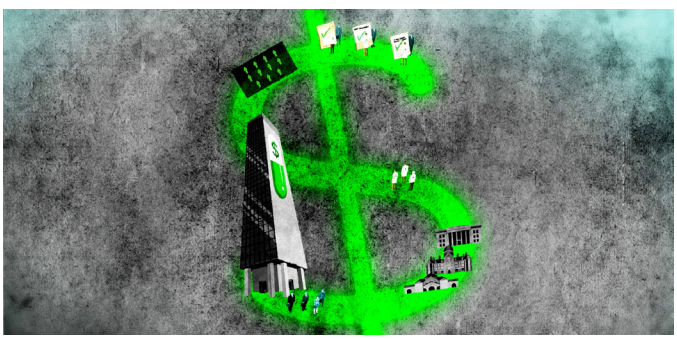
- In traumatic situations such as a war, domestic violence, etc., a person's startle response, insomnia, and hypervigilance are useful and adaptive reactions for survival. However, when the environment changes, these responses may no longer be useful or appropriate. People's adaptability to changed situations and their resiliency varies and is highly individual. How much do we really know about trauma and its impact on the brain, the body, the individual and the community?

- Recent studies have raised serious questions about the effectiveness of psychiatric medications for post-traumatic stress, (i.e., for veterans diagnosed with PTS, benzodiazepines increase suicide risk three-fold).[12,13,14] Typically insurance does not cover complementary and alternative therapies. Discuss the implications of having a system that reimburses for potentially harmful treatments.

CHAPTER 10: THE ROLE OF BIG PHARMA (~50:35)

Big Pharma's business model is to make profits for its shareholders and therefore to sell as much of its product as possible. Trials measuring drug effectiveness and safety, regulatory scrutiny, and the dissemination of results are significantly funded by Big Pharma. Doctors and patients are bombarded by marketing posing as research.

- Acknowledging Pharma's reality (a business motivated by profit), discuss the contribution of other stakeholders to the problem of over-prescription of psychiatric drugs (media, medical journals, guild groups, prescribers, regulatory bodies like the FDA, patients, culture, etc.).[15,16]
- How might practices in research and regulation change to ensure that there is no inherent conflict of interest in the testing and reporting of drug safety and efficacy?
- A number of mental health organizations and patient advocacy groups (NAMI, CHADD, etc.) accept money from pharmaceutical companies. Talk about whether you think this is a conflict of interest even if they disclose?
- How does the culture and direct-to-consumer advertising affect us - our choices, our health literacy, and our interactions with doctors? What forces contribute to our desire for a "quick fix?"[17]
- Pharma-funded trials do not examine drugs examine drugs over the long-term, or drugs in combination. Who should be responsible to fill this gap in the evidence base? What would a really good study or trial for a new drug look like?



IMPORTANT NOTE: There are organizations/programs that provide unbiased information, free of Pharma influence (e.g., Cochrane Collaboration, Therapeutics Initiative, PharmedOut). We recommend that everyone becomes familiar with them.

CHAPTER 11: LACK OF INFORMED CONSENT & LACK OF KNOWLEDGE (~56:17)

Most doctor appointments in the U.S. are 8 to 10 minutes long; this is generally not enough time for a thoughtful discussion about the risks, benefits, and alternatives to taking a medication. Deprescribing is not yet mainstream - academic curricula are inconsistent and doctors have few reliable sources of continuing education on these topics.

- What is the impact of pharmaceutical funding for research and training in medical schools, and other fields such as psychology, nutrition, social work, etc.?[18]
- What are some of the key elements that should be included when providing or receiving informed consent?[19]
- There is a great amount of variation in academic curricula about what informed consent should encompass. What should the criteria be for a more comprehensive and reality-based informed consent, including such things as cost/benefit of taking a drug, a discussion of possible side-effects, physiological dependence, difficulties around deprescribing and withdrawal, and the potential for protracted harm)?

CHAPTER 12: **CHARACTER RESOLUTIONS** (1:10:35)

By the end, all four of our main characters are better now that they are off medications. In spite of ongoing healing, they have reclaimed a sense of who they once were pre-medication. All are on their way to regaining the ability to feel emotion, empathy, and are experiencing a return of functionality. As a result of the knowledge gained through their experiences, each of them now feels empowered to take back control of their own bodies and lives. For the viewer, witnessing the stories of these characters brings hope. And it also brings a more complete understanding that psychiatric medications should be a last resort - that it is imperative to first consider the origins of the suffering and other possible ways of coping with it.

- Consider the implications of the lack of awareness about the potential dangers of psychiatric drugs for both children and adults. If you had political power, what kind of systemic changes would you make?
- Under what conditions should psychiatric drugs be an initial intervention or a last resort? What are some alternatives?
- Given what you now know having watched the film, imagine that you are a *professional* with a limited amount of time. A patient comes to you for a first visit. They are completely stressed out, anxious and barely able to function. Talk about how this film informs your practice going forward.
- Imagine you are a *patient* coming to a professional for a first visit. After seeing this film, what questions would you ask your doctor or therapist and why?
- Discuss the long-term impact on a psychiatric patient's family, their community and society when that patient suffers harm from taking the drugs as prescribed.[20]

CHAPTER 13: MEDICATING NORMAL WEBSITE & MORE INFORMATION (~1:17:45)

RESOURCES & SOCIAL MEDIA

For a full reading list, additional research and sources:

Film Website: www.medicatingnormal.com
Facebook: @medicatingnormalfilm
Twitter: @MedicatingNorm1
Instagram: @medicatingnormal
YouTube: www.youtube.com/c/medicatingnormal

RECOMMENED BOOKS

Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America by Robert Whitaker

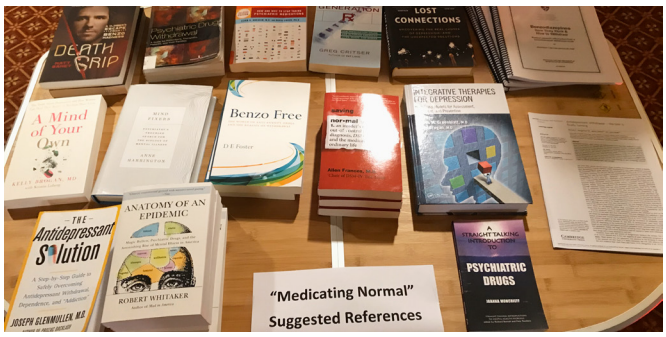
Mental Health Survival Kit and Withdrawal from Psychiatric Drugs by Dr. Peter Gøtzsche

Drug Dealer, MD: How Doctors Were Duped, Patients Got Hooked, and Why it's Hard to Stop by Anna Lembke, MD

Saving Normal by Allen Frances, MD

The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment by Joanna Moncrieff

Your Drug May Be Your Problem: How and Why to Stop Taking Psychiatric Medications by Peter Breggin, MD and David Cohen, PhD



ADDITIONAL IMPORTANT DISCUSSION TOPICS

- Did you feel uneasy at any point in this film? Talk about why.
- Explore implicit bias and defensiveness on the part of healthcare professional(s) ("Never in my career have I seen anyone harmed by these drugs.") and patient defensiveness aka "pill shaming" (i.e., "my meds work for me and I don't want to hear that they can cause harm").
- Discuss how people embrace mental illness diagnoses as their identities ("I am bipolar" versus "I feel anxious"). What are the pros and cons of labels (i.e., Bri was relieved when she got a label, for Angie labels were destructive)?
- How does insurance in the US impact mental health treatment?
- Pharmacovigilance: what is it and why is it important?
- There is a sensitivity among patients who take psychiatric drugs, about their medications being called "addictive." They distinguish between *physiological dependence* (caused by drugs taken as prescribed) and *addiction* (compulsive drug use despite harmful consequences).[21] Discuss the differences between addiction and physiological dependence in the context of taking psychiatric drugs as prescribed and withdrawing from them.

ENDNOTES

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