

The Mothers Act Disease Mongering Campaign – Part V

Contributed by Administrator
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http://www.naturalnews.com/026933_pregnancy_depression_SSRI.html

Friday, August 28, 2009 by: Evelyn Pringle, health freedom writer

(NaturalNews) This is part five of an article series by Evelyn Pringle. Find previous parts here: Part One (http://www.naturalnews.com/026634_d…), Part Two (http://www.naturalnews.com/026707_h…), Part Three (http://www.naturalnews.com/026742_d…) and Part Four (http://www.naturalnews.com/026926_d…). What follows is the full text of part five:

In the title of a paper in the May, 2009, Journal of Affective Disorders, Stephen Matthey, of the University of Sydney Infant, Child & Adolescent Mental Health Service Research Unit in Australia, asks, "Are we overpathologising motherhood?"

The paper was critical of self-report screening measures such as the Edinburgh Depression Scale for overestimating the rate of psychiatric disorders in motherhood. "The properties of the Edinburgh Scale show that around 50% of women scoring high are not in fact depressed," the paper's abstract reports.

The paper was further critical of the high percentage of women being screened as "at-risk". Classifying women to be "at-risk" based upon "the presence of a single risk factor is questionable given that the majority of women with risks do not become depressed, and also the rate of women reported to have at least one risk (up to 88%) is so high as to negate the usefulness of this concept," the abstract warns.

Matthey also questioned the use of the diagnostic criteria for depression in the DSM IV, such as weight loss, sleep problems and fatigue, which could easily be attributed to new parenthood rather than depression.

"Current estimates of the prevalence of perinatal distress, and of women with risks, are an overestimation of the true rates," the abstract concludes.

"The clinical practice of using the presence of a single risk factor, or a single high score on a self-report mood scale, to form part of the assessment to determine whether or not to actively intervene may also overpathologise the situation," Matthey warns.

"A more thorough understanding of these issues will improve our assessment procedures so that resources can be appropriately targeted to those women, and their families, who really need specialist mental health intervention," he points out.

With the above paper in mind, consider the posting on Postpartum Progress by Katherine on July 29, 2009, of: "A Nurse/Mother's Letter to Time Magazine: Alison Palmer."

In the letter to the editors, Palmer described herself as, "a maternal-newborn clinical nurse specialist, coordinator of a Postpartum Emotional Support Program, and most importantly as a mother."

It sounds like she works at the Maternity Center at Elliot Hospital in Manchester, New Hampshire, which "does about 2200 births per year," according to the letter.

"Postpartum depression or other mood and anxiety disorders occur at least 20% of the time, and can occur anytime in the first year after birth," Palmer claims in the letter.

"Our organization recently implemented an Inpatient Postpartum Depression Risk Assessment," Palmer told the editors.

"An 11-item questionnaire is distributed to EVERY new mother who delivers, and screens them into a risk category for developing PPD," she wrote.

"This screening tool identifies risk factors and does not indicate that a woman will definitely experience PPD," she said.

"Just like someone who smokes, is obese, has high blood pressure and a family history of cardiac disease is at higher risk for a heart attack, these PPD risk factors simply indicate that one might be at a higher risk for the illness," Palmer explained to Time editors.

"In our first month of screening, we had patients screen out as 46% low risk, 21% moderate risk, 30.5% high risk and 2.5% immediate risk," she reported.

"More than HALF of all of the new mothers who delivered had some increased risk for PPD," Palmer added.

"The "at-risk" moms view a PPD video, receive more in-depth PPD education, get follow up phone calls at home, are offered Visiting Nurse visits and are invited to attend weekly New Moms Groups and the Postpartum Depression Support Group," she told Time.

After reading the above information, on July 29, 2009, Amy posted a blog to Nurse Palmer on Postpartum Progress and asked: "Did the program refer the low risk women for further evaluation? Is low-risk considered at risk?"

"In the risk assessment survey, the mother needs to answer "NO" to ALL 11 items in order to be scored as "LOW" risk," Palmer wrote back to Amy, demonstrating that no mother will ever escape this dragnet.

“I always tell people there is no such thing as ‘NO RISK’, since simply giving birth puts a woman at risk due to the hormone and biological changes that occur,” she explained.

“Even answering ‘yes’ to one item on the survey puts mom in a ‘moderate risk’ category,” Palmer claimed.

“Women who score low risk still have routine PPD teaching done by the RNs,” she told Amy. “They just don’t have the follow up by VNA and phone calls.”

“Interesting,” Amy wrote back to Palmer. “I myself was told I needed drugs because of my high risk for PPD.”

“I was later told by a pediatrician, lactation consultant and OBGYN that perhaps I should consider staying on drugs permanently even during pregnancy or not having any more kids because of my high risk of having PPD again after the birth of any subsequent children,” she explained further.

“I had no problems at all after the birth of Toby,” Amy said. “I am thankful I did not listen to them.”

Nurse Palmer compares the use of ‘risk factors’ to diagnose women with mental disorders to the use of risk factors for other diseases. In June 2005, the Seattle Times published a series of reports including one titled, ‘Suddenly Sick,’ by Susan Kelleher and Duff Wilson, with the byline: ‘The hidden big business behind your doctor’s diagnosis,’ and discussed the successful trick of using ‘risk factors’ in past drug marketing campaigns.

“You are suddenly sick,” the authors wrote, “simply because the definitions of disease have changed.” And behind those changes, the Times

found, were “the companies that make all those newly prescribed pills.”

The authors noted that “Dartmouth Medical School researchers estimate that during the 1990s, tens of millions more Americans were classified as having hypertension, high cholesterol, diabetes or obesity simply because the definitions of those diseases were changed.”

“The medical profession’s term for these people is ‘the worried well,’” the authors said. “They are otherwise healthy people who have risk factors, such as high blood pressure or high cholesterol, but may never suffer a heart attack or stroke.”

“Every time the boundary of a disease is expanded — the hypertension threshold is lowered by 10 blood-pressure points, the guideline for obesity is lowered by 5 pounds,” they pointed out, “the market for drugs expands by millions of consumers and billions of dollars.” The results, they wrote:

“Skyrocketing sales of prescription drugs. Soaring health-care costs. Escalating patient anxiety. Worst of all, millions of people taking drugs that may carry a greater risk than the underlying condition. The treatment, in fact, may make them sick or even kill them.”

“Pharmaceutical firms have commandeered the process by which diseases are defined,” the Times found. “Many decision makers at the World Health Organization, the U.S. National Institutes of Health and some of America’s most prestigious medical societies take money from the drug companies and then promote the industry’s agenda,” the authors reported.

“Treatment guidelines established by international and national health organizations instruct physicians on diagnosis and treatment of disease and are meant to be scientifically pristine,” they said. But the Times found that for a broad spectrum of diseases, “the experts writing the treatment guidelines had drug-company ties ranging from research contracts to consultancies to stock ownership.”

Attack on Vogue Magazine Journalist

On April 29, 2009, Hale used her website to “refute” some of the top experts in the field, quoted by Alexis Jetter, in an article in the May issue of Vogue Magazine titled, “Pregnant Pause,” which warned that: “With a flurry of recent reports challenging the safety of antidepressant drugs for unborn babies, doctors and concerned mothers-to-be are rethinking the guidelines.”

“What alarms doctors is the sheer number of pregnant women who use SSRI antidepressants — perhaps as many as 250,000 in the U.S. each year — when we still know so little about how the drugs affect babies,” Jetter reported.

The number of pregnant women on SSRIs has apparently skyrocketed over the past three years. Back in 2006, the American Medical Association gave an estimate “that over 1% of pregnant women in the U.S., or more than 40,000, are taking antidepressants,” the Wall Street Journal reported in July 2006.

“SSRI usage dramatically increases the chances that a baby may be miscarried, born prematurely or too small, suffer erratic heartbeats, and have trouble breathing,” Jetter points out in Vogue.

In response to the article, Hale wrote a commentary titled, “Thoughts on exploring a ‘Pregnancy Pause,’” and sent it to Vogue. “I methodically refuted and balanced the article’s bias against medicating with anti-depressants during pregnancy,” she wrote, when publishing the letter in full on her website.

On May 6, 2009, Katherine posted a link to Hale’s site with the headline, “Hale Responds to Vogue Piece on Antidepressants in Pregnancy,” and Kleiman provided a link on her treatment center website, telling readers: “Please take the time to read her very thoughtful and well-researched post.”

Upon reading the commentary, anyone with knowledge on this topic would have a hard time believing that the human face, Hale, did the “methodical refuting” all on her own.

In the Vogue article, Jetter explains that serotonin, “the neurotransmitter that helps regulate mood, also sends crucial developmental signals to the fetal heart, lung, and brain.”

“Some scientists think that SSRIs, which prevent the body’s natural absorption of serotonin, could be tampering with essential cell growth,” she reports.

“Never before in human history have we artificially changed the architecture of brain development,” said Feng Zhou, PhD, of the Indiana University School of Medicine, in the Vogue article.

“We always predicted that developmental exposure to these drugs would have some deleterious effects,” Jean Lauder, PhD, of the University of North Carolina School of Medicine, told Jetter. “But no one was listening back then.”

Jetter also cites warnings by Dr Adam Urato, the guy who alerted JAMA to the undisclosed financial conflicts of interest among the authors of the Cohen Relapse in Depression study, and assistant professor of Maternal-Fetal Medicine at Tufts University School of Medicine, stating:

“Women and their providers have been told that even mild depression or anxiety will hurt their baby …. And these antidepressants are portrayed almost like prenatal vitamins that will level out their mood and lead to a healthier baby.”

“But antidepressants have not been shown to decrease rates of miscarriage or birth defects or low birth weight. On the contrary, they’ve been shown to increase those problems.”

“On top of that,” argues Urato, “only one voice is reaching the ears of most women’s health practitioners: that of a small coterie of influential doctors who he says underplay the dangers of antidepressants,” Jetter reported.

“Many of these physicians have accepted lucrative speaking fees and consulting contracts from drug companies,” she wrote. “And yet — sometimes without divulging those connections — these same doctors are shaping treatment guidelines.”

True to form, in her commentary, Hale referred to work by the industry shill Wisner. In fact, the Mothers Act disease mongers repeatedly tout papers by Wisner without disclosing her financial ties to the drug makers.

For instance, Hale’s headline for a March 28, 2009, blog read: “The Confusion of Ante-Partum Depression: To Medicate or Not?”

“Ante-Partum Depression” being another newly coined buzz term for depression during pregnancy, a disorder not listed in the DSM.

In her blog, Hale reported that: "A recent study by Dr. Katherine Wisner … Found that continuous exposure to either SSRI or Depression during pregnancy results in pre-term delivery rates in excess of twenty percent while mothers with no exposure to either depression or SSRI over the course of their pregnancy experienced rates of pre-term delivery at six percent or lower."

The actual study titled, "Major depression and antidepressant treatment: impact on pregnancy and neonatal outcomes," was published in the March 2009, AJP. And the researchers in fact found women exposed to continuous treatment with SSRIs had an increased risk for preterm birth of 23%, and women with continuous depression but no SSRIs had a lower increased risk of 21%, compared to a 6% rate for women with no depression and no SSRIs.

However, women reading spinmaster Hale's summary of the results were told "the pre-term delivery rates were the same with depression exclusive of SSRI treatment."

"So what's a pregnant depressed mama to do?," Hale wrote on her website.

"I read," she stated. "Voraciously."

"The two biggest sources of help for me," she said, "were Karen Kleiman's What Am I Thinking? Having a Baby After Postpartum Depression and Kornstein/Clayton's Women's Mental Health."

"Karen's book allowed me to realize my emotions were right on target for a woman facing pregnancy (expected or not) after surviving a PMD episode while Women's Mental Health laid out the risk factors in a no-nonsense manner," she wrote.

"I was convinced to stay on medication," Hales said, "after I read my risk for relapse went up by 50% if I discontinued my medication during pregnancy."

"With my risk factor already 50% higher than women having never experienced a PMD, there was no way I was giving myself a 100% risk of traveling down that road," she wrote.

Kleiman's book sells for about \$19 on Amazon and Women's Mental Health is listed for \$85.

In a May 12, 2009, Postpartum Progress blog, Katherine made sure to promote the continued use of SSRIs by pregnant women in posting a sentence from an editorial in the AJP titled, "Assessing Risk and Benefit: To Treat or Not to Treat Major Depression During Pregnancy With Antidepressant Medication," by Dr Barbara Parry, which states:

"Thus, all things considered, on the basis of the findings from the methodologically sound and rigorous study of Wisner et al. and the evidence available from long-term studies, this author thinks that the risk of untreated major depression outweighs the risk of effects of SSRI treatment on neonatal outcomes."

As part of the campaign against Vogue, Hale published in full a letter sent to Vogue from Arienne Einarson, without disclosing Einarson's drug industry ties or controversies surrounding Einarson's Canadian program.

In a blog on Hale's site, Einarson said of the Vogue article: "I am the author of the largest study on paxil (no drug company funding) published in a premier psychiatry journal and they certainly did not contact me. I WONDER WHY NOT?"

First off, maybe Einarson wasn't contacted because she is a nurse and not a doctor. She is the Assistant Director of Clinical Services of the Motherisk program at Toronto's Hospital for Sick Children, also known as SickKids, and works under Motherisk Director, Dr Gideon Koren.

And maybe it was because her often co-author, Dr Koren, was involved in one the biggest academic research scandals in history a few years back when he sent vicious letters to discredit fellow researchers and denied doing so until DNA evidence from postage stamps proved he was lying, years later. In September 2003, the Canadian Association of University Teachers reported in the CAUT Bulletin:

"The Ontario College of Physicians and Surgeons has formally reprimanded University of Toronto professor of medicine Dr. Gideon Koren. He had written anonymous harassing letters about Dr. Nancy Olivieri and three colleagues during Olivieri's dispute with the Hospital for Sick Children, the University of Toronto and Apotex Inc. He then had lied repeatedly to conceal his responsibility. The college also cited him for additional misconduct, in research."

"In its decision, the discipline committee said it was "deeply troubled by this case" and "seriously considered administering a more severe penalty" than that proposed to it, as it wished "to express unequivocally its condemnation of Dr. Koren's misconduct."

"It defies belief that an individual of Dr. Koren's professed character and integrity could author such vicious diatribes against his colleagues as he did in the "poison pen letters"; the committee wrote in its decision.

The committee described Koren's actions as "childish, vindictive and dishonest" and noted that "only when confronted with irrefutable scientific evidence of his guilt did he admit he was the perpetrator" of the letter campaign. The Teachers Association further explained in the Bulletin:

"The college's finding of research misconduct was in relation to a study on a drug to treat a blood disorder in children that Koren and Olivieri had once collaborated on. Olivieri identified risks that the drug was ineffective and caused liver damage, and voiced her concerns despite legal warnings from its maker, Apotex. Koren differed and, contrary to accepted norms, published an article on the drug using data from other researchers, including Olivieri, without their knowledge or consent."

"The penalty had been jointly proposed to the college discipline committee through prior agreement between counsel for Koren and counsel for the college," the Bulletin reported.

"The discipline committee did not have before it the facts that Koren had violated additional university and international norms of conduct in this publication," it pointed out.

“Koren had received hundreds of thousands of dollars in funding from Apotex after the company had terminated the drug trials in its efforts to prevent Olivieri from disclosing risks to patients, as well as the hundreds of thousands of dollars in funding he had received during the trials,” the newsletter reported, citing an journal article by the authors of “The Olivieri Report.”

It should be noted that Apotex went on to market a generic version of Paxil, or paroxetine. In September 2005, the FDA issued a warning about possible birth defects associated with Paxil when the drug is taken during the first trimester of pregnancy.

The warning was based on one study that found about a 2% risk of heart defects in babies born to mothers who took Paxil in early pregnancy, compared with a 1% risk in the general population, and a second study that found the risk of heart defects was 1.5% in babies whose mothers took Paxil in the first three months, compared with 1 percent in babies whose mothers took other antidepressants in the first trimester.

In October 2005, Einarson put out a paper titled, “The safety of psychotropic drug use during pregnancy: a review.”

“This article reviews the various classes of psychotropic drugs that are commonly used to treat psychiatric disorders—antidepressants, benzodiazepines, antipsychotics, antiepileptics, lithium and monoamine oxidase (MAO) inhibitors—in terms of their safety during pregnancy,” the abstract on PubMed states.

“A substantial number of women of childbearing age are prescribed psychotropic drugs, and because nearly 50% of pregnancies are unplanned, many women are still taking them upon becoming pregnant,” Einarson points out.

“Evidence-based information from epidemiologic studies indicates that most psychotropic drugs are relatively safe for use during pregnancy,” the abstract states. A November 2005 abstract for another Einarson paper on PubMed states:

“A number of pregnant women suffer from psychiatric disorders that require treatment with psychotropic drugs. A literature review suggests that these medications are relatively safe to use during pregnancy. Abrupt discontinuation of these drugs can have both physiological and

psychological ramifications, which include unpleasant physical symptoms and re-emergence of the psychiatric condition. Therefore, it is not good practice to discontinue these medications abruptly upon diagnosis of pregnancy.”

Here’s Einarson and Koren back in November 2005, still available on the Motherisk website, answering questions under the tab for “Pregnancy & Breastfeeding” with a heading: “Counseling pregnant women who are treated with paroxetine.”

One webpage says: “Motherisk questions are prepared by the Motherisk Team at the Hospital for Sick Children in Toronto, Ont.” In a November 2005 Special Supplement, the question was phrased as:

“I have always reassured my patients that taking an SSRI in pregnancy would not increase their risk for having a

child with a major malformation. However, I recently read the warning from Health Canada regarding the release of a study from GSK, stating that infants exposed to paroxetine may be at a higher risk of congenital malformations, specifically cardiovascular defects. Some of my pregnant patients who are taking paroxetine (Paxil) heard about this information in the media and called me to ask if they should stop taking it. What should I tell them?”

Their answer was:

“The new warning is based on small non peer review, unpublished studies. It ignored 2 published studies that failed to show such association, and no such association has been shown for SSRI’s as a class. The data suggested that even if there is a risk, it is small. The warning does not disclose the details of the cardiovascular malformations in these studies. Many cases of ventricular septal defect, the most common cardiac malformation, resolve spontaneously. Concerned mothers to be should know that beyond the first trimester a drug cannot cause cardiac malformation. Failure to treat depression during pregnancy can have significant negative ramifications for both mother and child, and it is the strongest predictor of postpartum depression.”

In December 2005, the FDA instructed GlaxoSmithKline to reclassify Paxil from a Category C to D for pregnant women. A Category D warning means studies in pregnant women have demonstrated a risk to the fetus. An advisory to “Neuropsychiatric and other healthcare professionals,” specifically stated that the “FDA has determined that exposure to paroxetine in the first trimester of pregnancy may increase the risk for congenital malformations, particularly cardiac malformations,” and advised:

“Physicians who are caring for women receiving paroxetine should alert them to the potential risk to the fetus if they plan to become pregnant or are currently in their first trimester of pregnancy. Discontinuing paroxetine therapy should be considered for these patients. Women who are pregnant, or planning a pregnancy, and currently taking paroxetine should consult with their physician about whether to continue taking it.”

A little over a year ago, a study in the April 2008 American Journal of Psychiatry, reported an “Evaluation of the Risk of Congenital Cardiovascular Defects Associated With Use of Paroxetine During Pregnancy,” with authors that included Einarson and Koren.

The conclusion for the abstract stated: “Paroxetine does not appear to be associated with an increased risk of cardiovascular defects following use in early pregnancy, as the incidence in more than 3,000 infants was well within the population incidence of approximately 1%.”

The Winter 2009 issue of the Canadian Journal of Clinical Pharmacology published a paper by Einarson titled, “Risks/safety of psychotropic medication use during pregnancy–Motherisk Update 2008.” The abstract contains the standard talking points, and states in part:

“Psychiatric disorders are relatively common among women of childbearing age, who may be prescribed psychotropic drugs. There remains a high level of anxiety regarding their safety among patients and healthcare providers alike, most likely because of the conflicting studies that have been published in the literature and warnings from government organizations.”

“The body of evidence in the literature to date suggests that psychotropic drugs as a group are relatively safe to take during pregnancy and women and their health care providers should not be unduly concerned if a woman requires treatment,” the abstract concludes.

Koren and Einarson routinely fail to list financial ties to drug makers in their papers. The following disclosure was published in the November 2008 American Journal of Psychiatry as a correction to an article for which no disclosures were made:

“Dr. Koren and Ms. Einarson have received research support from Janssen-Ortho and Wyeth. Dr. Koren has received research support from Apotex, Duchesnay, Novartis, and Pfizer. Ms. Einarson has received unrestricted research grants from GlaxoSmithKline for studying ondansetron in pregnancy and from Organon for studying mirtazapine in pregnancy. Dr. Einarson has received research support from Bristol-Myers Squibb, Eli Lilly, Janssen-Ortho, Lundbeck, Novo Nordisk, and Organon.”

When reposting Einarson’s letter on her website, Hale states, “Adrienne currently serves as Coordinator for the International Reproductive Psychiatry group at Motherisk in Toronto.”

At the start of the letter to Vogue, Einarson writes: “I am writing to you on behalf of an international group of individuals who are involved with reproductive mental health, as either clinicians, researchers and in some cases both.”

“We would like to voice our concerns regarding your recent piece entitled ‘Pregnant Pause,’ which we felt, did not achieve a balanced perspective on this issue, which was surprising to us, coming as it did from such a highly esteemed publication as Vogue,” she states.

Einarson makes claims on behalf of this group without identifying a single member by name. If these “International” groups exist, there is remarkably little information about it on the internet. A google search a couple months ago for “International Reproductive Psychiatry Group” brought up 2 hits – both to the comments above. A search for “North American Reproductive Psychiatry Group” had 2 hits – both to references made by Einarson at various times.

In her letter to Vogue, Einarson wrote: “Another disturbing theme that came up several times in the article, is that physicians hand out antidepressants like candy, and physicians in our group were most offended by this statement as they are very careful about prescribing antidepressants and would not give them to someone who does not require treatment.”

Here she is likely referring to Dr Urato’s warnings and statements such as: “What alarms doctors is the sheer number of pregnant women who use SSRI antidepressants – perhaps as many as 250,000 in the U.S. each year – when we still know so little about how the drugs effect babies,” as Jetter reported.

In conclusion in her letter to Vogue, Einarson refers to her “International” group again, and states: “Finally, and I am sure this was not your intention, several of our group members who are psychiatrists have reported that their pregnant patients have decided to stop taking their antidepressant since they read your article,” she claims.

She then gives what she calls “one example of the damage you may have caused by this highly biased and often inaccurate article.”

“After reading this article, a woman called her psychiatrist and informed her that she was not going to take her

Prozac anymore," she told Vogue, in what can only be considered good news.

Disease Mongers Wage War on TV Series

In a February 2, 2009, headline on Postpartum Progress Katherine gleefully announced: "ABC's Private Practice to Feature PPD Storyline";

ABC Television Network's "Private Practice" will feature a storyline related to postpartum depression on its February 12 episode, the blog reported.

"After the show, viewers will be directed to ABC's website to see a public service announcement on postpartum depression that will link to Postpartum Support International," Katherine wrote. "We don't know any details about the episode because it's top secret. I'll definitely be tuning in."

On February 11, 2009, Postpartum Progress told readers to: "Get Your DVRs and Your TV Dinners Ready," and Katherine wrote: "Don't forget this Thursday night (tomorrow) is the episode of Private Practice on ABC featuring a perinatal mood and anxiety disorder, and a link after the show to a new PSA on ABC.com."

However, on February 13, 2009, the tone suddenly soured with Katherine posting the headline: "ABC Television Should Be ASHAMED of 'Private Practice' Postpartum Psychosis Treatment";

"I'm horrified that I encouraged you to watch what I thought would be a responsible storyline about postpartum depression on the ABC network television show 'Private Practice,' she wrote.

"Never again," she said, "will I tell the readers of Postpartum Progress to watch something that I haven't already seen myself and can't fully endorse."

"Sorry I waited to write about this until now," she continued, "but I was so spitting mad late last night I couldn't calm down enough to type,"

"Last night's episode was promoted, both to the public and to the members of Postpartum Support International, as one about postpartum depression," she said, "but — surprise, surprise — it immediately devolved into a show about postpartum psychosis and a mom attempting to kill her child by holding her down under the water in the bathtub."

"Every time the media, whether entertainment or news, chooses to cover perinatal mood and anxiety disorders," Katherine claimed, "the portrayal is always of some out-of-control woman committing or attempting to commit infanticide."

Katherine obviously could not accept that the show was not meant to be a pitch for the new cottage industry of "Reproductive Psychiatry" or an extension of the disease mongering campaign for all the other "illnesses" in the "perinatal mood and anxiety disorder spectrum." The plot rightfully remained focused on the rare occurrence of "postpartum psychosis."

"We have to stand up at some point and let the media know the way they treat perinatal mood and anxiety disorders, and mental illness in general, is unacceptable," Katherine wrote, to incite readers.

"Just as I stopped going to Tom Cruise movies," she said, "I will not watch Private Practice ever again."

"In fact," she said, "I may stop watching my favorite ABC show 'Grey's Anatomy' and switch over to NBC which has equally compelling shows in the 9pm EST time slot ('The Office' and '30 Rock')."

"I ask you to please join me to PULL THE PLUG ON PRIVATE PRACTICE," Katherine told readers.

"I also encourage you to write about this on your own blogs and use the tag 'Pull the Plug on Private Practice'," she advised all the other disease mongers.

Katherine then went on to list "some other bloggers' takes on this" and included excerpts from a blog by Susan Stone, posted on the website for her treatment center, with a headline that said: "'ABC's Private (Mal)Practice Fails to Present the Facts In a Botched Opportunity to Raise PPD Awareness."

Katherine also provided a link to a blog by Hale with a title, "'ABC's Private Practice Misses the Mark."

On February 13, 2009, tag-team member, Hale, chimed in with the headline: "More irresponsibility from ABC regarding PMD's," and told visitors to her website: "A quick visit to Katherine Stone's blog this morning got my juices revving again. And Susan Dowd Stone was not happy about the display either."

As if anybody gives a rat's butt about whether the two Stone broads are happy or not.

"Katherine is calling for a boycott of the show and I have to wholeheartedly agree," Hale wrote.

"Pull the Plug on Private Practice and their sham of attempting to represent the medical world," she said. "How dare they drop the ball on such a sensitive topic!"

"No voice will have a louder effect than a sudden drop in viewership because that means decrease in advertising and then well, if a show isn't profitable anymore...," she wrote.

"Spread the word — and stop watching," Hale told readers.

On February 15, 2009, Katherine announced: "Warrior Moms Pull the Plug on ABC's 'Private Practice'";

"I'm so happy to hear from those of you who are choosing to stop watching 'Private Practice' (and a lot of you quitting 'Grey's' too) or to speak out against ABC's irresponsible portrayal of perinatal mood and anxiety disorders like postpartum depression, postpartum anxiety and postpartum psychosis," she wrote in the blog.

"And my original post is also over on PsychCentral (thank you Dr. John Grohol for allowing me a little real estate on your amazing site)," she reported.

In fact, Grohol allowed Katherine to repost her entire rant in full on the PsychCentral.

In a reply on Grohol's site, an "anonymous" commentator, calling himself a shrink, wrote: "As a psychiatrist, although I did not see this show, I have seen how TV and movies portray mental health issues, and the consensus is the majority overtypifies symptoms and issues, as mainstream illness is not 'exciting' enough to warrant a show to titillate/wow audiences."

"My advice," the shrink said, "although wary to give it, is ask NAMI to get involved if they see it as a viable issue. They have the manpower to mobilize people."

NAMI of course being another Big Pharma front group that serves as funnel of drug company money to fund disease mongering campaigns, called the "National Alliance on Mental Illness." NAMI is listed as a main supporter of the Mothers Act on Susan Stone's Perinatal Pro site, and was recently forced to admit that 56% of its funding since 2005, came from the pharmaceutical industry.

The February 15, 2009, headline on Postpartum Progress read: "In Their Own Words: Why They'll Never Watch ABC's 'Private Practice' Again";

"I wanted to share with all of you some of the commentary I received, so that you can see the kind of impact media, whether news or entertainment, has on vulnerable women," Katherine wrote.

On February 17, 2009, she posted a headline with instructions on: "How to Contact the Media About Responsible Mental Health Representation," and provided a link "to contact ABC to share your feelings directly on the 'Private Practice' episode," complete with a clickable email address for

Anne Sweeney, President, ABC Entertainment.

It's worth mentioning that despite all the efforts to intimidate ABC by the disease monger above, a rerun of the same episode of Private Practice just aired a few weeks ago.

Pringle Ordered to Cease and Desist

Evelyn Pringle's first in a series of articles on the Mothers Act was published on April 7, 2009, with the title, "Mother's Act Fuels Multibillion Dollar Industry," by Scoop Independent News, and several other internet dailies.

The same day, Pringle received an email from Susan Stone with orders to: "Immediately correct current and past falsehoods in all posts, articles, blogs, communications and other media content regarding me and my practice."

"In addition you are warned to cease and desist from future false and libelous statements with regard to my practice, income, funding and resources," Susan informed Pringle, and went on to misstate the comments and topics discussed in the article.

"As far as your comments about the legislation which are ridiculously inaccurate," she said, "I wonder how you can intentionally mislead thousands of suffering women who need treatment."

"It appears your anti pharma agenda has clouded your reason, your compassion and your ability to be truthful in journalism," Susan told Pringle.

"A blind copy of this email is being sent to my attorney," Susan wrote, clearly as an intimidation tactic meant to shut Pringle up due to a fear of being sued.

"You can blind copy anything you want to your attorney or to anybody else for that matter," Pringle replied in email. "It's a free country."

"I plan to blind copy my reply to several people," she told Susan.

"Nothing I reported is factually incorrect or false but I have no intention of wasting my time debating with you," Pringle said. "The article will remain as is and I will try to remember to mention your intimidation tactic in my next Mother's Act article."

"As far your phony line about me misleading "thousands of suffering women," save it for your future victims," Pringle told Susan.

"Maybe you could have one of the Big Pharma front groups listed on your site as backing the Mother's Act put out a press release warning members of Congress not to read my articles," she advised Susan.

"From this day forward, I want you to cease and desist contacting me," Pringle told her.

On April 7, 2009, on the website for her treatment center, Kleiman also swung into action with the headline:

“Mother’s Act “Scoop”ed Again.”

“Those of you who know me, know that I try hard to resist the temptation to repond to any misinformed rant with respect to postpartum depression,” she stated.

“It’s really not worth my time to defend the work that we do,” she added. “But still …” Kleiman wrote, and went on to warn readers:

“To any of you who inadvertently found yourself reading a piece called “Mother’s Act Fuels Multibillion Dollar Industry” by Evelyn Pringle, please be advised.

Here’s the article’s opening tease line: “Motherhood has fallen prey to the psycho-pharmaceutical complex. If new legislation as the Mother’s Act becomes law, the drugging of infants through pregnant and nursing mothers will no doubt increase.”

“We should be flattered to have received attention from an excellent writer who spends a great deal of her time seeking media-soaked and provocative avenues for her unique perspective and right to free speech,” Kleiman wrote. “But when it gets personal, it reveals the flaw in this particular effort of hers.”

“I suspect that if Ms Pringle were to sit down with Katherine Stone, Susan Dowd-Stone or myself, she might actually understand this issue a bit better,” she continued. “If she could step down from her big Pharma platform for long enough to see the other side of this picture that is inundated with women in real life who are pleading for their lives, she might consider another angle to her protest.”

“Let’s not be distracted,” Kleiman said. “And let’s certainly hope that Ms Pringle never experiences the hardship of loving someone who suffers with a severe mental illness.”

Just like clockwork, the human face Hale showed up on Kleiman’s website and added the comment: “Couldn’t have said it better myself, Karen.”

On April 8, 200, Amy picked up on the postings and ran the headline: “Karen Kleiman Attacks Evelyn Pringle,” on her “Bitter Pill” website.

“Evelyn Pringle has angered the beast,” Amy said. “After months of ignoring victims who speak out against The MOTHERS Act and pretending that the pro-informed consent movement did not exist, it seems that the perinatal “experts” are gearing up for an online twist-a-thon.”

Pringle responded to Kleiman with the following comments in a blog on Kleiman’s website: “I am going to do everything in my power to derail this profiteering scheme, for one reason and one reason only, to protect the helpless, voiceless victims – the fetus and nursing infants.”

“I have been investigating and reporting on off-label drug marketing schemes set up with screening scams since 2004, and this is the most disgusting one I’ve covered because it is aimed straight at the nursery and most

helpless victims in the world," she wrote.

Queen of the Spin Masters

On April 6, 2009, Grohol allowed Katherine to publish an entire article, also posted on Postpartum Progress, on PsychCentral, with the truthful title for a change of, "MOTHERS Act To Drug America's Moms for Fake Postpartum Depression."

However, the article was actually an attack on the people and groups that have worked to expose the Mothers Act for what it is, and quite possibly Katherine's most brazen disease mongering article to date.

"The emotional health of approximately 1 million American families each year depends on this," she claimed in regard to the need to get the Mothers Act passed.

"Because honestly," she wrote, "if we can't get this one bill passed, how are we going to tackle the much bigger task of helping every single woman with a perinatal mood or anxiety disorder who needs help in this country?"

"There are some people who, for whatever reason," Katherine said, "have decided to convince others that the singular purpose of the Melanie Blocker Stokes MOTHERS Act is to line the pockets of the pharmaceutical companies and drug our nation's mothers."

Katherine then posed the question: "Have these people not seen the research?," and proceeded on with a rant of totally false and misleading statements about the medical problems occurring in women and infants resulting from the treatment or non-treatment of pregnant women for depression.

Do they not know, she said, that women with untreated depression during pregnancy are (1) twice as likely to have preeclampsia, (2) twice as likely to have a C-section, (3) twice as likely to have a preterm delivery, and (4) twice as likely to have their baby go to NICU?

A good place to start the debunking process is with the false claims about preeclampsia, because it leads to preterm birth and babies ending up in intensive care, if they live at all.

Preeclampsia is a disorder of pregnancy typically occurring after the 20th week of gestation. "It is characterized by sudden and dangerous spikes in blood pressure, protein in the urine, abnormal swelling of feet, face, and hands, upper abdominal pain, and nausea," according to the Preeclampsia Foundation.

"The only known treatment is to deliver the baby," the Foundation states. "Preeclampsia is the most common known cause of premature birth and responsible for half a million neonatal deaths worldwide."

"Women taking antidepressants experienced significantly higher frequency of birth complications, including

preeclampsia, gestational diabetes, and premature rupture of membranes, than women with depression who had not taken antidepressants during pregnancy," according to a report on a study presented at the Annual Meeting of the American Academy of Child & Adolescent Psychiatry, by Psychiatric News on December 7, 2007.

A more recent study in the March, 2009, AJP, titled, "Selective Serotonin Reuptake Inhibitor Use and Risk of Gestational Hypertension," assessed the effects of treating pregnant women with SSRIs on the risks of gestational hypertension and preeclampsia, compared to women who did not receive SSRIs during pregnancy or received SSRIs only in the first trimester of pregnancy.

The study found gestational hypertension "was present in 9.0% of the 5,532 women who were not treated with SSRIs and 19.1% of the 199 women who were treated with SSRIs."

"Among women who received treatment, gestational hypertension was present in 13.1% of the 107 women who received treatment only during the first trimester and in 26.1% of the 92 women who continued treatment beyond the first trimester," the research showed.

"The occurrence of preeclampsia was 2.4% among women who were not treated with SSRIs, 3.7% among women who were exposed to SSRIs only during the first trimester, and 15.2% among women who continued SSRI treatment beyond the first trimester," according to the study.

Then there is the study by the drug company hack, Wisner, discussed above that found women exposed to continuous treatment with SSRIs had an increased risk for preterm birth of 23%, and women with continuous depression but no SSRIs, had a lower increased risk of 21%.

Voiceless victims

The warning section on the labeling for antidepressants contains the following statements on babies being born to women who use the drugs during pregnancy, listing features "consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome";

Neonates exposed "late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. . . . Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying."

In some states, mothers who take street drugs are arrested for subjecting newborns to drug withdrawal, yet the antidepressant withdrawal syndrome is no less traumatic. The only wall separating culpability between the two drug ingesting mothers is that addicts are usually aware of the consequences of their use, while the naive mothers on legal drugs are seldom warned about the withdrawal effects they may cause.

An August, 2006 study in the Archives of General Psychiatry compared babies born to depressed mothers treated with SSRIs to those born to depressed mothers who were not treated, and found a significantly greater incidence of respiratory distress, 13.9% vs 7.8%, as well as longer hospital stays for infants exposed to SSRIs. The study also found birth weight and gestational age were significantly less in SSRI exposed infants.

"These findings are contrary to an expectation that treating depressed mothers with SSRIs during pregnancy would be associated with lessening of the adverse neonatal consequences associated with maternal depression,"

lead researcher, Dr Tim Oberlander, told Reuters on August 25, 2006.

On August 13, 2009, Psychiatry Update carried the headline: "SSRI babies need monitoring" for a report by Louise Wallace on a study in the Australian and New Zealand Journal of Psychiatry that found infants exposed to antidepressants in late pregnancy were at risk of discontinuation symptoms and more likely to suffer from jaundice and be admitted to special care nurseries.

"In more than 50 pregnant women who took part in the prospective study, newborns exposed to SSRI antidepressants had more symptoms including reflux, poor sleeping and feeding, crying, sneezing and tremor than those who were not exposed," Wallace wrote.

The authors of the study, "suggested the length of hospital stay for mothers who are exposed to antidepressant medication in late pregnancy should be reviewed and that the length of stay should be measured in days rather than hours after giving birth," Wallace reported.

"Symptoms such as tremor, irritability and jitteriness may be easily confused with convulsions, which may result in misdiagnosis and significant associated morbidity for the infant," the authors said. "This suggests the need to clarify diagnostic criteria for the neonatal to improve identification and management."

On July 19, 2006, the FDA issued a warning that: "A recently published case-control study has shown that infants born to mothers who took selective serotonin reuptake inhibitors (SSRI's) after the 20th week of pregnancy were 6 times more likely to have persistent pulmonary hypertension (PPHN) than infants born to mothers who did not take antidepressants during pregnancy."

Infants with PPHN require intensive care nurseries often with mechanical assistance to breath, and 10% to 20% do not survive even if they receive treatment. Those that do, may experience developmental delays, brain abnormalities and hearing loss.

PPHN normally occur in 1-2 live births per 1,000. Based on the estimate of 250,000 pregnant women taking antidepressants in the US, and a rate increase of 6-fold, the rate of babies born with PPHN would increase from between 250 and 500 per year, to between 1,500 and 3,000.

A number of jury trials are scheduled to begin in the US this fall involving families of infants born with heart birth defects as a result of women not being warned about the danger of taking Paxil while pregnant, with jury selection in the first case, at last check, scheduled to begin in Philadelphia on September 10, 2009.

More than 600 birth defect cases are currently pending against Paxil maker, GlaxoSmithKline, alone in the combined Multi-District Litigation in Pennsylvania.

Recruitment of Life-long customers

In the article on Grohol's website, in reference to people fighting against the Mothers Act, Katherine asks: "Do they not know that women with untreated postpartum depression can go on to have chronic depression for

the rest of their lives?"

No, but we do know that Katherine was diagnosed with what must be chronic and possibly life-long "postpartum OCD" in 2001, because she is still on antidepressants eight years later in 2009, and was still calling the drug company shill, Jeffrey Newport, her shrink in 2007.

But then much to the drug makers' delight, many people are forced to take antidepressants for years. The author of the new book, "Drug-Induced Dementia: A Perfect Crime," Dr Grace Jackson, explains that many patients find they can not stop. Not because they develop a craving, she says, "but because the withdrawal effects are severe and often misinterpreted by doctors as proof of a relapse into depression."

In the book, "The Antidepressant Solution," Dr Joseph Glenmullen calls this situation the "antidepressant catch 22," because withdrawal symptoms like anxiety, depression, insomnia, and crying spells can mimic a patient's original condition. "When this happens, patients are needlessly put back on the drugs, often for years and despite severe side effects," he reports.

In July 2009, UK expert, Dr David Healy, author of the new book, "Mania: A Short History of Bipolar Disorder," issued a "SSRI Withdrawal Guide," available on Bob Fiddaman's popular website, "Seroxat Sufferers Stand Up and Be Counted."

"One of the biggest problems of SSRI dependence involves women who are on treatment and unable to stop who wish to become pregnant," Dr Healy warns in the guide. "Getting off an SSRI at present seems more difficult for women than men, even with the incentive of wishing to become pregnant."

Dr Jackson warns that almost all psychiatric drugs either sensitize the brain to other addictions, such as benzos cross-sensitizing to alcohol or stimulants cross-sensitizing to cocaine, or become addictive substances on their own.

For most patients, she says, the use of psychiatric medications fulfills four of the seven DSM criteria for dependence including: (1) tolerance; (2) withdrawal; (3) larger amounts consumed, or longer use than intended; and (4) continued use despite the fact that the treatments cause significant suffering and disability, such as impaired judgment when driving, insomnia, sexual dysfunction, or impulsivity.

This knowledge provides additional reasons to fight against the Mothers Act disease mongering campaign in order to prevent the forced drugging of more helpless and voiceless infants through pregnant and nursing mothers.