8. Some Possible Links Between Drugs and Violence.

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Abstract:

'Conventional wisdom' within the field of medical psychiatry as evidenced by a great many practitioners, is that mental imbalance is most effectively addressed with drugs. New demonstrably efficacious compounds are supported with studies and touted as a primary therapeutic interventional pathway for the treatment of illness. After study and direct observation, I have deduced several specific facts and relations which are not acknowledged within the current field of psychiatry and may constitute a surprising and consistent factor in the rash of unexplained social violence and rampage killings which have become so prevalent. The specific theory, sociopathic patterns, pathogenic etiology, neuroscience and psychology are revealed which underlie this new rash of social pathology.

Theoretic introduction. 5-HT and repression. The key Indoleamine—our unconscious gateway; of civilization, creativity and hell.

Today, we are in a unique position. For the first time in pharmacological history we have achieved a level of specificity which has hitherto been inaccessible, and many hands are to be shaken and bows taken. SSRI drugs have specifically targeted the re-uptake of a single neurotransmitter, 5-HT (5-Hydroxytryptamine), and made a new level of neuro-chemical specificity, and individual targeted therapeutic activity available to millions. So, let us assess this new discovery, which I can attest by my personal experience, is most efficacious. As a sufferer of debilitating OCD for many years, you can rest assured in the knowledge that these drugs do work, and are effective in preventing the symptoms of OCD. Those who claim that these potent drugs are ineffective, and have no use or benefit, *are lying to you*. The drugs work. A skilled clinician, should you be lucky enough to find one, can prescribe them in the correct dosages to control your symptoms. Those will be high doses. Now that that is settled, you should also know another fact: Those studies [examine who funds studies] and sources, which claim these drugs are easily withdrawn, and the resultant symptoms are fairly short lived, most definitely and assuredly, *are lying to you*. Please know the fact: SSRI drugs administered in the proper high doses for disorders such as OCD over long periods, cause permanent damage to the repressive system—

Repression is 5-HT dependent (Norman, 2009, 2010, 2011, 2013, 2013*a*).

That dry statement, "Repression is 5-HT dependent," has consequences and specific implications, some unexpected, which have changed in ways both positive and otherwise, the entire landscape of psychology. Now, old and vital questions have been answered, and the question of the existence of unconscious fantasy (Talvitie & Ihanus, 2005) and its influence on behavior and the transference have finally been lain to rest (Norman, 2011, 2013, 2016, 2016*a*). First, I will begin with a general assessment of the specific ontogenetic manifestations and neuroscientific

mechanisms involved.

The various transformations of illness which parallel the reduction in repressive functioning as SSRI withdrawal occurs, are necessary symptomatic products of the return of repressed material to consciousness (Freud, 1896, p.170 [first usage of the phrase]), and demonstrate the common defensive and purposive mechanisms of neurotic and psychotic illness (Freud, 1896; Norman, 2010, 2011, 2013). The result is surprising, not because it supports the Freudian idea of all such illness being manifestations of defense rather than random imbalance, but, because the usual barriers which favor one illness over another, the "predispositional" factor itself, seems to have been cast aside (Norman, 2013). This is easily accounted for if we remember that this is an artificial neurosis/psychosis, not a typical one, and hence, must be assessed on its own footing. The mechanism by which it and its transformations are created, is clear: a relative reduction in 5-HT in the synaptic cleft due to the resumption of normal 5-HT re-uptake, and a resultant wholescale reduction in repressive function (alongside concurrent effects due to any physiological damage from extended treatment). With repressive function permanently impaired, what were predispositional influences favoring illnesses which are dependent upon high levels of repressive functioning such as OCD, are now exposed in their internal construction, repression peeled back, and the core of hysterical illness laid bare. The resultant hallucinatory hysterical psychosis, demonstrates little symbolic distortion of its reactive components, which may be assessed quite directly.

This psychosis, which can be reverse engineered to allow us access to undistorted unconscious content in some cases, has specific concurrent manifestations regarding perception. Repression and the unconscious have subsumed under their functioning, not only a temporally "passive" role (retroactively defining reality) *in relation to the level of perceived conscious input* of previous externally derived experience, functioning not only in the familiar role as a receptacle for containment, affective dampening, dynamic removal and allocation to experience of *preexisting* internal (interoceptive) unconscious stimuli such as memories and fabricated conglomerations such as unconscious fantasies via transference, but also an active one as well. This active real-time repressive function whereby all of perceptual experience has its energetic incoming presentation reduced, *actively repressed* in large measure into the unconscious *as it happens,* I have called: The Active Unconscious (Norman, 2010). Although the concept was conceived before I read the Freud, this is a more functionally connected and useful extension of Freud's stimulus barrier (Freud, 1920, p. 27). This reduction in the ability to partly repress the full force of *external* experience (exteroceptive increase), which runs in close tandem with the concurrent loss of ability to repress the influence of our *internal* perceptions stemming from the unconscious (interoceptive increase), form the full measure of repression proper, and are inexorably joined, rising and falling together in their level of functioning in direct and dependent relation to the increase or decrease in systemic levels of 5-HT.

There is ample neuroscientific evidence to support and explain this mechanism, by virtue of which I myself have been transformed from an extrovert who wanted only more and more intense stimulus, performing before larger and larger crowds, into an introvert, a man who is

overwhelmed by natural beauty, weeps openly and often, and feels a sunbeam on his flesh with the same shuddering amazement I used to gain only by way of the most extreme and daring behavior. It is as if the very most basic and fundamental of psychical relations has been altered, and not in any subtle way! The idea that SSRI drugs are specific in their action, is both laughable, and utterly mistaken. These drugs target one of the most evolutionarily ancient systems in the brain, as is evidenced by the central location of the serotonin producing nuclei, which dispense 5-HT to no less than 15 receptor types (Panksepp, 1998, p.111). The list of behavioral functions which *do not* involve brain serotonin is quite short, and can be represented by a single digit: Zero. Yes, 5-HT is so basic, its functions so diverse, we can say: 5-HT is involved…*in everything* (Panksepp, 1998, p. 103). The psychical effects of serotonin depletion and supplementation are no mystery, and neither are its general systemic effects:

Jaak Panksepp, founder of the burgeoning discipline known as Affective Neuroscience, has made one of the most profound, direct and reliable contributions to our knowledge of human and animal neural affective dynamics, from both evolutionary and biological perspectives. This careful and detailed researcher, has by way of experiment and observation come to certain conclusions about the role of brain serotonin in brain processes and behavior.

Firstly we read in Panksepp (1998) [citation form altered]:

"There are good reasons to believe that this system mediates a relatively homogeneous central state function. All motivated and active emotional behaviors including feeding, drinking, sex, aggression, play and practically every other activity (except sleep), appears to be reduced as serotonergic activity increases (Coccaro & Murphy, 1990; Jacobs & Gelperin, 1981) (Panksepp, 1998, p. 111)."

The fact that 5-HT has *some* receptors which increase anxiety, is in my view, not at all inconsistent with the role of 5-HT mediating repression, as anxiety is in many cases the causal instrument by which repression is instated (Freud, 1926; Brenner in Rickman, 1957; Norman, 2010, 2011). We read a general description of the effects of brain serotonin on mental stimulation of both interoceptive and exteroceptive origin, which makes some good sense of the relation between 5-HT and repressive function both "passive" and "active" as previously described. Description from a diagram of 5-HT pathways (Panksepp, 1998):

"Serotonin. Function: reduces impact of incoming information and cross talk between sensory channels" (p. 107). As to the resultant behavioral modifications when brain 5-HT is reduced, (which closely parallel those of REM deprivation): ". . . such animals are behaviorally *disinhibited:* they are more active, more aggressive, hypersexual, and generally exhibit more motivational/emotional energy. . . In short, they appear to be manic." (p. 141).

And lastly, we read:

> "In general, it seems that one higher cerebral function of brain serotonin is to sustain stability in perceptual and higher cognitive channels. When this constraint is loosened by a global reduction of 5-HT activity, the probability of information from one channel crossing into another channel is increased. Thus a mild reduction in brain serotonin activity may be an important ingredient for the generation of new insights and ideas in the brain, while the sustained reduction of serotonin might lead to chaotic feelings and perceptions, contributing to feelings of discoherence and mania.
>
> In sum, perhaps it is this loosening of sensory-perceptual barriers between different brain systems that characterizes dreams, hallucinations and the florid phases of schizophrenia, as well as normal creativity. . . it is worth noting that just as low brain serotonin characterizes the dream state, it also promotes heightened emotionality, both positive and negative. It is a neurochemical state that leads to impulsive behavior in humans (Halperin et al., 1994; Linnoila, et al., 1983; Roy et al., 1988), even ones as extreme as suicide (Asberg, et al., 1976; Brown et al., 1982; Coccaro, 1989). Probably the most striking and replicable neurochemical finding in the whole psychiatric literature is that individuals who have killed themselves typically have abnormally low brain serotonin activity." [Panksepp, 1998, p. 142]

I hope the exact and full implications of this statement are becoming more clear: "Repression is 5-HT dependent." In less technical language you can imagine brain 5-HT, its particular manifestations and effects to be better summed in this less precise but more descriptive phrase: 5-HT is the lid on hell. So now that modern pharmacology has removed the blinders, and allowed us direct access into the forbidden ugliness which is within all mankind, this hidden fuel of his ascension and decline, for all of sublimation and depravity are found within this secret—*let us look*. We will see the main of Freudian theory, this hideous and unflattering picture of inner reality… is essentially correct. However, the situation does not unfold quite as the effects do with animals, and indeed, an SSRI withdrawal subject would wish for a blessed mania to quell their pain, for unlike animals, we have super-ego, and super-ego is masochistic, as a punitive garrison set up within personality (Freud, 1930, pp. 123-124; Norman, 2013*a*). When we add a punitive super-ego wish to an id wish with reduced repression we have the exact description of the dynamic which creates hysteria proper (Freud, 1915, pp. 180-185). I hope it is now becoming clear to the reader, why, SSRI withdrawal encourages *hysterical hallucinatory psychosis.*

Drugs and Murder – a possible link:

We are in an age which is fraught with change, some positive and some less so. It seems as if the basic fabric of our culture has torn, as if a qualitatively new and distinct rash of horror and criminal activity has overtaken this age and defined it: the rampage killing, a new sort of crime which appears to defy explanation, but do be sure this is false, and an explanation is at hand. Indeed, these crimes are nothing if not utterly predictable. I will offer up my theory as to the psychological mechanism involved here.

So what has changed? Why are there so many rampage killings, now as never before appearing

with such alarming frequency, school shootings, mall murders, movie theatre massacres and the like? There have always been guns in our American society, always so very many guns, but no, these shootings and murders are appearing on a scale never before seen. Ergo: the mechanism must lie elsewhere. There have been neglectful parents and bad children throughout history, so very many bad parents and ugly mean spirited children, but no, these crimes are so tragic and only now, so prolific, so violent and today so much more frequent. Ergo: the mechanism must lie elsewhere. The answer is, although belatedly, becoming clear. I will list but a few cases with partial pharmacological histories and then analyze the connecting factor:

John Shick, 2012, age 30, killed one injured six, was shot by police. Nine different anti-depressants were found in his apartment.

Hammad Memon, 2010, age 14, Shot and killed a student at school. He was taking the SSRI Zoloft.

Christopher Wood, 2009, age 34, cut and shot his wife and three children and committed suicide. He was taking the SSRI Paxil.

Jason Montes, 2009, age 33, killed his wife and shot himself. He was taking the SSRI Prozac.

Steven Kazmierczak, 2008, age 27, killed five, wounded twenty-one then killed himself. He was taking the SSRI Prozac.

Jeff Weise, 2005, age 16, killed his grandfather, grandfather's girlfriend, then drove to the high school, killing seven, wounding five and shooting himself. He was taking the SSRI Prozac.

Doug Williams, 2003, age 48, shot fourteen co-workers, killing six before turning the gun on himself. He was taking the SSRI Zoloft.

Eric Harris, 1999, age 18, along with Dylan Klebold, age 17, shot and killed twelve students and a teacher, wounding twenty-six others before killing themselves. Harris was taking the SSRI Luvox; Klebold's medical records are unavailable.

Kip Kinkel, 1998, age 15, shot his parents to death with a rifle, went to school and open-fired in the cafeteria, killing two and wounding twenty-five. He had been taking the SSRI Prozac.

So let me state at the outset that nothing could be more puerile, reactionary and short-sighted than to condemn an entire class of worthy drugs which are potentially so beneficial, like SSRI drugs, of which Prozac is the most prominent representative. When properly prescribed these drugs do vital and good work. However, these drugs work in specific ways which entail risks. These risks are utterly predictable and have largely been ignored. Do note the similarity in behavior connecting the above mentioned crimes which all entail a violent outburst and then, in many cases end in death by police or suicide. This pattern is created as a psychological function of the neuro-chemical effects of SSRI therapy, tolerance and withdrawal, as these factors interact in specific and predictable ways. Although websites such as SSRIstories.com and the Citizens Commission

on Human Rights website at cchrint.org offer information correlating these crimes with SSRI use and withdrawal, there is not enough information specifying the psychological mechanisms which yield these behavioral effects. I will offer a general analysis of those mechanisms here.

Conscious vs. Unconscious: To understand these factors, we must first understand the basics of unconscious psychology. When an external threat is perceived, we run away or fight. However, the situation is different if the threatening factor comes from within us. Our own ideas, memories and thoughts can be every bit as dangerous to us, and to society, as an external enemy. As we grow up, we learn to control our aggressive and sexual instincts. These ideas and instincts are never truly gone, and can be seen to "reappear" in certain circumstances, such as under conditions of painful deprivation, madness and war, where every murderous human instinct can be seen to reemerge. These instincts then, have never disappeared, rather, they have been repressed, and made unconscious. Society is built upon the bedrock of repression and the unconscious. Psychology informs us, that as these internal instinctual threats return to consciousness, we become ill. In the language of Freudian psychology: symptom formation is a function of the return of the repressed.

I have discovered that SSRI drugs positively affect mental processes by reinforcing repression: repression is 5-HT (5-Hydroxytryptamine) dependent, and SSRI drugs increase 5-HT in the neuronal network by preventing re-uptake of the neurotransmitter in the synaptic system. [I will refer you to the latest edition of Goodman and Gilman's *The Pharmacological Basis of Therapeutics* for a complete description of the neurochemistry involved in the effects of SSRI therapy.] By increasing the amount of 5-HT in the neural system, and preventing the repressed from entering consciousness, they quell mental illness. However, as is the usual case with drugs, tolerance develops and functions as partial withdrawal, and, many patients do, in fact, withdraw from these drugs. In this instance, the effect is reversed, and repression is circumvented, allowing unconscious material to enter consciousness. So the drug that helps by way of reinforcing repression, causes illness as repression is reduced by way of tolerance or withdrawal.

This reduction in overall repressive function manifests itself as an unusual artificial hysterical psychosis, where both aspects of repression are circumvented, amnesia, and distortion via compromise-formation symbolism. If the dose is high, and the term of treatment long, upon withdrawal the effect is severe. In delusion, the psychotic is afforded a level of protection, as his delusion is a sort of distortion, a symbolic transformation of the wishes and/or mnemic experiences which are returning to consciousness and creating his illness (Freud, 1911, pp. 1-82; 1924, p. 151). Now, in SSRI withdrawal, even this most basic protective function of dream and delusion is defeated, and the most energetic and severe of unconscious material can gain direct and unfettered access to consciousness, free from any distortion. The effect to the ego is absolute and certain: damage of the most severe sort. Super-ego/ego is directly exposed to the most toxic unconscious contents, and its repressions further disintegrate, further revealing the very most energetic and highly disturbing hidden ideations. Sleep, in some cases, may be curtailed to as little as three hours or less a night. Soon, hallucination completes the picture, and a new sort of even more dangerous and severe psychosis is seen to emerge.

I will briefly traverse a secondary avenue of interest before completing the picture. Although the

technical, psychological and medical information associated with these drugs is substantial, the fact that repression itself is affected to create behavioral effects has been utterly ignored. *The fact that repression is 5-HT dependent has not been articulated.* The result is clear: as repression is decreased through SSRI withdrawal, two things can be counted upon:

1. A mental illness, whatever its relation to repression, be it defined by the deepest repressions such as OCD or not, *will* be converted into an hysterical illness as hysteria is formed through the return of repressed unconscious contents under *low levels of repression* (or I postulate *perhaps* trigger the emergence of schizophrenia if the subject is predisposed). That is why hysterics demonstrate conversion hysteria, a bodily innervation of opposing wishes, in lieu of more typical repressive means (Freud, 1915, pp. 184-185), or anxiety hysteria, a common hysterical reaction in children, who have yet to develop a high level of repressive function (Freud, 1909, pp. 1-149; 1915, pp. 182-184).
2. As hysterical illness is formed through SSRI withdrawal, the job of analysis is made much easier, as unconscious ideations which are pathogenic are more easily accessed (Norman, 2011). It should be noted that these contents are likely to reveal themselves as negative transference, which although shunned in modern analysis, is in fact the key to un-riddling the puzzle.

Now we must add but one more bit of information and the analysis will be clear. Our aggressive drives are deeply repressed. These drives are repressed as a function of conscience, of guilt and super-ego, which acts as a conscious "reaction formation," an opposite which fills up consciousness as a replacement, a substitute for the repressed drive (Freud, 1923, p. 56). Sadism, violence used to control an object with no concern for that person or object, is chief among those drives we repress. The unconscious is filled with sadism. When we add guilt to a sadistic stream of great force and potency, the sadism "turns round" on the subject and becomes masochism, the chief representative of the death instinct (Freud, 1919, pp. 193-194; Norman, 2011, p.116).

Guilt + Sadism = Masochism. Now the analysis is plain:

A mentally ill person is placed on SSRI drugs that function to enforce their repressive facility which is failing and creating illness as their overly potent repressed drives return to consciousness. Soon the drug fails to maintain its effect as tolerance ensues, or, the subject withdraws from the drug. Now, repression is defeated, and unconscious content becomes conscious in its most toxic, direct and uncensored form. The subject identifies with his sadistic thoughts which present with such energetic force, as to be utterly irresistible. Once his hatred is spent, the guilt he feels for his actions is revealed, and added to his freed conscious sadistic drives to form masochism, and suicide, often suicide by way of police intervention. The psychology is utterly obvious, and, predictable. (Of course, the more likely result is suicide alone, and the above mentioned pattern of behavior is formed in those cases where sadistic ideation has obtained an energetically predominant place in the mental architecture).

Now imagine the combat veteran, trained in the art of killing, he returns to our shores, a hero, but ill for his service, ill for the guilt of killing. He is prescribed an SSRI drug, and feels better. Soon he tires of the debilitating side effects, and discontinues therapy. Can you see it? What will become of him then? What will become of us? If you are taking one of these drugs, I urge you not to stop. If you do stop, do it slowly, so very slowly, and be careful. These people who kill are

not so different than any of us, in fact, any of us could be one of them. Although perhaps differing in intensity and proportion, all of us have these drives… every single one. The only difference is that we can contain them, and can not see them, can not see this part of ourselves. Perhaps the only real difference between one of these killers and one of us, is a misfortune of human honesty, in that they, are unfortunate enough to know a little too much—of themselves. So when you wonder what separates a mad killer from one of us, you may be surprised to learn the difference may be as small as a single question - a question, of human honesty.

Concluding remarks:

The pharmaceutical industries and their lobbies spent ~$235,107,261 in 2015 in support of their interests. These financial giants pour many millions of dollars into advertising and costly informational distribution aimed directly at patients and physicians. However, the number of well funded studies examining the long term effects of SSRI treatment are scant. Not surprisingly, the result of studies which have been conducted are in keeping with my personal findings and research, and indicate permanent damage associated with SSRI use in depression (El-Mallakh et al. 2011). Other trustworthy researchers and doctors have found the same (Breggin, 2011). To my knowledge no studies are available detailing the long term damage associated with the very much higher doses used to treat populations with OCD. Two of the most widely used drug types in the treatment of mental illness, antipsychotics (including the newer 'atypical antipsychotics') and SSRI drugs, have both been scientifically demonstrated to cause permanent damage: tardive dyskinesia and tardive dysphoria respectively. The consequences extend past the personal lives of those affected, and influence society at large. Therefore I wish to suggest these possibilities:

1. Studies which are not funded by the pharmaceutical industries must be conducted which spell out the frequency and level of damage incurred through *all the SSRI dosage levels currently advised in treatment regimens for all conditions and populations treated*.
2. That information should be *actively distributed* to patients and doctors and included in product advertising and labeling where it is made plain in large typeface.
3. Serious consideration must be paid to new approaches which allocate potentially damaging drugs a safer place as a third tier treatment option, and serious consideration and priority given to other more healthful modes of treatment such as talk therapies and others, which may then replace potentially harmful drugs as primary first tier interventionary tools in the treatment of mental disease.

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