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REPORT IN THE CASE OF JOHN D.¹

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I. Purpose and Brief Summary

At the time of the alleged assault, Mr. John D. [an alias] (born 1.23.43) was a 73-year old man with no history of violence or criminal activities. Reportedly, he hit his wife with a cleaver. At the time he had diabetes, an old myocardial infarction (heart attack), and other medical disorders, and was on multiple medications with adverse psychoactive effects, with critical decreases and increases in dosage leading up to the alleged offense of assaulting his wife on 5.31.15.

Mr. John D. is charged with attempted murder. His wife, Mrs. John D., is supportive of him and refused to press charges in the belief that his action were caused by the adverse effects of his multiple medications. She describes her husband as growing increasingly agitated, irritable, angry, suspicious and delusional over a several month period. His condition dramatically worsened after additional medication changes on his 4.15.15 visit to the doctor. After that visit, he developed his first hallucinations. At the last visit to his physician with his wife one month later on 5.14.15, his wife reported her husband's hallucinations. Additional medication changes were made and seventeen days afterward on 5.31.15, he committed the unprecedented, unprovoked, bizarre assault on his wife.

I have been asked to evaluate the case for the potential role of medication and/or other factors in causing or contributing to his actions on 5.31.15. My review of the records indicates that, at the time of the assault, Mr. John D. suffered from a medication-induced confusional state with delirium and psychosis (hallucinations), which acutely disrupted his conscious control over his behavior, as well as his memory for the events. People in this condition can become extremely irritable and dangerous, since their impulses are no longer under conscious control.

Mr. John D. did not suffer from a "mental illness" with all the controversy concerning the diagnosis of mental illnesses and the complexity of evaluating the capacity for conscious, responsible action when suffering from them. Medication-induced confusional states with delirium and psychosis are well-documented, often acute (short-lived) neurological disorders of the brain that *by definition*, disrupt consciousness, self-awareness, personal responsibility, and self-control. In this case, the probability of Mr. John D. enduring such an involuntary intoxication was greatly increased by multiple factors including polydrug treatment with multiple medications known to cause this kind of brain dysfunction, age, infirmity, and improper medical evaluation and treatment for his developing confusional state with delirium and psychosis.

It has proven impossible to interview Mr. John D. at this time in jail by telephone due to his deafness; but I have sufficient information to draw all of my conclusions within a reasonable degree of medical certainty. His wife states he does not recall the incident, which is very common after involuntary intoxications. She has described his mental state surrounding the incident to the police and to me much better than he now can. In addition, I have reviewed extensive medical records from before the incident and even more in-depth and intensive medical records *after* the incident. He is now so confused that he becomes confused about whether he cut his wife or she cut him. Indeed, the extensive medical records following his incarceration indicate that he now has "encephalopathy" (brain disease). The records repeatedly state that he is such a poor "historian" that he can explain much if anything about his past medical condition and treatment, and not even very much about his current condition. He is such an inadequate reporter that the doctors state that they must rely on other sources of information than Mr. John D. Given these circumstances, my own interview of him would

probably not significantly modify any of my opinions. However, if there is a trial, I will try to interview him in person before I testify.

II. Background of the Expert

Please see my resume (**Appendix O**). It includes bibliographies of my writings in three separate groups of my books, peer-reviewed scientific articles, and book chapters. It has a lengthy list of trials in which I have testified since 1985, many of which deal with medication-induced violence and suicide. I have probably written, lectured and testified on this subject more than any others in the field.

My forensic work in this arena became especially significant in the early 1990s when a consortium of attorneys with the approval of an Indiana court appointed me the single scientific expert for all the combined Prozac product liability suits against Eli Lilly, many of which involved drug-induced violence. My book, *Medication Madness: the Role of Psychiatric Drugs in Cases of Violence, Suicide and Medicine* (2008b) is the most thorough examination of these phenomena. I have also written extensively about violence induced by medications in another medical book, *Brain-Disabling Treatments in Psychiatry*, Second Edition (2008a).

I am a psychiatrist licensed to practice medicine in New York State. I have been in practice since 1968, and have written nearly 50 peer-reviewed articles and more than 20 books, both popular and medical, many of which deal extensively with the issues in this case. My most recent medical book is *Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients and their Families* (Springer Publishing Company, 2013). The first half of the book discusses adverse drug effects that might require or encourage drug withdrawal and the second half deals with how to withdraw as safely as possible.

Since 1991, I have been studying, writing about, and on numerous occasions testifying about, the risks of antidepressant-induced abnormal behavior, including suicide, mania, and violence. In the early 1990s, I was the single scientific expert selected by numerous attorneys and approved by an Indiana court to analyze discovery materials in approximately 150 combined product liability cases against Eli Lilly concerning Prozac-induced abnormal behavior, including suicide, mania and violence. I have been a consultant to the Federal Aviation Agency (FAA) on the risks of antidepressants for pilots. My work influenced the new Warnings put into the FDA-approved antidepressant labels in 2004-2005. In 2010, I testified before the U.S. Congressional Committee on Veterans Affairs about the adverse effects of antidepressants on active duty soldiers, including the production of violence, suicide and mania. The hearings were held by the committee chair in response to my book, *Medication Madness: The Role of Psychiatric Drugs in Cases of Violence, Suicide and Crime* (New York: St. Martin's Press, 2008).

The following include some of my most relevant peer-reviewed scientific articles and one recent book chapter:

Breggin, P. A Case of fluoxetine-induced stimulant side effects with suicidal ideation associated with a possible withdrawal syndrome ('crashing'). *International Journal of Risk & Safety in Medicine* 3, 325-328, 1992.

Breggin, P. Fluvoxamine as a cause of stimulation, mania, and aggression with a critical analysis of the FDA-approved label." *Ethical Human Sciences and Services*, 4, 211-227, 2002.

Breggin, P. Suicidality, violence and mania caused by selective serotonin reuptake inhibitors (SSRIs): A review and analysis.” *International Journal of Risk and Safety in Medicine*, 16: 31-49, 2003/2004.

Breggin, P. Recent U.S., Canadian and British regulatory agency actions concerning antidepressant-induced harm to self and others: A review and analysis. *International Journal of Risk and Safety in Medicine*, 16, 247-259, 2004.

Breggin, P. Recent regulatory changes in antidepressant labels: Implications for activation (stimulation) in clinical practice. *Primary Psychiatry*, 13, 57-60, 2006.

Breggin, P. Court filing makes public my previously suppressed analysis of Paxil’s effects. *Ethical Human Psychology and Psychiatry*, 8, 77-84, 2006.

Breggin, P. How GlaxoSmithKline suppressed data on Paxil-induced akathisia: Implications for suicide and violence. *Ethical Human Psychology and Psychiatry*, 8, 91-100, 2006.

Breggin, P. Drug company suppressed data on paroxetine-induced stimulation: Implications for violence and suicide. *Ethical Human Psychology and Psychiatry*, 8, 255-263, 2006.

Breggin, P. Intoxication anosognosia: The spellbinding effect of psychiatric drugs. *Ethical Human Psychology and Psychiatry* 8, 201-215, 2006. (**Appendix M**)

Donald Marks; Breggin, Peter; and Braslow, Derek. Homicidal ideation causally related to therapeutic medications. *Ethical Human Psychology and Psychiatry*, 10, 134-145, 2008

Breggin, P. Antidepressant-induced suicide, violence, and mania: Risks for military personnel. *Ethical Human Psychology and Psychiatry*, 12, 111-121, 2010.

Breggin, Peter. Psychiatric drug-induced Chronic Brain Impairment (CBI): Implications for longterm treatment with psychiatric medication. *International Journal of Risk & Safety in Medicine*, 23, 193-200, 2011.

Breggin, Peter. TBI, PTSD, and psychiatric drugs. A perfect storm for causing abnormal mental states and aberrant behavior.” In Brock, H. and Else, R.C. (Eds.). *The Attorney’s Guide to Defending Veterans in Criminal Court*. Minneapolis, MN: Veterans Defense Project. Chapter 10, pp. 251-264, 2014.

Breggin, Peter. The rights of children and parents in regard to children receiving psychiatric Drugs. *Children & Society*, 28, 231-241, 2014.

Breggin, Peter. Rational Principles of Psychopharmacology for Therapists, Healthcare Providers and Clients. *Journal of Contemporary Psychotherapy* 46: 1-13, 2016 (**Appendix L**)

Also in respect to Mr. John D.'s case, in addition to my clinical, research, and forensic experience in the arena of medication adverse effects, I also have similar experience in the family of domestic relations and violence. This experience including a lifetime of couples and family therapy, teaching about domestic abuse, and also writing about it, most recently in my book *Guilt, Shame and Anxiety: Identifying and Overcoming Negative Emotions* (2014).

III. Material Reviewed

Medical records of Dr. X.
Interview by telephone with Mrs. Mrs. John D., 3.18.16
Walgreens, Your Personal Prescription Information for 2015
County Sheriff's Department Materials:
Refusal to Prosecute signed by Mrs. John D.
Supplemental Report
Victim Mrs. John D. (police report with no identifying marks)
Photos of wound, the victim talking on phone, the meat cleaver
Arraignment Hearing 8.6.15 (charges listed)
Searches related to criminal record (none found)
Searches related to ownership of guns (guns described)
Pre-Conviction Report by [deleted]
Reporters Transcript of Preliminary Hearings, 6.23.15

IV. County Authorities

A. Allegations

Count 1. Attempted murder on or about 5.31.15.

Count 2. Injuring a Spouse

"It is further alleged... [he] personally inflicted great bodily injury upon MRS. B., under circumstances involving domestic violence."

"It is further alleged... [he] personally used a deadly and dangerous weapon(s), to wit, MEAT CLEAVER... and causing the above offense to be a serious felony..."

It is again described as "a serious felony, violent felony" or an offense requiring "state prison."

B. Probation Officer's Report

The Probation Officer summarized:

The investigating detective Vande Vegte, indicated the defendant and the victim are an elderly couple. They were involved in a verbal dispute when

the victim left the room where they were fighting and went into the bathroom. The defendant followed her into the bathroom a few minutes later with a butcher knife and struck her in the neck with it. The defendant immediately called 911 and told the operator what he did. Offices responded and the victim stated that he didn't mean to do it and that they are having trouble regulating his medications. p. 0039

Further in the report, the Probation Officer stated, "according to the police report the defendant takes multiple medications."

In the "Evaluation," the Probation Office summarized and concluded:

The defendant does not have any documented criminal convictions. The defendant is reported to have strong ties to his family and community. The defendant's actions in the instant offense are considered violent and serious in nature. It appears, the defendant and the victim were involved in a domestic violence incident that escalated to great bodily injury on the elderly victim. The defendant used a butcher's knife to assault his elderly wife. His actions demonstrate that he poses a significant threat to the victim. Although, the crime is serious in nature, the defendant does have [sic] strong family ties, does not have a criminal history, and his medications may have played a mitigating role in the offense. P. 0045

Based on the defendant's "actions," he was found ineligible for parole. If convicted, state prison rather than probation was recommended.

C. Victim Statement Refusing to Press Charges

Victim = Mrs. John D.
Suspect = her husband

Mrs. John D.
Victim [REDACTED]

Mrs. John D.'s

On 06-01-15, I drove to Victim [REDACTED] house and interviewed her. I asked Victim [REDACTED] to tell me what happened. Victim [REDACTED] immediately said her husband (Suspect [REDACTED] was not in his right mind. Victim [REDACTED] said Suspect [REDACTED] had recently had his medications changed and the new medications changed his demeanor and temper. Victim [REDACTED] said Suspect [REDACTED] recently told her that he thought he was having hallucinations. Victim [REDACTED] said Suspect [REDACTED] would never attack her like that and she believed that the new medications are what caused the incident.

I again asked Victim [REDACTED] to tell me what happened. Victim [REDACTED] said she recently contacted an attorney to update her Trust. The attorney sent a letter home and Suspect [REDACTED] found it on the desk. Suspect [REDACTED] assumed that Victim [REDACTED] was trying to cut him out of the Trust and he became angry. Victim [REDACTED] and Suspect [REDACTED] argued in the bedroom for a while. Victim [REDACTED] said she got tired of arguing and she walked out of the bedroom. Victim [REDACTED] went into the bathroom and sat down on the toilet. Victim [REDACTED] added that she did not shut the door to the bathroom while she was on the toilet. A few seconds later she heard feet stomping on the ground. She then felt a sharp pain in the right side of her neck. She looked up and saw Suspect [REDACTED] standing in the doorway of the bathroom and holding a meat cleaver in his right hand. Victim [REDACTED] asked Suspect [REDACTED], "What did you do? How bad is it?" Suspect [REDACTED] looked at her, said he was sorry and said he was going to call for an ambulance. Suspect [REDACTED] left the bathroom and called 9-1-1. A few minutes later the deputies and fire department arrived at the house.

Victim [REDACTED] again said her husband would never hurt her and that he was not in his right mind because of the medication change. I asked Victim [REDACTED] if she wanted to prosecute Suspect [REDACTED] for Domestic Assault. Victim [REDACTED] said she did not. Victim [REDACTED] then read and signed a Refusal to Prosecute form (attached).

D. "Victim Mrs. John D."

The following appears to be the entire of a police officer's summary of an initial interview of Mrs. John D.

In regard to prosecution against [redacted] my husband
John D.

I, [redacted] being the complaining witness/victim in the above case and having discussed the case at length and to my satisfaction with a representative of the Los Angeles County Sheriff's Department now state that I do not wish to prosecute the above named person(s). I further state that I will not sign a complaint and request that none be issued. I understand that the Los Angeles County Sheriff's Department is willing to continue its investigation into this matter, but nevertheless I do not desire further investigation not prosecution. I further state that any actions taken in this matter by the Los Angeles County Sheriff's Department were based on information provided by me. I further agree that I will not hold the Los Angeles County Sheriff's Department or its representative(s) responsible or liable in this matter.

My reason(s) for requesting that no further action be taken is as follows:

Change of Mels. Davengs brains & hallucinations
Having him go to anger management would
be a great thing for him to do plus have
subjection he is taking checked out also
to see if he has had a small stroke.

This action on my part is free and voluntary and I have not been coerced, threatened or intimidated in any matter whatsoever.

Handwritten initials or mark

V. Analysis of Medications Prescribed by Dr. X

A. Overview of Mr. John D.'s Medications that Caused or Contributed to his Psychosis and Violence on 5.31.15

Multiple medical and medication factors contributed to causing Mr. John D.'s unprecedented, unprovoked, isolated and bizarre incident of 5.31.15. The polydrug treatment was the main causes, but other factors made him vulnerable to adverse drug reactions affecting his brain and mind, and also to dyscontrol with violence.

This section will examine four medications that were started or whose dose was dramatically changed at the time of 4.15.15 visit to the doctor, after which he developed his first hallucinations, or at the 5.14.15 meeting with the doctor, after which he committed the unprecedented, unprovoked, bizarre assault on his wife. All of the quotes concerning adverse reactions originate from the FDA-approved Full Prescribing Information (also called the label) for the drug.

It is widely recognized in medicine and psychiatry, and often noted in FDA-approved literature, that psychoactive substances are most likely to have an impact on the brain and behavior soon after they are begun, as well as during dose changes, and during withdrawal.

The familiar example of alcohol may help to illustrate this. The first few or several times individuals drink alcohol they are likely to get seriously drunk and too behave stupidly or recklessly, and sometimes violently. Once an individual becomes used to drinking alcohol, especially on a regular basis, they may not feel or display such dramatic reactions. However, if they drink more than usual (that is, raise the dose of the drug), they again become compromised mentally and behaviorally. Similarly, if they reduce the drug or stop entirely, they may develop withdrawal symptoms and psychosis in the form of delirium tremens.

There are however, two main difference between alcohol-induced disinhibition, psychosis or violence, and that produced by medications, such as those in this case. First, people are expected to understand that alcohol can induce bad behavior and to anticipate the problem, and to control their level of drinking (that is, the strength of the dosage). Second, alcohol gives obvious signs of intoxications, including slurred speech and impaired gait, while the medications in this case would produce no such warnings. Thus, the individual, like Mr. John D., becomes psychotic without realizing it and usually without attributing it to the medication. He thinks he is being normal when it crosses his mind to do something horrible.

Here are the five medications that were started or had their doses changed dramatically before the development of hallucinations and/or before the violent episode:

1) NORTRIPTYLINE (an antidepressant). (Appendix A1) There is no explanation for why Dr. X added this drug to the regimen at this time; it is extremely hazardous for the elderly and frail. This appears to be the patient's first exposure to the drug, which in itself, could have tipped him over into psychosis and violence. Because it was prescribed as 10 mg 1 or 2 "every night at bedtime," it may have been intended as a sleep medication, but the drug in fact is among the most stimulating in regard to antidepressants. It at night adds to the hazard of

insomnia and sleep disturbances with agitation. His wife from her memory believes he was taking two because he was not sleeping well.

It appears that this was the patient's first exposure to this drug, greatly increasing the likelihood of a harmful adverse drug reaction.

The warnings in regard to nortriptyline are extensive in the FDA-approved Full Prescribing Information. What follows is only a sample. Note the specific reference to "*irritability, hostility, aggressiveness, impulsivity, akathisia* (psychomotor restlessness)"—a virtual prescription for violence.

WARNINGS

Clinical Worsening and Suicide Risk ...

All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality.

Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms.

Families and caregivers of patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to health care providers. Such monitoring should include daily observation by families and caregivers.

Bold in original

Nortriptyline has an FDA-mandated and approved Medication Guide (found at the end of the Full Prescribing Information, which specifically mentions "acting aggressive, being angry, or violent" as a risk to be especially aware of and to report to the doctor.

Call a healthcare provider right away if you or your family member has any of the following symptoms, especially if they are new, worse, or worry you:

- ! thoughts about suicide or dying
- ! attempts to commit suicide
- ! new or worse depression
- ! new or worse anxiety
- ! feeling very agitated or restless
- ! panic attacks
- ! trouble sleeping (insomnia)
- ! new or worse irritability
- ! acting aggressive, being angry, or violent
- ! acting on dangerous impulses
- ! an extreme increase in activity and talking (mania)
- ! other unusual changes in behavior or mood

The above Warnings are part of a relatively recent (2005-2005) class warning for all antidepressants. They constitute a veritable prescription for violence.

The section on *ADVERSE REACTIONS: Psychiatric* found with this specific drug is unique to the drug and confirms that it is an especially dangerous drug in respect to the dangerous array of adverse reactions. Note the emphasis on *elderly*:

ADVERSE REACTIONS ...

Psychiatric – Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia, panic, nightmares; hypomania; exacerbation of psychosis.

Notice the specific mention of hallucinations, delusions, and exacerbation of psychosis, along with disorientation and confusional states (especially in the elderly). This is a prescription for potential out-of-control violence. Remember that Mr. John D. was more than simply elderly, he was frail, ill, and overmedicated, vastly increasing the likelihood of a negative reaction to this drug. In addition, giving it in the evening was especially dangerous and could have accounted for the early morning assault after awakening from a difficult night.

The above list in the ADVERSE REACTIONS section is not a part of the new class label, but results instead from the testing of nortriptyline itself during the original drug testing for FDA approval. To illustrate this, I have also included a PDF of the 1998 FDA approved label for Pamelor (nortriptyline) (**Appendix 1B**, p. 1890). It contains the identical warning under *Adverse Reactions: Psychiatric*:

Psychiatric – Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia, panic, nightmares; hypomania; exacerbation of psychosis.

This is remarkable because these adverse reactions were noted in the original drug testing long before there was a class warning and long before it was widely recognized that antidepressants were this dangerous in regard to producing severe psychiatric disorders and long before there was so much emphasis on the vulnerability of the elderly to psychiatric adverse reactions. Thus, the existence of these risks with this particular drug was noteworthy before it was generally recognized for most or all antidepressants.

By a stroke of good fortune, I was able to locate the very first FDA-approved summary for nortriptyline in my archives (**Appendix 1B**). It is *Supplement A* (a separate booklet) to the 1967 PDR. This document provides more of the actual data as initially presented by the drug company to the FDA and then published. It again confirms the uniquely dangerous qualities of this often over-stimulating drug, including the special hazard to the elderly. The entire section on Adverse Drug Effects is worth reviewing, but the following paragraph is especially relevant to Mr. John D.' case (p. A7, column 3):

Although the anticholinergic effects, as a group, were not considered disturbing (save delayed micturition), those in the stimulatory category were. These symptoms, too, were transitory and reversible, lasted usually less than seventy-two hours, and customarily responded to reduction in dosage. However, one side-effect, confusional state, seen in 117 of the 1,888 patients (6 percent), was considered to be severe by 62 percent of the 117 cases. This category includes disorientation in the senile group, hallucinations in the psychotic patients, and a few cases of anxiety to the point of panic in neurotic subjects.

That 6 percent of patients developed a confusional state with disorientation in elderly (senile) patients and hallucinations, and hallucinations in already psychotic patients, is most extraordinary. It is also important to reemphasize that Mr. John D. was more than simply elderly, he was frail, ill, and overmedicated, hugely increasing the likelihood of a negative reaction to this drug such as confusion and psychosis. The drug company correctly identifies these especially severe adverse effects as “in the stimulating category;” stimulating or activating symptoms commonly include aggression, hostility, and violence, which are found in the updated label and Medication Guide for the drug (**Appendix A1**). Notice that the confusional state is short-lived, as in Mr. John D.' case. The FDA considers an adverse effect that occurs in 1% of patients to be frequent. Six percent is six times the minimum rate for categorizes an adverse effect as frequent. Furthermore, 62% of these cases were considered “severe.” In a severe confusional state, an individual is essentially “unconscious,” completely lacking in self-awareness, judgment, impulse control, and all other higher faculties.

It was a tragedy to prescribe this drug in this vulnerable patient, especially after he was already suffering from a newly developed psychosis with hallucinations.

2) HYDRALAZINE (antihypertensive). (Appendix B) He was started on hydralazine on 4.15.15 before the hallucinations and his wife subsequently attributed Mr. John D.'s hallucinations and behavior to this drug. For reasons not explained in the medical record, the doctor continued this medication on 5.14.15. This in itself was sufficient to have caused the event of 5.31.15. Accord to wife, 25 mg tablets 3 times daily.

The Full Prescribing Information for hydralazine (Appendix A), under “neurologic” [includes psychiatric] adverse reactions to the drug states:

Neurologic

peripheral neuritis, evidenced by paresthesia, numbness, and tingling; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety.

Initiate therapy in gradually increasing dosages; adjust according to individual response. Start with 10 mg four times daily for the first 2 to 4 days, increase to 25 mg four times daily for the balance of the first week. For the second and subsequent weeks, increase dosage to 50 mg four times daily. For maintenance, adjust dosage to the lowest effective levels.

3) CLONIDINE (antihypertensive). (Appendix C) This drug for treating hypertension was started on 2.4.15 at 0.1 mg twice a day. This is the usual starting dose but the Full Prescribing Information specifically warns that the elderly may need a smaller dose (see quote below). Because he was elderly and even frail, and because he was being given other antihypertensive medications, this was an especially high dose. The medication was stopped two months later on 4.15.15. After the hallucinations were reported to the doctor, the clonidine was then restarted 5.14.15 at 0.2 mg twice a day, *double* the recommended starting dose (much more than the equivalent of doubling, given Mr. John D.'s condition). The large dose of clonidine was probably one of the more significant contributors to Mr. John D. deteriorating further after the initial start of his hallucinations. This drug is also very sedating and would add to the other CNS depressants. The Full Prescribing Information specifically notes the risk of causing hallucinations and delusions, and related problems.

WARNINGS

Withdrawal

Patients should be instructed not to discontinue therapy without consulting their physician. Sudden cessation of clonidine treatment has, in some cases, resulted in symptoms such as nervousness, agitation, headache, and tremor accompanied or followed by a rapid rise in blood pressure and elevated catecholamine concentrations in the plasma.

....

ADVERSE REACTIONS

Central Nervous System: Agitation, anxiety, delirium, delusional perception, hallucinations (including visual and auditory), insomnia, mental depression, nervousness, other behavioral changes, paresthesia, restlessness, sleep disorder, and vivid dreams or nightmares.

....

DOSAGE AND ADMINISTRATION

Initial Dose

0.1 mg tablet twice daily (morning and bedtime). Elderly patients may benefit from a lower initial dose.

4) BACLOFEN (for muscle spasms). (Appendix D) The drug was administered three times a *day as needed*. The Drug was started 2.4.15 at 5 mg per day and then doubled to 10 on 5.14.15 despite wife's report of her husband's hallucinations. Because it was started only three months before the report of hallucinations and a little less than four months before the assault, it could have played a key role in these events.

Warnings

a. Abrupt Drug Withdrawal: **Hallucinations** and seizures have occurred on abrupt withdrawal of Baclofen. Therefore, except for serious adverse reactions, the dose should be reduced slowly when the drug is discontinued.

Adverse Reactions

Neuropsychiatric: **Confusion (1 to 11%)**, headache (4 to 8%), insomnia (2 to 7%); and rarely, **euphoria, excitement, depression, hallucinations**, paresthesia, muscle pain, tinnitus, slurred speech, coordination disorder, tremor, rigidity, dystonia, ataxia, blurred vision, nystagmus, strabismus, miosis, mydriasis, diplopia, dysarthria, epileptic seizure.

5) DOXAZOSIN (antihypertensive). (Appendix E) (also treats benign prostatic hypertrophy). Prescribed as needed for higher blood pressure readings. This medication was started on 4.14.15 at 4 mg per day. It was reduced to 2 mg daily on 5.14.15. The FDA-approved Full Prescribing Information does not specifically mention hallucinations or psychosis but it does list an array of adverse drug reactions related to severe psychiatric disturbances consistent with hallucinations, psychosis and/or violence:

Additional adverse reactions have been reported, but these are, in general, not distinguishable from symptoms that might have occurred in the absence of exposure to Doxazosin. The following adverse reactions occurred with a frequency of between 0.5% and 1%: syncope, hypoesthesia, increased sweating, **agitation**, increased weight. The

following additional adverse reactions were reported by <0.5% of 3960 patients who received Doxazosin in controlled or open, short- or long-term clinical studies, including international studies. Cardiovascular System: angina pectoris, myocardial infarction, cerebrovascular accident; Autonomic Nervous System: pallor; Metabolic: thirst, gout, hypokalemia; Hematopoietic: lymphadenopathy, purpura; Reproductive System: breast pain; Skin Disorders: alopecia, dry skin, eczema; **Central Nervous System: paresis, tremor, twitching, confusion, migraine, impaired concentration;** Psychiatric: paroniria [terrifying abnormal dreams], amnesia, emotional lability, abnormal thinking, depersonalization;

There is no mention of any withdrawal problems.

B. Probable Contribution of Other Medications to Mr. John D.'s Condition on 5.31.15

Mr. John D.'s was prescribed another three medications which he was taking chronically for longer periods of time that also are known to cause hallucinations, psychosis and other serious mental disturbances. Because there was no change in the doses prescribed shortly before the incident, we cannot so directly link them to the incident. However, their strong capacity to produce hallucinations, psychosis or other mental disturbances indicates that they have prepared the way or added to the impact of the more recently increased or newly introduced drugs.

The three drugs are:

(6) OMEPRAZOLE (for gastric problems). (Appendix F) Commonly known as Prilosec, this drug is for gastric stress of various kinds. Used at this routine dose of 20 mg, there are many relevant reports to the FDA in the Post Marketing period use of the drug. The FDA-approved Full Prescribing information provides this information, including *aggression* and *hallucinations*:

Nervous System/Psychiatric: Psychiatric and sleep disturbances including depression, agitation, aggression, hallucinations, confusion, insomnia, nervousness, apathy, somnolence, anxiety, and dream abnormalities; tremors, paresthesia; vertigo

(7) HYDROCODONE AND ACETAMINOPHEN (opiate for pain). (Appendix G) Commonly known as Norco, this drug, like all opiates, is a central nervous system depressant and adds to the effects of all the other potential CNS depressants the patient is taking. The FDA's Full Prescribing Information for Norco states:

Adverse Reactions

The most frequently reported adverse reactions are lightheadedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in

nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence, mood changes.

(8) OXYBUTYNIN (for bladder control) (Appendix H) (probably the one drug in this list prescribed by a different physician, urologist Shahrud Aynehchi). This drug, prescribed in the Extended Release (ER) 5 mg form, belongs to a category of anticholinergic drugs that have potentially severely negative effects on the brain and behavior. The Full Prescribing Information for this drug has a Precaution specifically about this problem. A Precaution is a much higher level of warning than a simple list of adverse reactions:

PRECAUTIONS

Central Nervous System Effects

Oxybutynin is associated with anticholinergic central nervous system (CNS) effects

(See **ADVERSE REACTIONS**). A variety of CNS anticholinergic effects have been reported, including hallucinations, agitation, confusion and somnolence. Patients should be monitored for signs of anticholinergic CNS effects, particularly in the first few months after beginning treatment or increasing the dose. If a patient experiences anticholinergic CNS effects, dose reduction or drug discontinuation should be considered.

DITROPAN should be used with caution in patients with preexisting dementia treated with cholinesterase inhibitors due to the risk of aggravation of symptoms.

VI. Medical Conditions Contributing to Frailty and Drug Sensitivity

A. The Effect of Mr. John D.'s Role of Chronic Pain Syndrome

There is considerable clinical and scientific evidence linking chronic pain syndrome with violence before, to the degree that treating these patients increases a doctor's risk of being assaulted (See **Appendix I**, Fishbain et al., 2000). Mr. John D. had two sources for his pain: diabetic peripheral neuropathy (the main cause) and a lower back condition. Chronic pain syndrome is an important factor in this case because it makes the patient more susceptible to adverse drug reactions affecting the brain and behavior. However, chronic pain syndrome is much less likely by itself to lead to violence than the combination of drugs to which he was exposed.

D. Additional Medical Factors Contributing to the Episode of 5.31.15

In addition, there were multiple other medical issues that made Mr. John D.'s especially susceptible to an adverse drug effect upon his brain and behavior:

(1) He was 73 years old. Older people have greatly increased sensitivity to mind-altering drugs. His many medical problems prematurely aged him, so he was functionally much older than his chronological age (see next paragraph).

(2) He was suffering from multiple medical problems, including diabetes (controlled with medication) with neuropathy; "suboptimally controlled" high blood pressure (p. 122); chronic kidney disease (CKD), stage II (mild); bladder control problems; benign prostatic hyperplasia; peripheral vascular disease; morbid obesity; osteoarthritis; chronic pain syndrome with dependence upon opiates; low testosterone; and impaired hearing. His weakened, biologically vulnerable condition would have made him more susceptible to adverse drug reactions involving his brain and mind.

(3) Improper medical care also contributed to Mr. John D.'s episode on 5.31.15. Without going into detail, here are some of the inadvisable approaches in his treatment: First, prescribing the polypharmacy that caused hallucinations and then amplified his abnormal mental state; second, failing to take first-time hallucinations seriously enough, to describe and document the nature and frequency of the hallucinations, and to specifically investigate if there were command hallucinations (e.g., telling him to harm his wife); third, the failure to respond to his wife's suggestion that the hallucinations were caused by the hydralazine, including gathering and recording more information about the reasons for Mrs. John D.'s conclusion, and stopping the medication, given its capacity to induce severe mental dysfunction; fourth failing to do even a rudimentary mental status, disclosing Mr. John D.'s state of mind, tendency for suicide or violence, or nature of his hallucinations and possible delusions.

VII. Interviews with

My telephone interview with Mrs. John D. confirmed the following relevant facts:

1. Mr. John D. took his medicines as directed, doing so very carefully with trays for different times of the day.
2. Mr. John D. used no other psychoactive substances.
3. Mr. John D. was not psychotic or confused until shortly before she reported it to the doctor at the last interview.
4. Over several months, Mr. John D. became more irritable and angry, as well as suspicious, paranoid and probably mildly deluded leading up to the violence. She increasingly began to suspect that the medicines were harming his mental capacities.
5. Mr. John D. had no prior history of violent behavior nor of any mental disturbance or psychiatric treatment.
6. At the time he struck her with the cleaver, Mr. John D. did not understand what he had done and had to ask his wife what happened and if she was hurt. He was distressed when he realized what he had done.
7. Mr. John D. has no memory of the event between going to the bathroom in the morning and calling 911. His memory was not good for the time of calling 911 and the police arriving.

8. There was no immediate provocation. The event occurred in the morning before they had spoken. The police reported titled “Victim Mrs. s John D.” is incorrect in several ways, including that the assault was preceded by an argument. (Even if they had argued, there is no reason to believe that Mr. John D. would have acted as he did without a drug-induced confusion and delirium with psychotic features.)

VIII. Mr. John D.’s Mental State During the Episode on 5.31.15

Mr. John D.’s diagnosis at the time of the event was Medication-Induced Delirium with Psychotic Features. Mr. John D. was *confused, delirious* and *psychotic* at the time he assaulted his wife. *As a result, his brain function, and hence his conscious, rational mind, was globally disrupted and he was not in control of his behavior. He was unconscious, but not in the sense of being asleep or in a coma. He was unconcious because the drug-induced dysfunction of his brain made him unable to bring his behavior under conscious, volitional, or self-determined control.* This confusional, delirious and psychotic state, as typically occurs, was drug-induced and acute (short-lived).

Mr. John D.’s mental state or condition at the time of the event has several overlapping aspects: (1) confusion, (2) delirium, and (3) psychosis. There are two basic neurology textbooks in common use and they address this condition. Both describe a state of drug-induced confusion and delirium with psychosis similar to that of Mr. John D.’s tragic episode.

The first textbook is Lew Rolland and Timothy Pedley’s (2010) *Merritt’s Neurology, 12th Edition*. A chapter titled “Delirium and Confusion” (**Appendix K**) describes delirium as follows:

Delirium is a confusional state with rapid onset and fluctuating course accompanied by alternations in consciousness and the sleep-wake cycle, disturbance of thinking and memory, disorder attention, hallucinations and delusions, and physical agitation or hypoactivity. P. 4

Note the “alterations in consciousness” which is a basic part of all definitions of confusion with delirium, as well as a key aspect of involuntary intoxication under the law. This definition and description of delirium and confusion is key to understanding that the individual’s behavior is not under conscious control because consciousness has been impaired.

Merritt’s Neurology emphasizes the role of medications as a cause of delirium (pp. 4-5) and refers to them as “intoxications.” This, too, is key to understanding that various medical drugs do indeed cause involuntary intoxications with disturbances in consciousness.

Merritt’s Neurology has a table titled “Medications Causing Delirium” (Table 2-1, p. 5) (**Appendix K**). It lists 20 categories or individual drugs that cause delirium. Eight drugs or drug categories that cause dementia were prescribed simultaneously to Mr. John D. in April and May 2015:

1. tricyclic antidepressants (nortriptyline)
2. anticonvulsants (gabapentin)
3. benzodiazepines and other sedatives (baclofen is not a benzo, but is closely related, and it is a sedative)
4. clonidine (clonidine)

5. atropine and related anticholinergic compounds (oxybutynin [Ditropan])
6. propranolol (atenolol, identical in mechanism of action)
7. furosemide (furosemide, known as Lasix) [not included in my list in this report. Nothing in the FDA-approved label confirms this, and I restricted myself to that source.]
8. narcotics (hydrocodone)

In summary, according to one of the two major textbooks of neurology, Mr. Davidson was taking 8 medications that can cause delirium. The list is largely the same one I developed independently while evaluating the case, except that the textbook's list adds one that I did not include (furosemide or Lasix) while my list instead includes omeprazole. With the addition of Lasix, this makes a total of 9 drugs that Mr. John D. was taking that put the functioning of his brain and mind at risk. This is a huge combined risk.

In addition, Merritt's states "In elderly patients, anticholinergic and hypnotic agents are particularly common causes of drug-induced delirium" (P. 4). Most or all of the above drugs are in one or both these two categories: anticholinergics represented by (#1 and # 5) and hypnotics represented by # 2, # 3, and # 8, and to a degree by #'s 1, 4-7, all of which can be hypnotic, that is, sleep-inducing). Mr. John D.' medication regimen was a prescription for delirium. As we shall see, his physical condition and related issues made a disastrous mental/behavior reaction even more inevitable.

The other major, familiar textbook of neurology is *Principles of Neurology, Tenth Edition*, 2014 by Allan Ropper et al. Its observations on confusion, delirium and psychosis are entirely consistent with *Merritt's Neurology*.

Delirium and confusional states are discussed under the rubric "Confusional Syndromes" (pp, 426 ff.). The textbook's definition of delirium again strikes at the heart of the question of consciousness:

To summarize, the entire group of acute confusional and delirious states is characterized principally by *an alternation of consciousness* and by prominent disorders of attention and perception, which interfere with the speed, clarity, and coherence of thinking, *the formation of memories*, and *the capacity for performance of self-directed and commanded activities*. P. 426. Italics added.

Once again, the individual suffering from delirium is described as essentially lacking in the capacity to make conscious, self-directed, or responsible decisions or actions.

The confusional state designated as delirium includes acute confusion as well as "overactivity, sleeplessness, tremulousness, and prominence of vivid hallucinations, sometimes with excessive sympathetic activity" (p. 426). In other words, this is the over-excited, hallucinated expression of confusion rather than the slowed down version. This is also the type of delirium that is most likely to lead to agitated, angry and even violent behavior.

The psychotic aspect of the confused, delirious and psychotic condition is defined in the textbook as follows: "From the neurological perspective, the generic term *psychosis* applies to states of confusion in which elements of hallucinations, delusions, and disorder thinking compromise the prominent features" (p. 426). Hallucinations were the first prominent indicator of Mr. John D.' brain dysfunction and worsening mental condition.

The "etiology" or causation of these conditions is predominantly from drugs. According to the *Textbook of Neurology*, in addressing confusional states, "The most frequent in general

practice are drug intoxications and endogenous metabolic encephalopathies...” (p. 427). Mr. John D. suffered from a drug intoxication from multiple medications.

Mr. John D.’s condition grew over several months, resulting in the hallucinations recorded in the visit of reported in the medical visit of 5.14.15, ending in violence seventeen days afterward on 5.31.15.

I have noted that this confusional state characterized by delirium and psychosis is not a “mental illness” with all the controversy surrounding these diagnoses and with the absence of a sound pathophysiological basis for them. The textbook, *Principles of Neurology* (Ropper et al., 2015) has a section on the “Pathophysiology of Confusional States.” The textbook states that many of the physiological measurements of brain function are similar to coma, occurring on a metabolic or biochemical level, and sometimes in the brain waves. “These changes surely reflect one aspect of the central problem—the diffuse impairment of the cerebral mechanisms...” (p. 428). Specifically in regard to the confusional state called delirium, with hyperactivity and hallucinations, EEG changes are less common but do occur.

The textbook, in discussing confusional state, has a special section titled “Confusional States and Delirium Induced by Medication.” In the first sentence it states, “*In considering the pathophysiology of delirium and confusion, it must be again emphasized that drug intoxication—predominantly with drugs prescribed by physicians—is among the most common causes in practice*” (p. 429, italics added).

A good practical discussion of medication –induced delirium with psychotic features can be found in Gleason (2003) (**Appendix J**). For a general discussion of how psychiatric drugs impair the function of brain and mind, sometimes causing violence, see Breggin (2008a&b) and Breggin (2013) (**Appendix M**). For a specific scientific analysis of how drugs, even without dementia, can cause “medication spellbinding” and drive people to violence, see Breggin (2006) (**Appendix L**).

Further discussions of medication-induced “intoxication delirium,” as in this case, can be found in the American Psychiatric Association’s (2013) *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Under their suggested use of the ICDN-10 coding system, Mr. John D. suffered from *Multiple Medication Substance Intoxication Delirium, acute, hyperactive, severe, with psychotic features (F19.921)*.

IX. After the Arrest of Mr. John D.

A. Transcript of Preliminary Hearings, 6.23.15

In response to state’s attorney direct examination, Mrs. John D. testified that she is 66 years old and that she and her husband have been married for 46 years. They have an adopted son, Sonny.

The incident occurred at approximately 6:15 am in the morning of 5.31.15.

Because of a nerve conditions that makes her legs shake, she had been sleeping on the couch. “I got up, made coffee, and my husband passed and went into his bathroom and I went into my bathroom. And I was sitting there, and I was reading a book. [attorney interrupts] I noticed that my husband was standing in the doorway and I looked up at him. And he had this strange look on his face. [attorney]. Yes. In his right hand, he had a meat cleaver. [attorney asks if she felt any pain or noticed anything]. Not until I felt something like a drip down and I went like this [indicates right lower neck]. Then I looked. And it was blood.” ... “I looked at it and I

asked him, I said, 'What did you do?' I said, '— ,what did you do.'" ... "He did not respond "for a second or so, then he looked at me and we started talking a little. I said, you know, I started crying. He says, 'I got to call 911.' [She then showed the wound to him] ... "He said he was sorry, and 'And I have to call 911 now.' ... He left. And he called 911. No, there was an instant I asked. I said, 'Let me see what it looks like. Maybe I can fix it and we won't have to call the police or ambulance.'" Because **I'm a nurse**, I was going to fix it." She was unable to fix it and the police and an ambulance arrived.

She estimates she stayed in the hospital two to two-and-half hours. She received stitches: 8 on the inside of the muscle and 8 on the outside. She no longer takes pain medications.

In response to Mr. Petroff's [defendant's attorney, Allen Petroff] cross-examination:

Her husband has health issues and takes 14 to 16 medications a day.

She confirms the medications have side effects of "confusion," "agitation," and "alter his mood."

She confirms that recent change to his medication had "altered his behavior." She spontaneously lists, "His mood swings, kind of spaced off. Feeling funny, he would say. So, you know, he would talk about different thing and he would say he was hallucinating about different things or he ws feeling fun ny, and he go lay down."

They went to doctor on May 15, 2015 [16 days prior to assault] and "and she had given him this pill before. He was telling her he was feeling funny and hallucinating." The doctor said to cut it in half. [stricken as hearsay]

When her husband was standing there after the assault he asked her something about money and getting money from tenants. [unclear to me] "Then he kind of came out of it and his eyes were kind of glassy. He came out of it and said he was sorry, that he had to call 911." He still had the meat cleaver in his hand but she confirms she was not scared.

They had fire arms in the house (stricken).

The judge agrees to allow the allegations.

B. 911 Audio Recording

The recording started at 6:30 am 5.31.15 and last about 12 minutes. Overall, the 12-minute 911 audio recording displays Mr. John D., at the moment, as a man who has no awareness of the consequences of his actions in regard to harming his wife physically and emotionally, to ruining his own life, or even to provoking the police when they arrive with guns drawn, as he yells at them to put their guns down or to shoot him. Witnessed out of context, he would sound like a man severely intoxicated on alcohol who had become belligerent, angry, uncaring, and oblivious to the consequences of his behavior. He was intoxicated, but on prescribed polydrug treatment. He also sounds some moderately demented irritable older men who yell aggresssively, making demands that are utterly senseless, thoughtless, and provocative. This kind of behavior in a facility almost always result in heavy medicating. Overall, Mr. John D.'s behavior behavior is consistent with what is commonly diagnosed as extreme irritability and is consistent with a drug-induced manic-like reaction that is out of touch with the reality of what he has done. This is also consistent with what will later be evaluated in this report as state of confusion and delirium with psychotic features, although psychotic features are not critical to the evaluation. He is in a medication-induced hyperactive delirium with his consciousness so deeply impaired by generalized brain dysfunction that he has no concept of right and wrong or

consequences. He is reacting to disinhibited anger with nothing to control it in the way of judgment, empathy, reason, self-awareness or consciousness.

Toward the end, the 911 operator him to sit down. He responds, “I can’t sit down.” She asks, “Why?” He responds, “I don’t know.” This is consistent with a drug-induced state of agitation called akathisia (literally, the inability to sit still), which can lead to violence and suicide. There is an enormous literature on akathisia caused by antipsychotic drugs and antidepressant drugs. In this case, it is probably a result of polydrug treatment. The *Diagnostic and Statistical Manual of Mental Disorders* (2000) describes akathisia and how it can drive a general worsening of the individual’s condition, as well as violence and psychosis (**Appendix N**).

C. Jail Medical Records

This 875-page record spans 5.31.15-11.17.15 and consists entirely of admissions to the LAC+USC Medical Center. These records show that Mr. Davidson appears to be completely oblivious of what he has done and its consequences when he goes to the Emergency Department complaining about his chronic backache, describing it as “not that bad,” and showing no signs that he has is enmeshed in a tragedy for himself and his wife. The records then show that he is again given polydrug therapy, with some overlapping medications, and he again deteriorates, and becomes diagnosed with *enecephalopathy*, a term that literally means “disorder of the brain,” usually one that is serious and widespread.

On the day he assaults his wife, 5.31.15 at around 10:15 am, less than four after he struck his wife in the neck with a cleaver and was arrested. Mr. John D. was taken to the hospital emergency department with a chief complaint of backache from a chronic disorder of thirty years duration (p. 2 of 58). The diagnosis after evaluation is chronic back pain. He is alert and calm, speaking in full sentences.

History of Present Illness

The patient presents with back pain. The onset was 30 years ago. The course/duration of symptoms is intermittent—not worsened from his usual pain... The character of the symptoms is dull. The degree at onset was moderate. The degree at present is moderate, but “not that bad.”

If one reads the emergency department report out of context, the major question would why the man even came to the emergency? He seems to look and act perfectly fine, and to be in little or no distress about a very old problem. In the context that he attack his wife with a meat cleaver that morning and was arrested by police with drawn guns—his visit to the E.D. is very bizarre.

He is only able to recall a few of medicines. He does not mention hydrocodone, so he is not drug-seeking.

When he is next evaluated on 6.12.15 at the Cardiology Outpatient Clinic for treatment evaluation he is taking the following medications (50 of 58):

1. *Metoprolol*
2. *aliskiren/amlodipine/hydrochlorothiazide*
3. *glyburide*,

4. *clopidogrel (Plavix)*
5. *benazepril*
6. *amitriptyline (50 mg)*
7. *gabapentin (not listed on 50 of 58, but see below)*

As I will describe in detail below, this once again is a deadly combination of polydrug therapies, many of which compromise mental function. He will be given even more medications and he will get increasingly worse.

Here are early signs of mental decline noted at the cardiology clinic:

Under cardiologist eval at a clinic in Downey, CA. He does not know the reason for being seen by a cardiologist, and does not know his name, does not know the reason for being on Plavix... Does not know the last time he was hospitalized. P. 50 of 58

On 6.17.15 through 6.22.15, Mr. John D. is hospitalized for a worsening condition of obstructive chronic bronchitis. His medications have increased as indicated by the admitting medications list (pp 26-27 of 409):

1. *aliskiren/amlodipine/hydrochlorothiazide*
2. *atenolol*
3. *amitriptyline (50 mg)*
4. *benazepril*
5. *clonidine*
6. *clopidogrel (Plavix)*
7. *gabapentin*
8. *glyburide,*
9. *metoprolol*
- 10 *simvastati*

He will be discharged on the same group of medicines (p18 of 409).

The antidepressant amitriptyline is less stimulating and less associated with confusional states than nortriptyline and that there is no narcotic. Nonetheless, it is a dangerous combination for an older gentleman in his physical condition. He is noted to be “constantly moving about” but alert and oriented (p. 51 of 58).

On 6.22.15 there is a record titled “Orders-Medications”. At about this time, physician’s begin to note that he is a “very poor historian” (34 of 409)—meaning he cannot remember or organize his past history of illness and treatment. His memory is so compromised that he “cannot accurately state DOB [date of birth] or medication list” (35 and 36 of 409). This is usually a sign of a serious brain disorder. Forgetting one’s own date of birth usually indicates something greater than mere memory loss, such as confusion or delirium. Furthermore, his short-term memory is impaired because he “cannot give clear history of what occurred earlier” and “For example, does not know that he is on Plavix” (36 of 49). Furthermore, he is so “unreliable” as a historian they try to fill in the record from an ER physician and the jail record (37 of 409). He does not even know the year.

Most dramatic, it is noted, “When asked why he was in hospital, he first reported that he was bleeding from his left neck and later on said he was here because his wife was bleeding from the neck” (37 of 409; also see other pages including 59 of 409). The latter difficult led to the conclusion that he had an “altered mental status” (38 of 409). The medical record will repeatedly cite this bizarre confusion about whose neck was stabbed as an indication of his mental decline. It will also repeatedly note that he is a poor history—that he cannot describe his illnesses and his treatment in the past. During this time (6.17-6.22.15) his signature looks grossly impaired (74 of 409).

On neurological examination on 6.18.15, signs of toxicity also show up as as his gait being “Asymmetrical, Slow, Unstead”; inequality in movement of his legs; and language difficulties (383 of 409). He also has multiple episodes of vomiting, which may or may not be drug toxicity; but the possibility was overlooked. (At other times, more cursory neurological examinations will fail to note the findings of this more carefully documented report.)

On discharge on 6.22.15 the diagnosis of encephalopathy is listed as “possible” and in another place as “questionable encephalopathy” (78 of 409). Medications are never considered as a possible cause. He is discharged on several forms of insulin for diabetes, as well as the following medications to be continued at “home,” that is, in jail (77 of 409).

1. *simvastatin*— Trade name Zocor, this is a strong potential culprit in Mr. John D.’s mental decline. According to the FDA-approved full prescribing information. It states, “There have been rare postmarketing reports of cognitive impairment (e.g., memory loss, forgetfulness, amnesia, memory impairment, confusion) associated with statin use” (p. 9) (see Zocor in bibliography).

2. *metoprolol* –very similar to propranolol, see list in *Merritt’s Neurology* of drugs that can cause confusion and delirium, **Appendix K**.

3. *atenolol* – see *metoprolol*

4. *aliskiren/amlodipine/hydrochlorothiazide*—According to the FDA-approved full prescribing information, one the components, amlodipine, can cause the following: “Psychiatric: sexual dysfunction (male and female), insomnia, nervousness, depression, abnormal dreams, anxiety, depersonalization” (p. 4) (see Norvasc in bibliography)

5. *glyburide*—This is a diabetic drug for lowering blood sugar that can cause hypoglycemia, but I do not it played a role in his encephalopathy with confusion and memory loss

6. *clopidogrel (Plavix)*—According to the FDA full prescribing information this drug can cause confusion and psychosis: “Psychiatric disorders: Confusion, hallucinations” (p. 7). See Plavix in bibliography.

7. *benazepril (Lotensin)*. This drug has psychiatric adverse reactions but it probably not a major contributor.

8. *amitriptyline (50 mg)*. This drug is similar to nortriptyline in **Part V** above and is almost certainly a major contribution to Mr. Davidson's mental decline in jail. Its category of tricyclic antidepressants is listed in *Merritt's Neurology*, **Appendix K**. In addition to the class warning for all antidepressants (see Part V), the FDA-approved full prescribing information gives a special warning about confusion, delirium and cognitive impairment with this drug when given to the elderly (See Elavil in bibliography). Given the following warning, it is astonishing that the prescribers in jail did not look at this drug, as well as the others, as a potential cause of the patient's encephalopathy with confusion and cognitive decline:

Geriatric Use

Geriatric patients are particularly sensitive to the anticholinergic side effects of tricyclic antidepressants including amitriptyline hydrochloride. Peripheral anticholinergic effects include tachycardia, urinary retention, constipation, dry mouth, blurred vision, and exacerbation of narrow-angle glaucoma. Central nervous system anticholinergic effects include cognitive impairment, psychomotor slowing, confusion, sedation, and delirium.

9. *gabapentin* (Neurontin). This is another potentially strong contributor (see anticonvulsant on list in *Merritt's Neurology*, **Appendix K**).

10. *clonidine*. Another strong potential contribution to his decline (see name on list in *Merritt's Neurology*, **Appendix K**).

As noted earlier, this is not quite as disastrous combination of drugs as this elderly, frail and ill individual received prior to committing violence. However, it serves to show that his brain remains sensitive to drugs and that his mental condition quickly declines under the impact of misguided polydrug therapy. It is a repeat of the "experiment" conducted on him before he became violent, but the results are less extreme because the regimen is less toxic and in jail his behavior would be more controlled and less stimulated than in normal living. The experiment is particularly convincing because he seems to be doing better earlier in jail, for example, when he first visits the cardiology clinic, at a time before his drug regimen grows even more extreme.

While in the hospital, the doctors begin on 6.22.15 to work him up for encephalopathy, including a lumbar puncture, which they are unable to perform because of his anatomy (38 of 409). He was kept for 5 days. Among other things on discharge they reported "occasionally states things that are incongruous with expected answers, uses many filler sounds" (39 of 409) and also "occasionally nonsensical statements" (bottom of page). His impression was "Encephalopathy-possible." Importantly, he was found to have no anxiety or depression, ruling out that as complicating factors in his mental status (55 of 409).

On 7.22.15 his principle diagnosis is an acute exacerbation of obstructive chronic bronchitis. Among a long array of secondary diagnoses, he is diagnosed with encephalopathy of unknown etiology (2 of 409).

Having failed once with the lumbar puncture, and having no recognition that the encephalopathy is medication-induced, the doctors lose interest in the problem after this time, rarely mentioning it, and always taking it for granted. This too often happens in the case of elderly patients. Nonetheless, there are continued notations that he is a "limited historian" (e.g., 34 of 81, on 8.12-13, 2015). He also endures a fall which, in the elderly, is often related to

prescribed medications (138 of 81, on 8.12-13.15). He remains a “poor historian” (21 of 24, 9.10.15).

From the viewpoint of the case, this medical record while Mr. John D. is in jail confirms the continued harmful impact of prescribed medications on Mr. John D.’ brain and mind. However, the drug combination is not as toxic and he is living within confined quarters, limiting social stimulation that might irritate or anger him.

X. Involuntary Intoxication

Beyond a reasonable degree of medical certainty, Mr. John D.’ case meets all the generally accepted criterion for an involuntary intoxication.

1. It would be impossible for Mr. Davidson and/or his wife to know or understand the risks associated with this drug because the risks are not represented in any one drug label or drug warning. The risks of developing a delirium with confusion, impaired consciousness and psychosis were enormous and indeed almost inevitable given the number of his drugs associated with these symptoms and their often synergistic effects. If he or his wife had been told the risks associated with this polydrug therapy, they would have either have refused the continued piling on of drugs, or they would have been mentally incompetent. No competent person would accept the risks associated with this polydrug therapy. This was a genuinely unknowing or involuntary intoxication.

2. All of the medications he took were prescribed, he took them all as prescribed, and he took no over-counter or illegal medications with psychoactive effects.

3. From Dr. X’s medical record, there is no evidence that he was warned by Dr. X that the medications, individually or in combination, could lead him to become violent. Mrs. John D. confirms that there were no warnings by Dr. X.

4. Even if he had read any and all accompanying pharmacy information, including any potential warnings of aggression or violence, he would not have been sufficiently warned about the extreme danger in his particular case. Similarly, even if he had read all the individual Full Prescribing Informations cited in this report, he would not have been sufficiently warned about his high degree of risk for committing violence. The reasons for these conclusions are:

- a. His risks were enormously increased by his drug-induced hallucinations.
- b. His risks were enormously increased by medical errors on the part of Dr. X.
- c. His risks were enormously increased by polypharmacy.
- d. His risks were enormously increased by multiple medication changes prior to the incident.
- e. His physician, Dr. X, according to the medical record did not anticipate the risk, and therefore would not have communicated about it.
- f. Even the risks published in the Full Prescribing Information do not fully disclose the risk of violence, which the drug companies have tried to minimize (Breggin, 2008a&b).
- g. Pharmacy handouts in general do not reflect the degree of risk for violence. They typically contain abbreviated summaries of what is in the Full Prescribing Information.

5. Even if he had prior knowledge that the drugs could make him violence (I have no evidence for this speculation), his judgment at the time of the incident was severely impaired by the medication regimen at the time of the incident, rendering him unable to control impulses, unable to see the consequences of his actions, and unable to know right from wrong.

XI. Summary and Conclusions

A. The High Degree of Certainty in this Case

All the observations in this section are made within a reasonable degree of medical certainty, and as noted below, often with a great deal more certainty than that, in regard to the cause of Mr. John D.'s single violent act. The certainty in this case is more clearly established than in most cases in my scientific articles and in my book, *Medication Madness: The Role of Psychiatric Drugs in Cases of Violence*. The certainty of the connection is also better established than in most of the cases in my extensive overall forensic experience.

This high degree of certainty is established by several factors:

- (1) The close proximity of the hallucinations and the then the violent episode to prior prescription drugs changes shortly before the occurrences;
- (2) The very large number of prescribed medications he was given that have specific warnings and mentions about psychosis, hallucinations, abnormal behavior and aggression in their FDA-approved Full Prescribing Information (at least eight medications);
- (3) Recognition at the time by the patient's wife and the prescriber that the initial hallucinations were new, unprecedented and medication-induced;
- (4) The medically flawed attempts to deal with the medication-induced hallucinations;
- (5) His wife's immediate recognition at the time that the violence that it was the product of an adverse drug reaction, and her determination not to have him prosecuted
- (6) The extraordinary number of physical compromises suffered by Mr. John D. that would make him especially susceptible to an adverse drug reaction, including age, infirmity, multiple illnesses, and a chronic pain syndrome;
- (7) The psychotic quality of the act, including that it was wholly unprecedented for Mr. John D., that it was presaged by hallucinations, that it was unprovoked (no heat of argument), that it was especially bizarre, that it was unprecedented in this man's life and that he appeared confused at the moment and then immediately called 911 *after* his wife showed him what he had done.
- (8) The "experiment" in jail where increasing amounts of polydrug treatment again began to cause him mental deterioration, this time with a diagnosis of encephalopathy.

B. The Effect of Recent Medication Changes in Causing Mr. John D.'s Episode of 5.31.5

Any one of the following medication was sufficient to cause the The combination is particularly potent in causing this behavior. This first group of drugs was either started or change in dose on the last two visits.

(1) **Nortriptyline**. The reason for starting this antidepressant on 4.15.15 are unclear. It was a huge mistake. It is an older highly stimulating antidepressant that is well known to cause hallucinations and psychosis, especially in the elderly. This antidepressant carries the recent class warning and Medication Guide mentions of *psychosis, aggression and violent behavior*. In addition, long before the FDA recognized that antidepressants as a group could cause these severe reactions, the FDA-approved Full Prescribing Information warned about this specific drug:

Psychiatric – Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia, panic, nightmares; hypomania; exacerbation of psychosis.

(2) **Hydralazine**: The start of hydralazine on 4.15.15 followed by the development of hallucinations, and the the continuation of hydralazine on 5.14.15, despite his wife’s report that she believed the drug was causing hallucinations, which is documented in the medical record. The FDA’s Full Prescribing Information draws attention to:

Neurologic

peripheral neuritis, evidenced by paresthesia, numbness, and tingling; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety.

(3) **Clonidine**: Stopping of clonidine on 4.15.15 with any recommended tapering, creating the potential for a withdrawal reaction, and then restarting of the drug on 5.14.15 after he was always hallucinating. The full prescribing information notes:

Central Nervous System: Agitation, anxiety, delirium, delusional perception, hallucinations (including visual and auditory), insomnia, mental depression, nervousness, other behavioral changes, paresthesia, restlessness, sleep disorder, and vivid dreams or nightmares.

(4) **Baclofen**: Starting baclofen on 2.4.15 about two and a half months before he started hallucinating and then doubling of baclofen on 5.14.15, after he was already hallucinating. The FDA’s Full Prescribing Information states:

Adverse Reactions

Neuropsychiatric: Confusion (1 to 11%), headache (4 to 8%), insomnia (2 to 7%); and rarely, euphoria, excitement, depression, hallucinations, paresthesia, muscle pain, tinnitus, slurred speech, coordination disorder, tremor, rigidity, dystonia, ataxia, blurred vision, nystagmus, strabismus, miosis, mydriasis, diplopia, dysarthria, epileptic seizure

(5) **Doxazosin**: Starting doxazosin 4 mg on 4.15.15 just before he started hallucinating and continuing it at 2 mg on 5.14.15. The FDA’s Full Prescribing Information States:

Central Nervous System: paresis, tremor, twitching, confusion, migraine, impaired concentration; Psychiatric: paroniria [terrifying abnormal dreams], amnesia, emotional lability, abnormal thinking, depersonalization;

C. The Effect of *Chronically Administered Medications* in Making Mr. John D. More Vulnerable to an Abnormal Mental Condition and Behavior, including Violence

(6) **oxybutinin**. This drug is an anticholinergic with the potential for a particularly negative impact on the mind and behavior. According to the FDA, the drug has these adverse effects:

A variety of CNS anticholinergic effects have been reported, including hallucinations, agitation, confusion and somnolence. Patients should be monitored for signs of anticholinergic CNS effects, particularly in the first few months after beginning treatment or increasing the dose.

(7) **hydrocodone**. This is a drug that can, but only rarely, produce abnormal mental conditions and behavior during routine use at these doses (unless in withdrawal), but whose CNS depressant effect would be additive to the effect of other drugs, adding to the disinhibiting effects that cause violence. According to the FDA, hydrocodone cause cause the following:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence, mood changes.

(8) **omeprazole**. This drug commonly causes a wide variety of abnormal behaviors, including hallucinations. The FDA's Full Prescribing Information states:

Nervous System/Psychiatric: Psychiatric and sleep disturbances including depression, agitation, aggression, hallucinations, confusion, insomnia, nervousness, apathy, somnolence, anxiety, and dream abnormalities; tremors, paresthesia; vertigo

Overall, the combined effect of all these medications would worsen their individual effects.

D. The Effect of the Chronic Pain Syndrome. Chronic Pain Syndrome is so commonly associated with violence that patient violence against them is a hazard to doctors who treat these patients.

E. The Effect of Multiple Physical Conditions on his Frailty and Drug Sensivity. Mr. John D. suffering from many physical disorders that made him relatively infirm and hence susceptible to adverse drug reactions involving his brain and mind:

- (1) diabetes with peripheral neuropathy
- (2) chronic pain syndrome related to the peripheral neuropathy
- (3) dependence on opiate pain medications due to above factors
- (4) peripheral vascular disease
- (5) chronic kidney disease (mild)

- (6) poorly controlled hypertension
- (7) myocardial infarction (old)

In addition, to these conditions, he had a number of other more common or routine problems that indicate and/or contributed to his relative infirmity for a man his age:

- (1) morbid obesity
- (2) osteoarthritis
- (3) lower back pain
- (4) low testosterone
- (5) benign prostatic hypertrophy
- (6) hearing loss
- (7) history of falling
- (8) bladder problems with incontinence
- (9) gastric problems (unspecified, but prescribed Prilosec)

Mr. John D. was infirm well beyond what is normal for his age.

F. The Effect of Older Age. His chronological age was 73, but given the medication effects and the medical conditions from which he suffered, his real age was much older. This made him especially vulnerable to adverse drug effects on his brain and behavior.

G. The Effect of Failures in Medical Care, including inadequate identification, handling and treatment of new onset hallucinations.

H. Conclusions

Mr. John D.'s wife from the beginning of her husband's unprecedented hallucinations told Dr. X, and Dr. X agreed in the medical record, that Mr. John D.'s hallucinations were caused by his medication changes. She later told the police that his medications caused his violence and that he did not need to be in jail. Her observations were well founded.

The multiple drugs given to Mr. John D., including medication additions and changes in close proximity to the development of the confusion and delirium with hallucinations and a violent episode, are the primary and necessary cause of his violence on 5.31.15. All the other factors, such as his age and frailty are contributing but not necessary factors. Some of medication, individually, could account for what happened, but in this case we have multiple culprits.

Merritt's Neurology, as we have seen, lists 20 drugs or categories of drugs that cause confusion and delirium. Mr. John D. was simultaneously prescribed *eight* of them! In addition, I have examined and quoted from the FDA-approved labels for *eight* drugs (7 of 8 overlap with the neurology test list) that confirm they cause confusion, delirium and/or hallucinations. This combination drugs was a mental/behavioral disaster waiting to happen.

In addition to the medication effects, Mr. John D. suffered from age, frailty, and a large number of medical conditions that made him more sensitive to drugs and to a disastrous impact on his brain and mind. His physician also failed to handle the initial hallucinations and his deteriorating mental condition, and worsened the outcome with his prescribing practices.

Even if he had studied every single piece of information given to him by the doctor and/or the drug store, he never could have known or anticipated the risk he was taking of developing confusion, delirium, hallucinations and violence. That is because he was taking so many drugs involving so many risks to his mind and behavior and that he really needed to know that he was headed for disaster. In the meanwhile, he took the medications as prescribed and did not indulge in any off-prescription drugs. In addition, the drug-induced condition he suffered from—confusion and delirium, with or without hallucinations—by definition robs the individual of conscious control of his mind and behavior. This lack of conscious self-determination (and hence personal responsibility) is the hallmark in every definition of confusion and delirium, with or without psychosis. In short, Mr. John D.'s condition fit every clinical and legal criterion for involuntary intoxication.

This was a perfect storm of causal and contributing factors to Mr. John D.'s irrational, bizarre, unprovoked and unprecedented drug-induced involuntary intoxication. It caused him to assault on his wife on 5.31.15. As I have described, I am convinced beyond the usual medical degree of certainty that without the medication regimen to which he was exposed, Mr. John D. would never have committed violence. I am also convinced beyond the usual medical degree of certainty that if a new prescribing physician were to approach his overall medication treatment and any future adverse drug effects in a more judicious matter, Mr. John D. will never again commit violence.

With as much certainty as is possible in medical science and forensics—far beyond the usual criteria of reasonable medical probability or certainty—Mr. John D. suffered from an *involuntary intoxication* from multiple medications that rendered him unconscious in the sense of that his consciousness was too impaired to control mind or behavior. He became unable to resist his impulses, unable to appreciate the consequences of his actions, and unable to know the difference between right and wrong at the time he committed the impulsive, out-of-control, confused and delirious act of violence of May 31, 2015.

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Appendices

FDA Full Prescribing Information for 8 Different Medications and 1 Article on Chronic Pain Syndrome

- A1. Nortriptyline FDA-Approved Full Prescribing Information (current since circa 2004)
- A2. Nortriptyline (Pamelor) FDA-Approved Full Prescribing Information (1998)
- A3. Nortriptyline (Aventyl). FDA-Approved Full Prescribing Information in *Supplement A to the Physicians' Desk Reference (PDR)* (1967)
- B. Hydralazine FDA-Approved Full Prescribing Information
- C. Clonidine FDA-Approved Full Prescribing Information
- D. Baclofen FDA-Approved Full Prescribing Information
- E. Doxazosin FDA-Approved Full Prescribing Information
- F. Omeprazole FDA-Approved Full Prescribing Information
- G. Hydrocodone and Acetaminophen FDA-Approved Full Prescribing Information
- H. Oxybutynin FDA-Approved Full Prescribing Information

Additional Appendices

- I. Fishbain, D., Cutler, R., Rosomoff H., and Steele-Rosomoff, R. (2000). Risk for violent behavior in patients with chronic pain: evaluation and management in the pain facility setting. *Pain Medicine*. June (2):140-55
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- O. Resume of Peter R. Breggin, MD

Original was signed.
Peter R. Breggin, MD