

My name is Dr. Kirk Anderson. I'm a psychiatrist and Diplomat of the American Board of Psychiatry and Neurology. I have international work experience in this area and have treated thousands of people with PTSD over the past 20 years. The international work experience allows a physician to see how medical ailments are treated in other cultures as well as having contact and discussions with some of the most brilliant physicians in the world.

The current medications available for PTSD are often ineffective and toxic. What once appeared to be a paranoid conspiracy theory regarding psychopharmaceuticals causing the symptoms that they are alleged to treat, is showing to be true with the antipsychotic class of pharmaceuticals. People appear to do better with their psychosis after 20 years if they were medication noncompliant. There is evidence showing that the antipsychotic class of pharmaceuticals leads to demyelination in the midbrain which appears to correlate with increasing psychotic symptoms. Despite short term improvements that are seen with antidepressant trials, data suggests that long term antidepressant use is associated with increased impulsivity and more problematic outcomes.

Evidenced based medicine is in crisis. Evidenced based medicine has become a matter of opinion. A cultural phenomenon is occurring which appears driven by industry that has resulted in the corruption of academic judgement. Only random control trials are taken seriously while millions of anecdotal reports are ignored. Even when the research is relatively well done, manufacturing standards and oversight have failed leading to contamination of medications and fraudulent labeling of medications. The \$750 million dollar settlement against Glasko Smith Kline is one example of such problems. It received little attention in the press. You can read about it on the U.S. Department of Justice website.

Despite the many potential problems and potential bad outcomes with the use of cannabis in PTSD, the currently available pharmaceutical options are not showing to be a safer options at all (Not even close). There will be bad outcomes with the cannabis approach as well as with pharmaceutical approaches to this condition.

Cannabis relieves pain and promotes good sleep which is crucial in this condition. Cannabis appears to lessen intrusive memories, lessen emotional reactivity, decrease the intensity of the negative flood of emotions, and inhibit the expression of rage, irritability and self-destructive behavior. It actually appears to greatly decrease the suicide risk in many individuals.

THERE IS NO PHARMACEUTICAL THAT CAN EVEN COME CLOSE TO THE BENEFITS OF CANNABIS IN PTSD.

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Employment history:

Private practice: June 2001 to present.

December 2015 to June 2016. Contract work three days weekly for Community Reach (Formerly Adams Community Mental Health Center), Thornton, Colorado. This involves adult outpatient services. Experience with chronically mentally ill, personality disorders and substance use disorders.

February 2015 through November 2015. Contract work two to three days weekly for Arapahoe Douglas Mental Health Network. This involved adult outpatient consultations, medication evaluations and forensic services.

November 2013 to December 2014. Contract work two days weekly for Vibrant Health Center. This work primarily involves providing medicinal marijuana counseling services to parents of children with medication refractory pediatric epilepsy and medicinal marijuana consultations for end stage illness in adults. Consultations regarding the use of non-psychoactive medicinal cannabis for chronic pain, psychosis and neurological conditions provided. These are counseling relationships, not treatment relationships.

Completed one year contract (April 2012 to April 2013) providing mental health services for the Government of New Zealand, Capital and Coast District Health Board in two different service areas: Early Intervention Services two days weekly and Health Pasifika three days weekly. The former involves intensive outpatient mental health services for high risk youth with first episode psychosis. A large well-staffed treatment team is utilized which includes: psychologists, nurses, social workers, occupational therapists and a cultural broker called a matua. There is a focus on multisystem involvement and neuroleptic tolerability and compliance. Experience attained with long acting injectable agents (olanzapine, risperidone, aripiprazole, paliperidone, haloperidol, zuclopenthixol, flupenthixol). Education attained regarding the use of cannabidiol in psychosis.

Health Pasifika involves working in strikingly different frameworks of understanding. Clients are Pacific Islanders often lacking words for expressing themselves in any way similar to the DSM V framework. The staff members are close and there is a family quality to their team approach. The shared visit model tends to nearly always be utilized. There is little privacy in the Islands. Treatment is family system focused. Chronic pain syndromes appear relatively absent in Pacific Islanders perhaps because one is never alone on an island. Interestingly, many clients presented with behavioral changes due to medical conditions.

The ability to hear voices is considered a gift in Polynesia. The "Hearing Voices Network" is an international resource on this matter. Education attained regarding managing schizophrenia and voice hearing without medications. Individuals with psychosis (DSM definition) are often given roles of high

status: master of ceremonies, curator at weddings. The perception of a psychotic disorder as a short term illness may contribute to a better long term outcome in some as evidenced by less stigmatization and more socialization. However, this perception may contribute to medication noncompliance and episodes of psychosis.

Private practice, full time from June 2001 to March 2012.

Formerly at: 3545 South Tamarac Drive, Suite #370, Denver, Colorado 80237.

Extensive experience with: crisis management and harm reduction, anxiety disorders, mood disorders, dissociative conditions, medical evaluations for organic causes of psychiatric symptoms, interpreters and international trauma, insurance billing, office management. Also, years of ongoing work with other providers, attorneys, and administrators. Experience with political asylum cases.

Expert witness testimony provided regarding client reliability and alleged torture events.

Rocky Mountain Survivor Center. Contracted psychiatry consultant, part time.

August 2001 to October 2003. Treating survivors of politically motivated torture and/or war trauma from around the world. Movement therapy with forensic observations proved diagnostic at times. Importance of sequential interpretation noted. Education attained regarding extensive torture methods and vicarious trauma.

Asia Pacific Development Center. Contracted psychiatric consultant, part time. 2001 and 2002. This role primarily involved prescribing for clients with chronic severe post-traumatic stress disorder in a micromanaged environment. Services were limited and segregated. Clients were often marginalized from mainstream society. Summation interpreters were utilized.

Eagle Lodge, Incorporated. Contracted psychiatry consultant, part time. 1998 to 2001. This dual diagnosis program for Native Americans was tribally funded. Nonintrusive interview approaches utilized. Dream interpretations were sometimes welcomed. Extensive experience with multigenerational PTSD attained. Profound social and environmental factors noted as barriers to recovery.

Adams Community Mental Health Center, full time staff psychiatrist.

June 1998 to June 2001,

(8989 North Huron Street, Thornton, Colorado 80260)

Experience includes large caseload of chronically mentally ill outpatients with a wide range of disorders as well as medication consultations with over 100 clients in nursing care centers.

This includes experience with severe mood disorders, psychotic disorders, medical/organic etiologies, trauma, substance addictions as well as the importance of social and environmental factors.

Education:

Psychiatry Residency: University of Colorado Health Sciences Center, Department of Psychiatry,

June 1995 to completion in June 1998.

(4200 East Ninth Avenue, C249-51, Denver, Colorado, 80262)

Interests include trauma therapy and cultural anthropology

Training experience included: Asia Pacific Development Center and Eagle Lodge Inc.

Internship: University of Colorado Health Sciences Center

Community Medicine Internship began June 1994, completed June 1995.

Medical Education: Medical Degree received from University of South Alabama College of Medicine

June 1994.

(1005 Medical Sciences Building, Mobile, Alabama, 36688)

Electives included neuropsychology, geriatric psychiatry and emergency psychiatry.

Undergraduate Education: University of Alabama at Birmingham, premedical program
Degree: Bachelor's in Science with major emphasis in biology, minor emphasis in chemistry and psychology, completed June 1990
(HUC 260, 1530 Third Avenue South, Birmingham, Alabama, 35294-1150)
Part time work as a lab assistant (1987-1990) in the Glycoprotein Biosynthesis Laboratory at Volker Hall.
Mentioned in research paper regarding modulation of phospholipase C activity under temperature and pressure.

COMMENTARY

New Data on Bias in Depression Trials

Peter M. Yellowlees, MBBS, MD | March 02, 2017

This is the Medscape Psychiatry Minute. I'm Dr Peter Yellowlees.

The possible effect of sponsorship bias has never been investigated for nonpharmacologic treatments, such as psychotherapy. Now, a team of investigators^[1] from the University of Padova, Italy, have examined industry funding and author financial conflict of interest in a meta-analysis of 45 randomized controlled trials directly comparing psychotherapy and pharmacotherapy for depression.

They found that differences between industry and non-industry-funded trials were significant, with pharmacotherapy consistently showing more effectiveness over psychotherapy in industry-funded trials, whereas five instances were found where authors of the original trial article had not reported financial conflicts of interest. The researchers concluded that industry-funded trials for depression appear to favor pharmacotherapy over psychotherapy and that disclosure of all financial ties with the pharmaceutical industry should be encouraged.

This is an important article for all of us who value objective science. It is common sense that funding sources and research sponsorship should, almost inevitably, both consciously and unconsciously lead investigators down paths of thinking and ideas that are congruent with the needs of their funders, even though most investigators try their utmost to remain objective and honest.

Our current system of clinical trials is heavily commercially funded by pharmaceutical companies, with the result that there is, at the very least, an unconscious bias from those involved to attempt to find positive results of pharmacotherapy. The results of this clever study of depression treatment support this hypothesis. Perhaps we should be doing more studies with different styles of control groups—using alternative therapies whenever possible—rather than other drugs or placebo preparations, and insisting on industry funding of nonbiological or related trials as part of their community obligations.

Thank you for listening to this Medscape Psychiatry Minute. Do enjoy your practice.

References

1. Cristea IA, Gentili C, Pietrini P, Cuijpers P. Sponsorship bias in the comparative efficacy of psychotherapy and pharmacotherapy for adult depression: meta-analysis. *Br J Psychiatry*. 2017;210:16-23.

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