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Treatment-induced Suicide: Suicidality as a potential effect of psychiatric drugs

Translation by Pia Kempker

"From this, the selection through suicide
lies in the direction of the strengthening of the population's living will
and its cheerful temper."
(Lenz , 1923, p. 23)

Depression can have many causes: psychosocial and political conditions, neurological diseases, metabolic disorders, aging, toxic substances and drugs. Physicians generally focus on organic or supposed organic depressions, for which they prescribe psychiatric drugs and electroshocks. It is hard for them to accept that many psychiatric drugs can cause or increase depression and suicidality. But in the medical and pharmacological specialist literature there are many reports about the depressive effects of psychiatric drugs. In particular neuroleptics, so-called antipsychotic drugs like haloperidol (one brand name for which is Haldol; for other trade names click here) and clozapine (one brand name for which is Leponex; for other trade names click here) often initiate depression and suicide. A suicide-register with special consideration of associated psychiatric drugs, electroshocks, restraint, and other forms of psychiatric compulsion could be effective as a form of prevention and lower the occurrence of depression and suicides.

Drug-associated depression and suicidality

Discussing studies on suicides in patients with the diagnosis "schizophrenia" and comparing suicide rates in different time periods, David Healy from the North Wales Department of Psychological Medicine in Bangor and colleagues plead for an explanation of the "excess of suicides among patients receiving treatment" (Healy, *et al.*, 2006, p. 227). If psychiatrists

choose to give the diagnosis "schizophrenia" or similar ones like "psychoses", their standard treatment is the administration of neuroleptics. At people with the diagnosis "schizophrenia" suicidality is found about 50 times more frequent than in the average society (Müller, 1989).

Neuroleptics have a blockading effect primarily against the transmitter dopamine resulting in Parkinson's disease. This is a complex of symptoms, characterized by walking with a stoop, muscle tremor and blurred speech. Parkinson's disease regularly results from dopamine blockade. The potency of neuroleptics is defined by their power to create Parkinson's disease; this is not an unwanted side effect, this is the therapeutic main-effect as defined by psychiatrists.

Parkinson's disease, primarily a disease of the movement-apparatus, involves alterations on the psychic level, too. Neurologists define them as Parkinson-personality. The symptomatology includes apathy, loss of willpower, depression and suicidality and states of confusion and delirium (Fünfgeld, 1967, pp. 3-25). In 1955, after the first administrations of the neuroleptic prototype chlorpromazine (Largactil, Megaphen and Thorazine; for other trade names click here), the German psychiatrist Hoimar von Ditfurth pointed to the parallels between the emotional Parkinsonian deadening after a brain disease and the emotional deadening after neuroleptic treatment:

> As we may believe, it looks like as if the psychic alterations provoked by Megaphen especially on the emotional level are from the same nature as the "affective deadening and restriction," which is registered so often at postencephalitic parkinsonists (people with Parkinson's disease after subsiding of an acute brain inflammation, P.L.) (p. 56).

Thus depression and suicidality are normal effects of neuroleptics, and thus psychiatrists accept them without question.

Frank J. Ayd (1975) from the Psychiatric Department of the Franklin Square Hospital in Baltimore, USA, wrote:

> There is now general agreement that mild to severe depressions that may lead to suicide may happen during treatment with any depot neuroleptic, just as they may occur during treatment with any oral neuroleptic. These depressive mood changes may transpire at any time during depot neuroleptic therapy. Some clinicians have noted depressions shortly after the initiation of treatment; others have observed this months or years after treatment was started (p. 497).

Otto Benkert and Hanns Hippius (1980), two German psychiatrists, answered the question, whether suicidality perhaps could be caused by an excessive dosage:

> "Depression, suicidality, states of excitement and delirium under the influence of drugs generally occur during doses prescribed by the treating physician" (p. 258).

Empirical data about suicides caused by psychiatric drugs are hard to find for many reasons, as psychiatrists themselves write. Psychiatrists do not notice or blame their courses of treatment as the cause of depression (Lehmann, 1996, p. 111). Asmus Finzen of the

Psychiatric Department of the University Berne, Switzerland, showed that the likely number of suicides in psychiatric institutions is vast; correct figures are, however, hard to find because

> ... In illness documents and discharge summaries you could often find no notice about the patients' suicide or death. If the suicide happened during a vacation, the patient's discharge date might be backdated. If the suicide attempt did not lead to an immediate death, in the illness document and statistics he would be considered as moved to the inner or surgical clinic" (1988, p. 45).

R. de Alarcon and M.W.P. Carney, two English psychiatrists, studied depressive mood changes after administration of neuroleptics with other variables staying the same. In the *British Medical Journal* they reported on suicides under the influence of fluphenazine (trade name Moditen; for other trade names click here), administered as part of community treatment, and described a fluphenazine trial on a 39 old man who already had tried to kill himself under the influence of this drug. When the psychiatrists had realized that this man regularly had developed suicidal intensions some days after the two-week depot-injections, they wanted to witness the mood-worsening effect of the neuroleptic with their own eyes. In the psychiatric institution the man was observed over four weeks, without being treated with neuroleptics, and without displaying anything remarkable at his mood. Then they injected him with 25 mg fluphenazine intramuscularly:

> During his stay in hospital he was interviewed by one of us (R. de A.) three times a week. For a week before the injection, on the days he was not due for an interview. His condition was discussed with the chief ward nurse and the nursing reports were perused. He was given the trial injection on a Wednesday at 3 p.m.; by mid-afternoon on the following day he felt low, wanted to be left on his own, and had no desire to talk to anyone, read, or watch television. He took to his bed at about 4 p.m. In the opinion of the charge nurse he was a suicidal risk. When interviewed on the Friday the change in external appearance was striking – he looked gloomy, he did not respond with a smile to a joke, and there was no spontaneous conversation. His answers were limited to what was strictly necessary. He denied any paranoid of hypochondriacal ideas or any feelings of guilt. He simply said that he felt very low and if he were alone in digs he would take his life. By Friday evening there was some improvement, and when he was interviewed again on Saturday he had returned to his usual normal self. (... de Alarcon and Carney gave a resume of their findings, P.L.) that some patients my become severely depressed for a short period after an injection of fluphenazine enanthate or decanoate. So far no pattern has been established regarding when an in whom this I likely to occur. The lack of adverse effects in the past is no indication that these may not appear in the future. In the trial case, for instance, the patient received fluphenazine enanthate for more than six months before he begun to react repeatedly to the injection with severe depression, and the same thing happened with other cases in the series" (1969, pp. 565-566).

In his placebo-controlled study, psychiatrist Peter Müller from the Psychiatric Department of the University of Göttingen, Germany, found that a much higher percentage of people treated with psychiatric drugs had depressive symptoms than people treated with placebos. In relation to lessening or withdrawal of the psychiatric drugs he wrote:

> In 47 cases the depressive mood lifted in 41 cases, in only two cases there was no change, and in four cases the effect was dubious. It was very surprising to see that in the predominant number of cases the reduction of the doses (normally to half of the former dose) alone lead to an improvement of the depressive symptoms. Often it was only a partial improvement, but even this brought clear relief to the patient. On the other hand, in other patients, or in the same ones whose situation improved only slightly when taking lower doses, complete withdrawal made them feel much better. Some patients reported that only now did they feel completely healthy again, as they had long before their depressions. The depressive symptoms, which were seen to be unchangeable by some psychiatrists, and which could possibly have been taken to be a start of organic disorder, vanished completely. The possible argument that these could be psycho-reactive effects caused by the patients' relief about the withdrawal of the psychiatric drug is refutable, because nearly all patients received depot-injections and were not informed about their doses or got placebo-injections. (...) Their change was quite impressive to themselves, their relatives and their medical examiners in some cases. The patients reported that now they felt completely healthy again. In the group of people still treated with psychiatric drugs, this was mostly not the case. These results quite definitely speak for pharmacogene influences and against psychiatric morbidity developments (1981, pp. 52-53 / 64).

Müller resumed:

> Depressive syndromes after the remission of the psychoses and under treatment with psychiatric drugs are not rare, but occur on about two thirds of the patients, and sometimes even more frequently, especially when depot-drugs are given. Without treatment with psychiatric drugs, depressive syndromes after a complete remission are only found in exceptional cases (ibid., p. 72).

Müller's reports are supported by many of his colleagues (Lehmann, 1996, pp. 57-87, 109-115). Some examples: Raymond Battegay and Annemarie Gehring (1968) of the Psychiatric Department of the University of Basel, Switzerland, warned after a comparison of treatment courses before and after the era of psychiatric drugs:

> During the last years, a shifting of the schizophrenic syndromes to a depressive syndrome was repeatedly described. More and more schizophrenias show a depressive-apathetic course. It became clear that often exactly that develops under psychiatric drugs, what should be avoided with their help and what is called a defect (pp. 107-108).

Walther Pöldinger and S. Siebern of the Psychiatric Institution Wil, Switzerland, wrote:

> "It is not unusual that depressions caused by medication are marked by a frequent occurrence of suicidal ideation" (1983, p. 131).

In 1976, Hans-Joachim Haase of the Psychiatric institution Landeck, Germany, reported that the number of perilous depressive occurrences after a treatment with psychiatric drugs increased at least ten times when compared with before the introduction of psychiatric drugs. The increase of the suicide rate is "alarming and worrying," said Bärbel Armbruster of the Psychiatric Department of the University of Bonn, Germany, in 1986 in the *Nervenarzt* – without, nevertheless, alarming the (ex-) users and survivors of psychiatry and their relatives, or even the public.

Rolf Hessö from the Psychiatric Department of the University of Oslo, Norway, informed about the development in Finland, Sweden and Norway in 1977; it seemed to be clear, "... that the increased incidence of suicide, both absolutely and relatively, started in the year 1955. This was the year that neuroleptics were introduced in Scandinavian psychiatric hospitals" (p. 122).

In 1982 Jiri Modestin wrote about his place of employment, the Psychiatric Department of the University of Berne, as well as the neighbouring psychiatric institution Münsingen:

> "Our results show a dramatic increase of the suicide frequency among the patients in Berne and Münsingen in the last years" (p. 258).

First hand reports about depression and suicidality

In the book *Coming off Psychiatric Drugs*, published originally in German language in 1998 (in English in 2004), Regina Bellion from Bremen (Germany) gave a report about her psychic condition under the treatment in the community:

> Alone at home. Three times a day I count my Haldol drops. I don't do much else. I sit on my chair and stare in the direction of the window. I have no sense of what is happening outside. I find it difficult to move. Nonetheless I am able to get up everyday. I don't notice that the apartment is getting dirty. It doesn't occur to me that I should cook something. I don't wash myself. I don't even ask myself if I stink. My misery progresses – but I don't even notice.
>
> I vegetate behind my neuroleptic wall and I am locked out of the world and out of life. The real world is further from me than Pluto is from the sun. My own secret world is also gone – my last refuge, and I had destroyed it with Haldol.
>
> This is not my life. This is not me. I may as well be dead. An idea has begun to take shape. Before winter comes I will hang myself.
>
> But before that I want to try and see if my life would be different without Haldol. I reduce the number of drops. I take less and less until I arrive at zero.
>
> After one month I am clean. Then I begin to notice how unkempt I am. I wash my hair, make the bed, clean the apartment. I prepare a warm meal. I even enjoy doing this. I can think again (2002, pp. 311-312).

Another user of psychiatric drugs, living in Bremen too, had gotten a prescription of Haldol and the antidepressant Aponal (active ingredient doxepin; for other trade names click here); under the influence of this combination she tried – fortunately without success – to end her suffering by suicide:

> When I got out again I would sit in my kitchen in front of the water-faucet, thirsty but yet unable to pour myself a glass of water or to bite into the bread that had become stale and hard. The supermarket was not far away, but I couldn't manage to get up and so I wished that I were simply dead so that I would have some peace at last. I was broken by my illness. I saw it as a punishment for two dark points in my life. Worst of all was the vicious circle of endlessly recurring psychotic patterns of thought. I tried again and again to think of something else even just for a moment – but it didn't work. My thoughts always revolved in the same circles, a hundred times a day, sometimes at a time-loop tempo in slow motion, other times constantly accelerating until my brain was spinning. And that was hell for me, the devil's game. I felt damned and abandoned by God with no hope of salvation. I could do nothing but suffer through this film, my life, lying down. I knew that I had to learn to have faith again, but I couldn't, and so I tried to end my life (Marmotte, 2004, p. 114).

Even clozapine, the prototype of so-called atypical neuroleptics, seems to have suicidal effects, as the report of Austrian Ursula Fröhlich in *Brave New Psychiatry* shows:

> Since I began taking Leponex (clozapine), I do not want sex anymore, did not feel like moving and had no joy in life. A life without joy is, however, worse than death. All that remained with me is watching TV, where I have watched others living for seven years. I am still alive biologically, but my senses are long since dead, everything that I former enjoyed I am not able to do anymore. In a way, my life does not exist anymore, I feel so empty and unimportant. In the mornings, the feeling is the worst. Every day I intend to start a healthy life the following day, to throw away the drugs, to drink many vitamins and fruit juices and to start with a daily fitness routine. The psychiatric drugs cause a feeling as if it was possible for me to start with a completely different, a new life the following day. But when I wake up in the morning I feel like smashed, and I never come out of bed before 9 o'clock, my depressions are so extreme that I think of suicide every day (cited in Lehmann, 1996, pp. 70-71).

Psychiatrists did not differ in their own experiences of these drugs. In 1954 and 1955 Hans Heimann and Nikolaus Witt (1955) of the Psychiatric Department of the University of Berne published their experiences after once taking Largactil, the prototype of chlorpromazine. They experimented with spiders and 1080 control subjects; they had three self-experiences and nine experiments with as many psychiatrists and pharmacologists. The marked inferior feeling and the feeling of powerlessness, structural element of the syndrome of Parkinson's disease caused by psychiatric drugs, after taking Largactil became very clear in the following excerpts:

> I felt physically and mentally ill. Suddenly my whole situation appeared hopeless and difficult. Above all, the fact that one can be so miserable and exposed, so empty and superfluous, neither filled by wishes nor by something else, was torturing. ... (After finishing the examinations): The tasks of life grew immense in front of me: dinner, go to the other building, come back – and all of that by foot. With that this state reached its maximum of uncomfortable emotions: The experience of a passive existence with clear knowledge of the other possibilities... (p. 113).

Suicide-register as an instrument of prevention

In February 2000, the German Organization of the (ex-) Users and Survivors of Psychiatry put forward the demand to the health minister to introduce a suicide-register with special consideration of associated psychiatric drugs, electroshocks, restraint and other forms of psychiatric compulsion (Lehmann, 2001, p. 46). The missing of a registration of suicides associated with psychiatric treatment methods, covering all areas of a country, is a serious evil; such data are a fundamental prerequisite for cause-research and an important basis for prevention and early detection. An obligation to notify the authorities of suicides associated with psychiatry and psychiatric drugs could enable preventive measures and instigate reliable studies that discover the connection between suicidality and the effects of psychiatric drugs. Not only neuroleptics, as shown, but antidepressants (Healy, 2001; Lehmann, 1996, pp. 194-204) and electroshock (Frank, 1990), too, should be watched very attentively and with a meaningful participation of independent organisations of users and survivors of psychiatry.

Reports of (ex-) users and survivors of psychiatry who have been pushed into suicide attempts after traumatizing treatment with psychiatric drugs, electro- and insulinshocks (see, for example, Kempker, 2000), must no longer be ignored. Physicians and relatives have to be informed about the risk of drug-caused depression and suicidality. The users of psychiatry need to be informed so that they can make a carefully considered and informed decision about taking or not-taking an offered psychiatric drug and if necessary can take less risky measures against their depression.

In 1999, Paul Barreira, M.D. and deputy commissioner from the Massachusetts Department of Mental Health in Boston, wrote about patterns in causes of suicides, mortality and reduced life expectancy of psychiatric patients:

> "From the standpoint of public policy, it is essential to conduct further research with databases from across mental health systems and different states to explain the differences in life expectancy and causes of death."

As long as suicide prevention programms are funded by drug companies earning money by selling these neuroleptics, which could cause suicidality, and as long as their representatives are in leading positions and even personally directly involved in suicide prevention programms, you will not even find a simple remark in such programms that neuroleptics could be one of the many risk factors of suicidality.

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