- Since 1997, the volume of DTC prescription-drug advertising in the US has ballooned. A number of complaints have been made about misleading prescription-drug advertisements. Complaints tend to focus on several factors: advertisements do not provide a complete picture of the advertised drugs; advertisements damage the patient-physician relationship; and advertisements increase patient demand for (and therefore costs of) the advertised drugs. But equally, other prescription-drug advertisements have been hailed as important educational tools in an era when patients want to be more involved in their own healthcare.

[2] Extracts from the US Food and Drug Administration website. Addresses are:
http://wxvw.fda.gov/fdac/features/l998/198_ads.htrnl
http://www.fda.gov/cder/ddmac/presentations/ostrdtc3O1/sld001.htm

Important

ENUSP does not accept any money from the drug industry. National, regional and local organisations, however, take their own decisions. For reasons of transparency, we refer to a (co-)financing by pharmaceutical companies as far as we know about it by the addition "sponsored by pharmaceutic companies".

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Treatment-induced suicide. Suicidality as a potential effect of psychiatric drugs.

Peter Lehmann

(Worked-over) Contribution to the conference *Coping with stress and depression related problems in Europe,* organized by the World Health Organization, the European Commission and the Federal Ministry of Social Affairs, Public Health and the Environment (Belgium), Brussels, October 25 – 27, 2001.

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 medical and pharmacological specialist literature there are many reports about the depressive effects of psychiatric drugs. In particular, neuroleptics, the so-called antipsychotic drugs like haloperidol (one brand name for which is Haldol) and clozapine (one brand name for which is Leponex) often initiate depression and suicide. A suicide register with special regard to 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.

Neuroleptics have a blocking 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 blockage. The potency of neuroleptics is defined by their power to create Parkinson's disease; this is not an unwanted side effect, but 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. It is a complex of symptoms including apathy, loss of willpower, depression and suicidality, and states of confusion and delirium (Fünfgeld 1967, p. 13ff). In 1955, after the first administrations of the neuroleptic prototype chlorpromazine (Largactil, Megaphen and Thorazine), 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 as if the psychic alterations provoked by Megaphen especially on the emotional level are of 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 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 prehaps 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 regard 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, too. 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 illness document and statistics he would be considered as moved to the internal 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 (market name for instance Moditen), administered as part of community treatment, and described a fluphenazine trial on a 39-year-old man who had already tried to kill himself under the influence of this drug. When the psychiatrists had realized that this man had regularly developed suicidal intentions some days after the biweekly 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 a period of four weeks, without being treated with neuroleptics, and without displaying anything remarkable in his mood. Then they injected him 25 mg of 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, during the day 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. During the interview on 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 or hypochondriac 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 may become severely depressed for a short period after an injection of fluphenazine enanthate or decanoate. So far no pattern has been established regarding when and in whom this is 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 began to react repeatedly to the injection with severe depression, and the same thing happened with other cases in the series.* (1969, p. 565f.)

In his placebo-controlled study, psychiatrist Peter Mueller 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:

> *The depressive mood lifted in 41 cases out of 47, 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 led to an improvement in 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 after 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 depression. The depressive symptoms, which were seen to be unchangeable by some psychiatrists, and which could have possibly been perceived as 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 pharmacogenetic influences and against psychiatric morbidity developments.

Mueller resumed:

> *Depressive syndromes after the remission of the psychoses and under treatment with psychiatric drugs are not rare, but occur in about two thirds of 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.* (p. 72)

Mueller's reports are supported by many of his colleagues (Lehmann 1996, p. 57 – 87, 109 – 115). Some examples are Raymond Battegay and Annemarie Gehring (1968) of the Psychiatric Department of the University of Basel, Switzerland, who 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 what develops under psychiatric drugs, is exactly something that should be avoided with their help and that is called a defect.* (p. 107ff)

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 to those before the introduction of psychiatric drugs. The increase in the suicide rate is "alarming and worrying", said Bärbel Armbruster of the Psychiatric Department of the University of Bonn, Germany, in the *Nervenarzt* in 1986 – without, nevertheless, alarming (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 in the suicide frequency among the patients in Berne and Muensingen in the last years.* (p. 258)

First-hand reports about depression and suicidality.

In the book "To come off psychiatric drugs", published originally in 1998, 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 fewer and fewer 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.* (Bellion 2002)

Another user of psychiatric drugs, living in Bremen too, had gotten a prescription of Haldol and the antidepressant Aponal (doxepine); 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 2002)

Atypical psychiatric drugs have suicidal effects, too, as the report of Austrian Ursula Fröhlich in *Brave New Psychiatry s*hows:

to be continued

translated by Pia Kempker

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FORTHCOMING EVENTS :
THE SPRING 2002 AND OUR BOARD MEETING IN THE NETHERLANDS APRIL, AMSTERDAM-UTRECHT : t o p i c s: -

- **M 0 N E Y**
- **M E M B E R S H I P (clarification of membership list)**
- **C 0 0 P E R A T I 0 N**
- **P U B L I C I T Y (issues with the newsletter)**
- **STRUCTURE (desk in Berlin)**
- **ANTI-STIGMA CAMPAIGNS**

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WELCOME HOME! It seems to be more than probable we have a new member from Bosnia Hercegowina/Serbian Republic. The same means we have a new stable partner country- see: organigramme, next page.