

About the Intrinsic Suicidal Effects of Neuroleptics

Towards breaking the taboo and fighting therapeutical recklessness¹

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Abstract

Suicide is a frequent death case in people with the diagnosis “schizophrenia.” These patients in general receive neuroleptics, which have an intrinsic suicidal effect. Meaningful programs to prevent suicides due to psychiatric treatment methods have to be developed.

There are placebo-studies, epidemiological surveys, first hand reports and experiences of test persons and even clinical research to furnish evidence about neuroleptic-caused depression and suicidality. Suicide registers run by former psychiatric patients, by psychiatrists and by governmental administrations until now suffer from reduced effectiveness.

Publications about the suicidal effects of neuroleptics – taboo until today – and suicide registers might reduce suicidality in “schizophrenics.”

Effective suicide registers with involvement of users and survivors of psychiatry would gather findings that could be used to warn the public, consumers, as well as caregivers. As long as there are so few alternatives beyond neuroleptic-based psychiatry, people have to protect themselves with advance directives and criminal charges.

Key Words: neuroleptic, antipsychotic, schizophrenia, intrinsic effect, side-effect, suicide, suicidality

Introduction

Nobody but the famous psychiatrist Brigitte Woggon from Zurich could better summarize the zeitgeist’s reductionist vision of humanity, personality, soul or self—how ever you prefer to call it—when she explained in the beginning of this century:

“Everything we feel is simply chemical: being moved by looking into the sunset, love, attraction, whatever—they are all biochemical processes, we have a laboratory in our heads” (cited in “Alles,” 2000, p. 54).

Result of the mainstream biological paradigm is the neuroleptic treatment of people with the diagnosis “schizophrenia” with psychotropics, whose main effect is the intervention in natural metabolic systems and the production of a secondary “therapeutic” illness by administering neuroleptics to cover the

¹ This article is an worked-out manuscript of my keynote lecture “The self, schizophrenia and neuroleptic iatrogenic injury in mental health and social care” to the 13th International Conference of the International Network of Philosophy and Psychiatry: “Real People: The Self in Mental Health and Social Care”, Manchester, United Kingdom, June 28-30, 2010. That lecture again was based on previous publications (Lehmann, 2002a, 2002b, 2002c, 2010b). All translations of the German citations into English are made by the author or by translators. The explanations in the italic brackets are written by the author.

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supposed primary one, the so-called schizophrenia. To trigger a remission in that way means simply to make people physically ill. Klaus Dörner, in Germany in his circles a well-respected so-called progressive psychiatrist, explains the modern treatment principle of trying to make “mental diseases” disappear together with the psychologist Ursula Plog:

“We temporarily turn the mentally suffering patient into a person with an organic brain disease, with ECT it happens in a more global way, but for a substantially shorter period of time than with pharmacological therapy” (Dörner & Plog, 1992, p. 545).

The newer generations of neuroleptics, the “atypicals” do not change a lot and are widely suspected of causing increased circulatory problems, abnormal blood cell counts, obesity, diabetes and receptor changes that can lead to chronic psychoses. As early as 2003, Gerhard Ebner, President of the Swiss Association of Psychiatric Medical Directors (who served on Janssen Pharmaceuticals’ Advisory Board regarding the introduction of Risperdal Consta, the first “atypical” depot neuroleptic), had to admit that there were “risks and injuries caused by the so-called atypical neuroleptics”:

“It is not a case of fewer side-effects, but of different ones which can be just as debilitating even if the patient isn’t immediately aware of them. Therefore, patients can be more easily motivated to take these drugs because they no longer suffer instantly and as much from the excruciating dyskinesias/extrapyramidal side-effects” (Ebner, 2003, p. 30).

Beside the high risk of being damaged physically, often with chronic consequences, users and survivors of psychiatry in Europe generally are systematically discriminated against in the medical and psychiatric sector. This was the result of an action project against “Harassment and Discrimination Faced by People with Mental Health Problems in the Field of Health Services”, organized in the framework of the “Community Action Programme to Combat Discrimination in 2001-2006” with support from the European Union. A transnational study within this program was designed and conducted by associations of (ex-) users and survivors of psychiatry and their families from the U.K., Austria, Germany, Spain, the Netherlands and France in conjunction with a Belgian research institute, Mental Health Europe and the European Network of (ex-) Users and Survivors of Psychiatry (ENUSP). Unfortunately there is no reason to believe that psychiatric patients outside of Europe are treated in a better way.

As one of many proposed measures to combat discrimination was the recommendation that laws espousing equality of treatment should be adopted and funds provided so that these laws can be put into practice. These laws should guarantee the respect of human rights in a pro-active way, and focus on the protection of human dignity, the right not to be violated, the right to self-determination, the right to privacy and the right to respect—for example through the legal protection of advance directives, or, for example, through the introduction of a suicide register (see “Harassment and Discrimination,” 2005).

Mortality registers are not unusual in the medical field to identify connections between reduced life-expectance, lethal outcomes of medical treatments and risk factors. Paul Barreira, M.D. and deputy commissioner from the Massachusetts Department of Mental Health in Boston, for example, 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” (1999).

In the psychiatric sector with its own laws, as in other total institutions, people have to deal heavily with discrimination and stigma. In case they receive the diagnosis “schizophrenia” or “psychosis”, as a rule psychiatrists administer so-called antipsychotics (neuroleptics), and these drugs have a lot of unwanted toxic effects (Lehmann, 1996a; 1996b). So it is no incidence, that the life-expectance of these psychiatric patients is reduced for – at average – two to three decades (Weinmann, Read, & Aderhold, 2009).

Newer psychiatric data show a consensus on the lifetime risk of suicide in people diagnosed as “schizophrenics” in rate of approximately 5%, ten times higher than in the general society (Hor & Taylor, 2010; Nordentoft et al., 2004; Heilä, Haukka, Suvisaari, & Lönnqvist, 2005; Qin & Nordentoft, 2005). But whereas mainstream biological psychiatry is fully in this process of “neuromythology”², there is an obvious lack of discussion of suicides in people with the diagnosis “schizophrenia triggered by biological neuroleptic treatment. For example, Karim Tabbane and colleagues from the Service Hospitalo-Universitaire de Santé Mentale et de Thérapeutique, Centre Hospitalier Sainte-Anne, Paris, refer to all possible causes of suicide, mentioned in the review of the literature about mortality and cause of death in people with the diagnose of “schizophrenia,” but do find any pharmacogene factor to mention:

“Premature death is highly linked to suicide. (...) Suicide risk factors are numerous. Some of them are accepted as valid and others are still discussed. The former are: male gender, young and medium age ten first years of the illness course, associated depressive symptoms, past history of suicide attempts, iterative relapses and post hospital discharge period. The latter are: social isolation, celibacy, unemployment, high level of instruction, delusional and hallucinatory activity and familiar rejection” (Tabbane, Jooper, Spadone, Poirier, & Olié, 1993).

Kahyee Hor and Mark Taylor from the National Health Service for Scotland undertook a systematic review of all original studies concerning suicide in people diagnosed as “schizophrenics” published since 2004. They also mentioned the possibility of treatment-caused suicide with no single word:

“Risk factors with a strong association with later suicide included being young, male, and with a high level of education. Illness-related risk factors were important predictors, with number of prior suicide attempts, depressive symptoms, active hallucinations and delusions, and the presence of insight all having a strong evidential basis. A family history of suicide, and comorbid substance misuse were also positively associated with later suicide” (Hor & Taylor, 2010, p. 81).

And in all studies, so they go on, the authors mention the delivery of and adherence to effective treatment as the only consistent protective factor for suicide: the “best available treatment for psychotic symptoms”, which is, as a rule, the treatment with the modern so-called atypical neuroleptics – incidentally the most expensive ones. One step further go Jari Tiihonen from the Department of Forensic Psychiatry at the University of Kuopio and colleagues in the evaluation of the life-expectance of psychiatric patients within the National Hospital Discharge Register, which allows authorities in Finland to track the life of all psychiatric patients. In a study paid by the Finish Ministry

² For many years, Rufer has criticized the insolence and scientific almightiness of modern psychiatry: “Neurobiology is booming, governments and industry are investing billions. The media have blown up the findings of brain research into a huge success—brain research, the ‘science of the century,’ is in the process of becoming the new social science. A new mythology has emerged—neuromythology” (2007, p. 383).

of Health and Welfare they write, that the life-expectance of psychiatric patients, which is reduced for 22.5 to 25 years compared with the general population, is not caused by the toxicity of psychiatric drugs; in contrast, they identify an anti-suicidal effect of neuroleptics and even an increase of the life expectance especially by neuroleptics in cumulative drug administration (Tiihonen et al., 2009). Using neuroleptics would even have a beneficial effect on the mortality of each cause, and the highest mortality rate they found in patients who withdraw neuroleptics (Haukka, Tiihonen, Härkänen, & Lönnqvist, 2008, pp. 691-692). While researchers found no difference in the suicide risk of people taking placebos or neuroleptics in a database of the US Food and Drug Administration (Khan, Khan, Leventhal, & Brown, 2001), in a register linkage study among so-called first episode patients Tiihonen and colleagues found a suicide risk of those not currently taking neuroleptics 37 times higher than in compliant patients (Tiihonen et al., 2006).³ When you know, that Jari Tiihonen from Finland, a high-income country where the cost of antipsychotic drugs is fully reimbursed, is maximal in league with Big Pharma (Lundbeck, Organon, Janssen-Cilag, Eli Lilly, AstraZeneca, Hoffman-La Roche, and Bristol-Myers Squibb) and makes money for delivering so-called expert opinions to Bristol-Myers Squibb and GlaxoSmithKline and for delivering lectures from Janssen-Cilag, Bristol Myers-Squibb, Eli Lilly, Pfizer, Lundbeck, Glaxo-SmithKline, and AstraZeneca (Tiihonen et al., 2011), you might be less surprised about his data, especially his message of lowered mortality through cumulative administration of neuroleptics (Tiihonen et al., 2009).

In their article about the influence of neuroleptics on mortality in people with the diagnose of “schizophrenia”, which is even worse than in Australian Aborigines, the German psychiatrist Volkmar Aderhold and colleagues destroy the picture of neuroleptics that enhance the life-expectance, which is drawn by Tiihonen and colleagues, and discuss all kinds of drug-related death causes (cardio- and cerebrovascular, digestive, endocrine, respiratory, infectious, genitourinary, neoplastic and nervous diseases including tardive dyskinesia and malign neuroleptic syndrome), but exclude suicide (Weinmann, Read, & Aderhold, 2009, p. 2) – because of methodological reasons. “Nebenwirkung Suizid” (*Side-effect Suicide*) entitles the critical pharmacist Gerd Glaeske (2011) – famous in Germany for a critical approach to Big Pharma – his article about drug connected suicides and warns, the ‘side-effect’ death by suicide would not be tolerable any longer. But he does not speak about neuroleptics, he means isotretinoine, a vitamin-A-derivative which is used in the treatment of severe acne.

Power conditions and hierarchies make it easy to mask responsibility for damages. And in the psychiatric sector we have to deal with Big Pharma’s billion-dollar profits. It is hard for harmed people to find authorities to listen to their voices. This is true also in the case of harm caused by psychiatric drugs, especially of neuroleptics and their propensity to induce suicidality.

Risk Factors for Depression and Suicidality

Although a suicide attempt may have medical consequences, it has more or less rarely, if ever, medical (biological) causes. In general, suicide occurs when a person makes a decision— a more or less deliberate, cognitive, psychological decision—to kill themselves because of unbearable felt pain (see Webb, 2010). Only as an exception is suicidality caused by a malfunction of the brain.

³ Taken the data seriously you would argue, that the authors ignore the fact, that, in general, people who deny psychiatric drugs are punished by denial of all forms of psychotherapeutic and social support. In the mentioned study this denial, which might enhance the suicide-risk, is totally ignored in the same way as all kind of social-economical factors– even if the authors themselves admit the latter deficit in their study.

There are a lot of well-known factors that can trigger depression and suicidal behaviour: political, social and economic, emotional and physical factors. Each suicide can arbitrarily be called a result of a psychiatric disease, if it makes people shiver and the cause is not accepted or understood.

Political reasons:

Political reasons for suicide can mostly be understood or at least accepted. For example, Salvador Allende, President in Chile, decided to shoot himself death on September 11, 1973, to prevent humiliation by Pinochet's inhuman military junta. In Nazi Germany, thousands of Jewish people escaped from persecution and deportation by suicide; people who had knowledge of secret resistance preferred suicide to ensure that they would not disclose secrets under torture. Nazi leaders like Hitler, Göbbels and Göring killed themselves to escape punishment, other Nazis followed their example to prevent living in a non-fascist society.

There can be social and economical reasons: for example, unemployment combined with hopelessness, the inability to cope with the burdens of war, the unhappiness of living alone or being divorced, living with a severe illness, being victim of mobbing, or failing in a relationship.

There can be psychiatric factors:

- Unhappiness, depression, and suicidal ideation can each arbitrarily be called a psychiatric disease
- Fear of forced admission (see, e.g., "Angst," 1988), or desperation about stigmatisation and discrimination which goes along with diagnoses like "schizophrenia" (Rufer, 1988) or desperation about an incurable psychiatric diagnosis can trigger suicide, especially when this stigmatisation is combined with discrimination, self-stigmatisation and social decline (see, e.g., Hentschel, Lehmann, Lindner, Stöckle, & Treusch, 1987)

There can be all kind of medical diseases and disorders:

- Neurological diseases like cerebrovascular diseases, tumours, Parkinson's disease
- Infections like AIDS or hepatitis
- Endocrinological diseases like morbus Cushing
- Metabolic disorders like dehydration
- Other diseases like carcinoma or alcohol dependence
- Genetic abnormalities in the serotonin system.

Pharmacological Reasons for Depression and Suicidality

Depression up to suicidality can be caused by medical or street drugs like

- Tuberculostatics (e.g., cyloserine)
- Antihypertensiv drugs (e.g., α -methyldopa or Beta blocker)
- Chemotherapeutics (e.g., decarbazine, prednisolon, procarbazine and the interferones)
- Oral contraceptive pills

- Drugs to treat addiction, for example varenicline prescribed to treat smoking addiction (trade name Chantix in the USA and Champix in Europe).
- Mephedrone (street drug, trade names “Bliss,” “White Lightning” or “Cloud 9”)

Depression up to suicidality can be caused by psychiatric drugs like

- Tranquilizers, e.g., benzodiazepines
- Mood stabilizers like antiepileptics
- Antidepressants
- Neuroleptics.

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 suicidality (see Lehmann, 1996a, p. 111). Asmus Finzen from the Psychiatric Department of the University Basel, Switzerland, showed that the likely number of suicides in psychiatric institutions is vast; correct figures are, however, hard to find because

“... in medical records 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 medical records and statistics they would be considered as moved to the inner or surgical ward” (1988, p. 45).

Depression, Suicidality and Non-Antipsychotics

Tranquilizers can produce or enhance depression and suicidality. There are several reports of depression and suicidality being caused by **benzodiazepines** like diazepam or alprazolam in people who had never dealt before with depression (Hall & Joffe, 1972; Remschmidt, 1980; Van der Kroef, 1979; Lydiard, Laraia, Ballenger, & Howell, 1987). And it is well known that chronic dependence on benzodiazepines as well as withdrawal from these drugs are combined with a high risk level of suicidality (see Lehmann, 1996b, p. 361).

Since December 2008, the U.S. Food and Drug Administration (FDA) requires manufacturers of **antiepileptic drugs** to add to products' prescribing information, or labelling, a warning that their use increases the risk of suicidal thoughts and behaviours (suicidality). This includes all antiepileptic drugs, including those used for psychiatric reasons. Recently, in 2010, a team led by Elisabetta Patorno of the Harvard Medical School in Boston, Massachusetts, published an exploratory analysis suggesting that the use of different antiepileptics may be associated with an increased risk of suicidal acts or violent deaths (p. 1401).

Since the introduction of the classic **antidepressants**, psychiatrists have noted a tendency towards the chronification of depressions. This phenomenon is not likely to disappear due to the “down regulation” of serotonin and noradrenalin receptors. Down-regulation results in a degeneration of the receptors as a reaction to artificially raised transmitter levels at the synapses. In 1995, psychiatrist Marc Rufer from Switzerland expressed the following warning regarding selective serotonin re-uptake inhibitors (SSRI):

“In the long run, they diminish the effect of serotonin. If the serotonin deficit hypothesis of depression were correct, SSRI would have to cause rather severe depressions” (p. 144).

In 2004, the Medical Drug Commission of German Medical Professionals came to the conclusion

“that, especially in connection with the severe excitatory side effects of SSRI, you have to expect a risk of suicidal activities generally and non age-related, which is illustrated by accordant case reports” (Arzneimittelkommission).

Psychiatric publications show not only, that there is no difference between the effect of placebos and antidepressants (Khan, Warner, & Brown, 2000), but there is an enhanced risk of self-harm (Gunnell, Saperia, & Ashby 2005) and suicide attempts in SSRI (Fergusson et al. 2005) as well as suicide attempts in adults and suicides in children in all kinds of antidepressants (Olfson, Marcus, & Shaffer, 2006). Similar like the German Medical Drug Commission, on March 2004, the U.S. Food and Drug Administration (FDA) issued a public health advisory regarding worsening depression and suicidality in pediatric and adult patients being treated with 10 newer antidepressants (bupropion, citalopram, fluoxetine, fluvoxamine, mirtazapine, nefazodone, paroxetine, sertraline, escitalopram, and venlafaxine). Even when the warning was reduced in May 2007 to young adults ages 18 to 24 during initial treatment (generally the first one to two months), the list of antidepressants with a “black box warning on their products’ labeling to include warnings about increased risks of suicidal thinking and behavior, known as suicidality” does not look more inspiring confidence:

Anafranil (clomipramine)	Pamelor (nortriptyline)
Asendin (amoxapine)	Parnate (tranylcypromine sulfate)
Aventyl (nortriptyline)	Paxil (paroxetine HCl)
Celexa (citalopram hydrobromide)	Pexeva (paroxetine mesylate)
Cymbalta (duloxetine)	Prozac (fluoxetine HCl)
Desyrel (trazodone HCl)	Remeron (mirtazapine)
Elavil (amitriptyline)	Sarafem (fluoxetine HCl)
Effexor (venlafaxine HCl)	Seroquel (quetiapine)
Emsam (selegiline)	Sinequan (doxepin)
Etrafon (perphenazine/amitriptyline)	Surmontil (trimipramine)
fluvoxamine maleate	Symbyax (olanzapine/fluoxetine)
Lexapro (escitalopram oxalate)	Tofranil (imipramine)
Limbitrol (chlordiazepoxide/amitriptyline)	Tofranil-PM (imipramine pamoate)
Ludiomil (maprotiline)	Triavil (perphenazine/amitriptyline)
Marplan (isocarboxazid)	Vivactil (protriptyline)
Nardil (phenelzine sulfate)	Wellbutrin (bupropion HCl)
nefazodone HCl	Zoloft (sertraline HCl)
Norpramin (desipramine HCl)	Zyban (bupropion HCl)

There is also a website *SSRI Stories – Antidepressant Nightmares* where you can find a collection of more than 3,800 news stories that have appeared in the media in the English language (newspapers, TV, scientific journals) or that were part of FDA testimony in either 1991, 2004 or 2006, in which antidepressants were mentioned.

Of course there are also voices saying that antidepressants like SSRI lower the risk of suicide, especially in teens (Kutcher & Chehil, 2007, p. 77). This perspective has been advanced by Stan Kutcher and Sonia Chehil, two psychiatrists from the Dalhousie University in Halifax, Canada, in a

booklet from the Lundbeck Institute. The pharmaceutical firm Lundbeck produces the SSRI escitalopram (Cipralext) and citalopram (Cipramil), the antiepileptic valproate (Convulex), the neuroleptic fluphenazine (Lyogen—also marketed as Modecate, Moditen, Prolixin), the tricyclic antidepressant nortriptyline (Nortrilen) and many other drugs. It funds prevention programs, organises press conferences with compliant psychiatrists.

As so-called progressive psychiatrists like David Healy from the North Wales Department of Psychological Medicine in Bangor, who publish about the suicidal effects of antidepressants (Healy, 2001), use criticisms of antidepressants to justify **electroshock** administration as an alternative (Shorter & Healy, 2007), we should bear in mind that depression and suicidality are well-known effects of electroconvulsive treatment (also known as electroshock and ECT), a procedure involving the passage of electricity through the brain in order to produce a convulsion—a barbaric method, which was not incidentally developed during the Zeitgeist of fascism. Manfred Sakel, the Austrian psychiatrist who developed insulin shock “treatment” in 1933, noted that the side effects of ECT, including amnesia, confusion, disorientation, and temporary euphoria, may result in a secondary reactive depression, sometimes leading to suicide (Sakel, 1956). Reports of suicide following the administration of electroshock may be found in Leonard Roy Frank’s anthology, *The History of Shock Treatment* (1978, pp. 23, 27, 32, 43, 54, 58-59, 61, 73, 78, 101, 134, 154) or in Linda Andre’s book *Doctors of Deception: What They Don’t Want You to Know About Shock* (2009). The way in which suicidality, triggered by the combination of insulin shock, electroshock and various psychiatric drugs, is experienced by the people themselves is detailed in the book *Mitgift – Notizen vom Verschwinden* (Dowry of Poison: Notes from disappearing), authored by Kerstin Kempker (2000; see also Lehmann, 2010a). The treatment she received as an adolescent with emotional problems following her parents’ divorce severely traumatized her and triggered a series of suicide attempts. Having survived both the treatment and the suicide attempts, Kempker was also able to describe how the psychiatric workers seemed to be unaware of the procedure’s traumatizing and suicide-triggering effects.

Compared to warnings in different medical and psychiatric drugs at least to some extent, the level of warning from suicide risks in neuroleptics is screamingly silent.

Depression, Suicidality and Neuroleptics

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). Discussing studies on suicides in patients with the diagnosis “schizophrenia” and comparing suicide rates in different time periods, Healy and colleagues plead for an explanation of the “excess of suicides among patients receiving treatment” (Healy et al., 2006, p. 227). For people with a little medical knowledge the reason seems obviously:

Neuroleptics have a blockading effect primarily against the transmitter dopamine resulting in more or less subtle Parkinson’s syndromes. This is a complex of symptoms, characterized by walking with a stoop, muscle tremor, blurred speech and the so-called Parkinson psyche. The personality changes, the self changes, both in the direction of apathy, depression, desperation, hopelessness, suicidality and disturbance up to psychoses. Parkinson’s disease regularly results from dopamine blockage. The potency of neuroleptics was 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.

Neuroleptics can produce akathisia (increased motor activity), an akinetic syndrome (muscle rigidity, bradykinesia [diminished movement of body musculature] or akinesia [loss of normal motor function]). Both are forms of Parkinson's disease, which in turn can produce torturing sleeplessness and promote suicide (Wolfersdorf & Etzersberger, 2011, pp. 150/173). But 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 chlorpromazine (*trade name in Germany: Megaphen*), 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” (p. 56).

Depression and suicidality are normal effects of neuroleptics, and thus psychiatrists accept them obviously without question. Frank J. Ayd of the Psychiatric Department of the Franklin Square Hospital in Baltimore, USA, wrote in 1975:

“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 Hippus (1980), two German psychiatrists, answered the question of whether suicidality could perhaps 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).

Richard de Alarcon and M.W.P. Carney, two English psychiatrists, studied depressive mood changes after the administration of neuroleptics with other variables staying the same. In the *British Medical Journal* they reported on suicides undertaken under the influence of fluphenazine, which had been administered as part of a community treatment program, and described a fluphenazine trial on a 39 year-old man who already had tried to kill himself under the influence of this drug. When the psychiatrists realized that this man had regularly developed suicidal intentions 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 mood fluctuations. They then injected him intramuscularly with 25 mg of fluphenazine:

“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 or 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” (1969, pp. 565-566).

In his placebo-controlled study, psychiatrist Peter Müller of the Psychiatric Department of the University of Göttingen, Germany, found that a much higher percentage of people treated with neuroleptics had depressive symptoms than people treated with placebos. In relation to the lessening or withdrawal of psychiatric drugs, he wrote in 1981:

“From 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 alone (normally to half of the former dose) 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” (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” (p. 72).

Müller's reports are supported by many of his colleagues (Lehmann, 1996a, pp. 57-87, 109-115). Some examples include 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-apatetic 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 Clinic Wil, Switzerland, wrote:

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

According to their Swiss colleague Christian Scharfetter, who emphasized the effective time of the maximal neuroleptic effect at the point of suicide (1986, p. 89), Rufer warned: “Schizophrenics, who receive neuroleptics in high dosages, kill themselves in increased numbers” (1988). In 1976, Hans-Joachim Haase of the Psychiatric Clinic 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 (Haase, 1976). 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 psychiatric magazine *Nervenarzt*—without, nevertheless, alarming psychiatric patients, their relatives and carers, or even the public.

Rolf Hessø of the Psychiatric Department of the University of Oslo, Norway, also spoke about the development in Finland, Sweden and his country 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 of his place of employment, the Psychiatric Department of the University of Berne, Switzerland, 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).

Firsthand Reports about Depression and Suicidality

In *Coming off Psychiatric Drugs* (published about the possibilities and experiences with coming off psychiatric drugs originally in German language in 1998), Regina Bellion of Bremen, Germany gave a report about her psychic condition under Haldol, administered by the community psychiatrist:

“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” (2004, p. 280).

Another user of psychiatric drugs, living in Bremen too, had gotten a prescription of Haldol and the antidepressant Aponal (active ingredient doxepin). Under the influence of this combination she tried—fortunately without success—to end her suffering, for which she made the diagnosed illness responsible, by committing 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).

Fortunately she decided to withdraw from her psychiatric drugs, and so she is still alive. Even clozapine (trade name: Leponex), the prototype of so-called atypical neuroleptics, seems to have suicidal effects casually, as the report of the Austrian Ursula Fröhlich suggests:

“Since I began taking Leponex 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 morning, 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, 1996a, pp. 70-71).

Psychiatrists do not differ in their own experiences with these drugs. In 1955, Hans Heimann and Nikolaus Witt of the Psychiatric Department of the University of Berne, Switzerland, published their experiences after once taking chlorpromazine. They experimented with spiders and 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 was torturing that one can be so miserable and exposed, so empty and superfluous, neither filled by wishes nor by something else... (After finishing the examinations, P.L.): 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 Registers

By Survivors of Psychiatry

In early 1983, the Irren-Offensive Berlin, an organization of psychiatric survivors (in that time a respectable non-dogmatic organization), together with a group for watching human rights' violations in psychiatry, publicly warned of suicides caused by neuroleptics, after they had received information about people who had hung themselves, gassed or poisoned themselves, jumped to death, or thrown themselves in front of subway trains ("Psychopharmaka," 1983; Klust, 1983). Through leafleting, they warned the public of the widely distributed neuroleptic, haloperidol. Within a short time bereaved individuals came forward with reports of suicides that had been undertaken under the influence of neuroleptics. On January 28, 1983, the foundation of the "Registration Center for (Self-) Murders by Psychiatric Treatment" was published within a press-conference, and a small minority of magazines and newspapers reported about it. A public call to support the initiative financially and structurally bore no results, and the initiative eventually came to an end due to the immense expenditure of human labour with the bereaved's anguish when they realized the true causes of their loved ones' deaths. But the demand for a public suicide register was born.

By Psychiatrists

Another type of suicide register was developed in the form of the "Arzneimittelüberwachung in der Psychiatrie" (AMÜP—a drug monitoring system in the psychiatric field) in Germany, which was founded in 1979 and supported by the National Health Administration of the German Government. Since the beginning of the 90s, after an experimental phase, psychiatric hospitals in this region have gathered data on complications that may have resulted from treatment, including the registration of preferential triggering of suicide attempts and suicides by drugs, in order to make risks public and develop programs for prevention and early detection (Haen, *et al.*, 1999, p. 93). Findings are discussed within the psychiatric community, where individual psychiatrists know each other quite well, "without prejudices and free of any know-it-all habits" (*ibid.*, p. 94). If a psychiatrist identifies a drug as potentially suicide-triggering, they send a report to the National Institute for the Safety of Drugs, the Drug Commission of the German Medical Association and the Drug Produces. Unfortunately, the authors of the article forgot to say how many reports they sent after 89 registered suicide attempts and suicides up to January 1998.

In a review published in 2002, Bavarian psychiatrists reflected on their results from 1991 through 1999 and the many methodological problems that arose from registering suicides and identifying the one exclusive cause which triggers suicidality. They mention, for example, problems with the definition of suicidality, if no activity in the direction to end the life is included, and plead for the further development of questionnaires and registration cards (Franke, Roider, Wolfersdorf, & Dobmeier, 2002).

Repeated friendly offers by the author as a board member of the European Network of (ex-) Users and Survivors of Psychiatry to discuss the possibility of including users and survivors of psychiatry into the Bavarian suicide register and to help make the registration criteria sharper and more effective, were without any response and result—like the Bavarian suicide register altogether.

By Governmental Administrations

A suicide register in Sweden was described by Janne Larsson⁴ from Sweden in October 2009. Referring to regulations in The Act on Professional Activity in Health and Medical Services (called Lex Maria), since February 2006 in Sweden all suicides committed in health care and within four weeks after the last health care visit should be reported for investigation to the National Board of Health and Welfare. Larsson shows figures about tables about the special neuroleptics (fig. 1),

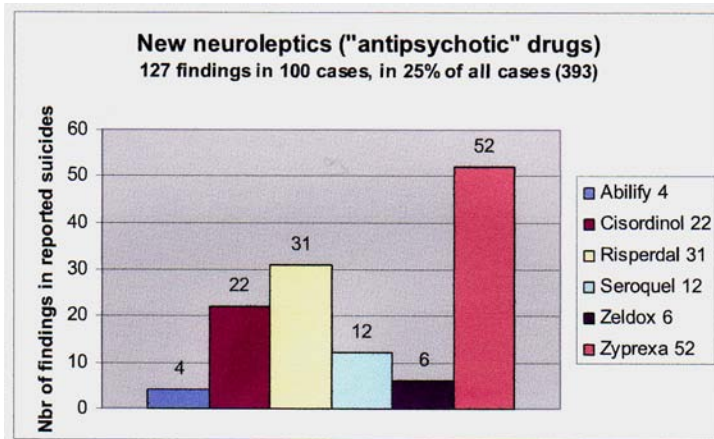


Fig. 1: "Atypical" Neuroleptics administered to people who committed suicide in Sweden in 2007 four weeks before they committed suicide

antidepressants (fig. 2) and tranquilizers (fig. 3) which were administered within four weeks before the suicide and explains the data of this subgroup:

"... according to the data received, 393 cases were reported to the six regional offices for 2007. (...)

In 338 of the 393 cases – 86% of the cases – the persons were treated with psychiatric drugs within one year before their suicide.

In 304 cases – 77% of the cases – the persons were treated with antidepressant drugs and/or neuroleptics. (...)

In 261 cases – 66% of the cases – the persons were treated with tranquilizers/hypnotics; drugs of the class benzodiazepines or similar newer compounds.

In addition to the above a considerable number of persons were treated with psychiatric drugs of other classes. These were drugs such as epileptic drugs recently started to be used as 'mood stabilizers' (Lyrica [*pregabalin*], Lamictal [*lamotrigine*]), 'ADHD drugs' (Concerta, Ritalin [*both methylphenidate*], Strattera [*atomoxetine*]) and other types of psychiatric drugs like Buprenorfin (*semi-synthetic opiate, used as pain-killer*) and Heminevrine (*clomethiazol*)" (Larsson, 2009, pp. 17-19).

⁴ Back home after my lecture in Manchester, I learned that on the internet Janne Larsson is mentioned in connection with so-called Citizens Commission on Human Rights (CCHR), whose Founding Commissioner is Thomas Szasz, a critical, Social Darwinist orientated and neo-liberal psychiatrist. CCHR, where Larsson published an article, seems to be a branch of Scientology. But a connection to Scientology, which goes beyond a simple publication at CCHR, can also be constructed by the friends of Big Pharma: to destroy one's credibility, like they try it all the time against people who publish about risks of psychiatric drugs. Larsson simply repeats data from the National Board of Health and Welfare and the Swedish National Board of Forensic Medicine, so a further discussion about his connection to CCHR would only draw off the attention from the stripped data: the prospective suicidal effects of psychiatric drugs.

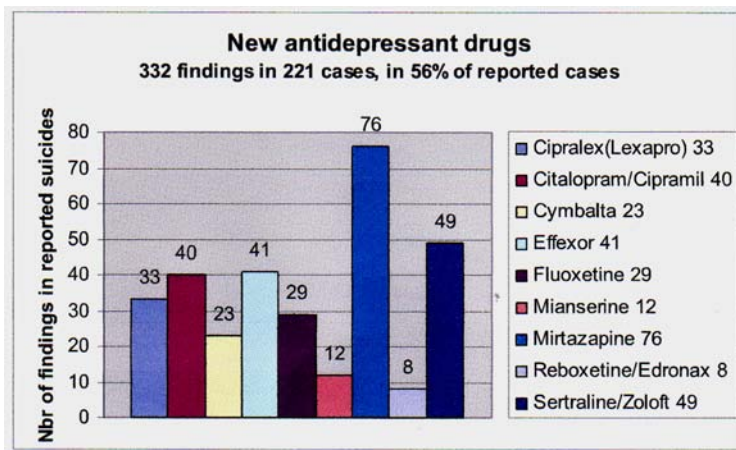


Fig. 2: Antidepressants administered to people who committed suicide in Sweden in 2007 four weeks before they committed suicide

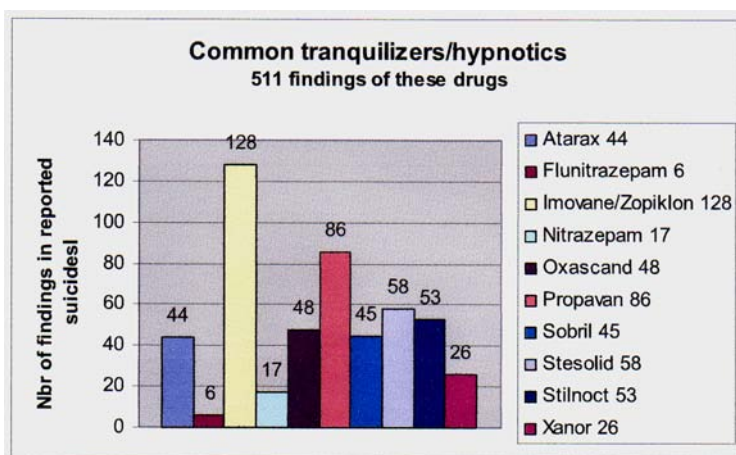


Fig. 3: Tranquilizers/hypnotics administered to people who committed suicide in Sweden in 2007 four weeks before they committed suicide

Larsson summarizes the 2007 results of the report:

“In 86% of the cases of suicide reported to the National Board of Health and Welfare for 2007 (chapter 4) – that is in 338 of 393 cases – the persons were treated with psychiatric drugs. In 0% (!) of these cases was the matter reported as a drug adverse event to the registry for drug adverse events at the Medical Products Agency (...). Instead of Eli Lilly claiming that the drug Zyprexa (*olanzapine*; *neuroleptic*) was involved in 0 cases of suicide in Sweden 2007, the fact was that the drug was involved in 52 cases in this subgroup of 338 persons. Instead of Wyeth claiming the same for Effexor (*venlafaxine*; *serotonin/norepinephrine reuptake inhibitor*), the fact was that the drug was involved in 41 cases in this group” (ibid., pp. 23-25).

Larsson’s report also includes data about the total number of suicides in Sweden 2007 and the preceding psychopharmacological treatment in these cases. And it includes autopsy data from the Swedish National Board of Forensic Medicine. Larsson shows also tables with the percentage of psychiatric drug classes found in autopsies at people who committed suicide (fig.4) as well as classes of psychiatric drugs which were found in their blood (fig. 5) and writes:

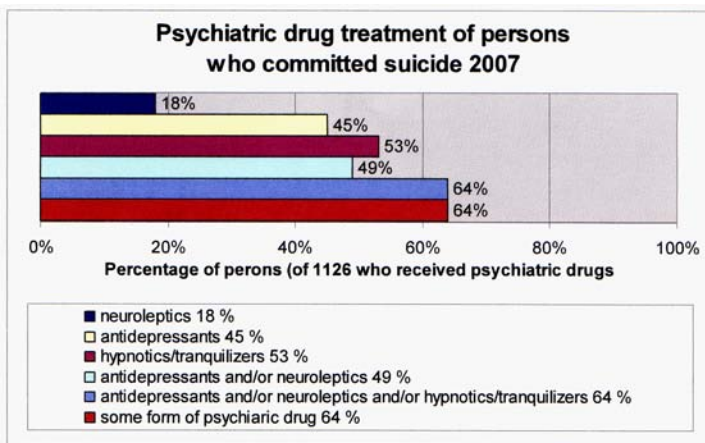


Fig. 4: Percentage of psychiatric drug classes found in autopsies at people who committed suicide in Sweden in 2007

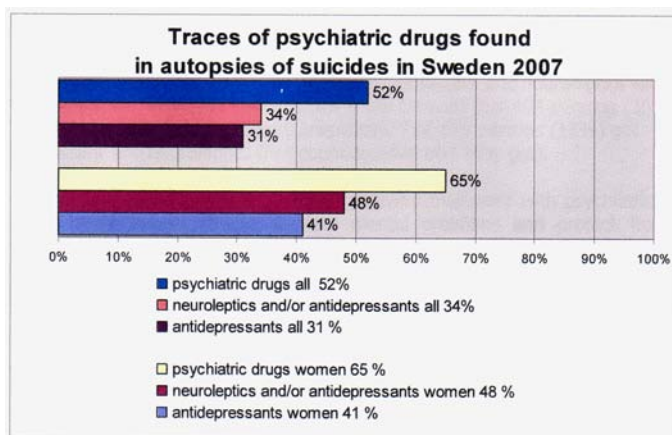


Fig. 5: Percentages of traces of psychiatric drugs found in autopsies at men and women who committed suicide in Sweden in 2007

“The method used was to request relevant unpublished data from the National Board of Health and Welfare, and from the regional departments of the National Board of Forensic Medicine, mainly using the Freedom of Information Act (FOIA). The Centre for Epidemiology in the National Board of Health and Welfare has released data about all suicides in Sweden 2007 and the preceding psychopharmacological treatment in these cases. The six regional offices of the National Board of Forensic Medicine have released data about the autopsies done for 2007 and the psychiatric drugs found in the blood of the persons who had committed suicide. (...)

The result shows that 1126 definite suicides were committed in Sweden in 2007 (325 women and 801 men). Of these persons 724 (64%) had filled a prescription for psychiatric drugs within a year of the suicide. Of the 325 women, 250 (77%) had filled a prescription for psychiatric drugs; for the 801 men the figure was 474 (59%).

Of the 325 women 196 (60%) had filled a prescription for antidepressants; for the 801 men the figure was 306 (38%).

In the forensic toxicological analyses traces of psychiatric drugs were found in 575 persons (52%) of the 1109 analyses done. Traces of antidepressant drugs were found in 132 (41%) of the women investigated. (...)

The conclusion is that a large percentage of the persons who committed suicide in Sweden in 2007 had received extensive treatment with psychiatric drugs within a year of and close to the suicide” (ibid., p. 2).

Consequences and Demands

Updated product labelling has to include a warning about an increased risk of suicidal thoughts or actions to help patients, supporters and psychosocial staff understand this risk. This has to be as a rule, even if there is only the suspect. Users of psychiatric drugs need to be informed so that they can make a carefully considered decision about taking or declining to take a recommended psychiatric drug. If necessary, they can opt for alternatives beyond psychiatry or less risky psychopharmacological treatments for their emotional problems.

Reports of (ex-) users and survivors of psychiatry who have been pushed into suicide attempts or suicidality after traumatizing treatments with psychiatric drugs, electro- and insulin shock, must no longer be ignored. They have to be included as keynote speakers, experts and teachers in education programs, congresses and the public media.

We have to face the fact that, from a Darwinist point of view, which was brought to perfection in Nazi Germany and is still rather common in the modern societies, the segregation of troubled or troublesome people is not something that everyone agrees should be prevented. This refers especially to people who usually have not violated any laws and therefore cannot be criminally prosecuted and imprisoned, but whose ideas and actions, values and life styles, disrupt or threaten to disrupt established power relationships. In 1923, Fritz Lenz, one of the most influential German eugenicists and advocates of racist population control, praised suicide—with the support of Eugen Bleuler, the leader of the mainstream psychiatry at that time (see Lehmann, 1994)—as a measure against “vulgarisation of the race”:

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

As an urgent measure, we have to use and improve advance directives to protect ourselves from unwanted treatment (Ziegler, 2007), where we clearly should mention, e.g. previous depressive states caused by psychiatric drugs, in instances when we have had such experiences. And we should demand the application of the criminal law: not only to penalize non-assistance of a person in danger, breach of standard of care or acquiescence of a perhaps deadly consequence, but especially to penalize the elements of an offence which—for example—the US American *Black's Law Dictionary* defines as recklessness. This means “Conduct whereby the actor does not desire harmful consequence but... foresees the possibility and consciously takes the risk,” or alternatively as “a state of mind in which a person does not care about the consequences of his or her actions” (Garner, 2005, p. 1053). Find more information about this highly recommendable law principle on the internet (“Recklessness,” 2011). In US-American, German, Swiss and many other courts, a wrongdoer who recklessly causes harm can be held to the same liability as a person who intentionally does so. If psychiatrists continue to administer psychiatric drugs with suicidal effects to people who are known to have underlying special risk factors, they should know that laws espousing equality can also be laws espousing of equality in legal responsibility for damages and practice of the criminal law. This should also be true for the owners and the leaders of drug companies which produce drugs with suicidal effects. Laws should be equal to all.

A suicide register with meaningful participation of independent organisations of users and survivors of psychiatry could enhance warnings of suicidal risks of psychiatric treatment methods. It could work, if the funds mentioned in the recommendations of the European Action Project against Harassment and Discrimination would be provided by the authorities and if it received the authority to gather data as well as the means to publish and publicize its findings.⁵ It could be organized nationally or regionally and should be legally covered; it should then be easily accessible (anonymous upon request) and should operate independently of medical and psychiatric institutions. When institutes of universities organize congresses together with organisations of users and survivors of psychiatry, why not also organizing joint applications for research funds, for example? Especially universities like the University of Preston (Lancashire) with its Institute for Philosophy, Diversity and Mental Health or the Aristotle University of Thessalonica with its Faculty of Philosophy, which will host the next European Congress of users and survivors of psychiatry in September 2010, could have a pilot function organizing joint research and teaching practice.

As a form of user-led or user-controlled research, delegates of independent organisations of users and survivors of psychiatry, as well as competent and independent individuals, have to be included in prevention programs and monitoring bodies with adequate remuneration. It would be rather counterproductive to include Big Pharma (see, e.g., the reasonable proposals of the Institute of Medicine, the health arm of the National Academy of Sciences in Washington, DC, in: Steinbrook, 2009) or to include psychiatrists, family organisations or so-called self-help organisations like GAMIAN, founded directly by Big Pharma directly (Boseley, 2007; Lehmann, 2009, pp. 34-35), who receive(d) money and other profits from Big Pharma.

The rate of suicides in people with emotional problems or people who are called “mentally ill” could be lowered meaningfully as a result of a functioning and independent suicide register. Where the damage has already been done, there may be at least be a chance to get financial compensation.. Enhanced knowledge about suicidal effects of neuroleptics and other iatrogenic injuries in mental health and could help people with diagnoses like “schizophrenia” to be protected from additional burden and risks. The self would be protected from changes caused by toxic drugs. Enhanced knowledge about suicidal effects of neuroleptics and other iatrogenic injuries would enable professionals in mental health, relatives, friends and other carers to support people to live their lives in freedom and peace.

References

- Alles, was wir fühlen, ist Chemie. Glück, seelisches Leiden und Psychopillen: Die Pharmakotherapeutin Brigitte Woggon debattiert mit der Psychoanalytikerin Brigitte Bothe (2000, June 8). *Weltwoche*, pp. 53-54.
- [Andre, L. \(2009\). *Doctors of deception: What they don't want you to know about shock*. Piscataway: Rutgers University Press.](#)
- Angst vor Anstalt – Sprung aus 7. Stock (1988, December 29). *AZ München*.

⁵ Six decades after the end of World War II the European Union is now funding research about suicides of Jewish people during the Nazi regime (“Freitod,” 2006). Why should it (or the UN, WHO, WPA or even Big Pharma) not also fund research about the increased incidence of suicides under the influence of neuroleptics, six decades after these drugs were introduced?

- Arzneimittelkommission der deutschen Ärzteschaft (2004). “Aus der UAW-Datenbank” – Suizidalität unter SSRIs [Electronic version]. *Deutsches Ärzteblatt*, 101(39). Retrieved April 7, 2009, from *Arzneimittelkommission der deutschen Ärzteschaft* website: <http://www.akdae.de/Arzneimittelsicherheit/Bekanntgaben/Archiv/2004/200409243.pdf>.
- Ayd, F. J. (1975). The depot fluphenazines. *American Journal of Psychiatry*, Vol. 132, pp. 491-500.
- Barreira, P. (1999). Reduced life expectancy and serious mental illness [Electronic version]. *Psychiatric Services*, 50, 995. Retrieved May 14, 2010, from *Psychiatric Services – American Psychiatric Publishing, Inc.* website: <http://psychservices.psychiatryonline.org/cgi/content/full/50/8/995>.
- Battegay, R. & Gehring, A. (1968). Vergleichende Untersuchungen an Schizophrenen der präneuroleptischen und der postneuroleptischen Ära. *Pharmakopsychiatrie Neuro-Psychopharmakologie*, Vol. 1, pp. 107-122.
- Bellion, R. (2004). After withdrawal, the difficulties begin. In [P. Lehmann \(Ed.\), *Coming off psychiatric drugs: Successful withdrawal from neuroleptics, antidepressants, lithium, carbamazepine and tranquilizers*](#) (pp. 279-290). Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing.
- Benkert, O. & Hippus, H. (1980). *Psychiatrische Pharmakotherapie* (3rd ed.). Berlin / Heidelberg / New York: Springer.
- Boseley, S. (2007, May 21). Drug firms and patient groups join in fight to overturn advertising ban [Electronic version]. *The Guardian*. Retrieved June 26, 2010, from *Guardian* website: <http://www.guardian.co.uk/business/2007/may/21/advertising.medicineandhealth>.
- De Alarcon, R. & Carney, M. W. P. (1969). Severe depressive mood changes following slow-release intramuscular fluphenazine injection. *British Medical Journal*, Vol. 3(5670), pp. 564-567 – <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1984352/pdf/brmedj02048-0044.pdf>.
- Dörner, K. & Plog, U. (1992). *Irren ist menschlich* (7th ed.). Bonn: Psychiatrie-Verlag.
- Ebner, G. (2003). Aktuelles aus der Psychopharmakologie. Das Wichtigste vom ECNP-Kongress in Barcelona 05.-09.10.2002. *Psychiatrie*, (1), pp. 29-32.
- Fergusson, D. et al. (2005). Association between suicide attempts and selective serotonin reuptake inhibitors: systematic review of randomised controlled trials. *British Medical Journal*, Vol. 330(7488), p. 396 – doi: 10.1136/bmj.330.7488.396 (Published February 17, 2005).
- Finzen, A. (1988). *Der Patientensuizid*. Bonn: Psychiatrie-Verlag.
- [Frank, L. R. \(Ed.\) \(1978\). *The history of shock treatment*](#). San Francisco: Self-publication.
- Franke, C., Roeder, S., Wolfersdorf, M., & Dobmeier, M. (2002). Zusammenhang zwischen Suizidalität und Psychopharmaka – Ergebnisse der AMÜP-Bayern 1991 bis 1999. *Psychopharmakotherapie*, Vol. 9, pp. 108-111.
- Freitod von Juden in der NS-Zeit wird erforscht (2006, February 20). *Berliner Zeitung*, p. 19.

- Fünfgeld, E. W. (1967). *Psychopathologie und Klinik des Parkinsonismus vor und nach stereotaktischen Operationen*. Berlin / Heidelberg / New York: Springer.
- Garner, B. (Ed.) (2005). *Black's law dictionary* (8th ed.). Boston: West Publishing Company.
- Glaeske, G. (2011): Nebenwirkung Suizid. Internetangebote für problematische Aknemittel. *Dr. med. Mabuse, Vol. 36*(191), pp. 70-71.
- Gunnell, D., Saperia, J. & Ashby, D. (2005). Selective serotonin reuptake inhibitors (SSRIs) and suicide in adults: meta-analysis of drug company data from placebo controlled, randomised controlled trials submitted to the MHRA's safety review. *British Medical Journal, Vol. 330*(7488), p. 385 – doi: 10.1136/bmj.330.7488.385 (Published February 17, 2005).
- Haase, H.-J. (1976). Pharmakotherapie bei Schizophrenien. In H.-J. Haase (Ed.), *Die Behandlung der Psychosen des schizophrenen und manisch-depressiven Formenkreises* (pp. 93-120). Stuttgart / New York: Schattauer.
- Haen, E., Aigner, J.-M., Jost, D., Lippert, E., Spindler, P. & Klein, H. (1999): Die Arzneimittelüberwachung in der Psychiatrie Bayerns (AMÜP-Bayern). *Arzneimitteltherapie, Vol. 17*(3), pp. 93-96.
- Hall, R. C .W. & Joffe, J. R. (1972). Aberrant response to diazepam. *American Journal of Psychiatry, Vol. 129*, pp. 738-742.
- Harassment and Discrimination Faced by People with Psycho-social Disability in Health Services—A European Survey (2005). Recommendations. Retrieved from *Peter Lehmann Publishing* website: <http://www.peter-lehmann-publishing.com/articles/enusp/recommendations.htm>.
- Haukka, J., Tiihonen, J., Härkänen, T. & Lönnqvist, J. (2008). Association between medication and risk of suicide, attempted suicide and death in nationwide cohort of suicidal patients with schizophrenia. *Pharmacoepidemiology and Drug Safety, Vol. 17*(7), pp. 686-696.
- Healy, D. (2001). The SSRI suicides. In C. Newnes, G. Holmes & C. Dunn (Eds.), *This is madness too: Critical perspectives on mental health services* (pp. 59-69). Ross-on-Wye: PCCS Books.
- Healy, D., Harris, M., Tranter, R., Gutting, P., Austin, R., Jones-Edwards, G. et al. (2006). Lifetime suicide rates in treated schizophrenia: 1875-1924 and 1994-1998 cohorts compared. *British Journal of Psychiatry, Vol. 188*, pp. 223-228.
- Heilä, H., Haukka, J., Suvisaari, J. & Lönnqvist, J. (2005). Mortality among patients with schizophrenia and reduced psychiatric hospital care. *Psychological Medicine, Vol. 35*(5), pp. 725-732.
- Heimann, H. & Witt, P. N. (1955). Die Wirkung einer einmaligen Largactilgabe bei Gesunden. *Monatsschrift für Psychiatrie und Neurologie, Vol. 129*, pp. 104-123.
- Hentschel, R., Lehmann, P., Lindner, K., Stöckle, T. & Treusch, H. (1987): Behandlungsergebnis Selbsttod – Ein klassischer psychiatrischer ‚Fall!‘. [Die Irren-Offensive – Zeitschrift von Ver-rückten gegen Psychiatrie, \(3\)](#), pp. 19-24.

- Hessö, R. (1977). Suicide in Norwegian, Finnish, and Swedish hospitals. *Archiv für Psychiatrie und Nervenkrankheiten*, Vol. 224, pp. 119-127.
- Hor, K. & Taylor, M. (2010). Suicide and schizophrenia: a systematic review of rates and risk factors. *Journal of Psychopharmacology*, Vol. 24(4), Suppl., pp. 81-90.
- [Kempker, K. \(2000\). *Mitgift – Notizen vom Verschwinden*. Berlin: Antipsychiatrieverlag.](#)
- Khan, A., Khan, S. R., Leventhal, R. M. & Brown, W. A. (2001). Symptom reduction and suicide risk among patients treated with placebo in antipsychotic clinical trials: an analysis of the Food and Drug Administration database. *American Journal of Psychiatry*, Vol. 158(9), pp. 1449-1454.
- Khan, A., Warner, H. A. & Brown, W. A. (2000). Symptom reduction and suicide risk in patients treated with placebo in antidepressant clinical trials: an analysis of the Food and Drug Administration database. *Archives of General Psychiatry*, Vol. 57(4), pp. 311-317.
- Klust, H. (1983). 30 Sekunden Zeitaufwand – für immer Ruhe. Erfassungsstelle für (Selbst-) Morde durch psychiatrische Behandlung (ESPB) gegründet. [Die Irren-Offensive – Zeitschrift von Ver-rückten gegen Psychiatrie, \(2\)](#), pp. 16-17.
- Kutcher, S. & Chehil, S. (2007). *Suicide risk management: A manual for health professionals*. Malden / Oxford / Carlton: Blackwell Publishing.
- Larsson, J. (2006, June). ADHD och amfetamin till fångar. Norrtäljeprojektet – ett etiskt oförsvarbart drogprojekt [Electronic version]. Retrieved June 26, 2010, from KMR – Kommittén för mänskliga rättigheter website: http://www.kmr.nu/artikel_norrt.htm.
- Larsson, J. (2009). *Psychiatric drugs & suicide in Sweden 2007: A report based on data from the National Board of Health and Welfare* [Electronic version]. Retrieved June 26, 2010, from Janne Larsson website: <http://psychiatricdrugs.jannel.se/#home>.
- Lehmann, P. (1994). “Progressive” psychiatry: Publisher J. F. Lehmann as promoter of social psychiatry under fascism. *Changes – An International Journal of Psychology and Psychotherapy*, Vol. 12(1), pp. 37-49. Extended version available on Peter Lehmann Publishing website: <http://www.peter-lehmann-publishing.com/articles/lehmann/j-f-lehmann.htm>.
- Lehmann, P. (1996a). *Schöne neue Psychiatrie. Vol. 1: Wie Chemie und Strom auf Geist und Psyche wirken*. Berlin: Antipsychiatrieverlag.
- Lehmann, P. (1996b). *Schöne neue Psychiatrie. Vol. 2: Wie Psychopharmaka den Körper verändern*. Berlin: Antipsychiatrieverlag.
- Lehmann, P. (2002a). Behandlungsergebnis Selbsttötung – Suizidalität als mögliche Wirkung psychiatrischer Psychopharmaka. *Co`med – Fachmagazin für Complementär-Medizin*, Vol. 8(3), pp. 32-34. Extended version available on Peter Lehmann Publishing website: <http://www.antipsychiatrieverlag.de/artikel/gesundheit/suizid.htm>.
- Lehmann, P. (2002b). Behandlungsergebnis Selbsttötung – Suizidalität als mögliche Wirkung psychiatrischer Psychopharmaka. *Psychologie & Gesellschaftskritik*, Vol. 26(IV), pp. 99-111.

Extended version available on *Peter Lehmann Publishing* website:

<http://www.antipsychieverlag.de/artikel/gesundheit/suizid.htm>.

- Lehmann, P. (2002c). Treatment-induced suicide: Suicidality as a potential effect of psychiatric drugs. *Journal of Critical Psychology, Counselling and Psychotherapy, Vol. 2*(1), pp. 54-58. Available on *Peter Lehmann Publishing* website: <http://www.peter-lehmann-publishing.com/articles/lehmann/suicide.htm>
- Lehmann, P. (2009). A snapshot of users and survivors of psychiatry on the international stage. *Journal of Critical Psychology, Counselling and Psychotherapy, Vol. 9*(1), pp. 32-42. Available on *Peter Lehmann Publishing* website: <http://www.peter-lehmann-publishing.com/articles/lehmann/pdf/inter2008e.pdf>.
- Lehmann, P. (2010a). Medicalization and irresponsibility. *Journal of Critical Psychology, Counselling and Psychotherapy, Vol. 10*, pp. 209-217. Extended version available on *Peter Lehmann Publishing* website: <http://www.peter-lehmann-publishing.com/articles/lehmann/medicalization.htm>.
- Lehmann, P. (2010b): Resisting psychiatric assault: A European initiative to introduce a suicide register [Electronic version]. In B. Burstow & S. Diamond (Eds.), *Proceedings of the PsychOUT Conference, May 7-8, 2010*. Toronto: Ontario Institute for Studies in Education, University of Toronto. Available on *UTORweb – individual web pages @ the university of toronto* website: <http://www.individual.utoronto.ca/psychout/papers/lehmann.html>.
- Lenz, F. (1923). *Menschliche Auslese und Rassenhygiene* (2nd ed.). Munich: J. F. Lehmanns Verlag.
- Lydiard, R. B., Laraia, M. T., Ballenger, J. C. & Howell, E. F. (1987). Emergence of depressive symptoms in patients receiving alprazolam for panic disorders. *American Journal of Psychiatry, Vol. 144*(5), pp. 664-665.
- Marmotte, I. (2004). The “Blue Caravan” on the road... In [P. Lehmann \(Ed.\), *Coming off psychiatric drugs: Successful withdrawal from neuroleptics, antidepressants, lithium, carbamazepine and tranquilizers*](#) (pp. 117-135). Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing.
- Modestin, J. (1982). Suizid in der psychiatrischen Institution. *Nervenarzt, Vol. 53*, pp. 254-261.
- Müller, P. (1981). *Depressive Syndrome im Verlauf schizophrener Psychosen*. Stuttgart: Enke.
- Müller, P. (1989). Der Suizid der schizophrenen Patienten und sein Zusammenhang mit der therapeutischen Situation. *Psychiatrische Praxis, Vol. 16*, pp. 55-61.
- Nordentoft, M., Laursen, T. M., Agerbo, E., Qin, P., Høyer, E. H. & Mortensen, P. B. (2004). Change in suicide rates for patients with schizophrenia in Denmark, 1981-97: nested case-control study [Electronic version]. *British Medical Journal, Vol. 329*(7460), p. 261 – doi: 10.1136/bmj.38133.622488.63 (Published June 22, 2004).
- Olfson, M., Marcus, S. C. & Shaffer, D. (2006). Antidepressant drug therapy and suicide in severely depressed children and adults: a case-control study. *Archives of General Psychiatry, Vol. 63*(8), pp. 865-872.

- Patorno, E., Bohn, R. L., Wahl, P. M., Avorn, J., Patrick, A. R., Liu, J. et al. (2010). Anticonvulsant medications and the risk of suicide, attempted suicide, or violent death. *Journal of the American Medical Association*, Vol. 303, pp. 1401-1409.
- Pöldinger, W. & Sieberns, S. (1983). Depression-inducing and antidepressive effects of neuroleptics. *Neuropsychobiology*, Vol. 10, pp. 131-136.
- Psychopharmaka – der todsichere Weg. Erfassungsstelle für Selbstmorde in der Psychiatrie (1983, January 31). *Tageszeitung (taz, Berlin edition)*, p. 15.
- Qin, P. N. & Nordentoft, M. (2005). Suicide risk in relation to psychiatric hospitalization: evidence based on longitudinal registers. *Archives of General Psychiatry*, Vol. 62(4), pp. 427-432.
- Recklessness (law) (n.d.). Retrieved July 20, 2011, from *Wikipedia* website: [http://en.wikipedia.org/wiki/Recklessness_\(law\)](http://en.wikipedia.org/wiki/Recklessness_(law))
- Remschmidt, H. (1980). Paradoxe Reaktionen und Interaktionen von Psychopharmaka bei Kindern und Jugendlichen. *Monatsschrift für Kinderheilkunde*, Vol. 128, pp. 636-641.
- Rufer, M. (1988). Schizophrene, die hoch dosiert Neuroleptika erhalten, begehen vermehrt Selbstmord. *Pro mente sana aktuell*, (3), p. 34.
- Rufer, M. (1995). *Glückspillen – Ecstasy, Prozac und das Comeback der Psychopharmaka*. Munich: Knaur Verlag.
- Rufer, M. (2007). Psychiatry: Its diagnostic methods, its therapies, its power. In [P. Stastny & P. Lehmann \(Eds.\)](#), *Alternatives beyond psychiatry* (pp. 382-399). Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing.
- Sakel, M. J. (1956). Sakel shock treatment. In A. M. Sackler, M. D. Sackler, R. R. Sackler, & F. Marti-Ibañez (Eds.), *The great physiological therapies in psychiatry: An historical perspective* (pp. 13-14). New York: Hoeber-Harper.
- Scharfetter, C. (1986). Die Selbsttötung schizophrener Menschen. *Schweizer Archiv für Neurologie und Psychiatrie*, Vol. 137(4), pp. 85-91.
- Shorter, E. & Healy, D. (Eds.) (2007). *The history of electroconvulsive treatment in mental illness*. Toronto: University of Toronto.
- SSRI Stories – Antidepressant Nightmares. *Anonymous* website: <http://ssristories.com>.
- Steinbrook, R. (2009). Contrdng conflict of interest: Proposals from the Institute of Medicine. *New England Journal of Medicine*, Vol. 360, pp. 2160-2163.
- Tabbane, K., Joobar, R., Spadone, C., Poirier, M. F. & Olié, J. P. (1993). Mortalité et causes de décès dans la schizophrénie : revue de la littérature. *L'Encéphale*, Vol. 19(1), pp. 23-28. English abstract retrieved July 23, 2011, from *NCBI – National Center for Biotechnology Information* website: <http://www.ncbi.nlm.nih.gov/pubmed/8275890>.
- Tiihonen, J., Haukka, J., Taylor, M., Haddad, P. M., Patel, M. X. & Korhonen, P. (2011). A nationwide cohort study of oral and depot antipsychotics after first hospitalization. *American Journal of Psychiatry*, Vol. 168(6), pp. 603-609.

- Tiihonen, J., Lönnqvist, J., Wahlbeck, K., Klaukka, T., Niskanen, L., Tanskanen, A. et al. (2009). 11-year follow-up of mortality in patients with schizophrenia: a population-based cohort study (FIN11 study). *Lancet*, Vol. 374(9690), pp. 620-627.
- Tiihonen, J., Wahlbeck, K., Lönnqvist, J., Klaukka, T., Ioannidis, J. P., Volavka, J. & Haukka, J. (2006). Effectiveness of antipsychotic treatments in a nationwide cohort of patients in community care after first hospitalisation due to schizophrenia and schizoaffective disorder: observational follow-up study. *British Medical Journal*, Vol. 333(7561), p. 224 –doi: 10.1136/bmj.38881.382755.2F (Published July 6, 2006).
- US Food and Drug Administration (2007). Antidepressant Use in Children, Adolescents, and Adults. Retrieved on July 28, 2011, from U.S. Food and Drug Administration website: <http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm096273.htm>.
- Van der Kroef, C. (1979). Reactions to triazolam. *Lancet*, p. 526.
- Von Ditfurth, H. (1955). Anwendungsmöglichkeiten des Megaphens in der psychiatrischen Klinik und Forschung. *Nervenarzt*, Vol. 26, pp. 54-59.
- [Webb, D. \(2010\). *Thinking about suicide: Contemplating and comprehending the urge to die*. Ross-on-Wye: PCCS Books.](#)
- Weinmann, S., Read, J. & Aderhold, V. (2009). Influence of antipsychotics on mortality in schizophrenia: Systematic review. *Schizophrenia Research*, Vol. 113(1), pp. 1-11.
- Wolfersdorf, M. & Etzersdorfer, E. (2011). *Suizid und Suizidprävention*. Stuttgart: Kohlhammer.
- Ziegler, L. (2007). Upholding psychiatric advance directives: “The rights of a flea”. In [P. Stastny & P. Lehmann \(Eds.\), *Alternatives beyond psychiatry*](#) (pp. 318-328). Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing.

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