

International Non-compliance and

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Humanistic Antipsychiatry¹

This paper makes a plea for the humanization of psychiatry and psychotherapy and the recipients of psychiatric services in a context where the use of harmful medication and de-humanizing praxis remains the norm.

The term 'humanistic antipsychiatry' is often misunderstood since 'antipsychiatry' is used variously in many countries to express their own cultural characteristics. Modern humanistic antipsychiatry is an undogmatic and humanistic movement. The Greek 'anti' means more than simply 'contra.' It means also 'alternative,' 'beyond' or 'independent.'

Humanistic antipsychiatry is orientated toward the interests of users and survivors of psychiatry whose main concerns are self-determination and freedom from bodily harm. Humanistic antipsychiatry is filled with a contrarian spirit and the fundamental conviction that:

- psychiatry as a scientific discipline cannot do justice to the expectation of solving problems that are largely of a social nature,
- its propensity and practice to use force constitutes a threat, and
- its diagnostic methods obstruct the view of the real problems of individuals in society.

For these reasons, humanistic antipsychiatry pleads for:

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- developing adequate and effective assistance for people in emotional difficulties
- safeguarding civil rights in treatment on a par with 'normal' patients
- joining forces in cooperation with other human rights and self-help groups
- support in withdrawing from psychiatric drugs and the use of alternative and less toxic psychotropic substances
- a ban on electroshock
- new ways of living with madness and being different – with as much independence from institutions as possible
- tolerance, respect and appreciation of diversity at all levels of life.

Psychiatric threat as a broad societal problem

The problem of the lack of support in times of emotional stress does not merely affect a minority; rather the broad spectrum of society is affected: those directly affected, their relatives, children, old people and the marginalized. Protection from psychiatric violence would have the effect of reducing anxiety in the whole of society. Apart from the positive effect on the health of society in general, the reduction in the flood of prescriptions for psychotropic drugs and the associated so-called therapeutic secondary diseases, with their resulting physical, psychological and social handicaps, would have a radical cost-reducing effect. Understanding and empathy for the pain suffered by psychotic or depressed people, with its roots in the way our culture is experienced, would lead to more personal insight and help prevent isolation and alienation.

Modern neuroleptics – an improvement?

In mainstream science, psychotropic drugs, especially neuroleptics, are seen as helpful antipsychotic medication making people responsive to therapy, alleviating psychoses, preventing or healing illness, and improving the quality of life, enabling psychiatric patients to be integrated into society and capable of working. When psychiatrists believe themselves to be unobserved, they use a different vocabulary; they speak of patients being 'emotionally walled in,' wearing 'emotional armour,' of 'Haloperidol corpses,' of the 'zombie syndrome' and the 'syndrome of the broken wing.'

Psychiatrists keep telling us that the never-ending flood of new psychiatric drugs cause fewer and fewer unwanted effects and are ever better tolerated; you can read this in the marketing material of the pharmaceutical companies.

Gerhard Ebner, President of the Swiss Association of Psychiatric Medical Directors (who served on Janssen Pharmaceuticals' Advisory Board regarding the introduction of Risperdal Consta®), spoke a different language in 2003 in a psychiatric journal as he emphasized the main difference between typical and so called atypical neuroleptics: improved compliance – in other words, the willingness of the patients to bow to the psychiatric treatment regime which characterizes the new 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: 30).

Studies and publications show that patients are never properly informed about the risks and so-called side effects of psychiatric treatment. They also show that information and help in coming off psychiatric drugs is withheld (Lahti, 2008). Human rights are systematically abused: people with psychiatric diagnoses are hugely discriminated against within the healthcare systems. Help in solving the problems that led to psychiatrization in the first place is rarely provided and treatment often leads to traumatization, resulting in years of psychiatrization. All of this happens without having the slightest effect on the psychiatrists, who until recently mistreated even adolescent patients, without obtaining any legal consent, with electro- and insulin-shock, and who remain nonetheless highly esteemed members of their fraternity. One such highly esteemed member is the German psychiatrist Henrik Uwe Peters, personal honorary member of the World Psychiatric Association (Lehmann, 2010). The fact that psychotropic drugs – just like other mind altering drugs like hashish or alcohol, for example – can neutralize emotional problems for a period of time only serves to increase the misery in the medium and long term.

Just how important well-founded professional information is for psychiatric patients when weighing the risks and benefits of psychotropic drugs and in deciding for themselves whether or not to take them can be seen in the known main risks of the modern *atypical* neuroleptics. Remoxipride (Roxiam[®]) was announced in 1991 as a 'rose without any thorns,' a well-tolerated drug without any unwanted effects. It was taken off the market three years later by the manufacturer because of a series of life-threatening cases of aplastic anaemia – anaemia characterized by the reduction of red and white blood cells due to a defect in the haemopoietic (blood-building) system, but this 'medication' is still available. Another example of tolerance problems with an *atypical* neuroleptic is sertindole (Serdolect[®]), which for a long time was considered to produce few unwanted effects. In 1998, in medical databases on the Internet, the term 'free of side-effects' could be found for this drug. The following quote is from the beginning of December 1998 from the Swiss medical journal *Ärzte Zeitung*: 'Sale of Serdolect[®] stopped – the reason was severe cardiac side effects and fatalities.' These fatalities have long since been 'buried' – in contrast to Serdolect[®].

New *atypical* neuroleptics are constantly being launched – the latest one is asenapine (Saphris[®]); they are all high-risk. Other risks of note associated with these substances are drug-induced deficit syndrome, obesity, hypercholesterinaemia (enhanced level of cholesterol in the blood), diabetes, irreversible receptor-changes responsible for tardive dyskinesia, apoptosis (increased cell-death) and mortality, especially when prescribed in combination with other drugs. But such *atypical* receptor-changes, which can lead to tardive

psychoses, are to be accepted as a calculated risk. Tardive psychoses are psychological disturbances which can occur during treatment with neuroleptics, when they are being withdrawn or later, and are typical for *atypical* neuroleptics. Ungerstedt and Ljungberg at the Karolinska Institute in Stockholm published results of studies in which rats were administered the conventional neuroleptic haloperidol and as a comparison the *atypical* clozapine (Leponex®). They believe that *atypical* neuroleptics modify subtypes of specific dopamine-receptors, produce their supersensitivity and contribute to the risk of new, increasing, or chronically powerful psychoses of organic origin, which can be understood as a 'counterpart to tardive dyskinesia' (Ungerstedt & Ljungberg, 1977: 199).

Modern psychiatry – a better psychiatry?

The psychiatry of the future appears in an even more sinister shape on the horizon: psychiatrists and pharmacologists are thinking of the development of new forms of administration for psychiatric drugs; for example depots, which can be introduced into the womb or rectum. In rats, it is already possible to implant haloperidol-depots into the back muscles which release the substance for a year. People who have been diagnosed as suffering from compulsive disorders can have a chip implanted into their brain to regulate their moods. The newest development comes from England: The South London and Maudsley Hospital is conducting trials in the tracking of psychiatric patients. The tracker system involves fitting patients with a steel ankle strap linked to a GPS tracking system that can then monitor the location of the person with the help of a satellite. Within the framework of the Swiss Early Psychosis Project or the so-called Schizophrenia Competence Network, children's and teenagers' difficulties in school or family are tracked in order to control them in the long-term with neuroleptics and continuous psycho-education. According to the so-called 'Recommendation of the Committee of Ministers to member States to ensure the protection of the human rights and dignity of people with mental disorder, especially those placed as involuntary patients in a psychiatric establishment,' accepted by the European Council in 2005, the administration of electroshock without the patient's prior consent, involuntary hospitalisation without a judge's order, and involuntary outpatient treatment is considered to be ethically acceptable. The European Union Lisbon Treaty of 2007 lays down the limitation of the human rights of psychiatric patients. Since their life-expectancy is already reduced by as much as three decades – most probably mainly as a result of cardiovascular disturbances, diabetes and suicidality by psychotropic drugs (Aderhold, 2007), it is high time for resistance at an international level, including in academic circles, against the life-threatening discrimination of psychiatric patients.

Who decides?

Since the alternative option of human help is not currently provided, people in emotional distress have to learn to deal with what is on offer. In so far as they

do not want strangers deciding their fate, they are well advised to protect themselves against arbitrary psychiatric decisions or physical injury by putting their wishes down in writing (in psychiatric wills, advance directives or patient wills, for instance) and thus have a direct influence on the quality of the treatment provided, or to start to build up alternatives. To this end, it is helpful to:

- organize
- cooperate with suitable organizations, institutions and people
- research (for example, evaluate psychiatric programs or alternative approaches)
- train themselves and others
- insist on being included in taking responsibility for themselves and always being included in the decision-making processes at all levels in order to ensure the quality of their care and never losing control over their own fate.

Human rights organizations, complaints offices, and ombudsmen and -women can aid helpless psychiatric patients become clients who know how to ask for the help they need as well as to demand their civil and human rights .

Of course, in undertaking the attempt to build up alternatives beyond psychiatry and to establish humane treatment conditions, everyone, including psychologists, interested in the healing and strengthening of the life force as well as in a society based on tolerance and equal rights is addressed. How can a person be helped through psychotherapy if she has been psychiatrically humiliated: the administration of personality changing psychotropic drugs make uncovering and resolving conflict with therapeutic support impossible right from the start. What is the point of considering what the best psychotherapeutic approach might be when neuroleptics impair the remittance of psychotic states due their tendency to cause apathy, and in approximately two-thirds of pharmacological treatments, lead to depressive, even suicidal states? Is it not time for psychologists to start studying the effects of psychotropic drugs and to become more and more noncompliant?

It is time to develop an understanding of the user/survivor discourse in the training of professionals and academics and for users and survivors of psychiatry themselves to be recognized as those with the most in-depth understanding of their values, meanings and relationships and for them to be recognized as the real experts (Bracken, 2007); this is especially true of those who have overcome their problems.

Users and survivors of psychiatry must reflect and approach the situation with care. Being a user or survivor of psychiatry is not in itself a category which makes one a better human being. It is most important to be respectful in one's dealings with each other, even when we have different preferences, and to aim for productive cooperation with all those who are striving against the dumbing-down, repression, exploitation, and standardization of human beings. We must

take care not to create new dependencies. We must never forget that, apart from our health, there is nothing more important than freedom and independence.

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2. My expression of gratitude to all those who have travelled this road with me over the last 30 years can be found on the Internet at www.peter-lehmann-publishing.com/articles/lehmann/pdf/honorary-doctor.pdf and will be published in JPCPCP in the June issue.