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About the Intrinsic Suicidal Effects of Neuroleptics

Towards breaking the taboo and fighting therapeutical recklessness[1]

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Abstract

Suicide is a frequent cause of death in people diagnosed with "schizophrenia." These patients generally receive neuroleptics, which have an intrinsic suicidal effect. There are placebo studies, epidemiological surveys, first-hand reports, test subject experience and clinical research providing evidence about neuroleptic-caused depression and suicidality. Publications about the suicidal effects of neuroleptics—currently taboo—and suicide registers might reduce suicidality in "schizophrenics."

Current suicide registers run by former psychiatric patients, by psychiatrists and by governmental administrations have been shown to have limited effectiveness, and meaningful programs to prevent suicide due to psychiatric treatment are needed. Publications about the suicidal effects of neuroleptics—taboo until today—and effective suicide registers involving users and survivors of psychiatry would gather findings that could be used to warn the public, consumers, and caregivers.

As long as there are so few alternatives beyond neuroleptic-based psychiatry, and as long as major pharmaceutical companies and professionals and organisations, sponsored by them, dominate the scientific and political discussion and suicide prevention programs and conceal the intrinsic suicidal effects in particular of neuroleptics, people have to protect themselves with advance directives and demands for penalties. Independent scientists are called to develop serious and user-orientated research.

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).

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[1] This article is a 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, and of my guest lecture to the Qualitative Research on Mental Health Conference, University of Nottingham, Nottingham, July 3-5, 2012. That lectures again were based on previous publications (Lehmann, 2002a, 2002b, 2002c) and published in various forms (Lehmann, 2010b, 2012a, 2012b, 2012c).
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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Since the 1950s, the standard biological psychiatric treatment for people with diagnoses like "schizophrenia" is a range of neuroleptic drugs, the so-called antipsychotics. These psychotropic drugs, result of the mainstream biological paradigm, intervene in the patients' (natural) metabolic systems and produce a "secondary illness" (Haddenbrock, 1964, p. 63) by administering these neuroleptics to cover the supposed primary illness. Klaus Dörner, a "progressive" German psychiatrist, and the psychologist Ursula Plog explain the modern treatment principle of trying to make "mental diseases" disappear:

> "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 generation of neuroleptics, the so-called atypicals, are widely suspected of causing increased circulatory problems, abnormal blood cell counts, obesity, diabetes and receptor changes that can, in time, also lead to chronic illnesses, including psychoses: so the problem is not cured, it is compounded. As early as 2003, Gerhard Ebner, President of the Swiss Association of Psychiatric Medical Directors (who served on Janssen Pharmaceuticals' Advisory Board on the introduction of Risperdal Consta, the first "atypical" depot neuroleptic), admitted that there were risks and injuries caused by "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 documented by an action project: "Harassment and Discrimination Faced by People with Psycho-Social Disability in Health Services—A European Survey,"[2] with support from the European Union. A transnational study was designed and conducted by associations of (ex-) users and survivors of psychiatry, psychosocial professionals and family organisations from the U.K., Austria, Germany, Spain and the Netherlands in conjunction with a Belgian research institute, Mental Health Europe and the European Network of (ex-) Users and Survivors of Psychiatry (ENUSP). There is no reason to believe that psychiatric patients outside of Europe are treated any better.

One of many proposed measures to combat discrimination was the recommendation that laws espousing equality of treatment should be adopted and funds provided to implement laws. These laws should guarantee respect for human rights in a proactive 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 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-expectancy, lethal outcomes of medical treatments and risk factors. Paul Barreira, M.D., deputy commissioner of 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).

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[2] For further information see www.peter-lehmann-publishing.com/articles/enusp/overview.htm. Retrieved June 19, 2012.

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 toxic effects (Lehmann, 1996a; 1996b). So it is no incidence, that the life-expectancy of these psychiatric patients is reduced by—on average—two to three decades (Weinmann et al., 2009).

New psychiatric data show a consensus on the lifetime risk of suicide in people diagnosed as "schizophrenics," a rate of approximately 5%, which is ten times higher than in the general population (Hor & Taylor, 2010; Nordentoft et al., 2004; Heilä et al., 2005; Qin & Nordentoft, 2005). In her book *Risikofaktoren für Suizid* (Risk factors for suicide) Barbara Schneider of the Psychiatric Clinic of the J.W. Goethe-University Frankfurt/Main calls suicide the most frequent cause of premature death in "schizophrenics" (2003).

But while mainstream "neuromythological psychiatry"[3] has a biochemical explanation for all human emotions, when it comes to the explanation of suicides of "schizophrenics," psychiatry explains this only by emotional and socio-economical factors. In a review of the literature about mortality and causes of death in "schizophrenics," Karim Tabbane and colleagues from the Service Hospitalo-Universitaire de Santé Mentale et de Thérapeutique, Centre Hospitalier Sainte Anne, Paris, refer to many possible causes of suicide, but do not mention any pharmacological factors:

> "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 et al., 1993).

Kahyee Hor and Mark Taylor of the National Health Service for Scotland (2010) undertook a systematic review of all original studies concerning suicide in people diagnosed as "schizophrenics" published since 2004. To the causes reported by Tabbane and colleagues, they add that comorbid substance misuse is associated with later suicide. But, of course, by "substance misuse" they do not mean neuroleptics prescribed by a doctor:

> "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 all these studies hold that the delivery of the "best available treatment for psychotic symptoms" is the only consistent protective factor for suicide: By this, they mean treatment with "atypical" neuroleptics—the most expensive ones with maximal profit for the major pharmaceutical companies. One step further go Jari Tiihonen of the Department of Forensic Psychiatry at the University of Kuopio, Kristian Wahlbeck of the Social Insurance Institution of Finland, Jari Haukka of the Department of Mental Health and Alcohol Research at the National Public Health Institute in Helsinki, and colleagues in the evaluation of the life-expectance of psychiatric patients within the National Hospital Discharge Register, which

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[3] 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" (Rufer, 2007, p. 383).

allows authorities in Finland to track the life of all psychiatric patients. In a study paid by the Finish Ministry of Health and Welfare they write, that the poor life-expectance of psychiatric patients (22.5 to 25 years less than 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:

> "In patients with one or more filled prescription for an antipsychotic drug, an inverse relation between mortality and duration of cumulative use was noted…" (Tiihonen et al., 2009, p. 1).

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, so the words of Haukka and colleagues:

> "Our results suggest that usage of antipsychotic medication has a beneficial effect on all-cause mortality, and also to some degree on suicide mortality" (Haukka et al., 2008, pp. 691-692).

While the database of the U.S. Food and Drug Administration, evaluated by Khan and colleagues, showed no difference in the suicide risk of people taking placebos or modern neuroleptics (Khan et al., 2001), Tiihonen and colleagues' register linkage study of "first episode" patients found that the suicide risk of those not currently taking neuroleptics was 37 times higher than in compliant patients (Tiihonen et al., 2006).[4] When you know, that Jari Tiihonen from Finland, a high-income country where the cost of antipsychotic drugs is fully reimbursed, has major connections to major pharmaceutical companies (AstraZeneca, Bristol-Myers Squibb, GlaxoSmithKline, Hoffman-La Roche, Janssen-Cilag, Lilly, Lundbeck, Organon, and Pfizer) and is paid to deliver "expert opinions" and lectures, and Jari Haukka has also major connections to major pharmaceutical companies (Astellas, AstraZeneca, Bristol-Myers Squibb, Janssen-Cilag, and Lilly) and is also paid to deliver "expert opinions" and lectures (Tiihonen et al., 2009, p. 626; 2011, p. 608), you might be less surprised about his data, especially their messages of lowered mortality and even lowered suicide rates through cumulative administration of neuroleptics.

Writing 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 present evidence that counters Tiihonen and colleagues' argument that neuroleptics enhance life-expectance and discuss many drug-related causes of death (cardio- and cerebrovascular, digestive, endocrine, respiratory, infectious, genitourinary, neoplastic and nervous diseases including tardive dyskinesia and malign neuroleptic syndrome), but exclude suicide—because of methodological reasons. "Nebenwirkung Suizid" *(Side-effect Suicide)* entitles the critical pharmacist Gerd Glaeske (2011)—famous in Germany for a critical approach to major pharmaceutical companies—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 major pharmaceutical companies' 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.

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[4] Taking Tiihonen and colleagues' data seriously, you could argue that the authors ignore the fact, that, in general, people who refuse psychiatric drugs are punished by denial of all forms of psychotherapeutic and social support. In the cited study, this denial, which might enhance the suicide risk, is totally ignored, as are all kinds of social-economical factors, although the authors admit the latter deficit in their study. Conversely, Khan and colleagues' study could be interpreted as proof that the effects of psychotherapeutic and social support that people receive together with placebos, prevent suicide.

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). Very rarely is suicidality caused by a malfunction of the brain.

There are many well-known factors that can trigger depression and suicidal behavior: political, social and economic, emotional and physical factors (Lehmann, 2010c). 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 for suicide can mostly be understood or at least accepted. For example, Salvator Allende, President in Chile, decided to shoot himself death on September 11, 1973, to prevent humiliation by Pinochet's inhumane 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, Goebbels 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 ("Angst," 1988), or desperation about the stigmatization and discrimination that goes along with diagnoses like "schizophrenia" (Rufer, 1988). Desperation about an incurable psychiatric diagnosis can trigger suicide, especially combined with discrimination, self-stigmatization and social decline (Hentschel et al., 1987), or traumatization by inhumane treatment (i.e., combined insulin- and electroshock, plus administration of all kind of psychiatric drugs; see Kempker, 2000; and Lehmann, 2010b).

There can be medical diseases and disorders: Neurological diseases like cerebrovascular diseases, tumors, Parkinson's disease; infection diseases like AIDS, Lyme borreliosis or hepatitis; endocrinological diseases like morbus Cushing; metabolic disorders like dehydration; cancer; alcohol dependence; or genetic abnormalities in the serotonin system—have all been found to trigger depression (see, f.e., Härter et al., 2007). Also environmental poisons like pesticides used by farmers are well-known to cause depression and suicidality (Bienkowski, 2014).

> "Suicidality can evidently also have chemical-biological causes in the brain" (cited in Schmalenberg, 2010, p. 21),

the German pharmacologists Bruno Müller-Oerlinghausen says about the possibility of brain malfunction, which can trigger suicidality.

Pharmacological Reasons for Depression and Suicidality

Depression leading to suicidality can be caused by all kind of drugs. It can be triggered by prescribed medical drugs like tuberculostatics (f.e., cyloserine), glucocorticoids (f.e., cortison), antihypertensiv drugs (f.e., α-methyldopa or Beta blocker), chemotherapeutics (f.e., decarbazine, prednisolon, procarbazine and the interferones), oral contraceptive pills, drugs to treat addiction (f.e., varenicline prescribed to treat smoking addiction—trade name Chantix in the USA and Champix in Europe).

Depression leading to suicidality can be caused by **illegal psychotropic drugs** like mephedrone (trade names “Bliss,” “White Lightning” or “Cloud 9”) (Rehfeld, 2011) or the amphetamine-like stimulant methylphenidate, which is on the Anti-Doping-Codex of the Olympic Society. Depression leading to suicidality can also be caused by **prescribed psychotropic drugs** like amphetamines, which are administered under the indication “attention deficit hyperactivity disorder.” Dexamfetamine (marketed as Dexedrine, DextroStat, etc.; component of Adderall) and methylphenidate (marketed as Attenta, Biphentin, Concerta, Daytrana, Equasym, Medikinet, Metadate, Methylin, Ritalin, Rubifen, etc.) can trigger severe depression and suicidal ideation (BNF, 2012).

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 et al., 1987). In 2012, the *British National Formulary* the chapter on contra-indications at benzodiazepines alprazolam, clonazepam (administered as antiepileptic drug), diazepam, chlordiazepoxide, lorazepam, meprobamate and oxazepam warn, that these psychotropics “... should not be used alone in depression or in anxiety with depression....” Also hypnotics which do not belong to the group of benzodiazepines can trigger depression, for example, bupropion, which is used to suppress bei nicotine dependence and can also trigger suicidal ideation, or zaleplon. In zolpidem and zopiclone, the *British National Formulary* demands caution referring to the side-effect depression (BNF, 2012). Further on 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 labeling, a warning that their use increases the risk of suicidal thoughts and behaviors (suicidality). This includes all antiepileptic drugs, including those used for psychiatric reasons. 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). In 2012, the *British National Formulary* mentions depression and/or suicidal ideation as side-effects in the clonazepam, which is used to prevent epileptic seizures, and in lamotrigine, oxcarbazepine and pregabiline, which are administered also as mood-stabilizers.

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).

And in 2012, the *British National Formulary* the chapter on antidepressants includes this warning:

> “*Suicidal behaviour and antidepressant therapy*. The use of antidepressants has been linked with suicidal thoughts and behaviour; children, young adults and patients with a history of suicidal behaviour are

particularly at risk. Where necessary patients should be monitored for suicidal behaviour, self-harm, or hostility, particularly at the beginning of treatment of if the dose is changed" (BNF, 2012, p. 243)

Psychiatric publications show not only, that there is no difference between the effect of placebos and antidepressants (Khan et al., 2000), but there is an enhanced risk of self-harm (Gunnell et al., 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 et al., 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 ten 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)
Asendin (amoxapine)
Aventyl (nortriptyline)
Celexa (citalopram hydrobromide)
Cymbalta (duloxetine)
Desyrel (trazodone HCl)
Elavil (amitriptyline)
Effexor (venlafaxine HCl)
Emsam (selegiline)
Etrafon (perphenazine/amitriptyline)
fluvoxamine maleate
Lexapro (escitalopram oxalate)
Limbitrol (chlordiazepoxide/amitriptyline)
Ludiomil (maprotiline)
Marplan (isocarboxazid)
Nardil (phenelzine sulfate)
nefazodone HCl
Norpramin (desipramine HCl)
Pamelor (nortriptyline)
Parnate (tranylcypromine sulfate)
Paxil (paroxetine HCl)
Pexeva (paroxetine mesylate)
Prozac (fluoxetine HCl)
Remeron (mirtazapine)
Sarafem (fluoxetine HCl)
Seroquel (quetiapine)
Sinequan (doxepin)
Surmontil (trimipramine)
Symbyax (olanzapine/fluoxetine)
Tofranil (imipramine)
Tofranil-PM (imipramine pamoate)
Triavil (perphenazine/amitriptyline)
Vivactil (protriptyline)
Wellbutrin (bupropion HCl)
Zoloft (sertraline 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.[5]

Meanwhile the *British National Formulary* asks for caution towards the side-effect depression, when mirtazapine is administered to patients with a "history of bipolar depression," and it mentions suicidal ideation as a side-effect in mirtazapine and suicidal behaviour in agomelatine, duloxetine, reboxetine, tryptophan, and venlafaxine as well as the two monoamine-oxidase inhibitors phenelzine and tranylcypromine (BNF, 2012). Antidepressants, which are used for other purposes, can also trigger suicidality. The *British National Formulary* warns at atomoxetine, a selective inhibitor of norepinephrine uptake which is administered under the indication "attention deficit hyperactivity disorder":

[5] See http://ssristories.com. Retrieved June 26, 2010.

> "*Suicidal ideation.* Following reports of suicidal thoughts and behaviour, patients and their carers should be informed about the risk and told to report clinical worsening, suicidal thoughts or behaviour, irritability, agitation, or depression" (BNF, 2012, p. 256).

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 of the Dalhousie University in Halifax, Canada, in a booklet of the Lundbeck Institute. The pharmaceutical firm Lundbeck produces the SSRI escitalopram (Cipralex) and citalopram (Cipramil), the antiepileptic valproate (Convulex), the neuroleptic fluphenazine (Lyogen—also marketed as Dapotum, Modecate, Moditen, Prolixin), the tricyclic antidepressant nortriptyline (Nortrilen) and many other drugs.

Depression, Suicidality and Neuroleptics

As previously stated, when psychiatrists give the diagnosis "schizophrenia" or similar ones like "psychosis," the standard treatment is the administration of neuroleptics. According to psychiatrist Peter Müller (1989) of the Psychiatric Department of the University of Göttingen, Germany, suicide in people diagnosed as schizophrenics is about 50 times more frequent than in the general population. Discussing studies on suicides in patients with the diagnosis "schizophrenia" and comparing suicide rates in different time periods, some psychiatrists 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 obvious: Neuroleptics have a blockading effect, primarily against the transmitter dopamine, resulting in more or less subtle Parkinsonian-type syndromes. Parkinson's disease seems to have a very close connection with dopamine blockage (Gerlach et al., 2003).[6] The potency of neuroleptics was defined by their power to create Parkinson's symptoms. 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]). Akathisia and akinesia are forms of Parkinson's disease, which in turn can produce torturing sleeplessness and inadmissible sexual and cognitive disorders and promote suicide (Neuner et al., 2008; Wolfersdorf & AG "Suizidalität und Psychiatrisches Krankenhaus," 2010; Wolfersdorf & Etzersberger, 2011, pp. 150, 173). Parkinson's disease, primarily a movement-disorder, involves mental and emotional alterations, too. Neurologists define them as "Parkinson psyche." The symptomatology can be seen in about five levels, progressing from: (1) aggrieved mood; (2) emotional flatness, instability, and depressed mood; (3) unrest and lowered mental dynamics; (4) whining, further declining of affect, vitality, will and interests; and (5) the demential fading of intellectual abilities (Fünfgeld, 1967, pp. 3-25).

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[6] In Parkinson's disease, the dopamine-transmitting neurons in that area of the mid-brain called the substantia negra die off. As a result, the brains of people with Parkinson's disease contain almost no dopamine. Dopamine-agonist drugs, like L-DOPA, a drug that can be converted to simulate dopamine (in that it binds to dopamine receptors in place of dopamine) are thus often used for Parkinson's disease to relieve the symptoms. Adapted from University of Texas website: www.utexas.edu/research/asrec/dopamine.html. Retrieved December 4, 2011.

In 1955, after the first administrations of chlorpromazine (trade names: Largactil, Megaphen, etc.), 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 is a normal effect of neuroleptics, and thus psychiatrists accept it 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).

English psychiatrists Richard de Alarcon and M. W. P. Carney 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, administered as part of a community treatment program, and described a fluphenazine trial with 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 of hypochondriacal ideas or any feelings of guilt. He simply said that he felt very low and if he were alone in digs he would take his life. By Friday evening there was some improvement, and when he was interviewed again on Saturday he had returned to his usual normal self" (1969, pp. 565-566).

In a placebo-controlled study, Müller 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 pharmacogenic influences and against psychiatric morbidity developments" (pp. 52-53, 64).

Müller continued:

> "Depressive syndromes after the remission of the psychoses and under treatment with psychiatric drugs are not rare, but occur in 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). Raymond Battegay and Annemarie Gehring (1968) of the Psychiatric Department of the University of Basel, Switzerland, warned after a comparison of treatment courses before and after the era of psychiatric drugs:

> "During the last years, a shifting of the schizophrenic syndromes to a depressive syndrome was repeatedly described. More and more schizophrenias show a depressive-apathetic course. It became clear that often exactly what 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 notunusual 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 treatment with psychiatric drugs increased at least ten times (Haase, 1976). The increase in 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, alerting psychiatric patients, their relatives and carers, or even the public. Rolf Hessö of the Psychiatric Department of the University of Oslo, Norway, wrote about the development in Finland, Sweden and his country; 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" (1977, p. 122).

In 1982, Jiri Modestin, reported his finding at the Psychiatric Department of the University of Berne, Switzerland, and the neighboring 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).

Compared to warnings about suicide risks of different medical and psychiatric drugs, the amount of warning about suicide risks of neuroleptics until today is screamingly silent. "Antipsychiatric drugs should be used in caution in (…) depression" (BNF, 2012, p. 225), demands the *British National Formulary*. "Patients with schizophrenia should have physical health monitoring," is a demand on the same page; but not the psychic status of the patients under neuroleptics. Depression as "side-effects" are mentioned only in depot-risperidone (Risperdal Consta), in tetrabenazine (used to suppress Parkinsonian movement disorders), and—together with suicidal ideation—in aripriprazole (BNF 2012).

Firsthand Reports about Neuroleptic-caused Suicidality

In *Coming off Psychiatric Drugs* (Lehmann, 1998, 2004),[7] the first book ever published about the possibilities and experiences of coming off psychiatric drugs, 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 in Bremen was given a prescription of Haldol and the antidepressant Aponal (active ingredient doxepin). Under the influence of this combination, she tried to end her suffering, for which held 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 "atypical" neuroleptics, seems to have suicidal effects, as reported by the Austrian Ursula Fröhlich:

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[7] Lehmann, P. (Ed.), *Coming off Psychiatric Drugs: Successful Withdrawal from Neuroleptics, Antidepressants, Lithium, Carbamazepine and Tranquilizers [Psychopharmaka absetzen – Erfolgreiches Absetzen von Neuroleptika, Antidepressiva, Phasenprophylaktika, Ritalin und Tranquilizern]* (published in German in 1998, in English in 2004, in Greek in 2008): Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing.

> "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 who have ingested these drugs have had similar experiences. 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 conducted three self-experiments and nine with psychiatrists and pharmacologists. The marked feelings of inferiority and powerlessness (typical elements of Parkinsonian symptoms), after taking the neuroleptic became very clear. One test person reported:

> "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).

Heimann and Witt's 1955 publication demonstrates the extreme depressive effect of neuroleptics. While they are aware of the theoretic possibility of living an active life, the experienced apathy caused by neuroleptics makes them feel as if they no longer have that possibility (and will never again have that possibility), and they may react with depressive desperation. Placebo studies, epidemiological surveys, first-hand reports, the experiences of test subjects and even clinical research show coinciding results.

Otto Benkert and Hanns Hippius, two German psychiatrists, demonstrated that the problem, in general, is independent from the dose:

> "But also small doses can trigger depressive moods, especially in elder patients. The danger of suicide in a pharmacogene depression is just as big as in a depression of another genesis and though has to be taken absolutely seriously. (…) Depression, suicidality, states of excitement and delirium under the influence of drugs generally occur during doses prescribed by the treating physician" (1980, pp. 257-258).

Newer studies show that there has been a trend over the years that people diagnosed with schizophrenia who kill themselves shortly after discharge from psychiatric inpatient treatment are doing so at increasingly younger ages (Wolfersdorf, 1996). In general, this immediate post-discharge period involves the intensive administration of neuroleptics, such as in the context of the Assertive Community Treatment model.

Suicide Registers and Psychiatric Drugs

For different reasons, as we will see, suicide registers have shown limited effectiveness, whether they are run by former psychiatric patients, by psychiatrists and by governmental administrations.

By Survivors of Psychiatry

In 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, gassed or poisoned themselves, jumped to death, or thrown themselves in front of subway trains (Klust, 1983; "Psychopharmaka," 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 establishment and funding of a suicide register bore no results, and the initiative eventually came to an end due to the immense expenditure of human labor 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, founded in 1979 by Manfred Wolfersdorf of the Psychiatric Hospital in Bayreuth, Bavaria, and colleagues and supported by the National Health Administration. Since the 1990s, after an experimental phase, psychiatric hospitals in this region have gathered data on complications that may have resulted from treatment, including the registration of drug-triggered suicide attempts and suicides by drugs, in order to make public information on risks and develop programs for prevention and early detection (Haen et al., 1999, p. 93). Findings are discussed within the psychiatric community "without prejudice and free of any know-it-all habits" (ibid., p. 94). If a psychiatrist identifies a drug as potentially suicide-triggering, they report to the National Institute for the Safety of Drugs, the Drug Commission of the German Medical Association and the Drug Producers. This article did not include information on how many reports were sent after the reported 89 registered suicide attempts and suicides prior to January 1998.

In a 2002 review, Bavarian psychiatrists reflected on their results from 1991 through 1999 and the methodological problems that arose from registering suicides and identifying the one exclusive cause that triggers suicidality. They mention, for example, problems with the definition of suicidality, if no overt suicidal act is committed, and plead for the further development of questionnaires and registration cards (Franke et al., 2002).

Repeated offers by the author, as a board member of ENUSP, in 2010 to discuss the possibility of including users and survivors of psychiatry in the Bavarian suicide register and to help make the registration criteria sharper and more effective, met with no response or result—like the Bavarian suicide register itself.

By Governmental Administrations

A suicide register in Sweden was described by Janne Larsson in October 2009. Referring to regulations in The Act on Professional Activity in Health and Medical Services (called Lex Maria), since February 2006, all suicides committed in health care and within four weeks after the last health

care visit must be reported for investigation to the National Board of Health and Welfare. Larsson's data about various neuroleptics (fig. 1), antidepressants (fig. 2) and tranquilizers (fig. 3) administered within four weeks of the suicide shows that:

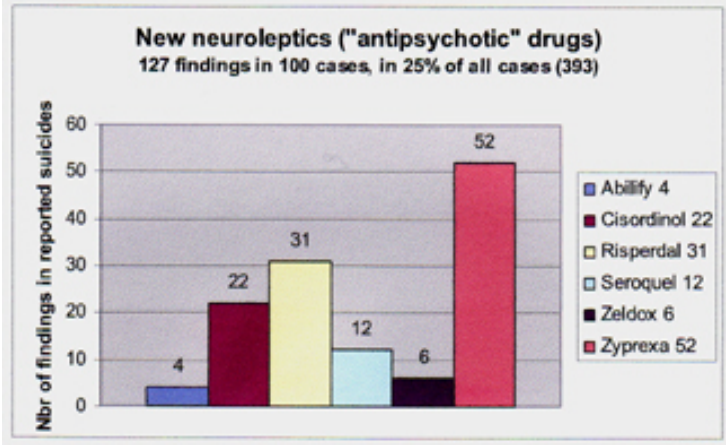

Fig. 1: "Atypical" Neuroleptics administered to people who committed suicide in Sweden in 2007 four weeks before they committed suicide

"… 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 of 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 was also 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).

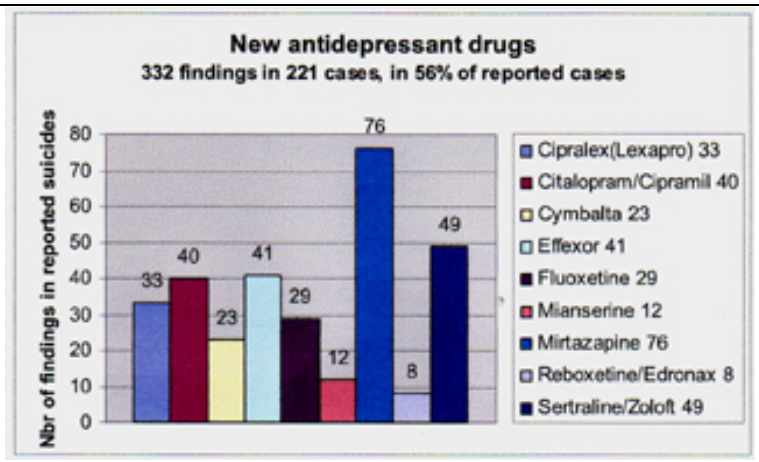

Fig. 2: Antidepressants administered to people who committed suicide in Sweden in 2007 four weeks before they committed suicide

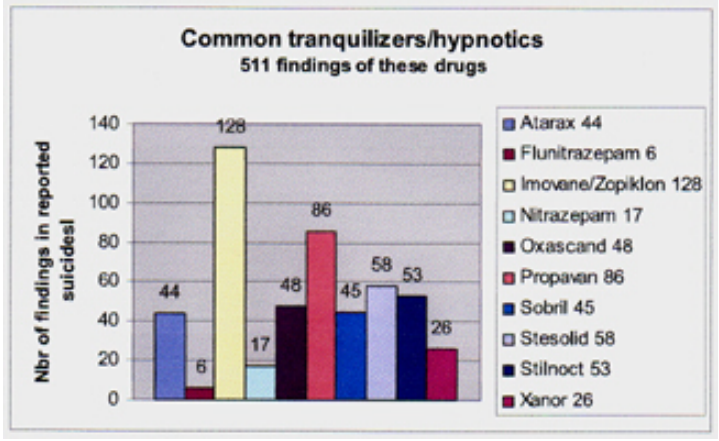

Fig. 3: Tranquilizers/hypnotics administered to people who committed suicide in Sweden in 2007 four weeks before they committed suicide

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

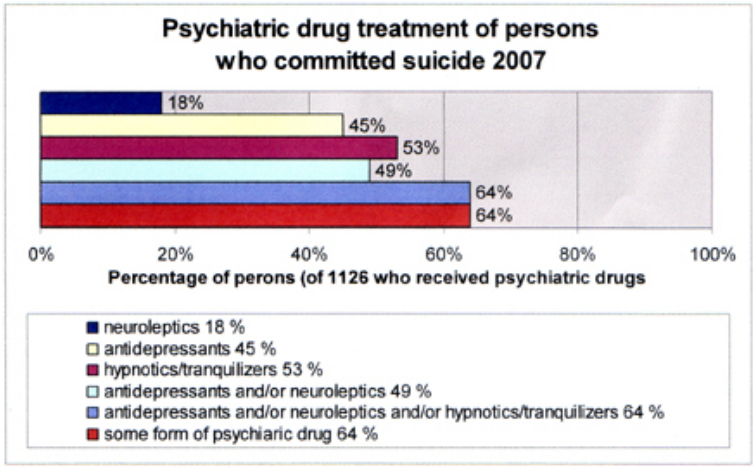

Fig. 4: Percentage of psychiatric drug classes administered to people who committed suicide in Sweden in 2007

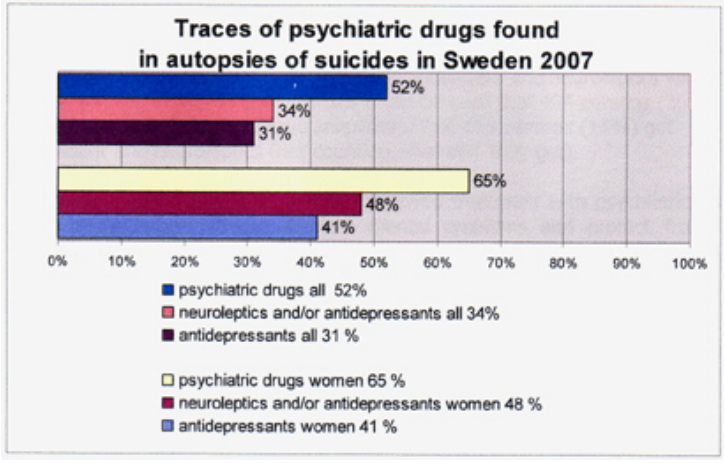

Fig. 5: Percentages of traces of psychiatric drugs found in autopsies at men and women who committed suicide in Sweden in 2007

> "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 (ibid, p. 2)

Larsson summarizes the results of the 2007 report:

> "In 86% of the cases of suicide reported to the National Board of Health and Welfare for 2007—that is in 338 of 393 cases—the persons were treated with psychiatric drugs. In 0% (!) of these cases was the suicide reported as a drug adverse event to the registry for drug adverse events at the Medical Products Agency (...).
>
> This report clearly shows one thing: A large majority of persons committed suicide after having had 'adequate drug treatment'—in the meaning used in psychiatry; the very treatment that should *prevent* suicide. (…)
>
> 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. 2, 23, 25).

More Risk Factors: Pharmaceutical Networks and Electroshock

> "Studies show, many people visit a doctor in the weeks before the suicide, but obviously the suicide hazard is not recognized" (Deutsche Gesellschaft für Suizidprävention, 2009, p. 3).

This you can read in the preface of the *National Suicide Prevention Program for Germany*, led by the psychiatrist Armin Schmidtke of the Department for Clinical Psychology at the University Würzburg, Chairman of the WHO European Networks on Suicide Research and Prevention and Foreign Adjuncent Professor of the National Centre for Suicide Research and Prevention of Mental III-Health at the Karolinska Institute in Stockholm. Schmidtke's residence is also the WHO Centre of Excellency in Suicidology and the WHO National Focus Point for Suicide Research and Prevention in Germany; his prevention program group is financially supported by AstraZeneca, Böhringer Ingelheim, GlaxoSmithKline, Janssen-Cilag, Krewel Meuselbach, Lichtenstein, Lilly, Lundbeck, Novartis, Organon, Otsuka-BMS, Pfizer, Pharmacia & Upjohn, Rhône-Poulenc Rorer, Sanofi-Synthelabo, Schwabe, Wyeth, etc. (see, f.e., Deutsche Gesellschaft für Suizidprävention & Klinik für Psychiatrie

und Psychotherapie des BKH Bayreuth, 1999; Deutsche Gesellschaft für Suizidprävention, 2004; 2009). The psychiatric drugs, which people in danger to kill themselves receive from their doctors, are not mentioned by Schmidtke and his National Suicide Prevention Program.

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

There are also other and even more effective possibilities to conceal the intrinsic suicidal effects in particular of neuroleptics in the public. International and national suicide prevention programs and conferences are regularly sponsored by major pharmaceutical companies. They publish books by psychiatrists themselves (see, f.e., Wolfersdorf et al., 1999) or they provide panels with speakers which are paid by them. Major pharmaceutical companies pull the strings at conferences where decisions about the policies of suicide-prevention programs are decided.

One example of total manipulation of the contextual discussion in conferences and politics is the Thematic Conference within the Series organized under the European Pact for Mental Health and Well-being entitled "Prevention of Depression and Suicide – Making it Happen," organized jointly by the Ministry of Health of the Republic of Hungary and the European Commissions' Directorate of Health and Consumers with the support of the Swedish European Union Presidency and in collaboration with the WHO Regional Office for Europe on December 10-11, 2009 in Budapest.[8] There, the Lundbeck International Neuroscience Foundation[9], registered in Denmark as an international non-profit foundation (formally independent from Lundbeck Pharma A/S, Denmark), was involved in the conference preparation and organized the "Depression Expert Platform: A neutral multi-stakeholder coalition of healthcare professionals (psychiatrists, psychologists, GPs) and organisations (patients, carers, health economists and the workplace)," where questions were discussed like "How to improve prevention and early diagnosis of depression" or "How to support research into new management options of depression" (Joubert, 2009).

Looking at the composition of the "Expert Platform on Depression," with its project adviser Iman Barilero, Divisional Director of the pharmaceutical company H. Lundbeck A/S, you find the same people who are always present at all those conferences, speaking as "neutral" stakeholders of science, patients' and family organisations, but who all receive financial support from the pharmaceutical industry. For example:

- GAMIAN-Europe (Global Alliance of Mental Illness Advocacy Networks), presenting itself as an independent patient-driven organization (Lehmann, 2009, pp. 2-3), obviously created by

[8] For more information see http://ec.europa.eu/health/mental_health/docs/ev_20091210_ag_en.pdf. Retrieved June 24, 2012.

[9] For more information see www.cnsforum.com/lundbeckinstitute/faculty/. Retrieved June 24, 2012.

Bristol-Myers Squibb[10] and almost solely financed by major pharmaceutical companies like AstraZeneca, GlaxoSmithKline, Johnson & Johnson, Lilly, Lundbeck, Organon, Pfizer, etc. (GAMIAN-Europe, undated)

- EUFAMI (European Federation of Associations of Families of People with Mental Illness, sponsored by AstraZeneca, Bristol-Myers, Janssen Pharmaceutica, Lilly, Lundbeck, Novartis, Pfizer, Roche, etc. (EUFAMI, 2011, p. 19)
- Norman Sartorius, member of the Lundbeck International Neuroscience Foundation Faculty, a former director of the WHO's Division of Mental Health and a former president of the World Psychiatric Association, having significant financial or other affiliation with Janssen-Cilag, Lilly, Lundbeck, Pfizer, Wyeth, etc. (APA 2007, p. XXXIII).
- Wolfgang Gaebel, a former president of the German Psychiatric Association, member of the Lundbeck International Neuroscience Foundation Faculty and having significant financial or other affiliation with AstraZeneca, Bristol-Myers Squibb, GlaxoSmithKline, Janssen Cilag, Lilly, Lundbeck, Novartis, Sanofi-Aventis, Wyeth, etc. (APA 2007, p. XXIV; Gaebel, 2011).

The general presentation for the Thematic Conference, for example, was written by Wahlbeck, who had stated—together with Tiihonen, Haukka and others—an increase of the life expectance especially by neuroleptics in cumulative drug administration (see above), and the "Template of action for the prevention of suicide" in the paper on conclusions by Schmidtke (2009). You will find a huge variety of proposals to collect suicide attempt data, enhance research and strengthen prevention programs; not surprisingly, the danger of psychiatric drugs with their ability to trigger depression and suicide are no topic ("Policy Brief," 2009; "Thematic Conference," 2009; Wahlbeck, 2009). The "experts" and organisations which are affiliated with the major pharmaceutical companies have the total sovereign interpretive powers and tell

- depression and suicide must be seen in a social and cultural context—which is fine in principle, but not so when important psychopharmacogenic reasons stay ignored;
- vulnerable and high-risk groups should be especially targeted—which is fine in principle (if "targeted" means "supported"), but not so when people receive neuroleptics instead of support;
- effective treatment of depression and prevention of suicide should be provided—which is fine in principle, but not so when suicide-triggering drugs and electroshock are defined as "effective treatment";
- there should be a relying on the positive impact of retained social networks and service user influence—which is fine in principle, but not so when major pharmaceutical companies send their branches as "service user" organisations;

[10] In an article about open and hidden Pharma lobbying, the independent German journalist Erika Feyerabend states: "Particularly the large self-help and patients' organizations prove as an ideal transmission conduit for the interests of pharmaceutical companies. Thus, the International Alliance of Patients' Organizations (IAPO) and the European division of the Global Alliance of Mental Illness Advocacy Networks (GAMIAN) agitate to abolish the ban on advertising prescription-only drugs. IAPO was created by a consortium of prominent pharmaceutical companies. GAMIAN is a creation of the pharmaceutical company Bristol-Myers-Squibb" (2004, p. 22).

- there is a need to enhance routine data collection of depression, suicide and their risk—which is fine in principle, but not so when the researchers, who design, evaluate, and interpret the data collection, are financially affiliated with major pharmaceutical companies.

So, when you broach out the issue of the intrinsic suicidal effects of neuroleptics, in discussions you will hear further on that

- there are so many possible reasons for people to kill themselves,
- the increased suicidal rates starting in the year of the introduction of neuroleptics is simply a result of the opening of the old-fashioned madhouses,
- the best available treatment for depressive, suicidal and psychotic symptoms was not offered optimally
- people kill themselves because they did not take their psychiatric drugs.

But beside banalities, naive evasions, ignorance and instrumentalization of the emotional suffering as advertising strategy for psychiatric drugs, there are still bigger dangers for people who dare to complain about depressive and suicidal drug effect. **Electroconvulsive "therapy"** (also known as electroshock therapy or ECT) is recommended more and more to treat psychiatric problems for people who suffer from severe psychiatric drug effects, who present with depression and psychopharmacological treatment resistance and are diagnosed as "non-responders" (Klinik und Poliklinik für Psychiatrie und Psychotherapie der Universität Leipzig, 2012). In 2012, early and subsequent ("maintenance") electroshock are promoted again, for example, in Austria, Germany, Italy and Switzerland (DGPPN, 2012; Falkai & Gruber, 2012)—as recommended by the Antidepressant Task-Force of the Collegium Internationale Neuro-Psychopharmacologicum, led by Norman Sartorius:

> "The risks of suicide that mark severe psychiatric illnesses are quickly relieved by ECT, although attention to continuation treatment is essential to sustain the benefit (...) and medication toxicity may require ECT as a first-line treatment (...). In the case of severe and life-threatening adverse events of antidepressants, in psychotic depressed patients and also in the case of severe adverse events due to antipsychotics, ECT monotherapy can be a safe first-line treatment. (...) ECT, too, can be an efficacious prophylactic tool (...). In general, ECT is one of the best-tolerated antidepressant therapies, with low risk for severe complications, even lower than TCA *(tricyclic antidepressants)*. (...) Psychosurgical interventions, such as stereotactically applied bilateral orbitomedial lesions for resistant severe depression, possibly show similar therapeutic effects" (Baghai et al., 2007, pp. 104-106).

"Progressive" psychiatrists like David Healy of the North Wales Department of Psychological Medicine in Bangor, member of the mentioned Antidepressant Task-Force of the Collegium Internationale Neuro-Psychopharmacologicum (Baghai et al., 2007, p. 199) and with significant financial or other affiliation with AstraZeneca and Teva (APA 2007, p. XXVI), publish about the suicidal effects of antidepressants (Healy, 2001) and use criticisms of antidepressants to justify electroshock administration as an alternative (Shorter & Healy, 2007). But depression and suicidality are well-known effects of electroshock, a procedure involving the passage of electricity through the brain in order to produce an epileptic seizure—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 electroshock, 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 that traumatizing and suicide-triggering effects of electro- and insulin shock are experienced by the people themselves and how the psychiatric workers are unaware of the procedure's effects, is exemplarily detailed in the book *Mitgift – Notizen vom Verschwinden* (Dowry of Poison: Notes from disappearing) by Kerstin Kempker (2000; see also Lehmann, 2010b).

Consequences and Next Steps

Updated product labeling for neuroleptic drugs should include a warning about the increased risk of suicidal thoughts or actions, in order to help patients, supporters and psychosocial staff understand these risks. This must be done even if there is only a fairly low incidence of this risk. Users of psychiatric drugs need to be informed so that they can make carefully considered decisions about whether to take a recommended psychiatric drug. Practices in psychiatric wards could be significantly improved to ensure that patients (and their carers and relatives) have much better information about the prescribed drugs—and their subjectively unwanted effects—and actively consent or deny to taking these. If they so decide, they can then opt for viable alternatives, either outside of pharmacological psychiatry or by using less risky psychopharmacological treatments for their emotional problems.

Reports of (ex-) users and survivors of psychiatry who have experienced suicide attempts or suicidality after treatments with psychiatric drugs, electro- and insulin coma shock that have traumatizing effects in many people must no longer be ignored. They must be more often included as keynote speakers, experts and teachers in education programs, conferences and in the public media.

As an urgent measure, individually, we must use and improve advance directives to protect ourselves from unwanted treatment (Ziegler, 2007), in which we clearly should mention factors like previous depressive states caused by psychiatric drugs, if we have had such experiences. And, collectively, we could even demand the application of criminal law, not only to penalize professional non-assistance to a person in danger (a breach of standard of care), 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, P. L.) a state of mind in which a person does not care about the consequences of his or her actions" (Garner, 2005, p. 1053).

In US, German, Swiss and other courts, a wrongdoer who recklessly causes harm can be held as liable as a person who intentionally does so.[11] If psychiatrists continue to administer psychiatric drugs with suicidal effects to people who are known to have underlying risk factors, they should know that laws espousing equality also demand equality in legal responsibility for damages under criminal law. This could be true for the owners and management of pharmaceutical companies that produce drugs with known suicidal effects. Laws should be applied equally to all. Psychiatrists who are indicated because of reckless administration of neuroleptics to patients who then hung themselves, should not come get

[11] You can find out more information about this principle of law on the internet: http://en.wikipedia.org/wiki/Recklessness_(law). Retrieved June 26, 2010.

away further on with the Public Prosecutor's reasons that they "administered drugs which are—successfully—also used in the division of the hospitals" (cited in Lehmann, 2010a, p. X).

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 funds recommended by the European Action Project against Harassment and Discrimination were provided by the authorities and if it received the authority to gather data, as well as the means to publish and publicize its findings.[12] It could be organized nationally or regionally and be legally authorized; it should then be easily accessible (anonymous upon request) and should operate independently of any medical and psychiatric institutions. As indicated, suicide registers run in this way produce very valuable data, though with perhaps somewhat embarrassing implications.

The involvement of experienced and independent users and survivors of psychiatry in qualitative research programs could make the difference. Jan Wallcraft, research fellow of the Birmingham University and University of Hertfordshire and freelance mental health consultant and researcher[13], explains:

> "Knowledge created by service user/survivor researchers is based on a different value system from that of professionals. The key values for service user/survivor-led research include a commitment to change, expertise based on personal experience, countering stigma, redressing power imbalances, and desired outcomes such as self management and recovery of a satisfying life. Involving service users/survivors in setting priorities, designing and carrying out research is likely to result in better quality research on more relevant topics. Service user/survivor-led research such as Strategies for Living can ask questions that are independent of existing services and treatments" (2007, p. 349).

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 counterproductive to include pharmaceutical companies in this research (see, for example, the proposals of the Institute of Medicine, the health arm of the U.S. National Academy of Sciences [see Steinbrook, 2009]) or to include people, organisations or so-called self-help organisations like GAMIAN (Global Alliance of Mental Illness Advocacy Networks) which receive(d) funding and other benefits from pharmaceutical companies (Boseley, 2007; Lehmann, 2009, pp. 34-35). Again, when this is done, the benefits outweigh the fairly minimal costs.

The rate of suicide in people with emotional problems or those labeled "mentally ill" could be lowered meaningfully with a functioning and independent suicide register. Where the damage has already been done, there may, at least, be a possibility to apply for financial compensation. Enhanced knowledge

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[12] 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 major pharmaceutical companies) not also fund research about the increased incidence of suicides under the influence of neuroleptics, six decades after these drugs were introduced?

[13] Janet Wallcraft was involved as a research consultant in an investigation of coming off psychiatric drugs, a research project led by users and survivors of psychiatry which was commissioned by MIND, the leading mental health charity in England and Wales (Read, 2005). They carried out 250 interviews and found that doctors were the least helpful group to those who reduced or came off psychiatric drugs (Wallcraft, 2007, pp. 348-349). It would be challenge for a new investigation to determine whether psychiatrists, who have an extremely high suicide rate (Blachly, 1968) and prescribe suicide-triggering psychiatric drugs, might be a helpful group to deliver humane help for people in depressive and other emotional distress.

about the suicidal effects of neuroleptics (as well as other iatrogenic injuries in mental health) could help to protect people with diagnoses like "schizophrenia" from additional burdens and risks from unpleasant effects of the drugs prescribed. Individuals could be more protected from damage caused by toxic elements in drugs. Enhanced knowledge about the suicidal effects of neuroleptics and other iatrogenic injuries would enable mental health professionals, relatives, friends and other carers to support people to live their lives in greater freedom and more peace of mind.

There is, however, a well-established Darwinist point of view (which was brought to perfection in Nazi Germany, is still rather common in the modern societies and might be the basis for the nonchalant faineance of many professionals, politicians and agents of social and health insurances) that the segregation of troubled (or troublesome) people is not something that everyone agrees should be prevented. This refers to people who usually have not violated any laws and thus cannot be criminally prosecuted and imprisoned, but whose ideas and actions, values and life styles disrupt (or threaten to disrupt) established relationships. Also psychiatrists can sympathize with population selection by suicide. For example, in 1923, Fritz Lenz, one of the most influential German eugenicists and an advocate of racist population selection, praised suicide—with the support of Ernst Bleuler, a leader of mainstream psychiatry (see Lehmann, 1994)—as a measure against "vulgarization 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).

Conflict of interest

The author has no actual or potential conflict of interest including any financial, personal or other relationships with other people or organizations within a quarter of a century of beginning the work at this article that could inappropriately influence, or be perceived to influence, his work. Especially he does not have any connection to the pharmaceutical industry and to organizations that are dependent on them, nor to Scientology, their subgroups or other sects of whatever color.

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