

Peter Lehmann

**Coming off 'atypical' neuroleptics
(like Clozaril, Risperdal, Seroquel, Zyprexa):
Challenges and experiences**

Workshop at "Alternatives 2011"

Orlando, Florida

October 29, 2011

“Atypical” neuroleptics

On the market

clozapine **Clozaril** ♦ amisulpride **Solian** ♦ sulpiride **Dolmatil**
tiapride **Delpral** ♦ remoxipride **Roxiam** ♦ risperidone **Risperdal**
sertindole **Serdolect** ♦ quetiapine **Seroquel** ♦ zotepine **Zoleptil**
paliperidone **Invega** ♦ ziprasidone **Geodon** ♦ olanzapine **Zyprexa**
perospirone **Lullan** ♦ aripiprazole **Abilify** ♦ iloperidone **Fanapt**
lurasidone **Latuda** ♦ blonanserin **Lonasen** ♦ asenapine **Saphris**

In the pipeline

cariprazine ♦ ocaperidone ♦ etc.?

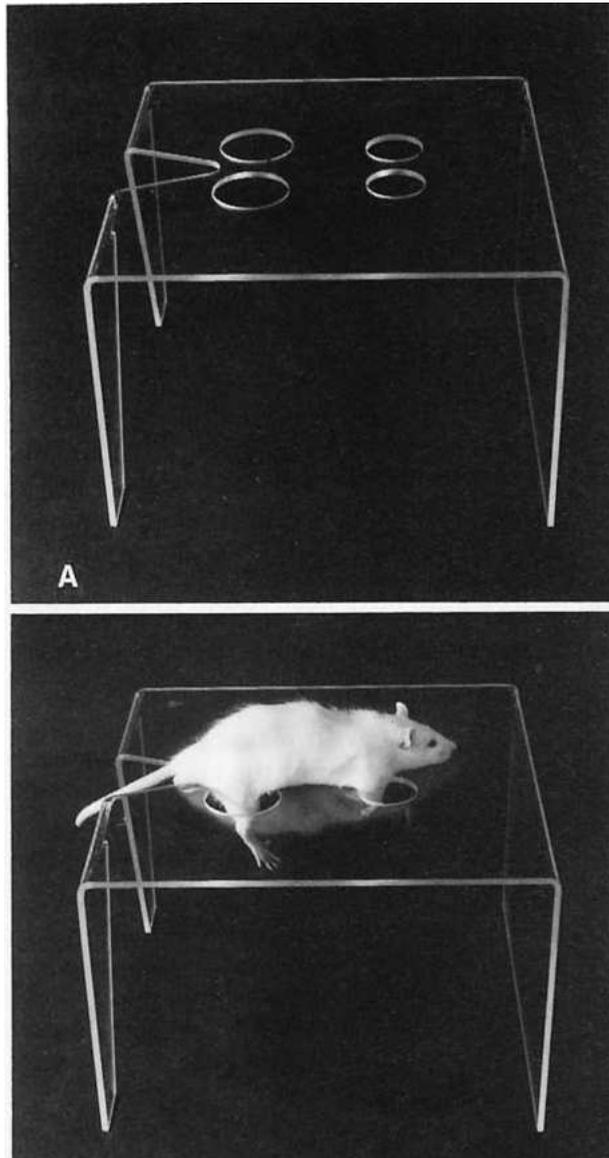
Typical neuroleptics



A. Traditional impact test

In J. Delay & P. Deniker (1961).
*Méthodes chimiothérapeutiques en
psychiatrie – Les nouveaux
médicaments psychotropes.*

Paris: Masson et Cie, p. 224



Difference between typical and “atypical” neuroleptics

B. Paw test for scientific differentiating of typical and atypical neuroleptics

Ellenbroek, B. A., Peeters, B. W., Honig, W. M., & Cools, A. R. (1987). The paw test: A behavioural paradigm for differentiating between classical and atypical neuroleptic drugs. *Psychopharmacology*, 93, 343-348

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We went “... in principle, one step back again and have recently developed substances (...) that, beside the mechanism primarily relevant for the ['antipsychotic'] effect, also influence additional mechanisms. But in contrast to the old substances, here the intent was to implement only such mechanisms into the molecular structure that dampen specific qualities of side effects (especially EPS [*extrapyramidal symptoms*]). Though, in the pharmacological sense, the newest generation of neuroleptics are 'dirty drugs', that is, substances with more than one mechanism of action” (p. 54).

Müller, W. E. (2003). Wirkungsmechanismen älterer und neuerer Neuroleptika. In F. König & W. Kaschka (Eds.), *Interaktionen und Wirkmechanismen ausgewählter Psychopharmaka* (pp. 37-54). 2nd edition. Stuttgart / New York: Thieme

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“Clozapine behaves similar to other neuroleptics, to which you add an increasing dose of anti-parkinsonian drugs” (p. 143).

Haase, H.-J. (1988). Neuroleptika: Fakten und Erlebnisse.

In O. K. Linde (Ed.), *Pharmakopsychiatrie im Wandel der Zeit* (pp. 137-154).

Klingenmünster: Tilia Verlag Mensch und Medizin 1988

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“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/extrapramidal side-effects” (p. 30).

Ebner, G. (2003). Aktuelles aus der Psychopharmakologie – Das Wichtigste vom ECNP-Kongress. *Psychiatrie* (Switzerland), online-edition, (1), 29-32

Chemical structure groups of “atypical” neuroleptics

azabiphenyles

benzamides

benzisothiazolylpiperazines benzisoxazoles

chinolines

dibenzapines

dibenzothiepinines

dibenzoxapines

iminodibenzyles

phenylindoles

thiazepines

thienobenzodiazepines

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“Interestingly, in most studies on withdrawal no position is taken on possible withdrawal symptoms apparently because the studies are not set up to deal with these findings” (p. 46).

Woggon, B. (1979). Neuroleptika-Absetzversuche bei chronisch schizophrenen Patienten. 1. Literaturzusammenfassung. *International Pharmacopsychiatry*, 14, 34-56

Withdrawal symptoms in animal research with neuroleptics

“At a dosage of 13.3 mg/kg of chlorpromazine, abrupt withdrawal led to a sudden death within 14 days, probably due to irreversibly blocked metabolic processes that stopped functioning (similar observations in human beings have been published in which death followed a brief stage of cramping)” (p. 487).

Sommer, H. & Quandt, J. (1970). Langzeitbehandlung mit Chlorpromazin im Tierexperiment. *Fortschritte der Neurologie-Psychiatrie und ihrer Grenzgebiete*, 38, 466-491

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“After cold turkey withdrawal from a high dose of neuroleptics (which produced extrapyramidal symptoms), extreme euphoria accompanied by a rapid pulse ('choc en retour' [*backfire*]) can be caused solely by the withdrawal, in contrast to the previous affective indifference.” (p. 67)

Selbach, H. (1963). Über regulations-dynamische Wirkgrundlagen der Psychopharmaka. In J. D. Achelis & H. von Ditfurth (Eds.), *Starnberger Gespräche 2* (pp. 53-74). Stuttgart: Thieme 1963

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“Long-term administration of antipsychotic drugs to animals induces supersensitive mesolimbic [*referring to nerve tracts from the mid-brain to the cerebral cortex*] postsynaptic dopamine receptors. It is possible that a similar process can occur in man. Following a reduction in the dose of antipsychotic medications, or their complete discontinuation, mesolimbic dopamine receptor supersensitivity could be reflected in rapid relapse of schizophrenic patients, the development of schizophrenic symptoms in patients with no prior history of schizophrenia, or in the necessity for ever-increasing doses of long-acting depot fluphenazine to maintain a remission” (p. 699).

Davis, K. L. & Rosenberg, G. S. (1979). Is there a limbic system equivalent of tardive dyskinesia? *Biological Psychiatry*, 14, 699-703

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“The authors suggest that dopaminergic supersensitivity also occurs in the mesolimbic [*referring to nerve tracts from the mid-brain to the cerebral cortex*] region after chronic neuroleptic exposure, resulting in the development of a supersensitivity psychosis. (...) An implication of neuroleptic-induced mesolimbic supersensitivity is that the tendency toward psychotic relapse in such patients is determined by more than just the normal course of the illness” (p. 16).

Chouinard, G. & Jones, B. D. (1980). Neuroleptic-induced supersensitivity psychosis. *American Journal of Psychiatry*, 137, 16-21

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“We suggest that the rapid deterioration observed in our cases was due to a clozapine-induced supersensitivity of the mesolimbic [*referring to nerve tracts from the mid-brain to the cerebral cortex*] DA [*Dopamin*] receptors parallel to the striatal [*referring to the subcortical striatum*] DA supersensitivity, which at least in part is thought to be involved in the development of tardive dyskinesia. (...) The rapid appearance of the symptoms after withdrawal, and the fact that new symptoms were apparent, support the suggestion of a clozapine-induced supersensitivity psychosis” (pp. 293-294).

Eklom, B., Eriksson, K., & Lindström, L. H. (1984). Supersensitivity psychosis in schizophrenic patients after sudden clozapine withdrawal.

Psychopharmacology (Berlin), 83, 293-294

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“There is a worsening of the psychosis (delusions, hallucinations, suspiciousness) induced by long-term use of neuroleptic drugs. Typically, those who develop supersensitivity psychosis respond well initially to low or moderate doses of antipsychotics, but with time seem to require larger doses after each relapse and ultimately megadoses to control symptoms” (p. 44).

Tornatore, F., Sramek, J. J., Okeya, B. L., & Pi, E. H. (1987). *Reactions to psychotropic medication*. New York / London: Plenum Medical Book Company

“Thus, a tolerance to the antipsychotic effect seems to develop” (p. 53).

Tornatore, F., Sramek, J. J., Okeya, B. L., & Pi, E. H. (1991). *Unerwünschte Wirkungen von Psychopharmaka*. Stuttgart / New York: Thieme

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“When a patient develops apparently new psychiatric symptoms after a psychotropic medication is stopped, a differential diagnosis must be made. The symptoms may represent one or a combination of the following: recurrence or rebound of the underlying illness, psychological or physiological withdrawal reactions or previously unnoticed or delayed drug side effects” (pp. 1129-1130).

Cole, J. O. & Lawrence, J. (1984). Alternative explanations for withdrawal psychosis. *American Journal of Psychiatry*, 141, 1129-1130

Medical withdrawal symptoms

- “(1) tend to occur earlier after drug withdrawal than schizophrenic exacerbation,
- (2) may be accompanied by other medical withdrawal symptoms, and
- (3) usually clear up spontaneously or with supportive treatment within a few days” (p. 292).

Lacoursiere, R. B., Spohn, H. E., & Thompson, K. (1976). Medical effects of abrupt neuroleptic withdrawal. *Comprehensive Psychiatry*, 17, 285-294

Catch-22 situation from a psychiatric perspective

- neuroleptics do not heal; patients need permanent treatment
- risks of long-term damages such as tardive dyskinesia
- psychiatrists are reluctant to discontinue neuroleptics for fear of liability
- risk of relapse / No relapse, even more complicated

Gilbert, P., Harris, M. J. M., McAdams, L. A., & Jeste, D. V. (1995). Neuroleptic withdrawal in schizophrenic patients: A review of the literature. *Archives of General Psychiatry*, 52, 173-188

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“Although adverse events, such as suicide, dissatisfied patients or relatives, loss of job, deteriorating course, and brain abnormalities, can all be observed during drug withdrawal, each of these is also commonly encountered in the clinical care of medicated patients!” (p. 193)

Carpenter, W. T. & Tamminga, C. A. (1995). Why neuroleptical withdrawal in schizophrenia? *Archives of General Psychiatry*, 52, 192-193

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“When looking back on the 25 years since neuroleptics have been made available to us, it can be concluded that indication predictors for a neuroleptic treatment have not been found but are essential. There are clearly patients who remain symptom-free even without neuroleptics, and there are those who continue to display symptoms while gaining no benefit from neuroleptic therapy and who become even more handicapped.”

Helmchen, H. (1983). Contribution to the discussion. In H. Hippus & H. E. Klein (Eds.), *Therapie mit Neuroleptika* (p. 171). Erlangen: Perimed

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“Today I unfortunately see very many cases of cycloid psychosis that remain in a toxic, pathological state because of constant medication, but which would be perfectly normal without medication. If one could prevent the development of further phases of psychosis with constant medication, then this practice would be justified, but unfortunately that is not the case. Thus those patients who would be healthy for extended periods, or perhaps forever, are held in a permanently toxic state...” (p. 3).

Leonhard, K. (1989). *Aufteilung der endogenen Psychosen*. 5th edition. Berlin: Akademie

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“Not one single patient, who - healed or improved - lived outside of the clinic over years or permanently, has ever taken long-term drugs. The assumption, that the majority of improved schizophrenics would stay improved on the long term only under the influence of neuroleptic drugs, is an error. First of all it is an error to assume that announcing relapses after remissions could be avoided by neuroleptic drugs. There are permanent remissions in great quantities and there are relapses under the influence of neuroleptics in great quantities” (p. 366).

Bleuler, M. (1972). *Die schizophrenen Geistesstörungen im Lichte langjähriger Kranken- und Familiengeschichten*. Stuttgart: Thieme

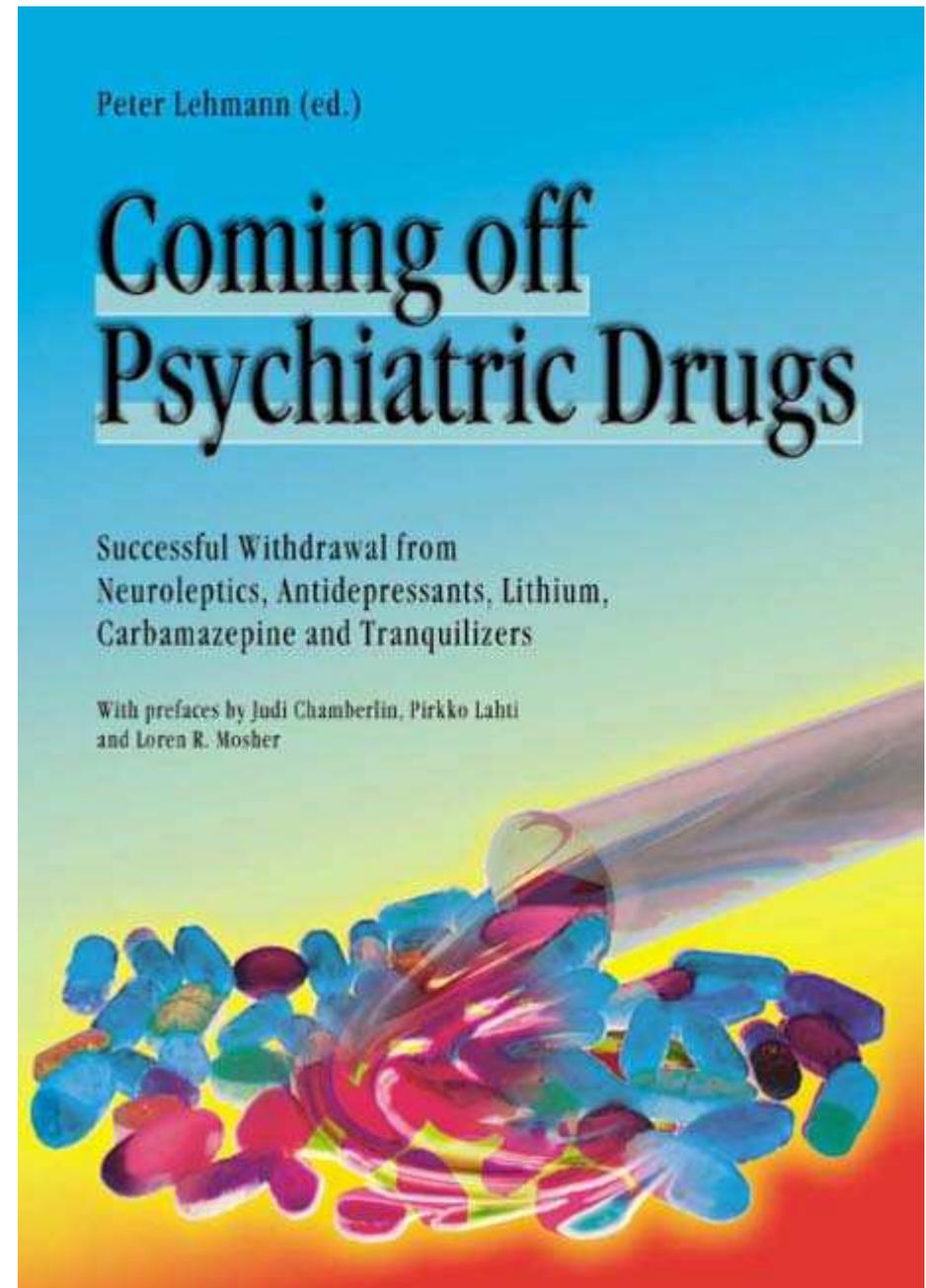
P. Lehmann (Ed.):

Coming off Psychiatric Drugs

**Successful withdrawal from
neuroleptics, antidepressants,
lithium, carbamazepine
and tranquilizers**

Prefaces by Judi Chamberlin,
Loren R. Mosher & Pirkko Lahti

Berlin / Eugene / Shrewsbury:
Peter Lehmann Publishing 2004



www.peter-lehmann-publishing.com/books/withdraw.htm

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Ideal preconditions for withdrawal:

- gradual dosage reduction, adequate speed of reduction
- responsible attitude
- supportive surroundings
- proper help
- competent professionals
- supportive self-help group

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Historical advice: Never come off psychiatric drugs without the doctor/psychiatrist’s agreement and under clinical supervision

➔ Mind Study 2005 (U.K.): Doctors were found to be the least helpful group to those who wanted to reduce or come off psychiatric drugs

Advice now: Seek information and support from a wide variety of sources. Take into consideration, your doctor might be indoctrinated by Big Pharma.

Read, J. (2005). *Coping with coming off*. London: Mind Publications

Information sources: www.peter-lehmann-publishing.com/comingoff

www.peter-lehmann-publishing.com/orlando

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Plan ahead:

- Change your doctor/psychiatrist
- Consider how to deal with the risk of losing housing, income, or other benefits
- Look for the right season for change
- Inform those close to you and those you trust of your plans
- Anticipate withdrawal problems

Anticipating withdrawal problems

“Withdrawal from psychiatric drugs can be a very trying experience. You should know that withdrawal can cause moderate to severe discomfort and outright misery at times. Being mentally prepared for this decreases the chance that you will become scared or discouraged. Patience and determination are needed” (pp. 56-57).

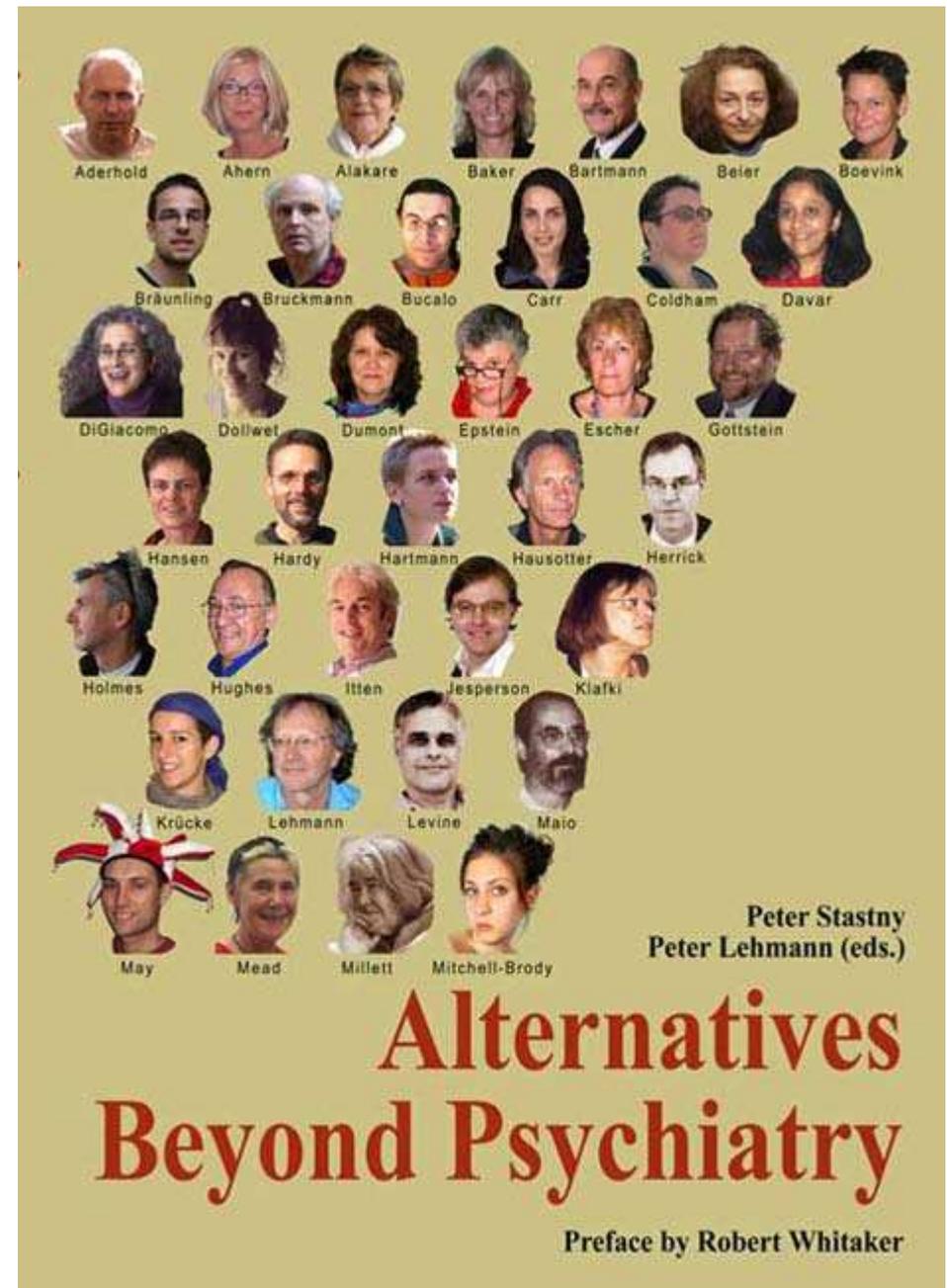
Network Against Psychiatric Assault (Ed.) (1984). *Dr. Caligari’s psychiatric drugs*. Berkeley: Self publication

**P. Stastny & P. Lehmann
(Eds.)**

Alternatives beyond Psychiatry

Preface by R. Whitaker

Berlin / Eugene / Shrewsbury:
Peter Lehmann Publishing 2007



www.peter-lehmann-publishing.com/books/without.htm

Get legal protection

- Advance directive, Psychiatric (Living) Will
- What do I need if I become anxious, depressive, suicidal, manic, or crazy?
- What will help me in that situation? What should I refuse?
- What will I accept? What am I risking?
- Who are the people who will support me?

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Create a quiet environment

- Keep away from relatives who cannot be burdened.
- Avoid stress and loud places.
- Don't answer the phone if that is associated with stress.
- Go somewhere peaceful (seaside, countryside, meditation center, church, library).

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Get enough exercise

- Walking, hiking, jogging, dancing, swimming, cycling, gymnastics, aerobics

Reflect

- Live with awareness.
- Keep a diary, write things down.
- Sensible and fulfilling occupation—a paid job or a leisure activity (especially writing)
- Self-help group, mutual support, mailing-lists on the internet
- Friendship, psychotherapy

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Nutrition

- Eat well—regularly, but not excessively
- Roughage, whole grain foods, salad, fresh vegetables, fresh fruit, lots of liquids

Avoid:

- stimulating drinks such as black tea and coffee
- prepared foods, white sugar, candy, soda
- drugs such as alcohol, marijuana (in case it has psychoses-like effects on you), cocaine and other stimulants

Palliative and cleaning methods

- Substances to palliate and to accelerate the substances' metabolism / degradation
- Coffee, black tea, nicotine, fruit juice, milk
- Detoxification
 - f.e., AcuPro-II-system to determine homeopathic remedies to stimulate the disturbed organism to recover
www.auraanalysis.com/en/html/acupro_ii_system.html
 - National Acupuncture Detoxification Association (NADA)
www.acudetox.com

Overcoming sleep disturbances

- Environmental pollutants, stress
- Evening meal with plenty carbs
- Whole foods, not too late in the evening
- Home remedies, i.e, milk with honey
- Herbal and homeopathic drugs
- Bach Flower remedies, aromatherapy
- Benzodiazepines (not too long)

Coming off in the Runaway-House

“There’s a lot of tea-drinking, various herbal teas, and sometimes coffee. The punching bag in the basement is used, even more than the wide fields that stretch from the end of the street to the next village. If you can’t sleep at night, you stay up and talk with us or those staying here or with yourself, take a bath, listen to music, read, cook something for yourself. The staff and/or the occupants love to take long evening walks” (pp. 270-271).

Kempker, K. (2004). Withdrawing from psychiatric drugs in the Runaway-house. In P. Lehmann (Ed.), *Coming off psychiatric drugs* (pp. 270-272). Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing

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“We are not only sentenced by others, muzzled by others. We always have more forces (and self-helping forces, too) available than we might have thought in dark days” (p. 141).

Wozart, G. (2004). Adversities. In P. Lehmann (Ed.), *Coming off psychiatric drugs* (pp. 138-141). Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing

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“Recognize your suffering and become your own therapist—help yourself” (Bert Gölden).

“They remain at risk as long as they still believe in even the smallest part of the message telling them their diagnosed illness could break out again if they don’t take the psychiatric drugs. The fateful prophecy of the psychiatrist can become true at any time—in other words: the relapse happens” (Dr med. Marc Rufer).

In P. Lehmann (Ed.), *Coming off psychiatric drugs*. Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing, pp. 100 / 209

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“During the years I developed the courage to face what I tried to cover with all my dependencies. (...) You have to find the courage to confess to yourself how things went so far” (Wilma Boevink).

“Whoever gets to the bottom of his psychotic experiences afterwards obviously does not run into the next psychotic phase all too soon” (Regina Bellion).

In P. Lehmann (Ed.), *Coming off psychiatric drugs*. Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing, pp. 80 / 284

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“Never again would I have the attitude that this couldn’t happen again. I now realized that if I encountered enough stress, combined with lack of sleep, that an altered state would likely occur. This realization left me feeling quite vulnerable” (p. 110).

Cohen, O. (2008). Crashkurs in Psychiatrie. In P. Lehmann (Ed.), *Psychopharmaka absetzen* (pp. 105-111). 3rd edition. Berlin / Eugene / Shrewsbury: Antipsychiatrieverlag

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“During my time of struggle, one of the most annoying things was all those people who believe that what had worked for them could also work for me. The path to peace and freedom is unique for each individual and very personal” (173).

Webb, D. (2004). “Please don’t die”. In P. Lehmann (Ed.), *Coming off psychiatric drugs* (pp. 164-173). Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing

Consequences and demands

- Oppose forced psychiatric treatment, especially legally protected conditions to long-term treatment.
- Collect and spread information about withdrawal problems.
- Develop special services for people to overcome dependence.
- Compensation for disability caused by psychiatric drugs.
- Develop methods, systems, services and institutions for acute, short-term and long-term help and support that does not depend on the use of psychiatric drugs at all.

Bach Jensen, K. (2004). Detoxification – In the Large and in the Small: Towards a culture of respect. P. Lehmann (Ed.), *Coming off psychiatric drugs*. Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing, pp. 303-309

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"The potential of neuroleptics to produce dyskinesia, a serious complication, in a considerable number of patients would indicate that an attempt should be made to withdraw in every patient" (p. 6).

Simpson, G. M. (1977). Neurotoxicity of major tranquilizers. In L. Roizin, H. Shiraki, & N. Grcevic (Eds.), *Neurotoxicology* (pp. 1-7). New York: Raven Press

"Conduct whereby the actor does not desire harmful consequence but... foresees the possibility and consciously takes the risk ... or does not care about the consequences of his or her actions" (p. 1053).

Garner, B. (Ed.) (2005). Black's law dictionary, 8. edition, Boston: West Publishing Company / [http://en.wikipedia.org/wiki/Recklessness_\(law\)](http://en.wikipedia.org/wiki/Recklessness_(law))

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