Peter Lehmann (ed.)

Coming off Psychiatric Drugs

Successful Withdrawal from Neuroleptics, Antidepressants, Lithium, Carbamazepine and Tranquilizers

With prefaces by Judi Chamberlin, Pirkko Lahti and Loren R. Mosher

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Psychiatric drugs are more dangerous than many (ex-)users and survivors of psychiatry and even physicians realize. Psychiatric drugs can cause serious adverse effects. Psychiatric drugs can also produce powerful physical dependence. For example, their withdrawal can cause sleeplessness, rebound and withdrawal psychoses, withdrawal-emergent tardive syndromes, return of base line psychological and emotional problems and even life-threatening withdrawal reactions (see pp. 25–38). Especially when psychiatric drugs have been taken for prolonged periods of time, experienced clinical supervision may be advisable or even necessary during the withdrawal process.

The problems which led to administration of psychiatric drugs may return when you stop taking them. Decisions to withdraw from psychotropic drugs should be made in a critical and responsible way. It is important to have a safe and supportive environment in which to undertake withdrawal (see pp. 311–321) and to consider the possibility that you may experience so-called relapse or worsening of your condition. Withdrawal may not work for everyone. Sometimes the difficulty of withdrawal or the base line psychological and emotional problems seem insurmountable, so people may decide to maintain on lower amounts of drugs or fewer drugs. Many psychiatrists do not support withdrawal and are convinced that people with psychiatric diagnoses like "schizophrenia," "psychosis," "manic depression" or "major depression" need psychiatric drugs or maintenance electroshock "therapy" for the rest of their lives.

We do not provide medical advice. Although this is the first book to describe positive experiences of coming off psychiatric drugs, it is not intended as a substitute for professional help. Should you have any health care-related questions, please call or see your physician or other health care provider promptly. The publisher, editor, authors and suppliers are not responsible if

you decide against this advice. Nor are they responsible for any damage you may experience from a medical and, in particular, psychiatric treatment.

If you choose to give weight to the various opinions expressed in this book, that is your choice, and is not based on any claims of special training or medical expertise by the publisher or editor (for professions and experiences of the authors see pp. 337–343). No alternative medicine, holistic remedy, or self-help method referenced in this book is being recommended as a substitute for professional medical advice, diagnosis or treatment, and no comparisons are being made between such alternative methods and treatment with electroshock or psychiatric drugs. Neither the publisher, editor, authors nor suppliers make any claim that their information in this book will "cure" or heal disease.

All (ex-)users and survivors of psychiatry in this book report from ultimately positive experiences with drug withdrawal. This is no coincidence because the editor only asked for positive experiences. Since many individual factors (physical and psychological condition, social circumstances etc.) exert a remarkable influence on the withdrawal process, the authors' individual statements should not be interpreted as transferable advice for all other readers.

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The publisher, editor, authors and suppliers undertake no responsibility for any consequences of unwanted effects either when taking psychiatric drugs or when withdrawing from them. They do not accept any liability for readers who choose to determine their own care and lives.

Peter Lehmann

Prefaces

Much of the conventional wisdom about psychiatric drugs is wrong. Psychiatrists and the pharmaceutical industry have successfully convinced much of the public, through the media, that psychiatric drugs are "safe" and "effective" in "treating" "mental illnesses." Let us look at each of these words in turn:

Safe—generally accepted to mean that they cause no harm, despite many known negative effects such as movement disorders, changes in brain activity, weight gain, restlessness, sudden death from neuroleptic malignant syndrome and many others.

Effective—generally accepted to mean that they reverse or cure the symptoms for which they are prescribed, despite the fact that much research has shown they have a generally sedating effect that masks not only the targeted behavior, but all activities.

Treating—generally accepted to mean that the prescribed agents have specific effects on specific disease processes.

Mental illnesses—generally accepted to mean that there are specific clinical entities known as "schizophrenia," "bi-polar disorder" etc., despite the fact that there are no known structural or chemical changes in the body that can distinguish people who have these so-called illnesses from those who do not.

How is it that these myths have been so successfully accepted as fact? For one thing, those promoting the drugs are authority figures, doctors and scientists who are generally accepted to be presenting value-free experimental results. Another factor, perhaps even more significant, is that those who are given the drugs and who are the ones who have spoken out about their negative effects, are automatically discredited by having been labelled mentally ill. The diagnosis of mental illness carries with it a host of associations, particularly that the person so labelled has impaired judgment and is not a reliable reporter of his or her own experiences.

Nonetheless, it is personal stories which in fact carry enormous weight in the evaluation of the value of these drugs. Reading the eloquent personal testimonials of people who have taken and then discontinued these drugs, some who started with the belief that they were truly lifesaving agents, should be considered along with the positive accounts of researchers and prescribers. In psychiatry, it is the experiences, thoughts and feelings of the patient which are considered to be diseased; therefore, these experiences, thoughts and feelings in response to treatment must be taken into account. Of course, many psychiatrists and other believers in the efficacy of psychiatric drugs can dismiss these accounts by considering them additional "symptoms," but this, of course, is circular reasoning.

The experiences of people who have taken (or continue to take) psychiatric drugs are enormously varied. Some people find them helpful in dealing with troublesome symptoms, and these people, of course, are unlikely to want to discontinue using them. In fact, within this group, many are willing to tolerate troublesome unwanted effects because they find the benefits outweigh the negatives. This group of people is not the subject of this book.

Instead, the book focuses on people who, for a wide variety of reasons, have decided that the drugs are not helpful to them, and who have made the decision to discontinue their use. Such a decision carries enormous consequences, as the treating physician almost always wants the patient to continue and the physician often has enormous powers (such as involuntary commitment) at his or her disposal in order to "persuade" the patient to continue. Indeed, the lack of support a person faces upon a decision to discontinue the use of drugs is often a factor in what is labelled relapse.

As an advocate and activist in the field of mental health and patients' rights (and as a person who discontinued the use of drugs as part of my own personal process of recovery), one of the most common questions I am asked is "how can I discontinue the use of psychiatric drugs?" There is a crying need for information on stopping safely, as well as for supportive structures (such as short-term residential programs and physicians who are willing to consider non-drug approaches) that will enable people who wish to withdraw to do so.

The act of choosing to stop taking psychiatric drugs may be taken for a variety of reasons. Often it is that the negative effects are more troubling than

the original problems, or it may even be that no positive effects are experienced at all (this was certainly my own experience). Unfortunately, the media image of a person who has stopped taking psychiatric drugs is the one that has captured the popular imagination: a person so deluded that he or she is unable to realize that his or her behavior is abnormal and who then usually goes on to commit some horrendous violent crime. Reading about real people and the complex reasons behind their decisions might be a way to counter this negative and destructive image.

It is often said that psychiatric drugs are given to people labelled mentally ill in order that those around them, such as medical personnel and family members, can feel better. Certainly, being around people who are troubled, especially when they are vocal about what is troubling them, can be wearing and difficult. But simply silencing them is not the answer. Instead, we need to listen carefully to the real experiences that people have so that we can learn the true costs of psychiatric drugs on people's lives.

Judi Chamberlin
Co-Chair, World Network of Users and Survivors of Psychiatry, Director of Education and Training, National Empowerment Center
Arlington, Massachusetts, October 30, 2002

This world wide first book about the issue "Successfully coming down from psychiatric drugs," published in Germany in 1998, primarily addresses individuals who want to withdraw based on their *own* decisions. It also addresses their relatives and therapists. Millions of people are taking psychiatric drugs, for example Haldol[1], Prozac[2] or Zyprexa[3]. To them, detailed accounts of

1 Neuroleptic, active ingredient haloperidol, marketed also as Dozic, Haloperidol, Peridol, Serenace

2 Antidepressant, active ingredient fluoxetine, marketed also as Auscap, Deprax, Eufor, Felicium, Fluohexal, Fluox, Fluoxetine, Lovan, Oxactin, Psyquial, Sarafem, Veritina, Zactin

3 Neuroleptic, active ingredient olanzapine

how others came off these substances without once again ending up in the in the doctor's office are of existential interest.

Many of my colleagues in the mental health field spend much of their time developing criteria for the application of psychiatric drugs. Diagnoses like compulsive acts, depression, dermatitis, hyperactivity, hyperemesis gravidarum, insomnia, nocturnal enuresis, psychosis, stuttering, travel sickness etc. can lead to the application of neuroleptics, antidepressants, lithium[1], tranquilizers and other drugs with psychic effects. This development of indications is a responsible task, rich with consequences.

Diagnoses and indications often result in a treatment with psychotropic drugs that can last for a long time. Who can predict whether the drugs—when time arrives—can be withdrawn from easily? From minor tranquilizers, especially the benzodiazepines, we already know the effects of dependency. Withdrawal without therapeutic help and without knowledge about the risks can take a dramatic course. What risks arise from the withdrawal of neuroleptics, antidepressants and lithium.

What factors favor successful withdrawal—successful in the sense that patients do not immediately return to the doctor's exam room, but live free and healthy lives, as all of us would wish? Have we not heard about pharmacogenic withdrawal-problems, receptor-changes, supersensitivity-psychoses, withdrawal-psychoses? Who is able to distinguish relapses from hidden withdrawal problems?

Do we not leave our patients alone with their sorrows and problems, when they—for whatever reasons—decide by themselves to come off their psychotropic drugs? Where can they find support, understanding and good examples, if they turn away from us disappointed (or we from them)?

Peter Lehmann, board-member or the European Network of (ex-)Users and Survivors of Psychiatry and former board-member of Mental Health Europe (the European section of the World Federation for Mental Health), has earned recognition for this difficult task as the first world wide expert to gather experiences from people themselves and their therapists, who have

1 Mood stabilizer, marketed also as Camcolit, Camcolith, Cibalith, Eskalith, Li-Liquid, Liskonum, Lithicarb, Lithium, Lithobid, Lithonathe, Lithotabs, Priadel, Quilonum

withdrawn from psychotropic drugs successfully or who have supported their clients to do so. In this manual 28 people from Australia, Austria, Belgium, Denmark, England, Germany, Hungary, Japan, the Netherlands, New Zealand, Serbia & Montenegro, Sweden, Switzerland and the USA write about their experiences with withdrawal. Additionally, eight psychotherapists, physicians, psychiatrists, social workers, psychologists, natural healers and other professionals report on how they helped their clients withdraw. Via the internationality of the authors the book provides a broad picture of different experiences and knowledge.

The book has a provocative message; life-experiences sometimes differ from scientific agreements. The book is based on the personal experiences of (ex-)users and survivors of psychiatry and the few professionals helping people come off psychiatric drugs. So it is a good place to begin the discussion. The book should be available in each medical practice, in each therapeutic ward, and in each patient's library.

Pirkko Lahti
Executive Director of the Finnish Association for Mental Health and President of the World Federation for Mental Health
Helsinki, August 19, 2002

"There is no tyranny so great as that
which is practiced for the benefit of the victim"—C.S. Lewis

This volume is devoted to a topic that is the subject of a great deal of misguided thinking these days. We live in the era of a "pill for every ill" but too little attention has been devoted to the pills given specifically to affect our psyches. What does it mean to medicate the soul, the self, and the mind? Webster's dictionary defines psyche in all three ways. Are not these chemicals ("psychotropic drugs") interfering with the very essence of humanity? Should not great care and thought be given to this process? If begun, should it not be continuously monitored? Since all three—soul, self and mind—are

at the core of each human being should not he/she determine whether these drugs should be taken based on her/his own subjective experience of them? The answer is, of course, a resounding yes.

Now let's get real. Since there are few objective indicators of the effects of these drugs the patients' own reports are critical. Do the psychiatrists and other physicians prescribing psychotropic drugs listen carefully to each patient's personal experience with a particular one? The answer to the question varies of course but if you speak a different language, are a member of a minority, poor, seen as "very ill" or forcibly incarcerated in a mental hospital the likelihood of being really listened to falls dramatically—although it is not very high for anyone.

Hence, the focus of this book—the stories of persons who were not listened to as they suffered torment of the soul, self and mind from psychotropic drugs—often given against their will, is very important. They are the stories of courageous decisions made against powerful expert doctors (and sometimes families and friends)—and the torment that sometimes ensued. Stopping medications began to restore their brains' physiology to their pre-medication states. Most had never been warned that the drugs would change their brains' physiology (or, worse yet, selectively damage regions of nerve cells in the brain) such that withdrawal reactions would almost certainly occur. Nor were they aware that these withdrawal reactions might be long lasting and might be interpreted as their "getting sick again." They are horror stories of what might happen (but does not have to happen) when attempting to return brains to usual functioning after being awash with "therapeutic" chemicals. Unfortunately, the suffering was usually necessary in order restore soul, self and mind—the essence of humanity.

However, because the drugs were given thoughtlessly, paternalistically and often unnecessarily to fix an unidentifiable "illness" the book is an indictment of physicians. The Hippocratic Oath—to above all do no harm—was regularly disregarded in the rush to "do something." How is it possible to determine whether soul murder might be occurring without reports of patients' experiences with drugs that are aimed directly at the essence of their humanity? Despite their behavior, doctors are only MD's, not MDeity's. They, unlike gods, have to be held accountable for their actions.

This book is a must read for anyone who might consider taking or no longer taking these mind altering legal drugs and perhaps even more so for those able to prescribe them.

Loren R. Mosher MD
Director, Soteria Associates
Clinical Professor of Psychiatry
University of California at San Diego
School of Medicine
August 26, 2002

The point of departure for this book is the moment at which those who are taking psychiatric drugs—the objects of psychiatric treatment—have already made their own decision to quit or to want to quit. This starting point may be alarming to those readers who look upon the consumers of these substances not as subjects with a capacity for individual decision-making but rather as psychologically unsound and, above all, unable to recognize their own illness (or alternately as consumers of pharmaceuticals from whom they can profit).

Psychiatric drugs are substances which are given to influence the psychic condition and the behavior of their patients. This book refers to the treatment of human beings only. Mentioned are neuroleptics, antidepressants, lithium, carbamazepine[1] and tranquilizers. The withdrawal of drugs used to treat epilepsy in the field of neurology is not a subject of this book.

- Neuroleptics (known also as "major tranquilizers") are so-called antipsychotic drugs, which are administered when physicians (mostly general practitioners, pediatricians or psychiatrists) decide to give a diagnoses such as psychosis, schizophrenia, paranoia, hebephrenia and hysteria. Other possible symptoms that lead doctors to prescribe neuroleptics are those sometimes considered psychosomatic in origin: whooping-cough, asthma,

1 Mood stabilizer, marketed as Atretol, Carbamazepine, Carbatrol, Epitol, Tegretol, Teril, Timonil

stuttering, disturbances of sleep and behavior in children, travel sickness, pruritus (itching) or vegetative dystonia. In the same way that rebellious or aggressive animals of all sorts are given drugs to calm stress-related reactions, so too are elderly disturbed people treated with neuroleptics.

- Antidepressants are given after diagnoses such as reactive, neurotic or brain-organic depression, restlessness, anxiety disorder or obsessive-compulsive disorder, night-anxiety, panic attacks, phobia (e.g. school-anxiety in children), nocturnal enuresis, insomnia and many others. Unhappy animals might receive antidepressants, too, for instance sad dogs, if they are locked up in the house all day while their master is at work.
- Lithium is administered mostly under diagnoses such as mania or schizo-affective disorder.
- The main psychiatric indication for carbamazepine (as well as the chemically-related oxcarbazepine[1] and valproate[2]) is the diagnosis of affective psychosis, especially when the treating psychiatrist has failed to reach the effect he desires with his normal psychiatric drugs. Carbamazepine, valproate and oxcarbazepine which are administered for the treatment of epilepsy in the field of neurology are not subjects of this book.
- Tranquilizers (sometimes called "minor tranquilizers") are substances which are administered after diagnoses such as a lack of motor impulse, depressed mood, phobia, neurosis, panic attack, sleep disorder. Tranquilizers which are administered for the treatment of epilepsy in the field of neurology, are not a subject of this book.

"Authors wanted on the subject: 'withdrawing from psychiatric drugs.'" This was the call for articles I sent out to relevant groups worldwide in 1995:

> "'Coming off Psychiatric Drugs. Successful Withdrawal from Neuroleptics, Antidepressants, Lithium, Carbamazepine and Tranquilizers.' This is the title of a book that will be published in German in 1997/98. A publication in English translation is intended later. We are looking for people who have been prescribed one or several of the above-mentioned psy-

1 Mood stabilizer, marketed as Trileptal

2 Mood stabilizer, marketed as Convulex, Depacon, Depakene, Depakote, Epilim, Sodium Valproate, Valpro, Valproic Acid

> chiatric drugs and who have decided to quit taking them. Of particular interest are positive examples that show that it is possible to stop taking these substances without ending up in the treatment-room of a physician or right back in the madhouse again. For that reason I am looking for authors willing to report—in exchange for royalties—about their own experiences on the route to withdrawal and who now live free from psychiatric drugs. I am also looking for reports from people who have successfully helped others to withdraw from psychiatric drugs in the course of their professional life (e.g. user-controlled support centers, natural healers, homeopaths, social workers, psychologists, pastoral workers, physicians, psychiatrists etc.) or in their personal life (e.g. supporting friends, relatives, self-help-groups etc.)."

I received a series of responses from people who were interested in contributing to this book, including people who had been taking psychiatric drugs as well as some professionals whose articles also appear in this book. One psychiatrist withdrew her offer to contribute, fearing (not without reason) that her practice might be flooded with people wishing to stop taking psychiatric drugs. Because I had received no responses from family members of (ex-)users and survivors of psychiatry, I sent my call for articles to the German "Association for Family Members of the Mentally Ill." The reaction was again silence. Is the reason for this perhaps that those family members who have organized themselves into support groups have been inundated in the past years with free lectures and information from the pharmaceutical industry?

In any case, it would be a mistake to reduce the problem of the prolonged use of psychoactive drugs and the possible complications arising from withdrawal to the fault of disinterested or naïve family members, irresponsible doctors, and the profit-oriented pharmaceutical industry. Two authors who had showed initial interest in contributing their experiences with withdrawal later took back their offer because they had "relapsed." One of them reported that she had mistimed her withdrawal to concur with a breakup. The other informed me that she was in a clinic again because she had experienced another psychosis. Did she experience what those in the field call a "withdrawal psychosis," or was she just overwhelmed with the sudden return of old problems that had yet to be worked through?

Throughout my endeavor to address this subject, I've been cautious enough never to urge others to stop taking psychiatric drugs. I was careful to only approach those who had already quit before I sent out my call for articles. Nonetheless, I wonder if I may have been responsible for leading others to quit in an unconsidered and potentially dangerous way just by having published material on the subject.

Ever since the emergence of psychiatric drugs, many people who have taken prescriptions have made their own decision to quit. One can only speculate how many people have attempted to quit after having been exposed to the idea in an uninformed way only to experience a "relapse" and eventually another prolonged administration of the drugs. I think it is safe to say that a great number of attempts to quit would have been more successful if those wishing to quit and those around them had been better informed as to the potential problems that may arise as well as of means for preventing the often-prophesied relapse. With only a few exceptions, many professionals have little considered how they can support their clients who have decided to withdraw. Responses such as turning their backs on clients and leaving them alone with their problems indicate that professionals have little sense of responsibility regarding this subject.

The many different methods of successfully withdrawing from psychiatric drugs cannot be represented in a single book. As the editor of this book, it was important to me that "my" authors, with the exception of the contributing professionals, openly describe the personal path they took as well as the wishes and fears that accompanied them. They were told that there was only one thing they should not do, namely, to tell others what they should do or to offer surefire prescriptions for how to withdraw. Every reader must be aware of the potential problems and the possibilities, of their own personal strengths and weaknesses, and of their individual limitations and desires such that they can find their own means and their own way of reaching their goal. These reports by individuals who have successfully withdrawn are intended to show that it is possible to reach this goal and to live free of psychiatric drugs.

My sincere thanks go to the numerous good people, who have helped with proof-reading and with other preparatory tasks: Bill Spath, Chie Ishii, Chris-

tina White, Craig Newnes, David Oaks and MindFreedom Support Coalition International (www.MindFreedom.org), Jeffrey M. Masson, Joey Depew, Laura Ziegler, Marc Rufer, Mary Murphy, Mary Nettle, Myra Manning, Peter Stastny, Ronald J. Bartle, Tricia R. Owsley and Wolfram Pfreundschuh. Without friends and supporters I would have been lost.

Two authors are no longer living: Ilse Gold, who died on September 7, 1998 from breast cancer, which developed after the psychiatric treatment, and Erwin Redig, who quitted his life on June 14, 1999 after repeated violent psychiatric treatment. They had deserved a life of a hundred years.

Peter Lehmann
Berlin, April 14, 2004

Translation from the German by Mary Murphy

Introduction

According to the literature, anyone trying to stop taking psychiatric drugs must reckon with withdrawal problems. Ample evidence is provided for this statement in my book "Schöne neue Psychiatrie" *("Brave New Psychiatry,"* Lehmann 1996b, pp. 356ff.). In this book, "Coming off Psychiatric Drugs," I only provide a summary of the withdrawal symptoms. They may or may not occur.

When one discusses the issue of dependency with psychiatrists, most often their first reflex is to deny the danger of dependency for users of anti-depressants and neuroleptics. For example, the psychiatrists of the German Pharmaceutical Watch Group for Psychiatry have defined dependency as follows:

> "Psychological dependency is understood as the irresistible longing for a medication in order to increase a feeling of well-being or to reduce uncomfortable symptoms. Physical dependence can be established with the appearance of withdrawal symptoms after the reduction or withdrawal of a medication." (Grohmann / Rüther / Schmitz 1994, p. 279)

The risk of further problems developing in addition to the usual withdrawal symptoms, for example a rebound effect or hypersensitivity, should be taken into consideration when deciding whether or not to withdraw. Rebound effects are counter-regulatory adjustment reactions that lead to a temporary pronounced recurrence of the original symptoms.

Rebound effects have a mirroring-effect that make it particularly difficult to recognize withdrawal symptoms as distinct from the original problems. Because a prolonged use of psychoactive drugs raises the probability of various withdrawal problems—in addition to the usual damage of using the drugs—it is wise to consider sooner rather than later whether or not the time has come to limit these risks and to withdraw in a safe manner.

Taking psychoactive drugs can, under certain circumstances, lead to a temporary relief of psychological stress; but at the same time this leads many peo-

ple slowly into dependency without their knowing it and with the support of the medical establishment. Many people attempt to stop taking psychiatric drugs, for a variety of reasons: lack of "therapeutic" effect; unwanted effects; pregnancy; lack of insight into their "illness." Generally they have been left to cope with withdrawal problems on their own. In popular medical advice books (Curran / Golombok 1985; Neild 1990; Trickett 1991; Gadsby 2000) there is no mention of withdrawal from carbamazepine, lithium, antidepressants or neuroleptics. A few specialist journals published apparently random reports of severe withdrawal symptoms. But until recently, textbooks and information leaflets aimed at psychiatric drug users and their families still claimed withdrawal symptoms only arose with tranquilizers. In the past few years withdrawal effects of the newer antidepressants have gained some public notoriety. It is even possible to find information about dependence on "atypical" neuroleptics like Zyprexa (Support4Hope 2003). You only have to search long enough in the internet.

Typical withdrawal studies demonstrate quite serious methodological deficiencies, which have also been noticed by doctors: double-blind studies, in other words studies where neither the subject nor the treating physician knows what substance is actually being administered, are as rare as the administration of a placebo to a control group (which is also problematical). Furthermore, there has been a lack of systematic follow-up, a lack of information on the duration of hospitalization and of prior treatment as well as of the strength of dose of the psychiatric drug being withdrawn. Also, the period covered by the studies is too short, and finally, what is meant by any "relapse" mentioned is left completely unclear (Andrews / Hall / Snaith 1976). Those being treated were considered "improved" if in the eyes of the administrator of the psychiatric drugs they were not ready to be discharged but caused less trouble on the ward (Glick / Margolis 1962).

As Bertram Karon from the Psychology Department of Michigan State University concluded, the only purpose of some of these studies is simply to justify the prescribing practices of psychiatric drugs (Karon 1989, p. 113). For example, the American psychiatrist Philip May in his "California Study" (May 1968), much quoted among his circle of colleagues, claimed to prove the superiority of neuroleptics, antidepressants and electroshock treatment over psychotherapeu-

tic procedures. However, the report failed to point out that the therapists he used were untrained and unpaid trainees. A further deficit is the fact that in long-term studies only subjects who are motivated to take psychiatric drugs are included (Tegeler / Lehmann / Stockschläder 1980); people who stop taking psychiatric drugs on their own initiative and who live without them do not figure in such studies and their experiences are ignored.

The fact that no distinction is made between withdrawal problems such as receptor changes caused by the treatment, rebound effects or supersensitive reactions and relapse is another serious deficiency. Brigitte Woggon from the Zurich University Psychiatric Hospital, who favors psychiatric drugs, sees problems with the lack of differentiation made, even drugs are abruptly withdrawn, between withdrawal symptoms and the return of the original psychological symptoms:

> "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." (Woggon 1979, p. 46)

Nonetheless, doctors continue to refer to their studies and speak with a great deal of pathos of a sudden relapse if the drugs are stopped without their authorization, particularly in the case of lithium, antidepressants and neuroleptics. The situation is somewhat different in the case of carbamazepine and tranquilizers. In contrast to its use in preventing epileptic fits in neurology, carbamazepine is rarely used alone in psychiatry—its claimed antimanic effect is disputed anyway (Lerer et al. 1985)—and there have been practically no withdrawal studies. Partly as a consequence of decisions reached in the law courts on compensation, awarded because patients were insufficiently informed on the risk of dependency associated with tranquilizers, these substances have come to be seen as problematic by orthodox medicine.

Tranquilizers

Taking tranquilizers involves a risk which should not be underestimated. The development of tolerance and rebound phenomena can occur after taking the psychiatric drugs for only a short time and in low dosage. Massive, life-endangering withdrawal symptoms, especially convulsions, can make stop-

ping psychiatric drugs a very dangerous undertaking. Often withdrawal symptoms are so pronounced that withdrawal can only be done under hospital care. After withdrawal, a rebound-like explosion of feelings that had been chemically repressed may be released.

Depression, in some cases long-lasting, as well as anxiety states or hallucinations and deliria may occur during withdrawal. A "fear of rebound" is a generally recognized withdrawal symptom associated with tranquilizers. These symptoms are associated with risks, not least the repeated prescription of psychiatric drugs, becoming a psychiatric "case," and the switch to even more risky psychiatric drugs such as antidepressants or neuroleptics.

Withdrawal symptoms can register in the central nervous system as EEG (electroencephalogram) disturbances, difficulty in concentrating, pressure headaches, generalized pain, nervousness, restlessness, disturbed sleep and disturbed perceptions such as an increased sensitivity to stimuli. According to many doctors, withdrawal symptoms such as insomnia and excitability can be traced to a reactive hyperactivity of receptors which have been chemically altered. Many speak of a "rebound insomnia." Sometimes this phenomenon continues for weeks or months until the molecular mechanisms have settled at a new tolerable level.

Various vegetative symptoms can also often be explained as unhealthy physiological rebound effects. These symptoms may last for weeks, making it difficult to interpret whether they are drug withdrawal symptoms or recurring symptoms of the underlying condition. Weight loss, hot-cold sensations, fever, and heart and circulatory problems often occur (the latter for example as a rapid heart beat, shortness of breath, constriction, a rapid pulse, dizziness and weakness). Breaking out in sweats is an accompanying symptom. Intestinal and stomach disorders are another common withdrawal symptom (diarrhea, nausea, loss of appetite). Stomach cramps also occur. Disorders affecting vision sometimes accompany these symptoms as well.

Withdrawal may also bring muscular and motor disturbances, for example, jitters and shaking, limb pain, back tension, an insecure gait, as well as alternating muscle contractions that may cause jerking and shaking.

Withdrawal symptoms occur at a rate of 30–50% even when withdrawal is gradual.

Especially in the case of benzodiazepine tranquilizers, the approaches to withdrawal studies are mixed. Some include reports on the (problematical) administration of carbamazepine, antidepressants or neuroleptics to suppress withdrawal symptoms, although they seldom include warnings of the additional toxic burden (e.g. Klein et al. 1994). The tranquilizers are frequently replaced on a long-term basis by other psychiatric drugs. All the same, in recent years several authors of such studies have spoken not just in favor of a gradual withdrawal of tranquilizers; they also observed good long-term results in avoiding relapses back to the original unproductive mechanisms of dealing with problems and in avoiding problems of new dependencies (Ashton 1987; Rickels et al. 1988). This was also true of people with varying diagnoses (Golombok et al. 1987) and even in the case of repeated relapses (Crouch / Robson / Hallstrom 1988). Even in the eyes of professionals self-help groups have proven to be effective (Tattersall / Hallstrom 1992), as has psychological support in learning non-psychopharmacological strategies (Ashton 1994) when they encouraged people to persevere, to actively confront the problems caused by the continuous use of tranquilizers (Bish et al. 1996) and when psychotherapeutic support was provided during withdrawal and in the ensuing months (Otto et al. 1993; Kaendler / Volk / Pflug 1996).

Carbamazepine

Withdrawal symptoms associated with carbamazepine appear to be relatively minor. Nonetheless, in the few known controlled studies on withdrawal, a series of psychological, central nervous, vegetative and motor disturbances occurred.

L.A. Demers-Desrosiers and his colleagues from the Montreal Neurological Hospital and Clinic published two case studies of first-time occurrences of psychotic symptoms in two people who had been taking the anti-epileptic drug carbamazepine for three and four years respectively to treat epilepsy and had withdrawn slowly (Demers-Desrosiers / Nestoros / Vaillancourt 1978). The British neurologist John Duncan, together with his colleagues as the Centre for Epilepsy in Chalfont/England, carried out a systematic withdrawal study of the drug carbamazepine. A double-blind study of 24 adults with epilepsy diagnoses was carried out in which some subjects withdrew slowly and some abruptly. According to the 1988 report, although all of them

continued taking a second anti-epileptic drug, 23 persons still showed withdrawal symptoms, including paranoia and confusion in one patient, a lack of energy in four patients, depression and/or irritability in five, tension and feelings of depersonalization in two, states of anxiety in three, a weak memory and loss of concentration in two, insomnia and/or headaches in four, loss of appetite in three, muscular pain in five, jerking in four, muscle jitters and/or an insecure gait in two. Some of these disturbances were accompanied by low blood pressure and a racing heartbeat. According to the neurologists, in comparison with the chemically closely-related tricyclic antidepressants, the carbamazepine withdrawal symptoms were not nearly as pronounced as was found in the first study (Duncan / Shorvon / Trimble 1988).

The biggest withdrawal problem, especially in people taking this substance for epileptic attacks or to suppress psychological states—possibly together with neuroleptics or lithium—, lies in the danger of the recurrence or sudden new occurrence of epileptic attacks.

Lithium

In the case of lithium the usual vegetative withdrawal symptoms seem not to occur. However, depending on dose, duration of administration, as well as the patient's physical and psychological state, rebound phenomena and states of confusion can be expected which bring with them the danger of renewed hospitalization. Therefore, a gradual approach is recommended when stopping this psychiatric drug.

In 1979 D.G. Wilkinson, a psychiatrist at Bethlem Royal Hospital in London, was the first to report on withdrawal problems, citing states of confusion (Wilkinson 1979). Other authors have since confirmed Wilkinson's statements: a state of fear increases, irritability and an unstable state as well as the rebound phenomena of mania and psychosis result. Y.D. Lapierre and his colleagues at the Royal Ottawa Hospital took into consideration what they found to be an unexpectedly high "relapse" rate after the withdrawal of lithium and came to the following conclusion:

> "Such quick relapses suggest some sort of exaggerated neurochemical or physiological response to abrupt withdrawal. (…) Such rebound pheno-

> mena have also been observed after withdrawal from benzodiazepines." (Lapierre / Gagnon / Kokkinidis 1980, p. 863)

J.R. King and R.P. Hullin from the High Roads Hospital in Ilkley, England found in 1983 that the relatively high number of cases of anxiety states and other withdrawal reactions (irritability and an increase of strong emotions) are obviously withdrawal symptoms and rebound phenomena, and that their occurrence two or three days after withdrawal is characteristic of the delayed reaction typical of withdrawal from medication (King / Hullin 1983). The excessive increase of "relapses" within a few weeks after withdrawal from lithium, which has often been described, was addressed by Janet Lawrence of McLean Hospital in Belmont, Massachusetts, who said:

> "Such withdrawal might trigger psychosis by altering neurotransmitter balance with previously unipolar depressed patients relapsing into depression and bipolar patients into mania. This is of especial interest as it implies that lithium treatment may adversely affect the natural history of the underlying disease in an analogous fashion to the rebound psychosis postulated for antipsychotics by Chouinard and associates." (Lawrence 1985, pp. 873f.)

More recent withdrawal studies with lithium do not show uniform results. In general, it was observed that gradual withdrawal reduces the risk of the recurrence of the same depressive and manic moods which had led to psychiatric treatment and the administration of lithium in the first place (Mander / Loudon 1988; Faedda et al. 1993; Suppes et al. 1993). One study showed that after getting through the first three months following withdrawal, relapses were no more frequent than in those persons who continued to take lithium (Mander 1986). Some psychiatrists expect the occurrence of a withdrawal rebound, in other words an increased risk of relapse with temporarily more severe "symptoms" especially if the psychiatric drugs are stopped abruptly (Hunt / Bruce-Jones / Silverstone 1992; Schou 1993). Others found no such rebound (Sashidharan / McGuire 1983) or at least only a partial one (Klein et al. 1991). The claim that lithium prevents depressive or manic attacks is not undisputed in orthodox medicine ("Lithium" 1969). Publications continue to appear on "individual cases" where the claimed protection provided by lithi-

um proved to be an illusion (Prien et al. 1984), as well as on considerable rates of relapse (Lusznat / Murphy / Nunn 1988) and several cases of suicide including while under the influence of lithium (Schou / Weeke 1988).

Antidepressants

In 1982 Dennis Charney and his colleagues at University of New Haven, Connecticut described the typical reaction to the withdrawal of antidepressants:

> "Symptoms first appeared approximately 48 hours after the last dose and included excessive anxiety, restlessness, and autonomic symptoms such as diaphoresis, diarrhoea, hot and cold flushes, and piloerection *(goose-bumps)*. In addition, the development of hypomanic and manic symptoms has been observed to occur during the first week after cessation of chronic TAD *(tricyclic antidepressants)* treatment." (Charney et al. 1982, p. 377)

When stopping antidepressants, more psychological withdrawal symptoms can be expected, for instance apathy, social withdrawal, a depressed mood, but also panic attacks, aggression, or delirium. Withdrawal psychoses can also occur.

Besides stomach and intestinal tract disturbances, insomnia probably represents the second most common withdrawal problem, according to Steven Dilsaver and John Greden of the University Hospital in Columbus, Ohio. Further symptoms of the central nervous system include headache, restlessness, hyperactivity, insomnia, a dazed state, apparently paradoxical improvements, tiredness, jittering and nervousness as well as disruptive dreams, for example nightmares. According to the German psychiatrists Otto Benkert und Hanns Hippius, severe cramping, which is known to occur particularly with the withdrawal of tranquilizers, can also develop when antidepressants are withdrawn, especially if the dosage had been high:

> "Favorable conditions for the development of severe cramping include beginning with a high dosage, rapidly increasing the dosage, or a rapid withdrawal from a high dosage. A sudden withdrawal from antidepressants after years of use should always be avoided." (Benkert / Hippius 1980, p. 34)

The occurrence of vegetative withdrawal symptoms has been observed in cases of both gradual and abrupt withdrawal. Intestinal tract and stomach

disorders, for example diarrhea, stomach ache, tenesmus (painful, lasting cramp-like urges to release the bowels or bladder), and associated nausea, vomiting and loss of appetite, are the most common symptoms. In addition, the following should also be mentioned: cold-sweats, weakness, an increase in libido, a racing heartbeat, abnormal heart rhythms, as well as lowered blood pressure and extreme anxiety associated with physical collapse.

Motor disturbances are a more rare. Some individual reports have noted also muscle pain, Parkinson-like symptoms such as slowed movement, cog wheel phenomenon, as well as restlessness and withdrawal dyskinesia.

In 1984 Dilsaver und Greden provided an overview of the available literature on withdrawal. They reached the conclusion that withdrawal symptoms very frequently appear, that is, in 21% to 55% of adults. Other authors reported a rate of 80% (Dilsaver / Greden 1984).

Withdrawal symptoms that include a worsening of the psychological state must carefully be separated from a return or relapse to the original psychological problems that led to treatment in the first place, according to Janet Lawrence at the McLean Hospital in Belmont, Massachusetts. The two are not easy to distinguish. A "relapse" occurs three to 15 weeks after withdrawal, whereas withdrawal symptoms occur within two weeks and usually subside within a week or two (Lawrence 1985). The problems associated with withdrawal from antidepressants are as old as antidepressants themselves. Already in 1960, the antidepressant pioneer Roland Kuhn wrote that withdrawal symptoms:

> "… can look really bad, under certain circumstances bringing on severe headaches, profuse sweating, tachycardia attacks *(racing heart beat)*, sometimes also vomiting, all of which disappear within a half hour of resuming the medication. This is a phenomenon that looks very similar to the 'withdrawal symptoms' of toxicomania *(drug dependence)*…" (Kuhn 1960, p. 248)

Rudolf Degkwitz, former president of the German Association for Psychiatry and Neurology, compared the withdrawal symptoms of psycholeptics (neuroleptics and antidepressants) with those of alcaloids, the group of substances to which morphine among others, belongs. In addition, sleeping pills are considered addictive, and it is known that withdrawal from them can bring on severe, even life-threatening, cramping. According to Degkwitz:

> "The reduction or withdrawal from psycholeptics leads, as described above, to considerable withdrawal symptoms that cannot be distinguished from those symptoms occurring with the withdrawal of alcaloids and sleeping pills." (Degkwitz 1967, p. 161)

The development of tolerance and rebound phenomena even after only short-term usage in moderate doses as well as receptor changes may necessitate a gradual withdrawal. This counteracts the risk of withdrawal symptoms (which can last for several weeks) being confused with the recurrence of the original problems thus leading to renewed prescription of antidepressants and other psychiatric procedures. In those withdrawal studies which deal with antidepressants psychiatrists reported, among other things, relatively good prognoses in the time after withdrawal in older people (Cook et al. 1986), especially if the subjects had been symptom-free for 16 to 20 weeks (Prien / Kupfer 1986). They do not, however, deal with the question of what use that statement is to people who despite or because of antidepressants are suffering from depressive symptoms. Other studies saw higher relapse rates after withdrawing all kinds of antidepressants (Misri / Sivertz 1991; Solyom / Solyom / Ledwidge 1991); but the suspicion that antidepressants lead rather to depression becoming chronic (Irle 1974, pp. 124f.) was not dealt with while the question of how to evaluate the effect of psychotherapy or self-help (which was not offered) was not even posed in the first place.

Neuroleptics

Psychiatrists have reported the following psychological withdrawal symptoms: a depressed mood, fear, a desire to run away, and fits of crying. Because a reduced dosage may result in motor disturbances and emotional pain caused by the neuroleptics becoming more pronounced and/or particularly intense (due to the fact that the emotional numbing of the drugs has subsided), a temporary—but nonetheless serious—risk of suicide may arise during withdrawal.

Tension, restlessness, destructiveness, aggression, irritability, and excitability may develop into withdrawal psychoses and delirious states. Fritz Reimer, like Degkwitz a former President of the German Association for Psychiatry

and Neurology, concluded the following concerning the possibility of post-withdrawal delirium that may last several days:

> "The ultimate factor in the delirium syndrome is certain to be the psychoactive pharmaceuticals. On the surface, it appears to compare to the withdrawal delirium of the alcoholic." (Reimer 1965, pp. 446f.)

Some psychiatrists deliberately employ withdrawal and its effects to provoke a so-called therapeutic delirium, for example to stimulate those with a "numbed foundation" and to create new target syndromes for the neurolepsy, as they put it (cf. Lehmann 1996a, pp. 125f.).

Tardive dyskinesia, that is, muscle disorders that appear during treatment, withdrawal or thereafter and which are not treatable nor controllable, have in the past been deemed impairments resulting from treatment, and some victims have been successful in obtaining compensation for this. In 1977 George Simpson from the Psychiatric Institute in Orangeburg, New York was the first psychiatrist to warn that:

> "The potential of neuroleptics to produce dyskinesia, a serious complication, in a considerable number or patients would indicate that an attempt should be made to withdraw in every patient." (Simpson 1977, p. 6)

In the same year, Urban Ungerstedt und Tomas Ljungberg at the Karolinska Institute in Stockholm published results of studies in which rats were administered the conventional neuroleptic haloperidol and as a comparison the "atypical" clozapine[1]. They believe that "atypical" neuroleptics modify subtypes of specific dopamine-receptors, produce their supersensitivity and contribute to the risk of new, increasing, or chronically powerful psychoses of organic origin, which can be understood as "counterpart to tardive dyskinesia" (Ungerstedt / Ljungberg 1977, p. 199). Since then, medical journals have steadily published findings on supersensitivity, rebound and withdrawal psychoses (Chouinard et al. 1979, 1984; Chouinard / Jones 1980, 1982; Borison et al. 1988; Ekblom / Eriksson / Lindstroem 1984).

The frequent damage caused by typical neuroleptics like haloperidol arises from changes in dopamine-D_2-metabolism, observable as motor disturban-

1 Neuroleptic, marketed as Clopine, Clozapine, Clozaril

ces; the usual damage caused by "atypical" neuroleptics like clozapine, sertindole[1] or quetiapine[2] goes in the direction of changing the metabolism of special subtypes of dopamine-receptors, dopamine-D_1 and -D_4, seen as producing or increasing mid- and long-term psychotic syndromes of organic origin. Frank Tornatore and his colleagues at the University of Southern California School of Pharmacy in Los Angeles warned of the development of supersensitivity psychoses:

> "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." (Tornatore et al. 1987, p. 44)

Supersensitivity should be understood as the result of an increased tolerance to the drugs, as they point out in an additional citation in the German translation of the book four years later: "Thus, a tolerance to the antipsychotic effect seems to develop." (Tornatore et al. 1991, p. 53)

Withdrawal symptoms related to the central nervous system are well known to psychiatrists. In 1960 psychiatrists at the University Clinic in Vienna published their initial observations on the effects of Melleril[3]:

> "What we noticed was that when medication was suddenly withdrawn, even after several months patients experienced insomnia and considerable restlessness as well as occasional states of pronounced excitability." (Hofmann / Kryspin-Exner 1960, p. 900)

Further symptoms in this area include headaches, restlessness, insomnia, nightmares, numbness and taste impairment.

Vegetative withdrawal symptoms that may occur include anorexia (or a lesser loss of appetite), binging, nausea, vomiting, gastritis, diarrhea, stomach

1 Neuroleptic, marketed as Serdolect

2 Neuroleptic, marketed as Seroquel

3 Neuroleptic, active ingredient thioridazine, marketed also as Aldazine, Mellaril, Rideril, Thioridazine

ache, colic, pronounced nasal discharge, sebaceous gland discharge, hot flashes, freezing, pronounced sweating, cardiovascular (i.e. heart and circulatory system) problems such as a racing heartbeat, dizziness and physical collapse. The dangers that proceed from the habituation of a vegetative state and a physical dependence on neuroleptics have been shown in a rabbit study by Helma Sommer and Jochen Quandt at the Psychiatric Clinic in Bernburg/Saale. Their observations were based on noted metabolic changes induced by chlorpromazine that caused a circulatory collapse after withdrawal from the neuroleptic, despite the fact that metabolism was in fact returning to normal. For six months, Sommer and Quandt administered neuroleptics to 20 rabbits. The four animals that had received the highest dosage (16.7 mg/kg) died after a brief fit of cramping:

> "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)." (Sommer / Quandt 1970, p. 487)

Withdrawal from neuroleptics can cause various muscle and motor disturbances. Parkinson-like disorders are common, and muscle jerking or withdrawal dyskinesia and tongue atrophy often increases or is initiated.

Roy Lacoursiere and his colleagues at the Veterans Administration Hospital in Topeka, Kansas, have stated that the rate of withdrawal symptoms of all kinds is as high as 75%. The observed rate will depend on how closely subjects are observed, how well the withdrawal symptoms can be distinguished from the "mental illness," and how well the psychological condition of the subjects before treatment has been documented. Thus it is no surprise that some psychiatrists have published rates of 0% (Larcoursiere / Spohn / Thompson 1976). Up to 80% of patients experienced vegetative and especially stomach and intestinal problems with withdrawal (Greil / Schmidt 1988, 1989). There is very little evidence available on the rate of supersensitivity psychoses. In 1982 the pharmacologist Guy Chouinard and his colleague Barry Jones at the University Clinic in Montreal reported that they had found signs of supersensitivity psychoses among 30% of the 300 patients they studied, many of whom had not necessarily gone through an abrupt withdrawal

(Chouinard / Jones 1982). Degkwitz has repeatedly reported on withdrawal symptoms—not publicly, but in specialized journals:

> "We now know that it is extremely difficult, if not impossible, for many of the chronic patients to stop neuroleptics because of the unbearable withdrawal-symptoms." (Degkwitz / Luxenburger 1965, p. 175)

George Brooks, psychiatrist at the Vermont State Hospital in Waterbury said:

> "The severity of the withdrawal symptoms may mislead the clinician into thinking that he is observing a relapse of the patient's mental condition." (Brooks 1959, p. 932)

Medical opinion on continued administration of neuroleptics is split. In 1995 Patricia Gilbert and colleagues in the Psychiatric Department of the University of California in San Diego published a meta-analysis in which they looked at 66 studies conducted between 1958 and 1993 on almost 5600 persons. They summed up the problems of the continued administration of neuroleptics for the treating physician:

> "The issue of prolonged neuroleptic treatment in a patient with chronic schizophrenia places the clinician on the horns of a dilemma. Since neuroleptic treatment does not cure schizophrenia, a large majority of such patients need long-term treatment. At the same time, prolonged use of these drugs carries a high risk of adverse effects, including TD *(tardive dyskinesia)*. It is therefore recommended that continued prescription of antipsychotic drugs over a long period not be undertaken without adequate justification for both clinical and legal purposes. This may imply attempts at neuroleptic withdrawal. Drug withdrawal, however, is associated with a risk of psychotic relapse. To complicate matters further, a number of patients withdrawn from antipsychotic therapy do not experience relapse, at least over a short period, while some patients maintained on therapy do experience relapse. Thus, the clinician and the patient have to choose between two unwelcome risks: relapse and adverse effects of continued treatment." (Gilbert et al. 1995, p. 173)

Both psychotherapeutic treatment providers and biologically-oriented psychiatrists admit in internal discussions that they do not know whether neuroleptics

in individual cases actually help or cause damage. William Carpenter and Carol Tamminga from the Maryland Psychiatric Research Center in Baltimore, who provided the opportunity of a controlled withdrawal, came to the conclusion:

> "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!" (Carpenter / Tamminga 1995, p. 193)

Hanfried Helmchen from the University Hospital in Berlin, a psychiatrist who can be seen as a strong supporter of long-term neuroleptic treatment, expressed himself back in the 1980s in a discussion among colleagues in a notably skeptical tone:

> "When looking back on the 25 years since neuroleptics have been made available to us, it can be concluded that indication predicators 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 1983)

His colleague Karl Leonhard from the Psychiatric Department of the Humboldt-University in Berlin differentiated what he determined to be "nuclear schizophrenias" versus so-called cycloid psychoses (for example anxiety psychoses, confusion psychoses, happiness psychoses or motility psychoses with a catatonic-like state). Based on this, he considered it malpractice if prescribed neuroleptics are not soon thereafter withdrawn again:

> "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…" (Leonhard 1980, p. 3)

Several further factors should make people think twice before allowing themselves to be pressured by doctors' and psychiatrists' frequent insistence on a long-term administration of neuroleptics:

- The duration of hospitalization is not shortened when neuroleptics are taken (Hartlage 1965); in fact people are discharged earlier if they take none at all (Epstein / Morgan / Reynolds 1962).
- The state of older people taking neuroleptics is worse in comparison with those who are free of psychiatric drugs (Tune 1992).
- The aim for rapid success—quiescence and management—is also considered by psychotherapists as absolutely misplaced: what is important is personal development as well a change in the kind of family relationships which lead to illness and mental disturbance (Haley 1989).
- Neuroleptics probably suppress "self-healing tendencies" (Ernst 1954, p. 588) and prevent "cure" (Stierlin / Wynne / Wirsching 1985; Harding / Zubin / Strauss 1987). Those who weather their crises without psychotropic drugs have better medium and long-term prognoses (Goldberg / Klerman / Cole 1965; Hogarty / Goldberg / Baltimore Collaborative Study Group 1974; May / Goldberg 1978; Wehde 1991, pp. 44ff.), and are less frequently "psychotic" than those treated with psychiatric drugs and land far less often in psychiatric wards (Young / Meltzer 1980; Heinrichs / Carpenter 1985).
- "Relapses" under neuroleptics result in longer periods of hospitalization than "relapses" which occur when no psychiatric drugs are used (Gardos / Cole 1976).
- Neuroleptics contribute nothing to long-term rehabilitation (Niskanen / Achté 1972), generally inhibit everyday "functioning" (Schooler et al. 1967), and often lead to social deterioration (Müller / Günther / Lohmeyer 1986).

Uninformed, isolated and therefore defenseless individuals are understandably afraid to be sent back to the loony-bin and to be forcibly treated with neuroleptics, so they go on taking neuroleptics at the insistence of "their" psychiatrists or their families. It is particularly important that this group of "users" of psychiatric drugs be exposed to the alternative experiences of others.

Translation from the German by Christina White