

Recovery from Psychosis and Depression by Taking Psychiatric Drugs versus Recovery by Coming off Psychiatric Drugs

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Some recover from distress – often labelled as disease – others recover from psychiatry itself

Key words: Recovery

Recovery is a relatively new concept within the psychosocial arena which is used by those critical of psychiatry as well as by mainstream psychiatry itself, and turns against the therapeutic pessimism of the past decades. 'Recovery' can mean, among others things, rediscovery, healing, improvement, salvation or the regaining of independence. A positive connotation of hope is common to all uses of this term, but it has many different implications, especially in combination with the administration or intake of psychiatric drugs. For some, recovery means recovering from a mental illness, a reduction of symptoms, or a cure. Others use it to signify an abatement of unwanted effects of psychiatric drugs after their discontinuation, or the regaining of freedom after leaving the mental health system, or 'being rescued from the swamp of psychiatry' (see Stastny & Lehmann, 2007a, p. 41).

Members of mainstream psychiatry base their hope on the conviction that mental problems are largely of a brain/organic nature, not of a social nature, and that psychiatry as a scientific discipline can do justice to the expectation of solving mental problems. They believe that its diagnostic methods do not obstruct the view of the real problems of individuals in society and that their propensity and practice of using force are completely justified and compatible with human rights declarations and the UN Convention on the Rights of Persons with Disabilities. They believe that electroshock does not harm the brain and

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that synthetic psychodrugs are helpful in principle and – apart from benzodiazepines – do not cause bodily dependence.

What psychiatric workers do with their patients – the objects of their treatment – has taken many names with different facets and nuances over years: psychiatric custodianship, therapy, empowerment, psycho-education, recovery. Apart from psychiatric mass murders during the time of Hitler's fascism, which were also called 'treatment', the goal was to manage the treated ones' diagnosed illness by psychiatric measures, to release them from their symptoms, or to alleviate them and to re-establish their condition before the outbreak of the illness. Progressive psychiatric workers would probably understand psychological symptoms as a part of a change of the personality (although fragile) that includes the chance for advancement and stabilization.

1.1 Origins of the term 'recovery'

In 1937, Abraham Low of the Psychiatric Institute of the University of Illinois Medical School in Chicago founded the non-profit organisation Recovery, Inc., for people with various psychiatric problems, 'a cornucopia of self-help methods and techniques that parallel those used in cognitive therapy' ('The Legacy', 2005, p. 1). The aim of the programme was to learn to cope with distressing trivialities of everyday life and – with the learned techniques and in conjunction with professional help – to gain expertise in coping with bigger challenges of life. The concept of Recovery, Inc., should be understood as an addition to professional care, not as its replacement: 'The issue of medications is never discussed – that's the physician's domain' (ibid).

After many decades of being ignored in the field of mainstream psychiatry, the term recovery was revalued at the beginning of the 1990s. Until then, people with psychiatric diagnoses like schizophrenia were considered inherently as chronically vulnerable and, in principle, incurable. They could only hope for suppression or alleviation of symptoms. However, activists of the self-help movement, who were able to live an independent and healthy life after withdrawal of psychiatric drugs or after recovery from the brain-damaging effects of electro- or insulin-shock, challenged the concept of incurability. The European Network of (ex-) Users and Survivors of Psychiatry (ENUSP, founded in 1991), the World Network of Users and Survivors of Psychiatry (founded in 1993), lectures by users and survivors of psychiatry at conferences and universities, as well as survivor-produced books, magazines, publishing houses and web sites could not be ignored any longer.

The basis for the reversal of the recovery-term was prepared by US authors like Sheilah Hill, with *They That Sow in Tears* (1969); Leonard Roy Frank, with *The History of Shock Treatment* (1978); and Judi Chamberlin with *On Our Own: Patient-controlled alternatives to the mental health system* (1979). In the UK, it was Jan Wallcraft, Jim Read and colleagues (Read & Wallcraft, 1994; 1995; Graley et al., 1994; Read & Reynolds, 1996; Wallcraft, 1998); Louise Pembroke (1994); and Ron Coleman (1999), who wrote books about personal experiences as well as

alternative concepts of so-called mental illnesses and professional practice in the 1990s. One decade later, Gareth O'Callaghan from Ireland published his *A Day Called Hope: A personal journey beyond depression* (2003) and Mary and Jim Maddock their *Soul survivor: A personal encounter with psychiatry* (2006).

In the German-speaking countries, there were authors like Tina Stöckle with *Die Irren-Offensive – Erfahrungen einer Selbsthilfe-Organisation von Psychiatrieüberlebenden* (*The Lunatics Offensive: Experiences of a self-help organization of victims of psychiatry*, 1983), and later biographical books like *Auf der Spur des Morgensterns – Psychose als Selbstfindung* (*On the Trail of the Morning Star: Psychosis as self-discovery*) by Dorothea Buck-Zerchin (1990).

Of course, users and survivors of psychiatry are – like psychiatric workers, carers and relatives – not a homogeneous group, concerning their problems, skills, experiences and valuations, as well as their views on psychiatric treatment and processes of recovery. An equal diagnosis does not make them equals. In her book, *A Road back from Schizophrenia*, Arnhild Lauveng, a former psychiatric patient and now a psychologist, gives cause for concern:

And that all of this people would have share the same perspective just because they use a variety of services within the same system is not realistic to me, and it doesn't coincide with user and dependent organizations. (...) They are all users of one or multiple services in the psychiatric health care sector, but they are different people, with different stories and personalities, and they don't share the same world-view, and they definitely do not have the same perspective (Lauveng, 2012, p. 86).

Looking back, Juan Mezzich, former President of the World Psychiatric Association (WPA), stated in the early 1990s that in psychiatry it would have become accepted that in their professional practice they have to deal with individuals, not only symptom carriers:

The term 'recovery' was coined within the rehabilitation field in the early 1990s when it became clear that the purpose of professional efforts in this area should not be simply to deal with illness and improve functionality unilaterally. Such professional efforts should also primarily address, in collaboration with the individual at hand, his/her totality as a human being, owner of a unique history and values as well as a particular range of potentials (Mezzich, 2012, p. 12 – English original by J. M.).

1.2 Recovery from the illness

In their understanding of recovery, many psychiatric workers have been influenced by William Anthony, director of the Center for Psychiatric Rehabilitation at Boston University, who is 'considered the father of the Recovery Movement' (Foundation, 2012, p. 6). Anthony himself was influenced by Judi Chamberlin, the grand dame of the self-help movement, who had worked at his center. Anthony summarized the descriptions of recovery in the US literature.

There:

Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993, p. 13).

Michaela Amering, WPA board member, and Margit Schmolke, member of the WPA-sections 'Psychoanalysis in Psychiatry' and 'Prevention and Psychiatry', also put 'mental illness', from which people should recover, into the center of her understanding of recovery. In their book, *Recovery – Das ende der unheilbarkeit (Recovery: The end of incurability)*, originally published in 2007, they consider:

Recovery as development from the limitations of a patient role up to a self-defined and meaningful life (...) for people who have to overcome serious psychiatric illnesses (Amering & Schmolke, 2012, p. 17).

They invoke Patricia Deegan, a US user of psychiatry, who considers the acceptance of disability as the basis of recovery:

Recovery often involves a transformation of the self wherein one both accepts one's limitation and discovers a new world of possibility. This is the paradox of recovery, i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do. (...) People with psychiatric disabilities are waiting just like that sea rose waited. We are waiting for our environments to change so that the person within us can emerge and grow. (...) It is our job to form a community of hope which surrounds people with psychiatric disabilities (Deegan, 1996).

Apart from the fact that of course all humans – and not only those with psychiatric diagnoses – are well-advised to know the own limitations (which should not exclude attempts of trials of frontier crossings), the question is raised for the recovery process of such users and survivors of psychiatry who do not accept the limitations and ascriptions of disability and weakness any more, which are set by outside agencies or temporarily integrated into self-perception; whose madness primarily consists of a troublesome and uncomfortable way of living and perceiving life or in a temporarily extraordinary state of mind with boundary expanding potentials and who therefore have been made to be psychiatric patients; who have been damaged by psychiatric drugs or electroshocks and who want to protect themselves from further electroshocks or find the way back to health and well-being by coming off psychiatric drugs; or who are searching non-medical ways to cope with problems or to recover from them.

This group of users and survivors of psychiatry is not acknowledged by the recovery concept of mainstream psychiatry. Pirkko Lahti, 2001-03 President of the World Federation for Mental Health, asked correspondingly:

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)? (Lahti, 2004, p. 14).

1.3 Recovery from psychiatric treatment

In 1981, Tina Stöckle interviewed the members of the then nondogmatic *Lunatics Offensive* for her social-pedagogic diploma thesis about their experiences and opinions. Without using the term recovery, in her resumé she described a political understanding of recovery, including recovery from psychiatric treatment:

Most of the members of Lunatics Offensive liberated themselves from psychiatric influence with the help and support from other survivors of psychiatry. They recognized the destructive and zombie effect of the drugs. They fight the disenfranchisement and the underlying term of mental illness. In contrast, the survivors of psychiatry want to learn to combine normality and madness in such a way that they can live in this society without getting pushed or forced to escape totally to the one pole – still only be mad. The group can carry out that they become stable in themselves and develop a totally new self-esteem agreeing with their virtual understanding and feeling of identity, and that the people learn to focus their rage and aggression against the destructive environment, instead of destroying themselves (Stöckle, 1983, pp. 253–4).

Peter Watkins, a psychiatric nurse in Australia who identified with the movement critical of psychiatry (Laing, Foucault, Breggin, Thomas, Romme, Mosher, Bracken etc.), published a holistic concept of recovery. After four decades of professional experience, he recognized the advantage of abstaining from predetermined approaches and trusting in the capability of humans to assign their problems a meaning and to make decisions which make their life finally more bearable. He based his elaboration of these ideas on anthologies with stories of recovery and on long-term studies, which use a strict set of criteria for the definition of recovery: continuing wellness in spite of – and often also because of – the rebelling mind, missed ‘relapses’ within two years and absence of taking neuroleptics (Watkins, 2009, p. 17).

With his concept of recovery, Watkins is in line with the British National Institute for Mental Health, which had defined the rebuilding of control over one’s own life as the most important criterion for recovery:

Recovery is not just about what services do to or for people. Rather, recovery is what people *experience themselves* as they become *empowered to manage their lives* in a manner that allows them to achieve a fulfilling, meaningful life and a contributing positive sense of belonging in their communities (NIMHE, 2005, p. 2 – original emphasis).

1.4 User- and survivor-oriented concepts of recovery

Users and survivors of psychiatry who accept psychiatric drugs, and those who refuse them, complain – as a general rule – about the fact that the right to make one's own decisions is taken away from them in states of crises. So for all of them, it is important to have alternatives beyond psychiatry as well as strategies toward implementing humane treatment within the current system; to have tools to determine possible processes of crises and recovery by themselves (Stastny & Lehmann, 2007b). Advance directives (Ziegler, 2007) belong to this category, as do recovery plans (Copeland, 2010) and recovery plans including advance directives (Perkins & Rinaldi, 2007).

Pat Bracken, Clinical Director of the Mental Health Service in West Cork and member of the International Network towards Alternatives and Recovery (INTAR), identified the central position in the recovery concept as that of users and survivors of psychiatry. He emphasized their rights of sovereignty of interpretation – a mindset which could unsettle those psychiatric workers who do not want to give up their view on psychiatry as the basis of their recovery concept:

This user/survivor discourse is not about a new paradigm or a new model, but reorients our thinking about mental health completely. It foregrounds issues to do with power and relationships, contexts and meanings, values and priorities. In the non-psychiatric literature about recovery, these become primary. As I read it, this literature does not reject or deny the role of therapy, services, research and even drugs but it does work to render them all secondary. (...) In my opinion, we should judge how much the recovery agenda is being accepted by looking at how much prominence is afforded this user/survivor discourse in the training of professionals and academics. The most radical implication of the recovery agenda, with its reversal of what is of primary and secondary significance, is the fact that when it comes to issues to do with values, meanings and relationships, it is users/survivors themselves who are the most knowledgeable and informed. When it comes to the recovery agenda, they are the real experts (Bracken, 2007, pp. 401–2).

Mike Slade of the Institute of Psychiatry at King's College London makes a similar point in his book *Personal Recovery and Mental Illness*; his recovery concept involves a shift away from traditional psychiatric ideology, such as attempts to manage risk and avoiding relapse with psychotropics, towards new priorities: supporting the people in working towards their self-defined goals and taking responsibility for their own life:

Supporting personal recovery requires a change in values. The new values involve services being driven by the priorities and aspirations of the individual, rather than giving primacy to clinical preoccupations and imperatives. This will involve mental health professionals *listening to and acting on what the individuals themselves say*" (Slade, 2009, p. 3 – original emphasis).

Wilma Boevink, social scientist, Professor of Recovery at the Hanze University of Groningen, and an active member of the Dutch user movement, described how individual stories turn into experiential knowledge from which psychiatric work can also profit:

To me, talking about and working on recovery with others is a political matter. I believe that mental health care users can help and support each other in their recovery to a far greater extent than is currently the case. Only learning from each other's knowledge, gained from our own experiences over so many years, will enable us to make stories in which we can recognise ourselves. Stories from which we can say: 'that is how it is, this is who I am, that is of help to me.' Our stories are not only of value to us. They also offer the possibility for professionals to learn to speak in a new language. A language that both users and professionals understand (Boevink, 2002).

1.5 Psychiatric drugs in the focus of the recovery discussion

In contrast to most psychiatric workers, many users and survivors of psychiatry challenge psychiatric drugs when they discuss recovery or quality of life. Of course, other issues are important, too, like self-stigmatisation, discrimination, withholding appropriate support, the dependence of the psychosocial system on major pharmaceutical companies, and reducing the human being to a psychiatric diagnosis. But one fact is often overlooked: that recovery under the influence of psychiatric drugs is rather unlikely.

The experiences of the Berlin Runaway-house, as reported by Kerstin Kempker in *Coming off Psychiatric Drugs*, show what people can do without. Community, support, experienced staff (if possible with their own experience of withdrawal) and responsible doctors can help to support needy and changeable users and survivors of psychiatry:

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.

The usual reasons for reaching for a pill, with which many who have spent time in psychiatry are familiar, are not found here. This is hard for some to take at the beginning of their stay here, because as much as they want to come off these

psychiatric drugs, the drugs also serve as a 'last crutch' – as something which is there for them when nothing else is there any more. It has proven valuable to offer a place in our 'safe' at such times. We reserve a supply of drugs there for these moments when nothing else works, as a last resort. Just having it on supply is usually enough to ward off its use. On route to the 'safe,' we make ourselves available not as staff who must be bothered for access to prn (*pro re nata; when required*) medicine, but as people who want to understand what is wrong, and who think of many things besides releasing the burden, bridging the gaps, or finding solutions – and least of all doling out pills. And because most people living here for more than two weeks are not taking psychiatric drugs (60%) and/or withdraw completely or gradually while here (40%), there is a lot of experience that gets shared concerning how one can 'do without,' and all that one can do again 'without' the drugs (Kempker, 2004, pp. 270–1).

Discussing psychiatric drugs should not end in a simple Pro or Con; in the frame of the right on self-determination, as demanded by the movement of users and survivors of psychiatry, it is up to the individual to decide about the benefit of these substances. In 1997, at the conference of ENUSP in Reading (UK), the delegates decided in one vote for a position paper on psychiatric drugs, which said:

Assessing the administration and taking of psychotropic drugs is an especially controversial issue. Taking neuroleptics, antidepressants, lithium, antiepileptics (administered as psychotropic drugs), psychostimulants (administered to children in order to subdue them) and tranquilizers can lead to apathy, emotional deadness, depression, suicidal states, paradoxical agitation, confusion and delirium, intellectual disturbances, loss of creativity, lack of concentration, memory problems, epileptic attacks, weakening of the immune system, hormonal and sexual disturbances, chromosomal and pregnancy damage, blood damage, disturbance of body temperature regulation, heart problems, liver and kidney damage, skin and eye damage, Parkinsonian disturbances, hyperkinesia, muscle cramps, movement stereotypy, or much more. On the other side, many individuals cannot exist in their life-conditions now without taking these psychiatric drugs (Lehmann, 1997, p. 4).

Getting along with one's current life conditions is not necessarily synonymous with recovery. To speak of recovery in the sense of healing caused by neuroleptics is more than problematic. For decades, psychiatric workers and pharmacologists deny that these substances have any healing effect. Even the term 'antipsychotic effect' would be questionable, according to the Swiss psychiatrist Manfred Bleuler, as it suggests the unlikely assumption that a neuroleptic would work:

independently of its sedating and relaxing still somehow different, directly on the psychosis. The effect of the neuroleptics does not depend on the basic psychic disease

the patient is suffering from. Neuroleptics are not specific cures for specific diseases with specific aetiology (Bleuler, 1975, pp. 164–5).

In 1980, Klaus Dörner, one of the most 'progressive' psychiatrists in Germany, and the psychologist Ursula Plog admitted the debilitating effects of neuroleptics. These substances turn the psychiatric patient more or less into a neurological patient, with the appearance and the disablement of a person with Parkinson's disease, (Dörner & Plog, 1980, p. 367). Twelve years later they confirmed:

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).

Often mainstream psychiatrists respond that with the newest generations of psychiatric drugs, everything will change. But the modern, so-called atypical neuroleptics (the first of which, clozapine [trade names Clopine, CloSyn, Clozalux, Clozaril, Denzapine, FazaClo, Leponex, Zaponex, Zopine, etc.], was developed in the early 1960s) do not have fewer unwanted effects, even if these drugs are widely preferred since they appear to cause fewer neuromuscular problems. Gerhard Ebner, President of the Swiss Association of Psychiatric Medical Directors (who served on Janssen Pharmaceuticals' Advisory Board regarding the introduction of Risperdal Consta, the first 'atypical' depot neuroleptic), had to admit:

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).

1.6 Problems beyond psychiatric drugs

Even if psychiatric drugs – with their risks or unpleasant effects for mind and body – are a burden for psychiatric patients, simply stopping them, whether slowly or abruptly, often is not a sufficient way to cope with one's mental problems. Getting mad is a signal showing the necessity of a change, says Maths Jespersen, a regional secretary of the Riksförbundet för Social och Mental Hälsa (Swedish National Organization of Users and Survivors of Psychiatry):

Madness is no illness to be cured. My madness came to call up a new life for me (Jespersen, 2004, p. 76).

Indeed, those who learn to take feelings seriously, to follow their own intuition and to take notice of and to react to warning signals of a developing crisis, are

more likely to escape the danger of having psychiatric drugs prescribed a second time. When users and survivors of psychiatry understand the connection between violence or abuse and their difficulties, when they understand mad and troubling symptoms and react in alternative ways to crises, it is easier for them to break off emotional involvement from life problems and deal with them. The quest for understanding that begins at the end of an acute phase of madness or depression takes on preventative qualities, as Regina Bellion, a German survivor of psychiatry, says:

Whoever gets to the bottom of his or her psychotic experiences afterwards obviously does not run into the next psychotic phase all too soon (Bellion, 2004, p. 284).

Some co-authors of *Coming off Psychiatric Drugs: Successful withdrawal from neuroleptics, antidepressants, lithium, carbamazepine and tranquilizers* (Lehmann, 2004), who gave accounts of how they came off psychiatric drugs without once again ending up in the doctor's office, regard it as a fundamental condition to notice their own (co-) responsibility for their lives, their problem-burdened past and their responsibility for their future.

In the same anthology, professional helpers note their humane presence and their availability in the critical moments of coming off as a prerequisite for effective support. But the users and survivors of psychiatry have to do their share in overcoming the problems that can appear when coming off, too. Constanze Meyer, psychologist and psychotherapist in Berlin, knows that this is not always easy:

These solutions have in common that they normally need much time and an active confrontation with the own situation and the own attitudes and patterns of behavior (Meyer, 2004, p. 253).

The problems which led to administration of psychiatric drugs may return when people stop taking them for different reasons, so it is important to understand the reasons for one's problems. Experiences within the self-help movement of users and survivors of psychiatry show that the belief that it was the 'evil others' (neighbours, husband, wife, parents, family doctor, psychiatrist, police, psychosocial services, etc.) or the 'mental illness' (metabolic disturbance, genetic disposition, vulnerability, etc.) that led to the administration of the psychiatric drugs in the first place can prevent or make it more difficult for people to take full responsibility for their own lives, since the habit of looking for someone or something to blame is hard to break. Mental crises – like physical crises – offer a chance for change; in fact, they demand it. This calls for dealing with one's own history, whether in dialogue with oneself, in a self-help group, with friends, relatives, or therapists, as long as they are free of the baggage of psychiatric beliefs and power play.

Marc Rufer, a Swiss doctor and psychotherapist, who in his practice saw many consumers of psychiatric drugs who were willing to come off them, appealed to professionals to provide support, not only in the physiological withdrawal process, but also in working through their stories and history:

The individuals themselves have to understand what has happened to them, what they experienced and why they reacted this way rather than another way. Where does the problem lie, how did it develop, what triggered the worsening of the problem which led to the need for help or to conspicuous behavior? It is vital that this subject is dealt with and that it is dealt with in depth. What happened? Who was involved? Has it to do with school, work, parents, relationship, sexuality? Has it to do with jealousy, dependency, addiction? Has it to do with problems of performance, for instance the feeling, the fear, or even the certainty of not performing satisfactorily, of not meeting the demands and expectations of parents, teachers, or partners? Has it to do with the fear of not passing exams, of not earning enough, of not being a satisfactory sexual partner? Has it to do with growing up, with a child leaving home? Is it about loneliness, the impossibility of approaching other people or developing relationships with other people and maintaining these relationships? These are questions which we can all agonize over. If they increase, if they remain unresolved for a long time, they are capable of leading to states of madness.

Where is the delicate point which led to the calamitous development? All this needs to be clarified, with self-reliance being the main aim as well as the knowledge: 'From now on I can avoid such developments. I am in control, it is in my hands. I do not need any doctor, any medication or institution' (Rufer, 1990).

Mainstream psychiatrists would probably not agree with Rufer, as they see mental problems largely as symptoms of brain disorders. According to Pat Bracken and colleagues, reducing emotional problems to neurological problems prevents recovery:

Reductionist models fail to grasp what is most important in terms of recovery. The evidence base is telling us that we need a radical shift in our understanding of what is at the heart (and perhaps soul) of mental health practice. If we are to operate in an evidence-based manner, and work collaboratively with all sections of the service user movement, we need a psychiatry that is intellectually and ethically adequate to deal with the sort of problems that present to it (Bracken et al., 2012, p. 432).

1.7 Psychiatric drugs or recovery?

All people, but especially people who decide to try to recover with psychiatric drugs, should know that the life expectancy of psychiatric patients is reduced by – on average – two to three decades (Ösby et al., 2000; Colton & Manderscheid, 2006; Manderscheid, 2006; 2009; Aderhold, 2007; Weinmann et al., 2009; Chang et al., 2011; Lehmann, 2012) and that for three decades, the mortality rate has continued to grow (Saha et al., 2007, p. 1126).

While you can discuss without end the role of psychiatric drugs in the early deaths of psychiatric patients, if psychiatric workers, nurses included, are interested seriously in recovery processes, they should inform their patients and their relatives about the possible unwanted effects especially of neuroleptics, the most risky group of psychiatric drugs. In general, they are administered without informed consent, especially without information about unwanted effects which could be identified as early warning symptoms for developing chronic and lethal diseases. Without being able to identify these warning symptoms, the patients, their relatives, supporters and carers cannot react appropriately in case of these effects, but rapid response would be life-saving (Lehmann, 2013).

Users of psychiatry and psychiatric workers should seek information in time and think carefully about the risks and possibilities of coming off psychiatric drugs, especially when the drugs have been administered long-term. And if the decision is to withdraw, then they should come off step by step, when required (Lehmann, 2004). Too-rapid withdrawal of neuroleptics can cause chronic damage. If, at withdrawal, psychotic symptoms appear, this could point to developing (organic-based) supersensitivity psychoses, which might become chronic by further administration of neuroleptics and make each recovery process impossible; so it would be important to use non-neuroleptic methods to alleviate withdrawal symptoms.

Of course, antidepressants can also trigger chronic problems. One is the danger of dependence. In the early 1970s doctors expressed the suspicion that antidepressants lead to depression becoming chronic (Irlé, 1974, pp. 124–5). Meanwhile, the study led by Paul Andrews (2011) in the Department of Psychology, Neuroscience & Behaviour at the McMaster University in Hamilton, Ontario (Canada), showed that synthetic antidepressants interfere with the brain's natural self-regulation of serotonin and other neurotransmitters, and the brain can overcorrect once medication is suspended. Therefore, new depression would be triggered, Andrews explained:

We found that the more these drugs affect serotonin and other neurotransmitters in your brain – and that's what they're supposed to do – the greater your risk of relapse once you stop taking them. (...) All these drugs do reduce symptoms, probably to some degree, in the short-term. The trick is what happens in the long term. Our results suggest that when you try to go off the drugs, depression will bounce back. This can leave people stuck in a cycle where they need to keep taking antidepressants to prevent a return of symptoms (quoted after Patients, 2011).

Andrews and colleagues concluded that it is important to inform patients about the risk of dependency before the administration of ADMs (antidepressant medications):

Drugs that promote the risk of relapse or withdrawal upon discontinuation can cause dependence on the drug to prevent the return of symptoms. Consequently, such drugs must be managed carefully and patients must provide informed consent for their use. ADMs are sometimes prescribed to people with alcohol or illicit drug dependencies, because the use of such substances to medicate feelings of anxiety and depression is thought to play a role in the dependency. Ironically, the use of ADMs to help people wean off such substances might merely replace one dependency with another (Andrews et al., 2011, p. 15).

The reason for this dependency lies in the down-regulation of the serotonin- and noradrenalin receptors as a reaction to the artificial levels of transmitters in the synapses caused by the antidepressants; the receptors become insensitive and degenerate. In 2012, Andrews and colleagues explained once more:

It is a principle of evolutionary medicine that the disruption of evolved adaptations will degrade biological functioning. Because serotonin regulates many adaptive processes, antidepressants could have many adverse health effects. For instance, while antidepressants are modestly effective in reducing depressive symptoms, they increase the brain's susceptibility to future episodes after they have been discontinued. Contrary to a widely held belief in psychiatry, studies that purport to show that antidepressants promote neurogenesis are flawed because they all use a method that cannot, by itself, distinguish between neurogenesis and neuronal death. In fact, antidepressants cause neuronal damage and mature neurons to revert to an immature state, both of which may explain why antidepressants also cause neurons to undergo apoptosis (programmed death) (Andrews et al., 2012).

Referring to the serotonin re-uptake-inhibitors (SSRI) Marc Rufer warned long ago:

In the long-term, the effect of serotonin is weakened. If the serotonin deficiency hypothesis of depression were correct then the SSRI should cause very severe depression (Rufer, 1995, p. 144).

Neuroleptics and antidepressants should be a focus of the recovery discussion, not only because of their risks, but because they can also inhibit self-healing tendencies. With the first systematic self-experiments with the neuroleptic prototype chlorpromazine (trade names Clonactil, Largactil, Thorazine, etc.) in the early 1950s, Klaus Ernst of the Psychiatric University Clinic Zurich came to this conclusion. After testing neuroleptics on himself and his wife Cécile, he pointed out the double-edge effects of modern neuroleptic symptom suppression. His detailed description gives an idea of why the opportunity for and support of recovery and successfully conducting psychotherapy that aims at resolving conflicts under psychiatric drugs, especially neuroleptics, is so compromised:

But it is certain that the drug suppresses the entire affective spectrum and not merely its pathological elements. Such a broad suppression might also affect impulses issuing from our self-healing tendencies. Individual, albeit, irreproducible impressions of acute patients led us to wonder whether the medicinally caused apathy did not in fact lead to a solidification of the psychotic development, affecting both relapse and remission (quoted after Itten, 2007, p. 244).

The list of potential drug-caused damages should be the focus of those who think about the facts which enable or prevent recovery processes. Negative reports about the effects of psychiatric drugs, however, are unwanted in a field which is dominated by the major pharmaceutical companies and their financial interests and is meaningfully influenced by them (Mosher, 1998). This problem appeared, for example, at the conference 'Alternatives 2011 - Creating Our Own Communities of Wellness and Recovery' in Orlando, Florida, which was financed by the Substance Abuse and Mental Health Services Administration (SAMHSA), part of the US Department of Health and Human Services. In her inaugural address Pamela Hyde, director of SAMHSA, complained about the reduced life expectancy by - on average - 25 years of psychiatric patients, who have to deal with obesity and diseases like diabetes or heart diseases. She called for a national dialogue with slogans like 'Behavioral health is essential to health! - Treatment is effective! - Prevention works! - People recover!' (Hyde 2011). Her administration even distributed information sheets of different organisations, among others, from the American Heart Association and the American Stroke Association, about metabolic syndrome and heart diseases, and from American Diabetes Association about life with diabetes. In these leaflets, different possible risk factors were listed; significantly, psychiatric drugs were absent. Further, SAMHSA distributed so-called KITs (Knowledge Informing Transformation) to support recovery: leaflets with titles like 'Illness Management and Recovery - Providing information, support and skills to promote recovery, and other advice'; for example:

Strategies to help people who choose to take medication tailor the medication schedule to best fit their daily routine. (...) New strategies to help them manage their stress, and significantly improve their lives. (...) Relapse prevention plans to spot early warning signs of a coming relapse and think through ways to prevent relapses (...). This KIT and all of the Evidence-Based Practices KITs are recovery-orientated - created with the goal of helping people with behavioral health conditions to live fulfilling lives and contribute to their communities while striving to reach their own full potential (SAMHSA, 2011).

Hints for the conference participants (among them many consumers of psychiatric drugs), that all the named health problems can be caused by psychiatric drugs, that psychiatric drugs can have serious recovery hindering effects, that, for example, Eli Lilly & Co., the pharmaceutical company which

produces Zyprexa, paid 690 million US-\$ to settle some 8,000 lawsuits filed by people who reported that taking the neuroleptic Zyprexa resulted in unwanted weight gain, diabetes, other metabolic diseases, and death (Frank, 2005), were missing. The major pharmaceutical company Janssen Pharmaceuticals, Inc., operates in the same way. In August 2012, the firm wrote in its newsletter *Choices in Recovery*:

Research has shown that the life expectancy for people living with a serious mental health condition is, on average, 25 years shorter than the general population. Heart disease, diabetes, respiratory diseases, and infectious diseases (such as HIV/AIDS) are the most common causes of death among this population (Janssen Pharmaceuticals, 2012a).

People should improve their total wellness, Janssen Pharmaceuticals, Inc., advised, and made these suggestions:

Eat more healthfully (e.g., eat more fruits/vegetables) / Smoke less / Quit smoking / See a primary care physician for a yearly physical exam / Work on getting better rest/sleep / Begin a light exercise program (if your doctor approves) (...) / Talk to your doctor about medication options (ones you can take daily or every few weeks) / Learn more about your condition / Communicate openly and honestly with the doctor / Try to remain hopeful! (Janssen Pharmaceuticals, 2012b).

But no word that the mentioned diseases could be caused by their neuroleptics and that wellness could improved by coming off the neuroleptics. If you read medical literature carefully, you can see on the other hand, that medical opinion on continued administration of neuroleptics is split. In 1977, George Simpson from the Nathan Kline Psychiatric Institute in Orangeburg, New York, was the first psychiatrist to disclose:

The best treatment, at the moment, is the gradual withdrawal of neuroleptics with the substitution of minor tranquilizers to relieve anxiety. 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).

Because of the dependence risk of minor tranquilizers (benzodiazepines), today Simpson might suggest a less dangerous substitute for neuroleptics. Hanfried Helmchen from the Psychiatric University Hospital in Berlin, a man 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 sceptical tone:

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, 1983).

Karl Leonhard from the Psychiatric Department of the Humboldt-University in Berlin 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).

Following his long-term study as far back as 1972, Manfred Bleuler saw no indication of an improved course or conclusion in patients following long-term treatment with neuroleptics. In fact the opposite seemed to be the case:

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 (Bleuler, 1972, p. 366).

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 5,600 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 (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).

1.8 Addressing contradictions

To speak about recovery without mentioning the risks of psychiatric drugs is good for the interests of the pharmaceutical industry which, in societies with free markets, understandably is primarily oriented to profits. If their products can be praised as recovery-promoting it is good for sales.

With this approach, the new, tendentious emancipatory recovery concept is bent. Existential problems are veiled from psychiatric patients, their relatives, carers and the interested public; the inherent contradictions are made taboo. Such a domesticated concept of recovery can easily be integrated into the system of mainstream psychiatry, without practice having to change. Patients will be damaged further by psychiatric drugs, or – if the drugs are not recognised as seriously risky – will accrue additional health burdens in addition to their existing vulnerability, which also reduce their life expectancy so much.

If the disturbing effects of psychiatric drugs, which make recovery more difficult or obstruct or prevent it, are ignored, and the associated recovery concept cannot be taken seriously any longer, then recovery would become an empty notion. Existing contradictions, which would have to be part of the recovery discussion, lie in the entire psychiatric field: open and taboo damages caused by psychiatric drugs, particularly neuroleptics, and brain damage caused by electroshock, as well as other factors, which obstruct recovery processes. Concepts of recovery which try to exclude these factors should be regarded as typical psychiatric labelling fraud. In a fair discussion, at least the different approaches of recovery – taking psychiatric drugs or of recovery by coming off psychiatric drugs – should be shown openly. People could then make their own informed decisions about how to proceed.

Author note

All translations of the German citations into English are made by the author or by translators. Explanations in italics are written by the author.

Translation by Mary Murphy. Thanks to *Deutsche Klassenlotterie Berlin* and *Der Paritätische Wohlfahrtsverband Berlin* for funding the translation. Thanks to Darby Penney for support in translation matters.

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 colour.

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