

# Early Warning Signs of Chronic or Lethal Diseases Due to the Administration of Neuroleptics<sup>1</sup>

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Neuroleptics tend to be administered without informed consent or information about unwanted effects. This paper describes the early warning symptoms for developing chronic and lethal diseases. It is hoped that such information may enable patients, their relatives, supporters and carers to react appropriately.

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**Key words:** neuroleptics, withdrawal, early warning signs, neuroleptic malignant syndrome, mortality

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Neuroleptics, the so-called antipsychotic drugs, are conductive factors for the high mortality of psychiatric patients. 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. But rapid activity would eventually be life-saving.

## **Reduced life expectancy**

The life expectancy of psychiatric patients is reduced by – on average – two to three decades (Ösby et al., 2000; Colton & Manderscheid, 2006; Weinmann et al., 2009; Aderhold, 2010, pp. 48–57). Over three decades the mortality has been growing continually (Saha et al., 2007, p. 1126). In August 2012, Janssen Pharmaceuticals, Inc., confirmed this catastrophe 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

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disease, diabetes, respiratory diseases, and infectious diseases (such as HIV/AIDS) are the most common causes of death among this population. (Janssen Pharmaceuticals, 2012).

Some psychiatrists, like major pharmaceutical companies, do not see the effects of the administered drugs to be the crucial factor for the reduced life expectancy of psychiatric patients, but more their often precarious economic situation and their unhealthy way of living. But should the miserable health condition of psychiatric patients and the never securely determinable effects of psychiatric drugs not be even more reason to prevent them from a further bodily burden? One could argue that the second and third generations of neuroleptics, the so-called atypical neuroleptics do have less unwanted effects. And indeed, at first glance, they seem to be subjectively better tolerated. However, the 'atypical' neuroleptics are widely suspected of causing increased respiratory and circulatory problems, heart disease, diabetes, abnormal blood cell counts, obesity, apoptosis<sup>2</sup>, metabolic syndrome<sup>3</sup>, and receptor changes that can lead to chronic psychoses. As early as 2003, 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 that there were 'risks and injuries caused by the so-called atypical neuroleptics':

It is not a case of fewer side-effects, but of different ones which can be just as debilitating even if the patient isn't immediately aware of them. Therefore, patients can be more easily motivated to take these drugs because they no longer suffer instantly and as much from the excruciating dyskinesias/extrapyramidal side-effects (Ebner, 2003, p. 30).

#### **Early warning signs and the decision to withdraw**

What if you want to withdraw from neuroleptic drugs and do not know how to proceed?<sup>4</sup> What if you want to prevent the increased risk of conditions such as apoptosis, priapism<sup>5</sup>, vaginism<sup>6</sup>, circulatory collapse, pneumonia, or sudden cardiac death, which might result from the administration of neuroleptics and be of some interest especially to psychiatric patients, whose life expectancy is shortened by more than two to three decades compared with the general population? What if doctors do not do preventative or on-going check-ups (such as blood count, lipid profile<sup>7</sup>, liver values, EKG, examination of the ocular fundus (eyeground), EEG, and tongue protrusion test<sup>8</sup>) and do not check if you have health preconditions that preclude the administration of neuroleptics? And what if you experience the early warning signs and precursors of emerging dangerous 'side'-effects of psychiatric drugs seriously and want to withdraw, whether you are a doctor or a person taking the drugs?

Based on experience, there are early warning signs that may suggest potentially irreversible or even lethal damages and may suggest reducing the dosage of the neuroleptics or withdrawing them at once or gradually:

- Loss of energy and lack of interest in talking and social contact: precursors of a possible chronic deficit-syndrome (neuroleptic apathy syndrome/'broken wing'-syndrome<sup>9</sup>)
- Parkinsonism<sup>10</sup>, apathy, lack of willpower and depressed mood: possible precursors of suicidality
- Feelings of weakness, fatigue, loss of energy, indifference, temporary nausea, movement disorders like tremor and muscular rigidity as precursors of states of confusion, which begin with inner restlessness, agitation, feeling driven and anxious and end in states of delirium<sup>11</sup> which might turn lethal in individual cases
- Increased prolactin level as a possible precursor of neoplasm in the mammary glands which can develop into breast cancer<sup>12</sup>
- Fatigue, sugar excretion in the urine, increased amount of urine, dry mouth, increased thirst along with inappetence, impotence, menstrual disorders, reduced resistance against infections, fatty liver, cirrhosis of the liver and sight disorders: signs of reduced glucose tolerance (pathological alterations of blood sugar balance, especially increased blood sugar levels), which might result in chronic diabetes<sup>13</sup>
- Increased hip size and body mass index: precursors of possible chronic obesity, along with increased mortality
- Temperature rise connected with neurological symptoms: possible precursors of malignant hyperthermia<sup>14</sup>
- Increase of noticeable muscular problems (characterized by disorders of muscle tension and movement), polypnea (enhanced respiratory rate, connected with reduced oxygen supply), tachycardia, increased salivation, increased sweating, impaired consciousness and light fever, general lability of the autonomic nervous system, muscle stiffness and other noticeable muscular problems: possible precursors of neuroleptic malignant syndrome<sup>15</sup>
- Stress-induced cardiac insufficiency as a risk factor for – increased three-fold in the case of neuroleptics – massive and life-threatening heart complications of all kinds
- Obesity, disorders of fat metabolism, high blood pressure and insulin resistance as the underlying causes of metabolic syndrome, which is associated with a high risk of massive vascular diseases and in this combination exceptionally dangerous and may trigger a myocardial infarction or apoplectic stroke

- Dry mouth, gingivitis and reduced oral hygiene: possible precursors of caries and parodontopathies (inflammation of the gums and periodontium [tissues that both surround and support the teeth] with loss of teeth)
- Increased liver values and fatty liver are possible precursors to chronic jaundice and persistent liver cell damages. If untreated or if one continues to take drugs toxic to the liver, one may develop hepatic fibrosis (alteration of liver cells in connective tissue) and eventually irreversible cirrhosis of the liver with massive complications including liver failure<sup>16</sup>
- Delayed wound healing, angina, 'flu without flu' (unexplainable malaise in connection with unclear symptoms in the autonomic nervous system), symptoms like fever, shivering attack, inflammation of the tongue, oral mucosa, gums, neck, pharynx and ears, sore throats, sweating, weakness, infirmity, rash, joint pain, ulcers in the anal region, jaundice, lassitude, loss of appetite, vomiting, diarrhea, swelling of the lymph nodes, liver cell damage: possible precursors of a life-threatening agranulocytosis<sup>17</sup>
- Thickening of the blood, disturbed blood flow and alterations of the natural consistency of the blood in connection with longer restraint: precursors and risk factors for life-threatening thromboses and embolisms<sup>18</sup>
- Pigment deposits in the eye: possible precursors of chronic damage to the retina, the cornea and the optic nerve and worsening of an eventually existing glaucoma<sup>19</sup>
- Difficulty swallowing, feeling of nasal congestion, feelings of anxiety, slight respiratory distress, appetite disorders with nausea or vomiting, colicky pains and crampy diarrhea, general feeling of weakness, muscular pain, abnormal feelings of tingling, dizziness and finally the onset of a 'Pseudo-Parkinsonism' with tremor and muscle stiffness, propulsion (disturbance of gait in which the patient, during walking, steps faster and faster with progressively shorter steps and passes from a walking to a running pace and may fall forward), salivation, seborrhea oleosa (moist, oily skin disorder with the formation of yellow-brown crust) and rigor of the facial muscles possible precursors of aspiration (suctioning of blood or vomit in the trachea or bronchial tubes) with subsequent mouth-tongue-throat syndromes like asphyxia (life-threatening state of suffocation)
- Tremor and other muscle disorders: possible precursors of tardive dyskinesia<sup>20</sup>.

Also troublesome symptoms when withdrawing from neuroleptics can be warning signs of persistent damage. The quick onset of psychotic symptoms

when reducing psychiatric drugs can indicate a developing supersensitivity psychosis (of organic nature, which – in case of ongoing administration of neuroleptics – can result in a tardive (chronic) psychosis).

### **Psychiatric recklessness**

So, what if someone decides in a reflective way to abstain from neuroleptics? What if, despite existing risk factors like reduced glucose tolerance, elder age, obesity, fatty liver, reduced physical activity or disorders of the fat metabolism, neuroleptics are administered initially or further on? What if female psychiatric patients get pregnant and are concerned about the potential risks of neuroleptics to their babies? What if parents or guardians of adults would decide it is best for the health of their wards to come off psychiatric drugs? What if psychiatric professionals want to protect their patients from toxic risks because of medical responsibility? Or if they want to protect themselves from the risk of legal liability due to reckless prescription of drugs when warning signs of harm are present. What if psychiatric professionals do not attempt to withdraw their patients from neuroleptics to prevent possible suddenly occurring or undetected developing diseases, but behave recklessly?

The *Black's Law Dictionary* defines as recklessness:

Conduct whereby the actor does not desire harmful consequence but ... foresees the possibility and consciously takes the risk [ ... or alternatively as] a state of mind in which a person does not care about the consequences of his or her actions (Garner, 2005, p. 1053).

In US, British, German, Swiss and many other courts, a wrongdoer who recklessly causes harm can be held to the same liability as a person who intentionally does so. Also, to be held responsible under civil law, the second-degree intention is sufficient. The chance of a conviction increases if you – under the eyes of a witness! – hand over a writ about the observed effects of psychiatric drugs (which might be early warning signs of chronic or lethal damages) to the prescribing or administrating person with the request to 'rethink the prescription' and attach the writ to the 'medical record'. The standard defence of doctors by claiming that prescription is 'common practice' might then work not any more so easily when adverse effects developing during ongoing treatment are obvious and documented. Common practice in medicine is – or at least should be – to examine patients for risk factors before starting a treatment and monitoring treatment in case adverse effects develop. But be aware: most psychiatrists hate documents – like the devil the holy water – and will try to tap the writ back into your hands.

But what if you want to withdraw from neuroleptic drugs and do not know how to proceed? There are many rational reasons to educate oneself about the issues associated with withdrawal from neuroleptics and on ways to minimize their use. Facing the many possible withdrawal symptoms and

problems, it is of fundamental interest to look at detailed accounts of how others came off these substances without once again ending up in the doctor's office. And, as a professional, to learn, how colleagues working in psychotherapy, medicine, psychiatry, social work or natural healing, report on how they helped in the withdrawal process. But beware of Know-it-alls and patent recipes, be careful towards and kind to guides when coming off or withdrawing psychiatric drugs: the uniqueness of individuals, their problems and their possibilities mitigates against any hope of a generalized approach. To generalize the diversity of strategies, needs, resources and conditions will lead into a deadend-street.

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### Endnotes

- Note about liability: I do not provide medical advice. Although this is the first paper to summarize early warning signs of chronic or lethal diseases due to the administration of neuroleptics, it is not intended as a substitute for professional help. Should you have any health care-related question, please call or see your physician or other health care provider promptly. I am not responsible if you decide against this advice. Nor am I responsible for any damage you may experience from a medical or psychiatric treatment or its termination.
- Atrophy of the brain cells and decomposition of the DNA.
- Also known as 'deadly quartet', 'Reavan's syndrome' or 'syndrome X'.
- Find more information about coping with withdrawal and returning emotional problems in: Peter Lehmann (Ed.), *Coming off Psychiatric Drugs: Successful withdrawal from neuroleptics, antidepressants, lithium, carbamazepine and tranquilizers*. Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing 2004, and in: Peter Lehmann, 'What helps me if I go mad?' In Peter Stastny & Peter Lehmann (Eds.),

*Alternatives beyond Psychiatry* (pp. 44–75), Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing 2007.

5. Pathological, painful and prolonged stiffening of the penis, which may require urological surgery and create impotence.
6. Pathological, painful and prolonged vaginal spasms.
7. A lipid profile is the outlined result of blood fats (cholesterines and triglycerides) to estimate the risk of development of vascular diseases (especially the coronary and cerebral vessels) and the danger that plaques (parietal deposits) from altered cholesteroline – and lipid drops can generate in the arteries, so that the vessels get less elastic and narrow, which reduces the blood flow and may lead to high blood pressure, overweight and diabetes.
8. Test to check the ability to maintain tongue protrusion; abnormal movements inside or around the mouth suggest that abnormal tongue movements may prove a more helpful sign for early detection of tardive dyskinesia (Simpson et al., 1984, p. 98).
9. Persistent listlessness and reduced will power, spontaneity, reactions to the surroundings and emotional impulses.
10. Symptom complex of shaking palsy, mainly hypokinesia up to akinesia, tremor and muscle stiffness as well as increased salivation.
11. Along with reduced cerebral perfusion and oxygen uptake of the brain with subsequent syndromes like the inability to fall or stay asleep, persistent sleeplessness, physical infirmity and massive fatigue, persistent Korsakoff syndromes (a profound loss of the ability to hold something in the mind and hence the completion of memory gaps by compositions, memory disturbances up to memory loss and a brain-organic psychosyndrome [possible condition after leucotomy or administration of neuroleptics, characterized both by disinhibition and being aimless on the go as well as, more frequently, by extensive loss of energy, fussiness, emotional and intellectual retrogression, poverty of thoughts, affective flattening, euphorically toned weakness of criticism, tactlessness, and egocentricity]).
12. Prolactin is a hormone which mainly increases growth of the breasts during pregnancy and lactation. In men and women it also affects the regulation of sex hormones in the hypothalamus and in the pituitary gland.
13. Along with damage to the vessels, eyes and nerves, especially the nerves of inner organs.
14. Disorder of the regulation of the body temperature with life-threatening fever, which may result in heatstroke with circulatory failure and irreversible central-nervous damages.
15. Life-threatening symptom complex of fever, muscle stiffness and clouding of consciousness.
16. Death rate probability within five years: 50%. Most common cause of death in advanced cirrhosis of liver: bleeding of varicose veins of the gullet, acute hepatic failure and liver cell cancer.
17. Dying of the white blood cells, often with extremely rapid onset, with life-threatening consequences (blood poisoning, pneumonia and bleeding).
18. Blockages of the administration of blood and oxygen, which is vital for the single organs, by clots, which can stick at the narrow point of the bloodstream.
19. 'Psychiatric drugs with well-known anticholinergic effect (working against the release of the neurotransmitter acetylcholine, P.L.) should be used only if an ophthalmologic investigation did not give rise to a contraindication, whereby we give more meaning to the morphologic situation in the iridocorneal angle than to the level of the intraocular pressure. Be very cautious with the administration of anti-Parkinsonian drugs' (Leuenberger & Labhardt, 1965, p. 185).
20. Symptom complex with potentially irreversible involuntary muscle movements (movement stereotypes, muscle cramps or hyperkinesia [movement disorders characterized by profuse activity of the musculature]) and reduced life expectancy.

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