Peter Lehmann (Ed.)

Coming off Psychiatric Drugs

Successful Withdrawal from Antipsychotics, Antidepressants, Mood Stabilizers, Ritalin and Tranquilizers

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

Third, updated and expanded ebook edition

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Prefaces

"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—as 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.

Dr. med. Loren R. Mosher (1933-2004)
Director, Soteria Associates
Clinical Professor of Psychiatry
University of California at San Diego
School of Medicine
August 26, 2002

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 labeled mentally ill. The diagnosis of mental illness carries with it a host of associations, particularly that the person so labeled 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 labeled 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 labeled 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 (1944-2010)
Director of Education and Training, National Empowerment Center, Lawrence, Massachusetts;
Board Member, MindFreedom International
June 20, 2006

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 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[4], 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 favour 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 of 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 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, 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. Based on the personal experiences of (ex-) users and survivors of psychiatry and the few professionals who assist people to come off psychiatric drugs, the book is a good place to open the discussion. The book should be available in every medical practice, in every therapeutic ward, in every patient library.

Pirkko Lahti
President of the World Federation for Mental Health (2001-2003)
Helsinki, August 19, 2002

This book is written for people—the objects of psychiatric treatment—who have decided to quit taking psychiatric drugs or who want to quit them sooner or later. This may be alarming to readers who look upon consumers of these substances not as persons capable of making their own decisions, but rather as psychologically unsound subjects who are, above all, unable to recognize their own illness (or alternately, as consumers of pharmaceuticals from whom they can profit).

Psychiatric drugs are substances intended to influence mental conditions and behavior. This book only includes the treatment of humans. It includes discussion of neuroleptics, antidepressants, lithium, carbamazepine[5], psychostimulants and tranquilizers. The withdrawal from 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, paediatricians or psychiatrists) give a diagnosis such as psychosis, schizophrenia, paranoia, or hebephrenia. Possible symptoms that may result in a prescription for neuroleptics are sometimes considered psychosomatic in origin: whooping-cough, asthma, 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 older persons who may have similar bothersome behaviours 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 (for example, school-anxiety in children), nocturnal enuresis, insomnia and many others. Unhappy animals

also might receive antidepressants; for instance, sad dogs locked up in the house all day while their master is at work.

- In psychiatry, lithium and anti-epileptics are administered as mood stabilizers or phase prophylactic drugs. Lithium is administered mostly for diagnoses such as mania or schizoaffective disorder. The main psychiatric indication for carbamazepine (as well as the chemically-related oxcarbazepine[6] and valproate[7]) is the diagnosis of affective psychosis, especially when the treating psychiatrist has failed to reach the effect he desires with his normal psychiatric drugs. As noted above, carbamazepine, oxcarbazepine, valproate and other antiepileptic drugs administered for the treatment of epilepsy are not discussed in this book.
- Psychostimulants (e.g., methylphenidate[8]), are prohibited by the doping list of the Olympic Society. These substances have a sedating effect on children and youngsters and are administered when they behave in a troublesome way and child psychiatrists decide on diagnoses like “ADHD” (“attention deficit hyperactivity disorder”) or “minimal cerebral dysfunction.”
- Tranquilizers (sometimes called “minor tranquilizers”) are substances which are administered after diagnoses such as a lack of motor impulse, a depressed mood, phobia, neurosis, panic attack, or sleep disorder. Tranquilizers which are administered for the treatment of epilepsy are not covered in 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 psychiatric 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 centres, 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 and 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 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 response was, once again, silence. Is the silence perhaps attributable to inundation in the past years of these family member groups with free lectures and information from the pharmaceutical industry?

In any case, it would be a mistake to oversimplify 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 mis-timed her withdrawal to concur with a break-up. 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 endeavour to address this subject, I've been cautious 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.

One can only speculate how many people have attempted to quit without enough information, 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 of the potential problems that may arise, as well as tools to prevent the often-prophesied relapse. With only a few exceptions, many professionals have not considered how to 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 sure-fire 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, so 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.

Berlin, April 14, 2004
Peter Lehmann

To the Second, Actualised Ebook Edition

People from all over the world ask me again and again for names of psychiatrists who can help with withdrawal, but this question generally cannot be answered. Economic issues may be involved, because—unlike the diagnosis “dependence on benzodiazepines”—there is no diagnosis “dependence on neuroleptics” or “dependence on antidepressants.” Therefore, physicians can’t easily bill health insurance for services that help people discontinue these drugs. You can be angry about this, but what would be the benefit of putting yourself in the care of an inexperienced and unwilling physician? Who would take his car to a repair garage from which no car ever left in a roadworthy state?

Many consumers of psychiatric drugs are convinced they need their physician’s absolute agreement to withdraw. But people who stop taking psychiatric drugs against their physician’s advice are just as likely to succeed as those who come off with physician agreement. This was the finding of the research project “Coping with Coming Off,” commissioned by the national organization Mind in England and Wales. Funded by the British health ministry, a team of users and survivors of psychiatry carried out 250 interviews to investigate experiences with coming off psychiatric drugs. The forms of support found most helpful were: support from a counsellor, a support group or a complementary therapist; peer support; information from the internet or from books; and activities such as relaxation, meditation and exercise. Physicians were found to be the least helpful group to those who wanted to reduce or come off psychiatric drugs (Read, 2005; Wallcraft, 2007). Following this study, Mind changed its standard advice to patients. Historically, their advice was not to come off psychiatric drugs without consulting a physician first. People were reminded of the indoctrination of physicians by Big Pharma (Darton, 2005, p. 5) and advised to seek information and support from a wide variety of sources (Read, 2005). The contribution by Susan Kingsley-Smith will help people to find their own path.

To prevent misunderstandings, I cannot repeat often enough: In the book, only stories about attempts to withdraw that end positively were included, as I asked expressly for articles about successful

experiences. Withdrawal can also fail or may not lead to the desired and sustained drug-free life; this is commonplace. As successful withdrawal is generally taboo in the psychiatric literature (literature largely sponsored by the pharmaceutical industry), it seems justified to give a forum to a reality which has so far been ignored, as counterweight to the mass of ideological and one-sided information.

Self-determined withdrawal is not only taboo, it has been declared a risk factor for psychiatric disorders. This arises, for example, from the diagnostic primer *Diagnostic and Statistical Manual of Mental Disorder* (DSM), distributed worldwide. Its code number V15.81 (Z91.1)—"Noncompliance with Treatment"—which comes out of the section on "Additional conditions that may be a focus of clinical attention"—can be applied to anyone who wants to stop taking psychiatric drugs. It should be documented in the patients' psychiatric records if they decide to go ahead and withdraw on their own decision and give their personal interests and value judgments a higher priority than those of the prescribing psychiatrists:

> "The reasons for noncompliance may include discomfort resulting from treatment (e.g., medication side effects), expense of treatment, decisions based on personal value judgments or religious or cultural beliefs about the advantages and disadvantages of the proposed treatment, maladaptive personality traits or coping styles..." (American Psychiatric Association, 2000, p. 739).

Ever since the emergence of psychiatric drugs, many people who have taken prescriptions have made their own decision to quit. As a National Institute of Mental Health study in the USA indicated in 2006, three-quarters of all treated people in this large-scale study eventually quit taking neuroleptics of any kind, because they did not make them better or because of the intolerable, unwanted effects (McEvoy et al., 2006; Stroup et al., 2006). This practice is consistent with the theoretical knowledge of doctors who have long recognized that it was time to withdraw prescribed psychiatric drugs, but did not and still do not act on that knowledge. In 1978, as the crème de la crème of mainstream psychiatry celebrated the 75th anniversary of the opening of the University Hospital Psychiatric Clinic in Munich, Fritz Freyhan from Washington, D.C., admitted:

> “In the 1950s, psychiatrists with experience of psychotropic drugs had to use all their powers to persuade their colleagues of the benefits of the medicinal treatment. In recent years we have reached the point where psychiatrists, experienced in the psychiatric drugs, can drastically alleviate the sufferings of their patients by withdrawing all anti-therapeutic drug treatments” (1983, p. 71).

In 2010, the German internist Jutta Witzke-Gross discussed the cascades of prescribed medicine for physical conditions as well as psychiatric drugs for elders. Referring to the various interactions and unwanted effects (for example, circulation disorders), she concluded:

> “Quitting medicine can be the best clinical decision and result in a significant clinical benefit including a reduction of the tendency to fall (…). You should also always remember that one option to coming off drugs is not to start with the drug at all” (pp. 29/32).

My sincere thanks go to the numerous people who have helped with proof-reading and with many other preparatory tasks: Ronald J. Bartle, Joey Depew (†), Chie Ishii, Myra Manning, Jeffrey M. Masson, Mary Murphy, Mary Nettle, Craig Newnes, Tricia R. Owsley, Darby Penney, David W. Oaks, Wolfram Pfreundschuh, Marc Rufer, Bill Spath, Peter Stastny, Christina White, Reinhard Wojke, and Laura Ziegler.

Peter Lehmann
Berlin, September 27, 2013

Translation from the German by Mary Murphy & Christina White

To the Third, Updated and Expanded Ebook Edition

Manufacturers of antidepressants and neuroleptics, and those who administer them, continue to avoid talking about physical dependency these substances may cause. So far, manufacturers do this only about the antidepressants tianeptine[9] and sertraline[10]. Psychiatric associations refuse to include the diagnosis of “physical

dependence on neuroleptics or antidepressants" in their diagnostic manuals.

Without such a diagnosis, there is no warning about stopping too quickly and no information about possible withdrawal symptoms and how to avoid or alleviate them. The treated persons have little chance of claiming inpatient support for withdrawal, compensation, and rehabilitation measures. Without such a diagnosis, doctors believe that they are not obliged to inform patients about the risk of physical dependence on neuroleptics or antidepressants. In addition, they may find it difficult or impossible to bill health insurance companies for measures to alleviate and overcome dependency.

However, several manufacturers of neuroleptics are beginning to protect themselves against recourse claims by warning of withdrawal syndromes, some of which are life-threatening, and to pass on the risk of litigation to doctors. The first instance of a successful claim for damages against a pharmaceutical company in the USA occurred in 2019 against Johnson & Johnson in the amount of US-$572 million, because the drug firm had downplayed the risk of addiction to their painkillers. This decision could indicate that, in future, courts will make similar judgments in claims for damages when drug firms also downplay the risk of physical dependence on antidepressants and neuroleptics. For example, the Swiss company Lundbeck AG, the licensee of the neuroleptic Clopixol[11]), informed doctors in its 2014 information leaflet that a sudden withdrawal of this substance could lead to severe withdrawal symptoms; newborns whose mothers received this substance during pregnancy should be monitored by intensive care and hospitalised for a longer time if necessary, in view of the life-threatening risks associated with withdrawal:

> "Abrupt withdrawal from zuclopenthixol can be connected with withdrawal symptoms. The most frequent symptoms are: Sickness, nausea, anorexia *(lack of appetite)*, diarrhea, rhinorrhea *(nasal hydrorrhea)*, sweating, myalgia *(muscular pain)*, paresthesia *(subjective cutaneous sensations experienced spontaneously in the absence of stimulation)* , sleeplessness, restlessness, fear and irritability. Patients can have feelings of dizziness, feel alternating cold and warmth, and tremble. Usually, the symptoms begin within 1-4 days after

withdrawal and fade away after 7-14 days. Abrupt withdrawal of the medication has to be avoided. (...)

After birth, newborn babies whose mothers took antipsychotics (including zuclopenthixol) during the third trimester of the pregnancy have the risk of extrapyramidal-motoric symptoms *(disturbances of the muscle tension and the course of motion)* and/or withdrawal symptoms. These symptoms can include agitation, unusually increased or decreased muscle tonus, tremor, drowsiness, breathing difficulties, or feeding problems.

The complications may have different severity. Sometimes they were self-limiting, in other cases they required neonatal monitoring in the intensive care unit or a longer hospitalization."

The results of the above-mentioned British MIND study from 2003-2004 have since been confirmed by a comparable study in the USA. Here, too, psychiatrists were identified as the profession that is mostly unhelpful in discontinuing psychotropic drugs (Ostrow et al., 2017). It is long overdue that psychiatrists gain skills so they can assist patients in withdrawal. It should be a matter of course that doctors do not kick their patients out when they want to stop taking psychiatric drugs and ask for help. However, experience shows that this is exactly what often occurs. The psychiatrist Asmus Finzen, former medical director of the psychiatric clinics in Wunstorf, Northern Germany (1975-1987), and Basel, Switzerland (until 2003), stated:

> "Many threaten to abandon their patients—and some do so. But this is not compatible with the principles and ethics of their profession. It may even be malpractice: If a patient wants to withdraw or reduce medication that he has been taking for a long time, the doctor in charge has to help him—even if he disagrees" (2015, p. 16).

As shown by the specialist information provided to doctors by manufacturers, there are many psychopharmacology-related occasions which require immediate reduction or complete discontinuation. These include depression or suicidal tendencies (if new); signs of liver dysfunction or tardive dyskinesia (muscle disorders that become chronic over time); increased intraocular

pressure; cardiac arrhythmia; and many more (Lehmann, 2017, pp. 29-85). At the same time, manufacturers often irresponsibly prescribe extremely short withdrawal periods (Langfeldt, 2018), so that massive withdrawal problems and the re-prescription and up-dosage of psychiatric drugs are programmed.

In response to the lack of help and knowledge about withdrawal, representatives of the Dutch associations of pharmacists, family doctors, and psychiatrists, and a mixed association of psychiatric patients and relatives, set up the Discontinuation of Antidepressants Taskforce. They document ways of reducing in small steps, especially at the end of the withdrawal process, as well as withdrawal problems and ways to alleviate them. They also identify the signs of successful discontinuation (KNMP et al., 2018; Ruhe et al., 2019). In the United Kingdom, the Council for Evidence-based Psychiatry (CEP) is a leader in the field. This group of psychiatrists, researchers, and other interested parties works with public institutions and organisations for support in withdrawal. Among other suggestions, they recommend that Parliament initiate the development of nationwide services that must provide support with withdrawal to those who have been deprived of their health (CEP, 2019).

In the meantime, the first psychiatrists oriented towards conventional medicine have taken the initiative in Germany. Even before patients decide to take an antidepressant, they should be informed about the risk of dependency and rebound effects that may occur after discontinuation, says Tom Bschor (2018, pp. 121-122), medical director of the psychiatric department of the Schlosspark-Klinik in Berlin-Charlottenburg. Psychiatrists from some clinics in Rhineland-Palatinate warn clearly in informational brochures about the risk of physical dependence on antidepressants (NetzG-RLP, 2018, p. 12). Since 2018, some wards of psychiatric clinics in Germany are offering inpatient admission for patients for the controlled withdrawal of neuroleptics[12].

Meanwhile, for many people with bad experiences of withdrawal and their supporters, it has become clear that competent help is lacking for those who want to stop psychiatric drugs and need prescriptions for tapering strips, prescriptions for preparing

individually tailored dosages, instructions for the withdrawal of combinations, or who generally feel overwhelmed. Nevertheless, the opinion leaders in mainstream psychiatry are busy working to perfect their systems for controlling the consumption of psychiatric drugs and developing logarithms in withdrawal studies to predict an "evidence-base" determining who should take psychiatric drugs in the long term. However, the participants in such studies are not informed about withdrawal problems and measures to minimize them, so that the results ("You have to take them permanently!") are pre-determined (Lehmann, 2016).

In the new edition, I added one article. Susanne Cortez describes the possibility and the necessity of small step tapering at the end of the withdrawal process after a long period of taking psychiatric drugs, with the example of the neuroleptic quetiapine[13], in her article "And finally atypically careful." And I included the latest information on tapering strips, prescriptions for preparing individually tailored dosages and further possibilities for small-step reduction, as well as suggestions for discontinuing combinations in my closing words "And now, how to proceed? A resume."

It cannot be pointed out often enough that the withdrawal attempts in this book were all positive. As a counterbalance to the mass of one-sided information from the pharmaceutical industry and mainstream psychiatry, I explicitly asked for successful experiences. It should be common knowledge that withdrawal can also fail or may not lead to a life permanently free of psychiatric drugs as desired. Some people have the experience that—for whatever reason—they cannot cope with their living conditions without psychiatric drugs, regardless of the risks associated with long-term administration. They and their doctors are advised to read the article "Minimaldosierung und Monitoring bei Neuroleptika" ("Minimal dosage and monitoring in neuroleptics") by the German psychiatrist Volkmar Aderhold (2017), and the information provided by the Discontinuation of Antidepressants Taskforce on the minimal dosage of new antidepressants (KNMP et al., 2018, p. 2).

My sincere thanks go to Darby Penney who has helped with proof-reading and to Peter Stastny who has advised in translating special

psychiatric terms.

Peter Lehmann
Berlin, March 10, 2020

Footnotes

1 Neuroleptic; active ingredient haloperidol; marketed as Avant, Haldol, Halkid, Haloperidol, Haloxem, Haloxen, Serenace.
2 Antidepressant; active ingredient fluoxetine; marketed as Afeksin, Affex, Deprexin, Flonital, Fluohexal, Fluox, Fluoxetine, Fluxil, Fluzac, Gerozac, Lovan, Magrilan, Movox, Olena, Oxactin, Plazeron, PMS-Fluox, Prozac, Prozamel, Prozep, Salipax, Sarafem, Zactin; component of Symbyax.
3 Neuroleptic; active ingredient olanzapine; marketed as Olancer, Olanzaccord, Olanzapin, Olanzapine, Olanzine, Olazax, Ozapram, Rolyprexa, Tevatiapine, Zalasta, Zypadhera, Zypine, Zyprexa; component of Symbyax.
4 Mood stabilizer; marketed as Camcolit, Carbolith, Eskalith, Li-Liquid, Liskonum, Lithicarb, Lithium, Lithobid, Priadel.
5 Mood stabilizer; marketed as Carbagen, Carbamazepine, Carbatrol, Epitol, Equetro, Storilat, Syntopine, Taver, Tegretol, Teril, Zen.
6 Mood stabilizer; marketed as Oxcarbazepine, Oxtellar, Trileptal.
7 Mood stabilizer; marketed as Convulex, Depacon, Depakene, Depakote, Epilim, Episenta, Epival, Sodium Valproate, Valproate, Valproi.
8 Marketed as Adhansia, Aptensio, Artige, Concerta, Cotempla, Daytrana, Delmosart, Equasym, Jornay, Medikinet, Metadate, Methylin, Methylphenidate, QuilliChew, Quillivant, Ritalin, Rubifen, Tranquilin, Xaggitin, Xenidate.
9 Marketed as Stablon.
10 Marketed as Depreger, Eleva, Inosert, Lumaz, Lustral, Seretral, Serimel, Serlan, Serlift, Sertralin, Sertraline, Setrona, Stimuloton, Tatig, Xydep, Zoloft.
11 Active ingredient zuclopenthixol; marketed as Clopixol, Zuclopenthixol.

12 See www.antipsychiatrieverlag.de/info/absetzinfos/websites.htm#kl

13 Marketed as Atrolak, Biquelle, Brancico, Geroquel, Mintreleq, Noletil, Notiabolfen, Quesery, Quetapel, Quetex, Quetiapin, Quetiapina, Quetiapine, Quentiax, Seropia, Seroquel, Setinin, Sondate, Syquet, Tevaquel, Zaluron.

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