DR. CALIGARI'S PSYCHIATRIC DRUGS

of cardiac rhythm, it should be noted that several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing characteristic electrocardiographic changes while taking the drug. The use been
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Background material on the cover was enlarged from psychiatric-drug information for the neuroleptic Mellaril published in the PHYSICIANS' DESK REFERENCE (1977). The Mellaril information for "Persistent Tardive Dyskinesia" is identical to that published for several other neuroleptics carried in the same PDR edition.

Cover consultant: John Patrick Sullivan.

Printer: Alonzo Printing Co., Inc., South San Francisco.

Publication date: March 1984.

How to order Dr. Caligari's PSYCHIATRIC DRUGS: Send $4.50 (postpaid) for each copy to the Network Against Psychiatric Assault (NAPA), 2054 University Ave., Berkeley, CA 94704. For orders of five (5) or more copies, the cost is $2.50 per copy (postpaid: based on March 1984 postal rates). Bookseller's discount is 40% (off the $3.50 cover price).

DR. CALIGARI'S

PSYCHIATRIC DRUGS

Network Against Psychiatric Assault

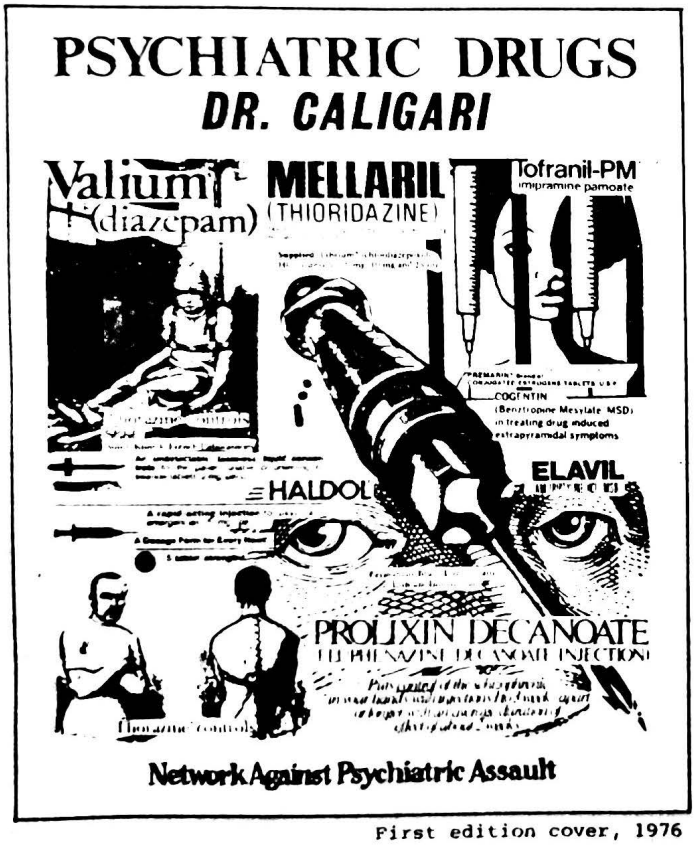
Berkeley, California
1984

Table of Contents

INTRODUCTION

This booklet is the outgrowth of a regular series of columns about psychiatric drugs which began appearing in *Madness Network News* in 1972. David L. Richman, M.D., a physician practicing in Berkeley, California, has written almost all of these columns under the pen name Dr. Caligari. This name comes from the classic German silent film, *The Cabinet of Dr. Caligari* (1919), which in its original form was highly critical of psychiatry and its so-called treatment practices.

The Network Against Psychiatric Assault (NAPA) published the first edition of this booklet in March 1976. A revised version was printed in May 1978, and now, in March 1984, we publish this third edition, revised and much expanded.



First edition cover, 1976

The combined efforts of many people made the current edition possible. David Richman wrote most of the material. Leonard Roy Frank and Art Mandler were primarily responsible for editing and production. The following individuals made many useful suggestions and criticisms: Anne Boldt, Dee dee Nihera, Sherry Hirsch, Wade Hudson, Jenny Miller, Barbara Quigley and Sally Zinman.

All the proceeds from the sale of this edition go to NAPA to further its work in the psychiatric inmates liberation movement. (A partial listing of movement groups is on the inside back cover). Organized in 1974, NAPA is committed to fighting against the use of psychiatry as a tool of social control. In particular, we are opposed to forced drugging, electroshock, psychosurgery, solitary confinement, restraints and involuntary commitment. To end these practices NAPA has carried out numerous demonstrations and political actions, beginning in 1974 at San Francisco's Langley Porter Psychiatric Institute where electroshock was being forcibly administered. In 1976 NAPA conducted a 30-day sleep-in demonstration at the office of California Governor Edmund G. Brown to protest the forced "treatment" and forced labor without pay of state hospital inmates. More recently, NAPA has held demonstrations at Herrick Hospital, a Berkeley shock center.

NAPA also played a key role as a member organization in the Coalition to Stop Electroshock, which in 1982 initiated and led a successful ballot campaign to ban electroshock in Berkeley. (A local court overturned the ban and the ruling is now on appeal.)

Currently, NAPA sponsors a self-help group. We look forward to working with others to develop genuine alternatives to the psychiatric system. These programs would be participant-run and free of drugs and psychiatric labeling. Examples might be: drop-in centers, detoxification programs to aid people withdrawing from psychiatric drugs, residential crisis centers and longer-term residences. Through these programs people could receive assistance without sacrificing their freedom and self-respect.

Anyone who is interested in participating in NAPA activities or who would like information about the psychiatric inmates liberation movement is invited to write, call or visit our office in Room 406, 2054 University Ave. (near Shattuck), Berkeley, California, (415) 548-2980. An ad in the back of this booklet lists literature available through NAPA. Also in the back is an ad for *Madness Network News* with subscription information.

Chapter 1

GETTING DRUGGED: AN OVERVIEW

1. Why This Book?

An estimated 35 million people in the U.S. are regular psychiatric drug users.[1] In 1975 American physicians wrote 240 million pharmacy prescriptions for psychiatric drugs, "enough to keep every American fully [drugged] for a month."[2] Of these prescriptions, 35 million were for neuroleptics [e.g., Thorazine, Haldol, Prolixin], enough to keep 2 million people continuously drugged for a year.[3] During 1969, 28.3% of all pharmacy prescriptions were for psychiatric drugs.[4] These figures for pharmacy prescriptions do not include the psychiatric drugs dispensed in clinics and institutions.

The purpose of this booklet is to provide up-to-date, comprehensive, and easily understood information about the various psychiatric drugs. The use of these drugs is not only widespread but growing. Whether administered forcibly, coercively or voluntarily, adequate information about their nature and effects is rarely made available. Time and time again, we have talked to people who have experienced disturbing effects without even knowing that they were drug-related.

We hope that the information in this booklet will help educate all those involved with these drugs, including people getting or thinking of taking them, concerned family and friends and health-care workers. Reliable information about drug effects, toxic effects and medical complications is crucial to ensure a truly informed consent process.

2. Disclaimer

From the outset, we wish to make it clear that we reject both the notion of mental illness as a medical disease and the diagnostic categories based on this model, such as psychosis, schizophrenia, or manic-depression. To support this model and justify the use of drugs and other psychiatric procedures, psychiatrists in recent years have developed various brain biochemical theories. There are many natural chemicals, called neurotransmitters, which are vital for brain and body functioning. Nerves produce and release these chemicals, which include: dopamine, epinephrine (adrenalin), norepinephrine, serotonin, acetylcholine, gamma-aminobenzoic acid (GABA), histamine, and endorphins. Psychiatric drugs interfere with neurotransmitter chemical function and have inherently toxic potentials. Psychiatrists theorize that abnormalities in these neurotransmitter chemicals cause "mental illness" and that their drugs normalize brain function. Our position is that there are no grounds for accepting psychiatry's basic assumptions concerning so-called mental illness and its supposed biochemical origins.

We also want known our strong opposition to all forms of involuntary psychiatric intervention, including involuntary commitment, forced drugging, seclusion rooms, and restraints. We oppose the use

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1. P. Schrag, *Mind Control*, (New York: Pantheon, 1978), p. 136.
2. Ibid., p. 35
3. Ibid.
4. C. Muller, "The Overmedicated Society: Forces in the Marketplace for Medical Care." *Science*, 176 (1972): 488-92.

of electrically-induced convulsions (electroshock or ECT) and the use of psychosurgery (lobotomy, amygdalotomy, etc.) under any circumstances. In addition, we do not endorse the use of psychiatric drugs, although we recognize the right of individuals to decide for themselves whether or not to use such drugs.

3. The Whys and Wheres of Getting Drugged

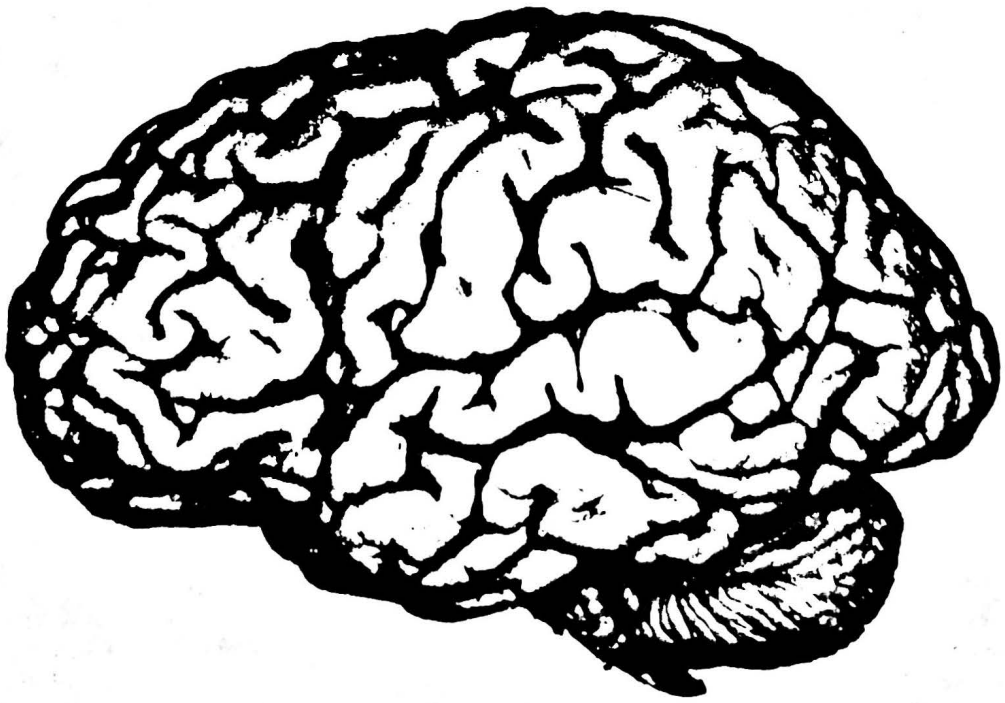
The use of psychiatric drugs is pervasive in many institutions, including schools, prisons, hospitals, nursing homes, institutions for the so-called retarded, board & care homes, and community mental health centers. Many people get these drugs as outpatients from non-psychiatric physicians because of various bodily disturbances believed to be psychosomatic or related to stress, nervousness, and anxiety. These include problems with sleeping, eating and digestion, bowel habits, heart and breathing functions, pain conditions, and headaches. Other people get psychiatric drugs as outpatients from both psychiatrists and non-psychiatric physicians for labeled psychiatric problems, such as panic attacks, phobias, anxiety, depression, and psychosis. Finally, many people are drugged while they are in psychiatric facilities.

4. Drug-Induced Damage

Given psychiatry's use of police powers to lock-up and "treat" people against their will, and the fact that this almost always involves drugging, the struggle for the right to refuse treatment and the right to informed consent is of utmost importance. However, even in the best circumstances, where there seems to be free choice, the use of psychiatric drugs almost always involves a serious lack of straightforward information about drug effects and toxic reactions. This information is essential for making active, knowledgeable and responsible decisions about drug use, especially for protecting oneself from the danger of drug-induced damage.

Almost all psychiatric drugs are depressants that slow down brains and bodies. The primary effect of drugs like Thorazine, Elavil, and lithium is to place the user in a chemical straitjacket. These drugs "control symptoms" by restricting the individual's ability to think, feel and act. Furthermore, this control often comes at the cost of discomfort, disability, and sometimes death.

Every drug or chemical that you take can damage your brain and body. In medicine, a drug's sought-after, beneficial



effects are called drug effects, while its unwanted, harmful effects are called toxic effects, adverse reactions, and allergic reactions.[5] Penicillin, for example, can stop many bacterial infections, but occasionally people have died from sudden allergic reactions. Aspirin can help relieve pain and reduce fever. However, aspirin can cause stomach irritation, ulcers, and hard-to-control bleeding as side effects. It can also cause asthmatic attacks as an allergic reaction, and kidney damage (if high doses are used over many years) as a toxic effect. And finally, an aspirin overdose can poison and even kill.

Psychiatric drugs are often misleadingly called tranquilizers or medications. This gives them an aura of promoting health and well-being. Unfortunately, that is often far from the truth in terms of their actual chemical effects. These drugs have the brain as their target, and because of the brain's vital role in coordinating and regulating all body organs and functions, drug effects are felt from head to toe. The ability of neuroleptic-type drugs, like Thorazine, to cause permanent brain damage (called tardive dyskinesia) highlights the serious risk of damage inherent in the use of psychiatric drugs and reinforces the need to respect their dangers.

Psychiatric drugs can make people feel terrible and look weird. Because people getting drugged often have not been warned about these drug effects, they may interpret them as symptoms of some form of mental illness or of physical disease. This is especially true with the strongest psychiatric drugs, such as neuroleptics, anti-depressants, and lithium,

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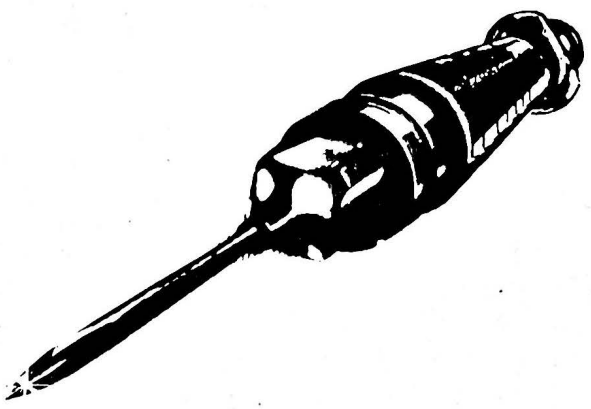
5. Other terms include idiosyncratic drug reactions and hypersensitivity reactions. We believe that all of these terms are often used to misrepresent what psychiatric drugs actually do. What psychiatrists regard as a beneficial drug effect is often experienced by those getting drugged as quite distressing and disabling. This is the drug's primary effect, not a secondary one as terms like side effect suggest. To correct this abuse of language, we will use the term *drug effects* in place of side effects, adverse effects, and the like.



I had dizziness, fainting, palpitations: these were interpreted as "anxiety" and "trauma." I had nausea, gagging, and this was interpreted as "psychosomatic." There was some feeling inside of me that I was choking and I wanted to get out of me. I had lack of sexual desire: they said I was afraid of my sexuality. I had jerkiness, muscle rigidity, cramps, tightness, numbness, tingling: they said this was my body trying to tell me things and I was holding back. What was I afraid of? I had hallucinations. I was confused, disoriented. I had the sweats. They checked me for early menopause. There were outbursts from an extreme fearfulness, and this was interpreted as dramatics or "the truth coming out." The difficulty thinking, concentrating, focusing, recalling, made me unable to read. I wandered off when I spoke. I couldn't think things out. Nothing made sense. I forgot everything. When I complained, I was told this was part of my problem. I didn't want to do these things....Some things were dangerous, like the instant drowsiness, where I would appear drunk. I would fall. The slurred speech was interpreted as my not wanting to assert myself and get my words out, for some reason. It seems, to some degree, that I was given medication and then treated for symptoms it caused.

Fancher Larson, Public Hearings on Psychiatric Drugs, San Francisco, CA, July 23, 1981.

which we call *major depressants*. The major depressants are chemical strong-arms used to control what psychiatrists call disturbed or agitated behavior. The *minor depressants* (like Valium and Librium) are usually voluntarily used to relieve anxiety, primarily because of their initial pleasant, alcohol-like effects. They also have serious problems, including risks of addiction and withdrawal difficulties. All psychiatric drugs are potentially harmful and should not be taken casually.

5. Where is Psychiatry Coming From?

The history of psychiatry is filled with the use of fearsome and painful punishments. Those labeled mad have been locked in small prison cells, chained, whipped, and subjected to debilitating "treatments" (see books by Hunter and Kraepelin in Bibliography, p.59).

In addition, psychiatric inmates were given drugs to induce nausea, vomiting, diarrhea, and convulsions in the misguided belief that such purging would help them. Another psychiatric idea was that skin wounds which were infected and oozing pus would purge "madness." Thus, the old psychiatrists (then called alienists) created blisters and wounds and then rubbed them with irritating drugs and powders to make sure they got infected.

In the 1800s and through the early part of this century, psychiatrists believed masturbation (called onanism at the time) was a main cause of insanity. They frightened many people with this lie and, moreover, used it to justify various forms of genital mutilation and other so-called treatments now recognized as outlandish and barbaric.

6. Better Living Through Chemistry

With the growth of the pharmaceutical industry, especially since World War II, the psychiatrist's new line has been that pills and chemicals will solve people's problems. When they observed how well certain drugs restrained "troublesome" patients, they developed theories of a biochemical basis for so-called mental illness to support the use of these drugs. The age of biological psychiatry was born. Chains and straitjackets now come in chemical form.

This new development is just the latest in a long series of psychiatric lies and self-deceptions. If anything, drugs make it more difficult for people to solve their problems. By prescribing drugs, psychiatrists are able to present a facade of medical legitimacy. In fact, they are drug pushers. If a drug is illegal and bought on the street, its use is considered dangerous, unhealthy, and an addiction or habit. If a drug is legal, prescribed by a physician and sold by a pharmacist or obtained through a hospital, then it is considered necessary, safe, and beneficial, and its use is called maintenance rather than addiction. Thus, there is heroin and barbiturate addiction on the one hand, and lithium and Prolixin maintenance on the other.

Today, the largest promoters of drug addiction are the psychiatrists and the drug companies, and their efforts have paid off handsomely. The psychiatrists' median annual income is currently over $70,000,[6] while pharmaceutical company sales since the introduction of these drugs have skyrocketed. Take for example the case of Smith, Kline & French (SKF), which in 1953 acquired from a French firm the U.S. commercial rights to

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6. *Medical Economics*, Sept. 13, 1982, p. 253.

Drug Manufacturers and Their Products

Manufacturer	Drug
Abbot Laboratories	Cylert, Nembutal, Placidyl, Tranxene
Ayerst Laboratories (American Home Prod.)	Antabuse, Premarin
Boehringer Ingelheim	Preludin, Serentil
CIBA Pharmaceuticals	Lithobid, Ludiomil, Ritalin, Serpasil
Dupont Pharmaceuticals	Symmetrel, Moban
Ives Laboratories	Surmontil
Lederle Laboratories	Artane, Asendin, Loxitane
Eli Lilly	Aventyl, Seconal, Tuinal
McNeil Pharmaceuticals	Haldol
Mead Johnson Pharmaceuticals	Desyrel
Merck, Sharp & Dohme	Cogentin, Elavil, Triavil, Vivactil
Merrell Dow Pharmaceuticals	Norpramin
Miles Laboratories (Dome Division)	Lithane
Park-Davis (Warner-Lambert)	Benadryl, Centrax, Nardil
Pennwalty	Adapin
Pfizer Pharmaceuticals (Roerig Div.)	Atarax, Navane, Sinequan
Roche Laboratories	Dalmane, Librium, Limbitrol, Marplan, Taractan, Valium
Sandoz	Mellaril, Restoril, Sanorex
Schering	Permitil, Trilafon
Smith, Kline & French (SmithKline Beckman Corp.)	Benzedrine, Compazine, Dexedrine, Eskalith, Stelazine, Thorazine
E.R. Squibb & Sons	Amitid, Prolixin
Upjohn	DepoProvera, Halcion, Xanax
USV Pharmaceuticals	Pertofrane
Wyeth Laboratories (American Home Prod.)	Ativan, Equanil, Serax, Sparine

APA President George Tarjan accepts a check for $10,000 from Edward F. X. Lawlor of Smith Kline & French for the APA Presidential Fund, which is used by the president for programs of his choice.

Psychiatric News ("Official Newspaper of the American Psychiatric Association"), October 7, 1983

the neuroleptic Thorazine. By December 1953, five months before being marketed, this drug had been tested on only 104 psychiatric inmates in the U.S. Nonetheless, the FDA approved its distribution and SKF mounted an awesome promotional campaign, advertising in psychiatric journals and hiring a special Thorazine task force of 50 detail men to pitch its new product to psychiatrists. Within one year two million people in this country were being administered Thorazine and SKF's overall sales jumped by one-third. Thorazine continued to figure prominently in SKF's growth as revenues increased from $53 million in 1953 to $347 million in 1970.

The powerful influence of the pharmaceutical industry on drug-prescribing practices is remarkable. Through control of drug research, development, clinical testing, and the distribution of drug information (in both professional journals and the public media), the drug companies are able to shape the attitudes of practically everyone. Drug advertising and drug public relations campaigns are often the most important factors in deciding how drugs are prescribed and dispensed.

7. It's All in Your Mind, Or is It?

There are many reasons why people ultimately become anxious, lethargic, sad, confused, get ulcers, can't sleep and the like. The possibility that these problems are being caused by an undiagnosed medical, neurological or drug-induced disorder should be carefully considered. Before taking any psychiatric drug, one should have a complete medical history, an evaluation of current drug use (including prescribed, over-the-counter or street drugs), a physical exam, and necessary laboratory tests (including x-rays and CT scans). Medical problems may require specific treatments; for example, those with an underactive thyroid gland may need to take thyroid hormones.

Contrary to what psychiatrists claim, there is no proof that psychiatric drugs correct any physiological imbalances. They are not medications like antibiotics for infections. In fact, evidence shows that they frequently create physiological problems due to their depressant and toxic effects.

As an extension of the sedating effects of most psychiatric drugs, people may become depressed, sometimes to the point of suicide. At other times, these drugs can cause people to become distraught and confused, which in psychiatric jargon is called toxic psychosis. This condition, which takes many forms, is often attributed to "mental illness" rather than recognized as drug-induced.

Often, problems that occur when drugs are stopped are in fact related to drug withdrawal. The difficulties experienced from drug withdrawal may be seen as a relapse and used to justify resumption of drug use.

Drugs do not solve life crises or help people acquire the understanding, skills, and energy necessary for success or even survival in these difficult times. Drug use often causes dependency and reinforces the belief that only an external force or agent can solve one's problems. The possibility of serious and at times life-threatening drug reactions should serve as a warning to those who think they can simply drug away life's problems.

[Psychiatric drugs] are used, not to heal or help, but to torture and control. It is that simple. And the questions surrounding their use are not scientific or medical; they are political. When we talk about who shall administer what drugs to whom and under what circumstances, we are talking about power over people's lives. These are dangerous drugs, dangerous from a physical point of view and from a moral point of view. They are dangerous because they imbue the dispenser with tremendous power and reduce the receiver to a state of helplessness. They are especially insidious because they leave no marks and because their victims--mental patients, old people, poor people, "criminals"--are among the most powerless and stigmatized groups in our society.

Janet Gotkin (co-author, TOO MUCH ANGER, TOO MANY TEARS), testimony, Hearings, U.S. Senate Subcommittee, THE ABUSE AND MISUSE OF CONTROLLED DRUGS IN INSTITUTIONS (Washington: U.S. Printing Office, 1977) p. 17.

Chapter 2

CONSENT AND COERCION

1. Informed Consent.

Technically speaking, informed consent to a medical treatment requires the presence of three elements: knowledge of the procedure (including benefits and risks), free choice (absence of force or coercion), and legal competence (absence of a court ruling of mental imcompetence). Coercion is inherent in all psychiatric facilities, whether the inmate is voluntarily or involuntarily confined, and in all relationships between a "patient" and a psychiatrist, given his or her power to lock people up. When a psychiatrist recommends or prescribes psychiatric drugs, it's all too frequently an offer that can't be refused. But even if there were no coercion, informed consent from psychiatric-drug candidates would be rare, because psychiatrists do not fully and accurately inform them about drug risks and dangers. Psychiatrists know that the more information they divulge and the more honest they are about these drugs, the more resistance to taking them they will encounter.

Walter Gurbo

2. The Right to Refuse Psychiatric Drugs.

Nowhere in the U.S. do psychiatric inmates have an absolute right to refuse psychiatric drugs. In most states, psychiatric inmates simply have no rights at all in this connection: psychiatrists do not have to inform them about the effects of these drugs and may administer them over the inmates' objections by means of heavy-handed force and violence. In a few states, psychiatric inmates (particularly so-called voluntary patients) have the technical right to refuse psychiatric drugs, but in practice, this right is easily denied, usually by having a psychiatrist declare an emergency situation (the inmate is said to be in danger, or in imminent danger, of harming him/herself or others), by having a review panel (almost always made up of physicians) authorize the administration of drugs, or by having, if the inmate has been ruled legally incompetent, his or her conservator or guardian consent to the use of drugs.

The situation for involuntary psychiatric inmates regarding the right to refuse drugs is particularly bad, and likely to become worse if the American Psychiatric Association (APA) has its way. The APA's "Guidelines for Legislation on Psychiatric Hospitalization of Adults" includes this paragraph:[1]

> Since it is a prerequisite to involuntary commitment that the person lacks capacity to make an informed decision concerning treatment, the treatment facility shall be authorized to administer medications or other treatments to such persons consistent with good medical practice without their consent, except insofar as particular laws or regulations require consent for special therapies...

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1. *American Journal of Psychiatry*, (March 1983): 679.

WARNING!

MENTAL PATIENTS ARE NOTORIOUS

DRUG EVADERS*

Many mental patients "cheek" or hide their tablets and then dispose of them. Unless this practice is stopped, they deprive themselves of opportunities for improvement or remission . . . deceive their doctors into thinking that their drugs have failed . . . and impose a needless drain on their hospital's finances.

When drug evaders jeopardize the effectiveness of your treatment program—

SPECIFY LIQUID CONCENTRATE†

THORAZINE® STELAZINE® COMPAZINE®

brand of chlorpromazine | brand of trifluoperazine | brand of prochlorperazine

Liquid Concentrate is the practical dosage form for any patient who resists the usual forms of oral medication. It can easily be mixed with other liquids or semisolid foods to assure ingestion of the drug.

*According to Goldman, from 25% to 40% of hospitalized mental patients attempt to evade oral medication. (In Trifluoperazine: Clinical and Pharmacological Aspects, Philadelphia, Lea & Febiger, 1958, p. 74.)

†For hospital use

SK&F Smith Kline & French Laboratories, Philadelphia
leaders in psychopharmaceutical research

Mental Hospitals, February 1962

3. Drug Resisters.
All psychiatric inmates should be aware of the fact that resistance to taking drugs "voluntarily" almost always leads to various forms of coercive or forced drugging. Inmates suspected of cheeking (pouching pills in the cheek and spitting them out later) may be forced to take the drug in liquid form (in juice or water) in the presence of the staff. Drug refusers may be given intramuscular injections against their will. According to one psychiatrist, a drug proponent, "intramuscular administration of (Thorazine) increases its potency about four-fold in comparison with doses given orally." Because psychiatrists see inmates who refuse their drugs as being "sicker" than those who comply, they are drugged more heavily. The same holds true for those inmates who make known their belief that the drugs are harmful and poisonous, which many psychiatrists label a paranoid delusion.

4. Drugs and Violence. Psychiatrists claim that forcing drugs on psychiatric inmates is necessary to prevent violence, even though the great majority of inmates have neither been accused nor convicted of a criminally assaultive act. According to Lee Coleman, himself a psychiatrist, "this rationale amounts to nothing more than preventive chemical detention." Furthermore, most violence in psychiatric facilities is perpetrated by staff on inmates when they fail to comply with "treatment" programs. From this perspective, inmate violence is self-defense.

5. Criteria for Improvement.
Psychiatrists lower drug dosage levels not in response to inmate requests or pleadings, but according to their perception of the inmate's "improvement." Psychiatrists measure improvement in terms of cooperativeness, reduced complaining, conformity to cultural norms, and respect for authority, particularly theirs. Thus, inmates are faced with a serious dilemma. If they want their drugs reduced, they must learn to play the "good patient" game. If they are unwilling or unable to play the game or if they play it badly, they are likely to suffer the consequences of continued or even increased drugging.

6. Dangers of Being a "Difficult Patient".
Psychiatrists generally regard psychiatric inmates who fail to improve or "deteriorate" (i.e., become more disruptive or rebellious, or refuse to eat, etc.) as prime candidates for much heavier drugging and possible candidates for electroshock (ECT). This applies to inmates who are labeled schizophrenic (who are on neuroleptics), depressed (who are on anti-depressants), and manic depressive (who are on lithium and/or neuroleptics).

7. Psychiatric Drugs and Outpatients.
Individuals released from psychiatric facilities are usually misled or coerced into taking drugs as outpatients. Some, while still institutionalized, are told, "You are mentally ill and will have to take medications for the rest of your life." They are then given the self-fulfilling *psychiatric curse*, "If, once released, you don't take the drugs, you'll go crazy again and need to be rehospitalized." Others are told more pointedly that failure to take the drugs will result in their being forced back into an institution. Still others, as community health clinic outpatients, are scheduled for regular, mandatory Prolixin shots, the numbing effects of which can last for 6 weeks.

Chapter 3

PRESCRIPTION PRACTICES

1. Drug Names

Drug names can be confusing because each drug has at least two different names: the drug company's trade name and the generic name.

- *Trade Name:* This is a drug name created by a drug company's promotion department for its brand of a particular drug.
- *Generic Name:* This is a drug name that is based on the chemical structure of the drug.

For example: *Thorazine* is the drug company's trade name for a drug whose generic name is *chlorpromazine*. Smith, Kline & French has copyrighted the name Thorazine so that any other drug company that manufactures and sells chlorpromazine must use the generic name or make up its own trade name. Thus, Chlor-PZ is the trade name for USV Pharmaceutical's brand of chlorpromazine. Prescriptions can be written in the drug's trade or generic name, which will appear on the bottle of pills received at the pharmacy. Most doctors use the trade name in writing prescriptions. The only basic difference, in most cases, between a trade-named drug and a generic-named drug is that the former costs more.

2. Prescriptions and Drug Information on Drug Containers.

On both the drug prescription and the typical plastic bottle containing the drug there usually will be the following information:

A. Drug name (trade or generic name): e.g., Thorazine or chlorpromazine.

B. Drug dose strength (written in milligrams or mg. A milligram is one thousandth of a gram): e.g., Thorazine 100 mg.

C. Instructions for drug use: e.g., "Take 1 pill 3 times a day."

D. The number of pills in the bottle: e.g., #60.

E. The expiration date of the drug (the date when the drug becomes too old to use safely): e.g., a prescription written and filled in August, 1983, may have an expiration date of August, 1985. WARNING: Do not use drugs after the expiration date has passed.

F. Other special instructions or warnings, often on small self-adhesive stamps: e.g., "Take drug after meals;" or "Caution, sedating effects of this drug may make driving or operating machinery dangerous!"

3. Drug Forms and Strengths

Drugs in general come in various forms including pills, tablets, capsules, liquids, intramuscular or intravenous injections, rectal suppositories, inhaled powders, nasal sprays and adhesive band-aid type patches impregnated with drugs. Most psychiatric drugs are given as pills (with a hard coating), tablets, capsules, syrups (elixirs), or intramuscular injections. The injections can be short-acting (with effects lasting 1-3 days) or long-acting (with effects lasting 2-6 weeks from a single injection). The oral forms can also be short-acting (taken 3-4 times a day), or longer-acting (taken only once or twice a day). The longer-acting forms are often called sustained release (SR), controlled release (CR), or spansules.

Pills, tablets and capsules come in various strengths differentiated by color, shape and size (with larger doses usually being larger pills). All drugs have a set of numbers and letters on each pill, tablet and capsule that are a code for identifying the drug with a drug information source like the *Physicians' Desk Reference (PDR)*. Examples:

- Thorazine (chlorpromazine) comes in the following strengths: 10 mg, 25 mg, 50 mg, 100 mg, 200 mg (in orange pills of increasing size). In addition, there is a sustained-release form called Thorazine spansules in strengths of 30 mg, 150 mg, 200 mg and 300 mg (in orange capsules of increasing size).
- Valium (diazepam) comes in the following strengths: 2 mg (white tablet), 5 mg (yellow tablet), 10 mg (blue tablet), and a sustained-release form called Valrelease in 15 mg yellow and blue capsules.

The daily dose is figured out by multiplying the strength of each dose by the number of times a day it is taken. For example, if one is taking 50 mg pills of Thorazine, 4 times a day, then the total daily dose is 200 mg.

It is important to realize that drugs have different strengths, so that 50 mg of 1 drug does not equal 50 mg of another drug. For example, Prolixin, a neuroleptic, is much more potent than Thorazine, another neuroleptic: 2 mg of Prolixin is equivalent in strength to 100 mg of Thorazine. It is also important to note that the dose of one type (or category) of drug is not comparable to that of another type. For example, 10 mg of Valium, an anti-anxiety drug, cannot be compared with 10 mg of Stelazine, a neuroleptic, because they are different kinds of chemicals.

4. Guidelines for Drug Doses and Duration of Treatment.

Dosage practices for psychiatric drugs are generally far more random than those for medical drugs such as antibiotics. Although the FDA has established general guidelines, doctors frequently deviate from them, often exceeding the recommended upper limits. There is also great variation in the length of drug treatment; often people are kept on psychiatric drugs for prolonged periods of time, even for a lifetime (this is known as maintenance therapy). Psychiatrists themselves often disagree with one another about different aspects of psychiatric drugging. More recently, there has been a tendency toward administering large doses of drugs, especially neuroleptics, to control more vigorously those "symptoms" they find most disturbing. As one psychiatrist has commented, "When in

Common Drug Prescription Abbreviations

a.c. - before meals
b.i.d. - twice a day
cap. - capsule
cc. - cubic centimeter
h.s. - at bedtime
hypo - hypodermically
i.m. - intramuscular injection
i.v. - intravenous injection
mg. - milligram
ml. - milliliter (= cc.)
p.r.n. - as needed
q.d. - once a day
q.h. - every hour
q.i.d. - 4 times a day
sig. - instructions
stat. - immediately
tab. - tablet
t.i.d. - 3 times a day

doubt with Thorazine, increase the dose rather than decrease it."

5. Titration of Drug Dosage.

Titration is the common practice psychiatrists employ to determine the drug dosage given each day. They make an educated (or not so educated) guess as to a starting dose based on factors like sex, age, weight, health problems (especially liver, heart, or kidney disease), nature of the problem, and their fears of violence or disruptive behavior. Then every day or so they increase the dose until the drugged person becomes obviously sedated and immobilized or clearly toxic (e.g., displays serious drug-induced muscle reactions). Using such rough guidelines, psychiatrists over time adjust dosages.

6. Polypharmacy.

To control "symptoms," psychiatrists frequently prescribe several, sometimes as many as 7 or 8, different psychiatric drugs at the same time. For example, people may be simultaneously given 2 different neuroleptics, an anti-parkinsonian, an anti-depressant, and sleeping pills. The variety of drug combinations and dosage levels is almost endless. Rarely have any of these combinations been tested scientifically. Because of the interactions these drugs may have with each other and with other non-psychiatric drugs the individual may be taking, the effects are likely to be more unpredictable and toxic than when single drugs are used. Polypharmacy is clearly a dangerous practice.

Chapter 4

GENERAL PRECAUTIONS

Most psychiatric drugs are depressants that impair the brain and nervous system. Since the brain and nervous system control all body organs and functions, the depressant effects of these drugs can lead to a variety of harmful, possibly fatal, reactions. In particular circumstances, however, these drugs pose greater than ordinary risks. Listed below are *general precautions*, or warnings that apply to nearly all psychiatric drugs. Additional warnings are contained in the *special precautions* section of each drug-category chapter.

1. You should have a complete medical examination before taking any psychiatric drugs. Various laboratory tests, such as urinalysis, blood tests, chest or head X-rays, CT-scan, or electrocardiograms (EKG), may be necessary. All relevant information, including diseases you have or have had, drugs you take or have taken, operations and allergies, should be reviewed and discussed. Of course, the risks and supposed benefits of psychiatric drugs and alternatives to taking them should be carefully considered.

2. It is important for you periodically to undergo medical examinations while taking psychiatric drugs. These may include physical exams, neurological testing, and a variety of laboratory tests. Each type of psychiatric drug has the potential to damage certain parts of the body. Depending on the type of drug being used, certain kinds of examinations or tests at regular intervals will be required.

3. Psychiatric drugs are more dangerous for people having any of the following conditions: alcohol abuse, arthritis, blood disease (anemia), brain disease (stroke, tumors, senility), circulation problems, diabetes, drug abuse, enlarged prostrate gland (in men), epilepsy (convulsions, seizures), eye disease (glaucoma), heart disease, kidney disease, liver disease, lung disease, Parkinson's disease, stomach disease (ulcers), thyroid disease, bladder disease. This list is not complete.

4. Psychiatric drugs can be very dangerous, even lethal, when combined with prescription, over-the-counter or street drugs, especially the following ones: amphetamines (speed), anti-convulsants, arthritis drugs, asthma drugs or inhalers, diet pills, digitalis (and other drugs for the heart), diuretics, anti-hypertension drugs (for high blood pressure), and ulcer or irritable bowel drugs. Psychiatric drugs are also highly dangerous when combined with each other, or with other depressants such as alcohol, antihistamines (cold pills), and narcotics (or other pain pills).

5. Everyone reacts differently to drugs and dosages. Of course, the larger the dose, the more likely you are to suffer bad effects. Children, the elderly, and the sickly are more sensitive to the effects of these drugs and cannot tolerate adult dosages. Caution should be exercised when changing the level of dosage, especially when increasing it. In addition, factors like weight and current physical condition need to be considered.

6. Avoid particularly those psychiatric drugs to which you have previously suffered allergic reactions, and be careful of other drugs in the same category.

7. If a problem develops which may be drug-related, it is important to discuss this situation with a knowledgeable person. Drug-induced problems can occur for a variety of reasons, including illness, change of drug dose, or the taking of other drugs.

8. It should be noted that often when these drugs are processed into pills, tablets, etc., additional materials are used. These include fillers such as lactose (a sugar), dyes such as tartrazine, and preservatives. Rarely, people have allergic reactions to these substances. For example, tartrazine dyes may bring on a skin rash or an asthmatic attack, and in people with lactose intolerance the

consumption of lactose can lead to abdominal discomfort, gas and diarrhea.

9. When considering any surgical or dental procedure, you should inform the surgeon or dentist about any psychiatric (and for that matter any other) drugs you are taking or have recently taken.

10. Do not use more than the prescribed dose. Some people do this when they are feeling more nervous and upset. It may be that these feelings are themselves a drug reaction which should be discussed with someone familiar with psychiatric drugs.

11. If you are taking psychiatric drugs more than once a day and forget a dose, just skip it and take the prescribed dose at the next scheduled time. Don't take a double dose to make up for a missed one.

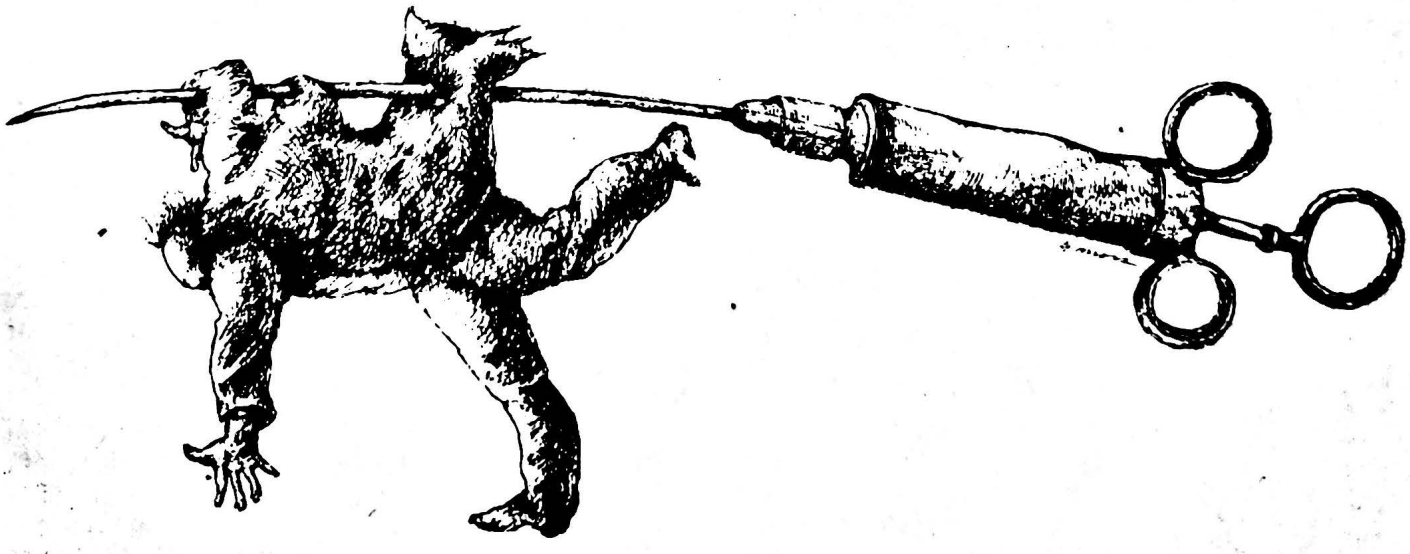
12. Keep all drugs in a safe place out of children's reach to avoid accidental poisoning. All drug containers have an expiration date on them which indicates when the drug becomes too old for safe use. Throw out all drugs which have passed their expiration date.

13. Psychiatric drugs often cause tiredness, lethargy, drowsiness and reduced ability to concentrate. Because of these sedative effects, people taking psychiatric drugs should avoid driving a vehicle, operating dangerous machinery, or engaging in any activity which requires concentration and attention for maximum safety. The sedating effect of psychiatric drugs is often more strongly felt when they are first taken or when the dose is increased. Special caution is required at those times. Other drug effects may also follow this pattern.

14. These drugs can alter normal patterns of sleep, although the significance of these changes is not clear. Alterations are more likely when the drugs are taken at bedtime. At times they can produce unusual nightmares and other sleep disturbances.

15. Drug effects on sexuality. Human sexuality is a complex process that involves the coordination of the brain, senses, spinal cord (especially the lower part), blood vessels, lubricating glands, pelvic muscles, erotic zones (e.g., genital areas, breasts, and lips), emotions, environment and a variety of interactions. All drugs, whether prescribed, over-the-counter or recreational, can affect sexuality. In addition, one's emotional state and various medical problems (e.g., diabetes, arteriosclerosis, thyroid gland disorders) can interfere with sexual functioning. Psychiatric drugs have the potential to hinder human sexuality in various ways and do so commonly.

The following are some of the potential sexual problems associated with the use of psychiatric drugs, particularly the



major depressants (i.e., neuroleptics, anti-depressants and to a lesser extent lithium):

A. Men

1) Reduction or elimination of sexual interest, drive, and of the ability to become sexually aroused, including lessened sensitivity of the erogenous zones.
2) Difficulty or inability to have or maintain an erection.
3) Reduction or elimination of ability to have orgasms; poorer quality of orgasms; painful orgasms.
4) Retrograde ejaculation. Upon orgasm, instead of coming out of the penis, the semen goes into the bladder. Afterwards, for a while, urine may look milky as semen becomes mixed with it. This is a particular problem with the neuroleptic Mellaril.
5) Priaprism (prolonged and at times painful erection, which may require emergency medical treatment).

B. Women

1) Reduction or elimination of sexual interest (same as in #1 above).
2) Reduction or elimination of normal vaginal lubrication with sexual arousal, which can lead to painful attempts at intercourse.
3) Vaginismus (unusual tightening or spasm of the vaginal muscles, which can make intercourse painful, difficult, or impossible).
4) Reduction or elimination of orgasms.

SPECIAL NOTE: Psychiatric drugs, especially the major depressants, can interfere with normal fertility in both women and men. To date, there has been little research in this area.

16. Drug effects on menstruation. Normal menstrual cycles involve the clock-like coordination of the brain, pituitary gland, ovaries, uterus, and the whole body. Various factors can interfere with menstrual cycles including psychological state and stress, strenuous physical activity, pregnancy, gynecological and hormonal problems, birth control pills and other drugs. Psychiatric drugs, especially neuroleptics and anti-depressants, can also effect menstrual cycles. Potential problems include:

- Irregular menstrual cycles.
- Changes in patterns of menstruation (e.g., duration and blood flow).
- Complete cessation of periods (amenorrhea).

It is important to remember that pregnancy should always be considered as a possible cause of menstrual changes. Active heterosexual women who are taking psychiatric drugs should undergo a pregnancy test (preferably a blood test, for accuracy) whenever menstrual irregularity becomes of sufficient concern. In this way, pregnancies can be immediately identified and the drug effects on developing fetuses minimized by eliminating psychiatric drug intake. In a related issue, birth control pills, aside from their other dangers (e.g., blood clots) can affect psychiatric drug levels. As an example, taking birth control pills along with Valium tends to raise Valium levels

in the blood, thus increasing their effects. Physicians should be notified about the combined use of any psychiatric drugs and birth control pills.

17. Pregnancy, delivery and breast feeding pose particular risks. Pregnant women and women planning to become pregnant should avoid psychiatric drugs. Pregnant women who are taking these drugs should seriously consider withdrawing from them (see chapter on Withdrawal, p.54). Psychiatric drugs taken during pregnancy increase risks for mother and unborn child alike. Without naming specific drug categories, here are some of the potential problems: miscarriages and spontaneous abortions are more common; pregnancy, labor and delivery are more dangerous; these drugs can cause birth defects, e.g., webbed feet, cleft palate and heart abnormalities. The relationship between the use of these drugs and mental retardation has not been established. Even more uncertain and complex is the relationship between the use of these drugs and what is now called behavior teratogenesis (BT). BT refers to abnormalities in behavior caused by subtle damage to the brain resulting from drug exposure in the womb. In addition, babies born of mothers taking depressant drugs tend to be lethargic, have breathing and feeding difficulties, muscular problems and reduced ability to bond with parents. Infants can also suffer drug withdrawal reactions after delivery. These can occur hours, days or weeks after delivery. Psychiatric drugs can not only be passed from mother to child in utero, but also through the milk while nursing. For this reason, women on these drugs should not breast-feed their children.

18. The elderly are highly sensitive to psychiatric drugs. They are at higher risk for developing brain dysfunction and permanent brain damage. "Tardive dyskinesia, parkinsonism, and the loss of various mental functions tend to develop spontaneously in the aged population. Drug intoxification hastens this process, and with age, the drug effect and the age effect combine."[1] Elderly people should undergo thorough examinations before taking psychiatric drugs and be carefully monitored once they start. For elderly people who have medical problems and are taking medical drugs, the risks of taking psychiatric drugs are even greater. Drug dosages used on the elderly should be lower than dosages for younger adults.

19. Psychiatric drugs can cause effects opposite to what are supposedly intended. The psychiatric term for this condition is paradoxical reaction, or toxic psychosis. Those taking drugs may freak-out, go crazy, act bizarrely, hallucinate (hear voices, see visions), become confused and disoriented, or agitated. Psychiatric drugs may also render a person "catatonic," that is, totally immobile and apathetic. Psychiatrists, mental health workers and half-way house operators are apt to see such effects as signs

After hundreds of days locked up she's free, a scared woman, enough pills in her purse for 100 suicides, a total dependency on the shrink who by this time is plaguing her with sexual innuendo and she is so lonely for a friend she can't stand it. And she can't think and wonders how she used to remember things and speak her mind. She's quiet now, reads cook books and she's very much into drugs. She's lonely, meets a man, gets married--the shrink and husband shake hands, therapy over, she's cured. Still lonely, she has a baby, a baby born of a momma force-fed drugs, born with fingers and toes webbed and the momma thinks "thank god that's all." She knew, like women in Viet Nam know --our children are being poisoned by white men. Men have always feared our wombs and the power of birth. And the pills, Stelazine, Thorazine, Prolixin --they are money, they are power, they are death. In giving up the pills I no longer identified with sickness. My long struggle for rebirth began.

Ahni, in MADNESS NETWORK NEWS, Vol. 3, No. 6, 1976, p. 4.

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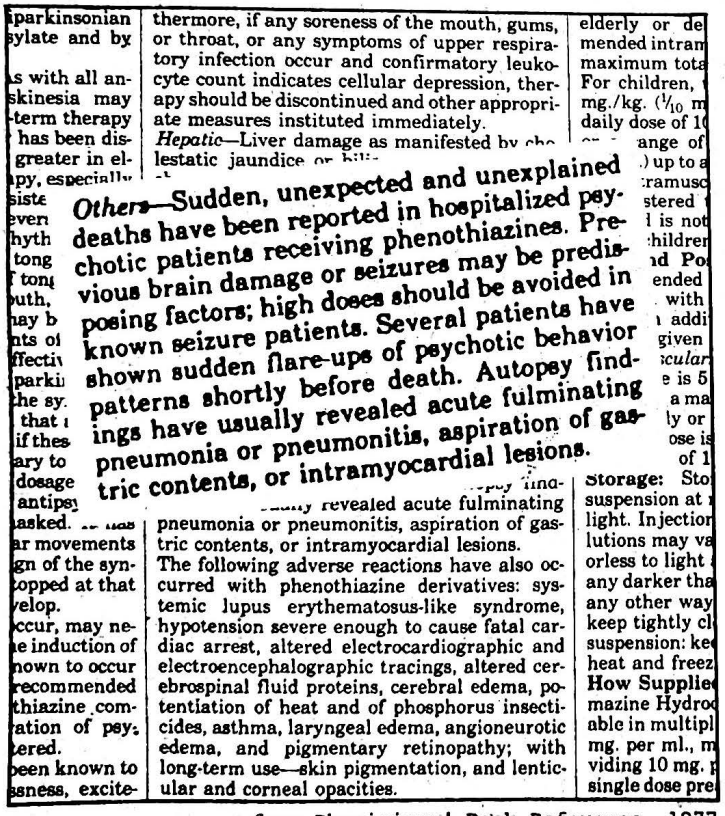
1. P.R. Breggin, *Psychiatric Drugs: Hazards to the Brain*, (New York: Springer, 1983), p. 126.

of a serious form of mental illness, which then becomes the justification for increased drugging. Of course, this approach only aggravates the problem. If someone on these drugs begins to feel or act weirdly, suspect the drugs. The solution to this problem is to stop whatever drugs are being taken or at least reduce their intake.

20. What psychiatrists call "depression" -- lethargy, apathy, nervousness, hopelessness, helplessness and unhappiness -- is a serious problem often unrecognized as drug-related (drug-induced). Because of their depressant and debilitating effects, psychiatric drugs can make people feel so bad that they want to kill themselves, either by overdosing or some other means. Again, the solution is to eliminate or cut back on the drugs being taken. The suicide risk is particularly severe with long-acting injections of Prolixin, where approximately 7 days after the injections, as the drug level in the blood peaks, the drug-induced despair is at its worst. A 1969 study describes 16 cases of severe depression, including 5 suicides, following treatment with injectable Prolixin.[2]



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thermore, if any soreness of the mouth, gums, or throat, or any symptoms of upper respiratory infection occur and confirmatory leukocyte count indicates cellular depression, therapy should be discontinued and other appropriate measures instituted immediately.

Hepatic—Liver damage as manifested by cho... ...lestatic jaundice or hili...

elderly or de... ...mended intram... ...maximum tota... For children, ... mg./kg. (1/10 m... daily dose of 1... ...ange of ... ...) up to a ...ramusc... ...stered ... ...l is not ...hildren ...d Po... ...ended ... with ... addi... given ...icular ...e is 5 ... a ma... ...ly or ...ose is ... of 1...

Others—Sudden, unexpected and unexplained deaths have been reported in hospitalized psychotic patients receiving phenothiazines. Previous brain damage or seizures may be predisposing factors; high doses should be avoided in known seizure patients. Several patients have shown sudden flare-ups of psychotic behavior patterns shortly before death. Autopsy findings have usually revealed acute fulminating pneumonia or pneumonitis, aspiration of gastric contents, or intramyocardial lesions.

...topsy find... revealed acute fulminating pneumonia or pneumonitis, aspiration of gastric contents, or intramyocardial lesions.

The following adverse reactions have also occurred with phenothiazine derivatives: systemic lupus erythematosus-like syndrome, hypotension severe enough to cause fatal cardiac arrest, altered electrocardiographic and electroencephalographic tracings, altered cerebrospinal fluid proteins, cerebral edema, potentiation of heat and of phosphorus insecticides, asthma, laryngeal edema, angioneurotic edema, and pigmentary retinopathy; with long-term use—skin pigmentation, and lenticular and corneal opacities.

Storage: Sto... ...suspension at ... ...light. Injectio... ...lutions may va... ...orless to light ... ...any darker tha... ...any other way ... ...keep tightly cl... ...suspension: ke... ...heat and freez... **How Supplie...** ...mazine Hydroc... ...able in multipl... ...mg. per ml., m... ...viding 10 mg. ... ...single dose pre...

from Physicians' Desk Reference, 1977

21. Psychiatric drugs can cause death. The major depressants (neuroleptics, anti-depressants and lithium) can bring on "severe life-threatening reactions in their routine dosage range." For anti-anxiety drugs such as Valium to be fatal, "they must be taken in very large overdoses, and even then they are most likely to be lethal only when combined with other drugs, including alcohol, barbiturates or the various major psychiatric drugs."[3] (For additional information on drug-related deaths, see Neuroleptics, sect. II.3, p. 28).

22. Electroshock in combination with psychiatric drugs. Electroshock (ECT) is an inherently brain-damaging procedure and should never be used (see "electroshock premedications" section in Miscellaneous Drugs, p.50). When combined with psychiatric drugs, electroshock dangers are magnified. There are clearly documented risks when ECT is used on persons taking lithium (see Lithium, sect. III. 9, p.40). When anti-anxiety drugs (e.g. Valium) and sedative-hypnotics are being used, their anti-convulsant effects mean that more electricity is needed to produce a convulsion with ECT. Electroshock damage is related to how much electricity passes through the brain: thus the more electricity, the more brain dysfunction and injury. When neuroleptics (e.g., Thorazine) and anti-depressants (e.g., Elavil) are used in conjunction with ECT, the risks are even greater. Published reports of deaths resulting from ECT/Thorazine combinations began appearing in 1956, soon after the neuroleptics were introduced.[4]

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2. R. de Alarcon and M.W.P. Carney, "Severe Depressive Mood Changes Following Slow-Release Intramuscular Fluphenazine Injection." *British Medical Journal*, 3 (1969): 564-7.

3. P.R. Breggin, *Psychiatric Drugs*, p. 126.

4. L.B. Kalinowsky, "The Danger of Various Types of Medication during Electric Convulsive Therapy" (letter to editor). *American Journal of Psychiatry*, 112 (March 1956): 745.

Chapter 5

NEUROLEPTICS

(major tranquilizers, anti-psychotics)

Trade Names	Generic Names	Adult Dosage Range low--mg/day--high		Relative Strength[1]
PHENOTHIAZINES				
Compazine	prochlorperazine	15	150	10
Dartal	thiopropazate	10	150	10
Mellaril	thioridazine	25	800	100
Proketazine	carphenazine	25	200	25
Prolixin, Permitil	fluphenazine	2	20	2
Quide	piperacetazine	20	160	10
Repoise	butaperazine	10	100	10
Serentil	mesoridazine	30	400	50
Sparine	promazine	50	1000	100
Stelazine	trifluoperazine	2	40	4
Thorazine	chlorpromazine	30	1000	100
Tindal	acetophenazine	20	120	20
Trilafon	perphenazine	4	64	8
Vesprin	trifluopromazine	60	150	25
MISCELLANEOUS				
Haldol	haloperidol	1	15	2
Loxitane, Daxolin	loxapine	10	250	10
Moban, Lidone	molindone	5	225	10
Navane	thiothixene	6	60	4
Orap	pimozide	0.5	30	2
Taractan	chlorprothixene	30	600	100

I. GENERAL INFORMATION

The neuroleptics are psychiatry's most powerful drugs. The term neuroleptic means nerve-seizing and describes the semi-paralyzing effect these drugs have on the brain and nervous sytem. Neuroleptic drugs are typically used to control people whom psychiatrists label schizophrenic, manic-depressive, or psychotic. Psychiatrists claim neuroleptics can suppress symptoms, such as confusion, delusions, hallucinations, withdrawal, uncooperativeness, excitability, extreme anxiety, aggressiveness, and violence.

These drugs were developed in the early 1950s as versions of the antihistamines. Their strong sedative effect made them useful for inducing artificial hibernation during surgery. Introduced to psychiatry in 1953, they quickly became the major control weapons in all psychiatric institutions, for the most part supplanting barbiturates, insulin shock, electroshock and lobotomy. The first neuroleptic chemical family was called phenothiazines, of which the first were Thorazine

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1. Relative strength: the strength of various neuroleptics can be compared with each other. For example, 100 mg of Thorazine is equivalent in strength to 2 mg of Prolixin, 100 mg of Mellaril, or 8 mg of Trilafon.

and Stelazine. An early proponent of the neuroleptics described Thorazine as "a pharmacological substitute for lobotomy."[2]

> *The blunting of conscious motivation, and the ability to solve problems under the influence of chlorpromazine [Thorazine] resembles nothing so much as the effects of frontal lobotomy. The lobotomy syndrome was familiar to psychiatrists in 1954 [the year that chlorpromazine was introduced into North America] because so many lobotomized patients had accumulated in mental hospitals. Research has suggested that lobotomies and chemicals like chlorpromazine may cause their effects in the same way, by disrupting the activity of the neurochemical, dopamine. At any rate, a psychiatrist would be hard-put to distinguish a lobotomized patient from one treated with chlorpromazine.*
>
> Peter Sterling, Ph.D., "Psychiatry's Drug Addiction," THE NEW REPUBLIC, December 8, 1979, p. 17.

Neuroleptic drugs are usually given as pills, capsules or intramuscular injections. There are two forms of injections: short-acting, which take effect rapidly and last about as long as pills (4 to 24 hours) and long-acting (or depot) with effects that come on more slowly and last as long as 6 weeks after 1 shot. The long-acting injections are usually given every week, every other week or at longer intervals. For example, there is Prolixin Hydrochloride which is a short-acting injection, and Prolixin Enanthate or Prolixin Decanoate which are long-acting forms of the same drug. Prolixin Hydrochloride also comes in pill form.

The range of drug dosages listed on page 19 are drug-company guidelines: psychiatrists can legally prescribe doses above the highest recommended levels. There are several important terms that describe this practice:

1. Rapid Neuroleptization. This refers to the practice of giving newly admitted, so-called resistive or agitated psychiatric inmates repeated intramuscular injections of neuroleptics, particularly Haldol, on an almost hourly basis until they are subdued. This is an extremely dangerous form of chemical straitjacket.

2. Snowing. Psychiatrists heavily drug psychiatric inmates they regard as assaultive, violent, and uncontrollable with injections, sometimes in combination with oral drugs, that are far above the recommended upper-limit doses (i.e., 1500-3000 mg of Thorazine or equivalent doses of other neuroleptics). According to one proponent of this practice, the "snowed patient (is) rendered powerless, under control, and often asleep."[3] Snowing can lead to convulsions, coma and death.

3. Megadosing. With the "most difficult patients," psychiatrists may administer incredibly large doses of neuroleptics, using daily doses of Prolixin of 1200-1800 mg.[4] This is the equivalent of 60,000-90,000 mg of Thorazine, or more than 60-90 times the recommended upper-dosage limit. Obviously, the effects of such drugging can be disastrous.

> *I was given two chubby orange tabs of straight Thorazine, which brought me to a state resembling vegetation within twenty minutes. One does not argue or think in this state. After all, have you ever argued with a radish or a yam?*
>
> Francie Schwarts, BODY COUNT (San Francisco: Straight Arrow, 1972).

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2. H.E. Lehmann, "Therapeutic Results with Chlorpromazine." *Canadian Medical Association Journal*, 72 (1955): 91-9.

3. W.S. Appleton, "The Snow Phenomenon: Tranquilizing the Assaultive." *Psychiatry*, 28 (1965): 92.

4. A. Rifkin, et al., "Very High Dosage Fluphenazine for Nonchronic Treatment-Refractory Patients." *Archives of General Psychiatry*, 25 (Nov. 1971): 398.

HELPS KEEP THE REAL IN REALITY

Effective Management of Psychotic Symptoms

- Calms hyperactive behavior
- Controls hostility
- Decreases delusions, auditory and visual hallucinations
- Allays underlying fear, anxiety and tension
- Lessens unusual thought content, paranoid ideation
- Reduces emotional withdrawal

Before prescribing, see complete prescribing information including dosage and symptoms and treatment of overdosage, in SK&F literature or *PDR*.

Indications
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: For the management of manifestations of psychotic disorders.

Probably effective: For control of the manifestations of manic-depressive illness (manic phase). For the control of moderate to severe agitation, hyperactivity or aggressiveness in disturbed children.

Possibly effective: For control of excessive anxiety, tension and agitation as seen in neuroses.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Comatose states, presence of large amounts of C.N.S. depressants, or bone marrow depression.

Warnings: Avoid using in patients hypersensitive (e.g., blood dyscrasia, jaundice) to any phenothiazine. Caution patients about activities requiring alertness (e.g., operating vehicles or machinery), especially during the first few days' therapy. Avoid concomitant use with alcohol. May counteract antihypertensive effect of guanethidine and related compounds.

Use in pregnancy only when essential. There are reported instances of jaundice or prolonged extrapyramidal signs in newborn whose mothers had received chlorpromazine.

Precautions: Use cautiously in persons with cardiovascular, liver or chronic respiratory disease, or with acute respiratory infections. Due to cough reflex suppression, aspiration of vomitus is possible. May prolong or intensify the action of C.N.S. depressants, organophosphorus insecticides, heat, atropine and related drugs. (Reduce dosage of concomitant C.N.S. depressants.) Anticonvulsant action of barbiturates is not intensified. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.

Patients on long-term therapy, especially high doses, should be evaluated periodically for possible adjustment or discontinuance of drug therapy.

Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, fainting, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes have been reported, but relationship to myocardial damage is not confirmed; neuromuscular (extrapyramidal) reactions; pseudoparkinsonism, motor restlessness, dystonias, persistent tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms, catatonic-like states, cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions and photosensitivity, exfoliative dermatitis, contact dermatitis; lactation and breast engorgement (in females on large doses), false positive pregnancy tests, amenorrhea, gynecomastia; hyperglycemia, hypoglycemia, glycosuria; dry mouth, nasal congestion, constipation, adynamic ileus, urinary retention, miosis, mydriasis; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment; mild fever (after large I.M. dosage); hyperpyrexia; increased appetite and weight; a systemic lupus erythematosus-like syndrome; peripheral edema. NOTE: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.

Supplied: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg., in bottles of 100; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg., in bottles of 50; Injection, 25 mg./ml.; Syrup, 10 mg./5 ml.; Suppositories, 25 mg. and 100 mg.; Concentrate, 30 mg./ml. and 100 mg./ml.

Smith Kline & French Laboratories, Philadelphia SK&F

THORAZINE®

brand of

CHLORPROMAZINE

Tablets: 50 mg. of the HCl

II. DRUG EFFECTS

1. Non-Muscular Reactions

These effects are usually most severe during the first few weeks or months after starting neuroleptic drugs, and then tend to diminish as the body adjusts. However, if the dosage levels are increased or new drugs are added, these effects can continue unabated or worsen.

A. Frequent Effects: sedation, drowsiness, lethargy, difficulty thinking, poor concentration, nightmares, apathy, emotional dullness, depression, despair, headache, dizziness, fainting (when first standing up), nasal congestion (stuffy nose), blurred vision, dry mouth, dry throat, a tendency to gag, excessive salivation, drooling, loss of appetite, nausea, vomiting, constipation, difficulty in urinating, menstrual problems, sexual problems, low blood pressure and weight gain.

B. Occasional and Rare Effects:

1) Skin rash, itchiness, easy sunburn (photosensitivity) and permanent blue-gray discoloration of the skin (usually only after several years' use).

2) Cessation of menstrual cycles.

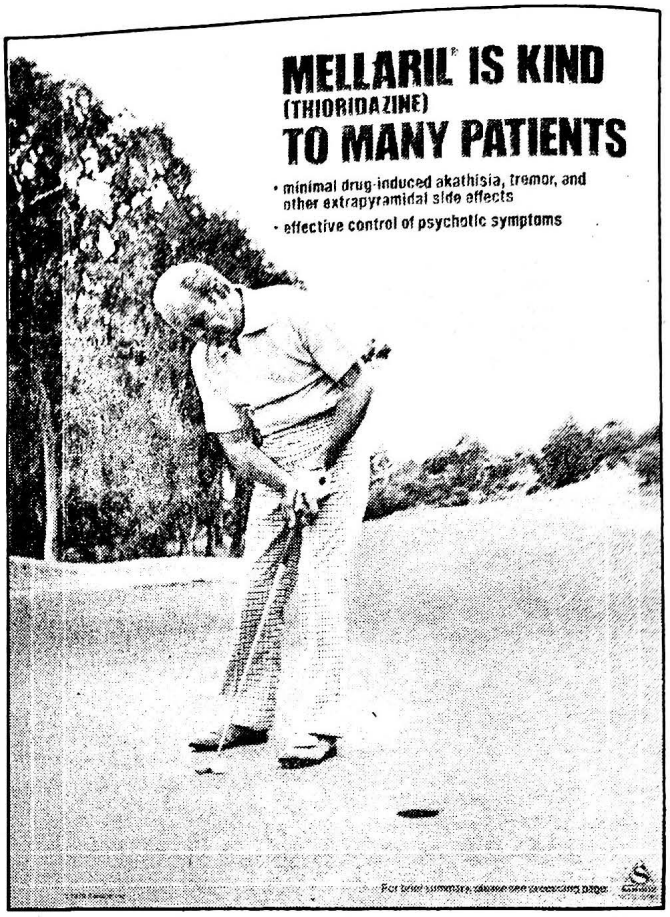
3) Swelling of breasts (at times painful) and secretion of milk from breasts (galactorrhea). These problems may occur in both women and men.

4) Increased risk of epileptic seizures.

5) Allergic form of hepatitis (liver disease) with jaundice (yellow eyes and skin), which usually appears 3-4 weeks after starting neuroleptics. There is some evidence that Thorazine more frequently than other neuroleptics, causes this type of hepatitis.

6) Eye problems, including permanent pigment deposits in the retina caused by Mellaril and permanent pigment deposits in the lens and cornea with Thorazine. Both conditions reduce vision. Only yearly examinations will detect this. Drugs should be stopped if pigment deposits appear. The neuroleptics make people vulnerable to attacks of glaucoma.

7) Decrease in white blood-cell count (agranulocytosis) causing infections (sore throats and the like) which can be fatal.



American Journal of Psychiatry, August 1980

8) Paralysis of the intestines: bowel movements stop completely. If this happens, all drugs should be halted and immediate emergency attention sought.

9) Heart problems, including low blood pressure, heartbeat irregularities and changes in electrocardiogram readings.

10) Interference with the body's temperature-control apparatus causing either very low or very high body temperatures.

[After 7 days on neuroleptics, one young woman complained of unbearable "fatigue"]: "I have slowed down. I talk slower and move slower. I feel like an old lady. I get tired from walking around the block. I feel discouraged about the future. I have no enthusiasm. I can't type nearly as fast at my job...I want my own personality back."

Anonymous, in P.R. Breggin, PSYCHIATRIC DRUGS: HAZARDS TO THE BRAIN (New York: Springer, 1983) p. 34.

During the period I was hospitalized, all of my behavior was attributed by staff to my "illness." Since I was then in a highly vulnerable emotional state, I half-believed that perhaps I was as "crazy" as I was constantly being told I was. The lack of information as to drug side effects contributed to this feeling, since I was discovering that my body was less and less under my voluntary control. The repetitive pacing which I found myself doing, and saw so many other people doing, made me feel (at least sometimes) that we all belonged in a mental hospital. Thorazine side effects make us look just like the stereotype of mental patients.... On summer days, when there was an opportunity to leave the ward and sit in the warm sunshine, many of us had to remain indoors. I discovered this side effect after a day in the sunshine, when my skin started to itch painfully. I was not warned in advance that this would happen. Nursing personnel are forewarned of allergic skin reactions; the PHYSICIANS' DESK REFERENCE states "contact dermatitis has been reported...accordingly, the use of rubber gloves when administering Thorazine is recommended."

Judi Chamberlin (author, ON OUR OWN), testimony, Hearings, U.S. Senate Subcommittee, THE ABUSE AND MISUSE OF CONTROLLED DRUGS IN INSTITUTIONS (Washington: U.S. Printing Office, 1977) p. 90.

■ ■ ■

My tongue was so fuzzy, so thick, I could barely speak...It was so hard to think, the effort was so great; more often than not I would fall into a stupor of not caring or I would go to sleep. In 8 years I did not read an entire book, or see a whole movie. I could not focus my blurred eyes to read and I always fell asleep at a film. People's voices came through filtered, strange. They could not penetrate my Thorazine fog; and I could not escape my drug prison. The drugs made me constipated as well as ravenously hungry. As a final misery they caused me to gain weight. For 8 years I took laxatives and suffered as I watched my body grow heavy and distorted. My hands shook so I could barely hold a pencil and I was afflicted with what Dr. Sternfeld lightly called "dancing legs," a Parkinsonian "side-effect" of these chemicals. For this I took a drug called Kemadrin, and if I missed a day or a dosage, my shoulder muscles would tighten into excruciatingly painful knots and my legs would go wildly out of control.

Janet Gotkin, testimony, Hearings, U.S. Senate Subcommittee, THE ABUSE AND MISUSE OF CONTROLLED DRUGS IN INSTITUTIONS (Washington: U.S. Printing Office, 1977) p. 15.

■ ■ ■

I recently obtained a prescription for one day's worth of Thorazine: five 10-milligram tablets, which cost $5.10 at a discount drug store...The drug's major effects don't really develop until the patient has taken Thorazine much longer than a single day. Nevertheless, in one day's dosage I got a clear idea of what lay ahead.

Simply put, Thorazine made me stupid. Because Thorazine and related drugs are called "liquid lobotomy" in the mental health business, I'd expected a great gray cloud to descend over my faculties. There was no great gray cloud, just small but unsettling patches of fog.

My mental gears slipped. I had no intellectual traction. It was difficult, for example, to remember simple words. I'd start to describe something and find myself unable to remember such terms as "screwdriver" and "volume." Watching TV--also known as "electronic lobotomy"--was harder than usual: the simple plot-lines seemed tangled.

Bill Mandel, columnist, SAN FRANCISCO EXAMINER, May 1, 1983.

■ ■ ■

A 1977 study revealed that 29% of all adult psychiatric inmates in California's 4 state hospitals were being administered in excess of 800 mg/day chlorpromazine (Thorazine) or the equivalent dosage of another neuroleptic.

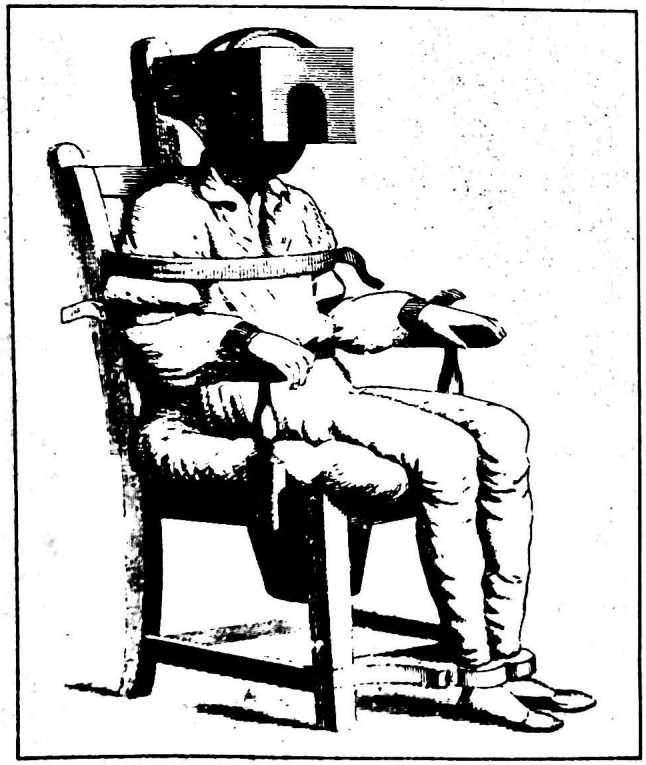
Assembly Office of Research, California Legislature (Daniel Chandler and Andrea Sallychild), THE USE AND MISUSE OF PSYCHIATRIC DRUGS IN CALIFORNIA'S MENTAL HEALTH PROGRAMS (Sacramento, June 1977) information on p. 103.

2. Muscular Reactions

A. Temporary Muscular Effects (extrapyramidal symptoms, or EPS).[5]

Abnormal muscle reactions are a very common effect of the neuroleptics: virtually everyone who has taken these drugs for longer than a few days at moderate or higher dosage levels has experienced EPS in some degree. Because each individual's neuroleptic response is unique, it is impossible to predict what the muscle reaction will be. However, one is more likely to have a serious reaction when:

- neuroleptic drugs are first used
- high doses are used
- doses are increased
- intramuscular injections
- the following neuroleptics are used: Haldol, Loxitane, Navane, Prolixin, Stelazine, and Thorazine.



Benjamin Rush, "The Father of American Psychiatry," called his invention the "Tranquillizer" (1810).

Extrapyramidal symptoms will gradually disappear when the drugs are stopped. If drugs have been used steadily for many months or years, however, it can take several months or more for the muscles to return to their previous level of functioning. Psychiatrists use anti-parkinsonian drugs in their attempts to minimize EPS (see chapter on Anti-Parkinsonians, p.32). But *remember*, the best way to relieve the distressing muscular effects caused by the neuroleptics is to stop taking them (see chapter on Drug Withdrawal, p.54).

"LET ME KNOW IF THERE ARE ANY SIDE EFFECTS."

Of the 5 major types of EPS described below, only the dystonias are painful. However, all forms of EPS can be extremely distressing and disturbing.

1) Dystonias (sudden, uncontrollable, painful muscle cramps and spasms). These movements can affect any muscle group in the body. Although neuroleptic-induced dystonic reactions occur infrequently, they usually are very painful, frightening and debilitating. They require emergency attention (see Anti-Parkinsonians I, p.32). The more common types of dystonias are:

- Oculogyric Crisis (fixed upward gaze). Sudden, severely painful eye muscle

5. This term refers to one part of the brain's muscle control system. Neuroleptic-caused malfunction of this system results in various muscular abnormalities. EPS and drug-induced Parkinsonism are terms often used interchangeably.

spasms lock the eyeballs into an upward position.

- Spasmodic Torticullis (turning of the head to one side). Involuntary muscle contractions on one side of the neck pull the chin in towards one shoulder or the other. Any movement from this position can be extremely difficult. This condition is also known as wry neck.
- Opisthotonus (arching of the back). Muscles along the spine from the neck to the lower back spasm and contract forcing the back to extend painfully. Walking may become impossible.
- Laryngeal-Pharyngeal Dystonia (throat spasms). Muscles in the back of the mouth (pharynx) and the throat (larynx) go into spasm, causing breathing, swallowing, and speech problems. Breathing difficulties can be very dangerous.

2) Dyskinesias (uncontrollable writhing, squirming, twisting, and grimacing movements, especially of the legs, face, mouth, and tongue). Facial tics, protrusion of the tongue, chewing, blinking, and shoulder shrugging are some of these movements.

3) Akathisia (severe restlessness). This condition is marked by an inability to sit or stand still, with pacing, foot-tapping, rolling-finger movements, rocking, shifting of weight while standing, shifting of legs while sitting, jitteriness, and an unpleasant inner sensation centering in and around the stomach.

4) Parkinsonism (muscle rigidity and shaking). Increased muscle tension causes varying degrees of stiffness, cogwheel rigidity (cogwheeling, jerky movements), tremors in the hands and legs, mask-like facial expression, stooped (robot-like) posture, shuffling gait ("Thorazine shuffle") and drooling.

5) Akinesia (zombie effect). This extreme form of Parkinsonism is characterized by stiff carriage, loss of spontaneity, weakness, few body movements or gestures, little or no speech, apathy, and a spaced-out look.

My four days at St. Francis Hospital [San Francisco] were, I believe, tragically typical. Two men in white coats greeted me, more or less without talking, and put me in locked seclusion. I spent two days in isolation. No one came in to talk with me for more than 30 seconds at a time, and then only to give me my food or my drugs. The drugs--what they call medication--came as they often do, in all sorts of shapes and colors: in my case four or five different pills at one time. At first I only pretended to swallow them and afterwards flushed them down the toilet. But they soon noted my tactic and insisted that I swallow them in their presence. Knowing that the needle would be the result if I refused, I consented.

All their drugs slowed me down a bit--I reckon they didn't give me enough to wipe me out--but otherwise I was basically the same as when I went in: very freaked out. After 10 days or so, however, the effects of the Prolixin began building up in my system and my body started going through pure hell. It's very hard to describe the effects of this drug and others like it. That's why we use strange words like "zombie." But in my case the experience became sheer torture. Different muscles began twitching. My mouth was like very dry cotton no matter how much water I drank. My tongue became all swollen up. My entire body felt like it was being twisted up in contortions inside by some unseen wringer. And my mind became clouded up and slowed down--before I had been reasoning incorrectly, but at least I could reason. But most disturbing of all was that I feared that all of these excruciating experiences were in my mind, or caused by my mind--a sign of my supposed sickness.

Prolixin, as I hope you know, is the most terrifying psychiatric drug on the market. Suspended in a special solution, a phenothiazine much like Thorazine, it is time released so that it works on your body and mind for weeks at a time. One injection every week or two and you have a nation of zombies, easily controlled--especially if the threat of incarceration can coerce them into appearing for their regular injection.

Wade Hudson, testimony, Hearings, U.S. Senate Subcommittee, THE ABUSE AND MISUSE OF CONTROLLED DRUGS IN INSTITUTIONS (Washington: U.S. Printing Office, 1977) p. 36.

B. Permanent Muscular Effects (tardive dyskinesia, or TD).[6]

As noted previously, neuroleptic drugs are capable of damaging certain parts of the brain that control muscle movement. Such damage can lead to prolonged or permanent effects on muscle tension and movement. This condition is called tardive dyskinesia (TD). It is marked by abnormal, rhythmical, involuntary muscle movements: most often of the mouth, tongue, face, and jaw. However, any muscle, particularly in the extremities, can be affected. This condition can result in problems sitting, walking, breathing, talking, and chewing, to name a few. Although there are various forms of TD, all the temporary muscular effects listed in the previous section can be seen as more lasting problems under the heading of tardive dyskinesia.

TD muscle movements usually last 5-8 seconds, are repetitive and rhythmical, and often make the person look strange and spastic. The movements are affected by one's emotional state: they increase with tension and anxiety and lessen with relaxation. The movements disappear during sleep.

Mouth movements in tardive dyskinesia can involve sucking, smacking and puckering of the lips, puffing of the cheeks (blowing), and chewing motions. There can be clenching of the jaw and grinding of the teeth, with side-to-side movements of the jaw. Facial tics and grimacing are commonplace. Speech can become garbled and the voice nasal. A grunting type of breathing pattern, at times quite loud, can also develop. There can be twisting or jerking of the head and sometimes of the entire body. Uncontrolled finger movements, foot-tapping, and other unusual movements are frequently observed in TD sufferers. These effects can be quite severe and obvious or so subtle that only a trained eye can detect them.

Tardive dyskinesia is a disfiguring and at times disabling problem, and the damage may also involve problems of lowered intellectual functioning, apathy, indifference, and dementia (senility).

There can be a behavioral component to TD as well. Drug-induced brain damage can cause emotional and psychological changes. Behaviors that have been observed in association with tardive dyskinesia include sharp mood changes, periods of quiet alternating with high activity, unusual speech patterns (including aimless or very loud conversation) and an overall poor level of functioning. Terms used to describe this syndrome have included tardive psychosis, iatrogenic schizophrenia and, most recently, tardive dysmentia.

Typically, this sort of behavior is labeled as a recurrence of a "mental disorder" and used as justification for resuming drugging, rather than recognized as being a result of drug-induced damage.[7]

Tardive dyskinesia is estimated to occur in anywhere from 20-55% of people who use neuroleptics for 2 years or longer. Uncommonly, these drugs cause TD after only a few months' use--in rare cases, after only a few weeks' use. There is no way of predicting who will or will not suffer TD from neuroleptic use. However, those who experience drug-induced temporary muscular effects are at higher risk of developing TD than those who don't. It also appears that the use of anti-parkinsonian drugs increases this risk. Another factor is age: the older you are, the more likely it is that you will develop neuroleptic-induced TD and that it will be permanent.

TD can appear while taking neuroleptics at accustomed doses, but is more likely to appear after the dose is reduced or during drug withdrawal. Quite often, it is only after the drug-withdrawal period that muscle movements start, indicating that possibly permanent brain damage has occurred. However, these movements sometimes occur only during, not after drug withdrawal, indicating that the damage is not permanent. This is called a *withdrawal dyskinesia*. When a person first experiences abnormal muscle movements during drug withdrawal, it is impossible to tell if these will stop after some days or weeks (withdrawal dyskinesia) or if they will last for a prolonged period

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6. *Tardive* means late-appearing, because it usually takes 2 or more years of neuroleptic use to produce this condition. *Dyskinesia* means abnormal muscle movement.

7. "Mental Illness from Psychiatric Drugs." *Science News* 124 (Oct. 1983): 214.

Prevention of Tardive Dyskinesia

1. Do not take neuroleptic drugs!!!

2. If neuroleptics are used at all, use them in small doses and for short periods of time.

3. While neuroleptic drugs are being taken, every three months have a thorough neurological evaluation by a physician, preferably a neurologist, who knows about TD.

4. Do not use neuroleptics for more than a few weeks to 3 months without taking breaks, called "drug holidays," during which the early signs of TD may appear. For example, at least 4 times a year, withdraw gradually from all neuroleptics and remain drug-free for 2 weeks to a month in order to detect any signs of brain damage (see chapter on Drug Withdrawal, p. 54). An evaluation should be made by a physician knowledgeable about TD. If there is any brain damage, the abnormal muscle movements characteristic of TD will start during or shortly after drug withdrawal. If such movements appear, neuroleptic use should not be resumed.

5. Whenever neuroleptics are stopped, slow withdrawal might reduce the risk of developing TD.

6. Avoid long-acting intravenous injections of neuroleptics like Prolixin Decanoate. All neuroleptics carry the risk of TD, but the risk appears to be greater with the longer-acting forms of administration.

or even indefinitely (tardive dyskinesia).

TD will generally surface within 2-4 weeks after complete withdrawal. It is important to remember that the abnormal muscle movements of TD may eventually disappear if all neuroleptics are stopped. It can take many months for this to happen: with some people, especially the elderly, it can take years. A recent study reported that it can take up to 5 years after stopping neuroleptic drugs for the dyskinetic movements to disappear.

Because there is no known remedy for tardive dyskinesia, prevention of the problem is of utmost importance. There have been numerous attempts to control this disease with all kinds of psychiatric drugs, anti-convulsants (and other neurological drugs), lecithin (phosphatidyl choline) and other substances. Unfortunately, so far no tested treatment has been more than minimally successful. Sometimes if neuroleptic use is resumed or the dose increased, TD movements may come to a halt temporarily. This merely masks the problem, while at the same time the underlying condition worsens as the brain sustains further damage from the neuroleptics.

Neuroleptic drugs were introduced in 1953, and the first reports of TD started appearing in the late 1950s. But it was not until 1972, after hundreds of these reports had been published, that the drug companies began including warnings about TD in their neuroleptic-drug ads and drug-information literature. And this happened only after the courts had awarded damages to several TD victims.

According to Peter Breggin, "Psychiatry has unleashed an epidemic of neurologic disease on the world. Even if tardive dyskinesia were the only permanent disability produced by these drugs, by itself, this would be among the worst medically-induced disasters in history."[8]

3. Death as the Ultimate "Side Effect"

In ads directed to psychiatrists, the drug companies list "sudden death" as a "side effect" of the neuroleptics. There are a variety of ways in which these drugs can be fatal: disordered body temperature regulation, bone-marrow poisoning, convulsions, blood clots, paralysis of the intestines, cardiac arrest, drug-induced despair leading to suicide, and asphyxiation caused by interference with the gag reflex. In 1978, a New York state medical examiner cited this last factor in 30% of all psychiatric-inmate deaths in Rockland County. The victims, according to Dr. Frederick Zugibe, died when they "vomited into their lungs because certain nerves necessary to prevent this from happening had been deadened by tranquilizers." He emphasized that "This is not unique to Rockland County. This

8. P.R. Breggin, *Psychiatric Drugs*, p. 109.

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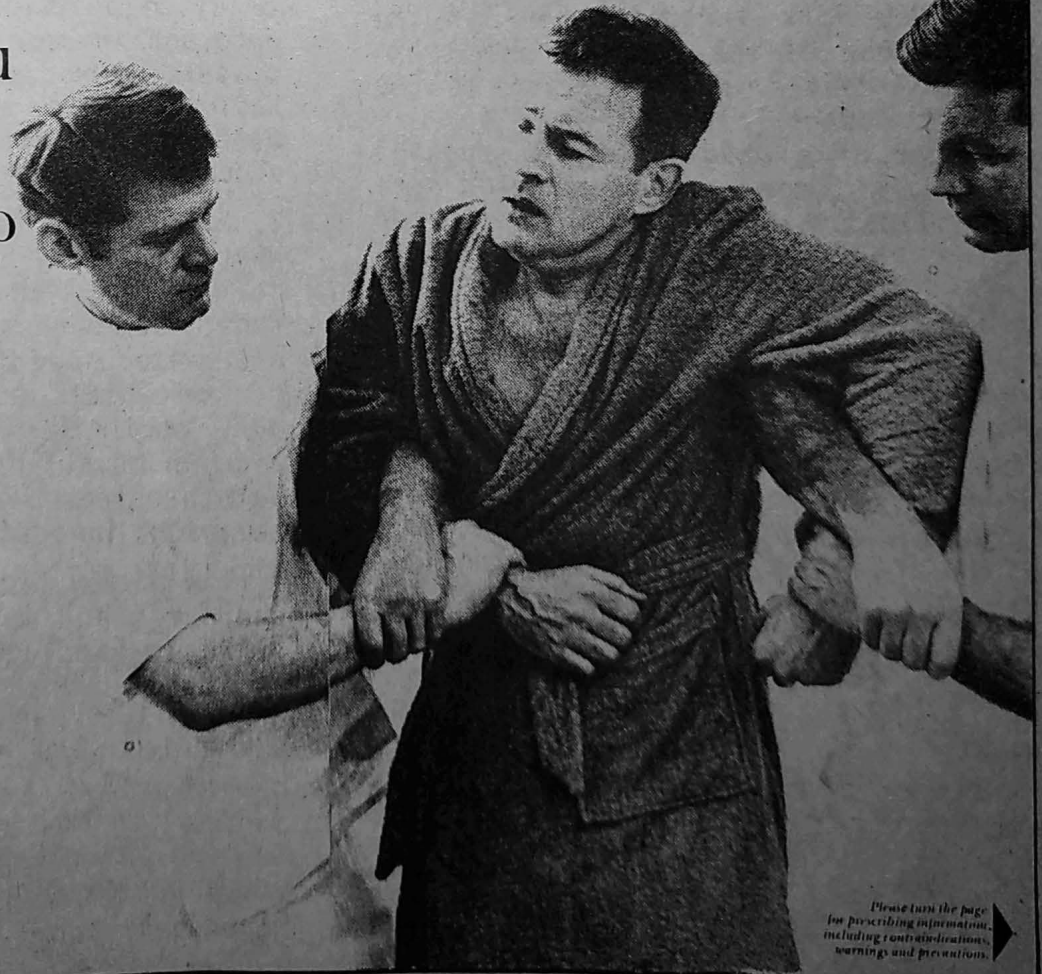

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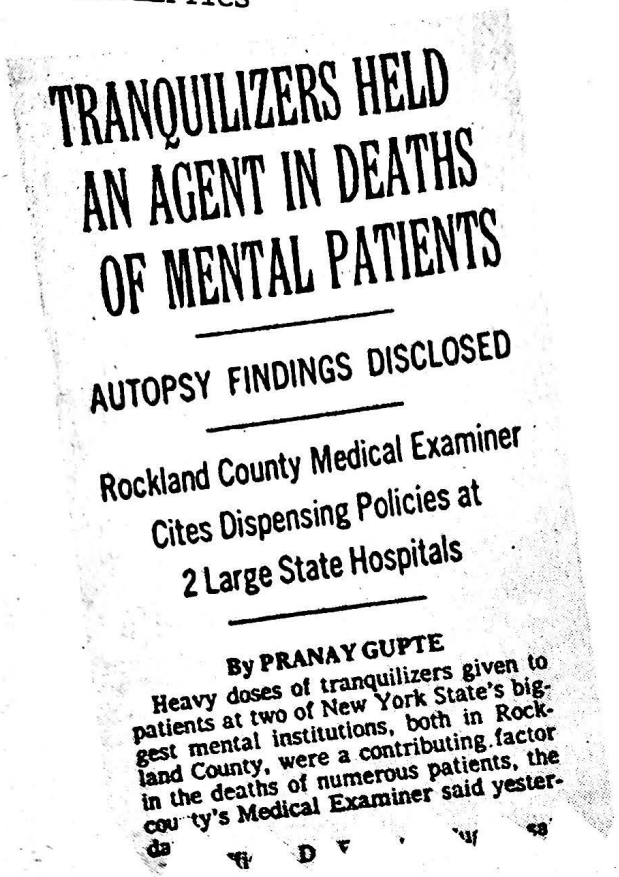
Clockwise, from upper left - American Journal of Psychiatry, February 1972, March 1982, October 1968



TRANQUILIZERS HELD AN AGENT IN DEATHS OF MENTAL PATIENTS

AUTOPSY FINDINGS DISCLOSED

Rockland County Medical Examiner Cites Dispensing Policies at 2 Large State Hospitals

By PRANAY GUPTE

Heavy doses of tranquilizers given to patients at two of New York State's biggest mental institutions, both in Rockland County, were a contributing factor in the deaths of numerous patients, the county's Medical Examiner said yesterda

The New York Times, July 17, 1978, p. 1

is going on in every institution in the state of New York and everywhere in the country. These deaths are not from overdoses. The deaths are occurring at the therapeutic dosage level."[9]

The danger of a drug-induced disruption of the body's temperature regulation system was illustrated by a 1981 newspaper report of the heat-stroke deaths of 11 psychiatric inmates and outpatients during a New York City heat wave. All of them were on neuroleptics at the time.[10]

In addition, there may be many neuroleptic-caused deaths that are not being reported as such. As Peter Breggin has explained, "the drugs suppress spontaneous complaints about disease symptoms, delaying treatment, and resulting in deaths that seem to come wholly from 'natural causes.'"[11]

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9. Quoted in R. Hughes and R. Brewin, *The Tranquilizing of America: Pill Popping and the American Way of Life* (New York: Harcourt Brace Jovanovich, 1979) p. 158.
10. H. Wyatt, "Drugs & Heat Probed in 11 Hospital Deaths." *New York Daily News*, July 16, 1981.
11. P.R. Breggin, *Psychiatric Drugs*, p. 72.

III. SPECIAL PRECAUTIONS (see chapter on General Precautions, p.14)

The following is a list of special precautions and warnings to help prevent neuroleptic-induced problems. Of course, the best preventive measure is to stop taking the drug. The next best is to reduce the dosage being taken.

1. Neuroleptics can interfere with the heart's electrical system, causing fast or irregular heartbeats and cardio-toxicity (or heart-poisoning). These effects can lead to heart failure and death. These risks are higher for the elderly and those with heart disease. Careful medical examination, including an EKG, before starting the drugs and regular evaluations while they are being taken are necessary.

2. These drugs can cause a drop in blood pressure, especially when first standing up, leading to dizziness, lightheadedness and fainting (orthostatic hypotension). If you have this problem, care should be exercised when getting up from a sitting or lying position. Rise slowly and hold onto some person or object until you are standing and no longer feeling dizzy. Failure to do so can result in broken bones from falls, particularly in the elderly.

3. Neuroleptics can impair the body's heat-regulating system. In hot, humid weather or with strenuous exercise, hot tubs, or saunas, the body can become overheated, leading to heat stroke, which can be fatal. In cold weather, lowered body temperature can result in hypothermia, an equally dangerous condition. For both problems, emergency attention should be sought immediately.

4. These drugs can poison the bone marrow where red and white blood cells are produced (agranulocytosis). When this happens, the number of white blood cells is abnormally reduced. This condition, which can be fatal, is signaled by frequent fevers, sore throats, and mouth sores. If you have this problem, neuroleptics should be discontinued and a blood test taken to determine your white blood-cell count.

5. The neuroleptics can make the skin very sensitive to sunlight and sunlamps

(photosensitivity). Even a small exposure can result in severe sunburn and blisters. In warmer climates this problem is more common.

6. Because these drugs can cause dry mouth and dry throat, which make chewing and swallowing difficult and increases the likelihood of gagging on food, it is important to take only small bites of food, eat slowly and chew well.

7. Neuroleptics can lower the seizure threshold and thus increase the danger of convulsions, a particular problem for those with a history of seizures.

8. One unusual neuroleptic reaction involves the sudden development of a high fever, profuse perspiration, rapid heartbeat, confusion, disorientation, and severe muscular reactions (often with rigidity and tremors). This condition is called neuroleptic malignant syndrome. In addition to stopping all neuroleptics, emergency attention should be immediately sought. The mortality rate for those afflicted with this syndrome is 12-20%. For survivors there is serious risk of brain damage.

9. Muscular reactions to these drugs can at times lead to serious complications, including:

- A state of drug-induced "catatonia," in which the person becomes so rigid that muscle movement is extremely difficult or impossible.
- The development of severe muscle cramps or dystonias of the breathing muscles (respiratory dystonia), leading to a puffing, panting, and a rapid breathing pattern with grunts or snorts.
- A spasm of the throat and voice muscle (laryngeal-pharyngeal dystonia) that can seriously interfere with swallowing and speech.

10. Neuroleptics had been implicated in the development of strokes with resultant brain damage. This may happen for a variety of reasons including interference with blood clotting (excessive bleeding which in turn can lead to other serious problems), interference with the heart, and blood-pressure problems.

11. Neuroleptics can increase the levels of a natural brain hormone called prolactin. Ordinarily, increased prolactin occurs only during pregnancy and breast feeding. Increased prolactin levels cause breast swelling and secretion of milk which can happen in both women and men. One concern is that these higher levels of prolactin may also increase the risk of breast cancer.

from a Squibb promotional brochure for Prolixin, September 1979

Chapter 6

ANTI-PARKINSONIANS

(anti-cholinergics)

Brand Names	Generic Names	Adult Dosage Range low--mg/day--high	
Akineton	biperiden	2	6
Artane, Tremin	trihexyphenidyl	2	15
Benadryl	diphenhydramine	25	200
Cogentin	benztropine	0.5	8
Kemadrin	procyclidine	2	20
Parsidol	ethopropazine	50	500
Symmetrel	amantadine	100	300

I. GENERAL INFORMATION

There is a good deal of confusion about the use of the anti-parkinsonian drugs. They are not "tranquilizers;" they are given *only* in an attempt to reduce disturbing, neuroleptic-induced muscular effects such as muscle cramps, shaking, muscle rigidity and restlessness (extrapyramidal symptoms). However, while the anti-parkinsonian drugs may reduce these muscle effects, they in no way lessen the impact of the neuroleptics on the brain, including their potential for causing permanent brain damage, more specifically tardive dyskinesia (TD). In fact, it appears that the use of anti-parkinsonian drugs may actually increase the risk of TD.[1] (See "tardive dyskinesia" section in Neuroleptics, p.27).

Anti-parkinsonian drugs come in both pills and injections. If while taking a neuroleptic you develop sudden, painful and distressing muscle cramps (dystonic reactions), then get an injection of an anti-parkinsonian drug as soon as possible. It will provide immediate relief. If necessary, go to an emergency room for this shot.

The other, less severe neuroleptic induced muscle reactions usually do not involve an emergency situation. In these instances, the anti-parkinsonian drugs are used in an attempt to minimize muscular discomfort and difficulty. But there

1. People with tardive dyskinesia should not take anti-parkinsonians. They usually worsen the symptoms of TD, although rarely they can offer some relief.

is controversy about these drugs because they too have harmful effects. The anti-parkinsonian drugs work by blocking the activity of a natural brain and nervous-system neurotransmitter chemical called acetylcholine, and thus their effects are called *anti-cholinergic*. These include: dry mouth, blurred vision, constipation, sedation, and difficulty urinating. The controversy lies in the fact that some psychiatrists, in their desire to prevent muscle problems, give anti-parkinsonian drugs to everyone taking neuroleptics. Other psychiatrists wait until muscle reactions develop before giving these drugs. Because of their damaging effects, it is probably better to use the anti-parkinsonian drugs only if serious muscle problems occur. If this happens, use the anti-parkinsonian drugs for 3-4 weeks and then stop taking them to see if the distressing muscular effects return.

II. DRUG EFFECTS

1. Frequent Effects: dry mouth and dry throat (possibly with problems talking and swallowing), blurred vision (especially near vision), constipation, difficulty urinating, drowsiness and fatigue, dizziness, mild nausea, and nervousness.

2. Occasional and Rare Effects: depression, weakness, severe nausea, vomiting, insomnia, numbness of the hands, skin rash, inflammation of the salivary glands, confusion, memory problems, difficulty reasoning, sexual problems, fainting, rapid heartbeat, and toxic psychosis.

III. SPECIAL PRECAUTIONS (see chapter on General Precautions, p.14)

1. Elderly males with prostate enlargement are particularly vulnerable to problems urinating while taking anti-parkinsonian drugs. This can lead to an inability to urinate, which is not only extremely painful but also a medical emergency.

2. These drugs can bring on an attack of glaucoma (eye disease with pain and possible loss of vision).

3. These drugs can speed up the heart and at times cause palpitations, which makes them especially dangerous for the elderly and those with heart disease.

Special Warning:

Anti-Cholinergic Poisoning

The anti-parkinsonian drugs can trigger a form of toxicity known as anti-cholinergic poisoning. Many psychiatric, medical, over-the-counter drugs, and even certain herbs have anti-cholinergic properties. When 2 or more psychiatric drugs with anti-cholinergic properties are taken at the same time (particularly when neuroleptics and anti-parkinsonian drugs are combined), the risk of developing anti-cholinergic effects, including poisoning, is considerably increased. These effects are cumulative. The symptoms of anti-cholinergic poisoning are: delirium (toxic psychosis), confusion, disorientation, delusions, hallucinations, agitation, nighttime restlessness, insomnia, nightmares, dry skin, fever (with risk of heatstroke), red skin (especially in the face), severe dry mouth and dry throat, constipation, paralysis of the intestines, inability to urinate, heart irregularities and poor muscle coordination and imbalance. Life-threatening convulsions and coma can occur.

Chapter 7

ANTI-DEPRESSANTS

Trade Names	Generic Names	Adult Dosage Range low--mg/day--high	
TRICYCLICS			
Adapin, Sinequan	doxepin	25	300
Aventyl, Pamelor	nortriptyline	25	100
Elavil, Endep	amitriptyline	25	300
Norpramin, Pertofrane	desipramine	25	300
Surmontil	trimipramine	25	300
Tofranil,[1] Janimine, SK-Pramine	imipramine	25	300
Vivactil	protriptyline	5	60
NEWER VERSIONS OF TRICYCLIC-TYPE DRUGS			
Asendin	amoxapine	50	300
Desyrel	trazodone	50	600
Ludiomil	maprotiline	25	225
Wellbutrin (soon to be released)	bupropion	150	750
Zelmid (soon to be released)	zimelidone	100	300
MAO INHIBITORS (monoamine oxidase)			
Marplan	isocarboxazid	10	30
Nardil	phenelzine	15	90
Parnate	tranylcypromine	10	30

COMBINATIONS[2] (an anti-depressant with another category of drug in a single pill)

Etrafon = Elavil + Trilafon (a neuroleptic)
Limbitrol = Elavil + Librium (an anti-anxiety drug)
Triavil = Elavil + Trilafon

PSYCHOSTIMULANTS[3] (amphetamines and quasi-amphetamines, particularly Ritalin)

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1. Tofranil-PM is a longer-acting pill taken once a day at bedtime.

2. These drugs come in various strengths, e.g., Triavil 2/10, 2/25, 4/10, 4/25, which mean Trilafon 2 mg/Elavil 10 mg and so on. Such "fixed" combinations make it difficult to adjust dosages (see "titration" in Prescription Practices p.13). The supposed advantages of these combinations are that fewer individual pills need to be taken and that the cost is less. However, combination drugs are but another form of polypharmacy (see p.13) and carry with them similar dangers, including drug-interaction problems.

3. Psychostimulant drugs are infrequently used for depression. Today the FDA does not allow physicians to prescribe amphetamines for depression, but it does allow them to use the quasi-amphetamines, like Ritalin, for this purpose, mostly in the elderly (see Psychostimulants, p.45, and Geriatric Drugs, p.48).

I. GENERAL INFORMATION

Psychiatrists prescribe anti-depressants for what they call depression. "Symptoms" of depression include low energy, unhappiness, anxiety, grief, insomnia, loss of appetite, loss of sexual interest, tearfulness, and apathy. These are some of the very same symptoms which the major depressant drugs (neuroleptics, anti-depressants, and lithium) often produce.

Psychiatry's first anti-depressant drugs were basically stimulants, or uppers, with amphetamines the most widely used. These drugs induce euphoria and a sense of energy, but their mood-elevating effects are short-lived. Moreover, after a period of time, this pleasant state changes to a very unpleasant state, or dysphoria. There are also serious withdrawal problems, including a rebound depression, which indicates the drug's addictive nature. Debilitating cycles are often set in motion when addicts continue using the drugs to prevent withdrawal depression.

The anti-depressants used today fall into two major chemical categories: the tricyclics and the MAO inhibitors (monoamine oxidase inhibitors). These drugs were accidentally found to have some mild mood-lifting effect, although they are not true stimulants, like the amphetamines. The tricyclics and MAO inhibitors, in fact, have primarily depressant effects on the brain, but mild stimulation can occur after a period of time, usually 2-4 weeks. Their so-called anti-depressant effect has been described as a dulling of depression. In other words, because of their depressant effects, one feels less of everything, including less depressed. This deadening effect on emotions and mood can be very unpleasant, sedating, and ultimately toxic.

However, even the stimulant effects of these drugs, which are more likely to be felt with the MAO inhibitors, can be unpleasant, sometimes triggering agitated states.

The anti-depressants are highly toxic chemicals. This is particularly true of the MAO inhibitors, which demand care and strict attention to diet. Most psychiatrists use MAO inhibitors only after a trial with the tricyclics.

The tricyclics are almost identical to the neuroleptics, with many properties and problems in common. However, muscular reactions, including tardive dyskinesia, are less frequent with the tricyclics.

Recently, the drug companies have been active in promoting 3 new anti-depressant drugs: Asendin, Desyrel, and Ludiomil. It is claimed that these new drugs work faster, have less cardiotoxicity and fewer anti-cholinergic and sedative effects. But these drugs are very similar to the older tricyclics and basically have the same kinds of dangers. Many physicians push the "latest" drugs because their toxic effects are not as well known as those of the older drugs. Of course, it is only after the large-scale, longer-term use of these new drugs that their harmful effects start to be recognized, with Thalidomide as a tragic example.

There are facts about the new anti-depressants that are of special concern:

1. Asendin. This drug is much like the neuroleptic Loxitane and has many of the same serious risks as the neuroleptics in general. Thus, there are now reports of Asendin causing extrapyramidal symptoms, tardive dyskinesia, sexual problems, menstrual problems, and bone-marrow poisoning. Moreover, a recently published study reports that Asendin has been associated with mortality and seizure rates far in excess of those for other anti-depressant overdoses.[4]

2. Desyrel. This drug has marked sedative effects, frequently causes orthostatic hypotension (lightheadedness or fainting when first standing up), and tends to be more irritating to the stomach. It can also cause headaches, decreased appetite (with consequent weight loss), and heart problems, which are of particular concern to the elderly and those with heart conditions.

3. Ludiomil. Like the tricyclics, Ludiomil carries risks of anti-cholinergic problems, orthostatic hypotension, skin rash, and sedation. The major drug effect of Ludiomil, however, is seizures. One psychiatrist recently reported that "seizures are occurring very frequently with this drug. In fact, some of my neurologist friends tell me that most of the referrals they're getting now [for] new patients with epilepsy are patients who've been treated with Ludiomil."[5]

II. DRUG EFFECTS

1. TRICYCLICS

A. Frequent Effects: sedation, drowsiness, lethargy, difficulty thinking, headache, dizziness (upon arising), blurred vision, dry mouth, nausea, constipation, and weight gain.

B. Occasional Effects: confusion, poor concentration, memory problems, nightmares (especially when taken just before sleep), panic feelings, extreme restlessness, salivation, excessive sweating, nasal congestion, abdominal cramps, frequent urinating, sexual problems, menstrual problems, skin rash, easy sunburn, numbness and tingling of skin, shakiness, and breast enlargement.

C. Rare Effects: delusions, manic reactions, delirium, seizures, fever, lowered white blood cell count (with risks of infection), hepatitis (liver damage), and heart attacks and strokes (especially in the elderly).

2. MAO INHIBITORS

A. Frequent Effects: low blood pressure, fainting (when standing up), restlessness, insomnia, dry mouth, blurred vision, nausea, loss of appetite, dizziness, drowsiness, weakness, constipation, headaches, muscle tremors and twitches.

B. Occasional Effects: confusion, memory problems, facial redness (flushing) and warmth, impaired liver function, difficulty urinating, sexual problems, numbness and tingling of the skin, palpitations, and problems with balance and coordination.

C. Rare Effects: skin rash, hepatitis, muscle spasms, and manic reactions.

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4. "Warning Sounded on Deaths from Antidepressant Overdose." *Psychiatric News*, Sept. 16, 1983.

5. Leo E. Hollister, quoted in "Newer Antidepressants Used after Initial Drug Fails," *Clinical Psychiatry News*, June 1983.

III. SPECIAL PRECAUTIONS (See chapter on General Precautions, p.14)

1. TRICYCLICS

A. The tricyclic anti-depressants can damage the heart (see Neuroleptics, sect. III.1, p.30). This risk is especially serious for the elderly and heart patients.

B. The tricyclics can cause a drop in blood pressure leading to dizziness, lightheadedness, and fainting (see sect. III.2, p.30).

C. These drugs can impair the body's heat-regulating system, which in hot weather can lead to heatstroke (see sect. III.3, p.30).

D. The tricyclics can reduce white cell production causing frequent fevers and sore throats (see sect. III.4, p.30).

E. These drugs can cause dry mouth and dry throat leading to swallowing and gagging problems (see sect. III.6, p.31).

F. These drugs can lower the seizure threshold, increasing the danger of convulsions (see sect. III.7, p.31).

G. Some physicians prescribe tricyclics, especially Tofranil, to children who wet their beds (enuresis). Involved here basically is the use of a tricyclic "side-effect," partial paralysis of bladder function, in an effort to normalize bladder habits. This is a particularly ridiculous and dangerous strategy. In addition to subjecting the child to all the toxicities of these drugs, including problems with aggressive and rage reactions, children in trying to please their parents have at times unintentionally poisoned themselves in the mistaken belief that taking more of the drug would lead to better bladder control.

H. The tricyclics when used with other drugs can have disastrous, rarely fatal, consequences. The tricyclics should not be combined with the following drugs: adrenalin, anti-coagulants, anti-parkinsonians, cold and allergy pills, depressants (especially alcohol), MAO inhibitors, nasal sprays (decongestants), and neuroleptics. (See also General Precautions, sect. 3, p.14). The sedative effects of the tricyclics are additive to those of other depressants.

I. The tricyclics are one of the most toxic depressant drugs. Overdosing, accidental or intentional, occurs frequently. As little as 10 times the daily dose can be lethal. Children have been killed with accidental overdoses: these drugs should be kept out of their reach. More people have killed themselves with tricyclics than with any other psychiatric drug, including barbiturates. In cases of overdosing, emergency attention should be sought immediately (see chapter on Overdosing, p.52).

2. MAO INHIBITORS

A. These drugs can reduce blood pressure significantly, causing dizziness and fainting (see Neuroleptics, sect. III.2, p.30).

B. Eating food containing the natural chemical tyramine while taking MAO inhibitors can cause dangerous and occasionally life-threatening reactions characterized by extremely high blood pressure with consequent risk of stroke or heart attack. Foods with tyramine include: aged cheese (brie, blue, cheddar), avocado, beer, chicken liver, chocolate, cream, fava beans, fermented food of all types, lox, pickled herring, raisins, sauerkraut, sausages, sour cream, wine (especially sherry and Chianti), yeast extracts, and yogurt. If you are taking MAO inhibitors, you should obtain a complete list of prohibited foods. Avoid excessive caffeine consumption.

C. Because of potentially grave, even lethal, drug interactions, the following drugs should not be taken with the MAO inhibitors: alcohol, adrenalin, anesthetics (including dental drugs like novacaine), anti-parkinsonians, cocaine, cough and cold medicines, antihistamines, narcotics (especially meperidine), nasal sprays, and tricyclics (see also General Precautions, sect. 3, p.14).

D. These drugs are even more toxic than the tricyclics. Overdosing is common. As little as 6 to 10 times the daily dose can be lethal (see chapter on Overdosing, p.52).

Chapter 8

LITHIUM

(anti-manic-depressive, anti-manic)

Trade Names	Generic Names
Cibalith-S (a syrup)	lithium citrate
Eskalith	lithium carbonate
Eskalith CR (slow release)	lithium carbonate
Lithane	lithium carbonate
Lithobid (slow release)	lithium carbonate
Lithonate	lithium carbonate
Lithotabs	lithium carbonate
Pfi-Lith	lithium carbonate

The typical dosage range is 600 to 1800 mg/day, usually 300 mg pills taken 3 or 4 times a day. Eskalith CR and Lithobid are taken only twice a day.

I. GENERAL INFORMATION

Lithium is a relatively new psychiatric chemical controller, having been first marketed in the early 1970s. It is given to control so-called excited and agitated states, often in people labeled as having a manic-depressive disorder, or mood disorder. For many people, lithium is used as a life-time, "maintenance treatment" like insulin for diabetes. They are told their disorder is caused by an internal biochemical imbalance that lithium supposedly corrects. However, there is no proof to support this theory, and lithium is an extremely poisonous substance. Lithium is also given to people with a variety of other problems, including alcohol abuse and "impulsive behaviors" in children as well as adults.

Like the other major depressants, lithium is basically a downer. Unlike all other psychiatric drugs, which are organic chemicals, lithium is an inorganic element (a mineral), that is given in salt form (usually lithium carbonate, sometimes lithium citrate). The body doesn't break down and metabolize lithium. It enters and leaves the body in exactly the same form. The kidneys remove most of the lithium from the body through unrination. Unfortunately, the almost inevitable result of this process is lithium-induced kidney damage. It is still unclear how often this damage becomes more than a minor problem.

Lithium becomes particularly hazardous when too much of it accumulates in the body. Therefore, the use of lithium demands even more care and attention than the use of other psychiatric drugs. Lithium toxicity can range from mild to severe in degree. If serious enough, toxicity can lead to permanent brain and kidney damage and death. The so-called therapeutic level of lithium is considered to be 0.8 to 1.2 mEq/l (mEq/l = milliequivalents per liter). When blood lithium levels go over 1.5 mEq/l, there is a serious risk of lithium poisoning. With levels over 2.0 mEq/l, the risk is grave. However, at times people can become lithium toxic at therapeutic levels (i.e., below 1.2 mEq/l), so the blood test is not without its limitations.

It usually takes several weeks for the full, controlling effects of lithium to develop; as a result other psychiatric drugs, especially the neuroleptics, are often used during this period, with significant risk of dangerous drug interactions.

II. DRUG EFFECTS

1. Frequent Effects: increased thirst, frequent urination (at times quite distressing), nausea, diarrhea, fine shaking (tremors) of the hands, drowsiness, lethargy, apathy, muscle weakness, lightheadedness, dizziness, difficulty thinking and concentrating, weight gain, rise in white blood cell count (leukocytosis), and rise in blood sugar.

2. Occasional Effects: metallic taste, abdominal aches, vomiting, feelings of being dazed or internally restrained, bed-wetting (due to lithium's effects on the kidneys), and decreased appetite.

3. Rare Effects: thyroid gland insufficiency with possible thyroid enlargement (goiter), headache, hallucinations, delirium, confusion, disorientation, sexual problems, skin rash, aggravation of psoriasis, acne, swelling of ankles and wrists, insomnia, seizures, catatonia (trance-like state), slow heartbeat and other EKG abnormalities of unknown significance, hair loss, muscle twitching, coordination difficulties, low blood pressure, restlessness, blurred vision, dry mouth, aggravation of pre-existing tardive dyskinesia, and a particular kind of increased frequency of urination called nephrogenic diabetes insipidus (which is not related to ordinary forms of diabetes).

III. SPECIAL PRECAUTIONS (see chapter on General Precautions, p.14)

1. WARNING: Because the so-called "therapeutic" level of lithium in the blood is very close to its poisonous level, lithium demands extreme care and medical guidance. Lithium poisoning does occur and can be fatal. To minimize this risk, the following precautions should be taken:

A. Before starting lithium, undergo medical tests to determine the state of your general health, especially with regards to kidney function. Tests should be made periodically while taking lithium.

B. When lithium is first started, lithium levels should be checked with blood tests every 2 or 3 days, then once a month for up to 6 months, then regularly once every 3-6 months. Lithium should not be taken in the morning of the day of the lithium blood test.

C. Take adequate amounts of salt and drink 8-10 glasses of water or other fluids daily. In other words, lithium should not be taken with a low-sodium diet.

2. Conditions when lithium poisoning is more likely to occur:

A. When a suicidal overdose is taken.

B. When more than the prescribed dose

is taken. Sometimes people do not follow dosage instructions and accidentally overdose themselves.

C. Any time there is prolonged, heavy sweating, hot weather, or strenuous physical activity. These conditions can lead to loss of body water (dehydration) and, in turn, higher lithium levels in the blood.

D. Any time the regular amount of table salt and water is reduced, or normal body fluids are lost. These conditions can occur whenever there is decreased appetite, nausea, vomiting, diarrhea, or fasting.

E. Any time diuretic drugs (water pills) are being used.

F. Any time a low sodium (low salt) diet is followed, as with people suffering from high blood pressure.

G. When kidneys are damaged or become infected (the kidneys regulate the amount of lithium in the body).

H. Any time you have the flu or any significant illness.

I. Unaccountably, some people become lithium toxic even though blood tests indicate a "therapeutic" lithium level.

3. Early symptoms of lithium poisoning: sluggishness, drowsiness, extreme restlessness, slurred speech, rough shaking of hands, muscle twitching, lack of coordination, staggering walk, drunk-like state, nausea, vomiting, and diarrhea.

4. IF LITHIUM POISONING IS SUSPECTED, STOP TAKING THE LITHIUM IMMEDIATELY. No harm will come from this. Get immediate medical attention, including a lithium blood-level check. Failure to deal with lithium poisoning within 2 or 3 days can lead to convulsions, coma, permanent brain damage, and death. The way you feel and your general health are more important than any blood test in determining whether or not lithium should be stopped due to suspected poisoning or other bad effects.

5. SPECIAL WARNING TO WOMEN: Pregnant women should not take lithium. It is especially difficult to control lithium levels during labor and delivery; and lithium, like other psychiatric drugs, can cause birth defects. Women should never breast-feed while taking lithium. (See General Precautions, sect. 17, p.17).

6. WARNING TO THE ELDERLY AND THOSE WITH HEART DISEASE: lithium can be harmful to the heart, although apparently less so than the neuroleptics and anti-depressants. The elderly are usually far more sensitive to lithium than younger people, and may only tolerate much lower doses.

7. Lithium combined with other drugs can cause dangerous and possibly fatal drug interactions (see General Precautions, sect. 4, p.14). Extreme care should be taken when lithium is used with neuroleptics. There have been numerous reports of severe "neurotoxic" reactions, particularly with lithium and Haldol, a common combination. It is not known why some people are more sensitive to serious problems with neuroleptic/lithium combinations, or who they are in advance of their taking such combinations.

8. Lithium's ability to cause a fine tremor can lead to problems with handwriting and holding cups, etc.

9. WARNING: when electroshock (ECT) is combined with lithium, the risk of a catastrophic reaction, including prolonged states of confusion and delirium, with serious brain dysfunction and possibly permanent damage, is very high.

10. Lithium can cause permanent, serious kidney damage. Lithium diminishes the kidney's ability to concentrate urine, which results in an increased need to urinate (polyuria). Over time, this condition usually becomes permanent, but for most people such damage to the kidneys is relatively minor. Anyone with kidney problems is at greater risk to suffer more serious effects. Even people with no kidney problems can develop serious lithium-induced kidney damage, including, rarely, kidney failure. Lithium toxicity increases this risk.

11. Rubidium, another mineral salt, is currently being tested. It is very similar to lithium and may some day become another psychiatric control tool. Psychiatrists are also experimenting with an anti-convulsant drug named Tegretol (carbamazepine) for use on so-called manic-depressives. Tegretol has a variety of potentially toxic effects, especially when combined with lithium.

Chapter 9

ANTI-ANXIETY DRUGS

(minor tranquilizers, minor depressants)

Brand Names	Generic Names	Adult Dosage Range low--mg/day--high	
BENZODIAZEPINES			
Ativan	lorazepam	1	10
Centrax, Verstran	prazepam	5	60
Dalmane [1]	flurazepam	15	30
Halcion [1]	triazolam	0.25	1
Librium [1]	chlordiazepoxide	15	100
Paxipam	halazepam	20	160
Restoril [1]	temazepam	15	30
Serax	oxazepam	30	120
Tranxene	clorazepate	15	60
Valium	diazepam	4	60
Xanax [2]	alprazolam	0.25	4
MISCELLANEOUS			
Atarax, Vistaril	hydroxyzine	50	400
Miltown, Equanil	meprobamate	200	1600
Tybatran, Solacen	tybamate	250	1200

Psychiatric News, February 7, 1973

I. GENERAL INFORMATION

As psychiatrists (and other physicians) often "treat" what they regard as major mental disorders (psychoses) with neuroleptics, or "major tranquilizers," so they often use anti-anxiety drugs or "minor tranquilizers" for so-called minor mental disorders (neuroses). Anti-anxiety drugs are very similar to barbiturates. Both are sedative-hypnotics and have depressant effects, with serious habit-forming potentials. They are used in an attempt to chemically control anxiety, nervousness, tension, sleep disorders and medical problems related to stress, such as ulcers, as well as medical problems that cause serious stress, such as heart conditions.

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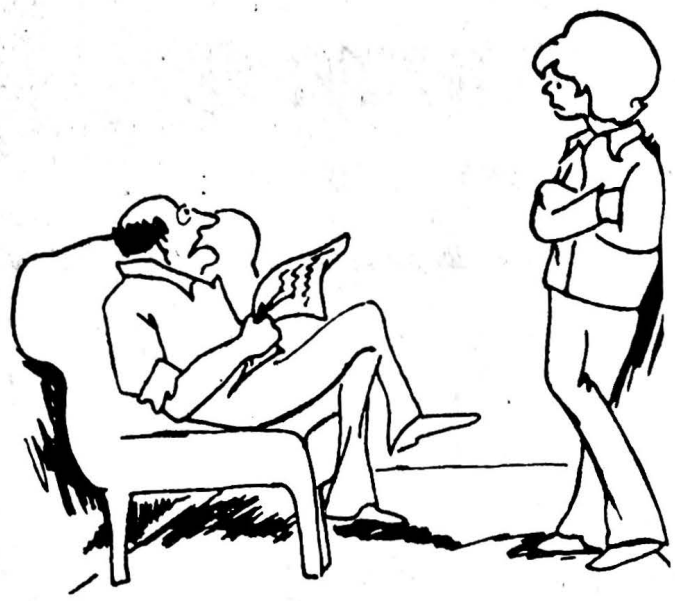
1. These drugs are promoted as sleeping pills.
2. This drug is promoted as having combined anti-depressant and anti-anxiety effects.



Crime, inflation...If it weren't for tranquilizers, I'd be on drugs by now.

II. DRUG EFFECTS

1. Frequent Effects: sedation, lethargy, drowsiness, dizziness, lightheadedness, problems with balance and walking, and dry mouth.

2. Occasional Effects: confusion, depression, headaches, blurred vision, nervousness, constipation, menstrual problems, sexual problems, muscle stiffness, lack of coordination, and weight gain.

3. Rare Effects: hallucinations, nightmares, severe depression, extreme restlessness, freak-outs, double vision, insomnia, nausea, stomach upset, bladder and urination problems, slurred speech, tinnitus (ringing in the ear) unusual skin sensations, muscle tremors, low blood pressure, and allergic hepatitis (jaundice).

> *I felt as if there were a screen between me and the outside world, as if I had been smoking dope for two hours. I went through strange mind changes with my head feeling all floaty and buzzy and my thoughts completely disjointed. It made me feel even more jumpy than when I was without the drug.*
>
> "Diana," in Linda Murray, "Valium and Librium: Harmless? Non-Addicting?" NEW WOMAN, July-August 1978, pp. 73-75.

III. SPECIAL PRECAUTIONS (see chapter on General Precautions, p. 14)

1. Anti-anxiety drugs are both psychologically and physically addictive. They should not be used for longer than 6 weeks at a time. Because they are habit-forming, withdrawal can be dangerous. Withdrawal should be gradual (see Drug Withdrawal, sect. IV.4, p.58).

2. SPECIAL WARNING TO WOMEN: These drugs are widely prescribed to women. Pregnant and breast-feeding women especially should avoid taking anti-anxiety drugs because they can cause serious problems for both mother and child (see General Precautions, sect. 17, p.17).

3. The major depressants (i.e., neuroleptics, anti-depressants, and lithium), Tagamet (cimetidine), Antabuse (disulfuram), and birth control pills can increase the sedating effect of anti-anxiety drugs.

4. Although the anti-anxiety drugs taken alone have a low overdose potential, when used in combination with alcohol and other drugs (see General Precautions, sect. 3, p.14), the overdose risk becomes very great. The National Institute on Drug Abuse reported that the "benzodiazepines (e.g., Valium, Librium, and Dalmane), when mixed with alcohol and/or other drugs, contributed to 54,000 emergency room visits and 900 deaths between May 1976 and April 1977."[3]

3. S. Price-Root, "An Epidemic of Tranquilizer Abuse," *San Francisco Chronicle*, Sept. 10, 1979.

Chapter 10

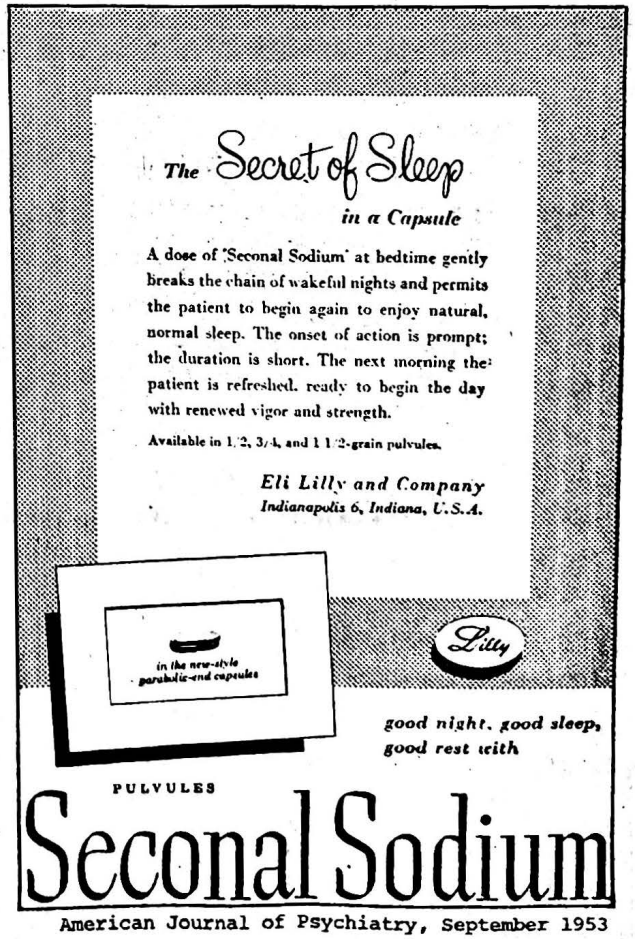
SEDATIVE-HYPNOTICS

(sedatives, sleeping pills)

Trade Names	Generic Names	Adult Dosage Range low--mg/day--high	
BARBITURATES			
Amytal[1]	amobarbital	15	200
Butibel	butabarbital	15	30
Luminal	phenobarbital	16	300
Nembutal	pentobarbital	30	180
Seconal	secobarbital	30	100
Tuinal	amobarbital & secobarbital	50	200
QUASI-BARBITURATES			
Doriden	glutethimide	15	30
Noctec, Beta-Chlor, Somnos	chloral hydrate	500	1000
Noludar	methyprylon	150	400
Placidyl	ethchlorvynol	100	600
Somnafac, Parest, Quaalude	methaqualone	150	300

I. GENERAL INFORMATION

The sedative-hypnotic drugs are depressant chemicals with effects much like those of alcohol. In low doses they produce drowsiness and lethargy (the sedative effect), and in high doses, sleep (the hypnotic effect). The basic drugs in this category are barbiturates. They were first developed and used in psychiatry as chemical controllers in the early 1900s. For nearly 50 years the barbiturates were psychiatry's primary drug weapon. One form of administration involved massive doses which caused people to sleep for days at a time. Many people died from this so-called sleep therapy.[2]



American Journal of Psychiatry, September 1953

1. Sodium amytal, a short-acting barbiturate, is used as a truth serum. An intravenous injection brings on a half-sleep state, during which the subject is interrogated. This procedure involves various risks.
Paraldehyde, an especially dangerous sedative-hypnotic, is now seldom used.

2. Some U.S. and European psychiatrists continue to use this procedure.

Barbiturates are still used as anti-convulsants, but their psychiatric use has been greatly limited since the introduction during the early 1950s of the newer depressants, like Thorazine and Valium. Barbiturates are still used as sleeping pills, but they have been largely replaced by the Valium-type sleeping pills (e.g., Dalmane, Halcion, and Restoril), which chemically are very similar (see chapter on Anti-Anxiety Drugs, p.41).

II. DRUG EFFECTS

1. Frequent Effects: drowsiness, headache, dizziness, dry mouth, nausea, vomiting, stomach irritation, hangover effect, apparent drunken state, lack of coordination (ataxia), and skin rash.

2. Occasional or Rare Effects: extreme restlessness, insomnia, and nightmares (with prolonged use).

III. SPECIAL PRECAUTIONS (see chapter on General Precautions, p.14)

1. The sedative-hypnotics are highly toxic. Mixing them with other drugs, especially alcohol, can lead to coma and death (see General Precautions, sect. 3, p.14).

2. These drugs are extremely addictive. Abrupt discontinuation is very dangerous. Gradual withdrawal is essential (see Drug Withdrawal, sect. IV.5 p.58).

Chapter 11

PSYCHOSTIMULANTS

Trade Names	Generic Names	Adult Dosage Range low--mg/day--high	
AMPHETAMINES			
Benzedrine	amphetamine sulfate	5	60
Desoxyn	methamphetamine	7.5	15
Dexedrine	dextroamphetamine	5	60
QUASI-AMPHETAMINES			
Diet Pills (anorexiants)			
Preludin	phenmetrazine	50	75
Sanorex	mazindol	1	6
Tenuate	diethylpropion	(75 mg a day)	
Anti-Hyperactivity Drugs			
Cylert	pemoline	18	112
Deaner	deanol	10	300
Ritalin	methylphenidate	5	60

I. GENERAL INFORMATION

Psychostimulants, as the name implies, are uppers. They stimulate the brain and nervous system. Amphetamines (speed) were the original psychostimulant drugs, although cocaine, which preceded the amphetamines, also could be included in this category. Because amphetamines can cause serious problems (including addiction, dangerous bodily reactions, severe withdrawal symptoms, and psychotic states), their use by physicians to counter depression and fatigue has been made illegal. The amphetamines are still available by prescription as diet pills but have been replaced in large part by the quasi-amphetamines, which are similar chemicals. Because they reduce appetite, they are sometimes called anorexiants.

Currently, the primary uses of the psychostimulants are for those who have sleep attacks (narcolepsy) and for children labeled hyperactive (formerly called minimal brain dysfunction, or MBD, and now called attention deficit disorder, or ADD). Although the major psychiatric use of the psychostimulants is for children labeled ADD, these drugs are being prescribed for adults who are now getting the ADD label in growing numbers. Especially vulnerable

American Journal of Psychiatry, September 1971

are the elderly who are labeled depressed, with "apathetic and withdrawn, senile behavior." The most commonly prescribed drug for ADD is Ritalin.

When used on children, the psychostimulants have a paradoxical effect: instead of stimulating, they sedate and act like the depressant-type psychiatric drugs. It is estimated that 1-2 million children of school age, primarily boys, are taking anti-hyperactivity drugs. At times parents are forced by school authorities to drug their children in order to keep them in school.

II. DRUG EFFECTS

1. Frequent Effects: restlessness, nervousness, insomnia, nightmares, loss of appetite and weight loss, abdominal pain, nausea, dizziness, headache, speediness, racing thoughts, and muscle tremors (especially of the hands).

2. Occasional and Rare Effects: skin rash, abnormal muscle movements and nervous tics (see sect. 7 below), drowsiness, heart palpitations and rapid heartbeat, increased blood pressure, tearfulness, outbursts of aggressiveness, fearfulness, and increased sensitivity to criticism and noise.

III. SPECIAL PRECAUTIONS (see chapter on General Precautions, p. 14)

1. When taken by children over prolonged periods, these drugs can stunt growth, both height and weight. If the drugs are stopped, the child can often make up partially for the stunting by a growth spurt. Every-other-day doses and drug-free periods (weekends, vacations, over the summer) are some of the strategies being used in attempts to control the stunting problem. In addition to the risk of retarded physical growth, there is also the danger of impaired intellectual and emotional

development. The long-term effects of these drugs on children are still poorly understood.

2. These drugs can increase blood pressure, which for the elderly is especially dangerous.

3. These drugs increase the risk of having an epileptic fit, and demand much more care when given to anyone with a history of seizures.

4. The psychostimulants can cause a state of extreme anxiety and restlessness and can trigger a toxic "psychosis."

5. These drugs are habit-forming and can lead to addiction, drug abuse, and withdrawal problems which are apt to be more serious for adults than for children.

6. Psychostimulants can cause severe allergic reactions in hypersensitive people. If symptoms of skin rash, fever, aching joints, nervousness, palpitations, or vomiting occur, seek emergency attention.

7. These drugs can trigger muscle disorders similar to those caused by the neuroleptics, e.g., tics, tremors, and dyskinesias. It is still unclear whether or not these drugs can lead to permanent brain damage. The fact that there have been a few such reports should cause serious concern for the fate of those individuals, especially children, currently taking psychostimulants.

Mrs. Verne Watson said she had felt forced by school officials into drugging her child and it has become "one big nightmare."

She said she had been constantly harassed by the school about her child's behavior and got a note from the school nurse which stated simply: "Your child is hyperactive. He doesn't sit still in school. Please see a physician."

Mrs. Watson said she tried to fight keeping her son on the drugs after she saw the "side effects" the pills were having on David, but when she told school officials she could no longer keep up the therapy, she was told that David might have to be expelled.

She added: "David would complain he didn't like the feel of his body when he took the pills. It took his appetite away and he would cry a lot. His dreams got so bad he couldn't even talk about them. He would get up in the night and walk the floor for hours. His body would shake and quiver something terrible."

Mrs. Watson said physicians kept increasing the dosage of Dexedrine until it reached 40 milligrams a day.

"His body began to tremble so much he couldn't hold certain notes during his trumpet lessons and he would plead: 'Could I just not take the pills on the day of my lessons?'"

Finally, she said, her son collapsed before school...and told her, "I just can't take them anymore, they're torturing me." She said she called the school that day and told officials, "David is not coming." Family court action has been initiated against her because of David's truancy, she said.

PROVINCETOWN JOURNAL, February 8, 1972.

Chapter 12

GERIATRIC DRUGS

Trade Names	Generic Names
ANALEPTIC STIMULANTS (often mixed with vitamins)	
Cerebro-Niacin, Eldertonic, Geravite, Geroniazol, Menic, Mentalert, Metrazol, Nicozol, Senilex	pentylenetetrazol[1]
METABOLIC STIMULANTS	
Circanol, Deapril, Hydergine	dihydrogenated ergot (ergoloid mesylates)
CEREBRAL VASODILATORS	
Cerespan, Pavabid, Vasodilan	papaverine (and related chemicals)
PSYCHOSTIMULANTS (see chapter on Psychostimulants, p.45)	
Ritalin	methyphenidate
MISCELLANEOUS	
Gerovital[2]	

I. GENERAL INFORMATION

For a variety of reasons, the elderly are particularly heavy users of all drugs, including psychiatric drugs. The effects of aging, acute and chronic medical problems, and psychosocial problems (e.g., retirement, deaths of spouses, financial difficulties, and placement in nursing homes[3]) all lead to emotional, psychological and physical difficulties. This sets the stage for the elderly getting labeled as having psychiatric dis-

1. Withdrawn from the market in 1984.
2. Developed in Rumania, Gerovital is legal in only a very few states. One of its components, procainamide, an anesthetic-type chemical, has allegedly antidepressant effects and also the potential for serious problems.
3. One study of 173 nursing homes in Tennessee revealed that 43% of 6000 residents were receiving neuroleptics (*American Journal of Public Health*, May 1980).

orders, and then being drugged. The elderly receive all types of psychiatric drugs (especially neuroleptics and antidepressants) and are much more sensitive to them than are younger people. Drug toxicity and drug interactions (with medical, psychiatric, over-the-counter drugs and alcohol, etc.) frequently result in serious, even life-threatening situations. Iatrogenic (i.e., drug-induced) problems among the elderly can lead to strokes, falls, hip fractures or other injuries and have become a common reason for hospitalization.

The drugs described in this chapter are used only on the elderly and are given in attempts to decrease the effects of aging and senility on brain function such as forgetfulness, more serious memory problems, confusion, disorientation, irritability, depression, unsociability, and poor self-care. Senility, also called dementia, involves the degeneration of brain tissue. The most common form of senility is Alzheimer's disease. As a warning, however, it should be noted that all psychiatric drugs and many medical drugs and medical conditions can mimic or intensify the symptoms of dementia. Therefore, the use of any drugs by the elderly demands special care and attention.

Geriatric drugs can cause disturbing and dangerous drug reactions and interactions. There is hardly any justification for using them.

II. SPECIFIC INFORMATION

1. Analeptic Stimulants. These are the most dangerous geriatric drugs and contain a chemical, pentylenetetrazol, which in high doses can cause convulsions.[4] Often this chemical is mixed with multivitamins and vitamin B3 (niacin or nicotinic acid, a vitamin with vasodilator effects). Niacin, when used in this way, has some dangers. The combination is often made up as a syrup or elixir with up to 18% alcohol as an "incentive."

- Drug Effects (pentylenetetrazol): seizures, low blood pressure, heart problems, insomnia, loss of appetite, nausea, vomiting, headache, confusion, disorientation, extreme restlessness, and fearfulness.
- Vitamin Effects (niacin/nicotinic acid): low blood pressure, irritation of stomach ulcers, liver damage, aggravation of diabetes, stomach upset, nausea, cramps, diarrhea, and a tingling flush of the face (with niacin).

2. Metabolic Stimulants. These are poorly understood chemicals of the ergot family. Ergot drugs include LSD and medical drugs used for migraine headaches and to stop bleeding after childbirth. The metabolic stimulants, especially Hydergine, are widely promoted for the elderly, despite their ineffectiveness. Fortunately, their toxicity is comparatively low.

- Drug Effects: slow heartbeat (this can be dangerous), nausea, and stomach upset.

3. Cerebral Vasodilators. These chemicals are supposed to improve mental functioning by opening blood vessels to the brain. However, they do not really do this, are much more likely to affect blood vessels elsewhere in the body, and can in fact make brain circulation worse, not better. They are also relatively low in toxicity.

- Drug Effects: nausea, drowsiness, skin rash, headache, dizziness, facial flush, sweating, weakness, and fast heartbeat.

4. During the 1930s, an injectible form of pentylenetetrazol, with the trade name Metrazol, was widely used as a convulsive procedure on psychiatric inmates. Metrazol shock was replaced by electroshock (ECT) in the early 1940s.

Chapter 13

MISCELLANEOUS DRUGS

Trade Names	Generic Names	Adult Dosage Range low--mg/day--high	
HORMONES			
Estrogens			
Premarin	conjugated estrogens	0.3	7.5
Anti-Androgens			
DepoProvera	medroxyprogesterone		
	cyproterone acetate		
ANTI-ALCOHOL DRUG			
Antabuse	disulfuram	250	500
NARCOTIC MAINTENANCE DRUG			
Dolophine	methadone	5	150
ELECTROSHOCK PREMEDICATIONS			
	atropine	.4	.6
Brevital	methohixital	50	120
Anectine	succinylcholine	20	40

I. HORMONES

1. Estrogens

A. General Information

This drug is an estrogen replacement for menopausal women. It is used to control physical symptoms of menopause, as well as alleged psychiatric problems.

B. Drug Effects

- Frequent Effects: nausea, vomiting, loss of appetite, stomach cramps and gas, breast tenderness and enlargement, breakthrough vaginal bleeding, and skin rash.
- Occasional or Rare Effects: bloodclots; there is some evidence indicating that estrogens increase the risk of cancer of the uterus and breast.

2. Anti-Androgens

A. General Information

These drugs block the action of natural male hormones, and thus produce a chemical form of castration. They are being experimentally used on sex offenders (e.g., rapists, pedophiliacs, and exhibitionists) to reduce their sex drive and their inclination to commit sexually-related crimes.

DepoProvera, in the form of long-acting intramuscular injections, is already being used on women as a birth-control technique. Because of its dangers, there is much controversy surrounding its use.

B. Drug Effects

Fatigue, weight gain, hot flashes, headache, insomnia, and severe sexual problems.

II. ANTI-ALCOHOL DRUG

1. General Information

The drug Antabuse is used on people with drinking problems. When combined with alcohol, it causes violent illness.

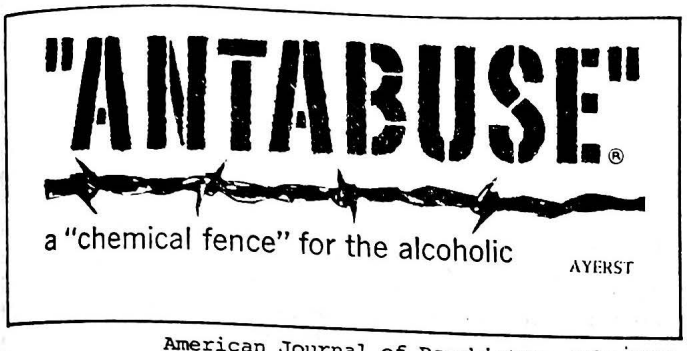
2. Drug Effects

- Frequent Effects: fatigue, drowsiness, headache, impotence, "toxic psychosis," strange metallic taste, and skin rash.
- Occasional or Rare Effects: confusion,

dizziness, throbbing in head and neck, nausea, vomiting, blurred vision, sweating, chest pain, heartbeat irregularities, redness of skin, and difficulty in breathing.

3. Special Precautions

Severe reactions to the combination of Antabuse and alcohol can cause death.



American Journal of Psychiatry, July 1959

III. NARCOTIC MAINTENANCE DRUG

1. General Information

Methadone is a narcotic (in pill form) often used as "maintenance treatment" for heroin addicts. In this way an illegal narcotic is replaced by a legal one. Many people find methadone more difficult to withdraw from than any other narcotic.

2. Drug Effects

- Frequent Effects: drowsiness, hallucinations, blurred vision, constipation, increased urination, sweating, increased thirst, reduced sex drive, menstrual problems, heartburn, numbness/tingling (particularly of the fingers), weight gain, and swelling of ankles and wrists.
- Occasional or Rare Effects: headache, nervousness, hiccoughs, diarrhea, difficulty in urinating, runny nose, and joint pain.

IV. ELECTROSHOCK PREMEDICATIONS

1. General Information

Over the last 30 years, a number of modifications in electroshock (ECT) administration have been made. These include the use of certain drugs prior to the application of electric current to the brain. These drugs in no way lessen the damaging effect that electricity has on brain function, and their use involves trade-offs. There is considerable evidence that the current techniques of ECT are even more destructive than the earlier ones.

A. Atropine

This anti-cholinergic drug reduces both salivation and secretions and thus protects against choking and against some of ECT's effects on the heart. It is given as an intravenous injection about 30 minutes before the electroshock is administered.

- Drug Effects: dry mouth, blurred vision, etc. (see also Anti-Cholinergic Special Warning, p.33)

B. Brevital

This short-acting barbiturate (anesthetic) is given as an intravenous injection to put people to sleep a few minutes before the convulsion. This drug can reduce fear and "treatment" resistance, as well as the pain that might otherwise be felt if the person were conscious when the current was applied. Since barbiturates protect against convulsions (raise the convulsive threshold), more electricity must be used, thus increasing the risk of brain damage.

- Drug Effects: breathing difficulties, throat spasms, and fall in blood pressure.

C. Anectine

Anectine is a muscle paralyzer (muscle relaxant) used to suppress the electrically-induced convulsion. When this drug is used in ECT, evidence of the convulsion is manifested by a mild twitching of the toes, legs, or arms. Anectine has been employed as an "aversion-therapy" technique. It paralyzes the breathing muscles causing sensations of drowning and suffocation which terrorize people into doing what they are told. In ECT, this kind of terror is rarely experienced because subjects are anesthetized and given artificial respiration to sustain breathing.

- Drug Effects: excessive salivation, fever, breathing difficulties, heart failure, fast or slow heartbeat, high or low blood pressure, and muscle pain.
- Special Precautions: Some people are particularly sensitive to Anectine and their cessation of breathing (apnea) can be dangerously prolonged, with brain damage or death a possibility.

Chapter 14

OVERDOSING

I. HOW IT HAPPENS

Psychiatric-drug overdoses, unfortunately, are not uncommon occurrences. Overdosing can be accidental or intentional. Because of deteriorating physical health or the cumulative effects of drugs already taken, people can even accidentally overdose by taking their prescribed dose. More often, however, accidental overdosing occurs when drugs are taken in greater than usual or prescribed amounts. In the case of institutionalized people, overdosing is more likely to happen when psychiatric drugs are administered in doses higher than recommended upper limits.

Being heavily drugged can result in confusion and forgetfulness about just how many pills have been taken, which then leads to taking even more pills. In addition, the use of sleep-inducing psychiatric drugs at night, when combined with the typical drowsiness that precedes sleep, increases the risk of accidental overdosing.

Children are at extremely high risk for fatal, accidental overdoses. They should not be allowed access to any drugs being taken by parents or other family members. Aspirin, by the way, is the biggest killer of children from accidental overdoses. Children can also accidentally overdose with drugs prescribed for them. This has happened with the antidepressant Tofranil, which is used to control bedwetting (see Anti-Depressants, sect. III,1.G., p.37).

In most cases, overdosing is a purposeful action made as a suicide "gesture" or attempt. Intense unhappiness and despair are common reasons for suicide. At times this condition may actually be drug-induced, i.e., brought on by the depressant effects of psychiatric drugs. Thus, drug-induced lethargy and depression, when combined with dehumanizing psychiatric experiences, and feelings of shame and hopelessness about one's being labeled mentally ill, can result in suicide attempts. Lowering the dose or stopping the drug altogether will frequently lead to the gradual lifting of a drug-induced depression.

II. WHAT TO DO WHEN IT HAPPENS

The basic approach to drug overdoses is to get emergency medical attention as soon as possible via ambulance, fire department, dialing 911, or by taking the person to an emergency room. It is extremely helpful to supply the treating physicians with any information you might have about what drug or drugs have been taken, when they were taken, and in what amounts. In this connection, any pill containers should be sent along with the person to the emergency room.

Once in the emergency room, the overdosed person, if in a coma or near coma state, is likely to have his or her stomach pumped before any more of the drug dissolves and enters the blood stream where its effect can be lethal. If the person is awake, a drug may be used to induce vomiting. In addition, other life-support measures may be necessary.

Some people have serious reservations about entering a hospital for the emergency treatment of overdosing. Their concerns include: 1) possible involuntary detention of the overdosed person on psychiatric grounds by hospital personnel who often assume that the overdose is intentional (this is a particular danger for former psychiatric inmates), and 2) stomach pumping is overused in many hospital emergency rooms (the same is true for induced vomiting, but to a lesser extent). These critics suggest using non-hospital emergency centers as an alternative. For example, in Berkeley, California, the Berkeley Free Clinic has an excellent overdose treatment program. It should be noted that non-medical, but trained, personnel operate this program, that the clinic is located a short distance from a hospital emergency center (for situations which they are not capable of handling), and that there are

Overdosage.
A. Signs and Symptoms
1. Mild: Drowsiness, stupor, blurred vision, excessive dryness of mouth.
2. Severe: Respiratory depression, hypotension, coma, convulsions, cardiac arrhythmias and tachycardias.
Also: urinary retention (bladder atony), decreased gastrointestinal motility (paralytic ileus), hyperthermia (or hypothermia), hypertension, dilated pupils, hyperactive reflexes.
B. Management and Treatment
1. Mild: Observation and supportive therapy is all that is usually necessary.
2. Severe: Medical management of severe SINEQUAN overdosage consists of aggressive supportive therapy. If the patient is conscious, gastric lavage, with appropriate precautions to prevent pulmonary aspiration, should be performed even though SINEQUAN is rapidly absorbed. The use of activated charcoal has been recommended, as has been continuous gastric lavage with saline for 24 hours or more. An adequate airway should be established in comatose patients and assisted ventilation used if necessary. EKG monitoring may be required for several days, since relapse after apparent recovery has been reported. Arrhythmias should be treated with the appropriate antiarrhythmic agent. It has been reported that many of the cardiovascular and CNS symptoms of tricyclic antidepressant poisoning in adults may be reversed by the slow intravenous administration of 1 mg to 3 mg of physostigmine salicylate. Because physostigmine is rapidly metabolized, the dosage should be repeated as required. Convulsions may respond to standard anticonvulsant therapy, however, barbiturates may potentiate any respiratory depression. Dialysis and forced diuresis generally are not of value in the management of overdosage due to high tissue and protein binding of SINEQUAN.

from an ad for the anti-depressant Sinequan, American Journal of Psychiatry, May 1979

very few places like it elsewhere in the country. We certainly recommend that other non-medical overdose treatment centers, like the Berkeley Free Clinic, be established. We also want to point out that many communities have poison-control centers that serve as excellent resources for information concerning overdosing.

While we strongly discourage the treatment of overdosing by untrained people, we recognize that there may be situations in which hospital or non-medical clinic emergency treatment is either unavailable or, for whatever reason, unwanted. In such cases a few simple emergency-treatment guidelines may be useful:

- If it is known that the person has not taken a lethal dose, it is best to let the person rest or sleep it off, while the attending person monitors his or her vital signs (i.e., heartbeat, blood pressure, breathing, and level of consciousness). The overdosed person's clothing should be loosened, especially around the neck. They should rest or sleep on their side to reduce the danger of asphyxiation on vomit or regurgitated food. It is not good to have them drink coffee or walk around. If they have a fever, sponge them with rubbing alcohol or lukewarm water.
- If the person is known or believed to have taken a lethal dose and if they are alert or not too groggy, getting them to vomit up the ingested pills can be lifesaving. Using syrup or Ipecac, warm salt water, or a finger in the back of the throat and tongue are good ways to do this. Do not induce vomiting if you don't know how to do it, if chemicals (such as lye or rat poison) have been swallowed, if the person is drowsy or asleep, or if the person has taken something other than pills, capsules, or tablets.

Even with trained people attending an overdosed person outside a hospital emergency room, there are risks, such as fatal respiratory or cardiovascular arrest, severe vomiting, seizures (especially continuous seizures, known as status epilepticus), and coma. These conditions, any of which an overdose can lead to, require hospitalization to minimize the risk of death.

In summary, don't be fooled by the fact that someone looks o.k. or is merely sleepy after a possible or known overdose. A host of problems can develop, some quite suddenly, others in a short period of time. If you are not trained in dealing with overdosing, be aware that in many communities you have a legal obligation to get the overdosed person to a treatment center or a hospital emergency room. Psychiatric drugs, especially anti-depressants, are killers. If you suspect that someone has taken a lethal overdose, don't let them just "sleep it off." It could be their last sleep.

Chapter 15

DRUG WITHDRAWAL
(HOW TO COME DOWN)

I. GENERAL INFORMATION

Just as psychiatrists usually offer little information about psychiatric-drug effects to those being drugged, they are likely to supply even less information about the effects of drug withdrawal and how to minimize them. Frequently, problems occurring during drug withdrawal or afterwards are seen as signs of relapse, a resurgence of "symptoms" previously held in check by the drugs. These explanations are used to justify the resumption of drugging, usually on a long-term basis.

Often, because of the unpleasant effects of the drugs, people suddenly stop taking them the first chance they have. This can cause even more serious drug-withdrawal problems. Sudden discontinuation of psychiatric drugs is NOT the best way to come down from them.

Because almost all psychiatric drugs are depressants of the brain and nervous system and act like a brake on body energies, drug stoppage, particularly when it is sudden, can lead to anxiety, restlessness, insomnia, irritability, gastrointestinal problems, muscular reactions, hallucinations, fearfulness, and weird behavior.[1] On the other hand, one might not experience uncomfortable or distressing withdrawal reactions and might, in fact, merely feel better, more alive, sensitive and energetic as the drug's depressant effects slowly wear off.

People of all ages, even newborns whose mothers took psychiatric drugs during pregnancy, can have withdrawal symptoms. After drugs are stopped, the time period before withdrawal symptoms occur is variable. Some people experience these symptoms within 8-24 hours after starting withdrawal, while for others withdrawal symptoms do not start for several days or a week or 2. In part, this depends upon how long the drugs have been taken and in what amounts, for most of these drugs accumulate in body tissues in the form of drug reservoirs. When drugs are no longer being taken or intake has been reduced and the blood's drug level falls, these stored drugs will start being released into the bloodstream. Tests have shown that neuroleptics can be detected in the body and urine for as long as 6 months after they have been discontinued.

Another factor to be considered is that drug effects are experienced most intensely when drug levels in the blood are either rising or falling: the more rapid these changes, the more intense the effects. Thus, when large and sudden increases in the drug blood levels occur, one is more likely to experience distressing *drug effects*. On the other hand, when drug blood levels fall rapidly, one is more likely to experience distressing *drug-withdrawal effects*.

Drugs are broken down, inactivated, and eliminated from the body at different rates. This factor, called the drug half-life, is very important. Drugs with short half-lives, that are eliminated quickly, lead to more rapid drops in blood drug levels and more intense withdrawal effects that start and end sooner. Drugs that have longer half-lives are eliminated more slowly by the body and cause withdrawal reactions that start later, but last longer. Neuroleptics, anti-depressants and the older anti-anxiety drugs (like Valium and Librium) have longer half-lives. Lithium and the newer anti-anxiety drugs (like Restoril, Halcion, and Serax) have shorter half-lives.

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1. Alcohol consumption presents a similar problem: after alcohol binges or long-term heavy alcohol use, one can experience withdrawal reactions, including hallucinations and a serious, sometimes life-threatening condition called delirium tremens, or the DT's.

There are a number of factors that bear on the difficulty of drug withdrawal:

- Type of drug taken.
- Dosage level and length of time drug has been taken.
- The person's general health and attitude about drug withdrawal.
- The quality of support received during the withdrawal period.
- The person's understanding of the withdrawal process, knowledge of the possible symptoms and problems to be encountered, and the concrete measures taken to alleviate such problems.

II. SCHEDULING

The best way to minimize drug-withdrawal problems is to reduce drug intake gradually. This is especially important if the drug has been taken for more than 1 or 2 months. If you have been taking small doses of psychiatric drugs, or have been taking such drugs for a brief time only (i.e., a few days or weeks), then you may wish to try discontinuing "cold turkey," that is, just stop taking the drug. With neuroleptics, anti-depressants, and lithium it is possible, although not advisable, to stop all at once regardless of how much or for how long you have been taking the drug. There are no life-threatening consequences to sudden withdrawal from these drugs, but there may be severe discomfort and distress.

With sedative-hypnotics and anti-anxiety drugs, if high enough doses have been taken for long enough periods, there can be life-threatening withdrawal problems. Under such circumstances, we strongly recommend gradual withdrawal.

Gradual, Stepped Drug Withdrawal: The 10% Formula

Using this formula, drug withdrawal is accomplished by slowly reducing the drug dose in sequential steps, taking as long as necessary at each step. If you have been taking psychiatric drugs for years, it may take many weeks, or even longer, to withdraw from them completely. Following this plan, the drug dose is lowered by 10% of the current dose in 10 successive steps over time. Here is the way this would work if at the time of starting withdrawal you were taking 500 mg of Thorazine a day: at each step, drug intake would be reduced by 50 mg (10% of 500 mg = 50 mg).

Step 1: Go from 500 mg to 450 mg a day. Wait several days or a week until you are free of distressing drug-withdrawal symptoms.

Step 2: Then go from 450 mg to 400 mg, again waiting several days or a week until you feel o.k.

Step 3: Then go from 400 mg to 350 mg, and so on until you have completely withdrawn from the drug.

If you are taking divided doses, i.e., some of the drug in the morning, some in the afternoon, some in the evening (a common practice), then there are several ways to put this plan into action. You could first reduce and eliminate the morning dose, then the afternoon dose, and finally the evening dose. Another way would be to reduce the morning dose by 50 mg (using the Thorazine example from above) as Step 1, then reduce the afternoon dose by 50 mg as Step 2, then reduce the evening dose by 50 mg as Step 3, then reduce the morning dose by another 50 mg as Step 4, and so on until complete withdrawal.

If after reducing the dose you experience what may be withdrawal symptoms, then stay at that level of dosage until the symptoms diminish or disappear before going on to the next step. As an alternative, go back to the previous step (at the higher dose level) where you felt comfortable and stay there for more time before going on to the next step.

Sometimes the first part of this reduction will not cause any problems. But then, as much lower doses are reached, problems will occur. For instance, going from 50 mg to no drug (again using the Thorazine example) can cause difficulties, in which case you could decrease the rate of dosage reduction at that time, going from 50 mg to 40 mg to 30 mg, and so on.

In order to use this step-by-step approach, it may be necessary for you to obtain different pill strengths or to cut tablets or capsules that you have. Pills that have a hard coating are difficult to break evenly. Tablets are usually scored,

meaning they have a groove down the middle which makes it easy for you to break them in half, or ultimately into quarters with your fingers. Capsules are harder to cut. If they are cut in half with knife or razor, the contents spill out, and you must keep the unused half capsule in a container.

Here is an example of a drug withdrawal schedule involving dosage reductions where cutting is necessary. If you are taking 60 mg of Valium a day (six 10 mg tablets) and want to use the 10% Formula, reduce the dose in increments of 5 mg, instead of 6 mg (10% of 60 mg = 6 mg). Thus, at Step 1, take 55 mg (five-and-a-half 10 mg tablets) a day (by breaking one 10 mg tablet in half). Then at Step 2, take 50 mg (five 10 mg tablets), and then 45 mg (four-and-a-half 10 mg tablets) at Step 3, and so on until you are off the drug entirely. If you experience some withdrawal symptoms when going from 5 mg (one-half of a 10 mg tablet) to none, try going from 5 mg to 4 mg (two 2 mg tablets), then to 3 mg (one 2 mg tablet and one-half of another 2 mg tablet) and so on. These dosages could be cut even finer, e.g., if you wanted to set the dosage level at 2 1/2 mg of Valium, you could take one 2 mg tablet and with a knife cut another 2 mg tablet in quarters and take one of the quarters (one-quarter of a 2 mg tablet = 1/2 mg).

Again, the 10% Formula is not an inflexible system for drug withdrawal. It can and should be adjusted to your individual needs.

III. PRACTICAL SUGGESTIONS

1. Diet

One of the purposes of withdrawing from psychiatric drugs is to cleanse the body, to rid it of accumulated poisons. Nausea, vomiting, and other stomach problems can be anticipated. What you eat during this period will influence your experience of the withdrawal and its outcome. Therefore, it is important to eat well, regularly, but not to excess. Some people report good results by *concentrating on* grains, beans, fresh vegetables, fresh or dried fruit, and uncooked, unsalted nuts, and *avoiding* junk food, sugar (candy, cakes, ice cream, and soft drinks), processed foods (canned and frozen), fried foods, animal products (meat and dairy), caffeine (coffee, most commercial teas, and some soft drinks), alcohol, and drugs like marijuana, cocaine and speed.[2]

2. Sleep and Relaxation

Insomnia (difficulty getting to sleep or staying asleep) is a common withdrawal problem. Adequate sleep and rest during the withdrawal period is extremely important. If sleep does not come easily, it is better to rest in bed than to pursue some activity. Some people have found it helpful to drink an herbal tea (valerian and camomile are good ones) to relax. Others have benefited from yoga and breathing exercises, warm baths, and massages before sleep.

3. Physical Exercise

As your body becomes free of drugs, in time you will almost surely have more energy than you had while taking the drugs. This energy can be used to further the withdrawal process if it is channelled into an exercise program. Some sort of regular activity will assist your body in eliminating the drugs. You might start swimming, walking, dancing, or doing yoga or aerobics. Moderation is a key principle: as you increase your activities, do so gradually.

4. Mental Exercise

Your mind is also likely to become more active during withdrawal. For some people this has proven to be a good time for learning new survival and social skills, as well as for study, reflection, and meditation.

5. Mental Attitude

Withdrawal from psychiatric drugs can be a very trying experience. You should know that withdrawal can cause moderate to severe discomfort and outright misery at times. Being mentally prepared for

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2. A note on smoking. It is not wise to stop smoking at the same time you are withdrawing from psychiatric drugs. Each process can lead to an increase in tension. When both are undertaken together, these tensions can be overwhelming. It is far better to get off psychiatric drugs first and then deal with the smoking problem.

this decreases the chance that you will become scared or discouraged. Patience and determination are needed.

6. Environmental Factors

Having a stable life situation during the drug withdrawal period is very important. Count yourself lucky if you are among people who understand the nature of drug withdrawal and support your efforts to go through it. If you must be among people who disapprove of your decision to go off drugs, you should insist upon their respecting your right to do so. Of course, during withdrawal you are better off being by yourself than with unsympathetic or hostile people. Many individuals have withdrawn from drugs *on their own*. As you come down from the drugs, you are likely to feel better physically and have more energy for improving your relationships and developing new ones, getting involved in the community, and tying in with a support system or creating your own.

IV. WITHDRAWAL EFFECTS BY DRUG CATEGORY

1. Neuroleptics

Drugs like Thorazine, Stelazine, Haldol and Prolixin are associated with 3 basic types of withdrawal reactions, usually starting a few days after the drugs are stopped or reduced, peaking during the first week and generally diminishing by the second or third week:

A. Nonmuscular Reactions: flu-like symptoms, such as nausea and vomiting (at times severe), sweating, runny nose, insomnia, diarrhea, restlessness, headaches, and aches and pains. With the exception of severe vomiting, all of these reactions can be suffered through without special attention.

B. Muscular Reactions: neuroleptic-induced parkinsonian symptoms, such as muscular rigidity, tremors, and stiffness, can persist for several months or longer after the drugs are stopped. Other abnormal, uncontrollable, rhythmic movements, particularly around the mouth, can last for many months, or even indefinitely if tardive dyskinesia has developed (see Neuroleptics, sect. II.2.A., p.24).

C. "Withdrawal Psychosis:" as people withdraw from the neuroleptics, they sometimes feel like they are going crazy. Often this is not recognized for what it is--a condition brought on by the withdrawal itself. This development can then result in a return to more intensive drugging. A far better course would be to slow down, not reverse, the withdrawal procedure.

Combinations.

If you have been taking a neuroleptic and an anti-parkinsonian drug, then come down from the neuroleptic first, as explained above, while taking the same dose

of the anti-parkinsonian. After you have completely withdrawn from the neuroleptic, gradually withdraw from the anti-parkinsonian over the following 2-4 weeks. This may be the most difficult and uncomfortable part of the withdrawal.

Prolixin: Long-Acting Injections.

Prolixin injections pose a unique withdrawal problem. These injections last from 2 to 6 weeks. Once you decide to withdraw, just stop getting the injections. You will gradually come down as the last shot wears off. If an anti-parkinsonian drug is also being taken, continue it for 6 weeks after the last Prolixin shot. After this period, taper off the anti-parkinsonian over a 2-week period. This is the safest way. You can also stop the anti-parkinsonian sooner and see what happens, then restart it if there is a problem.

2. Anti-Depressants

What has been said of withdrawal from the neuroleptics applies to the anti-depressants, such as Elavil, Tofranil, Norpramin and Vivactil, although muscular symptoms are usually less severe. Stopping these drugs abruptly is not recommended.

3. Lithium

Lithium, because it is a mineral salt and not an organic chemical like all other psychiatric drugs, presents a different type of withdrawal situation. Sudden discontinuation of lithium appears to be safe. The body will eliminate the lithium through the urine over the next 3 days to a week. Although there are no reports in the psychiatric literature documenting serious withdrawal reactions from lithium, personal reports indicate that there have been withdrawal difficulties, including freak-outs, insomnia, anxiousness and irritability. The best approach is to withdraw slowly from lithium over at least a 2-week period.

4. Anti-Anxiety Drugs

With the anti-anxiety drugs ("minor tranquilizers"), like Valium and Librium, it is crucial that withdrawal be gradual. Dosage levels should be reduced to nothing over at least a 1-week period. Abruptly stopping these drugs can produce dangerous withdrawal reactions, including life-threatening seizures. Even with gradual withdrawal, reactions can include: flu-type aches and pains, nausea, diarrhea, sweating, shaking, insomnia, anxiety, restlessness, dizziness, fevers, fearfulness, muscle tics, and "withdrawal psychosis." Withdrawal symptoms can occur immediately or shortly after the drugs are reduced or stopped and can build in intensity for a week to 10 days. It is during this early stage that seizures are most likely to occur. Withdrawal reactions of a milder nature can linger for several weeks or even a month or 2 after the drugs are stopped.

5. Sedative-Hypnotics

Sudden withdrawal from barbiturates and pseudo-barbiturates, such as Quaalude, Tuinal, and Placidyl, can be hazardous, with life-threatening seizures a possibility. If you have been taking these drugs continuously for longer than 2 months, it is necessary to reduce doses over a period of several weeks. Withdrawal symptoms with the sedative-hypnotics are similar to those of the anti-anxiety drugs.

6. Psychostimulants

Amphetamines and quasi-amphetamines like Ritalin are addicting drugs and withdrawing from them can cause serious problems. Unlike the sedative-hypnotics, there is no danger of life-threatening withdrawal seizures. But suddenly stopping psychostimulants can induce severe despair (at times of suicidal proportions), extreme fear, and withdrawal psychosis. Therefore, gradual withdrawal is strongly recommended. Other less serious withdrawal reactions include: apathy, fatigue, nervousness, irritability, and gastrointestinal symptoms. There is little documentation concerning psychostimulant-withdrawal problems for "hyperactive" children. But there are many published reports of such problems with adults, and it is reasonable to assume that children withdrawing from Ritalin-type drugs sometimes experience difficulties.

7. Geriatric Drugs

There is almost no information about withdrawal problems with geriatric drugs. In the absence of reliable information, slow withdrawal over a 2-week period, or longer, is advised.

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(Drug Names)

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Psychiatric Inmates Liberation Movement

(Partial Listing of Groups)

Advocates for Freedom in Mental Health, 4448 Francis, Kansas City, KS 66103

Alliance for the Liberation of Mental Patients, Box 30228, Philadelphia, PA 19103.

Alternatives to Psychiatry Association, 410 So. Dixie Hwy., Unit 14, Lake Worth, FL 33460

Amalie, Linnesgade 26, kld. tv., 1361 Copenhagen, Denmark

Auto-Psy, 45 St. Francois Est., Quebec City, Quebec, Canada JIK 1Y4

Campaign Against Psychiatric Injustice and Coercion (CAPIC), Box 228, Collingwood, 3066, Australia

C.A.P.A.B.L.E. (Citizens Against Psychiatric Abuse and Bureaucratic and Legal Entanglements), Talmage, CA 95481

Center for Independent Living - Mental Disability Independent Living Program, 2439 Telegraph Ave., Berkeley, CA 94704

Clientenbond, Postbus 645, 3500 AP, Utrecht, Holland

Coalition to Stop Electroshock, Box 3301, Berkeley, CA 94703

Irren-Offensive, Winterfeldstr. 38, 100 Berlin 30, West Germany

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Mental Health Consumer Concerns, 2727 Alhambra Ave., Suite 2B, Martinez, CA 94553

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Mental Patients Alliance of Central New York (Syracuse), Box 158, Syracuse, NY 13201

Mental Patients Association, 2146 Yew St., Vancouver, BC, Canada V6K 3G7

Mental Patients Liberation Front, Box 594, Cambridge, MA 02238

Network Against Psychiatric Assault (NAPA), 2054 University Ave., Berkeley, CA 94704

On Our Own, 5422 Belair Rd., Baltimore, MD 21206

On Our Own, 1860A Queen St. E., Toronto, Ontario, Canada M4L 1H1

Phoenix Rising, Box 7251, Sta. A, Toronto, Ontario, Canada M5W 1X9 ($6/year, $12 for institutions)

Portland Coalition for the Psychiatrically Labeled, 277 Cumberland Ave., Portland, ME 04101

Project Release, Box 396, FDR Station, New York, NY 10011

PROMPT, c/o 11 Ottershaw House, Horsell Rd., St. Paul's Cray, Kent, England

Psychiatric Inmates Rights Collective, Box 299, Santa Cruz, CA 95061

South Dakota Mental Health Advocacy Project, Box 618, Sioux Falls, SD 57101

Vermont Liberation Organization, RD #1, Johnson, VT 05656

Women Psychiatric Inmates Liberation Front, c/o Big Mama Rag, 1724 Gaylord St., Denver, CO 80206

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