Resisting Psychiatric Assault: A European Initiative to Introduce a Suicide Register[1]

Keynote Address

Peter Lehmann
In Any Case (Berlin)

Translations by Pia Kempker & Peter Lehmann

PsychOut: A Conference for Organizing Resistance Against Psychiatry, OISE, Toronto, 2010

[1] An early version of this paper was unofficially distributed at the conference "Coping with stress and depression related problems in Europe," organized by the World Health Organization, the European Commission and the Federal Ministry of Social Affairs, Public Health and the Environment (Belgium), Brussels, October 25-27, 2001. Revised versions were published in: Journal of Critical Psychology, Counseling and Psychotherapy (U.K.), Vol. 2 (2002), No. 1, pp. 54-58; Psychologie & Gesellschaftskritik (Germany), Vol. 26 (2002), No. IV, pp. 99-111; Co`med – Fachmagazin für Complementär-Medizin (Germany), Vol. 8 (2002), No. 3, pp. 32-34. For the time-limited lecture, this text has to be abridged. The explanations in the italic brackets are written by the author. The translations of the German citations into English are made by Pia Kempker and Peter Lehmann.
Thanks to Craig Newnes and Eugenia Tsao for corrections on the translation. Thanks to Leonard R. Frank, Jim Gottstein, Edmund Schönenberger and David Webb for their comments on drafts of this paper.

Introduction

An action project against "Harassment and Discrimination Faced by People with Mental Health Problems in the Field of Health Services" was organized as part of the "Community Action Programme to Combat Discrimination in 2001-2006" with support from the European Union. A transnational study within this program was designed and conducted by associations of (ex-) users and survivors of psychiatry and their families from the U.K., Austria, Germany, Spain, the Netherlands and France in conjunction with a Belgian research institute, Mental Health Europe and the European Network of (ex-) Users and Survivors of Psychiatry (ENUSP). This study found that psychiatric patients are systematically discriminated against in the medical and psychiatric sector. As one of many measures to combat discrimination, it was recommended that laws espousing equal treatment should be adopted and funds provided so that these laws could be put into practice. These laws should guarantee the respect of human rights in a pro-active way and focus on the protection of human dignity, the right not to be violated, the right to self-determination, the right to privacy and the right to respect—for example through the legal protection of advance directives or through the introduction of a suicide register (see www.enusp.org/documents/harassment/recommendations.htm). Mortality registers are not unusual in the medical field to identify connections between lethal outcomes and risk factors.

In the psychiatric sector, people have to deal with massive discrimination and stigma. Power conditions and hierarchies make it easy to mask responsibility for damages. We have to deal with Big Pharma's billion-dollar profits, and it is hard for injured people to find authorities to listen to their voices, particularly when they are harmed by psychiatric drugs such as antidepressants and neuroleptics, which can cause suicidality.

Of course, there are many reasons for depression and suicidality in the world. I will mention some of these and then focus on medical and pharmacological reasons. I will then mention placebo studies, epidemiological surveys, first-hand reports and case studies that demonstrate the frequency of depression and suicidality produced by neuroleptics.

A survivor-run register from Berlin, a register run by German psychiatrists, and a register run by the Swedish National Board of Health and Welfare will then be introduced. Finally, I will reflect upon the reasons why these registers did or did not develop meaningful programs to prevent suicides caused by psychiatric treatment and draw conclusions about what might help to protect our lives.

Risk Factors for Depression and Suicidality

Although a suicide attempt may have medical consequences, it rarely has medical (biological) causes. In general, suicide occurs when a person makes a decision—a deliberate, cognitive, psychological decision—to kill themselves because of unbearable psychological pain (see Webb, 2010). Very rarely is suicidality caused by a malfunction of the brain.

There are a lot of well-known factors that can trigger depression and suicidal behavior: political, social and economic, emotional and physical factors.

Political reasons:

- For example, in Nazi Germany, thousands of Jewish people escaped from persecution and deportation by committing suicide; others who had knowledge of secret resistance preferred suicide to ensure that they would not disclose secrets if they were tortured.
- There are also micropolitical reasons for suicide. For example, to stay in Germany, Hitler, Göbbels and Göring and many other Nazis killed themselves to escape punishment or to save themselves from having to live in a non-fascist society.

Social and economical reasons:

- Unemployment, combined with hopelessness
- The inability to cope with the burdens of war; the unhappiness of living alone or being divorced
- Living with a severe illness
- Failing in a relationship.

Psychiatric factors:

- Unhappiness, depression, and suicidal ideation can each arbitrarily be called a psychiatric disease
- Each suicide can arbitrarily be called the result of a psychiatric disease
- Fear of forced admission or desperation about an incurable psychiatric diagnosis can trigger suicide, especially when this stigmatization is combined with discrimination, self-stigmatization and social decline.

Medical diseases and disorders:

- Neurological diseases like cerebrovascular diseases, tumors, Parkinson's disease
- Infections like AIDS or hepatitis
- Endocrinological diseases like morbus Cushing
- Metabolic disorders like dehydration
- Other diseases like carcinoma or alcohol dependence
- Genetic abnormalities in the serotonin system

Pharmacological Reasons for Depression and Suicidality

Depression, which may or may not lead to suicidality, can be caused by medical drugs like:

- Tuberculostatics (f. e., cyloserine)
- Antihypertensive drugs (f.e., α-methyldopa or Beta blocker)
- Chemotherapeutics (f.e.. decarbazine, prednisolon, procarbazine and the interferones)
- Oral contraceptive pills
- Vitamins like the vitamin-A-derivative isotretinoin (which is used in the treatment of severe acne)
- Drugs to treat addiction, for example varenicline prescribed to treat smoking addiction (trade name Chantix in the USA and Champix in Europe)

Similarly, it can be caused by medical drugs like

- Tranquilizers like benzodiazepines, f.e. diazepam
- Mood stabilizers like antiepileptics
- Antidepressants
- Neuroleptics

Depression, Suicidality and Tranquilizers

Tranquilizers can produce or enhance depression and suicidality. There are several reports of depression and suicidality being caused by benzodiazepines like diazepam or alprazolam in people who had never dealt with depression (Hall & Joffe, 1972; Remschmidt, 1980; Van der Kroef, 1979; Lydiard, *et al.,* 1987). And it is well known that chronic dependence on benzodiazepines as well as withdrawal from these drugs are combined with a high risk level of suicidality (see Lehmann, 1996b, p. 361).

Depression, Suicidality and Mood Stabilizers

Since December 2008, the U.S. Food and Drug Administration (FDA) requires manufacturers of antiepileptic drugs to issue a warning that their use increases the risk of suicidal thoughts and behaviors (suicidality). This includes all antiepileptic drugs, including those used for psychiatric reasons. Recently, in 2010, a team led by Elisabetta Patorno of the Harvard Medical School in Boston, Massachusetts, published an exploratory analysis suggesting that the use of different antiepileptics may be associated with an increased risk of suicidal acts or violent deaths (Patorno, *et al.,* p. 1401).

Depression, Suicidality and Antidepressants

Since the introduction of the classic antidepressants, psychiatrists have noted a tendency towards the chronification of depression. This phenomenon is not likely to disappear due to the "down regulation" of serotonin and noradrenalin receptors. Down-regulation results in a degeneration of the receptors as a reaction to artificially raised transmitter levels at the synapses. In 1995, psychiatrist Marc Rufer from Switzerland issued this warning regarding selective serotonin re-uptake (SSRI)

> In the long run, they diminish the effect of serotonin. If the serotonin deficit hypothesis of depression were correct, SSRI would have to cause rather severe depressions" (p. 144).

In 2004, the Medical Drug Commission of German Medical Professionals came to the conclusion

> that, especially in connection with the severe excitatory side effects of SSRI, you have to expect a risk of suicidal activities generally and non age-related, which is illustrated by accordant case reports" (Arzneimittelkommission).

You all may know the website http://ssristories.com/ where you can find a collection of more than 3,800 news stories that have appeared in the media in the English language (newspapers, TV, scientific journals) or that were part of FDA testimony in either 1991, 2004 or 2006, in which antidepressants were mentioned.

Of course, there are also people saying that antidepressants like SSRIs lower the risk of suicide, especially in teens (Kutcher & Chehil, 2007, p. 77). This perspective has been advanced by Stan Kutcher and Sonia Chehil, two psychiatrists from the Dalhousie University in Halifax, Canada, in a booklet from the Lundbeck Institute. The pharmaceutical firm Lundbeck produces the SSRI escitalopram (Cipralex) and citalopram (Cipramil), the antiepileptic valproate (Convulex), the neuroleptic fluphenazine (Lyogen—also marketed as Modecate, Moditen, Prolixin), the tricyclic antidepressant nortriptyline (Nortrilen) and many other drugs.

As so-called progressive psychiatrists like David Healy use criticisms of antidepressants to justify electroshock administration as an alternative, we should also bear in mind that depression and suicidality are well-known effects of electroconvulsive treatment –procedure involving the passage of electricity through the brain in order to produce a convulsion—a

barbaric method, which was not incidentally, developed during the Zeitgeist of fascism. Manfred Sakel, the Austrian psychiatrist who developed insulin shock "treatment" in 1933, noted that the side effects of ECT, including amnesia, confusion, disorientation, and temporary euphoria, may result in a secondary reactive depression, sometimes leading to suicide (Sakel, 1956). Reports of suicide following the administration of electroshock may be found in Leonard Roy Frank's anthology, *The History of Shock Treatment* (1978, pp. 23, 27, 32, 43, 54, 58-59, 61, 73, 78, 101, 134, 154) or in Linda Andre's book *Doctors of Deception: What They Don't Want You to Know About Shock* (2009). A detailed account of how people experience suicidality, triggered by insulin shock, electroshock and various psychiatric drugs, can be found in the book *Mitgift –Notizen vom Verschwinden* (Dowry of Poison: Notes from disappearing), authored by Kerstin Kempker (2000). The treatment she received as an adolescent with emotional problems following her parents' divorce severely traumatized her and triggered a series of suicide attempts. Having survived both the treatment and the suicide attempts, Kempker was also able to describe how the psychiatric workers seemed to be unaware of the procedure's traumatizing and suicide-triggering effects.

Depression, Suicidality and Neuroleptics

Neuroleptics block the transmitter dopamine resulting in Parkinson's syndrome, a complex of symptoms, characterized by walking with a stoop, muscle tremor, blurred speech and the so-called Parkinson psyche. Parkinson's disease regularly results from dopamine blockage. The potency of neuroleptics was defined by their power to create Parkinson's disease. This is not an unwanted side effect; this is the therapeutic main-effect as defined by psychiatrists.

Depression and suicidality are normal effects of neuroleptics, and thus psychiatrists accept them without question. Frank J. Ayd of the Psychiatric Department of the Franklin Square Hospital in Baltimore, USA, wrote in 1975:

> There is now general agreement that mild to severe depressions that may lead to suicide may happen during treatment with any depot neuroleptic, just as they may occur during treatment with any oral neuroleptic. These depressive mood changes may transpire at any time during depot neuroleptic therapy. Some clinicians have noted depressions shortly after the initiation of treatment; others have observed this months or years after treatment was started (p. 497).

Otto Benkert and Hanns Hippius (1980), two German psychiatrists, answered the question of whether suicidality could perhaps be caused by an excessive dosage:

> Depression, suicidality, states of excitement and delirium under the influence of drugs generally occur during doses prescribed by the treating physician (p. 258).

R. de Alarcon and M.W.P. Carney, two English psychiatrists, studied depressive mood changes after the administration of neuroleptics, with other variables staying the same. In the *British Medical Journal,* they reported a case of a 39-year old man who attempted suicide after taking fluphenazine as part of his community treatment program. When the psychiatrists realized that this man had developed suicidal intentions some days after the two-week depot-injections, they wanted to witness the mood-worsening effect of the neuroleptic firsthand. In the psychiatric institution, the man was observed over four weeks, without being treated with neuroleptics, and without displaying anything remarkable mood fluctuations. They then injected him intramuscularly with 25 mg of fluphenazine. These were their observations:

> He was given the trial injection on a Wednesday at 3 p.m.; by mid-afternoon on the following day he felt low, wanted to be left on his own, and had no desire to talk to anyone, read, or watch television. He took to his bed at about 4 p.m. In the opinion of the charge nurse he was a suicidal risk. When interviewed on the Friday the change in external appearance was striking—he looked gloomy, he did not respond with a smile

> to a joke, and there was no spontaneous conversation. His answers were limited to what was strictly necessary. He denied any paranoid of hypochondriacal ideas or any feelings of guilt. He simply said that he felt very low and if he were alone in digs he would take his life. By Friday evening there was some improvement, and when he was interviewed again on Saturday he had returned to his usual normal self" (1969, pp. 565-566).

In his placebo-controlled study, psychiatrist Peter Müller of the Psychiatric Department of the University of Göttingen, Germany, found that a much higher percentage of people treated with neuroleptics had depressive symptoms than people treated with placebos. In relation to the reduction of withdrawal effects from psychiatric drugs, he wrote in 1981:

> From 47 cases, the depressive mood lifted in 41 cases, in only two cases there was no change, and in four cases the effect was dubious. It was very surprising to see that in the predominant number of cases the reduction of the doses alone (normally to half of the former dose) lead to an improvement of the depressive symptoms. Often it was only a partial improvement, but even this brought clear relief to the patient. On the other hand, in other patients, or in the same ones whose situation improved only slightly when taking lower doses, complete withdrawal made them feel much better. Some patients reported that only now did they feel completely healthy again, as they had long before their depressions. The depressive symptoms, which were seen to be unchangeable by some psychiatrists, and which could possibly have been taken to be a start of organic disorder, vanished completely. The possible argument that these could be psycho-reactive effects caused by the patients' relief about the withdrawal of the psychiatric drug is refutable, because nearly all patients received depot-injections and were not informed about their doses or got placebo-injections….Their change was quite impressive to themselves, their relatives and their medical examiners in some cases. The patients reported that now they felt completely healthy again. In the group of people still treated with psychiatric drugs, this was mostly not the case. These results quite definitely speak for pharmacogene influences and against psychiatric morbidity developments (pp. 52-53 / 64).

Müller resumed:

> Depressive syndromes after the remission of the psychoses and under treatment with psychiatric drugs are not rare, but occur on about two thirds of the patients, and sometimes even more frequently, especially when depot-drugs are given. Without treatment with psychiatric drugs, depressive syndromes after a complete remission are only found in exceptional cases (p. 72).

Müller's reports are supported by many of his colleagues (Lehmann, 1996a, pp. 57-87, 109-115). Some examples include Raymond Battegay and Annemarie Gehring (1968) of the Psychiatric Department of the University of Basel, Switzerland, who warned about the depressive effect of psychiatric drugs:

> During the last years, a shifting of the schizophrenic syndromes to a depressive syndrome was repeatedly described. More and more schizophrenias show a depressive-apathetic course. It became clear that often exactly that develops under psychiatric drugs, what should be avoided with their help and what is called a defect (pp. 107-108).

Rolf Hessö of the Psychiatric Department of the University of Oslo, Norway, also spoke about the development in Finland, Sweden and Norway in 1977; it seemed to be clear:

> …that the increased incidence of suicide, both absolutely and relatively, started in the year 1955. This was the year that neuroleptics were introduced in Scandinavian psychiatric hospitals" (p. 122).

In 1982, Jiri Modestin wrote about what he observed in his place of employment, the Psychiatric Department of the University of Berne, Switzerland, as well as in the neighboring psychiatric institution Münsingen:

> Our results show a dramatic increase of the suicide frequency among the patients in Berne and Münsingen in the last years" (p. 258).

Firsthand Reports about Depression and Suicidality

In *Coming off Psychiatric Drugs*, the first book ever published about the possibilities and experiences of coming off psychiatric drugs *(*published originally in German in 1998 and later in English in 2004), Regina Bellion of Bremen, Germany, gave a report about her experience with Haldol, a drug administered by her community psychiatrist:

> I vegetate behind my neuroleptic wall and I am locked out of the world and out of life. The real world is further from me than Pluto is from the sun. My own secret world is also gone—my last refuge, and I had destroyed it with Haldol.
>
> This is not my life. This is not me. I may as well be dead. An idea has begun to take shape. Before winter comes I will hang myself.
>
> But before that I want to try and see if my life would be different without Haldol. I reduce the number of drops. I take less and less until I arrive at zero.
>
> After one month I am clean. Then I begin to notice how unkempt I am. I wash my hair, make the bed, clean the apartment. I prepare a warm meal. I even enjoy doing this. I can think again (2004, p. 280).

Even clozapine (trade name: Leponex), the prototype of so-called atypical neuroleptics, seems to have suicidal effects, as the report of Austrian Ursula Fröhlich shows:

> Since I began taking Leponex I do not want sex anymore, did not feel like moving and had no joy in life. A life without joy is, however, worse than death. All that remained with me is watching TV, where I have watched others living for seven years. I am still alive biologically, but my senses are long since dead, everything that I former enjoyed I am not able to do anymore. In a way, my life does not exist anymore, I feel so empty and unimportant. In the morning, the feeling is the worst. Every day I intend to start a healthy life the following day, to throw away the drugs, to drink many vitamins and fruit juices and to start with a daily fitness routine. The psychiatric drugs cause a feeling as if it was possible for me to start with a completely different, a new life the following day. But when I wake up in the morning I feel like smashed, and I never come out of bed before 9 o'clock, my depressions are so extreme that I think of suicide every day (cited in Lehmann, 1996a, pp. 70-71).

Psychiatrists did not differ in their own experiences with these drugs. In 1955, Hans Heimann and Nikolaus Witt of the Psychiatric Department of the University of Berne, Switzerland, published their experiences after once taking chlorpromazine (marketed as Largactil, Thorazine), the prototype neuroleptic. They cited one example of neuroleptic effects in normal people:

> I felt physically and mentally ill. Suddenly my whole situation appeared hopeless and difficult. Above all, the fact that one can be so miserable and exposed, so empty and superfluous, neither filled by wishes nor by something else, was torturing. ... (After finishing the examinations): The tasks of life grew immense in front of me: dinner, go to the other building, come back—and all of that by foot. With that this state reached its

> maximum of uncomfortable emotions: The experience of a passive existence with clear knowledge of the other possibilities... (p. 113).

Suicide Registers

By Survivors of Psychiatry

In early 1983, the Irren-Offensive Berlin, a psychiatric survivor organization (in that time a respectable non-dogmatic organization not dominated by Machos), together with a group monitoring human rights violations in psychiatry, publicly warned of suicides caused by neuroleptics, after they had received information about people who had hung themselves, gassed or poisoned themselves, or threw themselves in front of subway trains. Through leafleting, they warned the public of the widely distributed neuroleptic, haloperidol. Within a short time, bereaved individuals came forward with reports of suicides that were committed under the influence of neuroleptics. On January 28, 1983, the foundation of the "Registration Center for (Self-) Murders by Psychiatric Treatment" was published within a press-conference, and a small minority of magazines and newspapers reported about it. A public call to support the initiative financially and structurally bore no results, and the initiative eventually came to an end due to the immense expenditure of human labor with the bereaved's anguish when they realized the true causes of their loved ones' deaths. But the demand for a public suicide register was born.

By Psychiatrists

Another type of suicide register was developed in the form of the "Arzneimittelüberwachung in der Psychiatrie" (AMÜP—a drug monitoring system in the psychiatric field) in Germany, which was founded in 1979 and was supported by the National Health Administration of the German Government. Since the beginning of the 1990s, after an experimental phase, psychiatric hospitals in this region have gathered data on complications that may have resulted from treatment, including the registration suicide attempts and suicides caused by drugs, in order to make risks public and develop programs for prevention and early detection (Haen, *et al.,* 1999, p. 93). Findings are discussed within the psychiatric community, where individual psychiatrists know each other quite well, "without prejudices and free of any know-it-all-habits" (ibid., p. 94). If a psychiatrist identifies a drug as potentially suicide-triggering, they send a report to the National Institute for the Safety of Drugs, the Drug Commission of the German Medical Association and the Drug Produces. Unfortunately, the authors of the article forgot to say how many reports they sent after 89 registered suicide attempts and suicides up to January 1998.

In a review published in 2002, Bavarian psychiatrists reflected on their results from 1991 through 1999 and found many methodological problems that arose from registering suicides and identifying one exclusive cause that triggers suicidality. They mention, for example, problems with the definition of suicidality and plead for the further development of questionnaires and registration cards (Franke, *et al.*).

I have made repeated friendly offers as a board member of the European Network of (ex-) Users and Survivors of Psychiatry to discuss the possibility of including users and survivors of psychiatry in the Bavarian suicide register and to help make the registration criteria sharper and more effective, but the professionals involved have expressed no interest in collaborative work.

By a Governmental Administration

A suicide register in Sweden was reported by the Swedish journalist Janne Larsson in November 2008. Referring to regulations in The Act on Professional Activity in Health and Medical Services (called Lex Maria), since February 2006 in Sweden, all suicides committed by people who have received medical attention within the past four weeks should be reported to the National Board of Health and Welfare for investigation. He explains:

> 1255 committed suicide in 2006. According to preliminary data from the National Board of Health and Welfare, these were comprised of 377 women and 878 men. (...) Of the 377 women, 267 (71%) received one or more psychiatric drugs in the categories of antidepressants, neuroleptics, hypnotics/tranquilizers; for men the comparable figure was 423 (48%). In total 690 (55%) of all the persons who committed suicide 2006 received treatment with psychiatric drugs in one or more of these classes" (pp. 4-5).

The data in 2007 were not better. "In total," Larsson writes:

> according to the data received, 393 cases were reported to the six regional offices for 2007. (...) In 338 of the 393 cases – 86% of the cases – the persons were treated with psychiatric drugs within one year before their suicide. In 304 cases – 77% of the cases – the persons were treated with antidepressant drugs and/or neuroleptics. In 261 cases – 66% of the cases – the persons were treated with tranquilizers/hypnotics; drugs of the class benzodiazepines or similar newer compounds. In addition to the above, in 115 cases (29%) the persons were treated with psychiatric drugs of other classes. These were drugs such as epileptic drugs recently started to be used as 'mood stabilizers' (Lyrica, Lamictal), 'ADHD drugs' (Concerta, Ritalin, Strattera) and other types of psychiatric drugs like Buprenorfin *(semi-synthetic opiate, used as pain-killer)* and Heminevrine *(clomethiazol)*" (pp. 14-16).

Larsson summarizes the 2007 results of the report:

In 86% of the cases of suicide reported to the National Board of Health and Welfare for 2007 (chapter 4) – that is in 338 of 393 cases – the persons were treated with psychiatric drugs. In 0% (!) of these cases was the matter reported as a drug adverse event to the registry for drug adverse events at the Medical Products Agency (...). Instead of Eli Lilly claiming that the drug Zyprexa *(olanzapine; neuroleptic)* was involved in 0 cases of suicide in Sweden 2007, the fact was that the drug was involved in 52 cases in this subgroup of 338 persons. Instead of Wyeth claiming the same for Effexor *(venlafaxine; serotonin / norepinephrine reuptake inhibitor)*, the fact was that the drug was involved in 41 cases in this group" (pp. 20-21).

Consequences and Demands

Updated product labeling has to include a warning about an increased risk of suicidal thoughts or actions to help patients, their supporters and psychosocial staff understand this risk. This has to be a rule. Users of psychiatric drugs need to be informed so that they can carefully consider the possible benefits and risks associated with psychiatric drugs, and, if necessary, opt for alternatives beyond psychiatry or less risky psychopharmacological treatments.

Reports of (ex-) users and survivors of psychiatry who have attempted or contemplated suicide after traumatizing experiences with psychiatric drugs, electro- and insulin shock must no longer be ignored. They have to be included as keynote speakers, experts and teachers in education programs, congresses and the public media.

As a form of user-led or user-controlled research, delegates of independent organisations of users and survivors of psychiatry, as well as competent and independent individuals, have to be included in prevention programs and monitoring bodies with adequate remuneration. It would be rather counterproductive to include Big Pharma (see, for example, the reasonable proposals of the Institute of Medicine, the health arm of the National Academy of Sciences in Washington, DC, in: Steinbrook, 2009) or to include psychiatrists, family organisations or so-called self-help organisations like GAMIAN who receive money and other profits from Big Pharma.

We have to face the fact that the segregation of troubled or troublesome people is not something that everyone agrees should be prevented. This refers especially to people who

have not violated any laws and therefore cannot be criminally prosecuted and imprisoned, but whose ideas and actions, values and lifestyles, disrupt or threaten to disrupt established power relationships. In 1923, Fritz Lenz, one of the most influential German eugenicists and advocates of racist population control, praised suicide—with the support of Eugen Bleuler, the leader of the mainstream psychiatry at that time (see Lehmann, 1992)—as a measure against "vulgarization of the race":

> From this, the selection through suicide lies in the direction of the strengthening of the population's living will and its cheerful temper (p. 23).

As an urgent measure, we have to use and improve advance directives to protect ourselves from unwanted treatment (Ziegler, 2007), where we can include important information about previous depressive states caused by psychiatric drugs. And we should demand that criminal charges be applied in cases of medical neglect and breach of standards of care, especially in cases caused by recklessness. This means "conduct whereby the actor does not desire harmful consequence but... foresees the possibility and consciously takes the risk," or alternatively as "a state of mind in which a person does not care about the consequences of his or her actions" (Garner, 2005, p. 1053). (For more information on this legal principle, see http://en.wikipedia.org/wiki/Recklessness_(law).) In American and many other courts, a wrongdoer who recklessly causes harm can be held to the same liability as a person who does so intentionally. If psychiatrists continue to administer psychiatric drugs with suicidal effects to people who are known to have underlying risk factors, they should know that there are prison cells waiting for them. This should also be true for the owners and the leaders of drug companies that produce drugs with suicidal effects. Laws should be applied equally for all.

A suicide register with meaningful participation by independent organizations of users and survivors of psychiatry could enhance warnings of suicidal risks of psychiatric treatment methods. It could work to publish and publicize its findings. It could be organized nationally or regionally and should be required by law. It should then be easily accessible (anonymous upon request) and operate independently of medical and psychiatric institutions.

The rate of suicides in people with emotional problems or people who are called "mentally ill" could be lowered meaningfully. People could live their lives in freedom and peace. If the damage is done already, at least there may be a chance to get financial compensation, the only language people from the psychiatric-pharmacological business understand.

References

Andre, L. (2009). *Doctors of deception: What they don't want you to know about shock*. Piscataway: Rutgers University Press.

Arzneimittelkommission der deutschen Ärzteschaft (2004). "Aus der UAW-Datenbank" – Suizidalität unter SSRIs. *Deutsches Ärzteblatt, 101*(39); retrieved April 7, 2009, from www.akdae.de/Arzneimittelsicherheit/Bekanntgaben/Archiv/2004/200409243.pdf.

Ayd, F. J. (1975). The depot fluphenazines. *American Journal of Psychiatry, 132*, 491-500.

Battegay, R., & Gehring, A. (1968). Vergleichende Untersuchungen an Schizophrenen der präneuroleptischen und der postneuroleptischen Ära. *Pharmakopsychiatrie Neuro-Psychopharmakologie, 1*, 107-122.

Bellion, R. (2004). After withdrawal, the difficulties begin. In P. Lehmann (Ed.), *Coming off psychiatric drugs: Successful withdrawal from neuroleptics, antidepressants, lithium, carbamazepine and tranquilizers* (pp. 279-290). Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing.

Benkert, O., & Hippius, H. (1980). *Psychiatrische Pharmakotherapie*. 3. edition. Berlin / Heidelberg / New York: Springer.

De Alarcon, R., & Carney, M. W. P. (1969). Severe depressive mood changes following slow-release intramuscular fluphenazine injection. *British Medical Journal*, 564-567.

Frank, L. R. (Ed.). (1978). *The history of shock treatment*. San Francisco: Self-publication.

Franke, C., *et al.* (2002). Zusammenhang zwischen Suizidalität und Psychopharmaka – Ergebnisse der AMÜP-Bayern 1991 bis 1999. *Psychopharmakotherapie, 9*, 108-111.

Garner, B. (Ed.) (2005). *Black's law dictionary*, 8. edition, Boston: West Publishing Company.

Haen, E., *et al.* (1999): Die Arzneimittelüberwachung in der Psychiatrie Bayerns (AMÜP-Bayern). *Arzneimitteltherapie, 17*(3), 93-96.

Hall, R. C. W., & Joy R. (1972). Aberrant response to diazepam. *American Journal of Psychiatry, 129,* 738-742.

Heimann, H., & Witt, P. N. (1955). Die Wirkung einer einmaligen Largactilgabe bei Gesunden. *Monatsschrift für Psychiatrie und Neurologie, 129,* 104-123.

Hessö, R. (1977). Suicide in Norwegian, Finnish, and Swedish hospitals. *Archiv für Psychiatrie und Nervenkrankheiten, 224,* 119-127.

Kempker, K. (2000). *Mitgift – Notizen vom Verschwinden*. Berlin: Antipsychiatrieverlag.

Kutcher, S., & Chehil, S. (2007). *Suicide risk management: A manual for health professionals.* Malden / Oxford / Carlton: Blackwell Publishing.

Larsson, J. (2008). *Psychiatric drugs & suicide: How medical agencies deceive patients and relatives.* Retrieved May 20, 2009, from http://jannel.se/psychiatricdrugs.suicide.pdf. An extended and updated version from October 2009 find on http://jannel.se/psychiatric.drugs.suicide.pdf.

Lehmann, P. (1994). "Progressive" psychiatry: Publisher J. F. Lehmann as promoter of social psychiatry under fascism. *Changes – An International Journal of Psychology and Psychotherapy, 12* (1), 37-49; extended version available at www.peter-lehmann-publishing.com/articles/lehmann/j-f-lehmann.htm.

Lehmann, P. (1996a). *Schöne neue Psychiatrie*. Vol. 1: *Wie Chemie und Strom auf Geist und Psyche wirken*. Berlin: Antipsychiatrieverlag.

Lehmann, P. (1996b). *Schöne neue Psychiatrie*. Vol. 2: *Wie Psychopharmaka den Körper verändern*. Berlin: Antipsychiatrieverlag.

Lenz, F. (1923). *Menschliche Auslese und Rassenhygiene*. 2., expanded and corrected edition. Munich: J. F. Lehmanns Verlag.

Lydiard, R. B., *et al.* (1987). Emergence of depressive symptoms in patients receiving alprazolam for panic disorders. *American Journal of Psychiatry, 144*, 664-665.

Modestin, J. (1982). Suizid in der psychiatrischen Institution. *Nervenarzt, 53*, 254-261.

Müller, P. (1981). *Depressive Syndrome im Verlauf schizophrener Psychosen.* Stuttgart: Enke.

Patorno, E., *et al.* (2010). Anticonvulsant medications and the risk of suicide, attempted suicide, or violent death. *Journal of the American Medical Association, 303,* 1401-1409.

Remschmidt, H. (1980). Paradoxe Reaktionen und Interaktionen von Psychopharmaka bei Kindern und Jugendlichen. *Monatsschrift für Kinderheilkunde, 128*, 636-641.

Rufer, M. (1995). *Glückspillen – Ecstasy, Prozac und das Comeback der Psychopharmaka*. Munich: Knaur Verlag.

Sakel, M. J. (1956). Sakel shock treatment. In A. M. Sackler, *et al.* (Eds.), *The great physiological therapies in psychiatry: An historical perspective* (pp. 13-14). New York: Hoeber-Harper.

Steinbrook, R. (2009. Controlling conflict of interest: Proposals from the Institute of Medicine. *New England Journal of Medicine, 360,* 2160-2163; retrieved May 4, 2010, from http://content.nejm.org/cgi/content/full/360/21/2160.

Van der Kroef, C. (1979). Reactions to triazolam. *Lancet,* 526.

Webb, D. (2010*). Thinking about suicide: Contemplating and comprehending the urge to die*. Ross-on-Wye: PCCS Books.

Ziegler, L. (2007). Upholding psychiatric advance directives: “The rights of a flea”. In P. Stastny & P. Lehmann (Eds.), *Alternatives beyond psychiatry* (pp. 318-328). Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing.

Contact: www.peter-lehmann.de