

For 25 years, doctors have been making their mental patients sicker.

Psychiatry's Drug Addiction

by Peter Sterling

"Judge Rules Mental Patients Sane, Doctors Crazy." Thus the headlines might have read on September 14. The inmates of New Jersey's five state mental hospitals had sued the state in a class action for the right to refuse psychoactive drugs. The patients claimed that the drugs with which they were being forcibly treated, far from relieving their illness, were causing them intolerable distress, impeding their recovery, and producing irreversible brain damage. The federal judge ruled that refusal of a drug, even by a patient who is

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psychotic, can "be prompted by a quite rational desire to avoid unpleasant side effects and a realistic appraisal that the medication is not helping. . . ." The judge chastized hospital physicians and state authorities for administering the drugs irresponsibly, often punitively, and for their "conscious and deliberate indifference to breaches of patients rights."

The treatment of the insane in New Jersey reflects standard practice across the country. Over the last 25 years psychotropic drugs have become virtually the universal and sole treatment for mental patients. But these drugs are toxic. The drugs at issue are the phenothiazines such as chlorpromazine and the butyrophenones such as haloperidol. They affect transmission of chemical signals between nerve cells,

especially neurons sensitive to the neurochemical, dopamine. Since these neurons are widely distributed in the brain from the retina to the frontal lobe, no single brain region remains unaffected.

The toxic effects of these drugs are extraordinarily varied. Some effects such as chronically dry mouth, blurred vision, and inability to ejaculate stem from the suppression of neural mechanisms that control glands and "involuntary" muscles. Other more serious effects stem from the disruption of normal neurochemical activity in "motor" areas of the brain. For example, the drugs commonly induce the symptoms of Parkinson's disease: trembling of the limbs, rigidity of the muscles, and "akinesia," literally an inability to move.

"Akathisia" is another common toxic effect, and one that would drive a sane man crazy. Its external signs are a motor restlessness, constant pacing, and fidgeting of the fingers, legs, lips, and jaws. Akathisia is experienced subjectively as an inability to find a comfortable position for one's body, so that the desire to move is constant and compelling. This toxic syndrome often is accompanied by states of intolerable anxiety or abject terror. Mistaking this toxic condition for mental illness frequently leads the psychiatrist to *increase* the drug dose, intensifying the akathisia to unbearable levels.

The most disfiguring and disabling of all the toxic drug effects is "tardive dyskinesia." This is a rapid, wholly involuntary writhing of the face, lips, tongue, jaws, and occasionally the limbs and trunk. These movements are so severe in one of the New Jersey plaintiffs that she is unable to wear dentures and must live on ground food. Another plaintiff suffers tardive dyskinesia as a Dante-esque torture: he continually bites his tongue. This disorder reflects permanent damage to certain parts of the brain's motor system; by the time it is diagnosed in most patients, it is too late to be reversed. Paradoxically, the syndrome is frequently *exacerbated* by withdrawal of the drugs which caused it. Despite a frantic search for new drugs to counteract it, tardive dyskinesia is without cure or prospect for one, except to restore the offending drugs. This may suppress temporarily some of the symptoms, but it will continue to cause unseen damage to the brain.

Tardive dyskinesia appears almost inexorably after years of chronic drug use, and older patients bear the highest risks. Roughly half the geriatric patients in New Jersey's state hospitals suffer tardive dyskinesia. As a result of this iatrogenic (physician-caused) disorder, a patient who recovers from his mental disorder continues to *look* crazy because of his bizarre movements. He is an object of suspicion and taunts by other patients and staff and, following release, as one may well imagine, by the general public.

The hospital staffs in New Jersey systematically ignore these toxic effects and attribute complaints about them to the patients' illness. The medical director of one state institution conceded at the trial that a quarter to a half of the patients at his hospital might

suffer from tardive dyskinesia, yet not a single patient's chart in that hospital bears the diagnosis. A nurse who insisted on charting one patient's abnormal movements was chastized for doing so by her superiors. A psychiatrist for the defense testified that most patients suffering drug-induced tardive dyskinesia are unaware that they have the disorder and "are not troubled by it." He went on to say that refusal to take drugs is an expression of the patients' illness and that "mini-epidemics" of drug refusal occur when "a couple of patients go around agitating each other to refuse medication. . . ."

Such attitudes displayed by the psychiatrists quite naturally lead the rest of the staff to deny the toxic effects of the drugs they administer, and to respond with cruelty rather than sympathy to complaints. The plaintiff who couldn't wear her dentures because of tardive dyskinesia was taunted by staff, who implied she was faking. When John Rennie, the leading plaintiff in the suit, refused to take drugs, he was beaten by an attendant ("human services technician"). Rennie's protest at the beating was dismissed as paranoia until he showed an official "patient advocate" where the stick was kept at the nurses' station. A more subtle way of intimidating patients who try to refuse medication is the threat of "Prolixin." This drug produces especially high incidence of akathisia and akinesia and, not uncommonly, a dramatic exacerbation of psychosis: Prolixin is given by needle in a long-lasting form; patients know that in refusing tablets of Thorazine or Haldol, they risk a two-week shot of Prolixin.

The staff of mental hospitals are not moved by idle cruelty, but rather by a rigid determination to continue administering the drugs. What is the source of this compulsion? The behavior of the psychiatric profession in this regard has the earmarks of a drug addiction. All the classic requirements for addiction were present in 1954 when chlorpromazine was introduced: a vulnerable population, pushers, and a powerful substance. Psychiatry was vulnerable because it suffered from the scorn long heaped upon it by the other medical specialties for having no therapy to offer but "talk." It was being encroached upon, furthermore, by the professions of psychology and social work with equally valid claims to provide talk therapy. And the nation's mental hospitals were bulging with more than half a million patients. The availability of "medicine" to treat the insane reinforced the concept that insanity is a medical illness. The drug gave psychiatry a chance to establish decisively its own niche in medicine, and hegemony in the treatment of the insane.

The drug was pushed hard with only the briefest glance at its toxicity. In 1953 Smith, Kline, and French purchased the rights to chlorpromazine ("Thorazine"), based on its demonstrated efficacy as an "anti-emetic," to control nausea and vomiting. As late as December 1953, only five months before it was marketed, chlorpromazine had been tested as a tranquilizer on only 104 psychiatric patients in the United States.

Thirteen months later it was being administered to about two million American patients. SKF mounted an impressive sales drive, adding a special Thorazine task force of 50 salesmen to its regular sales force of 300 for all products. The company convinced state legislatures to increase mental health appropriations and convinced hospitals to use the funds for the purchase of Thorazine. Much of SKF's growth, from net sales of \$53 million in 1953 to \$347 million in 1970, came from the success of Thorazine.

The other drug companies were not far behind, and chlorpromazine was followed by a variety of similar drugs. Next came other drugs intended to counteract some of the side effects of the tranquilizers. Psychotropic drugs, now manufactured by the ton, filled about 250 million prescriptions in 1974. Today it is common for a schizophrenic patient to receive up to six drugs simultaneously that have both reinforcing and opposing effects on the brain. Only psychiatrists, among mental health professionals, are permitted to determine the proper ingredients for this bouillabaisse.

The drugs are undeniably potent in treating the *symptoms* of psychosis. When a patient arrives strait-jacketed at the hospital raving that he is Christ or the Alpha-Omega, a shot of chlorpromazine appears to work a miracle. In a few hours he is calmer. He may still be deluded, but the intensity with which he presses his claims has abated. The chemical is not merely a sedative like the barbiturates: it can moderate the stark withdrawal of a catatonic as dramatically as it calms the excited patient. "Double-blind" studies prove that patients maintained on drugs within the hospital are more manageable. Compared to patients on placebos, their scores are low on the "Behavioral Disturbance Index" and high on the "Hospital Adjustment Scale."

This impressive effect led many psychiatrists to claim that the drugs act on the "core" of psychosis, that they are true "antischizophrenic" agents. Some hoped, too, that patients released with their symptoms suppressed by "maintenance" doses could rejoin the general community. But 25 years after chlorpromazine was introduced, these hopes have not been realized. It has become clear the drugs do *not* strike the core of psychosis. Studies have shown that patients treated with drugs, despite their apparently greater lucidity, are not more amenable to psychotherapy. In fact, patients on the drugs generally do not benefit at all from traditional psychotherapy. This finding probably reflects the harmful effects of the drugs, but it has been used as a reason for allowing psychotherapeutic programs of all kinds to deteriorate.

Most patients released from the hospital on "maintenance" drugs have not successfully rejoined the community. Typically these patients lead isolated lives in rooming houses at the community margins, where they often are cheated of their welfare checks by unscrupulous landlords. Roughly half to three-quarters of the patients on "maintenance" drugs relapse and return to the hospital. Patients treated with

drugs in the hospital and taken off the drugs at release also relapse at high rates. Patients who never received drugs fare best when released.

The blunting of consciousness, motivation, and the ability to solve problems under the influence of chlorpromazine resembles nothing so much as the effects of frontal lobotomy. The lobotomy syndrome was familiar to psychiatrists in 1954 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. Psychiatry once hoped that lobotomy also would make patients "amenable" to psychotherapy. It is clear in retrospect that neither surgery nor drug treatment could have that result because progress in psychotherapy requires not lack of interest from the patient, but wits and drive.

Mental hospitals began to empty after 1955. New Jersey state hospitals, for example, held 15,000 patients then and only about 4000 today. This massive "decarceration" is widely credited to the success of the psychotropic drugs, but there is really no evidence for this. The rates of release from mental hospitals began to rise in the United States and England in the late 1940s and early 1950s, before the drugs were introduced. Prison release rates also began to rise shortly afterward. The trend toward decarceration in both kinds of institutions resulted from a recognition of the astronomical costs of the new hospitals and prisons that would be required without a reversal of the trend toward incarceration. The availability of drugs cannot explain the increased release rates in prisons, nor for the high release rates for patients with chronic brain syndromes who rarely were treated with drugs.

The practice of Dr. Thomas Monro, physician of Bedlam in 1815, was to bleed, vomit, and purge all patients, beginning at the end of May. Conceding to investigators from Parliament the uselessness of these therapies, he explained, "That has been the practice invariably for years. . . . It was handed down to me by my father, and I do not know any better practice." The admission was particularly poignant, for by that time the success of "moral therapy" in treating the insane was well established. Since 1792 the York Retreat in England had calmed agitated patients by establishing an atmosphere of tranquillity. The Retreat relied on gentle supervision, warm baths, ample food, and porter, a malt liquor. Liquor was not used as an intoxicant, but to help patients recapture their sense of well-being. The physical design of the Retreat affirmed its therapeutic concept—private rooms lit by unbarred windows.

Moral treatment was effective. Between 1796 and 1861 the York Retreat discharged 71 percent of the patients who had been admitted within three months of illness onset. Worcester State Hospital in Massa-

chusetts, using the same approach during the years 1833-46, discharged 70 percent of those admitted within a year of illness onset. This figure is the more impressive since 10 to 20 percent of the admissions were for general paralysis (syphilis). Worcester's monumental 50-year follow-up study completed in 1893 showed that half of those released experienced no relapse and of the relapsing cases, only half were permanently rehospitalized. Few studies of drug treatment can claim so good a record.

The practice of moral therapy deteriorated under the impact of the industrial revolution, but has been revived during periods of social optimism. Following World War II, many hospitals again abolished physical restraints and solitary confinement. Staff once more mobilized patients to govern themselves on the wards and devised for them useful activities such as in-hospital work. Hospital staffs were reeducated to appeal to every possibility a patient might offer for reintegration and growth. The results, after almost a century of purely custodial care, were dramatic. This was the period in which lobotomy declined and mental hospital release rates began to rise.

These social techniques demand more skill, dedication, and money than drug therapy does. Some psychiatrists hoped that drugs would provide a useful adjunct to moral treatment, but the opposite occurred. Patients numbed by drugs could not benefit from moral treatment, so it declined, leaving the psychiatrists, now addicted, ever more starkly dependent on the drugs. Today, when a patient has received his medications and been introduced to the ward boob tube, he has had all of

what psychiatry offers in state hospitals.

Yet certain hospitals continue to experiment with moral therapy. The judge in the New Jersey case heard testimony about a small ward in a National Institute of Health facility where acutely psychotic patients were maintained without medication while they established relationships with other patients and staff. Patients contrasted sharply their experiences on and off the drug. On drugs they felt more comfortable and less frightened. "They cared less about things but they also had a feeling that they were somehow stuck in their experience. . . ." Off drugs, they had more anxiety, panic, and sleeplessness, but a greater "sense of being able to master their own experiences and some sense of being able to get out of something they'd been stuck in for many years." Off medication, patients had "a sense of at least experiencing their own experiences" and gained confidence, as they saw themselves improving without medication, that they were people who could cope.

The federal court in New Jersey ruled that patients must be informed of the potential harmful effects of the psychotropic drugs and told they have a right to refuse medication even after they have signed a consent form. The hospitals will have trouble ignoring or circumventing the ruling because New Jersey has a strong Division of Mental Health Advocacy. It was this division that employed the dedicated patient advocates to conduct the case on behalf of the patients. With luck, the case may even help psychiatry to kick its drug habit and focus once again on the more demanding, yet rewarding, practice of modern moral therapy.