Neuroleptics and mortality: a 50-year cycle

Invited commentary on . . . Schizophrenia, neuroleptic medication and mortality†

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The paper by Joukamaa *et al* (2006, this issue) would have interested Heinz Lehmann, a German émigré psychiatrist working at Verdun hospital in Montreal, who was one of the first clinicians to investigate the effects of chlorpromazine in North America and was the first to publish an article outlining its clinical impact (Lehmann & Hanrahan, 1954). Lehmann was no simple enthusiast for physical treatments, having demonstrated that mute and deteriorated people with schizophrenia in Verdun's back wards responded to placebo injections of 'new experimental hormones' when the injection site was painted with a disinfectant that left a prominent red stain (Lehmann, 1993). However, chlorpromazine was different. Although previous treatments had provided some benefits, nothing produced quite such dramatic effects in the experience of senior researchers such as Lehmann. Chlorpromazine ignited a wave of enthusiasm in psychiatry sufficient to sweep aside post-War differences between the Germans and the French, for instance, so that they and others convened to share their experiences on the benefits of the new drugs at international meetings rapidly organised by university departments rather than pharmaceutical companies.

Patients were equally enthusiastic. As Lehmann put it:

> 'Look you can't imagine. You know we saw the unthinkable – hallucinations and delusions eliminated by a pill! I suppose if people had been told well they'll die 2 years later they'd still have said it's worth it. It was so unthinkable and so new and so wonderful' (Lehmann, 1996).

But yesterday's enthusiasms commonly pall in the face of today's hazards. In the case of the older neuroleptics we discovered a range of extrapyramidal problems, culminating in tardive dyskinesia. Newer agents have brought other no less tricky hazards to light. Until finally Joukamaa *et al* almost seem to face us with the trade-off Lehmann envisaged 50 years ago. Treatment can, it seems, lead to an earlier death. In the current climate, such a finding is liable to lead some patients and clinicians to reject the benefits that treatments can confer in favour of a more conservative approach. This would be unfortunate. The antipsychotics can be all but curative in some delirious and paranoid states but almost no one, and certainly not Lehmann, ever thought they were curative of schizophrenia in general. Understandably, though, in the face of non-response or minimal responses, right from the start some clinicians increased the dose of individual neuroleptics a hundred-fold beyond what is now recognised as optimal, or added further neuroleptics to treatment cocktails when a particular neuroleptic had failed, in a dynamic that Ross Baldessarini (personal communication, 2005) has described as the allopathic compulsion. Sometimes these dose escalations or additional treatments have been given on the back of an apparently worsening clinical state that may in fact have been made somewhat worse by the treatment being administered.

The study by Joukamaa *et al* highlights the downside of this allopathic compulsion and reminds us that the agents we are using are potent and need to be handled with respect and wisdom. It emphasises that looking after the health of a person may mean more than just treating a target illness and suggests that sometimes we may need to resist our efforts to engineer specific cures. Mesmerised by the good that neuroleptics can produce, we can easily forget that sometimes all that is needed is a small amount of good and that the social network on a ward or in a community may then capitalise on such changes over a longer period to produce greater benefits.

As Lehmann (1996) put it

> 'Because of all that, I was kind of character cast as a psychopharmacologist . . . but that didn't really change my philosophy – to me drugs are only adjuncts, very helpful practical adjuncts, but psychiatry is not psychopharmacology. I don't think it ever will be'.

DECLARATION OF INTEREST

D.H. has been an expert witness for plaintiffs in a number of cases involving antidepressants and homicide or suicide, and an expert witness in a case involving the patent of an antipsychotic drug. He has spoken on manufacturers' platforms for a number of antipsychotic drugs.

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