

"potentially addictive" for neuroleptics, but there are more precise terms available for the situations he described. Restarting neuroleptics for unexpected psychotic decompensation or nausea and vomiting is hardly the compulsive consumption of drugs that the word "addiction" usually refers to.

When one considers the host of adaptive and compensatory mechanisms which occur in most drug-organism interactions, it is clear that tolerance, rebound phenomena, and physiological dependence are the rule rather than the exception in pharmacotherapy (4, 5). Understanding them is the best way to guide our management of withdrawal syndromes, as when one attempts to reduce or discontinue neuroleptics. Including these syndromes in the group of addictions, either directly or by implication, serves only to cloud the important clinical issues for ourselves and our patients.

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Dr. Breggin Replies

SIR: Dr. McCormick's response to my letter correctly observes that the word "addiction" stirs up emotion. It should! Many patients suffer such severe withdrawal symptoms that they feel compelled to continue taking neuroleptics, often despite painful side effects and the fear of tardive dyskinesia. By using the word "addiction," we will encourage ourselves and others to face the reality of how painfully difficult and even impossible withdrawal from these medications can be. In addition, as I described in my original letter, the problems associated with withdrawal from neuroleptics correspond exactly with the dictionary definition of addiction.

"Tolerance, rebound phenomena, and physiological dependence" may be the rule in pharmacotherapy, as Dr. McCormick suggests, but in regard to neuroleptics, the problems are sufficient to prevent many highly motivated patients from discontinuing these medications. They can feel overwhelmed by any one or several of the potential withdrawal symptoms: the mental symptoms of restlessness, agitation, anxiety, insomnia or sedation, loss of concentration, nightmares, or tardive psychosis; the embarrassing and sometimes painful and disabling dyskinesias; and the flu-like symptoms of nausea, vomiting, anorexia and weight loss, abdominal pains, headache, myalgia, paresthesias, rhinorrhea, alternating feelings of warmth and cold, diaphoresis, dizziness, malaise, and fatigue (1-3).

Dr. McCormick suggests that the withdrawal symptoms associated with neuroleptics are somehow related to "the specific conditions of drug discontinuation." Neuroleptic

withdrawal phenomena should not be dismissed as dependent upon a particular clinician's approach or upon other circumstances. Neuroleptic withdrawal symptoms are well-documented, with dozens of relevant reports (2, 3).

Dr. McCormick suggests that I should not "lump together the clinically distinct situations of tardive psychosis, withdrawal dyskinesia, and gastrointestinal upset." However, they have important characteristics in common. First, all three are withdrawal phenomena that make it difficult and sometimes impossible for patients to stop taking neuroleptics. Second, all three are probably produced by the same basic CNS mechanism, the hyperactive rebound of one or more previously suppressed neurotransmitter systems.

Labeling the neuroleptics addictive does not "cloud the important clinical issues for ourselves and our patients." Instead, it shines a clarifying light on them. The addictive label emphasizes that patients must be warned about the difficulty of withdrawing from these drugs. It enables us to feel compassion toward our patients during the withdrawal process and encourages us to seek psychosocial and medical means for relieving their distress. It reminds us not to give up too quickly when the patient has trouble adjusting to lower levels of medication. It helps separate the patient's personal or psychiatric problems from those resulting from medication withdrawal, often relieving the patient of shame and confusion over the difficulty experienced in the withdrawal process. If the addictive label also encourages physicians to be more cautious in prescribing these dangerous medications (1), that is an advantage as well.

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Clinical Differentiation Between Lethal Catatonia and Neuroleptic Malignant Syndrome

SIR: The description of the syndrome of lethal catatonia before the introduction of neuroleptics strongly supports the view that lethal catatonia and neuroleptic malignant syndrome are different conditions, a point that deserved further emphasis by Edgar Castillo, M.D., and colleagues in their article (1). The case of lethal catatonia described by the authors, however, did not manifest any classic catatonic symptoms, e.g., catatonic posturing with waxy flexibility, automatic obedience, negativism. It remains unclear, therefore, if this patient and some of the other cases described in the literature represent agitated psychoses of other types, including those of organic origin or manic excitement.

The authors did not provide convincing evidence for the argument that there are clear clinical differences between the two syndromes. The cardinal features of rigidity, autonomic instability, fever, excitement, and exhaustion can occur in both conditions. A review of the relevant cases in the literature does not suggest that there is predictable progression