The Pharmacology of Murder: SSRI Drugs, Hysterical Psychosis, 5-HT and Repression
by Rich Norman

We are in an age which is fraught with change, some positive and some less so. It seems as if the basic fabric of our culture has torn, as if a qualitatively new and distinct rash of horror and criminal activity has overtaken this age and defined it: the rampage killing, a new sort of crime which appears to defy explanation, but do be sure this is false, and, an explanation is at hand. Indeed, these crimes are nothing if not utterly predictable. As a matter of coincidence, I have been studying the psycho-pharmacology of certain substances which play a key role in these crimes, and I will offer up my theory as to the psychological mechanism involved here. This information is theory, no more, as I can not claim to have conducted the many studies needed to *prove* these facts, but after years of careful and exhaustive study, I am utterly certain of their truth, and myself am quite sure these ideas *are* facts, even if scientifically I must clearly state the ideas are but theory and no more.

So what has changed? Why are there so many rampage killings, now as never before appearing with such alarming frequency, school shootings, mall murders, movie theatre massacres and the like? There have always been guns in our society, always so very many guns, but no, these shootings and murders are appearing on a scale never before seen. Ergo: the mechanism must lie elsewhere. There have been lousy parents and bad children throughout history, so very many bad parents and ugly mean spirited children, but no, these crimes are so tragic and only now, so prolific, so violent and today, so much more frequent. Ergo: the mechanism must lie elsewhere. The answer is, although belatedly, becoming clear. I will list but a few cases with partial pharmacological histories and then analyze the connecting factor:

John Shick, 2012, age 30, killed one injured six, was shot by police. Nine different anti-depressants were found in his apartment.

Hammad Memon, 2010, age 14, Shot and killed a student at school. He was taking the SSRI Zoloft.

Christopher Wood, 2009, age 34, cut and shot his wife and three children and committed suicide. He was taking the SSRI Paxil.

Jason Montes, 2009, age 33, killed his wife and shot himself. He was taking the SSRI Prozac.

Steven Kazmierczak, 2008, age 27, killed five, wounded twenty-one then killed himself. He was taking the SSRI Prozac.

Jeff Weise, 2005, age 16, killed his grandfather, grandfather's girlfriend, then drove to the high school, killing seven, wounding five and shooting himself. He was taking the SSRI Prozac.

Doug Williams, 2003, age 48, shot fourteen co-workers, killing six before turning the gun on himself. He was taking the SSRI Zoloft.

Eric Harris, 1999, age 18, along with Dylan Klebold, age 17, shot and killed twelve students and a teacher, wounding twenty-six others before killing themselves. Harris was taking the SSRI Luvox; Klebold's medical records are unavailable.

Kip Kinkel, 1998, age 15, shot his parents to death with a rifle, went to school and open-fired in the cafeteria, killing two and wounding twenty-five. He had been taking the SSRI Prozac.

So let me state at the outset that nothing could be more puerile, reactionary and short-sighted than to condemn an entire class of worthy drugs which are potentially so beneficial, like SSRI drugs, of which Prozac is the most prominent representative. When properly prescribed these drugs do vital and good work. However, these drugs work in specific ways which entail risks. These risks are utterly predictable and have largely been ignored. You will please note the similarity in behavior connecting the above mentioned crimes which all entail a violent outburst and then, in many cases end in death by police or suicide. This pattern is created as a psychological function of the neuro-chemical effects of SSRI therapy, tolerance and withdrawal, as these factors interact in specific and predictable ways. Although websites such as SSRIstories.com and the Citizens Commission on Human Rights website at cchrint.org offer information correlating these crimes with SSRI use and withdrawal, there is not enough information specifying the psychological mechanisms which yield these behavioral effects. I will offer a general analysis of those mechanisms here. Please contact me directly to order a book on the subject, *The Tangible Self*, which contains more detailed information (Norman, 2011).

Conscious vs. Unconscious: To understand these factors, we must first understand the basics of unconscious psychology. When an external threat is perceived, we run away or fight. However, the situation is different if the threatening factor comes from within us. Our own ideas, memories and thoughts can be every bit as dangerous to us, and to society, as an external enemy. As we grow up, we learn to control our aggressive and sexual instincts. These ideas and instincts are never truly gone, and can be seen to "reappear" in certain circumstances, such as under conditions of painful deprivation, madness and war, where every murderous human instinct can be seen to reemerge. These instincts then, have never disappeared, rather, they have been repressed, and made unconscious. Society is built upon the bedrock of repression and the unconscious. Psychology informs us, that as these internal instinctual threats return to consciousness, we become ill. In the language of Freudian psychology: symptom formation is a function of the return of the repressed.

I have discovered that SSRI drugs positively affect mental processes by reinforcing repression: repression is 5-HT (5-Hydroxytryptamine) dependent, and SSRI drugs increase 5-HT in the neuronal network by preventing re-uptake of the neurotransmitter in the synaptic system. [I will refer you to the latest edition of Goodman and Gilman's *The*

Pharmacological Basis of Therapeutics for a complete description of the neurochemistry involved in the effects of SSRI therapy.] By increasing the amount of 5-HT in the neural system, and preventing the repressed from entering consciousness, they quell mental illness. However, as is the usual case with drugs, tolerance develops and functions as partial withdrawal, and, many patients do, in fact, withdrawal from these drugs. In this instance, the effect is reversed, and repression is circumvented, allowing unconscious material to enter consciousness. So the drug that helps by way of reinforcing repression, causes illness as repression is reduced by way of tolerance or withdrawal.

This reduction in overall repressive function manifests itself as an unusual artificial hysterical psychosis, where both aspects of repression are circumvented, amnesia, and distortion via compromise-formation symbolism. If the dose is high, and the term of treatment long, upon withdrawal the effect is severe. In delusion, the psychotic is afforded a level of protection, as his delusion is a sort of distortion, a symbolic transformation of the wishes and/or mnemic experiences which are returning to consciousness and creating his illness (Freud, 1911, pp. 1-82; 1924, p. 151). Now, in SSRI withdrawal, even this most basic protective function of dream and delusion is defeated, and the most energetic and severe of unconscious material can gain direct and unfettered access to consciousness, free from any distortion. The effect to the ego is absolute and certain: damage of the most severe sort. Super-ego/ego is directly exposed to the most toxic unconscious contents, and its repressions further disintegrate, further revealing the very most energetic and highly disturbing hidden ideations. Sleep, in some cases, may be curtailed to as little as three hours or less a night. Soon, hallucination completes the picture, and a new sort of even more dangerous and severe psychosis is seen to emerge.

I will briefly traverse a secondary avenue of interest before completing the picture. Although the technical, psychological and medical information associated with these drugs is substantial, the fact that repression itself is affected to create behavioral effects has been utterly ignored. *The fact that repression is 5-HT dependent has not been articulated.* The result is clear: as repression is decreased through SSRI withdrawal, two things can be counted upon: 1. A mental illness, whatever its relation to repression, be it defined by the deepest repressions such as OCD or not, *will* be converted into an hysterical illness as hysteria is formed through the return of repressed unconscious contents under *low levels of repression* (or I postulate *perhaps* trigger the emergence of schizophrenia if the subject is presupposed). That is why hysterics demonstrate conversion hysteria, a bodily innervation of opposing wishes, in lieu of more typical repressive means (Freud, 1915, pp. 184-185), or anxiety hysteria, a common hysterical reaction in children, who have yet to develop a high level of repressive function (Freud, 1909, pp. 1-149; 1915, pp. 182-184). 2. As hysterical illness is formed through SSRI withdrawal, the job of analysis is made much easier, as unconscious ideations which are pathogenic are more easily accessed (Norman, 2011). It should be noted that these contents are likely to reveal themselves as negative transference, which although shunned in modern analysis, is in fact, the key to un-riddling the puzzle.

Now we must add but one more bit of information and the analysis will be clear. Our

aggressive drives are deeply repressed. These drives are repressed as a function of conscience, of guilt and super-ego, which acts as a conscious "reaction formation," an opposite which fills up consciousness as a replacement, a substitute for the repressed drive (Freud, 1923, p. 56). Sadism, violence used to control an object with no concern for that person or object, is chief among those drives we repress. The unconscious is filled with sadism. When we add guilt to a sadistic stream of great force and potency, the sadism "turns round" on the subject and becomes masochism, the chief representative of the death instinct (Freud, 1919, pp. 193-194; Norman, 2011, p.116).

Guilt + Sadism = Masochism. Now the analysis is plain:

A mentally ill person is placed on SSRI drugs which function to enforce their repressive facility, that was failing and creating illness, as their overly potent repressed drives returned to consciousness. Soon the drug fails to maintain its effect as tolerance ensues, or, the subject withdrawals from the drug. Now, repression is defeated, and unconscious content becomes conscious in its most toxic, direct and uncensored form. The subject identifies with his sadistic thoughts which present with such energetic force, as to be utterly irresistible. Once his hatred is spent, the guilt he feels for his actions is revealed, and added to his freed conscious sadistic drives to form masochism, and suicide, often suicide by way of police intervention. The psychology is utterly obvious, and, predictable. (Of course, the more likely result is suicide alone, and the above mentioned pattern of behavior is formed in those cases where sadistic ideation has obtained an energetically predominant place in the mental architecture).

Now imagine the combat veteran, trained in the art of killing, he returns to our shores, a hero, but ill for his service, ill for the guilt of killing. He is prescribed an SSRI drug, and feels better. Soon he tires of the debilitating side effects, and discontinues therapy. Can you see it? What will become of him then? What will become of us? If you are taking one of these drugs, I urge you not to stop. If you do stop, do it slowly, so very slowly, and be careful. These people who kill are not so different than any of us, in fact, any of us could be one of them. Although perhaps differing in intensity and proportion, all of us have these drives… every single one. The only difference is that we can contain them, and can not see them, can not see this part of ourselves. Perhaps the only real difference between one of these killers and one of us, is a misfortune of human honesty, in that they, are unfortunate enough to know a little too much—of themselves. So when you wonder what separates a mad killer from one of us, you may be surprised to learn the difference may be as small as a single question— A question, of human honesty.

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