

Psychiatric drugs & suicide

**How medical agencies
deceive patients
and relatives**

By Janne Larsson



Introduction

This is a report about suicides committed in Sweden (with around 9 million citizens) for 2006-2007 and the psychiatric drug treatment that preceded these suicides.

The report has three main parts:

- It gives data about all suicides committed in 2006 and the psychiatric drugs that the persons received *within half a year before the suicides*.
- It compares this data with autopsy reports about psychiatric drugs found in the blood of persons who committed suicide in 2007.
- It gives extensive information about the psychiatric drug treatment given *within a year* to the *subgroup* of persons who committed suicide in 2007 and then were reported to the national agencies by reason of law ¹ - one third of all suicides committed that year.

The data presented on these pages should have been published by the responsible national authorities. This is a matter not only for Sweden. It can be assumed that the situations described in this report are the same or very similar in other countries in the Western world.

It is time for full investigations in many countries of the actual effects of psychiatric drugs.

It is my hope that the data presented will lead to politicians, officials, journalists and others starting to demand basic changes in the ways persons with mental problems are taken care of.

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¹ This according to the regulations in The Act on Professional Activity in Health and Medical Services (called Lex Maria). The reporting requirements are in effect since February 2006; the year 2007 is *the first full year* for these requirements. The requirements are that ALL suicides committed in health care and within four weeks after last health care visit should be reported for investigation to the National Board of Health and Welfare.

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Chapter 1

Suicides 2006 – preceding psychiatric treatment

The national agencies in Sweden, as those in other countries, are supposed to compile, analyse and publish data about the psychiatric treatment given to those who commit suicide. With the laws and registries existing in Sweden the agencies concerned have all opportunities to do that. However this has not been done and instead the vital information presented below has been concealed.

In July 2005 the rules for the registries in Sweden were changed. From that point on it has been possible for the national agencies to present more exact data about use of prescribed medications on an individual level. It is for example possible to present information about which psychiatric drugs the persons who committed suicide were treated with. The information below about suicides for 2006 comes from the National Board of Health and Welfare in Sweden; it is data that the agency has chosen not to publish.

The data concerns the following:

- **Which psychiatric drugs (in different categories) the persons filled a prescription for *within half a year of the suicide (2006).***

1255 committed suicide in 2006. According to preliminary data from the National Board of Health and Welfare ^{2, 3}, these were comprised of **377 women and 878 men.**

In total, 488 (**39%**) of all the 1255 persons who committed suicide for 2006 received treatment with antidepressants within 180 days before the suicide.

Of the 377 women who committed suicide, 197 (**52%**) received antidepressants; for the men the figure was 291 (33%).

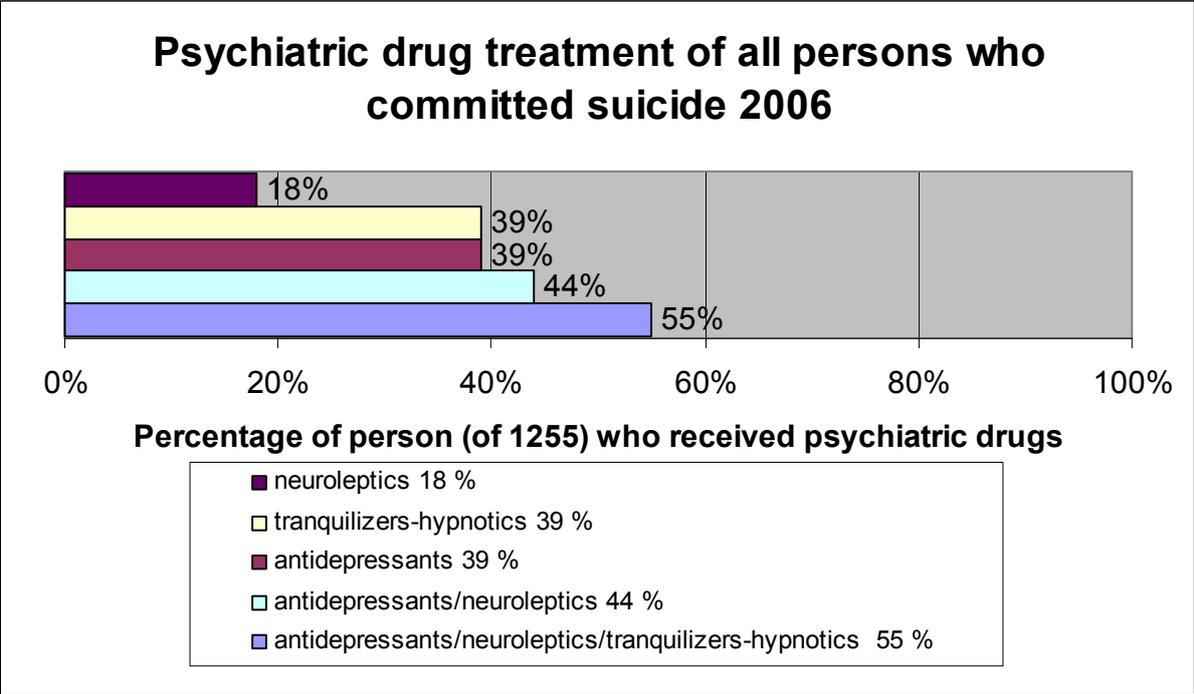
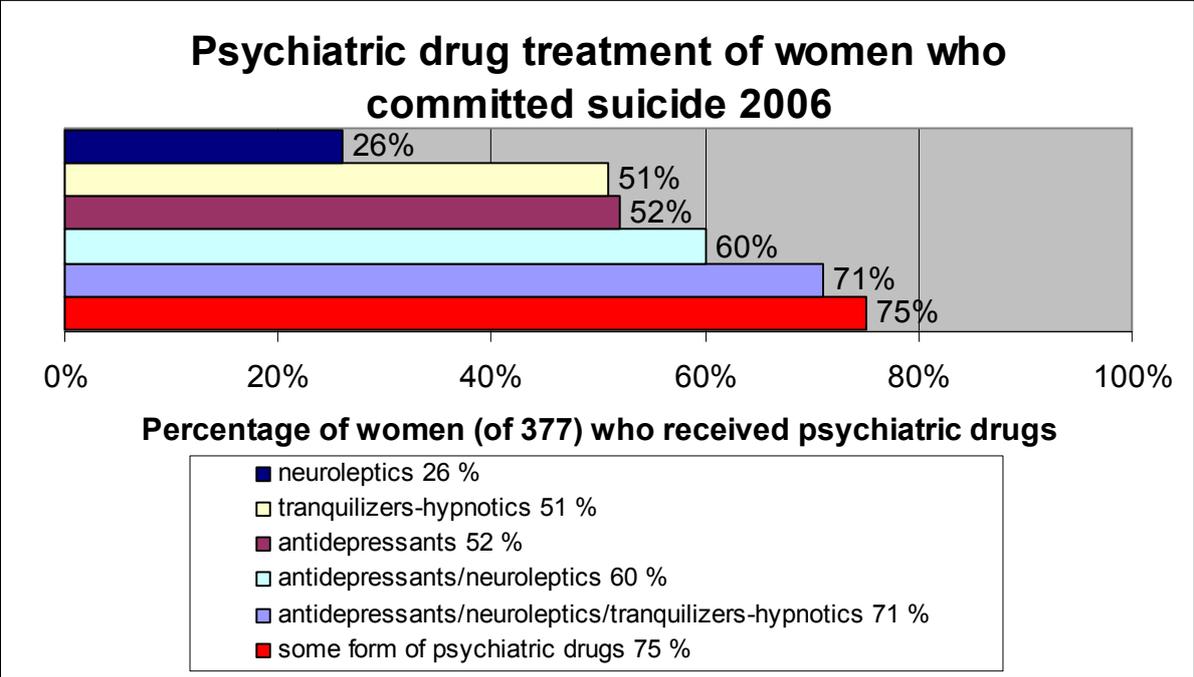
Of the 377 women, 226 (**60%**) received antidepressants *and/or* neuroleptics; for the men the comparable figure was 332 (**38%**). In total 558 (**44%**) of all who committed suicide 2006 received treatment with antidepressants *and/or* neuroleptics within 180 days before the suicide.

Of the 377 women, 267 (**71%**) received one or more psychiatric drugs in the categories of antidepressants, neuroleptics, hypnotics/tranquilizers; for men the

² Rickard Ljung, M.D., Ph.D., Charlotte Björkenstam, M.Sc. and Emma Björkenstam, B.Sc, *Ethnic Differences in Antidepressant Treatment Preceding Suicide in Sweden*, Psychiatric Services 59:116-a-117, January 2008, online on <http://ps.psychiatryonline.org/cgi/content/full/59/1/116-a>

³ The *final* statistics for suicides 2006 were published in July 2008, in (Swedish) *Dödsorsaker 2006*, <http://www.socialstyrelsen.se/Publicerat/2008/10117/2008-42-6.htm>

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.



As can be seen a large percentage (especially women) received treatment with psychiatric drugs that should have handled their mental problems and protected them from the ultimate consequence – suicide.

The data shows that many got more than one psychiatric drug. For the 377 women almost one fifth (**18%**) had filled prescriptions for *at least three* different classes of psychiatric drugs (antidepressants, neuroleptics, hypnotics/tranquilizers) and **41%** received *at least two* different psychiatric drugs within 180 days before their suicide.

The conclusion must be that a large percentage of the persons who committed suicide in Sweden in 2006 had received extensive treatment with psychiatric drugs within 180 days before their suicide.

This is, of course, remarkable as the psychiatric drugs in all marketing are presented as *medicines* – as drugs that correct a deficiency or a chemical imbalance in the brain. Psychiatric disorders are presented as *deficiency diseases* or *chemical imbalances* in the brain; in the world of biological psychiatry they are diseases like diabetes, and the psychiatric drugs are said to be exactly like insulin – *they correct the deficiency*.

Doctors have in many prominent campaigns got the message that psychiatric drugs, as antidepressants, *protect* against suicide; that they *prevent* "mental disorders". A well known example is the campaign for the antidepressant Effexor from the manufacturer Wyeth. In medical journals, doctors are shown a picture of a grave and a person who had committed suicide with the message: "*A depression can end unexpectedly fast.*" In other words: Give your patients treatment with Effexor and you can avoid a depressed state that ends in suicide.

The above results show clearly that there is an abyss between the marketing from pharmaceutical companies and their paid psychiatric opinion leaders, and the actual reality.

A warning must be issued to persons who take psychiatric drugs and to relatives to patients: It can be almost as dangerous to stop taking these drugs as it is to start with them. The harmful changes in the brain caused by the drugs can become very hard for the person who *abruptly* stop taking them. A qualified physician *must* carefully supervise the withdrawal.

Chapter 2

Psychiatric drugs

Psychiatric drugs are not natural substances that persons are deficient in, or vital substances that must be supplied to the body. The psychiatric drugs for "psychiatric disorders" cannot in any way be compared with the insulin that diabetics get or with vitamin C that human beings must have to not die. Yet they are presented in that way.

The idea that persons who are depressed are suffering from "chemical imbalances" and are deficient in the substance serotonin have been marketed by the pharmaceutical companies that sell antidepressants (in the class SSRI, such as Prozac, Paxil/Seroxat, Zoloft) for more than a decade. The intensive marketing has led persons to believe that their low mood is a *deficiency disease* – and that it is *vital* to supply the substance that corrects this deficiency – the antidepressant drug. Doctors have been subjected to "blackmail tactics" of the sort mentioned in Wyeth's "gravestone ad" (see chapter 1): Prescribe antidepressants or the depression can end unexpectedly fast; the person can commit suicide.

Doctors and patients have been told by Pfizer (Zoloft): "...depression may be related to an imbalance of natural substances between nerve cells in the brain ... Zoloft works to correct this imbalance ..." ⁴ And from Lundbeck/Forest: "Cipralext works by normalizing the serotonin levels in the brain." ⁵

But there is no scientific evidence that a low mood is caused by a "chemical imbalance" in the brain ^{6 7}. The hypothesis has been rejected with the following words by one of the most well known names in the field: "The serotonin theory of depression is comparable to the masturbatory theory of insanity." ⁸ (The old theory that masturbation caused insanity.)

Psychiatric drugs always have a toxic effect on the brain and on the body in general; a toxic substance being defined as a substance that "causes death or harm when ingested or absorbed by a living organism". And psychiatric drugs in a certain dose *always* cause harm to the brain – which is shown in the actual expected effect – as the "zombie effect" that elderly persons are systematically subjected to in elderly homes, or the "chemical lobotomies" that persons with psychotic reactions are given

⁴ Zoloft TV-ad, visited Nov 2008, <http://www.youtube.com/watch?v=6vfSFXXlnO0>

⁵ Lundbeck, (Swedish) Patientinformation about Cipralext, visited October 12, 2008, <http://sweden.lundbeck.com/Sweden/vardpersonal/depression/pdf/patientdagbok.pdf>

⁶ Leo/Lacasse, *The Media and the Chemical Imbalance Theory of Depression*, Society, (2007) visited July 27 2008, <http://www.springerlink.com/content/u37j12152n826q60/fulltext.pdf>

⁷ Leo/Lacasse, *Serotonin and Depression: A Disconnect between the Advertisements and the Scientific Literature*, PloS Medicine, (2005), visited July 27 2008, <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0020392>

⁸ Healy, quoted in the article *Ads for SSRI antidepressants are misleading, say researchers*, Medical News Today, (2005), visited November 22, 2008, <http://www.medicalnewstoday.com/articles/33290.php>

with neuroleptics (“antipsychotic medication”).^{9, 10} You could say that the “toxic dose” for psychoactive substances is the dose where they start having an effect on the behaviour – which in psychiatry is seen as the “therapeutic dose”.

We have seen in the earlier chapter that a large percentage of the persons who committed suicide in 2006 in Sweden had received psychiatric drugs – in many cases more than one drug. *If* the drugs would have corrected the assumed *deficiency* the “psychiatric disorder” would have been cured – and the persons would not have committed suicide.

This simple and obvious fact should lead to the abolishment of the current psychopharmacological “treatment” of persons with mental problems.

But psychopharmacological companies and psychiatrists work hard to preserve the myths. Despite the immense prescriptions of psychiatric drugs people are said to be “undertreated” – they don’t get *enough* psychiatric drugs, not early enough, not in a big enough dose, and not long enough.

And we definitely don’t become healthier. The increase in illness instead seems to be parallel to the increase in prescriptions of psychiatric drugs – which should get politicians to wonder what happened with the tax payers’ money. Most people would shake their heads if they would hear the assessment by leading biological psychiatrists over the percentage of persons in the society being “mentally ill”. As when the internationally known Swedish psychiatrist Goran Isacsson in April 2008 very seriously claimed that research shows that “... the yearly prevalence of psychiatric illness [among citizens] is estimated to be around 30 percentage”. According to Isacsson, almost one third of the population is mentally ill, and, of course, are in need of treatment, meaning psychiatric drugs.

Isacsson is a leading psychiatric consultant to the Swedish medical agencies and is behind many of the recommendations published by these agencies – recommendations which have led to the enormous increase in prescriptions of antidepressants and other psychiatric drugs in the country.

He has also used forensic toxicological screening results for suicides to gain support for his ideas and has published many articles in international medical journals about this. The message has been: Only a tiny percentage of persons committing suicide had antidepressant drugs in their blood at autopsy; there is a large “undertreatment” among those committing suicide; many more persons must be prescribed antidepressants to be protected against suicide.

In the next chapter we shall look on the reality that Isacsson has not told about.

⁹ Whitaker, *Affidavit*, (2007), visited November 30, 2008 <http://psychrights.org/Litigation/WhitakerAffidavit.pdf> (see all links to articles in the document).

¹⁰ Jackson, *Affidavit*, (2008), visited November 30, 2008, <http://psychrights.org/States/Alaska/CaseXX/3AN-08-493PS/JacksonOnNLtoxicity.pdf>

Chapter 3

Autopsy reports about psychiatric drugs and suicide

The Swedish medical agencies and their psychiatric consultants have used old data from forensic toxicological screenings to mislead the public and to heavily increase the use of antidepressants and other psychiatric drugs.

Government agencies have never published yearly national data about the relationship between psychiatric drug treatment and suicide. Politicians and the general public have not gained access to the information about which drugs persons committing suicide had received, or any analysis about what the extensive drug treatment could have meant for the later suicide.

Instead leading agencies like The National Board of Health and Welfare have published false and misleading information from autopsy reports: that there is a state of "undertreatment" that must be handled. In one of the most important new publications one could read ¹¹ :

"Of persons with a diagnosis of depression, who commit suicide, more than 80 percent are not treated at the time of death. Persons with depression are often not treated or are undertreated even after a suicide attempt ... To treat the underlying psychiatric disorder is thus a central component in suicide prevention."

Upon questioning, the agency says that these "facts" stem from an article by psychiatrist Goran Isacson. A closer examination shows that this article was published in the Journal of Affective Disorders – and in 1996 (!) ¹². The agency says that in this article "the yearly number of suicides with depression that took antidepressant drugs is estimated to be 120 of 1000 cases in Sweden (12%) and the yearly number of suicides not taking antidepressant drugs to be 880 of 1000 cases (88%)". It is further claimed that this data are supported by international research. Further the agency claims that "antidepressant drugs protect against depression, that is one of the most important risk factors for suicide" ..."and that suicidal behaviour correlate to inadequate prescription of antidepressant drugs".

The primary reference is once again the internationally known psychiatrist Goran Isacson.

¹¹ The National Board of Health and Welfare, (in Swedish) *Förslag till nationellt program för suicidprevention* (2006), <http://www.socialstyrelsen.se/NR/rdonlyres/430131BA-B8F8-43E6-A743-B59CE21CCDEB/6725/200610723.pdf>

¹² Isacson, *Epidemiological data suggest antidepressants reduce suicide risk among depressives*, Journal of Affective Disorders, 1996.

Facts are, as we have seen in chapter 1, that in the **same year (2006)** when the agency report was published 488 (**39%**) of **ALL** 1255 reported suicide cases had received antidepressants (within 180 days); for the women, 197 (**52%**) of 377 had received antidepressants (within 180 days).

The most important information in this area is the patients' **medical history**, the treatment history. Antidepressants, neuroleptics and other psychiatric drugs cause harmful changes in the brain and these brain dysfunctions *do not* vanish when the drugs are discontinued – in many cases they cause chronic dysfunction to the brain, exemplified by the known neurological harm caused by neuroleptics. Many patients also get *serious* withdrawal reactions; reactions that can be so severe that they can lead to suicide.

Discoveries of psychiatric drugs in forensic toxicological screenings of persons who have committed suicide are therefore of limited value. The fact that one cannot find any traces of psychiatric drugs in blood at autopsy does *not* mean that the earlier treatment was not having a **decisive** role on the later suicide.

The leading psychiatrist Isacsson has since the beginning of the 90's published articles about autopsy reports and antidepressants found in the blood of the persons who committed suicide. The purpose has been to show that the persons were "undertreated" and the conclusions have consistently been: too few persons got antidepressants and many more need the drugs.

In the article in the Journal of Affective Disorders, Isacsson reported that only 12% of those committing suicide were treated with antidepressants at the time of the suicide. Isacsson refers in the article to his other research projects that he says found similar results, that for only 16% of those who committed suicide traces of antidepressants could be found at autopsy ¹³. He further tells that he found that around 15% of those committing suicide had filled a prescription for antidepressants within three months before the suicide – and from this the conclusions about "undertreatment" could be drawn. Isacsson also states that it is "a consistent finding" that about 50% of the patients who commit suicides are depressed. (Compare with data in chapter 1.)

Now it's time to place the research of Isacsson and colleagues in the graveyard of history. If their data ever were correct they are not today and their wild conclusions, which so strongly have contributed to the immense prescription rates of antidepressants today, must no longer be allowed to affect the decision making process of medical agencies.

Today we know (see chapter 1) that 52% percent of the women who committed suicide 2006 received antidepressants within 180 days before the suicide, and that 39% of all (men and women) received the same. This must of course be compared with the figures from Isacsson et al that about 50% of those committing suicide have a depression. From this it can be assumed, even if antidepressants also are

¹³ Isacsson, et al, *Antidepressants, depression and suicide: An analysis of the San Diego Study*. Journal of Affective Disorders, 1994.

prescribed for other problems, that *not too many more than half* of those committing suicide can be candidates for antidepressants – but still 52% of **ALL** women who committed suicide in 2006 had received antidepressants within 180 days.

The National Board of Health and Welfare in Sweden has recently said that no real changes are to be expected for 2007 as to prescription rates and suicides – there is as yet no data available for preceding drug treatment in suicides for 2007 from the Board. As no real changes have occurred for 2007 we shall now ***compare the data in chapter 1, for 2006, with forensic toxicological screening results for suicides from 2007.***

Results from autopsy reports about suicides in Sweden 2007

Almost all suicides in Sweden are subjected to forensic toxicological screening. The autopsies are done in the six regional departments of the National Board of Forensic Medicine.

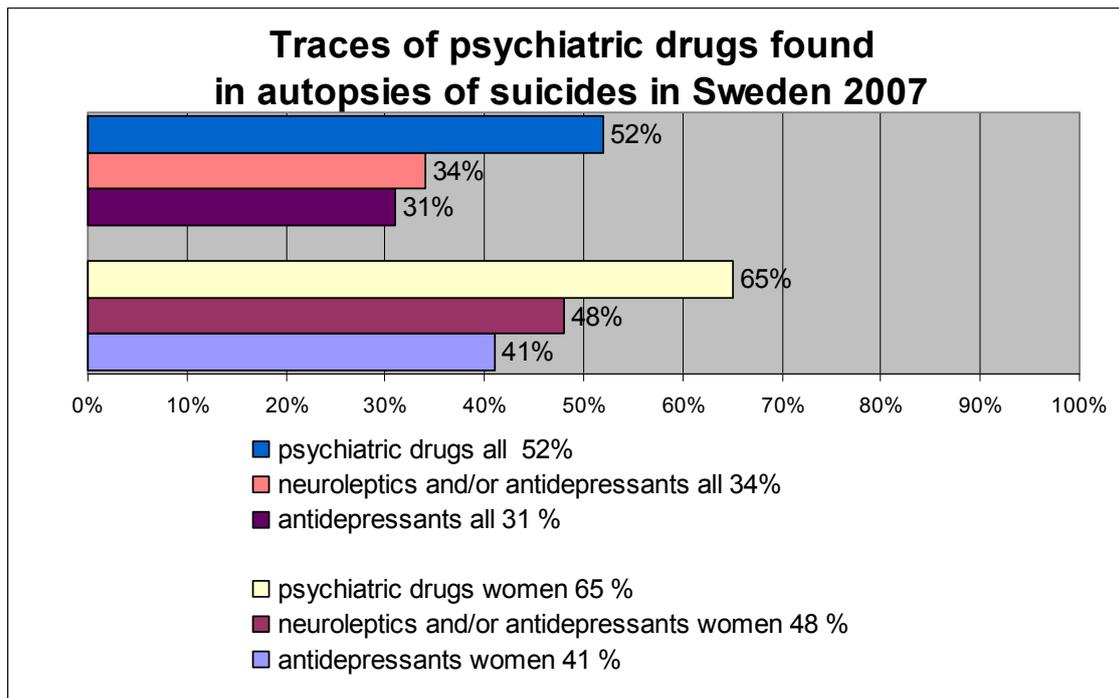
FOIA-requests were sent to the regional offices to get data about the autopsies done for 2007 and the psychiatric drugs found in the blood for the persons who had committed suicide. The data was very helpfully compiled and released by the regional departments.

1109 autopsy reports about suicides were done for 2007.

A review of these ¹⁴ shows that **132 (41%) of the 320 women examined had traces of antidepressants in their blood. 209 (65%) of the women had traces of psychiatric drugs (all categories) in their blood.** An interesting finding is also that 37% of the women had received *newer* antidepressant drugs (SSRI and other newer antidepressants) at the time of suicide.

The autopsy reports show that **31% of all men and women who had committed suicide in 2007 had traces of antidepressants in their blood. In total, traces of psychiatric drugs (all categories) were found in 575 (52%) of these men and women.**

¹⁴ Reservation must be done for smaller miscalculations and misclassifications in the compilation. The author has not had access to the original reports and of course not to the good resources for analysis or the statistical ability available for example for the National Board of Health and Welfare if that agency should have chosen to do a full investigation in the area.



Once again it must be emphasised that traces of psychiatric drugs in blood at autopsy have very limited value *in comparison with the patient's medical history*. As seen in chapter 1, and as we shall see more about in chapter 4, the persons who committed suicide in Sweden in 2006 and 2007 received *extensive earlier "treatment" with psychiatric drugs*. It is *this treatment* and its relation to the suicide which is the real important area.

At the same time, this compilation of the 1109 autopsy reports serve to reject the old data and conclusions presented by psychiatrists, like the earlier mentioned internationally known Goran Isacson – based on forensic toxicological screenings.

We know now that 31% of the persons who committed suicide in 2007 had traces of antidepressants in their blood at autopsy and that for the women it was 41%. The data from Isacson et al about 12% and that more than 80% are "untreated" at the time of death can be excluded from future publications.

We also know that 65% of the women had traces of psychiatric drugs in their blood and that the percentage for all (men and women) was 52%. (How many *more* persons for whom lesser amounts of psychiatric drugs, not traceable in these autopsies, were in their system, we don't know.)

Below is a table concerning what was found in the autopsies of women as regards antidepressants.

Type of antidepressant drug	Number of women
SSRI-drug	
Citalopram (Cipramil)	45
Fluoxetine (Prozac)	16
Paroxetine (Seroxat/Paxil)	2
Sertraline (Zoloft)	16
	In total 79 cases with women who got SSRI-drugs. (In the rare cases where the persons had got more than one SSRI-drug, only one has been counted). In 25% of the 320 women SSRIs was found.
Other modern antidepressants	
Duloxetine (Cymbalta)	2
Mianserine	1 (in 3 cases with another newer antidepressant)
Mirtazapine (Remeron)	17 (in 14 cases with another newer antidepressant, 1 TCA, tricyclic antidepressants)
Reboxetine (Edronax)	1 (in 1 case with another newer antidepressant)
Venlafaxine (Effexor)	19 (in 7 cases with another newer antidepressant)
	In total 40 cases + SSRI = 119/320 (37%)
Tricyclic antidepressants	
Carbamazepine (Tegretol) (included as a relative to these antidepressants)	2 (in 2 cases with an another antidepressant)
Clomipramine (Anafranil)	3 (in 1 case with an another antidepressant)
Amitriptyline (Tryptizol)	8 (in 4 cases with an another antidepressant)
Maprotiline (Ludiomil)	0 (in 1 case with an another antidepressant)
	In total 13 cases + newer antidepressants = 132
	In 132/320 – in 41% – of the women antidepressants were found

Chapter 4

Suicides 2007 reported per Lex Maria – preceding drug treatment

All suicides in Sweden committed in health care and within four weeks after last health care visit should be reported to the National Board of Health and Welfare, for investigation.

According to the publication *Suicides 2006, reported per Lex Maria*¹⁵ (in Swedish), the number of reports of suicides submitted to the National Board of Health and Welfare per the reporting requirements is estimated to be 400 per year. As described in earlier chapters around 1200 suicides are committed in Sweden in a year. Thus about one third of all suicides get reported to the National Board of Health and Welfare, *and it is for this subgroup of suicides that quite comprehensive information exists.*

For this study, data about the cases reported to the six regional offices of the National Board of Health and Welfare for 2007 was requested using the Freedom of Information Act (FOIA). ***Focus was on the psychiatric drug treatment that the persons received within one year of their suicides.*** (Note that the information in this chapter is taken from actual copies of patient journals where sensitive information has been excluded by the regional offices, *but* with full data about prescribed drugs included. In comparison the figures in chapter 1 of this report, for ALL suicides 2006, were from released figures from the registries of the National Board of Health and Welfare.)

In total, according to the data received, **393 cases** were reported to the six regional offices for 2007.

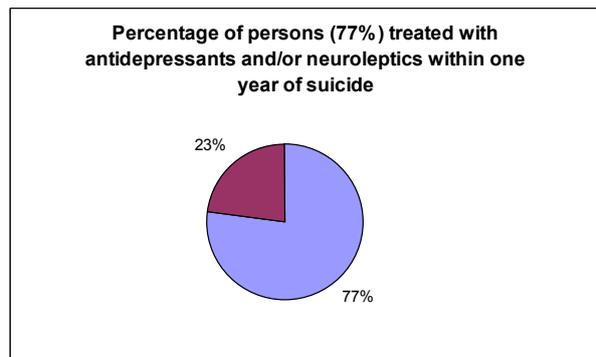
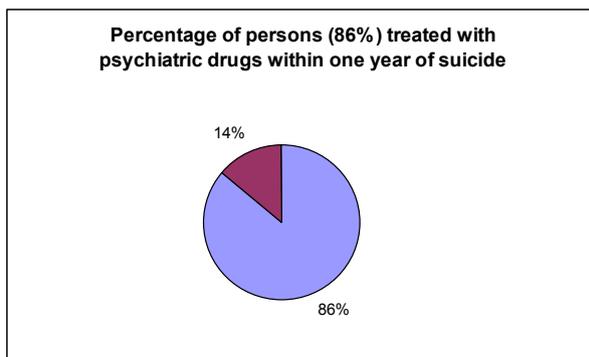
The information in these cases has been analysed with regard to what psychiatric treatment preceded the tragic suicide in each of the cases. Data has been compiled about the *classes* of psychiatric drugs used (neuroleptics, antidepressants, benzodiazepines etc.) and about the *individual* drugs used. For two regional areas, the drugs prescribed at the time of the suicide and those prescribed earlier, within one year of the suicide, have been divided up.

¹⁵ National Board of Health and Welfare, (Swedish) *Självmord 2006 anmalda enligt Lex Maria*, (2007), <http://www.socialstyrelsen.se/Publicerat/2007/9671/2007-109-22.htm>

The analysis of the treatment given shows the following:

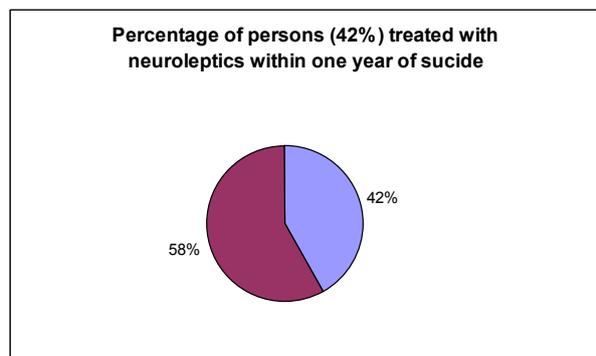
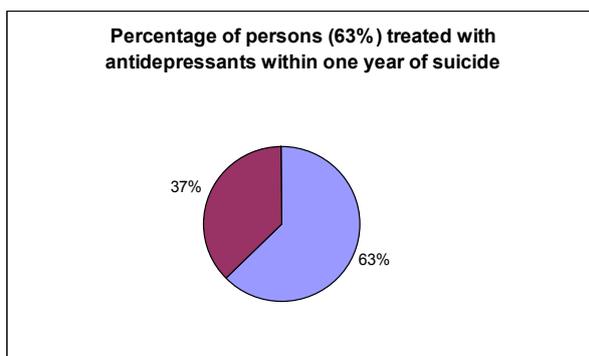
In 338 of the 393 cases – **86% of the cases** – the persons were treated with psychiatric drugs ***within one year of their suicide.***

In 304 cases – **77% of the cases** – the persons were treated with antidepressant drugs *and/or* neuroleptics.

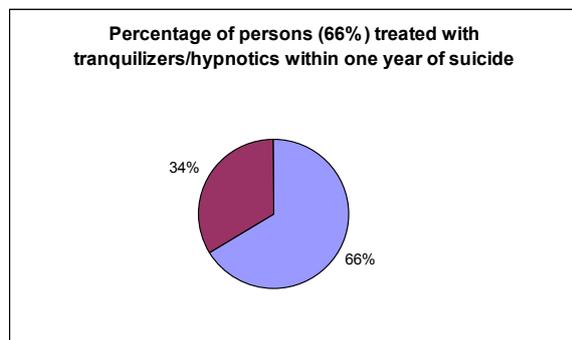


In 246 cases – **63% of the cases** – the persons were treated with antidepressant drugs.

In 164 cases – **42% of the cases** – the persons were treated with 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 and Heminevrine.

The total amount of psychiatric drugs used

What best shows the real situation is *the total amount of psychiatric drugs prescribed* for these persons.

"The amount of treatment" can be expressed in that the 338 persons (of 393) who got psychiatric drugs *on average* got 4 different drugs in the year before the suicide.

From the diagrams above it can be understood that many persons were treated with psychiatric drugs of *different classes* (not only *different tranquilizers* or *different antidepressants*). So, for example, 29% (98 persons) of the 338 persons prescribed psychiatric drugs were treated with neuroleptics *and* antidepressants *and* tranquilizers/hypnotics in the year before the suicide.

This does not mean that when one drug was prescribed another was taken away. On the contrary, in most of the cases the person was treated with many different psychiatric drugs *at the same time*.

Example 1: In the area of one regional office the persons treated with psychiatric drugs were taking (on average) 3.2 different drugs *at the time of their suicide*. 36% were taking 4 drugs or more.

Example 2: In the area of another regional office the persons treated with psychiatric drugs also were taking on average 3.2 different drugs *at the time of their suicide*. 32% were on 4 drugs or more.

Of the 338 persons receiving psychiatric drugs, 39 (12%) were reported to have received electroshocks (ECT) in the year before the suicide – one person had received a series of 12 electroshocks and 15 different psychiatric drugs within a year. These 39 persons had concurrently with the shocks been prescribed on average 5.6 different psychiatric drugs within a year.

Only 37 persons (11%) of the 338 had taken only 1 psychiatric drug during the year before the suicide.

The facts are obvious: The men and women in this group, in an overwhelming high degree, had committed suicide after having been “treated” with large amounts of psychiatric drugs in the year before and at the time of their suicide.

Chapter 5

“Adequate medication” and clinical trials

The persons described in the last chapter received “adequate treatment” – in the meaning used in psychiatry. The pharmaceutical companies’ unpublished clinical trials do however show the fact that the drugs increase the risk of suicidal behaviour.

The persons described in the chapter got:

- *the new antidepressant drugs* (Cymbalta 23 persons, Effexor 41, Zoloft/Sertralin 49, Cipralex 33),
- *the new forms of neuroleptics* (Risperdal 31, Zyprexa 52,)
- *the new hypnotics, similar to benzodiazepines* (Zopiclone/Imovane 128, Stilnoct [Ambien] 53),
- *the new “mood stabilizers”* (Lamictal 21, Lyrica 19).

See diagram and tables of the details, in the appendix, page 23.

And the persons who got this treatment were given on average 4 different psychiatric drugs in the year before their suicide.

There are – if one wants to *understand* the results presented in the earlier chapters – better sources of information than advertisement from the pharmaceutical companies and articles from the biological psychiatrists who have built their careers on promoting the message wanted by the industry.

Better sources of information are the *unpublished* clinical trials of psychiatric drugs done by pharmaceutical companies, and the important studies done by independent researchers.

A number of these studies show that antidepressants and neuroleptics *increase the risk of suicidal behaviour and directly cause effects that lead to suicide.*

Some of the articles in which these results are described – articles that give *lots* of references for persons wanting to know more – are: Healy, *Antidepressants and Violence: Problems at the Interface of Medicine and Law*, (2006) ¹⁷; Breggin, *Suicidality, violence and mania caused by selective serotonin reuptake inhibitors, (SSRIs): A review and analysis*, (2004) ¹⁸; Whitaker, *Affidavit* (A formal sworn statement of facts) about neuroleptics (2007) ¹⁹.

¹⁷ Healy, *Antidepressants and Violence: Problems at the Interface of Medicine and Law*, PloS Medicine (2006), visited 24 July 2008, <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0030372>

¹⁸ Breggin, *Suicidality, violence and mania caused by selective serotonin reuptake inhibitors, (SSRIs): A review and analysis*, International Journal of Risk & Safety in Medicine 16 (2003/2004) 31–49, visited 24 July 2008, <http://www.breggin.com/31-49.pdf>

¹⁹ Whitaker, *Affidavit* (A formal sworn statement of facts) about neuroleptics, (2007), visited November 30, 2008, <http://psychrights.org/Litigation/WhitakerAffidavit.pdf>

One of the phenomena described in the articles above is the *extreme inner restlessness*, which can be *caused* by neuroleptics and antidepressant drugs. The affected persons cannot sit still, feel compelled to move about, feel tortured from within. The condition is called akathisia (from Greek *a* [not] and *káthisis* [sitting]) and is caused by the drugs (not by any form of “underlying disease”).

That the phenomenon doesn't have anything to do with the person's mental problems – but is exclusively caused by the drugs – has been shown in studies where healthy subjects have taken the drugs and then been subjected to these effects. Akathisia is a condition that is known to drive persons to suicide (and to violent acts against others).

And the condition is also described in the official product information for neuroleptics, where it is even said to be *common* (occurring in 1-10% of the cases who get the drugs; see for example the text for Zyprexa ²⁰). Akathisia is also created by antidepressant drugs, which report the additional *common* harmful effect of *agitation*, (for example, see the text for Cymbalta ²¹). Akathisia and agitation are part of a spectrum of adverse effects of antidepressant drugs, starting with insomnia, nervousness and irritation, then progressing towards more serious effects like agitation, aggression, akathisia and mania ⁵.

In the articles above, the harmful effects of antidepressants and neuroleptics become visible. The ways in which these drugs contribute to or directly cause phenomena leading to suicide are also well described.

The long known harmful effects of tranquilizers and hypnotics (benzodiazepines) – including risk for suicide – are taken up in *Brain-Disabling Effects of Benzodiazepines* (1997) ²².

In the cases of suicide for 2007 reported to the National Board of Health and Welfare in Sweden, the persons received on average 4 psychiatric drugs in the last year. The persons had in lesser or greater degree been subjected to poisonous effects.

But if the effects described above are the “contributions” psychiatric drugs can have for the subsequent suicides – how are these effects reported to the registry for adverse effects in Sweden (called SWEDIS), at the Medical Products Agency (MPA) [comparable to MedWatch in the US and the Yellow Card Scheme in UK]? And how has the National Board of Health and Welfare considered these effects in its investigations about the suicides?

²⁰ Medicines Compendium, UK, Zyprexa, visited 24 July 2008, <http://emc.medicines.org.uk/emc/assets/c/html/DisplayDoc.asp?DocumentID=614>

²¹ Medicines Compendium, UK, Cymbalta, visited 2 August 2008, <http://emc.medicines.org.uk/emc/assets/c/html/DisplayDoc.asp?DocumentID=15694>

²² Breggin, *Brain-Disabling Effects of Benzodiazepines* (1997), from the book *Brain-Disabling Treatments in Psychiatry*, (Second edition 2008) visited 24 July 2008, <http://www.benzo.org.uk/breggin.htm>

Chapter 6

The breakdown of the reporting system

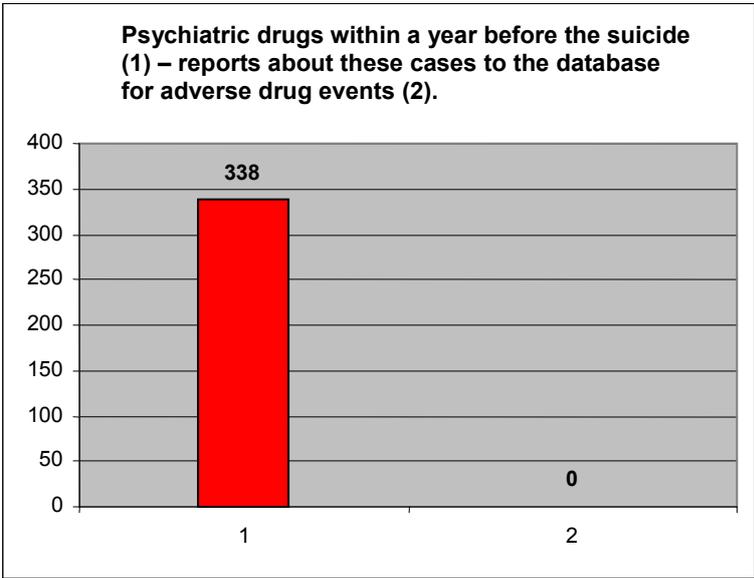
In 86% of the cases of suicide reported to the National Board of Health and Welfare for 2007 (chapter 4) – that is in 338 of 393 cases – the persons were treated with psychiatric drugs. In 0% (!) of these cases was the matter reported as a drug adverse event to the registry for drug adverse events at the Medical Products Agency (MPA).

Not in a single one of all these cases of suicide did the responsible doctor (in most cases psychiatrists) consider that the tragic result could have been caused by the psychiatric drug or that the drug was a suspected contributory factor for the fatal result.

Not a single adverse event report was submitted about the 338 persons who committed suicide after having been prescribed psychiatric drugs!

If anything should be held up as evidence for the complete breakdown of the adverse event reporting system, it must be this. If not even *fatal results* in the form of suicides following extensive treatment with psychiatric drugs are reported to the registry for adverse drug events, how should it then be with all other harmful effects patients are subjected to?

Doctors are to report all suspected serious drug effects to the Medical Products Agency. This reporting requirement must also reasonably be extended to the physicians at the National Board of Health and Welfare investigating the reported cases of suicide. But none of these doctors has considered that the extensive treatment with psychiatric drugs could have caused or strongly contributed to the fatal result. None of them has submitted an adverse event report.



Epilogue

Considering the results presented in this report, it is no longer possible to say that "more" of the same sort is the solution to the problem. It's not "more psychiatry" – more psychiatric drugs – that is the solution.

Politicians, trying to surpass each other in demanding more funds for a psychiatric industry that only means more "treatment" with psychiatric drugs, should know that they directly contribute to harming people and to the creation of more "results" of the sort presented in this report.

Subservient nodding and voting when psychiatric opinion leaders require changes in law, so that people can be drugged with force in their homes, and so that "drug treatment without exceptions" can be given for people with mental problems, only lead to an increase in the psychiatric results described earlier.

This report clearly shows one thing: A large majority of persons committed suicide after having had "adequate drug treatment" – in the meaning used in psychiatry; the very treatment that should *prevent* suicide.

There is no reason to believe that the reporting system for adverse drug effects work better in other countries. The catastrophic state of these "surveillance systems" makes it possible to keep destructive drugs on the market year after year. All it takes is for pharmaceutical companies to show that many persons have been exposed to these drugs, and that almost no adverse event reports have been submitted; so the drugs must be "safe and effective".

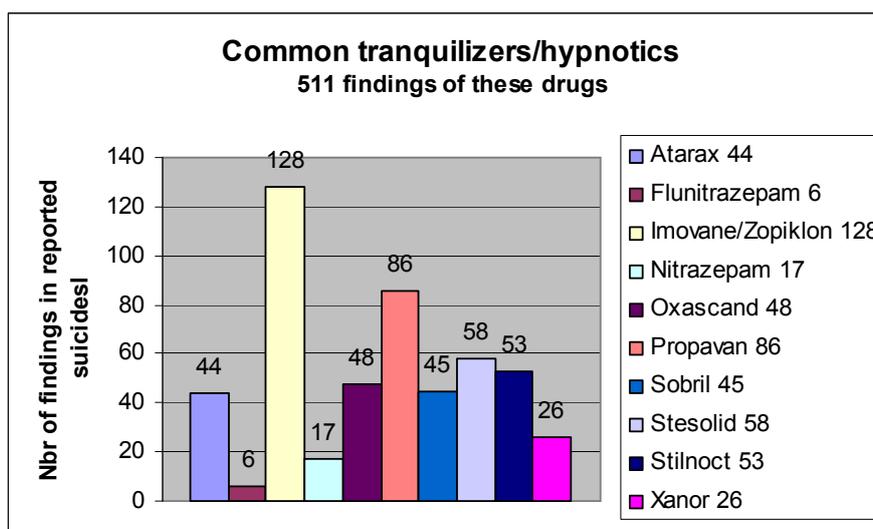
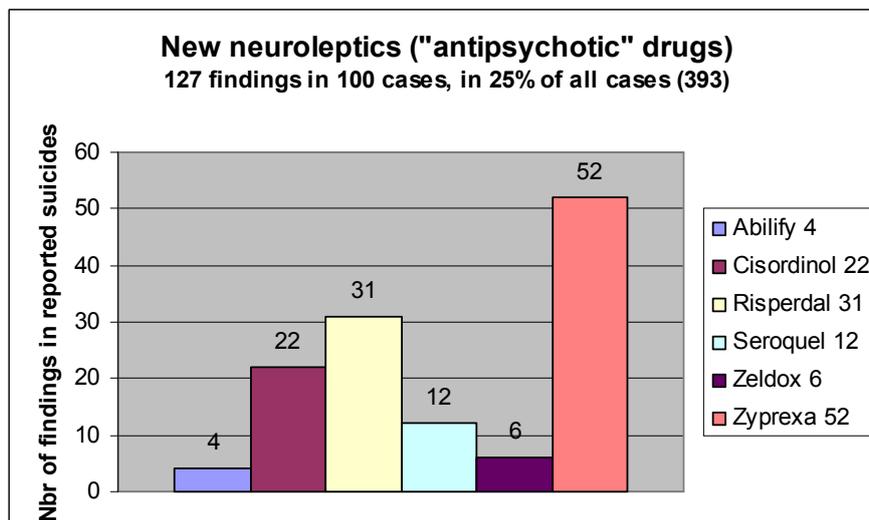
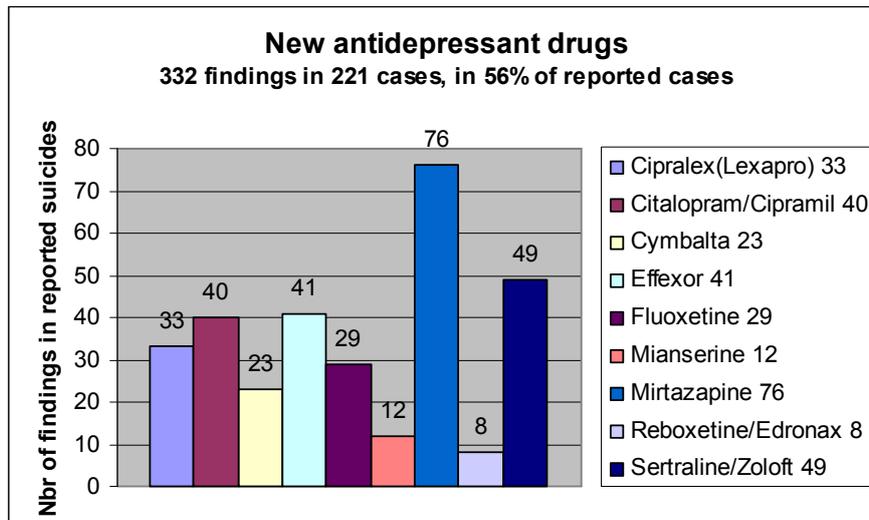
This example from Sweden shows that in 338 cases persons committed suicide after having been prescribed psychiatric drugs – and **none** of these cases were reported to the registry for adverse drug events. Instead of Eli Lilly claiming that the drug Zyprexa was involved in 0 cases of suicide in Sweden 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, the fact was that the drug was involved in 41 cases in this group.

The reporting system must be completely reformed right away. It must be made mandatory for health care professionals to directly report all suspected serious adverse drug effects, and persons not reporting must be disciplined. Patients must be fully informed about the actual harmful effects of the drugs and given the right to report these effects to the adverse events registry, with the promise of effective follow-up. The reformed system must not give room for the now ruling psychiatric concealment ideology, where obvious harmful effects of psychiatric drugs are treated as "symptoms" requiring more drugs. Instead *all* these effects must be reported as suspected harmful effects by the drugs.

And, most importantly, the data presented in this report must lead to *basic changes* in the ways in which persons with mental problems are being cared for.

Appendix

The 393 cases reported to the National Board of Health and Welfare for 2007 (see chapter 4-6) got among other psychiatric drugs, the following:



To exemplify the treatment this is an excerpt from *some* of the reported suicides from one regional office of the National Board of Health and Welfare – a compilation of the psychiatric drugs given some of the persons in the area *within one year before the suicide*:

Neuroleptics (as Risperdal, Zyprexa, Haldol) Antidepressants (as Prozac, Cipralex, Mirtazapine) Tranquilizers/Hypnotics (as Imovane, Sobril, Xanax) Other forms of psychiatric drugs (as Subutex, Concerta, Heminevrine)			
Fluoxetine, Propavan, Stesolid,	Citalopram, Theralene , Stilnoct,	Zyprexa, Lithionit, Zopiklon, Propavan, Zoloft, Oxascand,	Propavan, Risperdal Zoloft,
Mirtazapine, Zopiklon,	Xanor, Fontex, Stilnoct, Theralene , Stesolid,	Anafranil, Nozinan, Propavan, Theralene , Stesolid, Fluoxetine, Cymbalta,	Zoloft
Zopiklon, Mianserin	Remeron, Oxascand, Propavan, Effexor	Cymbalta, Zopiklon, Stesolid, Nozinan,	Mirtazapine, Atarax, Theralene , Propavan Zyprexa, Cymbalta
Oxascand, Zyprexa, Cymbalta,	Stilnoct, Propavan, Lergigan,	Zyprexa, Zopiklon, Cisordinol,	Zyprexa, Abilify
Citalopram	Mirtazapine	Heminevrin, Stilnoct, Propavan, Mirtazapine	Effexor, Theralene , Propavan, Oxascand, Citalopram, Lyrica
Zyprexa, Citalopram, Sobril,	Effexor, Citalopram, Lithionit, Stilnoct, Lamictal,	Nozinan, Theralene , Hermolepsin, Heminevrin, Sertralin, Carbamazepin, Stilnoct, Oxascand	Fluoxetine
Seroquel, Cipralex, Remeron, Haldol, Cipralex, Zeldox, Oxascand, Mirtazepin,	Lyrica, Sobril, Remeron, Lamotrigin, Zyprexa, Lamictal, Stilnoct, Propavan, Atarax, Klomipramin	Tryptizol, Stesolid, Nitrazepam, Seroquel, Sertralin Propavan, Imovane, Sobril, Antabus, Effexor, Mirtazapine,	Seroquel, Fluoxetine, Risperdal
Zopiklon, Oxascand	Theralene , Zopiklon, Zyprexa, Sobril,	Zopiklon, Atarax, Theralene , Mirtazapine, Sertralin, Ergenyl,	Zopiklon, Cymbalta, Mirtazapine, Propavan, Xanor, Sertralin, Oxascand,