

## Antidepressants behind 52 percent of all suicides among women

Incredible data have just been revealed that antidepressant drugs were behind 52 percent of all suicides among women (18-84) in Sweden (2006).

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This is not data from a limited study; it instead concerns information on a national level for ALL suicides (18-84 years) for 2006. The information is unique; registries now exist in Sweden making it possible for the National Board of Health and Welfare to see how many of the suicides were preceded by psychiatric drug treatment.

Among a total number of 377 women who committed suicide, 197 (52%) had filled a prescription for antidepressants within 180 days before their death. And 29 women (8%) had filled a prescription for neuroleptics ("antipsychotics") ONLY within 180 days before the suicide.

This means that 229 women - 60% - of those who committed suicide (18-84) in Sweden (2006) had filled a prescription for antidepressant drugs OR neuroleptics within 180 days before their suicide.

Neuroleptics were involved in total in 97 (26%) of the suicides among women, (68 women, 18%, got BOTH antidepressants and neuroleptics). NOT included in these figures is the percentage of women who got other forms of psychiatric drugs, like benzodiazepines.

The data are revealed just after the news broke that pharmaceutical companies have systematically hidden negative and exaggerated positive results in their clinical trials of antidepressants (see article Antidepressant Studies Unpublished in [NYT](#)), thus misleading patients and doctors for many years.

In general, pharmaceutical companies have used a "blackmail strategy" to get doctors and sad patients to believe that they MUST use the drugs - or else. In ads with pictures of gravestones they have proclaimed: "A depression can end unexpectedly fast" (Wyeth for Effexor.) Leading psychiatrists with financial interests in increased sales have been writing endlessly in medical journals about the "protective effect" of antidepressants against suicide. Shamelessly false statements that the psychiatric drugs correct a chemical imbalance (like a lack of serotonin) in the brain are still part of the official drug labels: "In depression the normal access to these [chemical] substances is lowered. Antidepressants can restore the deficits [of chemical substances] and give a normal function of the brain" (label for Remeron; Organon/Schering-Plough). "These medications help restore the normal levels of serotonin in the brain" (Cipramil/Celexa; Lundbeck/ Forest Laboratories).

But the new data from Sweden tell the real story: Antidepressants do NOT have a positive effect in preventing suicides - they were part of 52 percent of all cases of suicide among women (18-84) for the year 2006; they did obviously not correct any form of "chemical imbalance" in the brain for those women.

An earlier investigation 2007 of documents, gotten via FOI requests, gave information about suicides (2006) committed IN health care and UP TO four weeks after last health care visit. The information was made available when a new law was enacted making it mandatory to report all such suicides to the National Board of Health and Welfare. 367 suicides were reported per this law for 2006: More than 80 percent of the persons who committed suicide were "treated" with psychiatric drugs; in well over 50 percent of the cases the persons got antidepressants, in more than 60 neuroleptics or antidepressants.

Senior officials at the Board were not interested in revealing anything more about this. They had adopted the marketing lines of pharmaceutical companies and relied on evaluations from well-known Swedish SSRI-proponents, (like psychiatrists G. Isacson and A.L. von Knorring)

who for more than a decade have touted the new antidepressants as “life saving”. A senior official even said that “evidence based treatment of the underlying psychiatric disorder can reduce the risk for suicide”, referring to the “protective effect” that he believed antidepressant drugs had. The data about the large percentage of persons who had committed suicide, after having been “treated” with psychiatric drugs, were brushed aside by the official, saying the data “cannot currently be seen as a representative source for a discussion about these questions” (!). When the agency published its first analysis of cases from 2006, reported per the new law, there was not a single word written about the most compelling fact: Well over 80 percent of the persons who killed themselves were treated with psychiatric drugs.

A lot of requests have been made to get the Board to publish ALL data about suicides and preceding psychiatric drug treatment. They have been turned down. Decisions have been taken at the very top of the Board not to let the public know.

But now data have leaked out about ALL suicides (18-84) for 2006. For women the results are as above.

For men the figures for 2006 are as follows: Among a total of 878 men (18-84) who had committed suicide, 291 (33%) had filled a prescription for antidepressants within 180 days before their death. And 41 men (5%) had filled a prescription for neuroleptics (“antipsychotics”) ONLY within 180 days before the suicide.

This means that 332 men - 38% - of those who committed suicide (18-84) in Sweden (2006) had filled a prescription for antidepressant drugs OR neuroleptics within 180 days before their suicide.

Neuroleptics were involved in total in 119 (14%) of the suicides among men, (78 men, 9%, got BOTH antidepressants and neuroleptics). NOT included in these figures is the percentage of men who got other forms of psychiatric drugs.

Thus it can be said that 561 (45%) of ALL 1255 persons (18-84) who committed suicide in Sweden 2006 had filled a prescription for antidepressant drugs OR neuroleptics (not at all counting other psychiatric drugs) within 180 days before their suicide.

A certain number of the persons killing themselves can be expected to be suffering from drug induced akathisia – an extreme inner restlessness, a feeling of having to creep out of ones skin, a completely unbearable condition. It is CAUSED by the psychiatric drugs, not by any “underlying disease”. Akathisia is a condition that can make a person commit violent acts – against self or others. It is a condition officially recognized and taken up in the warning texts for the drugs. A number of the persons can also be expected to be affected by mania or hypomania – again CAUSED by the drugs; conditions also officially recognized; conditions that can lead to suicide.

Some of the valid questions in an objective investigation of suicides, where psychiatric drugs preceded the tragic event, would be: Was the suicide an effect of an unbearable condition created by the drugs (like akathisia)? Had the drug dose been increased – with a catastrophic result – when the worsened condition in actual fact was caused by the drug (while being blamed on the “underlying disease”)? Had the patient been subject to an abrupt discontinuation (with severe withdrawal symptoms as the result)? Was the catastrophic result very likely caused by concomitant use of psychiatric drugs? Had the patient been informed about all the serious harmful effects that these drugs can cause?

None of these questions are part of the form used when investigation suicides, worked out by senior officials at the National Board of Health and Welfare. These questions would – if asked and the answers used – save lives. But they would also threaten the profits of pharmaceutical companies and the careers of their hired psychiatrists. Therefore they cannot be asked.

The Swedish government has been notified about the concealment of data at the National Board of Health and Welfare (the hiding of data and neglect of analysis of drug induced harmful effects is decided at the very top; despite lower officials at the Board wanting to do a good job and let the public know the real story). The Minister for Elderly Care and Public Health (Maria Larsson) has not at all acted to make the hidden data known to the public. The Minister for Health and Social Affairs (Göran Hägglund) has been asked in parliament, the Riksdag, to start a formal investigation into the violence inducing effect (against self and others) of different psychiatric drugs, but his answer shows – at best – that he is living far from the real world. This is his view about the effectiveness of medical agencies, the adverse event reporting system and the speed of actions taken to protect the public: “If new data somewhere in the world indicate that a medical drug in use can have up to now unknown harmful effects, an alarm goes out that reaches responsible authorities over the world. The Medical Products Agency [the Swedish medical agency] fast conveys the information to prescribers and to pharmacies in Sweden.” (Answer in Swedish parliament, the Riksdag, December 2007.)

Well, now “an alarm” goes out, that data buried in the registries at the National Board of Health and Welfare – very close to the Minister – show that psychiatric drugs are behind an incredible amount of suicides. Will doctors and patients be told about it? And what consequences will it have for the “treatment guidelines”?

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(Very much is NOT KNOWN about the psychiatric treatment preceding the suicides above. For example the use of other psychiatric drugs or ECT in these cases are still completely concealed. The National Board of Health and Welfare has not published any documents about this.

Some persons might want to verify some of the figures above. They can actually do so in a newly published English article. The astonishing data above are made part of a published letter about “ethnic differences in antidepressant treatment”. This subject is of course of relative disinterest – especially as no differences were found – compared to the facts revealed that 52% of all women who committed suicide had gotten antidepressant drugs and 26% had gotten neuroleptics. See article: 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  
<http://ps.psychiatryonline.org/cgi/content/full/59/1/116-a> )

Janne Larsson  
reporter – investigating psychiatry  
Sweden