

Chemical imbalance

Do SSRI antidepressants lead to an increase in violent behaviour?

They are the kind of killings that would chill even a crime writer's blood. Not motivated by money or social gain, not spurred by revenge, jealousy, or long-repressed rage, these bizarre and brutal slayings are committed by seemingly average people against strangers, intimates, and themselves. Almost all are unprovoked. Many appear to come out of nowhere. They range from school shootings such as Columbine to incidents of parents drowning, suffocating, or shooting their children, and children stabbing, burning, or shooting their parents, grandparents, and siblings. They include suicides so unexpected that loved ones are stunned with disbelief.

Yet if some drug-awareness advocates, psychopharmacologists, psychiatrists, lawyers, judges, and juries are right, many are not random killings. The perpetrators have one thing in common: they took or were withdrawing from a class of antidepressant drugs known as selective serotonin reuptake inhibitors, or SSRIs. The public knows these drugs by their brand names: Prozac, Paxil, Zoloft, Celexa, and Luvox. The new antidepressants Effexor and Remeron, although not technically SSRIs, are close relatives.

In some ways, Canadians are very familiar with SSRIs. Though it's impossible to know exactly how many men, women, and children are taking them, we do know they are among the most frequently prescribed drugs in the world. According to pharmaceutical-information company IMS Health Canada, depression is the number two medical diagnosis in Canada. Almost 80 percent of patient visits to a doctor for depression results in a prescription, almost always for an SSRI.

Introduced as shiny new wonder drugs in 1987 (Prozac), SSRIs have recently lost much of their lustre. (The story of how some pharmaceutical companies manipulate data, refuse to publish negative research, and underplay negative results is too long to tell here. Suffice it to say that secrecy is part of the drug-approval process. Companies are not required to publish study results even if the majority of those studies reveal that the drug hurts more than helps.) Over the past three years, studies have shown that these drugs are little or no better at treating depression in children and adolescents than placebos. What's more, health regulatory agencies around the world have regularly increased their warnings about harmful side effects for both children and adults. Severe side effects are most likely during three phases: during the first few weeks of treatment; when the dose is increased or decreased; when the drug is stopped. Although the worst side effects are rare—say, one in 1,000 people—what happens when 30 million people take the drug?

About three years ago, Health Canada and the U.S. Food and Drug Administration warned the public about the increased risk for children and adolescents of suicidal thoughts and behaviour associated with all SSRIs except Prozac. Last year, that warning was extended to include adults. These risks, especially for children and adolescents, have received considerable media and medical attention. Less known and arguably more serious, however, is the link between SSRIs and violence toward others. Yet the FDA forced drug companies to put labels on all antidepressants stating that “anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia [inner turmoil so fierce it can lead to suicide], hypomania and mania” have been reported in adults and children taking these drugs. Health Canada went even further, warning in a May 2004 advisory of “severe agitation-type adverse events coupled with self-harm or harm to others” in both children and adults. (On December 5, though, the FDA announced—ahead of a December 13 meeting of medical experts convened to consider updating the warning label—that recent extensive surveys seem to show that the risk of suicidal thoughts in older adults using antidepressants actually declines.)

Health Canada media-relations officer Paul Duchesne says the original warning is based on reports the agency has received about people suffering serious side effects while on SSRIs. On Medeffect, the Health Canada adverse-reaction database, the effects listed range from “psychotic reactions” to “feeling strange” to “aggressiveness”.

“It’s because we’ve seen some reports and we need to advise Canadians,” Duchesne says in a phone interview from Ottawa.

Sara Bostock is a California drug-awareness advocate who believes that SSRIs play a key role in a wide range of violent acts. She’s not alone. Her belief is shared by an increasing number of psychiatric investigators and medical experts. But Bostock’s interest is personal. On Tuesday, January 15, 2002, she woke to faint but disturbing sounds. In the kitchen, not 12 metres from where she had slept, lay her 25-year-old daughter, Cecily. She had stabbed herself in the chest, twice, with a chef’s knife, making only a slight yelp and a thump when her body hit the floor. Suicide by stabbing is extremely rare, especially for women. Cecily, a talented designer and a graduate of Stanford University, had a boyfriend and scores of friends. Recently, however, her life had become stressful. She was having episodes of anxiety, racing thoughts, and insomnia. She took Paxil for two-and-a-half weeks before she died.

In a phone interview, Bostock describes her daughter’s suicide as “bizarre and unexpected”, even though she had been having problems about six months before her death.

“I feel that the possibility exists she was walking in her sleep—she didn’t turn on any lights—or she was in some dissociative state, because it was so unlike her...it just wasn’t consistent with anything in her character,” Bostock says from her home in Atherton, California.

“The weekend before she died she was almost zombielike, really very pale, could hardly talk; she had a look of terror on her face.”

Cecily’s suicide galvanized Bostock to find out everything she could about the neurological effects of these drugs. She immersed herself in research, enrolled in a neuroscience course at Stanford, and became a lightning rod for families who have lost loved ones on SSRIs. In 2004, Bostock testified before the FDA along with about 50 other people who had lost family or friends because of what they felt were SSRI-related side effects.

What she learned about how SSRIs are studied, approved, and prescribed was shocking, she says. She discovered that drug trials that do not produce favourable results do not have to be published or submitted as part of the drug-approval process. In Paxil’s case, she learned of unpublished evidence indicating those taking the drug had at least twice as much risk of suicidal thinking and behavior as those on a placebo.

Last spring, Bostock and others started up an on-line index of media stories, mainly criminal in nature, in which antidepressants were involved in some way (www.ssrstories.com/). Advocates argue that if medications play a significant role in these tragedies, widespread SSRI use is a public-health problem of epidemic proportions. The more than 1,100 incidents include 17 school shootings, 37 road-rage tragedies, and more than 100 murder-suicides. Here’s a sampling of the headlines: 12-Year-Old Kills His Grandparents (South Carolina, November 28, 2001); Mother Puts 14-Month-Old Daughter in Oven (Alabama, October 13, 2001); Psychologist Kills Wife, 2 Daughters and Attempts to Kill Self (Quebec, October 14, 2006); and 74-Year-Old Man Strangles Wife of 50 Years (Australia, August 1, 1999).

Could these tragedies be cases of medication-induced madness? Is the “age of Prozac” also the “age of going postal”? The dominant medical establishment dismisses these incidents as anecdotes, thereby relegating them to the scientific dustbin. But for some in the psychiatric field, they may be the blood-and-guts version of evidence found in clinical reports, controlled drug trials, and epidemiological studies.

American psychiatrist and psychopharmacologist Peter Breggin has been warning about the risks of antidepressant-induced suicide and violence for 15 years. His background includes a teaching fellowship at Harvard Medical School, a two-year appointment to the National Institute of Mental Health, and a faculty appointment to the Johns Hopkins University department of counselling. Many of his ideas were initially considered extreme but have been vindicated in the past two years.

“These drugs don’t cure depression—and they frequently cause or worsen it,” he writes on his Web site. “Regarding the most dreadful risk of depression, suicide, so-called antidepressants put depressed people of all ages at much greater risk of killing themselves.”

Also critical is Irish psychopharmacologist David Healy, a leading global scholar on antidepressant drugs and a professor at the Cardiff University college of medicine, Wales. Six years ago, Healy was offered a prestigious position at the University of Toronto that was retracted shortly after he gave a talk wherein he commented that Prozac and other SSRIs can lead to suicide. At the time, Eli Lilly, the maker of Prozac, was a major contributor to the University of Toronto.

In September, the medical journal *Public Library of Science Medicine* published a paper titled “Antidepressants and Violence: Problems at the Interface of Medicine and Law” by Healy and his colleagues. In it, they review a range of studies on three antidepressants (Paxil, Prozac, Zoloft) and conclude that data “point to possible links between these drugs and violent behaviours”. They also discuss nine court cases involving antidepressants and violence, six of which determined that the drug involved was either fully or partially responsible. Their main point, however, is that crucial information on this topic exists but is kept under wraps because pharmaceutical companies are not obligated to reveal it.

Society is “likely to continue to be faced with cases of violence associated with the use of psychotropic drugs, and it may fall to the courts to demand access to currently unavailable data. The problem,” the paper continues, “calls for an international response.”

You don’t have to look across the Atlantic or across the border, however, to find an in-house critic of SSRIs. Vancouver psychiatrist Jane Garland is head of the Mood and Anxiety-Disorder Clinic at B.C. Children’s Hospital and a UBC clinical professor. In a 2004 *Canadian Medical Association Journal* paper titled “Facing the Evidence: Antidepressant Treatment in Children and Adolescents”, Garland deplored ignorance about the true nature of SSRIs among both the public and the medical profession.

“The high placebo response of SSRIs may reinforce physician prescribing, and it has been difficult for many physicians to accept that SSRIs may be ineffective,” she wrote. “A complicating factor is that the public at large has now accepted the model of depression as a chemical imbalance for which medication is the treatment of choice, and physicians may experience pressure to prescribe. The disappointing reality is that antidepressant medications have minimal to no effectiveness in childhood depression beyond a placebo effect.”

Garland went on to conclude that “our efforts to establish a scientific basis for treating childhood depression are severely compromised by both unpublished research and the uncritical acceptance of published data.”

No doubt increased awareness of SSRIs’ suicide risk has resulted in fewer prescriptions for children and adolescents in Canada. American researchers recently reported that prescription rates have fallen by about 10 percent since the FDA warnings. Still, millions of children and adults continue to swallow these pills, unaware of their potential side effects and believing them to be their best bet against depression—and this at a time

when remedies such as exercise and talk therapy are largely ignored. Worse is that it happens as vital information about how SSRIs affect human behaviour is kept behind closed doors.
