

Young women, antidepressants and suicide

A report on the situation in Sweden 2013



Janne Larsson

We have read in the media that “psychiatric disorders” and the number of suicides are increasing among young women (15-24).

This increase is in Sweden parallel with a heavy increase in the prescription of antidepressants and other psychiatric drugs to young women.

The Swedish government invested 3.6 billion Swedish kronor (550 million USD) 2007-2011 for special projects in psychiatry¹. Part of this was a “Vision Zero” policy for suicide², and a target to reduce the rate of suicide during ongoing care contact by 30%. The money were intended to “provide persons with mental illnesses access to good, expert care and rehabilitation”. But the suicides were not reduced. In the media the project was correctly described as a big failure.

This report shows that the biggest failure was for young women (15-24). For this group the number of suicides even increased up to 2013.

We could say that if there was anything the government project “succeeded” with, it was to bring about an even sharper rise in the prescription of antidepressants and other psychiatric drugs to young women. The better “access to treatment” seems to have meant only more psychiatric drugs for these women.

The increased prescription of antidepressants occurred despite the warnings issued in 2007 about increased risk of suicidal behaviour in young adults ages 18-24 who take antidepressants³.

We will in this report see that the prescription of antidepressants to young women has never been higher than in 2013—and that the number of suicides has increased.

In a later, longer report the relationship between the increase in suicide and the prescription of antidepressants for young women during the last fifteen years, will be examined.

Janne Larsson

Reporter/Researcher

janne.olov.larsson@telia.com

Antidepressants and other psychiatric drugs to young women in 2013

In 2013, 48 young women (15-24) committed suicide in Sweden⁴. This was the second highest number in the last fifteen years.

At the same time the prescriptions of antidepressants to young women reached a level never previously seen.

In 2013, 36,141 young women (15-24) got antidepressants—6% of all women in the age group⁵.

The prescriptions of antidepressants for young women (15-24) was 14 DDD/TIND (Defined daily doses per thousand inhabitants per day) in 1999. This meant that 1.4% of all women in the age group potentially could be treated with antidepressants every day in the year. In 2013, the equivalent prescriptions were 52 DDD/TIND—an increase of 270% (see Figure 1). No other age group has had a similar increase in this time period.

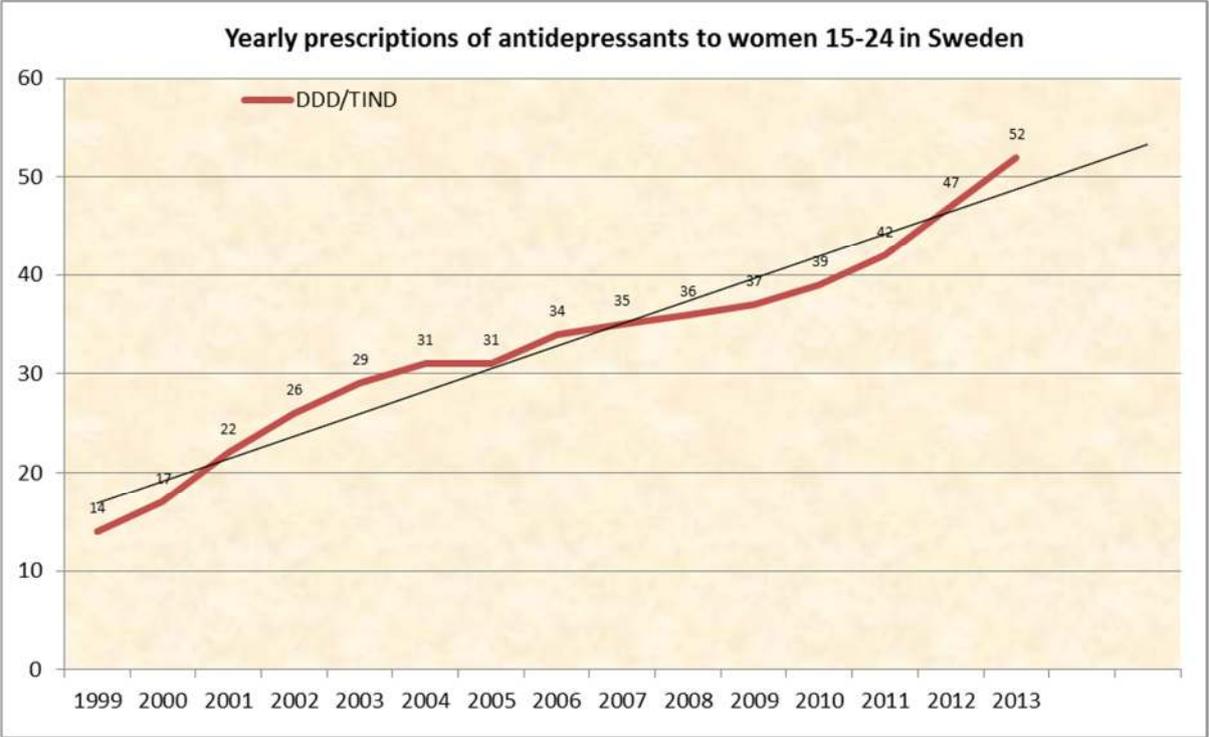


Figure 1. Prescriptions of antidepressants to women 15-24 years in Sweden for the years 1999-2013, counted in DDD/TIND.

In the Register on Prescribed pharmaceuticals in Sweden we can also see that the prescriptions of *other* psychotropic drugs have risen sharply the last years.

So for example, the number of young women who received antipsychotics, sedatives and hypnotics, has since 2006 increased from 19,567 (3.6%) to 33,328 (5.6%)—an increase of 56%.

“Access” to psychiatric care—in the meaning amount of psychiatric drugs prescribed—has never been higher for young women than in 2013.

But of the “active patient safety work”, which was supposed to be linked to the prescriptions, we cannot find anything at all: No adverse event reports have been submitted about suicide among young women in 2013⁶, although, as we will see in the next part, a very high proportion of the women had psychotropic drugs in the blood at the time they committed suicide.

This means that not a single one of these cases will be investigated by the Medical Products Agency (MPA). In the statistics of the MPA there will not be a single case in 2013, in which antidepressants or other psychotropic drugs were described as connected to suicides for women in this age group.

We will in the next part take a closer look at how the increased prescription of antidepressants and other psychotropic drugs was reflected in the forensic analyses performed in almost all cases of suicide.

Findings of antidepressants and other psychotropic drugs in toxicological analyses of suicides of young women in 2013

In 2013, 48 young women committed suicide in Sweden. In 44 of these cases, a toxicological analysis was done to find traces of psychotropic drugs, other medicines, alcohol and illegal drugs.

The results tell us that never before have so many of the young women who committed suicide had traces of antidepressants and other psychotropic drugs in the forensic analysis.

We shall, before we go further, stop and take a look at what government agencies and psychiatrists previously have published about the findings of antidepressants in analyses of suicides among young persons.

We find that nothing similar to the findings in this report has previously been published—which is highly remarkable as these data are not particularly hard to find.

What we have seen published are data that findings of antidepressants in toxicological analyses are far rarer than could be *expected*; information which then has been used to push forward the idea that antidepressants have a “protective effect” against suicide.

For example in the article *Update on the Toxicology of Suicide*, published in *Primary Psychiatry* (2013)⁷. There we can read references to the Swedish researchers Goran Isacsson and Johan Ahlner, and their findings of antidepressants in 20% of the suicides cases, and in only 4% in the 15-19 age group⁸. We can read about a study of suicide among young persons (13-21) in Utah (1996-1999), with findings of psychotropic drugs in only 3% of investigated cases. The article also refers to an investigation in New York (1999-2002) which found traces of antidepressants in only 2.8% of the cases.

The Swedish psychiatrist Goran Isacsson has since the beginning of the 90s 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 that too few persons got antidepressants and many more need the drugs in order to reduce the suicide rates.

In an early article in the *Journal of Affective Disorders*, Isacsson reported that only 12% of those committing suicide were treated with antidepressants at the time of death. Isacsson refers in the article to his other research projects, which he says found similar results, that for only 16% of those who committed suicide traces of antidepressants could be found at autopsy⁹. He further reports 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. Isacson also states that it is “a consistent finding” that about 50% of the patients who commit suicides are depressed.

Based on Isacson's research, the National Board of Health and Welfare has written in one of its major publications in the area of suicide prevention (2006)¹⁰: “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.”

With that short background we go back to what the results for 2013 show in Sweden.

Data from toxicological analyses (see Figure 2) show that 68% of the young women who in 2013 committed suicide in Sweden had traces of psychotropic drugs (antidepressants, sedatives, hypnotics, ADHD drugs) in the blood at the toxicological analysis¹¹.

41% of the young women had traces of antidepressants in their blood.

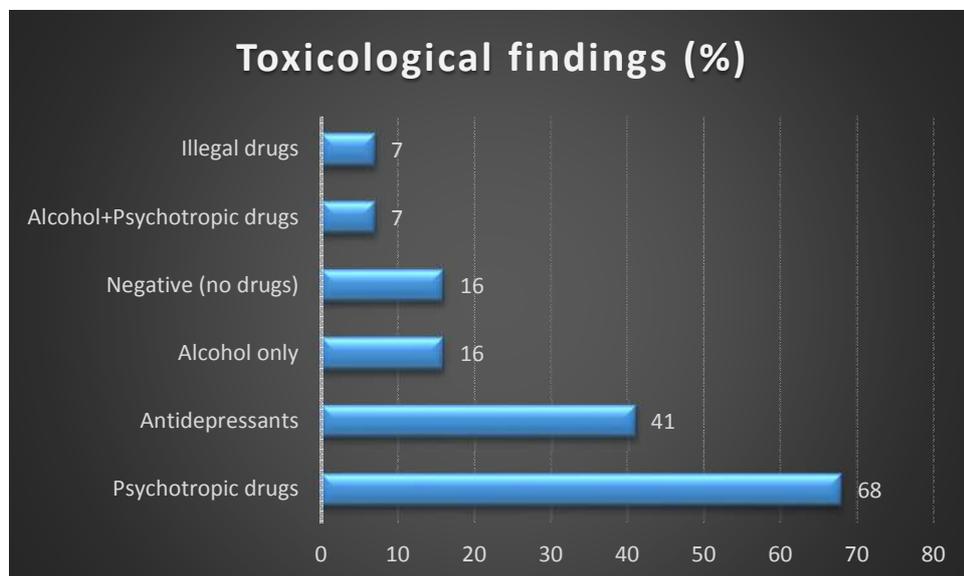


Figure 2. Toxicological findings in suicides of young women (15-24) in Sweden 2013. (The group Psychotropic drugs, 68%, Alcohol only, 16%, Negative, 16%=100%; illegal drugs were found together with psychotropic drugs in 7% of the cases, alcohol were found with psychotropic drugs in 7% of the cases.)

Thus we find a very different picture than the one presented in the official publications by government agencies and by leading biological psychiatrists.

We find not only that 68% of the young women had psychotropic drugs in the blood at the time of the suicide and that 41% had antidepressants, but also that a large proportion of the women received *lots* of psychotropic drugs of various kinds.

The heavy psychopharmacological treatment (which will be discussed in the subsequent, more detailed report), was reflected in the large number of findings of psychotropic drugs in the toxicological analyses:

43% of the women had two or more psychotropic drugs in the blood and 30% had three or more.

And we can say with certainty that 55% of the young women who committed suicide had filled prescriptions of at least two psychotropic drugs within 12 months before the suicide, and that 30% had filled prescriptions of three or more¹².

14% of the women had even filled prescriptions of psychotropic drugs from *four* different *classes* of psychotropic drugs within 12 months before the suicide—they had in that time received *four or more* different psychotropic drugs *on prescription*.

And all this had the consequence that *these* psychiatric drugs could be found in the toxicological analyses—each box corresponds to a particular case:

Promethazine (similar to neuroleptics) Venlafaxine (antidepressant) Mirtazapine (antidepressant) Olanzapine (neuroleptic) Pregabalin ("mood stabilizer")	Alprazolam Diazepam Oxazepam Temazepam Fluoxetine
Alimemazine (similar to neuroleptics) Alprazolam (benzodiazepine) Diazepam (benzodiazepine) Temazepam (benzodiazepine) Nitrazepam (benzodiazepine) Lamotrigine ("mood stabilizer") Sertraline (antidepressant) Bupropion (antidepressant)	Diazepam Temazepam Nitrazepam Fluoxetine (antidepressant) Lamotrigine Pregabalin Reboxetine (antidepressant) Ziprasidone (neuroleptic) Aripiprazole (neuroleptic)
Alprazolam Propiomazine (neuroleptic) Zolpidem (similar to benzodiazepines) Lamotrigine Sertraline Mirtazapine Alimemazine Diazepam Oxazepam (benzodiazepine) Lamotrigine	Citalopram Clonazepam Venlafaxine Sertraline Methylphenidate (ADHD drug)

Discussion

It has been known for years that the prescriptions of antidepressants to young women are rising steeply in Sweden, from having been at a low level in the end of the 90s. It has also been known that suicides in that group have *increased* in the same time period.

Yet no analysis of this correlation has been published by national authorities or by leading psychiatrists. How come?

The simple answer to that question must be that the information is at odds with the treatment ideology that these authorities and their psychiatric expert consultants put forward as “evidence-based”. Media has just followed and reported these experts' opinions, analyses and conclusions, without questioning.

Quite often, however, we have read articles with the content “she did not get help”, “sent home with antidepressants only”. It is as if these journalists intuitively understand that “help” is *something else* than what is provided with one or more psychotropic drugs. What is not understood is that “help” in biological psychiatry actually is *defined* as psychiatric drugs, “medicines”.

The marketing myth, that has been worshiped since the early 90s and that made it possible to turn mind altering drugs to specific “medicines”, is of course the “biochemical imbalance”; the idea that people with mental health problems suffer from a deficiency or an excess of certain neurotransmitters in the brain, and that specific medications correct, “normalize”, this imbalance.

The idea that persons who are depressed are suffering from “chemical imbalances” and are deficient in the substance serotonin has been marketed by the pharmaceutical companies selling antidepressants (in the class SSRI, such as Prozac, Paxil/Seroxat, Zoloft) for two decades. The intensive marketing has led people to believe that their low mood is a deficiency disease, and that it is *vital* to provide the “medicine” that corrects this deficiency—the antidepressant drug.

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 ...”¹³ And from Lundbeck/Forest: “Ciprallex works by normalizing the serotonin levels in the brain.”¹⁴

But there is no scientific evidence that a low mood is caused by a “chemical imbalance” in the brain^{15 16}. 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.”¹⁷ (The old theory that masturbation caused insanity.)

And Professor Peter Götzsche, chairman of the Nordic branch of the independent Cochrane Institute, writes in the book *Deadly Medicine and Organised Crime* (2013), under the title *The Chemical Imbalance Hoax*:

“Instead of trying to understand the patients, psychiatry has developed into a checklist exercise, which one could ask a secretary or the patients themselves to do. Diagnoses are often made after brief consultations of 10-15 minutes, after which many patients are told that they need a drug for the rest of their life to fix a ‘chemical imbalance’ in the brain. Very often, they are told that this is similar to being a patient with diabetes needing insulin. If this were true, the number of disabled mentally ill would have gone down after we introduced the antipsychotics and antidepressants, but instead, the number of persons with psychiatric diagnoses and disability pension has skyrocketed.”

And further:

“The chemical imbalance story, which is often being told about all psychotropic drugs, even for benzodiazepines ... is a big lie ...

Psychotropic drugs don’t fix a chemical imbalance, they cause it, which is why it is so difficult to come off the drugs again. If taken for more than a few weeks, these drugs create the disease they were intended to cure.”

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 with neuroleptics (“antipsychotic medication”)^{18 19}. 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 that a large proportion of the young women who committed suicide in 2013 received an *extensive* psychopharmacological treatment. If the drugs would have remedied the alleged *deficiency* then, based on the theory of the chemical imbalance, “the mental disorder” would also have disappeared—and the women would not have committed suicide.

Pharmaceutical companies and their affiliated psychiatric opinion leaders work hard to preserve the myths. Despite the very large increase in the prescription of psychotropic drugs it is said that the population is suffering from “undertreatment”—people are not getting *enough* psychotropic drugs, not early enough, not in large enough doses, and not long enough.

And we are definitely not gaining more “mental health” with this increased prescription. The increase in morbidity instead seems to be parallel with the increase in the prescription of psychiatric drugs—which should have led some healthcare politicians to question the impact of budgetary allocations. Most normal people would

also question how leading biological psychiatrists assess the proportion of “mentally ill” in the population, as when the leading psychiatrist Goran Isacson in April 2008 refers to research showing that “... the yearly prevalence of mental illness [in the population] is estimated to be about 30 percent”²⁰. Nearly a third of the population would at some point over the course of a year be mentally ill!

Given the results presented in this report one can no longer claim that *more* of the same kind is the solution to the problem. It is not *more* psychiatry—*more* psychiatric drugs—that is the solution.

The politicians who surpass each other in demands for higher allocation to a psychiatry which only means even more psychotropic drugs, should know that they directly contribute to create more of the results that have been presented in this report.

The data in this report must lead to fundamental changes in the ways in which the problems of these young women are taken care of.

¹ Statskontoret, The Government's psychiatry project 2007–2011 – final report (2012:24), <http://www.statskontoret.se/in-english/publications/2012/the-governments-psychiatry-project-20072011-final-report-201224/>

² Mental Health Compass, The Swedish National Programme for Suicide Prevention, visited November 2014, https://webgate.ec.europa.eu/sanco_mental_health/public/GOOD_PRACTICE/89/show.html

³ The FDA, the FDA Proposes New Warnings About Suicidal Thinking, Behavior in Young Adults Who Take Antidepressant Medications May 2, 2007 <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2007/ucm108905.htm>

⁴ The National Board of Health and Welfare, The Causes of Death Register, <http://www.socialstyrelsen.se/statistik/statistikdatabas/dodsorsaker>

⁵ The National Board of Health and Welfare, The Register on Prescribed pharmaceuticals in Sweden, <http://www.socialstyrelsen.se/statistik/statistikdatabas/lakemedel>

⁶ Data from the Swedish Medical Products Agency.

⁷ Dhossche Dirk M, Toxicology of Suicide, *Primary Psychiatry*, May 21, 2013 <http://primarypsychiatry.com/update-on-the-toxicology-of-suicide/>

⁸ Isacson G, Holmgren P, Ahlner J. Selective serotonin reuptake inhibitor antidepressants and the risk of suicide: a controlled forensic database study of 14.857 suicides. *Acta Psychiatr Scand*. 2005; 111 (4): 286-290.

⁹ Isacson, et al, Antidepressants, depression and suicide: An analysis of the San Diego Study. *Journal of Affective Disorders*, 1994. <http://www.ncbi.nlm.nih.gov/pubmed/7897092>

¹⁰ The National Board of Health and Welfare, (in Swedish) *Förslag till nationellt program för suicidprevention* (2006), (no longer available) <http://www.socialstyrelsen.se/NR/>

¹¹ Unpublished data from the National Board of Forensic Medicine, accessed via an FOI request.

¹² Unpublished data from the National Board of Health and Welfare.

-
- ¹³ Pfizer, Zoloft Our medicines, reviewed on September 19, 2009, (no longer available) http://www.pfizer.se/Sites/PfizerSE/Templates/Extension_3124.aspx?Letter=Z
- ¹⁴ Lundbeck, Patient information on Cipralext, visited September 19, 2009, (no longer available) <http://sweden.lundbeck.com/Sweden/vardpersonal/depression/pdf/patientdagbok.pdf>
- ¹⁵ Leo / Lacasse, The Media and the Chemical Imbalance Theory of Depression, *Society*, (2007) visited October 3, 2014, <http://www.springerlink.com/content/u37j12152n826q60/fulltext.pdf>
- ¹⁶ Leo / Lacasse, *Serotonin and Depression: A Disconnect between the Advertisements and the Scientific Literature*, *PLoS Medicine*, (2005), visited October 3, 2014, <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0020392>
- ¹⁷ Healy, quoted in the article *Ads for SSRI antidepressants are misleading, say researchers*, *Medical News Today*, (2005), visited October 3, 2014, <http://www.medicalnewstoday.com/articles/33290.php>
- ¹⁸ Whitaker, *Affidavit*, (2007), visited October 3, 2014, <http://psychrights.org/Litigation/WhitakerAffidavit.pdf> (see all links to articles in the document).
- ¹⁹ Jackson, *Affidavit*, (2008), visited October 3, 2014, <http://psychrights.org/States/Alaska/CaseXX/3AN-08-493PS/JacksonOnNLtoxicity.pdf>
- ²⁰ Isacsson, (in Swedish) *Psykiatri är en medicinsk specialitet – punkt!*, *Läkartidningen* 8 April 2008, visited October 3, 2014, <http://www.lakartidningen.se/engine.php?articleId=9211>