References

1. Bond GR, Drake RE, Becker DR: An update on randomized controlled trials of evidence-based supported employment. Psychiatric Rehabilitation Journal, in press
2. Drake RE, Bond GR: The future of supported employment for people with severe mental illness. Psychiatric Rehabilitation Journal, in press
3. Livermore GA, Goodman N, Wright D: Social Security disability beneficiaries: characteristics, work activity, and use of services. Journal of Vocational Rehabilitation 27:85–93, 2007
4. McHugo GJ, Drake RE, Whitley R, et al: Fidelity outcomes in the National Evidence-Based Practices Project. Psychiatric Services 58:1279–1284, 2007
5. Drake RE, Becker DR, Goldman HH, et al.: The Johnson & Johnson–Dartmouth Community Mental Health Program: disseminating evidence-based practice. Psychiatric Services 57:302–304, 2006

Predictors of Enduring PTSD After an Industrial Disaster

To the Editor: Only a few studies have examined the long-term effects (more than one year) of mass trauma on victimized communities (1,2). On September 21, 2001, a petrochemical plant exploded in the city of Toulouse, France. Victims were surveyed by using self-report questionnaires that assessed peritraumatic distress and dissociation and acute stress. A hierarchical multiple regression conducted with survey data gathered six months after the explosion indicated that all three constructs explained unique variance, accounting for 62% of the variance in symptoms of posttraumatic stress disorder (PTSD) (3). Here we report the results of a follow-up survey conducted 15 months after the explosion. The survey used the same predictors plus a measure of depression.

Five to ten weeks after the explosion, 892 potential study participants were sent self-report questionnaires to assess symptoms of acute stress (Stanford Acute Stress Reaction Questionnaire) and depression (Beck Depression Inventory). The 391 persons who responded were sent another self-report questionnaire six months after the explosion. The second survey retrospectively assessed peritraumatic dissociation (Peritraumatic Dissociative Experiences Questionnaire) and distress (Peritraumatic Distress Inventory) as well as current PTSD symptoms (Posttraumatic Stress Disorder Checklist). Fifteen months after the explosion, the 200 participants who responded to the second survey were sent the same questionnaire assessing PTSD symptoms, and 129 persons responded to this third survey.

To analyze the relationship between predictors and PTSD symptoms at 15 months, we computed Pearson correlations. Strong correlations with PTSD symptoms were found for peritraumatic dissociation ($r=.50$, $p<.01$), peritraumatic distress ($r=.58$, $p<.01$), acute stress symptoms ($r=.71$, $p<.01$), and depression symptoms ($r=.61$, $p<.01$). We computed a hierarchical multiple linear regression with PTSD symptom score as the dependent variable. Peritraumatic dissociation was entered first, followed by peritraumatic distress in the second step, symptoms of acute stress in the third step, and symptoms of depression in the fourth step. The model accounted for 59% of the variance in PTSD symptoms. All of our predictors were strongly correlated with persistent PTSD symptoms 15 months after exposure.

The number of dropouts and retrospective ratings of the peritraumatic responses should be acknowledged as potentially limiting the generalizability of these results. However, the study found that peritraumatic dissociation and distress, acute stress, and depression were related to the development and persistence of PTSD symptoms after an industrial disaster. Loss of control and helplessness-anger, measured with the Peritraumatic Distress Inventory, were strong predictors of posttraumatic stress one year after the World Trade Center disaster (4).

Philippe J. Birmes, M.D., Ph.D.
Laetitia Daubisse, M.D.
Alain Brunet, Ph.D.

Dr. Birmes is affiliated with the Traumatic Stress Laboratory, Young Unit 2511, Toulouse III University, and the University Hospital of Toulouse, Toulouse, France. Dr. Daubisse is with Mixed Research Unit S558, National Institute of Health and Medical Research (INSERM), and Toulouse III University. Dr. Brunet is with Douglas Hospital Research Center and McGill University, Montreal.

Acknowledgments and disclosures

The authors report no competing interests.

References

1. Norris FH, Friedman MJ, Watson PJ, et al: 60,000 disaster victims speak: part I. an empirical review of the empirical literature, 1981–2001. Psychiatry 65:207–239, 2001
2. Marshall GN, Schell TL, Elliott MN, et al: Psychiatric disorders among adults seeking emergency disaster assistance after a wildland-urban interface fire. Psychiatric Services 58:509–514, 2007
3. Birmes PJ, Brunet A, Coppin-Calmes D, et al: Symptoms of peritraumatic and acute traumatic stress among victims of an industrial disaster. Psychiatric Services 56:93–95, 2005
4. Simeon D, Greenberg J, Nelson D, et al: Dissociation and posttraumatic stress 1 year after the World Trade Center disaster: follow-up of a longitudinal survey. Journal of Clinical Psychiatry 66:231–237, 2005

Ethnic Differences in Antidepressant Treatment Preceding Suicide in Sweden

To the Editor: In the October 2007 issue Ray and colleagues (1) observed that the odds of receiving treatments for mood disorders in the year preceding suicide were lower for African Americans. The study of racial-ethnic differences in drug utilization among individuals with severe mood disorders is important. We analyzed whether similar undertreatment is present in Sweden, a country of nine million inhabitants. However, because Sweden has a different racial-ethnic composition than the United States, we analyzed country of birth instead of race.

We analyzed all suicides and deaths from undetermined intent among persons aged 18 to 84 in 2006 (N=1,255, or about 95% of all suicides). We examined use of prescription drugs in the 180 days before death. Persons born in Sweden, Denmark, and Norway, representing the Scandinavian countries, were compared with persons born in all other countries.

We first looked at antidepressant prescriptions. Of the 776 Scandinavian men in the sample, 259 (32%) (age-adjusted 95% confidence interval [CI]=28.5–35.2) filled a prescription for antidepressants in the 180 days before death. The corresponding figures were 176 of the 333 Scandinavian women in the sample (52%) (CI=46.7–57.5), 32 of the 102 foreign-born men (31%) (CI=21.6–39.5), and 21 of the 44 foreign-born women (43%) (CI=28.7–58.1).

We also examined use of antipsychotic drugs. Among Scandinavian men, 100 (13%) (CI=10.1–14.5) filled a prescription for an antipsychotic in the 180 days before death. The corresponding figures were 81 of the Scandinavian women (24%) (CI=19.5–28.9), 19 of the foreign-born men (18%) (10.7–25.4), and 16 of the foreign-born women (32%) (CI=19.8–44.6). Use of lithium was 2% or less in all groups.

As a comparison we analyzed use of these drugs among persons aged 18 to 84 years in the Swedish population in 2006 by country of birth. Among Scandinavian men, 6.1% (CI=6.05–6.10) had at least one filled prescription for an antidepressant. The corresponding figure for foreign-born men was 6.5% (CI=6.43–6.59). Among Scandinavian women the figure was 11.7% (CI=11.68–11.76), compared with 11.1% (CI=11.02–11.20) for foreign-born women. We did not analyze differences in inpatient or outpatient admission before suicide, although we have previously commented on postdischarge suicides in Sweden (2).

We have some minor concerns about the study by Ray and colleagues (1). Data used in that study represented suicides in different periods—1986 to 2004. Over those years, at least in Sweden, policies in regard to inpatient care changed. We also suspect that use of antidepressants increased substantially in the United States since the early 1990s as a result of the introduction of selective serotonin reuptake inhibitors (SSRIs). The increase in use of SSRIs in Sweden was sixfold between 1990 and 2004. In the study by Ray and colleagues, the mean age of African Americans who committed suicide was also nearly ten years lower than that of whites, which may indicate socioeconomic or other differences in the underlying white and African-American populations from which the samples were drawn.

Although one might suspect relative undertreatment of psychiatric disorders in the non-Scandinavian population in Sweden, it could not be verified by our analyses because we studied only drug utilization without knowledge of the underlying disease prevalence. However, the rates of prescription were similar for Scandinavians and foreign-born persons in our sample who filled a prescription for an antidepressant in the months before they committed suicide—and who therefore could be said to have been suffering from a severe mood disorder. This, together with the observed similar rates of prescription in the general population, could indicate equal access to drug treatment. The study by Ray and colleagues highlights an important issue in research on socioeconomic inequalities in care. Racial-ethnic differences in the use of medications may result from differences in religious and cultural beliefs that can affect both health-seeking behavior and attitudes toward suicide.

Rickard Ljung, M.D., Ph.D.
Charlotte Björkenstam, M.Sc.
Emma Björkenstam, B.Sc.

The authors are affiliated with the National Board of Health and Welfare, Stockholm, Sweden.

Acknowledgments and disclosures

The authors report no competing interests.

References

1. Ray WA, Hall K, Meador KG: Racial differences in antidepressant treatment preceding suicide in a Medicaid population. Psychiatric Services 58:1317–1323, 2007

2. Ljung R: Reduction in postdischarge suicide in Sweden. Psychiatric Services 58: 879–880, 2007

News Profiles Finance Interviews
TransWorldNews

Tuesday, April 7, 2009

Health and Wellness News

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).

United States 1/21/2008 08:04 PM GMT (TransWorldNews)

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. Isacsson 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 inte 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"?

(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

janne.olov.larsson@telia.com