

Peter R. Breggin, M.D.
101 East State Street, No. 112
Ithaca, New York 14850
607-272 5328

March 13, 2017

[This report was written to qualify me as an expert in the case, especially on involuntary drug intoxication. My testimony at trial was much broader and more clinical, based on additional medical records and texting. Nothing in this report is based on the sealed medical records of Conrad Roy]

REPORT IN THE CASE OF MICHELLE CARTER

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REPORT IN THE CASE OF MICHELLE CARTER

I. INTRODUCTION

A. Brief Summary and Conclusions

Michelle Carter, born August 11, 1996, was charged at the age of seventeen with manslaughter for allegedly encouraging her boyfriend Conrad Roy to follow through on his longstanding and repeated plans to commit suicide. The alleged crime was based on her texting to him from approximately June 29 to July 12, 2014, when he killed himself by exposure to carbon monoxide from a water pump he placed inside his automobile. Michelle had no in-person contact with Conrad at that time and for approximately one year prior. The texts indicate that Michelle considered Conrad to be her boyfriend, although they had only sporadic personal contact, no physical intimacy, and failed to get together when living less than one hour apart.

(1) A Compassionate Child and Teenager

Michelle was not an ordinary child and youngster. I have interviewed many people, including peers and adults, who know Michelle very well. Most also know her parents and all of them also know other people familiar with Michelle and her parents in their small community of Plainville.

The Plainville town website provides a description of the family-like atmosphere similar to those given to me by Michelle Carter's parents and all the individuals I have interviewed:

A small town of 8000, Plainville has maintained a rural charm. It has numerous public and private conservation areas and horse farms creating a pastoral setting. ... Today the spirit of Plainville is one of family – as it was 100 years ago and, hopefully, as it will remain 100 years hence.¹

Because of this small town setting, many of the people I interviewed about Michelle knew her from childhood and continued to know her at the time of the interviews. Many also knew her family and everyone knew other people who knew and admired Michelle and her family. No one was aware of any negative feelings toward Michelle in the community.

The interviews cover the span of Michelle's life from early childhood to the present, and provide a unanimous opinion of Michelle as an outstanding child and youth with untarnished character and positive values. Everyone without exception described Michelle as unusually kind, thoughtful, loving, responsible, playful, and ethical—a person who never harmed anyone and

¹ Town of Plainville website, retrieved on March 5, 2017 from <http://www.plainville.ma.us/Pages/index>

often supported others when they needed it. Words like “compassionate” and “generous,” not usually applied to young people from age 8 to 17, abounded in descriptions of Michelle. Michelle was and remains an extraordinarily prized member of the school and town community.

The alleged offense occurred in July 2014, the summer after her junior year in high school; and despite the state’s charges against her, Michelle was welcomed back to school. Her senior class took the unusual step of giving her two of the school’s prestigious awards called “Superlatives.” She was awarded the “Superlative” for “Most Likely to Brighten Your Day,” a sure indicator of how she is appreciated and loved as a positive and caring person. She also received the “Superlative” for “Class Clown.” Michelle is consistently described as “quiet,” “not very talkative,” and “leading by example” but with a good sense of humor. The Class Clown award was most likely based on her seemingly perpetual good cheer and sense of humor.

I am a psychiatrist, forensic expert, teacher, small business owner, and member of the community. In those roles, I have reviewed innumerable evaluations of individuals both young and old. In my entire career, I have never seen anyone of any age receive such unblemished, consistent and thoroughly positive endorsements as a wonderful person and contributing member of school activities and community.

In addition, everyone I spoke to knew many other people in their school and community who felt the same way about Michelle. Furthermore, everyone I interviewed said that no one they knew was ever critical of Michelle about anything.

Even when Michelle was struggling with anorexia starting at age 14, and sometimes looking dangerously thin at the time, she was never cranky, irritable, angry or unsociable with the people around her, including her doctors, her family, or the students and adults in her life. Those of us who have worked with anorexic children and their families know that anorexic young people characteristically develop negative attitudes that make them difficult to be around. Even when critically ill with anorexia as a fourteen-year-old, Michelle was always seen as friendly, cooperative and sociable.

Shortly before the alleged crime involving her texting, Michelle voluntarily chose to arrange for a brief hospitalization in an eating disorder program associated with Harvard’s McLean Hospital and was released as “improved.” Most remarkably, even her hospital record contains no negative words about her and gives her no psychiatric diagnosis other than anorexia. Hospital records are notoriously filled with negative interpretations of patient behavior.

At the time of the transformation in her texting with Conrad, Michelle’s weight was normal and stable, and she was not in a distressed condition. She continued to regularly take her antidepressant medication, Celexa, which was prescribed to her despite having failed to get FDA approval for children.

All the people interviewed said they would be happy to come to trial to testify on her behalf.

So what happened to Michelle? How could her personality and character and her behavior and attitudes toward people, as well as her ethics, seemingly transform overnight from a child described as “loving,” “kind” and “compassionate,” to a girl who for approximately ten days seemingly encouraged her boyfriend to complete his often-repeated intentions to commit suicide? How could her texting itself change overnight from caring and loving to bizarrely supportive of his plans to commit suicide?

(2) Antidepressants Can Change Personality, Character and Behavior for the Worse

Personality, character, lifelong attitudes, and consistent behaviors rarely abruptly change from good to bad in an abrupt and dramatic fashion. A person who is kind, generous, loving, and attentive to family, friends, and adults and peers in general, does not quickly and spontaneously change into someone who seems callous, indifferent, and grandiose toward anyone, especially someone she considers a good and even dear friend.

Some extreme personality and behavioral changes can be caused by severe and usually repeated trauma, such as endured in combat or captivity, or domestic or child abuse. Acute head injury with brain damage can also cause marked personality changes, for example, making even-tempered people irritable, angry and aggressive. Occasionally, inflammations of the brain, such as the now rare disorder called lethargic encephalitis, can make a person into someone who no longer possesses his or her previous character. However, these assaults on the brain and mind are nearly always obvious and documented. They usually leave serious lasting effects recognizable to friends, family or an experienced interviewer. There is nothing in Michelle's history to suggest any psychologically or physically traumatic events that abruptly affected her personality and conduct in late June and early July 2014. Nothing occurred in her relationship with Conrad or in her life that would account for a sudden transformation in how she related to him through her texting.

One well-known kind of traumatic event does commonly causes abrupt and often reversible negative changes for the worse in personality, especially in children and youth: exposure to psychoactive drugs. *Psychoactive drugs*² are a group of chemical agents that frequently produce an abrupt and dramatic transformation for the worse in a child or young person's personality, character, attitudes or behavior. Psychoactive drugs that can transform child and youth in profoundly negative ways include familiar substances such as alcohol and marijuana, and street drugs like PCP, as well as all psychiatric drugs.

All children have relatively unstable growing brains; relatively undeveloped sense of identity; relative difficulty with impulse control; and overall immaturity compared to adults. Because of these and other vulnerabilities, children are especially susceptible to the negative psychological and social effects of all psychoactive drugs. That is one reason why society prohibits or discourages exposing children to nicotine and alcohol.

Millions of parents, including those who have provided good homes for their children, can attest to how illegal psychoactive drugs have transformed their previously wonderful children into unrecognizably deceitful, destructive, and manipulative young people. Fortunately, many of these same parents can also attest to how their children recovered and became "themselves" again—decent, trustworthy members of the family and society—after they stopped using drugs.

The kind and intensity of negative changes in children caused by psychoactive drugs vary enormously. On one extreme, psychoactive drugs, especially antidepressants, can cause violence, suicide, mania, depression, and psychosis. They can also cause more subtle changes, such as choosing unsavory friends, losing interest in schoolwork, developing unusual ideas, or becoming obsessively preoccupied with dark thoughts or activities as in Michelle's case.

Any experienced emergency healthcare provider or law enforcement officer knows that an abrupt change for the worse in an individual's personality or behavior should raise a suspicion of psychoactive drug exposure. Campaigns to alert parents to the dangers of their children using illegal drugs usually emphasize the kinds of abrupt changes temporarily seen in Michelle,

² Psychoactive means "affecting the brain and mind or mental processes."

including “Unexplained, confusing change in personality and/or attitude” and “Sudden mood changes, irritability, angry outbursts...”³

There is no evidence that Michelle was exposed to any psychoactive drugs other than prescribed antidepressants, which commonly cause these same kind of dangerous changes in personality, character, attitude and behavior. This report will document that innumerable studies prove beyond *any doubt* that psychiatric drugs, especially antidepressants, *commonly* make dramatic changes for the worse in the character, personality, attitudes, and behavior of children, youth, and young adults. Confirmation will come in considerable detail from the FDA-approved Full Prescribing Information in the Warnings, Precautions and Adverse Drug Effects sections. Confirmation will also come from double-blind placebo controls clinical trials, more naturalistic studies, epidemiological studies, and clinical reports. These scientific studies will demonstrate that the changes can occur after long-term use of the medications; but they especially often occur within weeks or months of starting or switching to a new antidepressant drug or within weeks or months of a changes in dose, either up or down. Michelle had both long-term exposure and dramatic changes in the kind of antidepressant and its dosage within one-to-three months of the change in her texting.

Scientific studies from Harvard Medical School and Yale Medical School will show that up to one-third or one-half of children and adolescents placed on antidepressant drugs will develop behavioral abnormalities, often involving aggressive and antisocial behaviors. Michelle’s main drug antidepressant-induced symptom was “irritability,” which is over-reacting aggressively to frustration. Scientific studies will demonstrate that “irritability” is one of the most common, or the most common, adverse drug effect of antidepressant drugs.

The variety of psychological and behavioral abnormalities caused by antidepressants is seemingly infinite; but many fall into a group called activation or over-stimulation effects, which include loss of impulse control, aggression, hostility, and various manic-like symptoms such as grandiosity and extreme irritability, commonly in the absence of a full-blown manic reaction. As the report examines how often children and youth develop manic-like symptoms from antidepressants, keep in mind that these changes typically involve limited changes such as the grandiosity and preoccupations experienced by Michelle Carter, without the development of a full-blown manic episode or psychosis.

(3) Michelle’s Exposure to Antidepressant Drugs

Michelle had long-term exposure to antidepressants as well as a switch in drugs and dramatic dose changes within one to three months of the brief negative transformation in her personality, character, attitudes and behavior.

Michelle was started on the SSRI antidepressant Prozac (fluoxetine) at age fourteen on February 11, 2011. The doctor’s stated aim in giving her Prozac was to increase “weight gain” when Michelle was struggling with anorexia. With the exception of one hiatus of a few months, Michelle remained on Prozac until March 15, 2014 when, at age seventeen, her doctor switched her to another SSRI antidepressant Celexa (citalopram). This switch took place a little more

³ NCAD (National Council on Alcoholism and Drug Dependence). (2017). For Parents: What To Look For. Retrieved March 4, 2017 from <https://www.ncadd.org/about-addiction/signs-and-symptoms/what-to-look-for-signs-and-symptoms>

than three months prior to the time of her alleged offenses, and dose changes were made within a month of the alleged offenses.

While taking Celexa, Michelle's eating problems grew worse, and she asked to be hospitalized in an eating disorder program associated with Harvard's McLean Hospital in Boston on June 9, 2014. She was released as improved on June 18, 2014, approximately eleven days before she started texting with encouragement to suicide.

Even during this hospitalization at the eating disorder center there is no hint of Michelle having any kind of character or personal defects or any bad or even uncooperative behaviors. I do not recall seeing a psychiatric record like this one in which nothing bad or negative was recorded about a patient. Her only diagnosis was eating disorder and she had no diagnoses related to personality disorders or harmful behaviors toward others. The encouragement of suicide occurred over a span of time covering approximately 12 days that began approximately 10 or 11 days after her discharge. Throughout the time, she was continuing to take the newly prescribed Celexa without any sense on her part that it might be making her worse.

Michelle's parents recall that in the few months leading up to the tragic event, Michelle became somewhat reclusive, engaging less with the family, and finally spending a great deal of time by herself texting.⁴ Since Michelle was concerned about her eating problems, and had asked for and received inpatient treatment, they assumed her somewhat withdrawn behavior was related to her eating disorder. Although unusual, her changed behavior did not seem ominous to them at that time.

As noted, Michelle started taking Celexa approximately three months before the alleged offense, with dose changes approximately one month before the negative transformation in her personality and character. Antidepressant dose changes make an individual especially vulnerable to abnormal mental and behavioral adverse drug reactions. This report will examine many studies of children in scientific studies who undergo a worsening of personality and behavior on antidepressants. Unlike them, Michelle had additional physical problems making her especially vulnerable to adverse drug effects, including anorexia and liver dysfunction.

Again as noted earlier, Michelle has no prior history of acting aggressively, meanly, nastily or destructively toward anyone, including her peers. To an unusual if not extraordinary degree, she was appreciated, admired and even loved by her peers, teachers, coaches, and neighbors. She continued to be loved by her peers after the death of Conrad.

Beyond a reasonable degree of medical certainty, Michelle's negative conversation via texting with Conrad Roy in the ten days before his suicide was caused by an involuntary intoxication with SSRI antidepressants. The involuntary intoxication rendered Michelle unable to have the requisite *intent* to commit the crime. She was also unable to appreciate the wrongfulness of her words or to control her impulses in respect to speaking them. Even if she sometimes feared that other people might disapprove of how she was talking to Conrad, she herself was at the time convinced she was behaving properly. When shortly afterward she accused herself of having helped to kill him, she was experiencing the remorse of someone who was beginning to recover from the abrupt and typically short-lived episode of acute intoxication. She was beginning to react like the caring, responsible human being that she has always been.

Her medical diagnosis at the time was Antidepressant-induced Mood Disorder with Manic Features (irritability and grandiose expansiveness with gross impairment of judgment) (DSM diagnosis 292.84). Antidepressant toxicity turned Michelle from an unusually kind and

⁴ Interview with Dr. Breggin in his office February 25, 2017.

caring young person into a temporary condition of chemically-induced antisocial attitudes expressed in her bizarre, unprecedented texting to Conrad encouraging him to complete his plans for suicide.

Treating Michelle with SSRI antidepressants from age 14 to age 17 for “weight gain” during anorexia was not only “off label” (unapproved by the FDA), it was contraindicated and should never have been attempted. Prescribing SSRIs to a child who is severely anorexic has no clinical or scientific basis, and is fraught with risks. There are no scientific studies—not one—demonstrating the effectiveness of Prozac or Celexa in treating anorexia in children. Indeed, the Warnings in their FDA-approved Full Prescribing Information for both drugs warns that the medications cause “**loss of appetite and weight loss**”! Causing increased loss of appetite and weight in an already anorexic and at times emaciated child presents a massive risk to the child’s health and life.⁵

Treating anorexia in children with SSRIs not only has no scientific basis, but in addition Michelle had physical vulnerabilities that made these drugs especially hazardous and potentially lethal, including chronic liver dysfunction and grossly fluctuating weights from looking gaunt to looking normal. It is important to emphasize that neurotoxic harm done to Michelle starting at age 14 would become cumulative over the years and could have surfaced almost any time over the years; but as, this report will document, changes to a new antidepressant and changes in dose, as in Michelle’s case, are especially likely to cause an abrupt worsening in a child’s mental condition and behavior.

B. The SSRI Antidepressants as a Group or Class of Drugs

In evaluating the case of Michelle Carter and in analyzing the scientific literature, this report will refer to the group of drugs called SSRI antidepressants. The first was Prozac in 1989 and they have grown in number ever since. SSRI stands for Selective Serotonin Reuptake Inhibitor. These drugs are laboratory tailored to block the removal of the neurotransmitter serotonin from its active normal site in the synaptic space between neurons. Neurons are the nerve cells most directly involved in neurotransmission. The drugs block the reuptake process, so that more serotonin presumably remains behind and active in the brain. The theory behind SSRI antidepressants is that it will benefit depression and other disorders by increasing the amount of serotonin in the synaptic space and thereby increase the strength of serotonergic neurotransmission. This flooding of the synaptic space with serotonin and its effects on adjacent neurotransmitter systems, such as dopamine, produces many of its adverse effects. The neurotransmitter serotonin is very widespread and can be found throughout the brain and body, including the gastrointestinal system and bloodstream. The neurotransmitter dopamine is the main nerve bundle communicating from deeper in the brain (the basal ganglia) to the frontal lobes. It is also found in the hypothalamus. Medication-induced dysfunctions of these two

⁵ “Decreased appetite and weight loss have been observed in association with the use of SSRIs,” according to the FDA-Approved Full Prescribing Information for Celexa (2009, p. 14; **Exhibit N**). See ahead for more information. There is debate about whether these SSRI antidepressants can cause weight gain with long-term use in adults; but if that weight gain does occur, it is pathological—that is, it is the result of medication-induced abnormalities in impulse control or in metabolism.

massive neurotransmitter systems that ultimately affect the entire brain can lead to an infinite variety of abnormal mental and behavior states.

The discussions that follow will at times focus on Celexa or Prozac individually and at other times on the SSRIs as a group with common adverse effects. The precedent for discussing the adverse effects of these drugs as class or group exists in all textbooks of psychiatry and pharmacology.⁶ Furthermore, all the materials that I will cite in this report from the FDA-approved Celexa and Prozac Full Prescribing Information are based upon the *class* or group Warnings and Precautions for SSRIs and will appear in identical or nearly identical form in all the Full Prescribing Information Warnings and Precautions for all SSRI antidepressants. Similarly, the Medication Guide for Celexa or for Prozac will carry much of the same basic information found in the Medication Guide for all other SSRI antidepressants. When this report reviews the contents of the FDA-approved Full Prescribing Information and Medication Guide for Celexa and Prozac, almost all the material excerpted and discussed are based upon a class warning for all SSRI antidepressants that has been mandated by the FDA for the entire group of drugs.

II. CREDENTIALS OF THE EXPERT

Because this is a Daubert Hearing, I will review my credentials more extensively than usual for a forensic report.

A. Summary Overview of My Most Relevant Credentials

I am a psychiatrist licensed to practice medicine in New York State with inactive licenses in Washington, DC, Virginia and Maryland. I have an active practice in Ithaca, New York. I frequently see patients in their teens and because my office is in a college town, many other patients are young adults. Because I have a subspecialty in clinical psychopharmacology with an emphasis upon identifying and treating adverse drug effects, I have evaluated many who have behaved bizarrely or harmfully under the influence of psychiatry drugs, including Prozac and Celexa.⁷

I am among the most clinically and forensically experienced and extensively published psychiatrists in the world with respect to a subject in this case—antidepressant-induced abnormal behavior including mania, psychosis, violence and suicide. I have written more than 20 medical and popular books, and more than 50 peer-reviewed scientific articles, most of which deal with the subject of adverse medication effects. I have been asked to lecture on these subjects before federal agencies and U.S. Congressional Committees. Please see my Resume (**Exhibit A**) for a complete list of my professional publications.

My book, *Medication Madness: the Role of Psychiatric Drugs in Cases of Violence, Suicide and Crime* (2008, St. Martin's Press) is the most comprehensive analysis of abnormal behavior produced by psychiatric drugs, with many illustrative cases involving antidepressants causing violence, suicide, mania

⁶ Examples of discussing the adverse effects of SSRI antidepressants as a class or group include the classic textbook, *Goodman and Gilman's the Pharmacological Basis of Therapeutics, 12th Edition* (L. Bruton, Ed., New York: McGraw Hill Medical, 2011),; all recent editions of the commonly used annual resource book, *Drug Facts and Comparisons* (St. Louis: Walters Kluwer, 2017); and all recent editions of the most widely used textbook in psychiatry, *The American Psychiatric Press Textbook of Psychiatry, 6th Edition* (R. Hales, S. Yudofsky & L. Weiss, Eds., Washington, DC: American Psychiatric Press, 2014).

⁷ For a presentation of 50 of my cases, see Breggin, P. (2008b).

and psychosis. It includes cases involving Prozac and Celexa. My latest medical book is *Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients and their Families* (2013, Spring Publishing Company) is the only medical book that focuses on why and how to stop taking psychiatric drugs. It examines recent findings in respect to the adverse effects of psychiatric drugs. My most recent scientific article on adverse drug effects was an overview report titled “Principles of Rational Psychopharmacology” (Breggin 2016) (**Exhibit B**).

In 1985, I was the scientific expert on *adverse drug effects in children* at the landmark Consensus Development Conference on ADHD and its Treatment put on by the National Institutes of Health (NIMH) and the National Institute of Mental Health (NIMH) (see **Exhibit C** for the paper I wrote for the conference). In 2010, when the U.S. Congressional Committee on Veterans Affairs held a daylong hearing on the harmful effects of psychiatric drugs on the military and veterans, the committee chair selected me to be the opening key expert (see Breggin, 2010, **Exhibit D**, for the article that I wrote for the hearing). I have been invited to testify before Congress on several other occasions and many times before federal agencies, such as the National Institute of Mental Health (NIMH) and the National Institute for Neurological Disease and Stroke (NINDS) about psychiatric treatment, including medications.

I have also been an expert consultant to the FAA (Federal Aviation Agency) on the harmful effects of antidepressants on pilots

When the FDA was considering an upgrade of the adverse effect warnings for its Full Prescribing Information for antidepressants such as Prozac and Celexa in 2003-2004, the director of the FDA committee concerned with this activity gave my large review article on the subject to every member of the committee to be read before the hearings (Breggin, 2003/2004a, **Exhibit E**) The article, “Suicidality, violence and mania caused by selective serotonin reuptake inhibitors (SSRIs): A review and analysis” was one the first extensive reviews and analyses concerning SSRI adverse mental and behavior effects. The FDA executive for the committee reviewing the subject gave a copy of my paper to every member of the committee. That paper, and my related testimony before the FDA, influenced changes made in the Full Prescribing Information (also known as the label or package insert) for all antidepressants, including Prozac and Zoloft. These changes pertain to the continuum of activation/stimulation that, in the extreme, becomes drug-induced psychosis and mania. My work has helped to upgrade the Warnings and Precautions in the FDA-Approved Full Prescribing Information for dozens of antipsychotic drugs.

I am a Life Member the American Psychiatric Association with recent special recognition for 50 years of membership. I am a member of World Association of Medical Editors and an editorial board consultant or board member of several journals including the *International Journal of Risk and Safety in Medicine*, *The Psychotherapy Patient*, *The Humanistic Psychologist* and the *Journal of Mind and Behavior*. I am also a reviewer on several journals including *Medical Hypotheses* and the *Journal of Medical Ethics*. I am the co-founder and former Editor of the peer-reviewed journal, *Ethical Human Psychology and Psychiatry*.

I have taught in graduate schools for decades, including the Washington School of Psychiatry and graduate school counseling departments at Johns Hopkins, the University of Maryland and SUNY Oswego.

My most extensive medical expert work began in 1993-1994 when I was appointed by a consortium of attorneys and confirmed by the Circuit Court of Indiana to be the sole scientific expert for purposes of discovery in more than 150 cases against Eli Lilly & Co. concerning violence, suicide and mayhem allegedly caused by Prozac. This provided me a knowledge base unavailable to almost any other

medical expert, and I have shared this knowledge through my books and scientific articles, as well as public and professional presentations.

For considerably more information about my background and credentials, please see my Resume (**Exhibit A**) and my professional website, www.breggin.com.

B. My Research and Publications

I have been publishing in the field of psychopharmacology for more than 50 years, starting in 1964 with a scientific research article on psychopharmacology in the peer-reviewed *Journal of Nervous and Mental Disease* (article number 1 in my resume list of peer-reviewed articles). I have now written more than 50 peer-reviewed articles and more than 20 books, both popular and medical, many of which deal extensively with the issues in this case. Here are my three most recent books, each focused on the adverse effects of psychiatrics and how to withdraw from psychiatric drugs, including the SSRI antidepressants.

Breggin, P. (2008a). *Brain-Disabling Treatments in Psychiatry, Second Edition*. New York, Springer Publishing Company

Breggin, P. (2008b). *Medication Madness: The Role of Psychiatric Drugs in Cases of Violence, Crime and Suicide*. New York, St. Martin's Press.

Breggin, P. (2013). *Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients and Their Families*. New York, Springer Publishing Company.

The following list contains a selection of some my scientific publications most relevant to this case:

Breggin, P. A Case of fluoxetine-induced stimulant side effects with suicidal ideation associated with a possible withdrawal syndrome ('crashing'). *International Journal of Risk & Safety in Medicine* 3, 325-328, 1992. [Fluoxetine is Prozac]

Breggin, P. Fluvoxamine as a cause of stimulation, mania, and aggression with a critical analysis of the FDA-approved label." *Ethical Human Sciences and Services*, 4, 211-227, 2002. [Fluvoxamine is Luvox, another SSRI antidepressant]

Breggin, P. Suicidality, violence and mania caused by selective serotonin reuptake inhibitors (SSRIs): A review and analysis." *International Journal of Risk and Safety in Medicine*, 16: 31-49, 2003/2004. (**Exhibit E**)

Breggin, P. Recent U.S., Canadian and British regulatory agency actions concerning antidepressant-induced harm to self and others: A review and analysis. *International Journal of Risk and Safety in Medicine*, 16, 247-259, 2004. (**Exhibit F**)

Breggin, P. Court filing makes public my previously suppressed analysis of Paxil's effects. *Ethical Human Psychology and Psychiatry*, 8, 77-84, 2006a. **(Exhibit G)**

Breggin, P. How GlaxoSmithKline suppressed data on Paxil-induced akathisia: Implications for suicide and violence. *Ethical Human Psychology and Psychiatry*, 8, 91-100, 2006b. **(Exhibit H)**

Breggin, P. Drug company suppressed data on paroxetine-induced stimulation: Implications for violence and suicide. *Ethical Human Psychology and Psychiatry*, 8, 255-263, 2006c. **(Exhibit I)**

Breggin, P. Recent regulatory changes in antidepressant labels: Implications for activation (stimulation) in clinical practice. *Primary Psychiatry*, 13, 57-60, 2006d. **(Exhibit J)**

Breggin, P. Intoxication anosognosia: The spellbinding effect of psychiatric drugs. *International Journal of Risk and Safety and Medicine*, 19, 3-15, 2007 **(Exhibit K)**.

Marks, D., Breggin, P. and Braslow, D. Homicidal ideation causally related to therapeutic medications. *Ethical Human Psychology and Psychiatry*, 10, 134-145, 2008.

Breggin, P. Antidepressant-induced suicide, violence, and mania: Risks for military personnel. *Ethical Human Psychology and Psychiatry*, 12, 111-121, 2010. **(Exhibit D)**

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Breggin, P. The rights of children and parents in regard to children receiving psychiatric drugs. *Children & Society*, 28, 231-241, 2014. **(Exhibit L)**.

Breggin, Peter. Rational Principles of Psychopharmacology for Therapists, Healthcare Providers and Clients. *Journal of Contemporary Psychotherapy*, 46, 1-13, 2016

C. Review of My Courtroom Testimony

(1) Testimony in Massachusetts

My first-ever appearance as a psychiatrist in court was approximately 55 years ago in Boston in 1962-1963 when I was a resident in psychiatry at Harvard's Massachusetts Mental Health Center. I appeared at an involuntary commitment hearing of one of my patients. I began testifying in court as an independent medical expert starting in the early 1970s. My available records of court testimony go back thirty years to 1987. Since that time, I have testified in court more than 90 times.

Four of my trial appearances since 1987 have been in Massachusetts. The last time was in 2004, but since then I have also consulted and written reports for cases that have been settled before trial. In reverse chronological order, here are the four cases in Massachusetts where I have testified in court:

1. *Matley v. Minkoff*, January 2004. Lowell, Massachusetts. A mentally retarded woman was treated with neuroleptics from age 18-22 and developed tardive dyskinesia. As the plaintiff's only expert, I testified concerning the treatment of mental retardation, neuroleptic drugs, and tardive dyskinesia. The jury found for the plaintiff and awarded \$200,000.
2. *Burns v. Bain*. Superior Court of Suffolk, Massachusetts, Department of Trial Court Civil Action, No. 00-1593B, March 6, 2002. Finding of Medical Tribunal in favor of the Plaintiff. The case involved the long-term administration of the benzodiazepine, Ativan. Based on my report, the tribunal found that evidence sufficient to "to raise a legitimate question of liability appropriate for judicial inquiry."
3. *Siegel v. H. T. Ballantine*. Superior Court Suffolk, Civil Action No. 77735. Massachusetts. 1991. Malpractice. A man believed he was injured by psychosurgery. I testified in trial on psychosurgery, analgesic and psychiatric drugs, including on causation and standards of care. The jury found for the defendant.
4. *Cornish and Cornish v. H. T. Ballantine*. Superior Court Middlesex, No. 82-6729. (circa 1987). Massachusetts. Malpractice. On behalf of a man injured by psychosurgery. I testified on the effects of various analgesic and psychiatric drugs, and psychosurgery, and including causation and standards of care standards of care. The jury found for the defendant.

(2) Testimony in North America, including Federal Court

I have been testifying in court about SSRI antidepressants since 1991. In 1993-1994, I was appointed by a consortium of dozens of attorneys, and approved by the U.S. District Court for the Southern District of Indiana (Indianapolis), to be the sole scientific expert to review all of

the scientific discovery for the combined cases 150 plus cases against Eli Lilly for violence, suicide and other extreme behaviors allegedly caused by Prozac. In 1994, I testified in the initial case in Kentucky. From then on, I became significantly involved in legal cases involving most or all of the SSRI antidepressants.

For brevity, however, I will begin my more thorough review of cases with the year 2010. **Since 2010, fourteen of the sixteen cases in which I have been qualified to testify in court have involved the same classes of drugs that were given to Michelle Carter, the antidepressants.**

Twelve of the fourteen cases involve antidepressants that affect serotonin neurotransmission. Six of the cases are criminal, including one in Canada. At least four were in U.S. District Courts. The first and most recent one was a U. S. District Court case in Pennsylvania with a very thorough Daubert hearing in which I was qualified as an expert in psychiatry, psychopharmacology and the specific SSRI antidepressant Paxil;

In reverse chronological order, here are the 14 cases since 2010 involving abnormal behavior caused by antidepressants and a couple of other psychiatric drugs.

1. Ponzini et al. v. Monroe County et al., case number 3:11-cv-00413, in the **U.S. District Court** for the Middle District of Pennsylvania in Scranton. September 15, 2016. In the case of a 46-year-old man who committed suicide in jail after being restarted on the antidepressant Paxil, a federal jury awarded \$11.9 million including \$8 million in punitive damages against the healthcare provider and its individual personnel. The federal judge qualified me as a psychiatrist, psychopharmacologist and expert in the drug Paxil. I testified concerning how Paxil causes suicide in general and in this specific case. See www.breggin.com for more information.

2. State of Iowa v. Moffitt. Criminal number FECR276050. June 29, 2015. Testified about role of antidepressants bupropion (Wellbutrin) and trazodone in aggravating or causing violence and murder.

3. State of Utah v. Drommund. Second Judicial **District Court**, Farmington, Utah. January 13, 2015. Criminal Case Number 051701317FS. Testified in a hearing before a judge in a review of a murder case involving psychiatric drugs causing violence and murder, primarily Effexor (venlafaxine), but also Provigil, Zyprexa, Trazodone, and Depakote.

4. Archer v. Grange Insurance Associates August 20, 2014 in binding arbitration before the Washington Arbitration & Mediation Services, Case number 130530002. This complex case surrounded a brain injury sustained in an automobile accident with multiple symptoms of traumatic brain injury (TBI) that led to the prescription of the antidepressant Paxil and eventual suicide. I testified about causation, as well as irresistible impulse. The plaintiff's family was awarded \$55,900 of a possible \$125,000 insurance policy.

5. Amedia V. United States of America. Case Number 4:2011CV00378. August 22, 2014. Arizona **District Court**, Tucson, Division Office, County of Pima. Malpractice against the Veterans

Administration for causing addiction to benzodiazepines and tardive dyskinesia. Testified concerning addiction and its treatment, FDA labels and approval process, and adverse effects of polydrug treatment including sertraline (Zoloft), bupropion (Wellbutrin), fluoxetine (Prozac), trazodone (Desyrel), temazepam (Restoril), venlafaxine (Effexor), propranolol (Inderal), oxazepam (Serax), primidone (Mysoline), benztropine (Cogentin), quetiapine (Seroquel), lorazepam (Ativan), diazepam (Valium), paroxetine (Paxil, olanzapine (Zyprexa), lamotrigine (Lamictal), mirtazapine (Remeron) and zolpidem (Ambien).

6. Sheridan v. Lehman, August 2014, Superior Court of New Jersey Law Division: Monmouth County, Docket No. MON-L-1913-11. Malpractice case. A man with no significant prior history of mental disorder committed suicide 16 days after he was prescribed Lexapro and Ativan by his internist. I testified on causation, including the scientific literature, FDA approval process, and drug labeling.

7. Angel v. Segal, State of Illinois, February 2014, in the Circuit Court of Cook Count, Illinois, County Department, Law Division, No. 09 L 3496. I testified concerning autism and psychiatric drug treatment, including antidepressants Paxil and Zoloft and antipsychotics Zyprexa and Risperdal, in a case of tardive dyskinesia and tardive akathisia in a fifteen-year-old boy. The jury awarded \$1.5 million.

8. Baker v. Giant. November 19, 2013. State of Indiana in the Allen Circuit Court. Case No.02c01-1209-PL-79. Testified in malpractice case against a family doctor involving the suicide of a child taking Celexa. Testified about standard of care, adverse drug effects, causation, and FDA procedures.

9. Hollier v. Giant. May 2013. Case No 79061 in the **District Court** Lamar County Texas, 62nd Judicial District. I testified about a family doctor's treatment of a cervical pain patient with morphine, methadone, propoxyphene, fentanyl transdermal system (Duragesic), and other sedative and analgesic drugs, including benzodiazepines Xanax and Valium, and abrupt withdrawal.

10. Rivera v. Babaknia, Superior Court of California, Orange County, Case No. 30-00101673. Approved to testify in malpractice suit involving suicide on Paxil and Xanax. January 24, 2012 83. Mazella v. Beals in the Supreme Court of the State of New York. November 21, 2012, a Syracuse jury awarded \$1.5 million in a suicide malpractice suit involving antidepressants, including Paxil and Effexor. I testified on general and specific causation, and on negligence in hospital and outpatient care.

11. Manitoba v. a Youth. May 25, 2011. Canada. Judge Robert Heinrichs held a hearing to determine if a 17 year old who knifed a friend to death should now be sentenced as a juvenile or an adult. The hearing centered on my testimony that an involuntary intoxication with Prozac caused the boy's violent assault on his friend. The judge qualified me as an expert in psychiatry and psychiatric medication. In his written opinion

on September 16, 2011, in the case of “Her Majesty the Queen and C.J.P” (Citation #2011 MBPC 62), Judge Heinrichs concluded, “Dr. Breggin’s explanation of the effect Prozac was having on C.J.P.’s behavior both before that day and in committing an impulsive, inexplicable violent act that day corresponds with the evidence” (p. 18).

12. Torrence v. Southwest Internal Medicine, In the County Court of the 9th Judicial Circuit in and for Orange County, Florida. Case No. 2006CA11146. Division 37. Approved to testify on causation and negligence in malpractice case involving suicide on Zoloft and Xanax.

13. Florida v. Mourra. Criminal Trial. F. Wesley “Buck” Buck Blankner. Stanton/Orlando, Florida. August 23, 2011. I was qualified to testify on the SSRI antidepressant Zoloft (sertraline) as a cause of violence during withdrawal from the drug. 80. Torrence v. Southwest Internal Medicine, In the County Court of the 9th Judicial Circuit in and for Orange County, Florida. Case No. 2006CA11146. Division 37. Approved to testify on causation and negligence in malpractice case involving suicide on Zoloft and Xanax.

14. Colorado v. Van Damme. Criminal trial. Denver area. November 2010. I was qualified to testify on the role of the SSRI antidepressant Lexapro (escitalopram) in causing or contributing to violence.

D. Case Examples of My Clinical and Forensic Experience involving Abnormal Behavior Caused by Psychiatric Drugs

Michelle’s abnormal mental and behavioral reaction to Prozac followed by Celexa, as “bad” as it seems, was mild compared to many other people. To show the greater severity of other drug-induced abnormal behaviors and to illustrate the underlying consistencies between Michelle’s case and many others, I have evaluated, the following excerpt is from my peer-reviewed article in the *International Journal of Risk & Safety in Medicine* (Breggin 2007):

In the process of writing a new book,⁸ I have reviewed several dozen cases selected from many years of clinical and forensic practice in which I have evaluated individuals who developed suicidal, violent or criminal impulses or behaviors while under the influence of psychiatric drugs.

The most common medication offenders have been the newer antidepressants, benzodiazepines (anti-anxiety sedatives) and stimulants but all categories of psychiatric drugs have been involved, including mood stabilizers and neuroleptics.

One of the most frequent common and serious offenders has been the combination of SSRI antidepressants and benzodiazepines, especially alprazolam (Xanax). In one case a man with no prior criminal history began taking fluoxetine (Prozac) and alprazolam to reduce the strain before

⁸ Breggin (2008a). *Medication Madness*.

starting a new and exciting job. He began to watch a video of the movie *The Saint* and decided it would be fun to mimic him. He robbed his wife's bank, his mother's bank, and his local drug store wearing a minimal disguise. Before one of the robberies he stood outside discussing his vintage automobile with a passerby. He was easily apprehended and seemed to have no idea what the fuss was about until the mediations were withdrawn. He was mostly worried about making an upcoming business appointment. He thought he was doing fine – or better than ever.

During the robberies, this man was suffering from a Substance-Induced Mood Disorder with Manic Features. He had no history of any violent or criminal activity and denied any fantasies about committing crimes before being placed on the medications. In my report in his criminal case I emphasized that he suffered from an organic, drug-induced neurological disorder (Substance-Induced Mood Disorder with Manic Features) and not from an ill-defined mental disorder. Due to my report and a corroborating report from an expert hired by the state, he was found Not Guilty by Reason of Insanity caused by psychiatric drug intoxication.

In another case involving the same two drugs, fluoxetine and alprazolam, administered over a longer period of time in higher doses, a businessman became dependent on the alprazolam and also developed manic-like symptoms. After he was charged with insider trading, he was unable to adequately defend himself and was in my opinion wrongly convicted. While incarcerated he underwent a severe withdrawal from alprazolam. He too had failed to perceive what was happening to him until he was removed from the drugs. In fact, he thought he was performing on an especially high level.

Like most of my legal cases, he had no previous history of breaking the law and no apparent penchant for extravagant behaviors. In court I testified that he had a Substance-Induced Mood Disorder with manic features. During a break in my testimony, his malpractice suit against his psychiatrist was settled for \$250,000.

Another man became psychotic shortly after starting sertraline (Zoloft) and believed that his wife had been taken over by a dangerous alien from another world. In order to destroy the alien inside her, he drove their car into a barrier. She was thrown from the car, and he tried to beat her to death as she lay helpless by the roadside. Fortunately, she survived. In a case in which I played no role, he was found Not Guilty by Reason of Insanity. Only after he began to recover over the subsequent weeks of psychiatric incarceration did he begin to suspect that medications might have caused his psychosis. He was released after several months of commitment to a mental hospital and allowed to remain in the community under supervision. His therapist recommended that I take over the psychiatric portion of his treatment. I gradually removed him from a cocktail of medications and he has done very well during a several-year follow up. He suffered from a Substance-Induced Mood Disorder with Mixed Manic and Depressive Features, and Psychosis. He did not

experience a manic euphoria but he did believe he was on a mission to save himself and the world.

The above cases all had manic features. In other cases, compulsive suicidal or violent behaviors developed without associated manic-like features. A sixteen-year-old girl was begun on fluoxetine (Prozac) to relieve the stress she was undergoing while being diagnosed for an obscure gastrointestinal disorder that eventually went away. Shortly after starting on the fluoxetine, she felt compelled to stab her mother to death but experienced no other adverse drug effects. At the last moment, she confessed her intentions to her mother, and completely recovered when removed from the antidepressant. She was, however, left with years of wrestling with how she could have felt compelled to do such a thing. Now in her thirties, she felt relief after talking with me about what had happened to her and how frequently other good people have developed bizarre impulses on these medications. She had no prior history of suicidality or violence, and has not experienced any since coming off the medication years ago. There were no legal ramifications to the case.

In another case, a man who was recently begun on paroxetine (Paxil) for mild chronic depressed feelings became obsessed with killing himself. He drove his car into an unsuspecting policeman in order to knock him down and obtain his gun. Fortunately, he did not kill the officer and a bystander prevented him from obtaining the gun. He was agitated but not manic during the episode. After my report in his case, the police officer agreed that drugs must have driven his impulsive action, and an agreement was reached that led to only a brief incarceration. On follow up he has done well for several years. Although there are numerous references in the literature to compulsive suicidality, there are few that describe compulsive violence.

In all cases the suicidal, violent or criminal behaviors were unprecedented in the individuals' lives and seemed in retrospect to be very alien and inexplicable to them. None of the acts were repeated after the individual stopped taking the medications. In evaluating the cases, I interviewed surviving victims of drug toxicity and their families and acquaintances. In all of several dozen cases, except for the sixteen year old with the compulsion to stab her mother, I had complete access to detailed medical, school, and occupational records. In many of the cases my reports lead to acquittal on the basis involuntary intoxication, reduced charges, shortened sentences, or release from incarceration. Most of the cases were evaluated for legal cases but a number were clinical consultations.

As the patterns have emerged from re-examining these cases, I have been struck by the fact that victims of drug-induced abnormal mental states and behavior almost never seem to have an inkling that they are acting irrationally or that they are under the influence of their psychiatric drugs.

As another example of the failure to perceive mental dysfunction or drug-induced toxicity, a young man committed a series of eight knife-point robberies of his local gas stations, including those he and his family frequented. He used no disguise and was even warned on one occasion that a surveillance camera was photographing him. He was of course easily caught. He had been recently started on paroxetine (Paxil) which was continued during his trial and sentencing. He was allowed to return home briefly before beginning a lengthy incarceration and immediately robbed another local gas station using an identical knife and the same automobile, and was easily apprehended.

Only after the medication was stopped did he return to his pre-medication mental state and grasp the how irrational and disastrous his behavior had been. At no time while taking the drugs did he, or any of my other cases, realize that he was acting bizarrely and might be under the influence of medication. My report in the case led to a greatly reduced sentence.

Familiarity with medication effects does not necessarily prevent spellbinding. In several cases, the victims of drug intoxication were physicians, including one sophisticated psychiatrist who assaulted a female colleague and made a bizarre suicide attempt while taking fluvoxamine (Luvox). He was convicted of assault and continued on the antidepressant in prison. He did not realize that the drug might have been involved in his behavior until he was removed from it several months later. By the time he asked me to consult with him jail, it was too late to change the outcome, and his sentence would soon be over. However, he was vastly relieved to learn from me that many others had also become unaccountably violent while taking the newer antidepressants.

These adverse drug reactions are extreme, of course, and not typical of most people exposed to these agents. But I believe they provide a window into drug-induced phenomena that affect most if not all individuals who receive sufficient medication to modify their mental condition. Pp. 4-6

All of these individuals were suffering from involuntary intoxications with SSRI antidepressants, and in most cases their diagnosis was, like Michelle's diagnosis, an antidepressant-induced mood disorder with manic features, often including expansiveness and/or irritability.

E. Materials Reviewed by the Expert

(1) Materials Received From Attorney's Office

1. Consolidated text message communications between Michelle Carter and Conrad Roy, III
2. List of prescriptions of Michelle Carter

3. Various medical and mental health records of Michelle Carter
4. Michelle Carter's entire phone report

[REDACTED]

8. Arbour-Fuller Hospital

[REDACTED]

16. Mattapoisett Police Department Previous Suicide EMT Records Conrad Roy, III
17. Mattapoisett Police Department Previous Suicide Police Records Conrad Roy, III
18. Mattapoisett Police Department – Conrad Roy, II
19. Mattapoisett Police Department – Lynne Roy

[REDACTED]

22. McLean Hospital
23. Fairhaven Police Department Incident Report

[REDACTED]

25. Grand Jury Proceedings dated January 22, 2015
26. Grand Jury Proceedings dated February 4, 2015
27. Grand Jury Proceedings dated February 5, 2015

(2) Interviews

Michelle Carter and her parents David and Gail Carter in my office in Ithaca, New York February 25, 2015

By telephone, individuals who know Michelle: 1) Chuck Charles Quealy (February 28, 2017); (2) Jim Shaffer (February 28, 2017); (3) Charlene McEntee (March 1, 2017); (4) Evan Andrews (March 1, 2017); (5) Tim Mullen (March 2, 2017); (6) Jennifer Robillard (March 5, 2017)

III. The FDA-APPROVED FULL PRESCRIBING INFORMATION⁹

A. Background

⁹ Informally known as the Package Insert and formally described as the Label in the Code of Federal Regulations. Many but not all Labels are found in their complete form in the *Physician's Desk Reference* (PDR). A summary of the label is contained in magazines and newspapers that advertise the drug. The labels are very long and detailed, and the information given out, for example, in pharmacy handouts does not even count as a brief summary.

As noted in part **I** of this report, SSRI antidepressants are intended to increase serotonergic neurotransmission in the brain by preventing the brain from removing serotonin from its active sites in the synapses. Probably due to this hyper-activation or overloading of the serotonin system, patients experience numerous adverse drug effects, including the manic-like activation/stimulation syndrome ultimately caused in Michelle's case by Celexa. Prozac also played a role in priming Michelle's brain for this abnormal reaction. Because Prozac is the much older drug, more scientific literature is available on Prozac than on Celexa adverse drug effects; but they are both in the class of SSRI antidepressants with extremely similar and mostly identical adverse reactions. The analysis begins with Celexa, since it was the proximate cause of drastic change in personality, and will then look at Prozac to confirm its similar effects in priming her brain for the transformation in her personality and character.

The Full Prescribing Information (also called the Package Insert or label) by Federal Regulation contains the necessary information for the safe and effective use of the drug.¹⁰

The labeling must contain a summary of the essential scientific information needed for the safe and effective use of the drug.

The final form of the Full Prescribing Information or label is the result of collaboration between the drug company and the FDA, with considerable interaction between the two, and with the ultimate or final approval of the FDA. The entire FDA approval process is about the completion and FDA-approval of the Full Prescribing Information, which then constitutes approval of the drug for marketing in the USA. The date on the approval letter is the date after which the pharmaceutical company can legally market the drug.

B. Causation in Warnings, Precautions And Adverse Reactions sections of the Full Prescribing Information for Medications

(1) Causation in the Warnings and Precautions sections

The FDA takes the Warnings and Precaution sections very seriously. Considerable time is taken to negotiate with the drug companies over their contents, with the FDA invariably wanting stronger Warnings and Precautions, while the drug companies wanting them weaker. The following is excerpted from the Code of Federal Regulations:¹¹

Warnings and precautions. A concise summary of the most clinically significant information required under paragraph (c)(6) of this section, with any appropriate subheadings, including information that would affect decisions about whether to prescribe a drug, recommendations for patient monitoring that are critical to safe use of the drug, and measures that can be taken to prevent or mitigate harm. Pp. 25-26

Federal Regulations further dictate that the inclusion of adverse reactions into the Warnings and/or Precautions sections are based on "clinically significant" findings with

¹⁰ 21 CFR 201.56 (a) (1) (4-1-15 Edition)

¹¹ 21 CFR 201.57 (10) (4-1-14 Edition)

“reasonable evidence of a causal association with a drug.” Here is the full quote from the Code of Federal Regulations: ¹²

(6) *5 Warnings and precautions.* (i) *General.* This section must describe clinically significant adverse reactions (including any that are potentially fatal, are serious even if infrequent, or can be prevented or mitigated through appropriate use of the drug), other potential safety hazards (including those that are expected for the pharmacological class or those resulting from drug/drug interactions), limitations in use imposed by them (e.g., avoiding certain concomitant therapy), and steps that should be taken if they occur (e.g., dosage modification). . . . In accordance with §§314.70 and 601.12 of this chapter, the labeling must be revised to include a warning about a clinically significant hazard **as soon as there is reasonable evidence of a causal association with a drug**; a causal relationship need not have been definitely established. Bold added. Pp. 28-29.

When the FDA first addressed the highly contentious issue of antidepressants causing so many destructive adverse effects on the mind and behavior, the FDA publically declared that there was a “known association” (i.e., a demonstrated causality), between antidepressants and the activation/stimulation syndrome (**Exhibit M**). We shall find that the following string of adverse effects which are “known” to be associated with SSRI antidepressants is included in the Warnings and Precautions sections of the Full Prescribing Information for antidepressants, such as Prozac and Celexa:

The agency is also advising that these patients [i.e., taking antidepressants] be observed for certain behaviors that are **known** to be associated with these drugs, such as **anxiety, agitation, panic attacks, insomnia, irritability, hostility, impulsivity, akathisia (severe restlessness), hypomania, and mania**, and that physicians be particularly vigilant in patients who may have bipolar disorder. Bold added. (P. 1).

(2) Causation in the Adverse Drug Effect Sections

Causation is also required before the placement of drug-related events into the section on Adverse Reactions; but the causation requirement is somewhat weaker. The *Code of Federal Regulations* specifies that the adverse reaction section must contain “only those adverse events for which there is **some basis to believe there is a causal relationship between the drug and the occurrence of the adverse event.**”¹³

The analysis will examine the Warnings and Precautions sections and the Adverse Drug Reaction sections of the Celexa and Prozac FDA-approved Full Prescribing Information.

¹² 21CFR 201.57. (4-1-14 Edition)

¹³ Ibid. Bold added. P. 29.

C. The FDA-Approved Full Prescribing Information for Celexa (Exhibit N)

Part II demonstrated that Michelle had a marked negative transformation in her basic self after being exposed to unwarranted, dangerous treatments with SSRIs over more than a three-year period from age 14 to age 17, and that the transformation was rather abrupt within a short time after being changed from Prozac to Celexa, with additional changes in the dosing of Celexa in close proximity to her transformation of personality and character. The FDA-approved Full Prescribing Information for Celexa makes clear that Celexa causes behaviors similar to that with which Michelle is being charged. After examining the Full Prescribing Information for Celexa and Prozac, the report will go on to examine other widely used, recognized sources, as well as the scientific literature.

(1) The Activation/Stimulation Syndrome in Warnings and Precautions in the Celexa Full Prescribing Information

In one of my scientific papers, I described a stimulant or activation continuum of effects caused by the SSRI antidepressants, documenting it from my own clinical experience and many other research sources (**Exhibit E**). Under the heading, **SSRI-induced mania and the continuum of stimulation**, I wrote:

Mania with psychosis is the extreme end of a stimulant continuum that often begins with lesser degrees of insomnia, nervousness, anxiety, hyperactivity and irritability and then progresses toward more severe agitation, aggression, and varying degrees of mania.¹⁴

In the paper, I also included *akathisia* or psychomotor agitation, in the concept of activation or stimulation.

When the FDA committee in 2004 began deliberating upon upgrading the warnings for the SSRI antidepressants, the executive director of the committee had the above paper of mine distributed to every committee member and, in addition, I testified about these adverse effects in front of the committee. Following my efforts, the FDA included this concept of activation or stimulation in several places in the Full Prescribing Information for every SSRI antidepressant. Here are excerpts from the 2014 Celexa Full Prescribing Information relevant to activation/stimulation adverse effects of Celexa, as well as all other SSRI antidepressants:

a.

WARNINGS

WARNINGS-Clinical Worsening and Suicide Risk

...

All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical

¹⁴ Breggin (2003/2004, p. 32)

worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Bold in original. Pp. 7-8

b.

WARNINGS ...

Information for Patients ...

Families and caregivers of patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to health care providers. Such monitoring should include daily observation by families and caregivers. Bold in original. P. 8

c.

PRECAUTIONS ...

Patients should be advised of the following issues and asked to alert their prescriber if these occur while taking Celexa.

Clinical Worsening and Suicide Risk: Patients, their families, and their caregivers should be encouraged to be alert to the emergence of anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, mania, other unusual changes in behavior, worsening of depression, and suicidal ideation, especially early during antidepressant treatment and when the dose is adjusted up or down. Families and caregivers of patients should be advised to look for the emergence of such symptoms on a day-to-day basis, since changes may be abrupt. Such symptoms should be reported to the patient's prescriber or health professional, especially if they are severe, abrupt in onset, or were not part of the patient's presenting symptoms. Symptoms such as these may be associated with an increased risk for suicidal thinking and behavior and indicate a need for very close monitoring and possibly changes in the medication. P. 14

(2) Adverse Reactions Sections in the Full Prescribing Information for Celexa

After the **Warnings** and **Precautions** excerpted and discussed above, the Full Prescribing Information has another lengthy Section called **Adverse Reactions**. In that section, Adverse Reactions or side effects are summarized by category. According to the FDA label for Celexa, and other drugs, a *frequent* event occurs in “one or more occasions in at least 1/100 patients;” *infrequent* occurs “in less than 1/100 patients but at least 1/1000;” and *rare* occurs in “fewer than 1/1000 patients.”¹⁵ Under the heading of **Psychiatric Disorders** in the Celexa label, here is the complete description of adverse drug effects of Celexa:

Psychiatric Disorders - Frequent: impaired concentration, amnesia, apathy, depression, increased appetite, aggravated depression, suicide attempt, confusion. *Infrequent:* increased libido, aggressive reaction, paroniria, drug dependence, depersonalization, hallucination, euphoria, psychotic depression, delusion, paranoid reaction, emotional lability, panic reaction, psychosis. *Rare:* catatonic reaction, melancholia. P. 27.

Notice that the following adverse reactions, made bold for emphasis, occurred in the drug company studies in at least 1/100 patients: “**impaired concentration, amnesia, apathy, depression, aggravated depression, suicide attempt, confusion.**” At least 1/1000 patients endured the following: “**aggressive reaction...depersonalization, hallucination, euphoria, psychotic depression, delusion, paranoid reaction, emotional lability, panic reaction, psychosis.**” These rates would be much, much higher in Michelle’s case because she was given two different drugs over several years, rather than one drug for a few weeks; because she was not carefully monitored the way patients are monitored in controlled clinical trials; because Michelle was given the drug in a dangerous and unauthorized fashion for weight gain in anorexia; because Michelle had chronic liver dysfunction which can make drugs more toxic; and because Michelle was younger than most of the study patients,

D. The FDA-Approved Medication Guide for Celexa (Exhibit N)

The Medication Guide, attached to the end of the Full Prescribing Information is supposed to be given to patients and their families, and discussed with them. The FDA-Approved Label for Celexa addresses at some length the importance of the Medication Guide:

A patient Medication Guide about “Antidepressant Medicines, Depression and other Serious Mental Illness, and Suicidal Thoughts or Actions” is available for Celexa. The prescriber or health professional should instruct patients, their families, and their caregivers to read the Medication Guide and should assist them in understanding its contents. Patients should be given the opportunity to discuss the contents of the Medication Guide and to obtain answers to any questions they may have. The complete text of the Medication Guide is reprinted at the end of this document. P. 15

There is no evidence that Michelle or her family were ever given the Medication Guide.

¹⁵ p. 25

The risks of activation/stimulation and the associated behavioral changes are again emphasized in the Medication Guide:

What is the most important information I should know about Celexa?

Celexa and other antidepressant medicines may cause serious side effects, including:

1. Suicidal thoughts or actions:

- **Celexa and other antidepressant medicines may increase suicidal thoughts or actions** in some children, teenagers, or young adults within the **first few months of treatment or when the dose is changed.**
- Depression or other serious mental illnesses are the most important causes of suicidal thoughts or actions.
- Watch for these changes and call your healthcare provider right away if you notice:
 - New or sudden changes in mood, behavior, actions, thoughts, or feelings, especially if severe.
 - Pay particular attention to such changes when Celexa is started or when the dose is changed.

...

Call your healthcare provider right away if you have any of the following symptoms, or call 911 if an emergency, especially if they are new, worse, or worry you:

- attempts to commit suicide

- acting on dangerous impulses
- acting aggressive or violent
- thoughts about suicide or dying
- new or worse depression
- new or worse anxiety or
- panic attacks
- feeling agitated, restless, angry or irritable
- trouble sleeping
- an increase in activity or talking more than what is normal for you
- other unusual changes in behavior or mood

.....

7. Manic episodes:

- greatly increased energy
- severe trouble sleeping
- racing thoughts
- reckless behavior
- unusually grand ideas
- excessive happiness or irritability
- talk more or faster than usual

The above excerpts from the Full Prescribing Information and Medication Guide for Celexa describe a syndrome of extreme abnormal behaviors that are unusual or alien for the individual, including extreme impulsivity or out-of-control behavior, extreme irritability and resulting anger, aggressive behavior, unusually grand ideas, as well as, more generally, “sudden changes in mood, behavior, actions, thoughts, or feelings, especially if severe.”

E. Abruptness of Onset and Timing with Starting and Changing Doses

The bizarre changes in Michelle’s are “sudden” or “abrupt.” These descriptive words are used to describe the typical onset of abnormal mental and behavioral reactions induced by Celexa and other drugs (see above, the Full Prescribing Information, the Medication Guide, and other sources.)

In regard to when adverse effects are *most likely* to occur, the Celexa Warnings section stated that adverse effects such as activation are most likely to occur “especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases:”

All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times

of dose changes, either increases or decreases. Underline added. See above IIC (1) a. for remainder of the excerpt.¹⁶

Michelle in fact went through all of the likely conditions for producing adverse drug effects on the brain and mind: (1) it was in the initial few months of starting Celexa, (2) there were recent doses changes in Celexa, and (3) the changes were both increases and decreases.

In Michelle's case, she was removed from a long-term exposure to Prozac 20 mg and abruptly changed to Celexa 10 mg. Prozac and Celexa are about equally potent milligram for milligram, and so Michelle was subjected to a halving of the SSRI load on her brain. The combination of withdrawal from Prozac, which itself can produce an activation/stimulant syndrome, and the introduction of a new drug at roughly half the dose, somehow brought out the activation/stimulant syndrome at the time that it did. As in nearly all cases, we do not know exactly why the destructive drug-induced adverse effects abruptly began at the moment it did, but it is clear that it did take over Michelle's mind and behavior **under the dosing conditions that this most frequently occurs.**

F. Celexa Was Contraindicated as a Treatment for Michelle

In addition to these extraordinary warnings about adverse behavioral effects, the FDA-Approved Full Prescribing Information for Celexa does not approve the use of Celexa for any eating disorder or for any disorder in individuals under age 18. It also raises concerns about giving Celexa to patients like Michelle with liver dysfunction. In adults, liver dysfunction reduces the clearance of the drug from the body by 37% and doubles its half-life. This raises the risk of adverse effect from anticipated higher blood levels.

The Full Prescribing Information also contains a section on Pediatric Use (under age 18) that should have discouraged any rational physician from giving it to a young person with anorexia:

Pediatric Use

Safety and effectiveness in the pediatric population have not been established (see **BOXED WARNING and WARNINGS—Clinical Worsening and Suicide Risk**). Two placebo controlled trials in 407 pediatric patients with MDD have been conducted with Celexa, and the data were not sufficient to support a claim for use in pediatric patients. Anyone considering the use of Celexa in a child or adolescent must balance the potential risks with the clinical need.

Decreased appetite and weight loss have been observed in association with the use of SSRIs. Consequently, regular monitoring of weight and growth should be performed in children and adolescents treated with Celexa. Pp. 19-20

¹⁶ Speaking about the onset of suicidal thoughts and behaviors, the Medication Guide (see above) describe them as occurring “**within the first few months of treatment or when the dose is changed.**”

This pediatric warning for Celexa is unusual in explicitly stating that the company tried to get the medication approved by testing it on 407 depressed patients and “the data were not sufficient to support a claim for use in pediatric patients.” That is, the drug company tried and the FDA tried, but the drug, *after testing*, was not approvable for children!

G. Prozac FDA-Approved Full Prescribing Information for Prozac (Exhibit O)

Two excerpts from the FDA-approved Prozac label confirm that Prozac, much like Celexa, causes the activation syndrome with the potential for a transformation in personality and character and that patients and their families are supposed to be warned and educated about these dangers. Although Michelle was not taking Prozac at the time of negative texting, she had been exposed to it for years, up until 3 ½ months before the negative texting, and probably played a role in her final involuntary intoxication.

The same Code of Federal Regulations for causation of course applies to Prozac exactly as it does to Celexa in respect to the Warnings, Precautions and Adverse Drug Effects sections.

To avoid too much repetition, I will not excerpt and evaluate them as extensively from the Prozac label as from the Celexa. The following excerpts are from the Full Prescribing Information for Prozac:

(1) WARNINGS AND PRECAUTIONS ...

5.1 Clinical Worsening and Suicide Risk ...

All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for Major Depressive Disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality.

Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient’s presenting symptoms. p. 8 (bold in original)

In addition to the reference to mania in the above selection from the Prozac label, many other references occur throughout the label.

(2) The Prozac Full Prescribing Information in the WARNINGS AND PRECAUTIONS also warns against giving Prozac to patients like Michelle who suffer from eating disorders and are under weight:

Altered Appetite and Weight

Significant weight loss, especially in underweight depressed or bulimic patients, may be an undesirable result of treatment with PROZAC.

In US placebo-controlled clinical trials for Major Depressive Disorder, 11% of patients treated with PROZAC and 2% of patients treated with placebo reported anorexia (decreased appetite). Weight loss was reported in 1.4% of patients treated with PROZAC and in 0.5% of patients treated with placebo. However, only rarely have patients discontinued treatment with PROZAC because of anorexia or weight loss [*see Use in Specific Populations (8.4)*].

In US placebo-controlled clinical trials for OCD, 17% of patients treated with PROZAC and 10% of patients treated with placebo reported anorexia (decreased appetite). One patient discontinued treatment with PROZAC because of anorexia [*see Use in Specific Populations (8.4)*]. In US placebo-controlled clinical trials for Bulimia Nervosa, 8% of patients treated with PROZAC 60 mg and 4% of patients treated with placebo reported anorexia (decreased appetite). Patients treated with PROZAC 60 mg on average lost 0.45 kg compared with a gain of 0.16 kg by patients treated with placebo in the 16-week double-blind trial. P. 9-10

(3) Another section warns about the lack of information about long-term harmful effects on brain and behavior of young people and warns about danger signals from animal studies:

The safety of fluoxetine treatment for pediatric patients has not been systematically assessed for chronic treatment longer than several months in duration. In particular, there are no studies that directly evaluate the longer-term effects of fluoxetine on the growth, development and maturation of children and adolescent patients. Therefore, height and weight should be monitored periodically in pediatric patients receiving fluoxetine. [*see Warnings and Precautions (5.6)*].

PROZAC is approved for use in pediatric patients with MDD and OCD [*see Box Warning and Warnings and Precautions (5.1)*]. Anyone considering the use of PROZAC in a child or adolescent must balance the potential risks with the clinical need.

Significant toxicity, including myotoxicity, long-term neurobehavioral and reproductive toxicity, and impaired bone development, has been observed following exposure of juvenile animals to fluoxetine. Some of these effects occurred at clinically relevant exposures. P. 17

These observations make clear that the off-label use of Prozac in Michelle's case was not only baseless in terms of science, it was exceedingly dangerous, with the potential to cause a general worsening of her condition and an endless variety of abnormal changes in her brain and behavioral functions. In Breggin (2008a), I describe some of the known harmful changes to the brain caused by antidepressants.

The FDA-Approved Prozac Medication Guide contains many warnings similar to those in the Celexa version. For the sake of brevity it will not be excerpted here (see **Exhibit P**).

Starting Michelle on Prozac was a prescription for potential disaster and continuing her on Celexa brought the crisis to a head in the form of her drastic personality, character, attitude and behavior change.

PART IV. CAUSATION OF SSRI-INDUCED ABNORMAL BEHAVIOR IN CHILDREN AND YOUNG ADULTS

A. Qualities of an Antidepressant-Induced Manic Episode from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) (2000)* (Exhibit Q)

The *Diagnostic and Statistical Manual of Mental Disorders* created and published by the American Psychiatric Association (most recently 2000 and 2013) is intended to be the official diagnostic manual for psychiatry and seeks to be based on both consensus and scientific documentation (p. xxiii). The 2013 version of *DSM* is not significantly changed in respect to the sections cited here, and was published after Michelle was started on medication.

The *DSM-IV-TR* as well as earlier editions and the more recent one all confirm that antidepressants can cause mania or manic-like symptoms. This antidepressant-induced problem is sufficiently common and serious that it is mentioned many times in the *DSM-IV-TR* and may be the most frequently cited adverse drug effect described in the official diagnostic book.

For example, in the section on manic episodes (**Exhibit Q**), the *DSM-IV-TR* stated, "Symptoms like those seen in a Manic Episode may also be precipitated by antidepressant treatment such as medication..." (p. 361). The specific connection between antidepressants and the induction of manic-like symptoms or episodes was also confirmed when the *DSM-IV-TR* in its table for Criteria for Manic Episode excluded "manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication..." (p. 362). The *DSM-IV-TR* Criteria for Hypomanic Episode table similarly excluded to "Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication..." (bold added, p. 368; also see Pp. 406-407, and elsewhere). These two notes to the table indicated that when antidepressants and other chemical agents cause manic-like or hypo-manic like symptoms, the correct diagnosis is a substance-induced mood disorder with manic features and not a primary diagnosis of bipolar disorder.

Of special importance, an antidepressant induced manic-like episode need not have the euphoric or hyperactive quality of many manic episodes. It only needs to include either an "expansive" or "irritable" mood. The *DSM* is very clear that individuals can have these hypomanic or manic drug-induced episodes and "the full criteria for one of these episodes need not be met" (p. 405). In other words, a person can develop extreme irritability and obsessively encourage someone to commit suicide without having any manic-like symptoms other than an "elevated, euphoric or irritable" mood.

The psychological definition of an expansive mood is “characterized by unrestrained emotional expression, often accompanied by an overvaluation of one's importance or significance to others; sometimes merely another name for elevated mood.”¹⁷ An irritable mood is psychologically defined “as angry impatience and hasty temper in which a person is easily annoyed or roused to anger or aggression.”¹⁸ Michelle was bizarrely expansive in taking on the role of encouraging Conrad’s suicidal intentions and bizarrely irritable in suddenly acting annoyed or irritable in the face of Conrad’s failures to complete his suicidal intentions.

The detailed clinical descriptions of a manic episode in the *DSM-IV-TR* includes descriptions that remarkably apply to Michelle’s out-of-character behavior. Manic episodes include an “increased involvement in goal-directed behaviors...with a high potential for painful consequences,” which is exactly what happened to her in supporting Conrad’s plans to kill himself (p. 357). Similarly, it describes “goal-directed activity [that] often involves excessive planning” (p. 358).

In people undergoing a manic-like reaction, “almost invariably, there is increased sociability (e.g., ...calling friends ... at all hours of the day and night), without regard to the intrusive, domineering, and demanding nature of these interactions” (p. 358). When “texting” is substituted for “calling,” this too exactly describes Michelle’s radically changed behavior. This section of the *DSM* also describes these victims of mania as potentially suffering from “poor judgment” and “antisocial behaviors” that get them in trouble with the law. Many of these individuals, in fact, behave much more badly than Michelle, for example, by becoming “physically threatening,” “assaultive,” and “physically assaultive” (Pp. 358-359). As I describe in my book *Medication Madness* and my peer-reviewed scientific articles, I have evaluated many children and adults who, while under the influence of antidepressants, have killed or attempted to kill their spouses and children, or carried out schemes ruinous to themselves and other people.

Again relevant to Michelle, “Ethical concerns may be disregarded even by those who are typically very conscientious” (p. 359). The *DSM* also describes how behaviors can be “out of character” for the individual and how they will feel “regret” when the episode is over (p. 358). All of this is true of Michelle’s short time period of abnormal behavior on antidepressants.

Michelle’s behavior is best clinically categorized as “irritable” in her urging her friend to stop talking and to stop failing in his suicide attempts. Again relevant to Michelle, the *DSM* observed that, “If the person’s mood is more irritable than expansive, speech may be marked by complaints, hostile comments, or angry tirades” (p. 358).

This broad spectrum of antidepressant-induced adverse drug reactions certainly covers Michelle’s behavior. Even one word descriptions, such as disinhibition or irritability, would be sufficient to show for general causation that antidepressant drugs can cause the transformation experienced by Michelle. In this case, there are many such descriptive words in the Full Prescribing Information, the Medication Guide and in the *DSM* that describe one or another aspect of Michelle’s texting that are under scrutiny in this case. The following clinical studies confirm that the changes in Michelle were similar to and consistent with other descriptions of antidepressant-induced symptoms.

¹⁷ Oxford Dictionary of Psychology, 2015. Retrieved on February 7, 2017 from <http://www.oxfordreference.com/search?q=expansive&searchBtn=Search&isQuickSearch=true>.

¹⁸ Oxford Dictionary of Psychology, 2015. Retrieved on February 7, 2017 from <http://www.oxfordreference.com/search?q=irritable%20mood>.

B. Scientific Studies of Activation/Stimulation and Abnormal Behavior Caused in Children and Youth by SSRI Antidepressants

The earliest studies of the first SSRI antidepressant, Prozac (fluoxetine) showed an extremely high rate of drug-induced abnormal behaviors related to Michelle's case.

(1) Riddle et al., 1990 (Exhibit R)

In a study in part based on double-blind placebo-controlled clinical trials, Riddle et al. from the Yale Child Study Center at Yale Medical School examined their clinic patients age 8-16 and found that 50% of them developed behavioral abnormalities on Prozac, including social disinhibition, all of which were ended by reducing or stopping the medication. This is so extraordinary that I will quote the abstract in its entirety:

ABSTRACT

Twelve (50%) of 24 children, ages 8 to 16 years, treated with fluoxetine, 20 or 40 mg/day, for depressive or obsessive compulsive symptoms, developed behavioral side effects characterized by motor restlessness (n = 11), sleep disturbance (n = 11), social disinhibition (n = 6), or a subjective sensation of excitation (n = 3). No major changes in the neurological status of these children were observed. However, the three children with ADHD showed an exacerbation of symptoms on fluoxetine. Discontinuation (n = 5) or halving the dosage (n = 7) resulted in complete resolution of these unwanted symptoms within 1 to 2 weeks. In all 7 children whose doses were reduced, improvement of the depressive or obsessive compulsive symptoms was maintained on the lower dosage. Clinicians treating children with fluoxetine are cautioned to be aware of behavioral side effects which may be alleviated by dosage reduction or possibly by starting with lower doses. These side effects may be difficult to differentiate from common psychopathological symptoms such as hyperactivity, restlessness, and impulsivity. P. 193

Notice that one-quarter of the children (six) developed "social disinhibition" which describes Michelle during her episode of abnormal behavior and that three children had "a subjective sensation of excitement" which probably also characterizes her mental state at times. Notice that the drug effects, as in Michelle's case, were difficult to differentiate from "common psychopathological symptoms," including "impulsivity." This theme is repeated in the article. In Michelle's case, her drug-induced effects have been misinterpreted by the state as her spontaneous or self-directed behavior rather than as adverse drug effects.

(2) King et al., 1991 (Exhibit S)

Using in part double-blind placebo-controlled clinical trials, King et al. from the same Yale Child Study Center found activation/stimulation in a series of children 10-17 years old treated for obsessive-compulsive disorder with Prozac. Here is the complete abstract:

Abstract. Self-injurious ideation or behavior appeared de novo or intensified during fluoxetine treatment of obsessive-compulsive disorder in six patients, age 10 to 17 years old, who were among 42 young patients receiving fluoxetine for obsessive-compulsive disorder at a university clinical research center. These symptoms required the hospitalization of four patients. Before receiving fluoxetine, four patients had major risk factors for self-destructive behavior including depression or prior suicidal ideation or self-injury. Three hypotheses concerning the apparent association between fluoxetine and these self-injurious phenomena are discussed: (1) coincidence; (2) disorganization of vulnerable individuals secondary to drug-induced activation; and (3) a specific serotonergic-mediated effect on the regulation of aggression. P. 179

Consistent with this report and my own scientific opinions, the authors favor the explanations of vulnerable individuals developing drug-induced activation as well as a specific serotonin-mediated dysregulation leading to aggression.

The King et al. study was a controlled clinical trial. One of the study group patients displayed a frightening reaction that shows how desperately bizarre the SSRIs can make the internal life of a child (or adult). Like Michelle, the boy, age twelve, took no actual actions; but if he had not been in close observation in a research study, it might have turned out much worse. Surprisingly, the school shooting scenario evolved in the child's occurred before there were any nationally covered school shootings:

Thirty-eight days after beginning the protocol, F. experienced a violent nightmare about killing his classmates until he himself was shot. He awakened from it only with difficulty, and the dream continued to feel "very real." He reported having had several days of increasingly vivid "bad dreams" before this episode; these included images of killing himself and of his parents dying. When he was seen later that day he was agitated and anxious, refused to go to school, and reported marked suicidal ideation that made him feel unsafe at home as well. The protocol was interrupted, revealing that he had been on fluoxetine, 20 mg q.d. (0.57 mg/kg), since the beginning of the protocol. The medication was discontinued. P. 208

Sometime later when he was restarted on Prozac by other doctors, the child once again became acutely suicidal. The process described here, of starting and stopping a drug, and then starting and stopping it again—each time causing a severe adverse reaction which then cleared up when the drug was stopped—is called challenge-dechallenge-rechallenge-dechallenge. It confirms the causal role of the drug in creating the adverse event.

(3) Jain et al., 1993 (Exhibit T)

Jain et al. at the University of Pittsburg examined the charts of children and adolescent retrospectively to evaluate the progress of youngsters age 9-18 years old given

Prozac. Although they found considerable improvement, they also found serious adverse effects. Here is the Abstract:

ABSTRACT

The charts of 31 hospitalized children and adolescents (ages 9-18 years) with major mood disorders were retrospectively reviewed to examine the efficacy and side effects of treatment with fluoxetine. After treatment for a mean duration of 35 days, clinical improvement was seen in 74% of these patients; 54% had "much" to "very much" improvement as measured by the Clinical Global Impression scale (CGI). The most common adverse effects were hypomania-like symptoms (23%), irritability (19%), gastrointestinal upset (13%), and insomnia (13%). No EKG changes, blood pressure changes, anticholinergic symptoms, sedation, weight changes, or seizures were observed. None of the patients experienced an increase in suicidal or parasuicidal¹⁹ behavior. Discontinuation of the fluoxetine treatment occurred in 28% of cases, most commonly because of increasing irritability and hypomania-like symptoms. The hypomania-like effects included a constant sense of silliness, increased activity, poor sleep, increased energy, an increase in the stream of thoughts (racing thoughts), or socially intrusive or obnoxious behavior. Fluoxetine triggered symptoms suggestive of hypomania in all four of the depressive bipolar patients. P. 259

The key sentences above are: "The most common adverse effects were hypomania-like symptoms (23%), irritability (19%), gastrointestinal upset (13%), and insomnia (13%)." Michelle was in a hypomanic state with her grandiose encouragement of Conrad's suicidal behavior and was certainly "irritable" in the way she reacted with frustration and irritation to his initially failed efforts to harm himself. Her behavior, like some of the children in this study, might also be categorized as "socially intrusive or obnoxious behavior."

(4) Wilens et al., 2003 (Exhibit U)

At a time when several SSRI were available, including Celexa, Wilens et al. from Harvard's Pediatric Psychopharmacology Center studied the adverse effects of these drugs on children and teenagers (mean age 12.2 +/- 3.2 years) by reviewing their medical charts. Here is the entire abstract:

ABSTRACT

Objective: Despite a rapidly growing literature on the efficacy of the selective serotonin reuptake inhibitors (SSRI) in the treatment of juvenile psychiatric disorders, relatively little is described about emotional,

¹⁹ Parasuicidal refers to any self-injurious behavior that is not intentionally suicidal. To some extent, it describes Michelle's behavior which was very destructive to herself.

behavioral, and cognitive adverse effects associated with their use. To this end we completed a retrospective analysis of medical charts to determine the incidence, nature, and clinical correlates of treatment emergent adverse effects in the behavioral, cognitive, and emotional domains.

Methods: We systematically evaluated the medical charts of children treated with SSRI for depressive or obsessive-compulsive disorders for a mean (\pm SD) of 26.9 ± 20.8 months to determine the incidence, nature, and clinical correlates of treatment emergent psychiatric adverse events (PAE). Charts were reviewed for diagnoses, type and dose of SSRI and adjunct medication, specific type of PAE, and time to onset and offset of PAE.

Results: In total, 82 charts of children and adolescents (mean age 12.2 ± 3.2 years) were examined. PAE occurred in 22% of children and were most commonly related to disturbances in mood. PAE were not associated with psychiatric diagnosis(es), age, sex, concurrent medications, doses or specific serotonin reuptake inhibitors. The onset of PAE was observed typically 3 months after SSRI exposure (median = 91 days). Although PAE diminished with SSRI discontinuation, those that emerged early in treatment diminished significantly more rapidly than those that emerged later (median offset was 10 and 49 days, respectively). Re-exposure to an SSRI resulted in another PAE in 44% ($n = 18$) of the group. *Conclusion:* Based on the retrospective review of medical charts, youth receiving SSRI appear to be at risk for treatment emergent PAE and recurrence with re-exposure to an SSRI. Prospective longer term studies evaluating the course and prognosis of youths manifesting PAE to SSRI are necessary.

p. 143

A number of aspects of the above abstract and other data in the text of the article directly apply to and shed light on Michelle's case, and allow for a summary of basic facts about SSRI antidepressants:

- (a) The study involved several SSRIs, including Celexa (citalopram).
- (b) The "treatment emergent psychiatric adverse events (PAE)" were common, occurring in 22% of children and adolescents.
- (c) The adverse drug effects frequently involved the activation/stimulation continuum with 12 of the young people (15% of the total who were treated) becoming "irritable." Irritable was by far the most common drug-induced symptom in this study and it was Michelle's predominate drug-induced symptom as she becomes seemingly frustrated and irritable over Conrad's efforts to commit suicide. Consistent with an activation/stimulation continuum, five of the young people (7% of the total) became "manic." Michelle suffered from bizarre irritability when she transformed from a caring and supportive person to one who was also encouraging suicidal behavior in her boyfriend. At the same time, there is an additional manic quality of taking it on herself in a grandiose manner to encourage him to finish his plans to kill himself.
- (d) It "typically" required 3 months of exposure before the drug-induced events occurred, which fits perfectly with when Michelle was begun on Celexa about three months before the abrupt transformation of her personality and behavior. The authors observed, "Our

data are consistent with Tierney et al.'s (1995),²⁰ who reported a minority of PAEs initially but the development of activation and other PAEs months after sertraline initiation" (p. 150).

(e) The following from the Abstract also applies to Michelle: "The occurrence of an adverse event was independent of psychiatric diagnosis, age, sex, concurrent medications, doses or specific serotonin reuptake inhibitors." In the text, they confirmed, "Contrary to our hypothesis, PAEs were not associated with the primary psychiatric disorder being treated (depression or OCD) or with additional psychiatric comorbidity" (p. 149). In other words, activation/stimulation with often bizarre behavior is a drug-effect that is at work independently of the characteristics of the individual undergoing it. This confirms that no individual should be concerned personally responsible for behaviors that are inflicted by psychiatric drugs across the human spectrum. Notice that the authors themselves, who are strong advocates for medications, had wrongly anticipated that the adverse effects were entirely associated with the drug but also with the patients' psychiatric condition.

(f) In regard to my use of SSRI studies in general to apply to Celexa, this study found the effects so similar for each of the SSRIs that they do not differentiate among them in describing the adverse events they produced.

(5) Reinblatt et al., 2009 (Exhibit V)

Using double-blind placebo-controlled clinical trials, Reinblatt et al. (2009) from Johns Hopkins conducted a study of "Activation Adverse Events Induced by the Selective Serotonin Reuptake Inhibitor Fluvoxamine in Children and Adolescents." "The aim of this study was to examine the prevalence of activation cluster adverse events (AC-AEs) in youths treated with the selective serotonin reuptake inhibitor (SSRI) fluvoxamine for anxiety and the relationship of AC-AEs to SSRI blood levels."

With the SSRI antidepressant Luvox (fluvoxamine) 10 of 22 patients (45%) 6-17 years old developed activation while only one of 23 placebo patients did (4%). Most subjects developed activation with 8 weeks and some at 10 weeks well within Michelle's exposure to the medications. The fluvoxamine level in the blood of 8 subjects with activation was higher in 8 individuals, but other factors, such as age and psychiatric condition, were not related. The researcher's concluded, "Close monitoring for AC-AEs, not only when initiating SSRI treatment but also throughout dose titration, is recommended for early identification of activation."

Eric Harris, one of the high school seniors who perpetrated the mass murders at Columbine High School, was taking Luvox leading up and during the shootings. The coroner's office autopsy ironically described him as having a "therapeutic" level in his blood.²¹

²⁰ Tierney E, Joshi PT, Llinas JF, Rosenberg LA, Riddle MA: Sertraline for major depression in children and adolescents: Preliminary clinical experience. *J Child Adolesc Psychopharmacol* 5:13-27, 1995.

²¹ Breggin, Peter. "Fluvoxamine as a cause of stimulation, mania, and aggression with a critical analysis of the FDA-approved label." *International Journal of Risk and Safety in Medicine*, 14: 71-86, 2002. Simultaneously published in *Ethical Human Sciences and Services*, 4, 211-227, 2002. I was an expert in several cases surrounding the Columbine High School shootings and had access to Eric's medical records and to the autopsy toxicology report.

(6) Amatai et al., 2015

Amatai et al. (2015) from highly respected research centers in Israel and Germany reviewed the subject of activation events in children and adolescents. In introducing their study, they described the size and seriousness of the problem, and its greater threat to children and adolescents:

Antidepressants are being increasingly prescribed for children and adolescents for the treatment of depression, anxiety, and other mental disorders. The selective serotonin reuptake inhibitors (SSRIs) are the major contributors to this trend. Children are especially prone to psychiatric adverse events of SSRIs relative to adults. Recently, attention has been addressed to a specific constellation of emotional and behavioral symptoms associated with SSRI treatment, termed activation syndrome.
p. 28

Amatai et al. provided an extensive review of the scientific literature indicating very high rates for activation in children and adolescents, including some of the studies described in this report. The researchers concluded:

There is a clear and considerable risk of excessive arousal or activation, and even hypomania or mania, in children and adolescents treated with SSRIs. The rates of these symptoms, even those diagnosed as mania or hypomania, are much higher than in adults with anxiety and depression. ... At present, we recommend close clinical monitoring during SSRI initiation or dose changes, which should reduce the risk of activation syndrome and more importantly recognizing it on time. p. 37

(7) Emslie et al. (1997)

In a double-blind placebo-controlled clinical trial, Emsley et al. found that 3 of 48 children (over 6%) on Prozac developed manic symptoms requiring them to drop out of the study. None of the placebo patients developed these severe reactions.²² No description of the manic symptoms is given.

There can be no doubt from the scientific literature that activation/stimulation with a variety of potentially dangerous changes in personality, character, attitudes and behavior is exceedingly common in children and adolescents taking SSRI antidepressants. Michelle Carter's episode of bizarre behavior is entirely consistent with an antidepressant activation syndrome with irritability; grandiosity; the obsessive pursuit of outlandish, unethical or dangerous goals; and lack of concern for the consequences. The lack of concern for others is particularly dangerous in combination with the disinhibiting effects.

²² The age group was 7-17 years old and the finding is buried on p. 1033.

C. Studies of Apathy, Emotional Blunting, Disinterest and Loss of Empathy Caused by SSRI Antidepressants in Children and Adults

The apathy, indifference, emotional blunting, and loss of empathy caused SSRI antidepressants tend to make individuals seem very unsympathetic. Numerous articles have described this effect and its dangerous results when individuals develop drug-induced lack of interest, concern and empathy that can ruin relationships and harm people.²³

The apathy syndrome can occur on its own or in combination with the activation/stimulation syndrome, and can play a part in causing destructive attitudes and behavior. In Michelle's case, for example, she minimized the upset Conrad's suicide would cause in his family, a bizarre attitude that is typical not of Michelle herself but of antidepressant-induced emotional blunting and indifference toward others. This effect can be viewed as *a reduction of the capacity to feel and to relate to oneself and others*. It is also a *detachment or loss of connectivity to self and others*

This drug-induced apathy or difference toward self and others is often associated with disinhibition, impulsivity or loss of control. The individual who no longer cares about the feelings of other human beings is no longer inhibited from perpetrating self-destructive, harmful behaviors.

(1) Read et al., 2014 (Exhibit W)

Michelle displayed indifference, lack of feeling or apathy not only toward the fate of her boyfriend, Conrad, but also toward the consequences of his death for his family and herself. The lack of empathy or caring, numbness about life and people, a disconnection from oneself and others, and failure to grasp consequences are among the most characteristic negative effects of modern antidepressants. Confirmation of this comes from a survey of 1,829 patients who took antidepressants (**Exhibit W**):

In the context of rapidly increasing antidepressant use internationally, and recent reviews raising concerns about efficacy and adverse effects, this study aimed to survey the largest sample of AD recipients to date. An online questionnaire about experiences with, and beliefs about, antidepressants was completed by 1829 adults who had been prescribed antidepressants in the last five years (53% were first prescribed them between 2000 and 2009, and 52% reported taking them for more than three years). Eight of the 20 adverse effects studied were reported by over half the participants; **most frequently** Sexual Difficulties (62%) and

²³ Marin RS. Differential diagnosis and classification of apathy. *Am J Psychiatry*. 1990;147:22–30; Barnhart WJ, Makela EH, Latocha MJ. SSRI-induced apathy syndrome: a clinical review. *J Psychiatric Pract*. 2004;10:196–199; Lee SI, Keltner NL. Antidepressant apathy syndrome. *Perspect Psychiatr Care*. 2005;41:188–192. I have also described the SSRI-induced syndrome in many of my books and articles, including Breggin (2010, p. 115) and Breggin (2013), pp. 58-59.

Feeling Emotionally Numb (60%). Percentages for other effects included: **Feeling Not Like Myself – 52%, Reduction In Positive Feelings – 42%, Caring Less About Others – 39%, Suicidality – 39%** and Withdrawal Effects – 55%. Total Adverse Effect scores were related to **younger age**, lower education and income, and type of antidepressant, but not to level of depression prior to taking antidepressants. **The adverse effects of antidepressants may be more frequent than previously reported, and include emotional and interpersonal effects.** (bold added, p. P. 67).

All of the above adverse drug effects in bold pertain to Michelle’s experience of a radical transformation in her character and personality from a caring person into one who became irritable and frustrated with her Conrad’s failed attempts at suicide.

Here are the specific results for Celexa (citalopram), the last medication taken by Michelle, for the percentage of patients who related the following symptoms (table 4, p. 70):

Feeling emotionally numb – 54% (9% severe)
 Feeling not like myself – 43% (8% severe)
 Reduction in positive feelings – 20% (3% severe)
 Caring less about others – 32% (1% severe)

The authors observed, “This diminished capacity to experience feelings, positive or negative, and to care about other people, might be characterized as a sort of ‘closing down’, a withdrawal from the emotional and interpersonal world” (p. 70). This “closing down” constitute *a reduction of the capacity to feel and to relate to oneself and others*. These results for patients reporting *severe losses* in their capacity to feel and to relate to themselves and others confirm that many people experience dramatic negative, dangerous changes in their personality or character while taking antidepressants.

People who experience this kind of *detachment or loss of connectivity to self and others* tend to become suicidal or aggressive. The authors observed:

Suicidality and aggression

In light of recent concerns about the possibility that ADs [antidepressants] can increase suicidality and aggression, it is important to note that 39% reported Suicidality, and 28% Feeling Aggressive, ‘as a result of’ the ADs. The Suicidality finding is similar to a recent study that found that 204 of 706 AD recipients (35%) experienced ‘treatment-increasing suicidal ideation’.

In the current study, Suicidality was correlated with younger age, with 56% of the 18–25²⁴ age group reporting this effect, 14% at

²⁴ There were no children under age 18 in this study. However, Michelle was approaching 18 and the data certainly confirms she was at higher risk for this distract adverse reaction of suicidality. Also, suicidality does not usually occur as an isolated adverse drug reaction, but

the ‘severe’ level. This is consistent with previous findings that young people are more at risk of suicide on ADs than adults. Pp. 70-71. (five citations to scientific papers deleted; see **EXHIBIT W**)

Although she did not experience it as aggression, Michelle’s behavior had elements of aggression in encouraging Conrad toward suicide. Although she was not suicidal, she was certainly preoccupied with his suicide.

In fact, the reported feelings are probably less frequent and less intent than the patient’s real feelings, because psychoactive substances tend to make people indifferent or unaware of how much they have been changed. Put simply “feeling emotionally numb” tends to make us less aware of how we are feeling. These observations that drugs mask their negative effects on the individual enduring them led me to develop the concept of intoxication anosognosia or mediation spellbinding (Breggin 2007 is found in **Exhibit K** and Breggin 2008a, 2008b and 2013 are listed in the brief bibliography at the end of the report).

(2) Goldsmith and Moncrieff, 2011²⁵

Goldsmith and Moncrieff (2011) in another kind of survey came up with similar results to Read et al. (2014). The authors analyzed spontaneous Internet reports about adverse effects of Effexor (venlafaxine) and Prozac (fluoxetine) as described by individuals who had taken these medications. They summarized:

In the current study we examined descriptions of the major psychoactive and physical effects experienced by users of two commonly used antidepressants, fluoxetine and venlafaxine, as reported on a patient-oriented web site. ... In the 468 descriptions we examined, the most commonly reported drug-induced psychoactive effects were sedation, impaired cognition, reduced libido, emotional blunting, activation (feelings of arousal, insomnia and agitation) and emotional instability. There were no differences between the two drugs in the prevalence of reporting of these effects. Activation effects were associated with involuntary movements, suggesting a physical basis. Emotional blunting was associated with cognitive impairment, reduced libido and sedation. Emotional instability, which included the reported side effects of increased anxiety, anger, aggression and mood swings, was related to activation effects and was more commonly reported by younger respondents. Increased suicidal thoughts were rare but were associated with both types of emotional effect. The effects identified are consistent with other data, and suggest that some antidepressants may induce emotional effects that are

includes, as this article concludes, the “closed down” syndrome of loss of interest in self and others.

²⁵ Goldsmith, L. and Moncrieff, J. (2011). The Psychoactive Effects of Antidepressants and their Association with Suicidality. *Current Drug Safety*, 6, 1-7.

experienced as unpleasant, may impact on the symptoms of mental disorders, and may account for the suggested occurrence of increased suicidal impulses in some users. P. 1

The patients were mostly women age 15-71, with depression as the majority diagnosis, followed by anxiety.

(3) Garland and Baerg, 2001 (Exhibit X)

Garland et al. (2001) described four cases of apathy and disinterest in children age 10 to 17 without activation. In none of the cases did the children themselves realize that something was wrong with them. The authors wrote:

An amotivational syndrome in children and adolescents treated with SSRIs may be more common than implied by the lack of published reports. Although it responds to dose reduction, its delayed onset and subtle features may not be recognized or may lead to increase in SSRI dose as the presentation overlaps with symptoms of residual depression and avoidance. Clinicians need to be alert to the potential for this syndrome and educate families to detect it. p. 185

There was no evidence of accompanying sedation, hypomania, physical behavioral activation, or extrapyramidal side effects. These cases also illustrate the marked detrimental impact on schoolwork, social relationships, and sports involvement at this developmental stage. Nevertheless, symptoms often go unrecognized as they are delayed in onset and subtle. The patients feel “fine,” and parents may attribute problems to other causes such as adolescence, suspected drug use, or a “bad attitude.” p. 186

Notice that the victim of the drug reaction is often blamed for the problem, such as “adolescence” and a “bad attitude.” The understandable tendency to attribute the individual’s actions to a “bad attitude” has resulted in the charges against Michelle.

One case was a ten-year old girl, who, like Michelle, showed poor judgment in what she said to others:

She had interpersonal boundary problems, asking people inappropriate personal questions, having poor judgment and thereby insulting and alienating both peers and adults. This was quite out of character for her, as she had previously been quite polite and sensitive to others. She did not seem to have insight into how inappropriate her statements were at the time. When her behavior was pointed out to her, she would appear to be upset about it later primarily because her mother warned her that this could cause her to lose friends. However, when describing her actions to the psychiatrist, she showed no appropriate embarrassment. She appeared unusually unconcerned and flat in affect, but the clinician had no baseline

to compare, not having seen her prior to medication. There was no evidence of general behavioral activation or hypomania such as overactivity, pressure of speech, irritable or elevated mood, or hyperarousal in the form of sleep disturbance. P. 184

(4) Reinblatt and Riddle, 2006 (Exhibit Y)

Reinblatt and Riddle (2006) present two cases of SSRI antidepressant-induced apathy in children, which they equated with other studies, “including SSRI-induced apathy, amotivation, emotional blunting, and drug-induced indifference” (p. 227). It is useful to add the psychological concept of “empathy” for others. They noted that the condition could lead to “disinhibition,” which is a factor in Michelle’s case. It can involve a personality change that leads to socially disinhibited behavior without manic-like symptoms. One of their two cases was a sixteen-year old girl:

At the 20th week of long-term treatment, she and her mother reported “disinhibition,” and friends worried that her personality had changed. Her friends noted that she seemed “different” and had become overly confident with strangers. The participant was noted to have engaged in more risk-taking behaviors and seemed socially disinhibited, although she did not exhibit any other manic symptoms; nor did she have any depressive symptoms. p. 229

Reinblatt and Riddle recognize that the apathy and disinhibition can be associated with activation as well, and describe this in the second case of a young boy who was hyperactive and had insomnia. Many cases of extreme violence, which I have evaluated, possess a strong element of apathy or disinterest (Breggin, 2008b). Others have also reported the association between apathy and uncharacteristic compulsions toward suicide and violence.

V. CLINICAL ANALYSIS OF MICHELLE CARTER’S CASE

A. Annotated Chronology of Flawed Medical Treatment with Antidepressants

At age 14, Michelle was given an extensive evaluation at the Walden Behavioral Care inpatient facility for her eating disorder. Michelle was described as suffering from anorexia that began with “restrictive eating” in September 2010, and with moderate depression, untreated. Her admission was “secondary to failure to restore weight as an outpatient.” Her weight of 85.6 pounds was “77% of ideal body weight.”

Michelle was “seen by Pediatrics, Psychiatry, Social Work, Nursing and Nutrition” with no detection of any aggressive or unusual attitudes toward other people or any symptoms of a personal disorder. She showed no antisocial tendencies, no lack of empathy or concern for others, and remorselessness. She had no history of perpetrating harmful behaviors. A seventeen-year old who shows such callousness toward others and such bizarre behavior usually has a considerable history of this kind of kind of behavior toward others, including family members, peers, and pets. There is nothing like this in Michelle’s medical record.

When she was started on Prozac on February 17, 2011 “in the hope of improved weight gain.” She was 14 years old. She weighed a mere 89.4 pounds. Her height and her BMI were not recorded when the decision to give Prozac was made; but three weeks later on March 10, 2011 her height would be 63.25 inches (5 foot 3 inches) in the 47th percentile, her weight would be 88.6 pounds in the 7th percentile and her BMI would be 15.6 in the 3rd percentile.

Michelle was emaciated. She was so ill from anorexia that she had abnormal liver function tests and “orthostatic vital signs.” Her blood pressure, when she stood, would drop from a low 84/66 when sitting to an even lower 74/50 when standing, putting her at risk of fainting or collapsing. A normal blood pressure for a 14-15 year old girl is 133/84.²⁶

March 1, 2009, Michelle was seen for follow up by Dr. Uzma Shah for follow up for her abnormal liver enzymes. Her weight was 90.6 pounds, in the 9th percentile. Dr. Shah observed, “This is a very emaciated young lady.” The doctor was unsure of the diagnosis and was sufficiently concerned to say that a liver biopsy might be needed in the future.

On March 29, 2011, the liver specialist followed up on Michelle’s abnormal liver functions. He noted that Michelle looked “gaunt and thin” and that her BMI was in the 2nd percentile. He thought her abnormal liver enzymes might be the result of a “refeeding syndrome.” The specialist suggest blood tests every 3 weeks and a follow up consult in 8 weeks.

A refeeding syndrome occurs when a person begins to eat after a prolonged fast. Potassium, phosphorous and magnesium serum levels can drop and in the extreme confusion, coma and death can follow. The *Textbook of Psychiatry*²⁷ warns that a refeeding syndrome is relatively frequent in anorexic patients who are beginning to stabilize and can lead to congestive heart failure. The text book states, “Consequently, the early stages of refeeding should be done in specialized medical settings for medically compromised patients at very low weight, and they should be regarded as requiring intensive medical monitors” (p. 568). Instead, Michelle was continued as a seemingly routine outpatient and, most astonishing, one week after this consult her primary care doctor raised her Prozac to 30 mg per day.

Michelle’s primary care physician, in a seeming lack of concern or interest, never reviews and describes in the medical record the seriousness of the gastroenterologist’s concerns. In an egregious error, the primary care doctor never enters the probable diagnosis of feeding syndrome into the record. The primary care doctor’s only reference to Michelle’s March 29, 2011 visit was “Saw GI today—lab work normal (except nonconvertor for Hep B) normal abdominal ultrasound today.” This note does not reflect the gastroenterologists concern about Michelle’s condition. Nor does the primary care doctor ever describe Michelle as “gaunt and thin” or as “emaciated,” the way the gastroenterologist does.

After Michelle was started on Prozac 10 mg on February 15, 2011, her dose was much too quickly doubled to 20 mg on February 23, 2011, which is the average dose for a normal adult in good physical health and certainly a huge toxic risk for an emaciated anorexic fourteen year old. Then on April 5, 2011, one week after the liver consult, the doctor, without explanation, raised Michelle’s Prozac to 30 mg. This was a mere 49 days (7 weeks) after the start of the drug. This was a drastic approach to the off-label and contraindicated use of Prozac in Michelle’s case.

²⁶ <https://www.ncbi.nlm.nih.gov/pubmed/2024295>

²⁷ Hales, R., Yudofsky, S. and Roberts, L. (2014). *American Psychiatric Press, Textbook of Psychiatry*. Washington, DC: American Psychiatric Press. Chapter 17: Feeding and Eating Disorders by Mitchell, J. and Wonderlich, S. pp. 557-586.

At that time, she was prescribed Prozac (fluoxetine) she was started on at that time was “for the hope of improved weight gain.” This off-label, unjustified, and dangerous use of Prozac was not aimed at any psychiatric diagnosis, but only at increasing her weight. **The doctor’s record does not even list a psychiatric disorder.**

Three years later, on February 28, 2014 and March 18, 2014 a change from Prozac to Celexa is again discussed, with the dose actually started around March 18, 2015. Once again, there is no formal psychiatric assessment or diagnosis and the medication change is made because of “fatigue” caused by Prozac.²⁸

In short, Michelle had no formal psychiatric diagnosis when she was put on Prozac “for the hope of improved weight gain” and no formal psychiatric diagnosis when she was switched to Celexa. There is no history verbally controlling or aggressive behavior, or any other form of antisocial, callous or malicious behavior; yet she becomes a caricature of this for the brief time from June 29, 2014 until their last communication on July 12—a period of less than two weeks. Indeed, other than anorexia, she had no formal psychiatric diagnoses, not even a personality disorder. At no time in the entire three year period of her treatment was Michelle ever given a diagnosis remotely related to the use of SSRI antidepressants in children and youth.

The 2009 Prozac FDA-Approved Full Prescribing information sets 20 mg of Prozac as the maximum dose for children for Major Depressive Disorder (which Michelle did not have) (**EXHIBIT O**, p. 5). To give this emaciated child with refeeding syndrome with liver dysfunction a dose in excess of what is mandated by the FDA and the drug company was unconscionable. Furthermore, the dose was raised at a time when Michelle had developed “headaches almost every day over last few weeks,” which the doctor seems to attribute to the Prozac. The doctor noted, “liver function tests abnormal.”

On August 16, 2011, four months and one week after raising Michelle’s Prozac to 30 mg, her primary care doctor reduced the dose to 20 mg. Michelle has gained weight and seems to be doing better, but the doctor never comments on how Michelle feels about her new weight—a critical issue in whether or not she will maintain it and function well mentally.

On September 29, 2011, Michelle’s primary care doctor reduced her Prozac to 10 mg. which the goal of stopping the medication in two weeks, or approximately October 14, 2011. This is a rapid withdrawal and problems should have been anticipated. At the next visit, her weight has gone up to 14.8 pounds, the 66th percentile. Although there is no discussion of Michelle’s feelings about this, the note says, “patient wasn’t allowed to see weight.” Since the weight loss was probably due to Prozac-induced abnormal metabolism and/or abnormal apathy about her weight gain, it would seem inevitable that with the withdrawal of Prozac her eating would become abnormal again.

Michelle had also begun to display abnormal behavior of a hypomanic quality. “Patient able to pop hip in and out, has been doing this for over a month as a joke.” She had injured her hip sliding into a base and was aggravating the problem.

²⁸ Under assessment on March 18, 2014, it is noted “anxiety stable” and that Michelle scored 2 [out of 4, rated as moderate] on the Anxiety Scale [presumably the Hamilton]. This does not constitute a formal or rational diagnosis of an anxiety disorder, such as Generalized Anxiety Disorder or Panic Disorder. Nor is there any indication that the change in medication has to do with treating anxiety.

On May 3, 2012, the primary care doctor's note read: "Returned mom's call—Mom concerned Michelle overeating – can stop herself from eating then exercises compulsively. Michelle now asking for help, but does not want to return to Foxboro office as is worried that office staff will view her as a 'failure.' Mom thinks Michelle around 100 lbs now (down 25 lbs!) ... Mom would like her to resume Prozac. "

This dramatic change for the worse in her anorexia was directly related to the mistreatment with Prozac, followed by its abrupt withdrawal, and rebound of her problems. However, Michelle's mother would not have the information to draw this conclusion. It is also reasonable to assume that Michelle's central nervous system was having difficulty returning to normal. Michelle was referred to a new primary care doctor (to be referred to as her second primary care doctor).

On May 8, 2012, Michelle was seen by her second primary care physician and Prozac was restarted at 10 mg for 30 days. At this point, she had been off Prozac from approximately October 14, 2011 to May 8, 2012, a period of almost seven months. She would remain on SSRIs from May 8, 2012 until the alleged crime in late June and early July 2014—a period of more than two years.

The May 8, 2012 note said, "She had an admission for eating disorder at Walden for six days but was discharged without any further follow up. The issue has been caloric restriction. Is binge eating and exercising excessively. School has been stressful." As far as I can tell, this is the first mention of binge eating. Michelle has had a weight loss of 30 pounds and is now in the 7th percentile again. The plan was to start Prozac again: "discussed warnings of making depressed and to call immediately if feels worse." I saw no similar warnings in the medical record of her first primary care doctor. Also, "Mom to call Harvard pilgrim to get referral to outpatient clinics for eating disorders." "Explained if she loses more weight will have to be admitted."

On May 22, 2012, her second primary's concern continued with Michelle's weight at 91.4, the 3rd percentile. Her blood pressure standing drops from 89/65 sitting to 79/60 standing, and her pulse drops from 60 to 48. The doctor decides to increase her Prozac to 30 mg, "which was previous dose." Once again, a very vulnerable Michelle is bombarded with a dose of Prozac above the average for the normal, healthy adult.

As before, Michelle's weight begins to go up. On July 10, 2012, when Michelle is 15 years and 11 months old, she weight 106.0 pounds, in the 24 percentile, and her blood pressure is up to 118/80, which is nearer to normal. A disastrous process is being repeated based on dependence on Prozac-induced abnormalities to raise her weight. She is still taking Prozac 30 mg. She continues to see her counselor.

On September 4, 2012, now sixteen years old, her weight is 131.8 in the 72%. She is doing well.

On October 16, 2012 at age 16 years and two months the doctor noted, "wt gain doing well with medication." She weighed 141pounds at 5 feet 4 inches in height, with a BMI in the 83rd percentile. "School is going well. Is playing softball. Doing well with medication no side effects."

On December 20, 2012, she is doing well at her "15-17 year well child care visit." She is continuing to do well and the Plan is "will try to decrease dose to 20 mg and if symptoms return will increase to 30 mg." The plan shows a lack of understanding of Prozac withdrawal. A one-third dose reduction after such a long exposure is significant and any symptoms that appear or reappear are likely caused by withdrawal.

On December 27, 2013 her weight is 150 pounds (86th percentile): “anxiety and anorexia controlled no issues with wt stable.” However, Michel is “tired a lot and does not want to go out.” The assessment is “fatigue from meds.” The plan is to discontinue Prozac and start Celexa in a week. “Start a 5 mg for a week then increase to 10 mg.” Her anxiety score is slightly up at 4.

There is a delay in restarting Celexa which appears to begin on approximately March 18, 2014 (see Second Primary Care doctor’s note on March 18, 2014.) Although it is uncertain, it appears she has been off Prozac for approximately 3.5 months. According to Michelle’s mother, her daughter was doing well for a time, and then developed bulimia with compulsive exercising unaccompanied by weight loss.

Thus, Michelle’s first exposure to Celexa begins March 18, 2014, approximately 3 months before Michelle suffers a severe negative transformation in her personality toward the end of June 2014.

There are two serious problems with this withdrawal plan. First, she is withdrawn very rapidly from 30 mg to zero in one week. This is extremely rapid. Because of Prozac’s long half-life the doctor waits another week before restarting, which would have been all right if the Prozac withdrawal had not been so short. Second, when she restarts Celexa at 5 mg and then continues it at 10 mg, she has cut her dose of SSRI in half. Celexa 10 mg is roughly equivalent to Prozac 10 mg. Nor is there any guarantee that one drug will successfully replace the other. Most switches go from Celexa to Prozac, and not Prozac to Celexa, because Prozac is sometimes considered the more benign medication, especially when planning a withdrawal. The relatively brief withdrawal, followed by restarting and continuing Michelle on approximately one-half the effective dose of antidepressant, would have been a shock to Michelle’s young and developing central nervous system, brain and mind.

On April 1, 2014, the primary care doctor conducted a more intensive evaluation for her annual wellness visit. Michelle was in the 11th grade and was 17 years 8 months old. Michelle is doing well with “normal relationships, no aggression, anxiety, depression.” This was two months before the negative transformation in her personality and behavior.

The Medication Note on April 1, 2014 indicates, without explanation, that she is restarting the Celexa at a dose of 5 mg for one week, followed by regular 10 mg doses.²⁹ All of these changes involving Celexa are within the three months prior to the negative transformation in her personality and well within the window in which severe mental and behavior reactions most frequently occur.

At this wellness visit, Michelle is doing very well: “Psych [evaluation] Neg. Normal relationships, no aggression, anxiety, depression.” She was not vomiting and her eating habits were “fair.” Michelle was doing so well that, for the first time since she became anorexic in 2011, her doctor made no set time for a follow-up visit. Instead, Michelle was advised to return for her next well-child visit at age 18-21 or to “call the office if ill.” This demonstrates that Michelle continued to be a young woman without abnormal behaviors or serious interpersonal or psychological problems. Unfortunately, it also displays the doctor’s cavalier attitude toward giving Celexa off-label to a teenager for no stated purpose and with no specific evaluation of the need.

²⁹ “Citalopram 10 mg (10 MG TABLE Take 1) PO QD, ½ tab po x 1 week then inc to 1 tab po qday x 30 days.”

On May 5, 2014 during a med check, the doctor noted her intention to decrease Michelle's Celexa to 5 mg per day. Under plan, she wrote "**decrease dose to 5 mg a day.**"³⁰ No taper was recommended and the doctor apparently did not consider the grave risk of halving the dose when she had been on large doses of SSRIs since March 2011. The reduction was in response to Michelle being "on 10 mg and not feeling any more energy. Has been going on walks more. Is still tired a lot with low energy." Under assessment, the doctor wrote, "anxiety controlled but tired all the time." The doctor also ordered a TSH level [thyroid].

Doses of Prozac and Celexa, milligram for milligram, are roughly the same. In the short time of little over one month, Michelle's doctor reduced her antidepressant medication from Prozac 20 mg to Celexa 10 mg (roughly equivalent to Prozac 10 mg) and then to Celexa 5 mg (roughly equivalent to Prozac 5 mg). In other words, the doctor dropped Michelle from Prozac 20 mg to the equivalent of Prozac 5 mg, in little more than one month. After a being so long on Prozac, this did not give her time for her brain and body to recover from withdrawal. It would have been a shock to her central nervous system, her mind, and potentially her behavior.

This medication change on May 5, 2014 was six weeks prior to the negative transformation of her personality and verbal behavior. Six weeks is well within the window of when the onset of adverse central nervous reactions would be expected to arise in association with a medication change. **This change brought about signs of a decline, following by the abrupt negative transformation of her personality and texting around time of June 29, 2014.**

By May 30, 2014, one month before her massive change in personality, character, attitudes and behavior, Michelle had already begun to decompensate, probably due to a combination of long-term exposure to the SSRIs Prozac followed by much too abrupt withdrawal, and a comparatively lower dose of Celexa compared to Prozac. Then she was reduced to Celexa 5 mg. For the first time in the medical record, she is "bingeing a lot." She was so upset she arranged admission into an inpatient eating disorder unit.

The medical record stated:

"Assessment: stable on 10 mg but is bingeing a lot no purging"

"Here for med check. Would like to go to a treatment program. She has been bingeing a lot"

"Will call insurance company to see about coverage for inpatient program"

"continue med at current dose"

Michelle's physician seems unaware of any possible connection between her decompensation and her medication changes. Michelle asked her doctor to get her insurance certified for inpatient care. To make this request, she must have been feeling worse leading up to the big change in her personality, but it's not mentioned at all in the record. She is now back on Celexa 10 mg, but the record does not tell us how long she took 5 mg before going back to 10 mg. No mention is made of the plan to reduce her Celexa to 5 mg.

³⁰ Emphases added. The repeat of the old medication schedule of Celexa 10 mg per day under Medications is almost certainly an oversight, given the above discussion of the reasons for reducing her to 5 mg per day.

On June 3, 2014, Michelle's primary care physician noted that she planned to call Michelle's insurance company "about coverage for an inpatient program." Her weight was 151.

On June 9, 2014, as noted earlier, Michelle was admitted by her own choice to Klarman Eating Disorder Unit at McLean, a prestigious Boston hospital with a Harvard service.

On June 16, 2014 Michelle had a "Consultation for Medical Clearance for Residential Treatment at Klarman EDU"—the eating disorder unit at McLean Hospital in Boston. The referral is by T. Weigel, MD, who is a psychiatrist at McLean. The note says she has had an eating disorder "on and off since 2011—restricting and bingeing—no purging; no laxatives; no diet pills. Exercise = running for hours per day (none for 3 months)." She weighs 152 pounds with a highest weight of 156. She is taking Celexa 10 mg per day. Her blood pressure is 110/70 with no orthostatic drop when she stands. She had her first menarche at age 13 (before Prozac) and she has had only five since then. She has a history of "cutting—last time 2/2014)." She is seen as medically stable but with constipation. The plan is "medications, Miralax" [1] and "reconsult PRN."

The inpatient care at the McLean facility was remarkable in several ways:

First, Michelle's only diagnosis on Axis I was 307.5 Eating Disorder NOS. She had no other primary psychiatric diagnosis such as Major Depressive Disorder or Generalized Anxiety Disorder.

Second, she had no diagnosis on Axis II, where personality disorders are placed. This indicates that they found no borderline, narcissistic, or otherwise disagreeable or destructive personality traits. Throughout the hospitalization, she is described as cooperative with anxieties about how people will look at her (her eating disorder).

Third, no negative behaviors are noted, such as anger, irritability, impulsivity, lack of caring and empathy or a tendency to be controlling.

In short, in her hospitalization for eating disorders June 9, 2014 to June 18, 2014, shortly before her allegedly crime, there is no indication of the kind of person who would encourage a boyfriend, or anyone else, to commit suicide.

On July 1, 2014, Michelle was seen by her primary care doctor for the last time before Conrad's suicide. The doctor wrote, "Had inpatient stay for a week at McLean." Although it is two days after she has already begun her bizarrely negative text messaging, the doctor does not notice anything different, and recommends that Michelle return in 6 weeks. She is "less tired" on the medications, which may reflect activation/stimulation adverse effect. The visit was a "med check" which typically lasts for 5 to 15 minutes in most doctors' offices.

Since she filled her last prescription for Celexa 10 mg, 30 tablets, on June 3, 2014, her prescription would not have carried her through July 12, 2014. However, her parents confirmed that the hospital pharmacy provided medications while she was in the hospital.

Drug-induced manic symptoms do not necessarily stop when the drug is stopped. In a study by Preda (2001), for example, antidepressant-induced manic-like states long outlasted termination of the drug, often requiring hospitalization with extreme measures such as heavy medicating or restraint. According to the last medical record in my possession, she stopped taking Celexa sometime after 12.12.15.

Only July 1, 2014, with her weight at 149.6, she saw her second primary care doctor again: "here for med check. Had inpatient stay for a week at McLean."—"is doing ok on med is less tired. Check mole." She is noted to be still taking Celexa 10 mg. The note reads "continue current dose of med, continue nutrition and psych, recheck in six weeks."

On or about June 29, 2016, Michelle underwent a dramatic change for the worse in her personality, character and behavior. She began to encourage Conrad Roy's suicidal efforts. In their texting, Conrad Roy again says he wants to kill himself. After a lot of texting back and forth, Michelle for the first time begins to encourage him and even provide suggestions for how to do it.

On July 12, 2014, she is texting Conrad. She speaks to her boyfriend. In the early morning hours there is an interchange about him trying to kill himself with the exhaust from a water pump in his car. He calls her to say it is not working and she urges him to keep trying. He kills himself at some time after that.

The texts indicates that Michelle is stricken after she begins to realize what has happened. She texts and phones him more than 70 times after his death before her phone is confiscated by the police. **This behavior displays persistent drug-induced manic symptoms.**

On August 12, 2014, she sees her second primary care doctor: "Here for med check. Using new nutritionist and therapist. Is doing better. Denies bingeing as much. Boyfriend killed himself a month ago. Says she is handling it ok." "Plan: continue current dose."

Michelle sees her doctor again on October 20, 2014: "here for med check. Doing well. Less tired. Eating well. Denies any bingeing and purging. Has more energy and is hanging out with friends." "Plan. Continue current dose. Recheck in 2 months." She is taking citalopram 10 mg.

On March 9, 2015, she saw her doctor again: "Here for Med Check. Has only been taking 5 mg and seems fine. Is in school and is doing ok. Was charged with involuntary manslaughter a couple of weeks ago for allegedly having some involvement in verbally pushing a friend to suicide. Nether Michelle nor her mother mentioned this I asked about it." The order is for Citalopram 5 mg.

She continues on Celexa 5 mg until December 25, 2015, when her weight is 148, in the 80%. The doctor's plan is to stop the Celexa 5 mg. Of great importance, she has been under the influence of an SSRI through the time since Conrad Roy's death for almost a year and a half.

B. Michelle's Involuntary Intoxication

Michelle Carter suffered from an SSRI antidepressant caused activation/stimulation syndrome in the two weeks before Roy's suicide as reflected in her messaging with him. The negative change in her character, personality and behavior was abrupt, and unrelated to any known change in her life or in her relationship with Conrad. Abrupt changes in character, personality are very often drug related, whether the medication is prescribed, recreational, or illegal. In this case, it was the prescription of off-label, inappropriate and dangerous SSRI antidepressants Prozac (fluoxetine) and Celexa (citalopram).

Seemingly overnight, Michelle transformed from a caring, loving, rational, social and successful young person into someone who seemed to feel and certainly professed loved but also became irrational and irritable enough at times to encourage her suicidal boyfriend with words to figure out how to commit suicide and to proceed with it. Her behavior in the form of what she said to Conrad at this point shortly before his suicide lacked empathy and concern for others. Her attitudes were grandiose, or manic-like, as she assumed a position of negative influence that was wholly alien to her and uncharacteristic of her. She seems unaware of the reality of what

Conrad is doing or its real consequences, and afterward cannot believe he has actually killed himself, and then goes on to imagine their life together again.

When Michelle contacts Conrad's phone over 71 times after his death, it further confirms her lack of reality, her confusion, and her manic-like tendencies.³¹ When she seems cunning in how she claims to have never worked so hard in her life to prevent him from killing himself, she may or may not be deluded; but the exaggerated tone again has a manic-like grandiose quality. When she is accused of seeming to like the attention in setting up a fund for her deceased friend Conrad, it might possibly be true, because people in a manic-like state crave attention and want to be the center, real or imagined, of everything that is happening. People in a manic state are often extremely self-centered, obnoxious, manipulative, and unappealing—but this chemically induced syndrome was not something Michelle chose for herself. However, Michelle's family regularly promoted fund raisers, Michelle often participated in them, and Michelle's mother was the one who required that the fundraiser must be held in Michelle's home town, where her mother knew how to go about conducting one.

Until she was given Celexa, there is no indication that she had anything but a memorably sweet and kind personality. After the shocking outcome of her texting, she gradually returns to her normal personality, and according to her parents, does not return fully to her real self until she is completely off the medication.

On September 15, 2014, Michelle texted her friend Boardman:³²

“I just get overwhelmed sometimes with what she says like she . • expects me to know what to tell her and I want to tell her the best things I can because I promised Coco I'd help his mom.and sisters get thru this like I told him I wont let theth go thru depression anid I told him I'd help them and always be there but now that I think of it, youre right she is depressed so I failed Coco I wasnt supposed to let that happen and now I'm realizing I failed him. Sam his death is my fault like honestly I could have stopped him I was on the phone with him and he got out of the car because it was working and he got scared and I fucking told him to get back in Sam because I . knew he would do it all over again the next day and I couldnt have him live the way he was living anymore I couldnt do it I wouldnt let him. And therapy didnt help him and I wanted him to go to McLean with me when I went but he would go in the other department for his issues but he didnt wanna go because he said nothing they would do or say would help him or change the way he feels: So I like started giving up because nothing I did was helping and but I should of tried harder like I should of did more and its all my fault because I could of stopped him but I flicking didnt all I had to say was I love. ou dont do this one more time and hed still be here and he told me he would give me signs to know he is watching Over me but I havent seen any and I just idk..:”.

³¹ Supplemental Narrative for Detective Scott. R. Gordon, p. 13.

³² Ibid. Pp. 17-18.

Because I am in this section of my report drawing conclusions about Michelle's attitudes surrounding the suicide and its aftermath, I want to emphasize that I did not question Michelle about these issues; and I am not relying upon anything she said to draw these conclusions. I strongly believe that I have more than enough evidence to make my observations based on medical records, the texts themselves, and the interviews I conducted, as well as my very extensive clinical experience and scientific research regarding involuntary intoxications.

Occurring two months after Conrad's suicide, the above rambling somewhat disjointed communication shows the persistence of manic-like mental processes and attitudes. Michelle remembers promising Conrad she would protect his parents from becoming depressed after his death. This is grandiose in the extreme—that a seventeen year old would intervene into his family's life to make it all better after Conrad's death. She seems to have actually believed she could accomplish it, and hence now feels like she has failed. Telling Conrad she would make sure his parents did not suffer from his death was not a manipulation to get him to kill himself. It was a genuine if bizarre belief that she could keep his mother from getting depressed—a false belief that rises to the level of a delusion.

Although she remains irrational and grandiose, the shock of Conrad's suicide and her brain's adaptation to its exposure to Citalopram which improves over time, is allowing her to struggle morally over what has happened. The texting indicates she is beginning to feel remorse.

As I have written about extensively in my book *Medication Madness* (2008b), people who act badly under the influence of psychiatric drugs often feel dreadful remorse afterward. They know what they did, in retrospect was bad, and without a pharmacological explanation, they have no relief from the guilt and remorse. In one case, a psychiatrist who had attacked and badly injured a colleague in a bizarre fashion finally grasped what he had done when he was finally withdrawn from antidepressants while serving a lengthy prison sentence. He asked me to come to the jail to consult with him. Since his release was coming up soon and an appeal for a new trial could jeopardize his release, he knew it was too late to help his case. He wanted to speak to me to affirm if the drugs had caused an involuntary intoxication, so that he would at last be able find some relief from his self-blame. He is the "sophisticated psychiatrist" whose case I published and excerpted from the journal on p. 20 of this report.

Michelle's following remark probably does reflect her feelings during the time before Conrad's death: "So I like started giving up because nothing I did was helping..." Her "giving up" turned into actual encouragement. She is becoming so irritable with Conrad that she turns from doing everything she can to keep him alive to encouraging him to follow through on his suicidal plans. Bizarre, as we have seen, is one of the most common and devastating negative impacts of the SSRI antidepressants, including Celexa.

Michelle's "giving up" in a frustrated and perhaps angry manner is characteristic of the grandiose, self-centered idea that if she could not help him then no one else could. This grandiosity is not rational and not characteristic of Michelle or any other normal person. If she had been functioning like the real or drug-free Michelle, she felt like giving up, would have been to call his family, the police, or someone else to intervene. In her chemically-induced manic-like state, she was his savior and she failed, and there was no one else in the world he or she could turn to. This is beyond adolescent self-centeredness. These are distortions more typical of an SSRI-antidepressant intoxication with manic features. The rapidity of the change is also characteristic, with many people describing it as "as if a switch turned on." It is more like a switch turning off—the chemical process required for empathy, caring, rational, and loving

relationships has been disrupted by the destructive forces of the medication's assault on her brain function.

For a long time, Michelle remained very loving to him in their texting and tried to help him get through his suicidal intentions. When he continued to feel suicidal and to talk about it, she completely reversed herself, and encouraged him to go ahead with his intended suicide. Again, this is not petty nastiness, a mean girl, or someone to be condemned; this is a child whose brain has grown up on antidepressants and whose brain had been rendered dysfunctional by the adverse effects of prolonged exposure to Prozac followed by a recent change to Celexa.

Although the medications were the primary and proximate cause of Michelle's manic-like reactions, it is also useful to consider that she based much of her life on making people happy. Interviews of people who knew and continue to know her confirm she was devoted to helping people. But Conrad's dreadful state of depression and anxiety was unrelenting and had not responded to treatment. Having never dealt with someone like Conrad, her failure to help him must have been confusing and distressing to her (see my Supplement concerning Conrad Roy to the Report in the Case of Michelle Carter). [My Conrad Roy Report is sealed by the judge]

Again, I am not basing these conclusions on anything Michelle has communicated to me, but rather I am basing it on the medical records, the texts and interviews (ahead), as well as my decades of clinical experience and scientific research regarding involuntary intoxications with psychiatric drugs.

As bizarre as Michelle's behavior became, it was not among the most extreme reactions that I have evaluated. Others in her condition, when exposed to antidepressants, have been much more grossly out-of-control, ending up in jail or involuntarily hospitalized in a wildly out of control condition. A significant percentage of psychiatric admissions are caused by antidepressant-induced psychosis and mania far more extreme than in Michelle's case (Preda, 2001 in **Exhibit Z-1**). Antidepressant-induced manic-like symptoms, without a full-blown manic episode, is more than sufficient to account for Michelle's behavior.

In summary, whether from direct antidepressant effects or from withdrawal effects, Michelle fits the diagnostic criteria for a Substance (antidepressant) induced manic-like disorder; and no other diagnosis accounts nearly as well for her condition. Her age, lack of a relevant diagnosis, liver dysfunction, and anorexia should have combined to prevent any rational physician from treating her with Prozac and Celexa.

Here are some of the additional criteria that confirm the causal relationship of her drug regimen to her behavior:

(1) Michelle has no history of antisocial personality traits or behavior or any mood disorder

An abrupt change in personality, character and behavior is commonly attributable to medication toxicity caused by prescription medication, recreational drugs like alcohol and marijuana, or street drugs. Since she had no history of non-prescription drug use, the first consideration in Michelle's case should have been the SSRI antidepressants she had been taking most of the time since February 11, 2011.

(2) Michelle's transformation takes place, as it often does in these cases, within a few months or less of a change in SSRI antidepressant medication

The medical record shows no concern about reducing the Celexa and withdrawing Michelle from it. Yet Michelle's brain has literally grown up on SSRI antidepressants. From ages 14 to 17, a period of very rapid and critical brain maturation, SSRI's have disrupted the development of numerous neurotransmitter systems in Michelle's brain. Her brain in turn has compensated by developing additional abnormalities to counteract the drugs. No one knows the full implications of a child's brain growing up in a drastically changed chemical milieu—in essentially a toxic condition. The SSRIs, as claimed by the drug companies, probably have their primary effect on serotonergic neurotransmission. However, serotonin nerves, which originate deep in the brain in the raphe nucleus of the brain stem, spread upward and constitute the most widespread neural network in the brain. In addition, the raphe nuclei and their serotonin nerves connect heavily to the origins of the dopamine nerves in the basal ganglia, profoundly affecting their function. Dopamine neurotransmission in the major pathway from deeper in the brain to the frontal lobes. These are the nerve trunks cut in surgical lobotomy. The SSRIs probably produce much of their flattening effect—the apathy, indifference and lack of empathy—by their disruption of dopamine neurotransmission to the highest centers of the brain in the frontal lobes whose proper function is required for higher human capacities such as love, empathy, caring, self-restraint and impulse control, insight and judgment.³³

It was appropriate to try to withdraw Michelle from SSRIs. However, she should never have been started on the drugs and any taper after several years on the medication had to be slower and with more intense warnings and supervision.

Based on my scientific knowledge and clinical experience in withdrawing both adults and children from SSRIs, these changes in Michelle's medication, after she had been taking the drugs most of the time from age 14 to age 17, were a potential disaster.

(3) The potential toxicity of the Prozac and Celexa were vastly increased by Michelle's special vulnerabilities

Michelle was a child, that she was physically ill with anorexia, and that she had confirmed chronic kidney dysfunction shortly before she was begun on SSRIs when themselves can cause liver dysfunction. More importantly, liver dysfunction will impair the body's capacity to metabolize (deactivate, destroy, or remove) the SSRIs, thereby causing higher blood concentrations with increased risks of adverse central nervous dysfunction that impairs the brain and mind.

Michelle at the start of her treatment with SSRIs was extremely underweight with percentiles in the single digits for her weight and BMI. She was described at one time as "emaciated." Being underweight would make her more vulnerable to iatrogenic overdosing. Beyond that, she was so underweight that her liver function was chronically impaired. This

³³ Serotonergic neurons which originate in the raphe nuclei interact with the dopaminergic neurons which originate in basal ganglia, so that serotonergic drugs like SSRI antidepressants can impair dopaminergic function. See Miguelez, C., Morera-Herreras, T. Torrecilla, M, Ruiz-Oretga, J. & Ugedo., L. (2014). Interaction between the 5-HT system and the basal ganglia: functional implication and therapeutic perspective in Parkinson's disease. *Front Neural Circuits*. 8: 21. Published online 2014 Mar 17. doi: 10.3389/fncir.2014.00021.

made her much more vulnerable to toxic effects, including more subtle impairments of her growth, development, and personality that might not show up until she grew older. It is a characteristic of drug toxicity that its worst effects may show up as the individual grows older.

We shall find that the intoxicating impact of antidepressant drugs is amplified in children and youth, with up to 50% suffering serious impairments in the function of the brain, mind and behavior. The reasons for the great frequency and intensity of this drug-induced reactions in children and youth are both biological and psychosocial. Biologically, the brain is still growing at a rapid rate with dramatic changes in its structure and function, making it difficult for young people to understand themselves and the world around them. The frontal lobes, which are required for higher human functions such as impulse control and judgement, are not fully evolved by adolescence and “frontal lobe development that extends beyond the adolescent years” has been scientifically documented.³⁴ Hormonal systems are surging in adolescence, adding to emotional instability and poor judgment. Psychologically and socially, children and youth lack the experience, wisdom, sense of identity, and social supports to resist the disruptive processes inflicted on their brains by psychoactive substances such as psychiatric drugs.

Overall, Michelle’s sudden brief onset of drug-induced manic-like symptoms relating to her boyfriend, Conrad, was not the product of her own intention but the product of a medication that never should have been prescribed to her.

(4) Michelle and Her Parents Were Not Prepared by the Prescribers to Recognize Adverse Drug Reactions Related to the Mind and Behavior

There is a single note in the second primary care doctor’s medical record that she warned about Prozac’s potentially worsening effects on depression of Prozac. There are no other warnings, including none at all of the risks surrounding drastic changes in personal, character and behavior.

In giving Celexa to an adult (let alone a child), the prescriber was urged by the FDA to share the Medication Guide with both the patient and the patient’s family (even in the case of an adult) and to discuss the Medication Guide with the patient and the family (p. 14 of Full Prescribing Information; also see below). This process would have revealed to Michelle and her family, and alerted them, that Celexa can produce exactly the kind of manic-like activation/stimulation syndrome she endured. The prescriber in this case did not go over the Medication Guide with the patient or family, and did not offer equivalent information and education.

(5) Further Implications of Blaming Michelle

This is perhaps the most critical aspect to understanding what happened to Michelle Carter. The more bizarre her behavior seems, the more it defies her previous compassion and love for her boyfriend. The more it offends our sensibilities—the more we can be sure that this indeed was not Michelle’s behavior, but the behavior of someone whose brain was being compulsively driven into a manic-like state by badly prescribed antidepressant drugs. Although

³⁴ Conklin, H., Luciana, M. Hooper, C. and Yarger, R. (2007). Working Memory Performance in Typically Developing Children and Adolescents: Behavioral Evidence of Protracted Frontal Lobe Development. Developmental Neurology, 31, 103-128. Quote from p. 103.

it is natural for people to want to hold Michelle or anyone else responsible for seeming to encourage a suicide, consider that this is not nearly the most egregious level of harmful behavior caused by Celexa and other antidepressants which have caused psychotic levels of mania and/or disinhibition and loss of self-control leading to murder and mayhem.³⁵

As we hear each new thing that Michelle said that naturally seems distressing to us, we must become objective and realize that this was not the normal or real Michelle speaking, and that it was the drug-intoxicated child who had no idea what was happening to her or why she was behaving in a manner so alien to her. Indeed, the more distressing her words, the more convinced we should be that she was “not herself” at the time.

In many patients, these drug effects lead to compulsive, impulsive, high risk behavior that is highly dangerous to themselves and others. As noted, many of the symptoms of activation/stimulation in the following materials are applicable as well to amphetamines. Unfortunately, patients taking SSRIs are too often left uninformed about these risks, and so their intoxication is involuntary and their actions are involuntary. Expecting to be helped by their medications, they simply do not know what is happening to them. This not recognizing or grasping the effects of drugs upon our mind and behavior is called *intoxication anosognosia* or more simply medication *spellbinding* (Breggin, 2007 in **Exhibit K**). It is an aspect of *involuntary intoxication* that meets all of the generally accepted criteria for that legal concept.

In this case, where the state has charged Michelle with manslaughter, the concept of “reckless” behavior appears in the definition of manslaughter. We shall find that “reckless” behavior is in fact one of the symptoms of the activation/stimulation syndrome caused by antidepressants. Therefore, even if it should appear that her behavior were “reckless” in its lack of regard for the consequences for her boyfriend, herself, and their families, Michelle herself should not be considered responsible for that reckless behavior which is known to be induced by brain intoxication that causes a manic-like reaction, leading to compulsive or involuntary behaviors during which Michelle lacked the conscious self-determination or judgment to take responsibility for what she is doing.

Although her behavior never reached the extreme level of a full-blown manic episode, she was undoubtedly well along the activation/stimulation adverse drug reaction continuum that, we shall find, includes hostility, aggressiveness, impulsive and reckless behavior, unusually grand ideas, excessive happiness or irritability, and other drug-induced symptoms described and scientifically documented in this report.

It is also important to re-emphasize that people who develop these activation/stimulant symptoms as a result exposure to SSRI medications are not acting intentionally. Instead, they are suffering a drug intoxication that drives or compels their behavior. Typically, they have no idea they are doing anything wrong or even behaving differently.

As the FDA-approved Full Prescribing Information indicates, these behaviors are not driven by a mental disorder, because they occur in patients receiving these drugs for non-psychiatric purposes. These reactions will occur in normal volunteers, in patients given these drugs for other purposes such as weight loss or smoking cessation, and indeed, some of these effects can be seen in animals given antidepressants who then become irritable, aggressive, hyperactive and unable to sleep. Some animals also become apathetic, which relates to the lack of empathy or concern for herself and others shown by Michelle.³⁶

³⁵ Breggin (2008a). Also see part **II D** in this report.

³⁶ Riviere, J. & Papich, G. (Eds.) (2009). *Veterinary Pharmacology and Therapeutics, 9th Edition*. New York: Wiley-Blackwell. Pp. 521-531.

This combination of irritability and aggression with loss of relationship (lethargy, not caring) leads to dangerous aggression. There is also agreement among veterinarians that Prozac in dogs, much like in humans, can cause activation or stimulation with increased irritable, anger, hyperactivity and other signs of SSRI activation/stimulation.³⁷ This reinforces the fact that the drug itself can trigger these reactions in animals, so that there is something about the drug itself, and not the “patient,” that will cause similar adverse effects in humans and in animals.

It is particularly tragic that a teenager under the influence of badly prescribed psychiatric drugs should be blamed for the aberrations in her mental life and communications. In effect, we are *criminalizing the victim of adverse drug effects*.

VI. INTERVIEWS

A. Interview with Michelle and Her Parents

On February 25, 2017, in my office in Ithaca, New York, I saw Michelle and her parents, David and Gail, from 2 pm to 5:45 pm with a short break. They were together during most of the entire interview.

Before the interview, as is my practice in similar legal cases, I had reached my basic conclusions and largely completed my report based on the records without speaking to the client or her family. As much as possible, I base my opinions on objective materials. I did not use the interview to determine Michelle’s state of mind at the time of the offense, which was objectively illustrated in the texting upon which the state relies.

The communications of defendants to psychiatrists about their state of mind at the time of alleged crimes are usually considered suspect by jurors, and indeed may be colored by self-interest, and so I try to base my conclusions on medical records and other more objective sources as much as possible. Therefore, in interviewing the family, I did not intend to rely on, did not rely upon, and did not elicit from Michelle anything about the state of her mind or mental condition at the time of the alleged crime.

In Michelle’s case, the allegations are based largely on the transcripts of text messages that I believe need to be addressed without the embellishments of Michelle’s retrospective recollections of what she was feeling or doing. Any answers given by someone about her state of mind at the time of the alleged crime would be complicated by her memory of the actual period versus what she had learned since then, and very likely by any conscious or unconscious concerns about her current dire straits while being charged with a serious crime. Time itself often distorts memories, especially of something as subtle, complex and evanescent as one’s state of mind at the time of a crime or during an involuntary intoxication.

³⁷ The Veterinarian Place lists aggression, anxiety, hyperactivity and restlessness as adverse psychoactive effects of Prozac. Retrieved March 10, 2017 from <http://www.veterinaryplace.com/dog-medicine/prozac-for-dogs/> Vet Info lists lethargy or over-calmness, anxiety, irritability or aggression, sleeplessness and hyperactivity. Retrieved March 10, 2017 from <https://www.vetinfo.com/side-effects-prozac-for-dogs.html>.

Based on my clinical experience and on the scientific literature, Michelle's ability to understand herself or to report accurately about herself at the time of the alleged crime would be seriously limited by years of exposure to antidepressants during the rapid growth and development of her immature brain and mind. Two years' time itself makes recollections vague, especially in young people. Severely stressful events become especially cloudy or confused. After involuntary intoxications, people can become especially confused about what happened. They blame themselves, as Michelle did during a later communication with a friend. Many if not most individuals report they cannot recall what happened under conditions such as these, or they can only remember fragments. Often their memories are confused by what they have subsequently learned. When I have adequate objective evidence, I rely on more objective evidence, such as the medical record; the individual's text messages; and interviews with people who know the individual.

At the time of my interview, there was nothing usual or abnormal about the behaviors or communications made by the three family members. Their relationships seemed strong and loving. Michelle was very bright and alert, and very eager to behave in a pleasing and respectful manner, much as her parents and subsequent interviewees told me. I spent much of the time discussing the various people in Michelle's life whom I could interview who could describe Michelle's personality and character over her lifetime. **There was no indication in the history given by the parents or by Michelle's appearance of any current or past antisocial traits.**

As in most families, Michelle's mother was much more aware of the details of her child's life than her dad was. Some of the points her mother made were that Michelle was well known and liked in their small town and in the combined school district with a senior class of a little more than 300 people.

Many adults in Plainville, as well as others who commuted there for school activities, knew Michelle as a neighbor or member of the community since she was a small child. They reported being dismayed by the accusations against Michelle, and welcomed her to remain at school and in their lives. Her mother brought up the two Superlative Awards, "Most Likely to Brighten Your Day" and "Class Clown" given one year after the alleged crime at high school graduation. Like her fellow student whom I later interviewed, Evan Andrews, her mother said that it was unusual for anyone to receive two awards and they confirmed her healthy social nature that led her fellow students to like and to approve of her. I had to ask many questions to elicit some of these positive aspects about Michelle and her family, because the parents seemed by nature reluctant to brag about their child. Other people I interviewed would be effusive in their appreciation and love of Michelle as a compassionate, caring, and helpful person with a delightful presence and sense of humor.

Michelle's mother stated that neither her daughter nor herself were ever warned about any dangerous mental or behavioral risks associated with either Prozac or Celexa. Michelle's mother went into the examining room for all of Michelle's medication appointments until the last few months before the alleged offense. Out of respect for Michelle's growing maturity, her mother then began waiting for Michelle in the waiting room, but was available if Michelle or the doctor wanted to bring her into the examining room.

Michelle's mother stated that she always took responsibility for giving her daughter the antidepressant medications and watched her take them in front of her. While she had little memory of Michelle was taking at what time, she was sure she and Michelle followed the doctor's instructions.

Neither Michelle nor her mother were given the Medication Guide for Prozac or Celexa. The prescribers and their staff never mention any potential adverse mental and behavioral effects. Michelle's mother believes she herself would have read the much more abbreviated pharmacy handout but cannot recall any details.

Michelle's involvement in developing a softball game activity to provide funds in honor of her deceased friend Conrad was Michelle's idea; but she would have learned from her parents to sponsor and direct philanthropic events because it is something that her parents regularly involve themselves in the community and with their children. (This was confirmed by several interviewees).

Michelle's mother cannot recall any bizarre behavior on Michelle's part at any time in her life, including during the period of the alleged crime. She did notice that during a "few months" leading up to the alleged crime, Michelle had become less engaged with her family, seemed somewhat withdrawn, and would spend more time in the basement. She also noticed that her daughter was going off by herself to text more during this time period. Mother's recollections of Michelle's problems mostly surround her increasing bulimia, which involved extreme exercise rather than vomiting. This led up to Michelle asking to go to the McLean eating disorder center, where she stayed June 9-June 18, 2014. When Michelle returned, her weight had gone up and she disappointed with the program, which was oriented to dangerously thin anorexics while Michelle's weight was normal.

In her sophomore year, Michelle wrote a vague letter (no longer available) to a friend about not wanting to live. It had no overt mention of suicide or suicidal intent but was concerning to a friend who took it to the guidance counselor, who contacted Michelle's parents. Michelle at the time said she was not suicidal but school regulations required that she be evaluated.

Michelle's mother confirmed that the development of bulimia with extreme exercise occurred mostly after starting on Prozac. Michelle's distressed note about not wanting to live occurred while she was taking Prozac, which already had a Black Box Warning about increasing causing suicidal behavior in children (**EXHIBIT O**).

Michelle's mother stated that she always gave Michelle her medication and that Michelle took it in her presence. She did this until the medication was stopped. She is therefore certain that Michelle always took the medication and always as prescribed. During the McLean ten-day hospitalization, the hospital provided her medication.

The most striking part of the interview was the number and quality of the individuals the family named for me to talk with about Michelle's character and personality over the years.

B. Interviews by Phone with People Who Know Michelle Well

I am in the process of interviewing people who know Michelle well. The interviews varied in length from 30-45 minutes and occurred in the order they are listed.

Since Michelle is from a small town and a relatively small high school, many people have known her since childhood in a variety of capacities. The interviews thus far conducted have an astonishing consistency in their description of Michelle as an unusually kind, empathic and even compassionate child, a youngster whom no one would suspect of bearing ill will or doing harm to anyone. Here are the complete details of the interviews thus far conducted:

(1) Chuck Charles Quealy (February 28, 2017)

Mr. Quealy is an insurance agent who volunteered to coach his own son and two daughters in softball and then continued to do for the community's traveling league, which prepares the students for high school softball within the school system. He explained that softball is very important in the community and its high school team has won state championships. He coached Michelle in softball in both the fall and summer seasons in 9th and 10th grade. He also coached her younger sister and he knows the Carter family well. His children also know Michelle and her sister. He saw her regularly when coaching her and has continues to see her several times or more a year.

In high school, she was "not a big strong kid" and so was not among the best players, as she was when younger (see Mr. Shaffer's interview below). She was appropriately competitive "but never took it for more than it was, a game. She had a good perspective on it being a game. She enjoyed being part of a team. The players were all her friends. Our team didn't have many from outside the school. The team traveled all over as friends."

When I asked what words he would use to describe her, he said "quiet" and "talkative at the same time" and laughed about the seeming contradiction. "Always willing to learn. Always putting the team first. Whatever the team wanted." "She didn't need to be a star; just wanted to be a good team mate." "Always the one to keep it light on the team." "She would be the one to break the tension and not take losing so seriously."

I asked if she was well liked and he quickly replied, "Yes." Team parties "were always at her house. A great family."

Michelle and her family lived a couple of streets away from his home and she would come over and visit spontaneously throughout high school, biking with her friends. She would sit and talk by pool. His daughters were a little older and she would visit and talk with them. She had a very good friend Courtney Murphy, who didn't play softball, but who wanted to come to all the games with Michelle.

When I asked if she was ever in any way a "mean girl?" He replied emphatically, "No. No. No," as if it were an outlandish idea. She was like sisters with her friends. Even when softball was over, they would come by his house and he would see her with other girls. In games, the girls were always cheering for one another.

He has heard she was charged with "assisted suicide or something like that; manslaughter?" He commented, "I don't think she had a mean bone in her body to be perfectly honest. Not a mean bone."

In response to my question to provide words to describe her character and personality, replied, "Fun. Out going. Just a fun kid enjoyed being with other kids. Loved being part of team. Traveled to Montreal and many other places. Good teens. Most favorite team I've ever coached" but not best team in terms of softball skills.

Michelle was "Always that nice kid." "She was a sweet and kind kid, always the one who would say don't worry about it. If a kid struck out, she'd be the one to say that's okay don't worry about it. She was never the one to pick on you for making a mistake." "Just a fun kid."

I asked if he had ever seen any negative behavior. He replied, "No, never, not one time I ever thought of her as a disciplinary problem. And trust me, I was tough." He is very emphatic about this.

I asked about Michelle's family and he replied, "Great family. I coached sister for multiple years, too. Lived a couple of streets away."

Could she be considered antisocial in any way? “That’s crazy. That’s not her. It doesn’t jibe with the kid I know.”

Overall, Mr. Quealy knows Michelle and her family very well, and his tone in talking about Michelle is very appreciative, warm and caring without any reservation. In my many interviews of adults about children in my practice, forensic work, and elsewhere, I have rarely heard such unalloyed appreciation of a child and youngster without even a hint of criticism.

(2) Jim Shaffer (February 28, 2017)

Jim Shaffer is Vice President for, Risk and Oversight foreign investing, for the State Street Bank in downtown Boston. He is a manager of people up to 50 at a time, now in more of an oversight role. He has known Michelle for about 12 years or since she was eight-years old, perhaps in the fourth grade. The last time he saw her was a “week ago maybe at the gym.” She ‘works out at a very intense pace, I certainly cannot keep up.’

He has known Michelle through the Plainville Athletic League (PAL) where he coached her in softball and through the gym at the North Attleboro YMCA where they both exercise and continue to do so. At the PAL, he saw her both as a coach and as an observer of her as child hanging out with other children at the YMCA: “Kids would play sports and hang out as well. So I saw her as a coach and also saw her from a social standpoint always hanging out.”

She has always been, “outgoing, energetic, fun and passionate person.” and “a fairly popular person with a quality group of friends.”

When asked if she was ever a mean girl or a nasty girl, he replied emphatically, “No.” “If anything she was the kind of girl who liked to make people feel comfortable.”

He knew her in 7th and 8th grade when she had an eating problem. “She was always a beautiful girl and she had lost 20 pounds and then two or three months later she looked “skeletal like” instead of “skinny.” Seeing her so “skeletal” gave him a bad feeling in the pit of his stomach. He recalls she was in middle school at the time.

When I asked how does she seem now, he replied that he saw her mostly at the gym where they would have “brief conversations.” He explained, “I can tell her that the events that have transpired have taken a toll on her. She still is funny when we interact.” He offered the example of meeting her after he was soaking wet with sweat after a heavy workout and “she looked at me and laughed and smiled, and chuckled.” He felt briefly self-conscious, until “she reassured me in a very playful way that I just looked like I was working hard.”

When asked what he has heard about her current situation, he said his understanding was he referred to what he had learned from the newspapers: She was in a relationship with a young man who had a plan regarding taking his life, that they were texting, and that at some point she didn’t encourage him to stop, and instead “she encouraged him to move forward.” He also recalled that subsequently she headed a fundraiser at the athletic league for mental health awareness in memoriam of the boy.

Mr. Shaffer explained that such behavior was “furthest from my mind from what Michelle would have been involved in.”

When I asked if she had been involved in any antisocial behavior, he replied, “Never when I’ve been around, no.”

When I asked if the behavior described in the newspapers was out of character for her, he replied “Yes. Literally almost unbelievable... I cannot rationalize it. Completely out of character.” He said he would be proud to have her for his own daughter and she was welcome in

his home. He went on to explain, "I've had a lot of interactions with her. Not long ago, he "chatted a about coaching and many kids came up and were completely engaging with her." This was last summer, since the bad publicity.

He further explained, "She was more an elite player than some of the other players, but "she was very supportive of others whose skill set wasn't up to her level."

I asked him if- he knew Chuck Quealy and he replied, "One of my best friends. " I said Chuck did not describe her as elite as a player. He thinks she was playing on a higher level before the eating disorder. "Michelle was fantastic. She would excel at very drill."

Even when having eating disorder, did she get mean or nasty. "I never saw that."

Most of his interactions with her continued to her freshman/sophomore year but after that the girls in general no longer hung out as much as the Athletic League. He did continue to run into her and/or her family. Both Carter children were always very polite and very nice. He has daughters a couple of years older, and he's sure Michelle came to house at times.

"Michelle would absolutely be welcome in my home."

When I asked about her parents, he replied, "Salt of the Earth people. Would do anything for you. Anything you would ask. Our league was always about volunteering and community, and I cannot think of anywhere Dave and/or Gail were not involved in volunteer activities. Very charitable."

I asked if her family being charitable went along with Gail wanting to do the event for Conrad Roy and if he would expect her mother was involved, too. He said such an activity was very typical of the family and he knew that her mother had been involved. He recalls participating in the event.

Like Mr. Quealy, Mr. Shaffer's view of Michelle is filled with appreciation, enjoying and caring with no hints of any rough edges or social problems.

(3) Charlene McEntee (March 1, 2017)

The Carter family moved next door to Mrs. McEntee and her family before Michelle was born and so she has known Michelle since she was a small child. Michelle has always looked up and related to Mrs. McEntee's daughter Kelsey, who is now 25 years old. Kelsey is like a big sister to her. When the news about Michelle hit the newspapers, Kelsey immediately reached out to her.

Mrs. McEntee also has a special perspective on both Michelle and her family because Mrs. McEntee has been a member of the Plainville School Committee (an elected position identical to a Board of Education; K through 6) for 18 years and a member of the Regional School Committee (intermediate and high school) for 12-13 years.

Her daughter Kelsey has been in regular touch with Michelle, and she herself sees her in passing on the street all the time, but she has not talked extensively with her for a few months. The recent lapse in contact is because Mrs. McEntee has spent most of her time since May 2016 taking care of her son who is having dialysis at Children's Hospital for a chronic illness. She stays in touch with Michelle through hearing about her from her daughter Kelsey.

Mrs. McEntee describes the Carter family as "very stable, loving, supportive, dedicated, very involved with kids." Both parents were very active participants in daughters' activities and both were always at school for any kind of event, such as fund raisers, special school nights, open houses, and parent conferences. "They are a very great and dedicated family. Michelle is a great kid, a sweet and quiet kid. She was and she still is."

When asked what she understands about what Michelle did, she replied she only had information from the media. “Supposedly texting and coerced this man to take his life.” Mrs. McEntee “cannot imagine” Michelle consciously coercing anyone about anything: “She’s not that kind of kid.”

When asked to describe Michelle, she summed up, “She’s quiet. Not loud or boisterous. Very athletic like a tomboy when young. But always very respectful. I know a lot of kids in their high school days raising hell and drinking. She was never like that. She was just... she *is* just a sweet quiet, caring little kid... She always asked about my son, Sean... Compassionate.” Throughout her growing up years, she saw Michelle, often with her daughter and her home, and at parties her daughter gave, despite the age gap.

In her role on the school committees for K-6 and intermediate and high school, Mrs. McEntee never heard anyone have any concerns about Michelle’s behavior. “I know she had some emotional issues of her own. I know she had her ups and downs with gaining weight.” When asked if Michelle sometimes became irritable when having her emotional or weight problems, she said definitively, “Not at all.” When asked if Michelle ever bullied anyone, she replied, “Not that I know of.” She said that her role on the school committees would have drawn her attention to anything “serious” that Michelle would have done.

I asked Mrs. McEntee to rate Michelle on scale of 1-10 for good kids,” and she replied, “From my experience, I would give her a ten. I really would!”

(4) Evan Andrews (March 1, 2017)

Evan is a nineteen-year old sophomore at Elon College in North Carolina studying business management. He has known Michelle since 7th grade, or about eight years, and graduated in the same high school class with her. He estimates the class size was 280-285.

The last time he spoke with her was today. He explained to me that she was not allowed to text. He said, “I call her every day” and “She’s my best friend.” He likes phoning instead of texting because it “Makes our conversations more meaningful because we hear each other’s voices, and you have to go out of your way to call.” He said, “We got close my junior of high school, four years ago. Both graduated in 2015.” They are not romantic involved and have never been. He was not in any of the texts or emails surrounding Roy and was unaware of what was going on. “We hung out a few times that summer, but I wasn’t around her so much during that time.”

Asked to describe her as a friend, he said, “Honestly, and not just because of the situation [of this phone call], Michelle is the best friend I’ve ever had. I can always count on her and I appreciate that because people my age it’s hard to find friends you can always count on no matter what.” He gave an example. “I’ve been dealing with anxiety since my sophomore of high school, and over the summer, I tried getting off my medicine, didn’t want to stay on it, thought I was in right state of mind to do it, and one day she came over with a huge mason jar of quotes of things she loved about me. Huge jar of notes that makes me smile.” He reported, “My junior year she was in my Spanish class, and I always looked forward to it, and her presence was always good.... I always valued that, seeing her throughout the day.” “I love her as far as friendship goes but not ‘in love’ with her.”

He and Michelle have shared a few of the same friends. Most of her friends stuck with her after the reports in the newspapers and media. She continues to have “a circle of friends, mainly girls but also some guys.”

I asked, “What kind of person has she been with friends in general. He replied, “Always happy. She’s always been funny. For example, I found out later she had some anxiety, but would never have figured it from knowing her.”

Evan also learned from Michelle at the end of their junior year, and before the incident, that she was on psychiatric medication and felt she needed help. He was surprised by that.

He has never known her to be mean, nasty, or bullying in any way. “No, never, at all in any way. That’s what makes the incident seem so strange.”

I asked if anyone disliked her before the incident and he replied, “No.”

I asked if he knew her family and he said, “Every time I’m home from school, I’m over her house a lot.” His parents live two towns over—25 minutes—in the same school district.

I asked if there were any bad things about her. He said, “No, she really is the sweetest girl. That why I can’t imagine anyone saying anything bad about her.” After he heard about the incident, “I reached out to her mom to see if there were anything I could do to help her case.”

I asked him if she had any manipulative or controlling qualities. He said, “As far as saying she’s manipulative or controlling, I always felt in high school she got pushed around or taken advantage of, so it was the other way around.” “High school’s tough, and if you’re a sweet genuine person people will take advantage of you. I remember people, even though they were friends, being tough on her, and if you’re a genuinely sweet person it’s easy to get taken advantage of.” I asked if Michelle was ever bullied? “One situation freshman or sophomore year that a girl on her softball team was bullying her. Three years older than Michelle. Not really the nicest girl either. Michelle and I were friends. Other people as well knew about the bullying. I remember seeing Michelle going to the counselor at school because of how she was being treated by this girl. I think the principal of the school put her foot down on the situation but I don’t know for sure.”

I asked if, when being bullied, Michelle react angrily or aggressively. He replied, “She was never cruel. She got ‘superlatives’ in her senior year, “Most Likely to Brighten Your Day.” She was also awarded the ‘superlative’ for “Class Clown,” and you don’t those without people liking you. We had a banquet for the senior year and that’s where they gave out superlatives. They don’t give out a lot. No more than 30.” He doesn’t recall anyone else ever getting two. “It doesn’t happen very often.”

When I asked him to rate her on a scale of ten for being a sweet, kind loving human being, he laughed, “Can I go *above* ten? Otherwise she’s a ten.”

(5) Tim Mullen (March 2, 2017)

Mr. Mullen works for Citizens Bank where he is a vice-president. He is the second of Michelle’s early coaches who has remained in touch with her. He coached her approximately from age 10 to 13. Mr. Mullen was so eloquent in describing Michelle and his high regard for her, that I hardly had to ask questions. He has three daughters and a son. His youngest daughter is one year younger than Michelle and his older daughter is about five years older than Michelle. His youngest daughter was on the softball team with Michelle.

Mr. Mullen spoke enthusiastically with the necessity of my asking many questions. He began by explaining why he called me. “I just want to be able to help out. I’ve followed along the newspapers. I coached Michelle for four years and she’s one of the nicest kids I’ve ever coached and I wanted to help.” “Such a mild mannered girl. I coached her close to ten years ago for a period of four years. She listened really well. Always really a well-behaved kid. And she

took coaching so well, listened and did exactly what I asked her to do. A good team member too. Quiet. Led by example. My oldest daughter was the same way. Taking it all in, not very vocal, and leading by actions. I always thought Michelle did a good job in behavior, performance, and attitude. I thought she was a good kid. You don't always have to be super-vocal to get noticed."

I asked where he would place her on a scale of ten on being good, loving or compassionate. He replied, "The Michele I've always known, I would give her a ten. I've always felt that way." "She was one of the most special kids I ever met. Softball. Soccer. I've coached a lot of kids, and she one of those kids you really enjoyed. Makes it worthwhile to coach. And her parents are great too. They really helped me. Dave used to help coaching. Gail is great too. But I knew the kid before I knew them."

I asked if he ever saw Michelle do anything mean, quirky, weird? "Never once. I've had kids who were. I had kids that had behavioral issues and a mean streak in them, including shy girls who surprised me sometimes by doing something mean, like squeezing an opponent's head too hard when shaking after losing a game. But I never saw anything bad behavior with her or when she was with other kids, parents or coaches."

"When they are little and start learning softball. I coached third base and I'd instruct the runner at third base, 'On the next pitch when the catcher gets it and starts to throw it back to the mound, I want you to steal home, and I don't care if you get caught, just go. Most kids would question me. She would listen to me and just do it without question. She took instructions excellently. Everything I ever asked as a coach."

"Usually 9-13 year olds, things get cliquey all the time. She wasn't that way at all. She was friendly with everybody on the team. She was good for everybody on the team. A good team mate. I never heard a bad word come out of her mouth. Always really positive." He never heard anyone say anything bad about her except in the press.

"Everyone in Plainville is in shock by the whole case, and surprised. I think anyone who knew her would say she was kind. I wouldn't say this about everyone. She left such a good impact on me because she was a good girl."

I asked him to tell me more about Michelle's athletic abilities and about the team. "This was a very accomplished team. One of them just threw a no hitter at West Point. Another is a You Tube sensation with hair and design, with millions of followers. My own daughter is doing very well. It was a unique group of kids, and Michelle was unique and special. ... Michelle was one of the top three athletes on my team. She played shortstop and third base. Very fast. Great at stealing bases. Never bragged about it. Also at soccer did a very good job."

"Sports bring out the personality in young people. Even though I coached all girl teams, I wanted them to play through injuries and to be competitive, and not quitting easily. ... Michelle was a good teammate who never gave up or got down if we were losing. I think personality shows more in sports than anywhere else and she was always good and never a negative." She was a year older than his youngest daughter. "They were friends. Michelle was very friendly with her. It's easy for older kids to get on the younger kids on the team but she was always good to younger kids. Michelle was usually among the older group of kids and she was always good to the younger ones."

I asked if he knew about eating disorder problems. "That was when I was seeing her only once a twice a year. I did notice how thin she was and I heard about it. And my wife and I theorized that it was due to the death of her grandparents and we also had heard that from others. I thought she would be a really good high school player but she was really too thin.

I asked him to describe their current relationship. “I continued to follow softball in region and I’d see her at the athletic field. She’d be with a friend or two. I’d say hi to her and she would come over. Some kids you coach for a few years and they act like they don’t know you and she’d always say hi. Once she reached high school age I saw her only a couple of times a year at high school games.” He added, “I can appreciate when a kid stays kind or friendly with their coach over the years. She was very social with me, absolutely.”

I asked how he heard about the incident. “Kind of strange. My daughter and I in airport saw it on TV. Also local media. Also *People Magazine*. They said her boyfriend committed suicide and then I was reading the excerpts in the newspapers of what they said she said bout her convincing him to do it. Reading quotes from phone conversation and texts. I was shocked. Knowing Michelle, I said there must be more to it. Then I heard it was more of an on-line relationship. Started worrying me that my daughters might be texting and what they were texting.” “More recently I read about medications that both were on. From the *Attleboro Sun Chronical*. About a month ago.” He also received information from Bostonchannel.com and Boston.com. He felt very strongly that the incident was being sensationalized and in some way required further explanation. He knows that Michelle’s mother “was crushed by unfair treatment by the media.”

I asked if he had seen Michelle since the incident and he explained, “I have. I saw her down at the Plainville Athletic fields. She greeted me. Said Hi. I just asked how she was doing. She seemed okay.”

(6) Jennifer Robillard (March 5, 2017)

Of the people I have interviewed, Ms. Robillard seems to know Michelle best and to have a relationship in which they confide in each on occasion. Ms. Robillard is 23-years-old, two or three years older than Michelle. She graduated college and is working full-time in her first year of teaching high school math in a town not far away from Plainville. Now that she has graduated and is working nearby, she has returned to living with her parents only a few blocks away from Michelle’s home.

Their families have been neighbors “just down the street” from each other for 15 years and she has known Michelle the whole time. She especially came to know her when Ms. Robillard coached her in middle school. Even when in college, Michelle stayed in touch, visiting when she came home during breaks and vacation.

Their relationship began as friend and mentor combined and now they are very close friends. When they were younger, Ms. Robillard would be the one to encourage Michelle when she was facing new tasks at school, in sports, or with her eating problems. From the time Ms. Robillard was getting ready to leave for college, the roles became equal in respect to helping each other. Michelle gave her support and courage when taking on new challenges such as going to college and starting first teaching job.

I asked her on a scale of 10 to rate Michelle from her own viewpoint for being “loving, caring, and not likely to hurt anyone,” and she immediately stated, “Absolutely put her at a 10. No reservations.” Even when pressed, Ms. Robillard could not recall ever hearing “mean” or “unkind words” come from Michelle.

Michelle never teased or hit other kids during sports or at any other time and instead she was supportive of them, absolutely.” She explained, “Michelle was always supportive of me going to college. That’s when the relationship changed from being a mentor. When I was home

sick from college, she was always there for me to tell me I could do it, that I was strong. Any time I needed to take a ride somewhere, I called her and she was willing to go with me.”

When asked to describe Michelle in a few words, she replied, “Caring. Cares about other people for sure. Compassionate. She has a kind heart. She was very motivated to lift your spirits. Like let’s go get ice cream. Or let’s do this or that. . . . I was fortunate to get the more intimate, private side of herself. She didn’t worry much but she cared about her grades, did well in school, and wanted to make sure she was going to get into a good college—all the typical stressors. I feel like I’ve gotten to know her very well. . . . I absolutely love her, one of my closest friends, always been there for me. . . . No mean side to her, even knowing the inside of her, no hint of that anywhere.” Because Michelle is not allowed to text, they “play phone tag a lot” and then talk on the phone when they get each other.

I asked Ms. Robillard if Michelle, when stressed by anorexia or in serious competition in sports, ever gave a hint that she had a dark side, a mean side. Ms. Robillard answered emphatically, “Never!” Michelle always remained a person who would try to “cheer you up” and never became difficult or irritable.

Because their hometown is small and because they have both moved in the softball circles, Ms. Robillard also knows many people who know Michelle. She cannot think of anyone who has an unkind word about Michelle, who does not like her, or who would not give her a good assessment.

She saw Michelle around June and July 2014 before and around Conroy’s suicide. Early in the summer, Michelle was “struggling a little with her own self-image,” especially her body image. Nothing wrong was going on in her Michelle’s that was causing this increase in her anorexia. They would go to the gym and play tennis together at times, but Ms. Robillard was also becoming increasingly busy. She had the feeling that Michelle was feeling unsure of herself and she knew that Michelle had chosen to enter the McLean eating disorder clinic. Asked to compare Michelle’s anorexia at age 14 to how was in June and July 2014, she explained that Michelle was better in 2014, but still having many issues with anorexia and seemed to be getting skinnier and to be exercising even more.

Ms. Robillard knew about Michelle’s success in the schools highly respected Business Class that won competitions traveling around the country. She knew her teacher was Mr. Dow. Michelle had mentioned Evan Andrews to her, but she does not know him. She never Conrad Roy, but heard a lot about him from Michelle. It was always positive.

When I asked Ms. Robillard her knowledge about Michelle’s criminal charge, she said, “I never had a conversation with her so she could come to me and relax and hang out and not worry about it. We haven’t really talked about it. All I know is about the stuff I hear on the news.” I asked her what she had read in the newspapers and she had difficulty speaking about it. When asked, she said she never wanted to repeat what was said about Michelle because “She’s my friend and I believe she’s a good person. I know her and it doesn’t sound like her.”

She did not know Michelle was taking antidepressants but was not surprised in light of Michelle’s visit to the McLean eating disorder program. She would not call Michelle depressed, but Michelle did at time fall into “a little funk,” mostly about her anorexia.

In describing how their relationship had developed over the years, she explained, “Michelle has definitely become a positive relationship for me—made me a better person.”

When asked if Michelle’s being given the award for Class Clown meant she was at times rambunctious or disruptive the way people might think of a class clown. Ms. Robillard said emphatically that Michelle was never a problem for anyone. She got the award, Ms. Robillard

believes, for her sense of humor and her ability to brighten people up. She said, “Her laugh alone is so funny you can’t help but laugh.” She added, “I don’t believe she ever had a detention in her life.”

When asked about Michelle’s feelings after Conroy’s death, replied that Michelle “went into a little bit of shock at first. Then the grief came in a little bit later. She spent time with friends a lot to cheer her up. Take her out to lunch. She seemed to go through a normal grieving.” When I asked about Michelle holding the fund raising event in his memory, Ms. Robillard said, “I thought it was awesome. He had died and she had had her own mental health issues. It was her chance to step out of her comfort zone and make a difference instead of falling into depression. I remember being proud of her. It was awesome. She put so much into it. Especially to play softball again which she loved so much. I was proud of her.”

When asked if Michelle could have been aggrandizing herself or seeking attention, she answered, “No, she never sought attention. Liked to fly under the radar. After her anorexia issues she was never looking for attention. Not her type of thing.”

Ms. Robillard said that currently Michelle is taking on line college classes. “Everything’s normal when I see her. She’s disappointed not to go to college.” Michelle is unsure, but she assumes Michelle has stayed at home because of all the bad publicity. However, she has not become withdrawn.

She last saw Michelle a week or two ago. Now that she has moved back home, Michelle expects to see her more often. “She’ll now stop by and knock on door because we’re so close.”

VII. OVERVIEW OF GENERAL AND SPECIFIC CAUSATION

A. General Causation

General causation looks at the scientific question, “Is there evidence that psychiatric drugs can and do in some cases cause the abrupt transformation in personality, character, attitudes and behavior seen in the case of Michelle Carter?”

(1) Limits of Double-Blind Placebo-Controlled Clinical Trials

Many valid sources or kinds of evidence go into decision-making and drawing conclusions in the science of psychopharmacology, as well in this specific report. Although double-blind placebo-controlled clinical trials are often touted as the “gold standard,” they are in fact very limited by their short duration, their small numbers, the exclusion of complicated or greatly impaired patients, and their emphasis on providing positive information for the drug-company sponsors.³⁸ They are also limited by the weekly visits and intense scrutiny of the subjects because, while good for the study and the patients, this kind of supervision never takes place in the real world of psychiatric drug prescribing, which is far more chaotic and hazardous

³⁸ For a discussion of the limits of double-blind placebo-controlled studies, drawing upon many citations to the literature, see Breggin, P. (2008a), pp. 352-361, including related observations by FDA insiders, including the director: Kessler, D. A. (1993). Introducing MEDWatch. A new approach to reporting medication and device adverse effects and product problems. Journal of the American Medical Association, 269 (21), 2765–2768.

than the controlled clinical trials. Michelle’s treatment, for example, bore no resemblance to controlled clinical trials in the lack of warnings and education about adverse effects, the lack of justification for prescribing her the antidepressants, the lack of sophisticated clinical supervision, the increased risks associated with her bulimia and liver dysfunction, the long-term exposures to antidepressants, their prescription to a child, and at times the too high antidepressant doses for a child. Remember as well that the studies in the Full Prescribing Information were based were limited to patients observed for only 4-6 weeks in clinical trials (p. 37 of Celexa Full Prescribing Information) rather than the several years of exposure to SSRIs that Michelle endured.

Information from double-blind placebo-controlled trials will be used in this report and much of information in the FDA-approved Full Prescribing Information is based on these kind of trials. However, information is also needed from other sources such as clinical experience, clinical reports, chart reviews, modified clinical trials and epidemiological studies. In developing causation, this report has cited the whole range of these sources of scientific information. This report also describes the causation findings in commonly used textbooks, such as the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders, Volume 5*, 2013, which in its recent editions makes clear that antidepressants cause mania and a variety of other adverse behavioral effects that grossly change personality, character, attitudes and behavior.

A massive amount of evidence confirms that SSRI antidepressants such as Prozac and Celexa can and often do cause abnormal behaviors in children up to age 18 that make them irritable, aggressive, lacking in judgment, disinhibited, impulsive and overly stimulated or activated in ways that resemble mania or bipolar disorder. What follows is some of the evidence for causation, all of which this report has already been addressed.

(2) The FDA-Approved Full Prescribing Information for Prozac and Celexa

Simply reviewing the information in the Celexa and Prozac Full Prescribing Information should allay any concerns about general causation—that Prozac and Celexa, given to an anorexic child and teenage girl, can cause a drastic negative transformation in her personality, character, attitudes and behavior that could include compulsively and bizarrely encouraging a loved-one toward suicidal behavior.

We have seen that the Code of Federal Regulations governing the Warnings sections of the Full Prescribing Information for Celexa and other SSRIs requires the publication in the Warnings and Precautions a “**clinically significant hazard as soon as there is reasonable evidence of a causal association with a drug.**”³⁹

We have seen that the FDA acknowledging a “known association” between the SSRI antidepressants and the spectrum of overstimulation effects called activation which they describe as “such as anxiety, agitation, panic attacks, insomnia, irritability, hostility, impulsivity, akathisia (severe restlessness), hypomania, and mania...” (**Exhibit, M**, March 22, 2004, p. 1). This string

³⁹ Code of Federal Regulations [Title 21, Volume 4]. [Revised as of April 1, 2008]. [CITE: 21CFR201.57] [Page 24-39] TITLE 21--FOOD AND DRUGS. CHAPTER I--FOOD AND DRUG ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED). PART 201_LABELING. Retrieved January 3, 2015 from <http://www.gpo.gov/fdsys/pkg/CFR-2014-title21-vol4/Attachment/CFR-2014-title21-vol4-sec201-57.Attachment> Bold added

of activation or over-stimulation symptoms appears in slightly altered form in every antidepressant Full Prescribing Information.

We have seen that the FDA-approved labels for Celexa (and all other SSRI antidepressants) contain elaborate warnings about medication-induced activation, including in the Warnings sections. The following quote from the Celexa Warnings (**Exhibit N**) was introduced earlier in this report:

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. P. 4

We have seen that the following Adverse Drug Reactions occurred in the drug company studies: In at least 1/100 patients: **“impaired concentration, amnesia, apathy, depression, aggravated depression, suicide attempt, confusion”** and in at least 1/1000 patients: **“aggressive reaction...depersonalization, hallucination, euphoria, psychotic depression, delusion, paranoid reaction, emotional lability, panic reaction, psychosis.”**

We have shown that the federal *Code of Federal Regulations* also designates what goes into these less stringent Adverse Drug Reaction sections of every drug label.⁴⁰ The *Code of Federal Regulations* specifies that the adverse reaction section must contain “only those adverse events for which there is **some basis to believe there is a causal relationship between the drug and the occurrence of the adverse event.**”

(3) The Official APA Diagnostic and Statistical Manual of Mental Disorders on Causation of Antidepressant-Induced Abnormal Behaviors

As also described earlier, the official American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, often refers to antidepressant-induced mania. In addition to those symptoms mention in the description of activation in the Full Prescribing Information for antidepressants, there are additional symptoms such as antisocial behavior, criminal behavior, “increased involvement in goal directed activities,” “goal-directed activity [that] often involves excessive planning,” grandiose behavior and other bizarre and abnormal reactions. Also specifically relevant to Michelle, “Ethical concerns may be disregarded even by those who are typically very conscientious.” Again relevant to Michelle’s behavior, which is best clinically categorized as highly “irritable,” the *DSM* observed that, “If the person’s mood is more irritable than expansive, speech may be marked by complaints, hostile comments, or angry tirades.”

This broad spectrum of antidepressant-induced adverse drug reactions certainly covers Michelle’s behavior. Even one word descriptions, such as disinhibition or irritability, would be sufficient to show that, as a general principle, that antidepressants can and do cause abrupt transformations in personality, character, attitudes and behavior such as endured by Michelle.

⁴⁰ Ibid.

The Full Prescribing Information, the *DSM*, and the studies in the next section all describe one or another aspect of Michelle's approximately 12 days of texting that are under scrutiny in this case.

(4) The Peer Reviewed Scientific Literature on Antidepressant-Induced Abnormal Behaviors in Children and Youth

Section **IV B** this report presented seven scientific studies spanning 1990-2015, documenting that SSRI antidepressants cause a large percentage of children and young people in Michelle's age group to develop very abnormal mental processes and behaviors when exposed to these drugs. As one example, Riddle et al. in a clinical study at Yale Medical School found that 50% of children age 8-16 in their clinic developed behavioral abnormalities on Prozac, including social disinhibition, all of which ended by reducing or stopping the medication.

As another example, Wilens et al. at Harvard found that 22% of children exposed to a number of antidepressants, including Celexa, developed psychiatric or behavioral abnormalities, often in the form of activation. Extremely relevant to Michelle, 12 of the young people (15%) became "irritable." Irritability was by far the most common drug-induced symptom in the study and it was also Michelle's predominate drug-induced symptom as she becomes seemingly frustrated and irritable over Conrad's efforts to commit suicide.

While under the influence of the antidepressants, victims of adverse drug effects on the mind, they do not know or recognize at the time that they are doing anything wrong. Instead, they feel a compulsion to behave in the new and destructive fashion. Not knowing why they are behaving in the way they are, they simply accept the behavior without questioning it.

These antidepressant-induced personality changes are described in many different ways, some of which are:

- (1) Apathy syndrome with lack of caring or empathy;
- (2) Obsessive preoccupation with dark ideas relating to suicide, violence and other destructive goals;
- (3) Activation/stimulant syndrome with aggression, irritability, impulsivity and loss of control over bizarre thoughts and behavior; and
- (4) Hypomanic and manic symptoms, such as grandiosity, compulsive planning with bad outcomes, and loss of ethical concerns.

There is considerable overlap among these drug-induced syndromes. All of them impair empathy, caring, judgment, and the ability grasp the implications of one's actions for self and others. Often these individuals are also thinking and behaving in an obsessive and compulsive manner in respect to their changed thinking and behavior. It is no exaggeration to say that antidepressant drugs can inflict *temporary chemically-induced antisocial personality traits and attitudes* upon their victims—disorders that usually gradually abate after exposure to the offending agent is stopped.

Overall, there can be no doubt about general causation: the SSRIs can make people behave the way Michelle did, and indeed they frequently make people behave much worse. These drugs have been involved in multiple murders, even of parents killing their children.⁴¹

⁴¹ Breggin (2008b). *Medication Madness: The Role of Psychiatric Drugs in Cases of Violence, Suicide and Crime* (New York: St. Martin's) is the most comprehensive study of drug-induced abnormal behaviors.

B. Specific Causation

Specific causation brings general causation to bear on the case itself, asking “If antidepressants can cause abrupt transformations in personality, character, attitudes and behavior such as in Michelle’s case, did antidepressants in fact do this in Michelle’s case?” This decision requires ruling out other more likely causes and showing that psychiatric drug intoxication is very likely on its own merits. There were no other potential causes of Michelle’s dramatic transformation for the worse; and the pattern of her transformation is very consistent with antidepressant-induced adverse drug reactions.

(1) Was Michelle Carter Suffering from Conduct Disorder or Antisocial Behavior Disorder?

This report contains detailed descriptions of 30-45 minute interviews with people who knew and often continue to know Michelle well, and who also knew other people in the community who know her. Many of them also knew and continue to know her family. She grew up and continues to live in a small community where the good and bad actions of people tend to be well known.

The evidence from the interviews leads to the conclusion that everyone one who knew Michelle considered her to be quiet, loving, caring, very special human being. All those who also knew her family and considered her parents to be remarkably outstanding parents and citizens.

But did Michelle have negative qualities? Is there even a hint of antisocial attitudes in her life and behavior? Everyone interviewed said she had no dark side, no tendencies at all to meanness or aggression. To the contrary, even after the death of Conrad Roy, Michelle’s class voted to her the “Superlative” award for “Most Likely to Brighten Your Day.”

An examination of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders, Volume V* (2013) discloses that Michelle has not a single characteristic or behavior associated with a diagnosis of antisocial personality disorder. Furthermore, at the time of the tragic events, Michelle was not old enough to be diagnosed with that disorder. In addition, a pattern of such bad behavior has to be more or less life long, whereas Michelle’s life-long story is that of a very good child and teenager.

If Michelle did display any antisocial tendencies as a child, they could be assessed by looking at the criteria for the official diagnosis of conduct disorder (**Exhibit Z-2**), which is the childhood version of antisocial personality disorder.

Conduct Disorder is a category poorly constructed with some listed behaviors that are relatively common among otherwise normal children such as shoplifting and running away from home overnight at least twice. Yet the interviews with her parents, as well as all the other non-family members, does not disclose a single characteristic or behavior listed as a potential sign of conduct disorder, even those that are common among normal children. For a diagnosis of conduct disorder, she would require at three of the listed behaviors, while she has none. Furthermore, the criteria for conduct disorder require that “The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning,” which is certainly not true for Michelle.

Once again, we are faced with explaining how a child with such a pleasant personality and character, and such good attitudes and behavior, could end up texting in a manner that anyone, include her normal self, would find distressing.

(2) Does Michelle Have the Personality Type of a Perpetrator?

The diagnostic viewpoints in the *Diagnostic and Statistical Manual of Mental Disorders*, including the diagnosis of conduct disorder and antisocial personality disorder, focus on behaviors rather than on feelings, thoughts, attitudes, or values. We have shown that Michelle displays not one behavior consistent with these negative diagnoses; but what about her actual attitudes and psychological tendencies?

In order to focus on the *psychology* of perpetrators rather than merely their behavior, in 1992, I developed the clinically oriented concept of the Perpetrator Syndrome (**Exhibit Z-3**). It has proven to be a useful tool in distinguishing between people who habitually tend to harm others and those who have harmed others a result of involuntary intoxications. The perpetrator syndrome consists of the following attitudes and psychological tendencies:

1. Deny or minimize the damage they are doing to others
2. Rationalize the harm they are doing
3. Blame the victim
4. Suppress their own feelings of empathy
5. Deny or rationalize their own prior victimization at the hands of others
6. Persistently react with anger and blame toward others based on much earlier feelings of shame and humiliation.
7. Dehumanize their victims
8. Feel empowered through their perpetrations
9. Seek to resolve conflicts through authority, power, and domination
10. Become grandiose and self-centered
11. Become alienated from their genuine basic needs

Throughout Michelle's life, she displayed none of the above attitudes or psychological traits, except during her involuntary intoxication. The Perpetrator Syndrome offers a stark contrast between Michelle and criminally minded individuals.

(3) Was Michelle Reacting to Radically Changed, Intense Circumstances?

Nothing happened in Michelle's relationship with Conrad during the time of the alleged offense that might have abruptly made her feel vindictive, jealous or vengeful. Furthermore, even if there were some such provocations, it is unlikely that any conflict with a friend like Conrad could have transformed her personality so drastically. In addition, although they both texted about loving and caring for each other, their relationship lacked the passionate sexual attachment so common among youngsters their age that more easily generates vindictive, jealous or vengeful feelings. They lived relatively near to each other—within less than a one hour drive—but had not found the motivation to see each for at least a year. Considering how intensely many young people of their age become involved with each other, theirs was not a typical romantic relationship. It was more like a friendship.

Unlike Michelle, Conrad Roy was a troubled young person who had made a very serious suicide attempt and been psychiatrically hospitalized. All this happened before he had a significant relationship with Michelle. True to her nature, Michelle devoted herself to being kind to him and by talking him out of harming himself—until the involuntary intoxication transformed her brain and mind into someone with attitudes and behaviors wholly alien to and at odds with her genuine personality and character.

(4) Michelle's Involuntary Intoxication

Here is a summary of some basic factors contributing to the conclusion that Michelle had an involuntary intoxication with Celexa on top of Prozac:

1. Prior to and after the bizarre texting that began in late June 2014, Michelle's character throughout her life has always been good-natured, loving, compassionate, and responsible. She displayed these traits in her texting with Conrad Roy until her abrupt transformation toward the end of June 2014.

2. Everyone who knows Michelle admires her and no one can think of a single time she has been mean to or has harmed another person, even with careless or impulsive words. Her life has often involved helping and supporting people, and never harming them. She has never been known to harm others, even mildly with words, even when under the stress of highly competitive sports or in the midst of her worst episodes of anorexia. Even when hospitalized for the treatment of anorexia shortly before the alleged crime, she was described as cooperative in the medical record, she was given no psychiatric diagnosis other than anorexia, and no negative attitudes or behavior were noted.

3. There are no changes in her environment or relationships sufficient to account for a drastic change in her personality, character, attitudes or behavior. There is no evidence, for example, that her relationship to Conrad was in any way threatened or threatening up to the moment she abruptly changed and began encouraging him to carry out his suicide plans. As best as anyone can ascertain, and according to the data in the texts, she had no serious problems in her life other than her continuing struggle with anorexia, which was not as serious as in the past and which she had always managed without any blemishes in her attitudes and behaviors.

4. The prolonged exposure to Prozac followed by the change to Celexa greatly raised the likelihood that she would have a serious adverse drug reaction that could change her personality, character, attitudes and behavior. Her young age of exposure (age 14 to 17) also increased her risk. Her chronic liver dysfunction, and her up-and-down anorexia, added to the risk of her being afflicted with an intense and dangerous adverse drug reaction.

5. The temporary transformation in her texting displayed the most common adverse effects of antidepressant drugs, including irritability (getting extremely and bizarrely frustrated with her boyfriend Conrad over his complaining about his failures to complete suicide); becoming aggressive in her texting him; and becoming grandiose in her decision-making about his need to commit suicide and in believing she could prevent his family from becoming depressed about it.

6. The guilt, remorse and self-blame Michelle expressed afterward is typical of good people who have endured an involuntary drug intoxication. Initially, they have no idea what made them behave so badly, for example by murdering or maiming someone. Like Michelle, they continue to take the offending drugs while blaming themselves.

7. Since stopping the Celexa, Michelle has continued to feel better, which confirms the drug was not helping and was instead having a negative effect on her.

8. Without the explanation that Michelle endured an involuntary intoxication with antidepressants, Michelle Carter's drastic transformation for the worse in personality, character, attitude and behavior toward Conrad remains inexplicable. With the explanation of involuntary intoxication, it becomes easily understandable because the changes in her personality, character, attitudes and behavior follow a pattern of adverse drug effects caused by antidepressants. That pattern consists, among other things, of the following:

1. Abrupt, drastic ego-alien change in personality for the worse
2. Loss of empathy for others and the development of apathy, indifference or lack of caring about harmful actions toward others
3. Dangerous irritability, in Michelle's case reacting aggressively against the failure of her boyfriend to carry out his plans
4. Unawareness of suffering from a drug-induced abnormal condition or being unlike her normal self
5. Gradual recovery after removal of the antidepressant drug
6. After the medications have been stopped, beginning to feel remorseful and blames herself, even though she was suffering from an involuntary intoxication

According to the criteria in the *Diagnostic and Statistical Manual of Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV-TR)*, the more accurate official diagnosis for Michelle is SSRI antidepressant mood disorder with manic features, including irritability and expansiveness (grandiosity). According to the *DSM* in all its recent editions, either the irritability or the grandiosity by itself would qualify her for this diagnosis of substance-induced mood disorder with manic features.

Michelle Carter did not, out of the blue, become a compulsive seventeen year old who encouraged her much-loved boyfriend into fulfilling his plans to kill himself. Until approximately twelve days before she began to act bizarrely, there was no hint of this kind of obsessive, irrational thinking. She was transformed from an empathic, loving youngster to someone who became bizarrely irritated with her boyfriend's failed attempts at suicide and felt compelled to encourage them. Research demonstrates that extreme irritability combined with

grandiosity as in Michelle's case are among the most common hallmarks of an antidepressant-induced mood disorder with manic features.

Michelle had been chemically bludgeoned with SSRI antidepressants from the age of fourteen until the events age the age of seventeen. Any seemingly antisocial or conduct behaviors on her part in the two weeks or less before Conrad's death are chemically-induced. The effects of the drugs would have been especially harmful because of her youth (age 14-19), her anorexia, her at times emaciated condition, her refeeding syndrome, and her abnormal liver functions. Meanwhile, the Paxil and Celexa were not only badly and wrongly prescribed, these medications were for many reasons *contraindicated* in her case.

Based on my experience with young people prescribed antidepressants, I expected Michelle to have some history of angry and irritable behavior, or other tendencies that adversely affected the people around her; but I have found nothing. In particular, Michelle's ability to handle the years of badly prescribed antidepressants with such continue good humor and care for other people is most remarkable and very rare in my extensive clinical and forensic experience. It is a tribute to the strength of her moral fiber and loving nature. Michelle is not a "mean girl." To the contrary, in the eyes of everyone who knows her, she is a wonderful person to have around who improves everyone's mood and attitude with her delightful presence. Tragically, she finally became a victim of psychiatry drug intoxication.

Michelle is not a villain. Michelle is a victim of psychiatric drugs inappropriately and badly prescribed for an extended period of her growth and development during her childhood and teenage years. During the days leading up to Conrad's death, she was suffering from an involuntary intoxication caused by psychiatric medications that her doctors should never have given to her.

Michelle Carter fully qualifies for a defense of involuntary intoxication for the alleged crime regarding the death Conrad Roy. An involuntary intoxication with antidepressants drove and shaped her behavior, producing an SSRI-antidepressant mood disorder with manic features, including irritability and grandiosity. The involuntary intoxication was caused by medications improperly prescribed by her doctors and not be any act of her own. This involuntary intoxication robbed her of the ability to form intent, to appreciate the wrongness of her conduct, or to control the impulses arising within her.

Michelle did not have a mental illness or psychiatric disorder as ordinarily understood. She suffered from brain dysfunction caused by a chemical neurotoxin. This is a genuine neurological disorder with a known physical cause in contrast to "mental disorders" such as major depressive disorder or bipolar disorder that do not have known physical causes or identifiable brain dysfunctions.

Michelle Carter is not to blame for her behavior during the period of the alleged offense when her brain function was much too impaired to take control over her obsessive, irritable behavior. She should not be held legally responsible for what she did. In her irritable, grandiose, manic-like state, she thought she was doing the right thing.

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