The College of Psychiatry of Ireland
Coláiste Síciatrachta na hÉireann

Antidepressant Medication - Clarification

The College of Psychiatry of Ireland 13 May 2010

Depression and suicide

Untreated depression can have a fatal outcome. Those experiencing moderate to severe depression frequently describe having thoughts of suicide. Suicidality (a spectrum of thinking and behaviour, from the person thinking of no longer being alive or a having a passive death wish to suicidal thoughts and / or suicidal acts) is one of the core symptoms of a depressive episode according to the two universally recognised psychiatric diagnostic systems. The lifetime risk of completed suicide approximates 6% in unipolar or bipolar depression[1] and may be closer to 15% in severe depression.[2] Antidepressants are effective in the treatment of depression[3] and thus lead to a reduction in suicidal thoughts. The effective treatment of depression is an important means of reducing suicide rates.[4]

Indications for antidepressant use and prevalence of use

Antidepressant medications are approved by the Irish Medicines Board (IMB). The indications for which antidepressants are licensed in Ireland include major depressive episodes, obsessive-compulsive disorder, post-traumatic stress disorder, bulimia nervosa and anxiety disorders. About 3% of Irish adults are current users of antidepressants.[5]

Adverse effects of antidepressants

People taking antidepressant drugs may experience adverse effects. In the past month there has been considerable discussion in Ireland of suicidality and homicidality as potential adverse effects of antidepressant medications, and selective serotonin reuptake inhibitor (SSRI) antidepressants in particular. Much of this discussion has been speculative. Clearly, suicide and homicide are events of the utmost gravity and any possible role of any treatment in precipitating such tragedies warrants the most thorough investigation. However, discussion of the risks involved must be based on evidence rather than conjecture or unfounded personal opinion.

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[1] Inskip HM, Harris EC, Barraclough B. Lifetime risk of suicide for affective disorder, alcoholism and schizophrenia. British Journal of Psychiatry 1998; 172: 35-37.
[2] Brådvik L, Mattisson C, Bogren M, Nettelbladt P. Long-term suicide risk of depression in the Lundby cohort 1947-1997 – severity and gender. Acta Psychiatrica Scandinavica 2008; 117: 185-191.
[3] National Institute for Clinical Excellence (NICE). Depression: the treatment and management of depression in adults (update). October 2009. http://guidance.nice.org.uk/CG90
[4] http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/
[5] National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit. Drug use in Ireland and Northern Ireland. 2006/2007 drug prevalence survey: sedatives or tranquillisers, and anti- depressants use results. Bulletin 6. Dublin: National Advisory Committee on Drugs, 2009.

Antidepressants and suicidality

In 2006, following formal evaluation at EU level, The Irish Medicines Board (IMB), in conjunction with its EU counterparts, updated the production information that comes with antidepressants to warn of a possible increase in suicidality during treatment, especially among children and young adults.[6],[7] A review was also conducted in the US, by the Food and Drug Administration (FDA), with similar advice issued.[8] Of note, studies involving older patients have shown a reduction in suicidality.[9] A very large American study from 2006, coming after the FDA's new recommendations, found that the risk of attempted suicide declined progressively after antidepressant initiation, from a peak in the month before treatment; there was no change during early treatment in the rate of completed suicide.[10]

At an individual level, treatment usually commences at a point when the patient's depression is worsening. As the therapeutic effect of antidepressants can be delayed for several weeks, there can be a period, early in treatment, when the illness is unresponsive (and possibly progressing) before the restorative effect of the treatment emerges. This leads to a period of risk following commencement which requires additional non-pharmacological support. Anecdotal cases of suicide sometimes mistakenly attribute these tragic events to the treatment rather than the illness itself. Also, people who are beginning to respond to antidepressant treatment may be more able, as energy and motivation returns, to act on suicidal thoughts that are inherent to their condition. That the early recovery period is potentially a period of increased risk for suicidality is something of which all doctors should be aware. The College of Psychiatry of Ireland, in unison with the IMB's advice, recommends close monitoring of all individuals commenced on antidepressant therapy.

Antidepressants and homicide

There is no evidence of a link between antidepressant use and homicide.

Commentators who assert that there is such a link rely largely on a small number of case reports of individuals who were homicidal after commencing antidepressants.[11] However, case reports cannot demonstrate a causal link. They cannot allow for the many factors that determine whether or not a person chooses to commit a violent crime. It is a fundamental error of thinking to argue that one event was caused by another because it occurred shortly afterwards.[12] Homicide by people who have recently started antidepressants is incredibly rare, but it occurs. It is not reasonable to expect that no person who had recently commenced antidepressants would ever commit violent crime. Antidepressants do not cause violence. Neither are they, nor can they be expected to be, an inoculation against violence.

The alleged link between antidepressants and violence is partly based on observation of an "activation syndrome", which includes agitation, irritability, impulsivity, and akathisia.[13] Akathisia is an unpleasant sense of inner restlessness that is often medication-related. It is an uncommon side effect of antidepressants, cited by some authors[11] as a particular risk factor for violence. The leap from observing restlessness in an individual to imputing

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[6] http://www.imb.ie/EN/Safety--Quality/Advisory-Warning--Recall-Notices/Human-Medicines/Antidepressants--Update-on-suicidal-thoughts-and-behaviour.aspx

[7] http://www.imb.ie/images/uploaded/documents/DSN%20-%20Final%20-%20September2008.pdf

[8] US Food and Drug Administration. Antidepressant Use in Children, Adolescents, and Adults. May 2nd 2007. http://www.fda.gov/drugs/drugsafety/informationbydrugclass/ucm096273.htm

[9] Barak Y, Olmer A, Aizenberg. Antidepressants Reduce the Risk of Suicide among Elderly Depressed Patients. Neuropsychopharmacology 2006; 31: 178-181.

[10] Simon GE, Savarino J, Operskalski B, Wang PS.Suicide risk during antidepressant treatment. American Journal of Psychiatry 2006; 163: 41-47.

[11] Healy D, Herxheimer A, Menkes DB. Antidepressants and violence: problems at the interface of medicine and law. PLoS Medicine 2006; 3(9): e372.

[12] Finocchario MA. Fallacies and the Evaluation of Reasoning. American Philosophical Quarterly 1981; 18: 13-22.

[13] http://www.fda.gov/Drugs/DrugSafety/PublicHealthAdvisories/ucm161696.htm

homicidal risk is a large one. No study has demonstrated a link between "activation syndrome" and homicide or homicidality.

Antidepressants and homicide: Evidence at a recent inquest

Evidence was given in a recent inquest at the Wicklow Coroner's Court that the self-inflicted death of a person (and by inference, the killing of another person) was most likely the direct result of SSRI antidepressant use – specifically, citalopram. The College of Psychiatry of Ireland is conscious that the events leading to these deaths are not completely understood nor is the mental state of the individual at the time. We address the inquest here simply to respond to the sworn expert evidence, which was, in our view, speculative.

It was claimed that an individual may have acted as he did because he was in a supposed "delirium", brought about by high blood levels of citalopram, on the night in question. A delirium is a syndrome characterised by fluctuating consciousness, disorientation to time, place, or person, and profound impairment of memory and attention. A person experiencing a delirium is incapable of deliberate and planned activity. This description is not consistent with the sworn evidence of the individual's behaviour of that night. This expert's justification of his delirium hypothesis on the grounds that the attack was "quite frenzied" is a non sequitur. There are no grounds to claim that a "frenzied" attack suggests delirium.

It was further suggested by this expert witness that if not a delirium, the explanation could have been a "mental automatism" caused by SSRI intoxication. Automatism refers to motor (not mental) activity, which, while appearing to the observer to be similar to purposeful behaviour, is performed in a semiconscious state without awareness of one's surroundings. A sequence of acts requiring awareness of one's environment and sequential planning is not consistent with automatism. There is no evidence that automatism is related to SSRI antidepressant drugs nor is there any credible evidence that automatism was involved in the events that culminated in two deaths and two other people being non-fatally stabbed in Bray in August 2009.

Assertions regarding antidepressants and violence: Concerns regarding stigma

The College of Psychiatry of Ireland is concerned that a mooted link between antidepressants and violence, which does not have a basis in scientific evidence, risks perpetuating a false and stigmatising stereotype that people living with mental illness are violent.

We would direct those interested in the matter to a seminal study recently published in the world's most prestigious psychiatry journal.[14] The take-home message of this prospective study of almost 35,000 people was that mental illness alone did not predict future violent behaviour. This is one of the most important findings in mental health research. In light of this and other findings, the College urges interested parties to avoid linking acts of violence to the symptoms or treatment of mental disorder without considering the evidence and the facts of each case.

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Contact: Andrea Ryder, External Affairs & Policy Manager
The College of Psychiatry of Ireland, 5 Herbert Street, Dublin Tel: 01 661 8450
Web: www.irishpsychiatry.ie Email andrea@irishpsychiatry.ie

[14] Elbogen EB, Johnson SC. The intricate link between violence and mental disorder. Results from the National Epidemiologic Survey on Alcohol and Related Conditions. Archives of General Psychiatry 2009; 66: 152-161.