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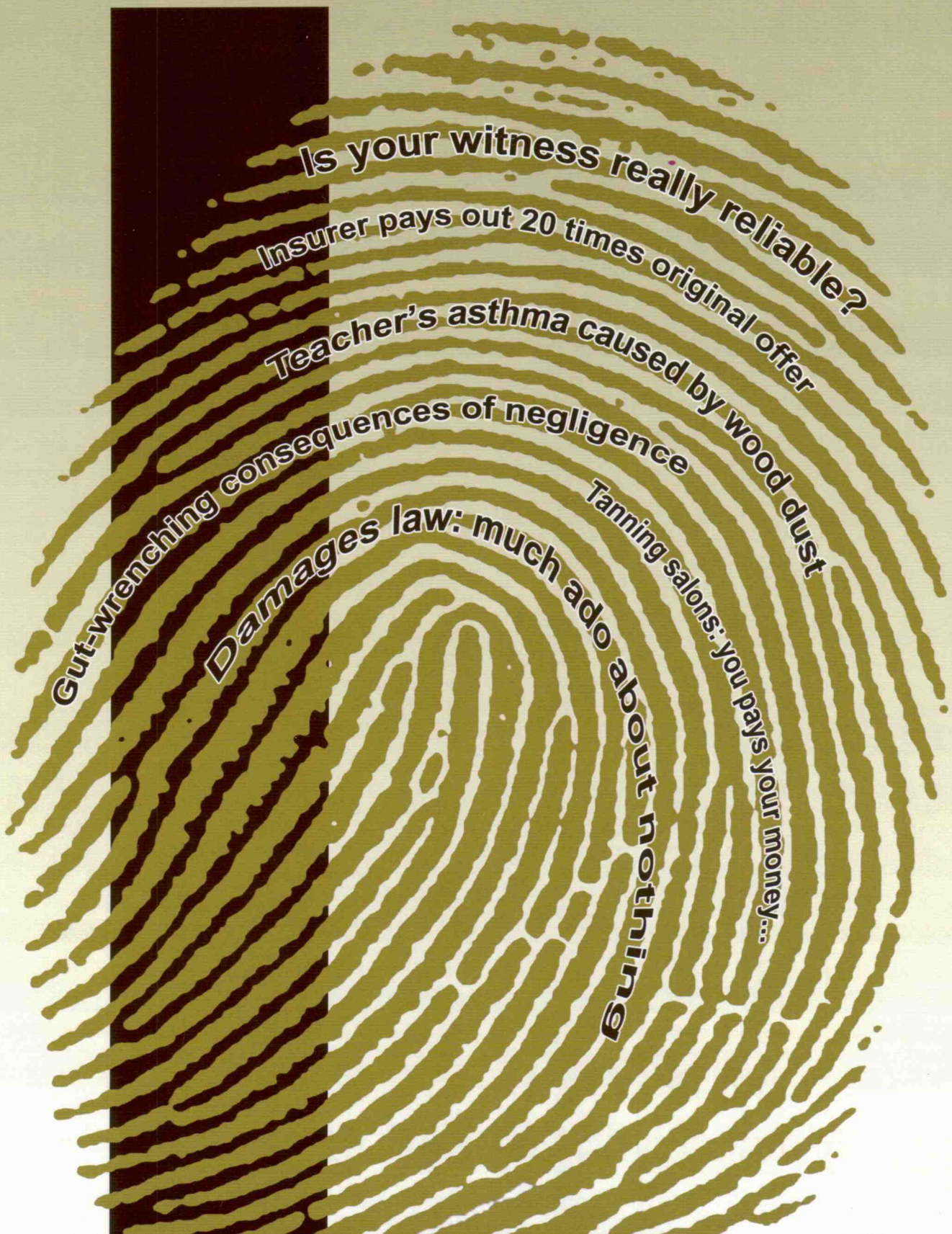

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Could the cure really be the cause?

by Dr MALCOLM VANDENBURG

THERE HAVE BEEN a number of cases in which selective serotonin reuptake inhibitors – SSRIs – are said to have been implicated in criminal defences, the issue being that SSRIs may predispose individuals to exhibit behaviour as an adverse effect of their therapy.

Cases have included motoring offences, shop lifting, robberies, and assaults.

Of particular importance have been the cases in which it has been alleged that the SSRIs have precipitated violent behaviour, resulting in at best criminal assault and at worst murder.

There have been some cases in which this has been accepted as a defence, others where it appears a crime of specific intent has been reduced to one of basic intent (such as murder to manslaughter) and others where it has been used in mitigation.

There have also been civil cases brought against the manufacturers of SSRIs where the manufacturer is alleged to have either not given adequate warning in product information or, worse, possibly had information which has not been either analysed or declared to regulators.

It appears to be near to impossible to establish the truth as opposing camps hold their beliefs with religious fervour.

The argument against the hypotheses that SSRIs may be implicated is the lack of hard scientific evidence that there is an association between SSRIs and violence, with even less evidence that such an association, if it exists, is causal.

There has been created what has been loosely called the 'three-legged defence': the lack of published scientific evidence, the association between the diseases for which they are used and such behaviour anyway and other factors predisposing to such behaviour demonstrated by the majority of those allegedly affected.

Opposing that is the view that SSRIs obviously alter thought and thus behaviour, and can probably produce agitation, frustration and dyskinesis, all of which lead to a predisposition to violent acts. The people who hold this view also have the opinion that there has possibly, if not probably, been concealment of vital information by the manufacturers of SSRIs as they try to improve the image of this class of compounds. They cite the number of cases in which SSRIs are implicated.

It has been hard, if not impossible to produce a list of these criminal trials with their outcomes and the reason for such, as well as to produce a list of civil cases with their outcomes.

They also point out the increasing regulatory warnings in product literature as evidence of an association.

There appear to be some important issues to resolve, although it may be impossible to reach a consensus across all interested parties. Those issues are:

- Is there an association between SSRIs and violent behaviour including homicide?
- Should this association be scientifically sustainable without the need to include suicide in general and violent suicide in particular, in the same group of adverse effects?
- If such an association exists, is it causal?
- May there be a difference in the association between different SSRIs, ie one or more may be associated and one or more may not be?
- Is there a sub-population of patients more likely to react adversely in this way to SSRIs and can they be identified prospectively?
- If they have exhibited violent behaviour in the past, is it possible for the SSRI to precipitate it again or make it worse?

All the above need to be considered separately in relation to adults, adolescents, and children as product labelling is different in all these groups.

If it is scientifically difficult, if not impossible, using usual pharmacoepidemiological and scientific methods to arrive at any conclusions, there still remains the possibility that in individual cases the SSRIs may be involved, due to the specific circumstances of the case, the personality of the patient and the adverse effects of the SSRIs.

It is to be hoped that further scientific research will be performed and published to solve the scientific questions on association and causality, as well as regulatory consensus in different countries with hopefully legal consensus with the establishment of criteria on which individual cases can be assessed.

In individual cases, it would also need to be considered as to whether the prescription of the drug is in accordance with manufacturer's recommendations and whether other therapy, care and management offered to the patient were appropriate.

• Dr Malcolm VandenBurg BSc MBBS MISMA FCP FFPM FRCP is a specialist in pharmaceutical medicine and psychopharmacology who has given opinions in many cases involving SSRIs associated with abnormal behaviour, violence and murder.

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