

## Correspondence

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**Contents** ■ Suicide trends and antidepressants ■ Cognitive–behavioural therapy for avoidant personality disorder ■ Anti-phospholipid antibodies, antipsychotic treatment and cardiovascular morbidity ■ Letters to the Editor

### Suicide trends and antidepressants

The suicide rate in Sweden decreased by 25% during the 1990s. After analysing trends for the years 1978–96, I proposed that the cause might be the concurrent increased use of antidepressants, and data from Norway, Denmark, Finland, Hungary and the USA supported this hypothesis (Isacsson, 2000). However, naturalistic studies do not allow definite conclusions, which is why the importance of testing this hypothesis in other studies was stressed. Reseland *et al* (2006) recently published an ‘extended’ (1961–2001) analysis of suicide and the use of antidepressants in the four Nordic countries. They interpreted two non-significant findings as ‘contrasting’ with my data: in Sweden and Denmark, the decrease in suicide started before the introduction of selective serotonin reuptake inhibitors (SSRIs); the suicide rate in Norway later stabilised despite increased use of SSRIs.

However, the classification of deaths was changed in 1969 with the introduction of the category of uncertain cause of death in ICD-8. Statistics before 1969 are therefore not comparable with later data. Furthermore, forensic pathologists only gradually became accustomed to the new

classification and the proportions of suicides to uncertain cases appear to have stabilised first in 1979 (Fig. 1). Thus, the decrease found by Reseland *et al* in ‘certain suicides’ in 1969–79 may be an artefact. A better way of handling the uncertain cases might be to add them to the certain suicides (Linsley *et al*, 2001). This would mean that the Swedish suicide rates increased in 1969–79, decreased in 1979–89 and decreased rapidly in 1989–99. The ‘pre-SSRI’ decrease in 1979–89 may be a result of the increased use of tricyclic antidepressants.

Stabilisation in suicide rates is to be expected. Antidepressants cannot save people who avoid doctors, who have treatment-refractory depression, schizophrenia or substance misuse from dying by suicide.

I conclude that the data of Reseland *et al* do not challenge the hypothesis that the increased use of antidepressants is the cause of the prominent decrease in suicide rate since 1990. Moreover, some ten studies provide strong evidence to support the hypothesis (Isacsson & Rich, 2005; Ludwig & Marcotte, 2005).

**Isacsson, G. (2000)** Suicide prevention – a medical breakthrough? *Acta Psychiatrica Scandinavica*, **102**, 113–117.

**Isacsson, G. & Rich, C. L. (2005)** Antidepressant drug use and suicide prevention. *International Review of Psychiatry*, **17**, 153–162.

**Linsley, K. R., Schapira, K. & Kelly, T. P. (2001)** Open verdict v. suicide – importance to research *British Journal of Psychiatry*, **178**, 465–468.

**Ludwig, J. & Marcotte, D. E. (2005)** Anti-depressants, suicide, and drug regulation. *Journal of Policy Analysis and Management*, **24**, 249–272.

**Reseland, S., Bray, I. & Gunnell, D. (2006)** Relationship between antidepressant sales and secular trends in suicide in the Nordic countries. *British Journal of Psychiatry*, **188**, 354–358.

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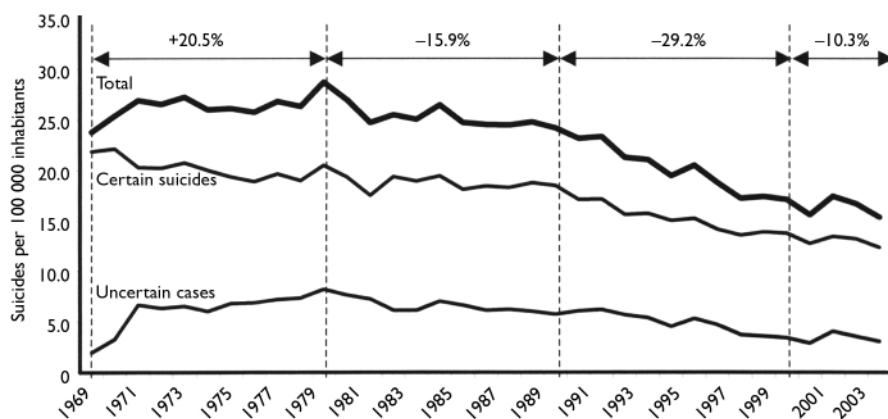
doi: 10.1192/bjp.190.1.79

**Author’s reply:** Professor Isacsson raises an important issue concerning the interpretation of national suicide data before and after the introduction (in 1969) of a new classification of deaths, ‘injury undetermined whether accidentally or purposely inflicted’ (ICD-8). The points he raises do not, however, invalidate our conclusions.

The exclusion of pre-1969 or even pre-1979 (the period when the use of suicide and undetermined categories had stabilised in Sweden) data from our analyses does not alter our main finding that suicide reductions in three of the four Nordic countries preceded the widespread use of SSRIs in the early 1990s. With the exception of Sweden, suicide rates continued to increase, rather than decrease, in the period 1969–79 in the Nordic countries, indicating that the changed classification had a minor impact on apparent trends in these countries.

There are well-recognised problems with interpreting ecological data to infer causal effects. Isacsson cites data from a number of countries where declines in suicide rates have coincided with increased antidepressant prescribing. However, data from other countries, such as England and Wales, Ireland and Italy, demonstrate the opposite pattern (Gunnell & Ashby, 2004). Professor Isacsson suggests that the reduction in suicide rate in Sweden in 1979–89, prior to the use of SSRIs, may be a result of the increased use of tricyclic antidepressants. This is possible, but data from Norway suggest that increased use of non-SSRI antidepressants in the 1970s and 1980s was associated with increases in suicide rates.

Isacsson suggests that the stabilisation in the decline in suicide rates is expected because not all people with depression consult doctors and conditions other than depression contribute to overall suicide numbers.



**Fig. 1** Suicide rates in Sweden 1969–2003. Percentages refer to the total (suicides + uncertain cases).