

Prozac notion

The World Health Organisation predicts that depression will soon be the second largest public health problem. Has the world become more depressing, or has the pharmaceutical industry simply become better at marketing antidepressants? In the latest exclusive essay from the London Review of Books, Mikkel Borch-Jacobsen examines the new 'epidemic'.

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La Fatigue d'être soi: Dépression et société by Alain Ehrenberg. Odile Jacob, 414 pp., €8.35, 21 August 2000, 2 7381 0859 8

Comment la Dépression est devenue une épidémie by Philippe Pignarre. Découverte, 92 pp., €14.48, 13 September 2001, 2 7071 3517 8

We all know how it happens. One day, without warning, you feel oddly removed from things and people, as if an invisible wall of glass were separating you from them. They go about their business but, for a reason that escapes you, none of it any longer concerns you. You could call out, but what would be the point? You aren't worth it, and the friendly overtures of others come as a justified reproach. Day by day, the wall grows a little thicker. Soon, you are no longer able to leave the house, your bedroom, your bed. The only thing you are left with is the pain of existing. You no longer eat or bathe or sleep. You are agitated and exhausted all at once. You keep thinking of the barbiturates, of the razor that would allow you to cut short the terrible insomnia.

We've all read stories like this in autobiographies, or in the innumerable newspaper articles devoted to this strange illness. The depressed person is a relative, a neighbour, a colleague. Perhaps tomorrow her story will be ours: depression, it's said, strikes one woman in five, and one man in 10. Its prevalence among the world's population at any given moment is of the order of 3 per cent. One in six depressed people commits suicide.

Fortunately, however, we're told on all sides that depression is no longer a fate. Antidepressant drugs have been around since the mid-1950s, and the new generation - the selective serotonin re-uptake inhibitors (or SSRIs) - work wonders. Under the influence of Prozac, Zoloft or Paxil, people for whom existence had been an unbearable burden suddenly find renewed pleasure in life, without having to suffer the unpleasant side-effects of the older generation of antidepressants, the tricyclics and the MAOIs (monoamine oxidase inhibitors). Admittedly, SSRIs sometimes lead to diminished libido and even, among men, to impotence, but that is surely a small price to pay for a restored capacity for happiness. 20 million people worldwide are now thought to be taking Prozac, and we are hearing reports of a new era of 'cosmetic psychopharmacology', in which drugs will be used to treat not only clinical depression, but daily mood swings and existential angst. So farewell Kierkegaard and Heidegger.

There is a problem, however, with this therapeutic optimism. If it is indeed true that antidepressants cure depression, how is it that the illness is spreading ever more widely? These books by Alain Ehrenberg and Philippe Pignarre, along with a third, published a few years ago by David Healy, forcefully underscore the incongruous fact that depression was never so prevalent as it has been since the introduction of antidepressants. It has always been with us, though it went by other names and sometimes assumed different shapes, depending on the era. From Hippocrates to modern psychiatry, 'melancholia' - that is, depressive psychosis, or 'endogenous' depression - has been described in remarkably consistent terms. Yet until very recently this type of depression was considered extraordinarily rare. Healy notes that in the North Wales Hospital between 1900 and 1945, only 50 out of a million patients were admitted for 'melancholia'. Today, by comparison, 948 out of every million admissions to psychiatric hospitals are for 'depression', of which 268 are considered severely melancholic or psychotic.

Even more striking, in the mid-1950s, when the Swiss psychiatrist Roland Kuhn discovered the antidepressant effects of imipramine on a number of patients suffering from 'endogenous' depression, the pharmaceutical company Geigy at first declined to finance the drug's development, judging the market to be too small. Less than 40 years later, in 1994, Prozac was the second bestselling medication worldwide, just behind the ulcer drug Zantac. In the meantime, depression's rise had been irresistible. In 1970, the psychiatrist Heinz Lehmann estimated that there were 100m cases worldwide. In the US alone, the number of consultations leading to prescriptions for antidepressants jumped from 2.5m to 4.7m between 1980 and 1989. In France, the number rose sevenfold between 1970 and 1996, and no fewer than 14m prescriptions were recorded in 1994. The World Health Organisation predicts that depression will soon become the second largest public health problem - the largest is heart disease. "What we are witnessing," Pignarre writes, "is a veritable epidemic." Yet as far as anyone knows, there is no such thing as a virus

causing depression. How, then, did the handful of melancholic patients in the 1950s become the millions of the 1990s?

The most frequently heard explanation is that depression has always been around, but that advances in science have enabled us to recognise it more easily. In 1956, when Roland Kuhn made his discovery, he thought he'd found a molecule that acted specifically on 'endogenous' or biological depression, to the exclusion of depressive neuroses attributable to an 'exogenous' or psychological cause. Very quickly, however, pharmacological research called this distinction into question by showing that other molecules were just as effective in alleviating both types of depression. From there it was obviously only a short step to the idea that one and the same biochemical dysfunction was at work in all cases of depression, and that it could be treated with well-targeted psychotropic drugs.

Simply by switching molecules and observing their effects, researchers began to discern the outlines of a new and ever-expanding psychiatric entity. Since the different families of antidepressants also proved effective in treating all sorts of other pathologies, it was concluded that these illnesses 'masked' depression (lazy reasoning, for one might just as well have concluded that the drugs were not anti-depressants). Thus other conditions were successively annexed to depression: panic attacks, anxiety, bulimia, obsessive-compulsive disorders, 'social phobia' (what used to be called shyness), autism, Tourette's syndrome, incontinence, neurological, cancerous, gastric and neck pain, migraines, post-traumatic stress disorder, alcoholism, tobacco and heroin addiction, constipation, hair loss and hypersensitivity to cold. Under the impact of antidepressants, not only was the distinction between the psychoses and the neuroses (and, by the same token, the professional niche of psychoanalysts) erased, but also that between psychiatry and general medicine. Everything has become depression, because every condition responds to antidepressants, the new panacea.

There is, of course, another, more cynical explanation for the seemingly limitless expansion of the diagnosis: that it profits the pharmaceutical industry, the tireless suppliers of new antidepressant drugs. Not so long ago, when a psychiatrist wanted to promote a new diagnostic category or treatment, he had to convince his colleagues and patients in a piecemeal fashion, with the help of a great many scientific reports and a fair amount of backslapping. These days, psychiatric disorders and their appropriate medication are packaged and sold together by pharmaceutical companies, who spare nothing to ensure that their research investments are profitable. There was no market for antidepressants in 1956? Never mind, the pharmaceutical industry would create one from scratch. In the early 1960s, seeking to publicise the antidepressant properties of amitriptyline, Merck bought 50,000 copies of a book called *Recognising the Depressed Patient*, by Frank Ayd, a psychiatrist, and generously distributed them among other psychiatrists and doctors worldwide. Ayd's thesis was that depression, far from being confined to asylums, could equally well be diagnosed in general medical wards and primary care surgeries. As Healy puts it, "Merck not only sold amitriptyline, it sold an idea."

Since then, countless public health campaigns have alerted general practitioners and the public to the necessity for recognising the signs of depression, investigations have been conducted into its social and economic costs, special series on the subject have appeared in magazines, and TV ads have unabashedly touted the virtues of the latest SSRIs - all of this financed, directly or indirectly, by the pharmaceutical industry. Doctors, public opinion leaders and journalists have not been bought off: no one is cheating here, everyone is genuinely convinced that he or she is echoing the most recent advances in science, starting with the researchers themselves. It just so happens that the industry's money is spent on researching this molecule rather than that one, this clinical trial rather than some other, or is allotted to this particular psychiatry department, this conference, this epidemiological study.

No wonder that the only theories which survive this Darwinian process are those that interest the industry. We know, for example, that approximately one-third of all depressed patients respond positively to a placebo, no matter how serious their depression (in the case of women presenting a single episode, the rate doubles). Even so, no one is financing studies on the role of non-specific factors in the treatment of depression, because there's no market for placebos. It is only in establishing a strong, 'specific' link between their product and this or that depressive pathology that pharmaceutical companies can claim to outdo their competitors - hence the constant redefinition of depression as one new drug after another is launched on the market. Healy summarises the situation neatly:

"Given the many revisions of psychiatric nosology during the last 30 years, it is clearly a mistake to think that mental illnesses have an established reality and that the role of a drug company is to find the key that fits a predetermined lock . . . we are at present in a state where companies can not only seek to find the key for the lock but can dictate a great deal of the shape of the lock to which a key must fit."

The logic of capitalism does not explain everything, however. Indeed, why is it depression that has taken hold in this way, rather than some other pathology? The industry might just as well have decided to promote anxiety, as it did during the 1960s, with 'tranquillisers' (benzodiazepines) such as Librium and Valium. It's tempting, therefore, to look elsewhere for an explanation for the steady rise of depression in the market for psychiatric disorders. If more and more people are depressed, might it not be because we live in a society that is more and more depressing? Left-leaning commentators often argue that the pharmaceutical industry has over-medicalised a real social misery, created by the stress of modern life, the loss of identity markers, the isolation of the individual, unemployment and so on. This argument isn't new: at the end of the 19th century, George Miller Beard was already associating 'neurasthenia' with the 'nervous fatigue' brought on by the pressures of living in large American cities. The problem with this sociological explanation is that it explains nothing. Even supposing that society is more inhuman than in the past, when socialised medicine and unemployment benefits didn't yet exist, why would this give rise to depression rather than anxiety, fatigue, 'nervous breakdown' or just plain anger?

Alain Ehrenberg, a sociologist, attempts to answer this question in *La Fatigue d'être soi*. Retracing in detail the history of depression since the 1950s (mainly in France), he shows very well how it ceased to be defined in terms of psychic pain, and came to be perceived more and more as a pathology of action. The new 'déprimé' lacks energy, is unable to 'perform', is inhibited in his work and his relationships with others. He suffers, the psychiatrists say, from 'psychomotor retardation'. And this new pathology emerges, as if by chance, in a society which values individual responsibility and initiative above all else. Just as Freudian neuroses were the pathology of a subject defined by prohibition and internal conflict, so contemporary depression is "the reverse of the sovereign individual, of the man who believes himself to be the author of his own life". In that sense, depression is not directly provoked or caused by contemporary society. Rather, Ehrenberg suggests, it is the negative 'counterpart' to the subjectivity created and so highly valued in this society.

In the last analysis, however, Ehrenberg continues to interpret depression's historical progression as a simple reflection - even if inverted and over-determined - of changes in society, so losing sight of the link between the epidemic and the marketing of antidepressants. He notes that the characterisation of depressed patients in terms of inhibition and psychomotor retardation "established itself at the very same moment that new antidepressants were launched on the market, most of which were effective on these inadequacies", but for him, this remains a pure coincidence, as if the development of the drugs opportunely reflected the rise of a condition that itself reflected the transformations of 'fin-de-siècle individuality'. Why not admit, inversely, that in this case something social has been produced by the invention of antidepressants: that if depression has spread to the extent it has, it's because it is that on which antidepressants have an effect?

This is the solution Pignarre proposes. If the new depression is thriving, it's because the new antidepressants are effective and, above all, more practical than tranquillisers and the first generation. 'Happy pills' were highly addictive, and tricyclics and the MAOIs had all sorts of unpleasant side effects. The SSRIs, on the other hand, are no more effective, but they present very few side effects. We shouldn't be surprised, therefore, if GPs prescribe them readily, nor if patients ask for more. Who cares that they are only masking depression if they allow the patient to be 'functional'? Who would be masochistic enough to undergo a long and costly psychoanalysis, with uncertain results, when all you need to do is go to the family doctor to get your dose of wellbeing? As Pignarre points out, "the new psychiatry would not have triumphed so rapidly were it not for the patients' consent and silent collaboration."

Antidepressants, in other words, 'recruit' depressives, and do so because they work. Each new one must first go through controlled trials intended to prove that it is more effective than a placebo and competitor drugs. In order to pass these tests, the proposed medication must yield results significantly better than previous drugs among a group of patients who have been selected because they present a pathology likely to respond to it. As Pignarre shows, it is at this early stage that patients are recruited. Each new molecule, if it is effective, creates a new group of patients, defined by the effects it produces: depressives needing stimulation, depressives needing to be tranquillised, anxious depressives, aggressive depressives etc. The new pathologies then spread throughout society as the drug penetrates the market and recruits (regroups) ever-increasing numbers of 'clients'.

The force of Pignarre's argument is that it never reduces the epidemic to a mere illusion, to an effect of marketing or to a pale ideological reflection of transformations in society. No one has been duped. Is this to say that biomedical psychiatry has at long last found the cause of depression, because it knows how to treat it? That's what the industry's advertisements would have us believe, but the researchers

themselves know better. It's not because substance X produces an effect on pathology Y that one may conclude that the substance acts specifically on the cause of Y. No one would think to say, for example, that aspirin is an 'anti-flu' medication on the pretext that it relieves flu symptoms, or that whisky is an 'antidepressant' because it lifts your spirits. To establish a causal relation, one would have to go beyond a simple correlation and isolate a necessary and sufficient cause, as with infectious diseases. Nothing in psychiatry allows us to claim that we've reached that point. Healy, Ehrenberg and Pignarre are all careful to insist that, as yet, every effort to link a biological marker to a clinical entity has ended in failure. Tricyclic antidepressants, for example, have nearly the same chemical structure as antipsychotics, and some of the latter are used in low doses as antidepressants, which shows that you can't establish a link between such-and-such a molecule and a specific psychiatric problem. "The antipsychotics and the antidepressants," Healy writes, "are neither specific in the sense of being specific to one disease nor specific in the sense of working regardless of the milieu in which they are delivered." The strength of the new biomedical psychiatry doesn't come, therefore, from the discovery of organic causes, but from placebo-controlled trials in which the effects of molecules are measured and compared. These trials don't tell us how the medication works, but only if it works, what works best, and on whom. Biomedical psychiatry is a form of rhetoric: it knows how to produce effects without knowing how to treat causes. Pignarre proposes calling it a 'petite biologie' to differentiate it from the larger biology that it mimics. When all is said and done, nothing distinguishes it from dynamic psychiatry and the various brands of psychotherapy, which also base themselves in the end on the effects (the changes) observed among patients. The only difference is that the rhetoric of the 'petite biologie' is incomparably more persuasive: how, faced with the accumulation of double-blind, randomised trials, could one possibly deny that antidepressants do indeed produce an effect?

The question is, however, on what? It's a mistake to say they produce an effect on depression, as if the illness existed independently of antidepressants; depression is nothing other than that on which antidepressants act. The reason so many of us are depressed is not because depression is spreading, but because we've been persuaded that 'depression' exists and can be treated. This is what Pignarre calls the 'syllogism': 1. I feel depressed; 2. I want to feel better; 3. I'm going to get a prescription for antidepressants. The point is that I wouldn't feel 'depressed' if I didn't know that there were drugs for treating it. That isn't to say that unhappiness, fatigue, inhibition don't exist; but they wouldn't congeal into 'depression' if antidepressants weren't holding this clinical entity together. Better (or worse) still, there is every reason to think that people who in another time would have felt anxious, or have had psychosomatic symptoms, now label themselves 'depressed' because depression is what we best know how to treat. Exactly as in dynamic psychiatry, symptomatic demand follows the fluctuations of therapeutic supply, with patients fitting their problem to the way in which they expect to be treated.

This is not to say that modern depression is a myth, an illusion we need only dissipate in order to recover from it. The distress of depressives is in every way real; but this reality is not hard-wired in their genes or neurotransmitters. In that sense, it is not a fate; change the medication and the therapy, and we would have a new illness.

Mikkel Borch-Jacobsen's books include *The Freudian Subject* and *The Emotional Tie: Psychoanalysis, Mimesis and Affect*.