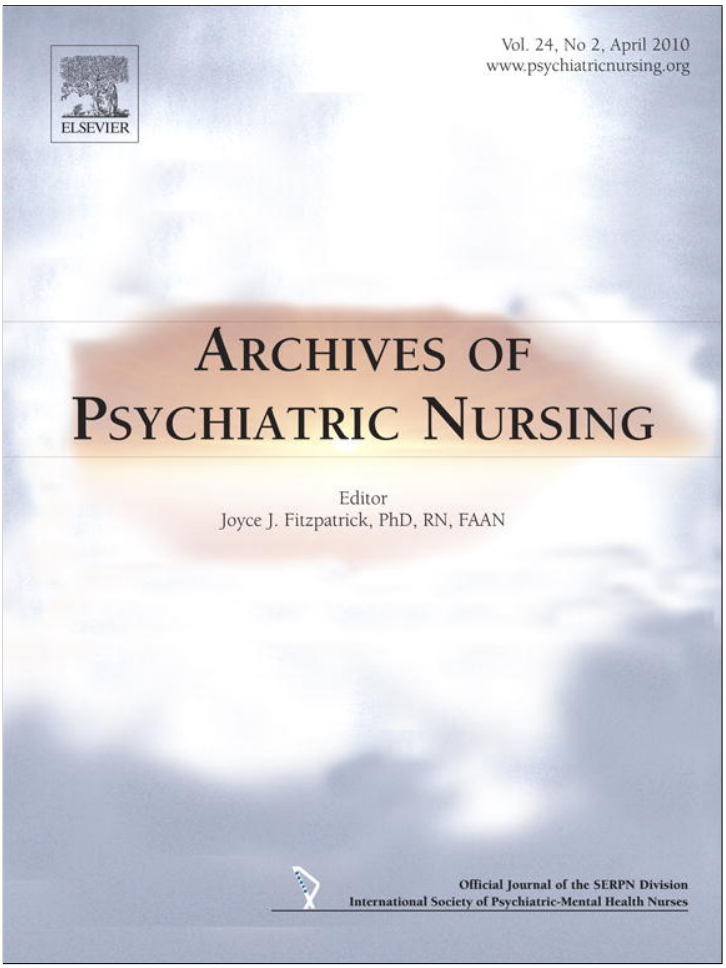

Challenging Normative Orthodoxies in Depression: Huxley's Utopia or Dante's *Inferno*?

John R. Cutcliffe and Richard Lakeman

Although there appears to be a widespread consensus that depression is a ubiquitous human experience, definitions of depression, its prevalence, and how mental health services respond to it have changed significantly over time, particularly during recent decades. Epistemological limitations notwithstanding, it is now estimated that approximately 121 million people experience depression. At the same time, it should be acknowledged that the last two decades have seen the widespread acceptance of depression as a chemical imbalance and a massive corresponding increase in the prescription of antidepressants, most notably of selective serotonin reuptake inhibitors (SSRIs). However, questions have been raised about the effectiveness and iatrogenic side effects of antidepressants; related questions have also been asked about whose interests are served by the marketing and sales of these drugs. Accordingly, this article attempts to problematize the normative orthodoxy concerning depression and creates a space in which an alternative can be articulated and enacted. In so doing, the article finds that the search for a world where the automatic response to depression is a pharmacological intervention not only ignores the use of alternative efficacious treatment options but may also inhibit the persons' chance to explore the meaning of their experience and thus prevent people from individual growth and personal development. Interestingly, in worlds analogous to this pharmacologically induced depression-free state, such as utopias like that in Huxley's *Brave New World*, no properly conditioned citizen is depressed or suicidal. Yet, in the same *Brave New World*, no one is free to suffer, to be different, or crucially, to be independent.

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ALTHOUGH THERE ARE significant problems in diagnosis and classification of depression (Van Praag, 2004) and the accuracy of associated epidemiological data should be treated with appropriate caution, evidence provided by the World Health Organization (WHO, 2008) indicates that the global rate of depression continues to rise. These rates have risen markedly over the last 20 years, as have corresponding rates of prescription of antidepressant drugs, most notably selective serotonin reuptake inhibitors (SSRIs). Riding squarely "on the back" of the media-perpetuated myth is the normative orthodoxy that if a person has depression, he needs "fixing" and that anyone (and

everyone) who experiences depression in their lives represents a somehow dysfunctional brain that is in need of a chemical. Inevitably, in these days of an immense political lobby wielded by the pharmacological industry, such "fixing" inescapably means psychotropic drug treatment.

The highly addictive nature (Young & Haddad, 2000) and questionable efficacy (Antonuccio, Burns, & Danton, 2002; Moncrieff, Wessely, & Hardy, 1998; Van Praag, 2005) of some of these drugs notwithstanding, the entire treatment paradigm ignores or dismisses a crucial axiom. Depression is an essential piece, if not maybe even a necessary component, of the human experience. We can no more deny this existential state of being than we can any other—including joy. Nevertheless, it is fair to say that the normative orthodoxy for "treating" or "fixing" depression in contemporary Western society is firmly embedded in a biological, "disease" model and the corresponding pharmacological response. Accordingly, in this article, we raise some questions about the contemporary orthodoxy regarding providing help to people experiencing depression, and in this "space," we explore an alternative emphasis. What we wish to do is to problematize the existing orthodoxy as a knowledge and power nexus, although without commenting on its "truth" value, and subsequently create a "space" in which an alternative can be articulated and enacted. We do strongly believe that the "automatic" use of antidepressant medication should be critiqued; that their use should be considered within a range of much broader contexts; and importantly, that as a mental health care community, we have a duty to place service users' needs at the forefront of this debate. Our article concludes by highlighting some key practice, education, research, and policy implications arising out of this alternative discourse, and these will be examined in more detail in a follow-up article. We hope that the much-needed robust debate is stimulated by this and the follow-up article and that readers will consider for themselves the wide-reaching implications for psychiatric–mental health nurses.

EPIDEMIOLOGICAL PICTURE: THE "GLOBAL" PROBLEM OF DEPRESSION—TRENDS OVER TIME

It is difficult to arrive at a precise epidemiology for mental health problems, including depression (Currie, 2005), because of our very conceptualization(s) of these phenomena. Some contemporary data indicate that as many people suffer from major depression as from other, more widely acknowledged, leading chronic conditions, such as heart disease or diabetes (IMS Canada, 2008). In Canada, depression is the fastest rising diagnosis made by office-based physicians; consultations for depression have almost doubled since 1994, and 81% of these consultations resulted in a prescription for antidepressant drugs (IMS Canada, 2008). Depression has been found to be the second most encountered condition in primary care next to hypertension, but it has been estimated that up to 50% of cases are missed (Cassano & Fava, 2002). Moreover, the WHO (2008) pointed out how depression is among the leading causes of disability worldwide.

Although there is disagreement regarding the epidemiology of depression, there is a strong consensus that depression can have a broad and holistic impact on persons with depression (Bell-Dolan, Reaven, & Peterson, 1993; Westgate, 1996). Additional data from the WHO (2008) indicate that the impact of depression on the global community is getting worse. Using the Disability Adjusted Life Years (DALYS) measure, depression was the fourth leading contributor to the global burden of disease in 2000. By Year 2020, depression is projected to reach the second place in the ranking of DALYS calculated for all ages and for both genders. Furthermore, the prevalence of depression has been found to be high in almost all chronic health problems and has been found to be associated with increased symptom burden, contributed to functional impairment, impeded self-care, and may be associated with increased mortality in some conditions (Katon & Ciechanowski, 2002). There is little controversy that the spectrum of depressive symptoms is common and that the consequences for quality of life, occupational and social functioning, and overall well-being for people experiencing depressive symptoms are a serious and costly problem. However, more controversial questions revolve around what this apparent pandemic means and what ought to be the response from the mental health services, including psychiatric nurses.

THE EFFICACY OF SSRIs: EQUIVOCAL EVIDENCE AND THE SPACE FOR REASONABLE DOUBT

Compelling evidence indicates that prescriptions for SSRIs have increased dramatically during

the last two decades or so. In the United Kingdom in 1999, there were 8.2 million prescriptions, whereas in 2005, this had more than doubled to 18.5 million (MIND, 2008). Similarly, Hemels, Koren, and Einarson (2002) pointed out how in Canada, between 1981 and 2000, total prescriptions for antidepressants increased by 353% from 3.2 to 14.5 million. Further, Currie (2005) noted how SSRIs have gradually squeezed out older antidepressants, such as the tricyclic, so that they now comprise 81% of the depression drug market. According to Barrkman (2008), antidepressants are the most widely prescribed medication in the United States; prescriptions have exceeded those of anticholesterol, antihypertensives, and analgesics. A total of 232.7 million prescriptions for antidepressants were written by physicians last year, 25 million more than that in 2003.

A number of rationalizations have been put forward in an attempt to explain such dramatic rises in prescription of antidepressant drugs and most especially SSRIs including the widespread, "common" nature of depression and allegations that the disorder is "growing" in successive generations, physicians' increased awareness of and thus comfort in diagnosing depression, and a growing population of better informed, more demanding consumers.

Not only is it the case that these theories lack convincing empirical support but also that alternative evidence and explanations exist. Munoz-Arroyo, Sutton, and Morrison (2006), for example, analyzed data from the Information and Statistics Division Scotland including psychosocial morbidity from the Scottish Health Surveys of 1995 and 1998 and general practitioner (GP) consultations from the continuous morbidity recording (CMR) dataset. They examined antidepressant prescribing trends for all Scottish practices and 54 stable CMR practices (175,955 patients). They concluded the following:

> There is no evidence of an increase in incidence, prevalence, care-seeking behaviour or identification of depression during the period of a sharp increase in antidepressant prescribing. Further work is required to explain the increase. (p 626).

Then, there is the issue of the questionable efficacy of SSRIs (and antidepressants per se). Far be it for the authors of this article to attempt to resolve the question of whether or not SSRIs are effective as such a resolution falls outside of the scope of this article. Furthermore, the authors acknowledge the cogent views of Goldney (2005) who drew attention to the (unavoidable?) selective nature of reviews of evidence and Balon (2003) who purported that "evidence may, as with beauty, be in the eyes of the beholder." Accordingly, it may be that the question will have different answers given that any review of the evidence is likely to be incomplete and will reflect what the particular authors regard as viable evidence (and what does not). Nevertheless, even the most cursory of reviews will show that the evidence is equivocal and that there is a growing volume of (for some) credible, scientific, and narrative–phenomenological accounts from people who have stopped taking SSRIs (see Lehman, 2004) that cast doubt on the efficacy of antidepressant medication.

In considering just some of this evidence from around the globe, in 2001, the Medicines Regulation Board, being the regulatory authority in the Netherlands, published the results of their systematic review of 77 studies, each focusing on treatments of major depression, which were undertaken between 1983 and 1997[1] (Storosum, Van Zwieten, Van den Brink, Gersons & Broekmans, 2001). The report reached the following conclusion: Suicide attempt rates did not differ significantly between placebo and experimental groups (those taking antidepressants). Very similar findings were discovered in the large-scale reviews undertaken by Kahn and colleagues (Kahn, Kahn, Leventhal, & Brown, 2001; Kahn, Warner, & Brown, 2000). The first review, which included 19,639 patients (from the Food and Drug Administration [FDA] database), showed that attempted suicide rates did not differ significantly in patients with depression treated with either placebo or antidepressants. Annual rates for attempted suicide were 0.4% and 2.7% on placebo, compared with 0.7% and 2.8% with antidepressants. Their 2001 study which included 23,201 patients produced comparable findings.

Similarly, a recent meta-analysis examining the efficacy of antidepressants (including unpublished studies), found that antidepressants were no better than placebo in treating anything but the most

[1] This represented the data for 12,246 patients with depression.

severe depression, and differences were negligible (Kirsch et al., 2008). Interestingly, this lack of effectiveness in clinical trials has been documented over many years. Antonuccio et al. (2002) pointed out that similar negligible effect sizes in favor of antidepressants have been found repeatedly in individual trials for more than 30 years. For example, in the meta-analysis of trials comparing antidepressants with active placebo of Moncrieff et al. (1998), it was found that in only two out of nine trials were there any significant effect in favor of antidepressants. Moncrieff and Kirsch (2006, p. 156) concluded that SSRIs have no clinically meaningful advantage over placebo and claims that antidepressants are more effective in more severe conditions have little evidence to support them.

SSRIs AND IATROGENESIS

Although pharmaceutical companies have for years denied some of the iatrogenic effects of SSRIs, there is now a widely accepted body of scientific evidence that highlights the (at least) doubling of the relative risk for both suicide attempts and completions for some people taking SSRIs (in comparison with older antidepressants and nontreatment groups; Healy, 2003). Furthermore, there has been a response, now internationally, to these documented effects from a variety of drug advisory bodies (such as the FDA and the Medicine and Health Regulation Authority).

A report in 2003 warned of the dangers of paroxetine: It increased the probability of suicide, worsening depression, agitation, and manic symptoms, followed by a similar report for venlafaxine also in 2003. Then in 2004, the U.S. FDA took the unusual step of issuing a ”black box” warning, issuing an advisory statement for all patients on antidepressants, stating that they should monitor for worsening of depression and suicidal tendency and signs of increased anxiety, agitation, panic attacks, insomnia, irritability, hypomania, and mania (U.S. FDA, 2004). These are by no means the only side effects that have been reported with SSRIs; the product information for Prozac shows that the drug is associated with 242 different side effects. Furthermore, Moore’s (1998) work highlights that Prozac was associated with more hospitalizations, deaths, or other serious adverse effects reported to the FDA, during a 10-year period, than any other drug in the United States. Such is the extent of potential side effects even after one stops taking SSRIs[2] that a diagnosis has been created: serotonin syndrome (Ener et al. 2003). This syndrome, associated with SSRIs, is a serious reaction causing neuromuscular excitability, hyperthermia, alterations to muscle tone, and changes to mental status. SSRIs also have a strong association with sexual dysfunction, with some studies suggesting prevalence rates of between 30% and 70% (Gregorian et al., 2002), and gastrointestinal (GI) problems, ranging from pain, dry mouth, nausea to GI bleeds (Haddad, 2001).

One should also be cognizant of the addictive nature of SSRIs, something which was vehemently and vigorously denied by the drug companies for years (Medawar & Hardon, 2004), even when the drug companies had data to indicate the addictive nature of SSRIs during the testing phase of Prozac (Medawar & Hardon, 2004). The highly addictive nature of SSRIs is now a matter of public record (Healy, 2003; Young & Haddad, 2000).

On a related note, investigators working for the U.K. Similarly, British Broadcasting Corporation (BBC) have discovered secret e-mails which reveal U.K.-drug-company-distorted trial results of an SSRI and failed to disclose a link with suicide in teenagers. According to the BBC (2008), the Medicine and Healthcare Products Regulatory Authority (MHRA) began a criminal investigation into this organization. Furthermore, the SSRI in question was banned for people under 18 years old after the MHRA revealed that companies own studies that showed that the drug trebled the risk of suicidal thoughts and behavior in children with depression.

SSRIs: A TRIUMPH OF MARKETING

Pharmaceutical companies are big business; indeed, they have been ranked the first or second most profitable industries in the world in most years since 1955 (Breggin, 1994). Data made available in the public domain in 2008 showed that sales of a new antidepressant (an SSRI and selective norepinephrine reuptake inhibitor) led to a 37% increase in sales revenue compared with the revenues of first quarter of 2007. The response from drug companies to independent studies into the efficacy of SSRIs is worthy of note. In a widely publicized meta-

[2] Please also see the later paragraphs for the documented experiences of those people who have tried to stop taking psychotropic medications.

analysis, Kirsch et al. (2008) found that antidepressants had a negligible (nonclinically significant) impact on depression compared with placebo. Yet, direct comment from the pharmaceutical companies on these findings is almost invisible. Of the 505 news and press releases published on the company's Web site, none addressed or commented on these findings. In the newspaper *The Independent* (Laurance, 2008, 26 Feb), a spokesperson for the company stated,

> Extensive scientific and medical experience has demonstrated that Fluoxetine is an effective antidepressant,

However, not a single scientific study was proffered to support this claim[3]. The company stated that Kirsch et al. (2008) failed to acknowledge the very positive benefits of SSRIs and their conclusions were at odds with the very positive benefits seen in actual clinical practice (Laurance, 2008; Kirsch, Moore, Scoboria, & Nicholls, 2002). Inversely, the company was less inclined to accept the phenomenological experience of clinicians and service users on the subject of withdrawal syndromes associated with SSRIs raised a couple of years previously, appealing instead to the lack of scientific evidence.

Although drug companies are under no statutory obligation to publish or disseminate the results of drug trials if they are unfavorable, one might argue that at the very least, drug companies should not exaggerate or distort these findings. Yet, there is evidence that suggests this has happened, that marketing has taken precedence over the dissemination of facts (BBC, 2008). One company spent 1.550 billion dollars on marketing, sales, and administration in the first quarter of 2008[4]. This marketing has paid phenomenal dividends, and it might be argued that the widespread acceptance of the orthodoxy of depression as a unitary brain disease, the failure to provide routinely other evidenced-based responses to people who present with "depression," and the portrayal of pharmaceutical companies as industrial, beneficent, benefactors might be considered triumphs of modern marketing.

[3] It is presumed that 1 or more of the 47 studies included in the analysis demonstrated the scientific proof.

[4] This did not include the cost of sales, manufacture, and others, and this far exceeded the 877 million dollars spent on research and development.

The relationship between psychiatry and the pharmacological industry is widely perceived as problematic, even from within mainstream psychiatry (see the presidential address of the former president of the APA, Sharfstein, 2006; Moncrieff, Hopker, & Thomas, 2005). Most peer-reviewed medical journals have a requirement for authors to disclose the nature of their relationship with pharmaceutical companies, and this may go some way in enabling consumers of research to judge if there are conflicts of interest at play (Godlee, 2008). However, the alarming increase in the use of "ghost writers" in some trials, coupled with some evidence of undeclared conflicts of interest, perhaps undermines the faith that one can place in those results that are published in some drug trials. For some, contemporary psychiatry is so entangled with the pharmaceutical industry that it is difficult to tease out the position of the pharmaceutical industry or companies from those of psychiatrists. Godlee (2008), the editor of the *British Medical Journal*, offered some highly critical remarks of these writing–reporting practices when she highlighted that,

> There has been no shortage of outcry or official condemnation—including clear statements from the World Association of Medical Editors, the International Committee of Medical Journal Editors, and industry itself through its Good Publication Practice guidelines—that undeclared conflicts of interest and ghost writing are unacceptable.... What is clearly wrong is writers, academics, or clinicians concealing under their coat tails an army of company spin doctors intent on distorting the scientific record.

THE EXPERIENCES OF SERVICE USERS WHO WISH TO "COME OFF" ANTIDEPRESSANTS

As valuable although conflicting as drug trial evidence may be, these data can only ever provide an incomplete representation of the full picture; this evidence needs to be complimented by narrative, phenomenological data, supplied by the very people who have taken (and in some cases, who have stopped taking) psychotropic drugs. Drug trial data, methodological limitations notwithstanding, can provide some evidence of reported reductions in symptoms and reports of improved function; nevertheless, the lived experiences of taking (and discontinuing) the drugs are just as important in a comprehensive evaluation of their utility. Such a viewpoint is echoed repeatedly in the international literature emanating from the so-called *service user*

or survivor movement. Chamberlin (2004) purported for example that it is the personal stories that carry enormous weight in the evaluation of psychotropic drugs. This may be even more necessary given Lehman's (2004) and Lahti's (2004) arguments that the life experiences of service users who take psychiatric drugs sometimes differ from scientific arguments. Mosher (1999, 2004) remarked that because there are few objective indicators of the effects of psychiatric drugs, the patient's own reports become critical. It is increasingly difficult for those who champion the normative orthodoxy in mental health care to ignore the service user movement and its associated "voice" (Walcraft, 2003). This movement brings an increasing emphasis on the central position of the service user and his or her views on the planning, delivery, and subsequent evaluation of public mental health care services; it understandably brings a corresponding erosion of the hegemony of the "professionals."

It is noteworthy that the experience of coming off psychiatric drugs appears to be heavily influenced by how one decides to enact this and by the level of support one receives. Maio (2008) declared how his precipitous withdrawal from psychiatric drugs left him with weeks of fear, tension, and stress and terrible flu-like symptoms. The 28 contributors in Lehman's (2004) book, each of whom decided independently to come off their psychiatric drugs and many of whom did so in a planned and systematic way, all managed to cease taking the drugs and did not experience the extent of withdrawal symptoms described by Maio. However, these reports also indicate that none of the contributors found coming off drugs easy, many had to attempt this more than once (having found the withdrawal symptoms too difficult to bear), and noticeably that most had to go through this process of coming off without the support of their psychiatrist and/or physician and only the active support of relatives or friends.

The findings of MIND's (2008) latest report *Coping With Coming Off* reiterates not only the well-documented withdrawal problems that people often experience when they decide to stop taking psychiatric drugs (in this case SSRIs) but also worryingly the simultaneous lack of support that these individuals received from their psychiatric carers (mostly GPs and psychiatrists). Despite having made an informed decision to stop taking their drugs, 30% reported being compelled to do so (under the U.K. Mental Health Act), 52% felt to be under the threat of compulsion, and 70% had pressure to keep taking the drugs.

If one examines the service user views literature which has accumulated over time, a number of themes appear repeatedly and consistently, including the overzealous reliance on medication, the desire for talking therapies in place of (or in addition to) medication, and the (extensive) level of dissatisfaction with this overuse of medication (and its associated iatrogenic effects). In addition to the literature already cited, more recent and methodologically robust evidence continues to identify the same issues. The Service User Research Enterprise (2007) document identifies five priority areas for research (in mental health care): social and welfare issues, involvement in services, medication, alternative treatments, and ethnicity. This document declares that many service users feel that there is an overreliance on medication and that experience of and concerns with side effects are common place. Service users would like to see research to investigate the effectiveness and appropriateness of medication. Moreover, many service users are concerned about this overreliance on medication and feel that they have limited access to psychological therapies (Healthcare Commission, 2007).

In summary, there appears to be a well-developed body of evidence emanating from the service user movement and one that is fairly consistent over time, which indicates a sense of dissatisfaction with the overzealous prescription of psychotropic medications (including SSRIs). For those that have acted upon this sense and attempted to stop taking their psychotropic medications, the experience appears to be consistently problematic and traumatic, and the success of this action may be linked to the level of support the individual receives. What also appears to be the case is that these are seldom (if ever) flippant or "spur-of-the-moment" decisions; these are difficult choices with no easy option. As a result, we would urge those within the normative orthodoxy to consider Campbell's (2005, p. 33) argument when he stated,

> Individuals have made a reasoned and courageous choice to confront their distress and opt for a life which, while continuing to be a major struggle, is lived without the deadening effects of psychiatric drugs. The least we can do is respect their experienced point of view.

SO WHAT CAN WE DO? ARE THERE ALTERNATIVES TO THE NORMATIVE ORTHODOXY?

With apologies to Huxley, the *Brave New World* predicated by the normative orthodoxy is one in which everyone can be cured from depression once the right pharmacological–biological intervention can be found. However, not only are we unable to assert this as a scientific academe at the moment as no biological markers which constitute the necessary external validating criteria exist for depression (see for example Stevens, 2007). Indeed, no blood test, pathognomonic test, or specific anatomical lesion can be found for any major psychiatric disorder (see also Breggin, 2000). Moreover, the hegemonic orthodoxy regarding depression subsequently dismisses an axiomatic truth: Changes in mood and, with that, periods and experiences of depression are a part of the human condition (Szasz, 1961, 2007). Ergo, to be human is to experience depression at some point during one's existence. Accordingly, it can be argued then that to posit and strive for a *Brave New World* that is free of depression is analogous to wishing to change the very nature of the human condition.

The authors are not suggesting that persons experiencing depression should simply be abandoned as their experience is simply "part of being human"; what we are arguing, however, is that there is a "space" for adopting a parallel discourse for dealing with depression in which it is regarded as part of the human experience and thus not necessarily something that has to be "cured" or "fixed" (see Szasz, 1961, 2007). Rather, it might be considered an experience that people need assistance to live with or through. Further, this parallel discourse emphasizes a range of nonpharmacological interventions for alleviating depression, each of which has an evidence base, including exercise regimens, cognitive behavioral therapy, exposure to light therapy, and other talking therapies, including exploring the meaning of experiencing depression.

Many studies have shown exercise to be an excellent antidote for mild to moderate depression (see Paluska & Schwenk, 2000 for an excellent review of this evidence). Indeed, Paluska and Schwenk (2000, p. 169) noted,

> Recent meta-analyses of clinically depressed men and women of all age groups found substantial decreases of depressive symptoms following both short and long courses of exercise.

Furthermore, when exercise was combined with psychological care, even greater improvements in mental health scores were recorded (Craft & Landers, 1998; North, McCullagh, & Tran, 1990). Although the mechanisms of the action of exercise on depression are not currently understood[5], the current state of the evidence allows Paluska and Schwenk (2000, p. 169) to conclude the following:

> Physical activity appears to be as effective as other therapeutic modalities for the treatment of mild or moderate depressive symptoms.

Similarly, the effectiveness of "light therapy" as a mechanism for treating people experiencing so-called *seasonal affective disorder* has been known for decades. Evidence indicates that being exposed to or "bathed" at least 30 minutes a day in bright artificial light can be as effective as an antidepressant medication. Kripke's (1998) ongoing work and more especially his 1998 study produced findings that indicate how light treatment of nonseasonal depression produced net benefits in the range of 12%–35%, often within 1 week. Further, Kripke concluded that light therapy appeared to produce faster antidepressant benefits than psychopharmacological treatment.

Next, we consider the apparent therapeutic value of, for want of a better expression, "talking therapies", and here, we use this term to encompass specific forms of therapy (e.g., cognitive behavioral) to a more nonspecific, interpersonal work[6]. Although it should be acknowledged that talking therapies did fall out of favor in recent years, perhaps because of a hitherto limited evidence base and because they can be expensive and time consuming, numerous authors have drawn attention to the efficacy and value of talking therapies for people experiencing depression (National Institute for Health and Clinical Excellence [NICE], 2007; Smale, 2000). Perhaps the most compelling recent evidence here is that of the STAR∗D study (NIMH, 2008; Thase et al., 2007) where it was found that switching to or adding cognitive therapy (CT) after a first unsuccessful attempt at treating depression with an antidepressant medication was generally as

[5] Given that the precise mechanism of depression is not known, this should not be surprising.

[6] What the authors refer to "working in a counseling way," it means the characteristic day-to-day practice of effective psychiatric–mental health nurses.

effective as switching to or adding another medication, but remission may take longer to achieve. The value and efficacy of talking therapies for depression, particularly mild and moderate depressions, have also been enshrined in the United Kingdom's most recent NICE (2007) guidelines for the management of depression. Indeed, the guidelines purport that in such cases antidepressants are not recommended because the risk-to-benefit ratio is poor. In addition to exercise, guided self-help, and "generic" talking therapies, cognitive behavioral therapy is specifically recommended.

Further evidence was provided in the 2002 study conducted at Vanderbilt University in Nashville and the University of Pennsylvania (DeRubeis et al., 2005; Hollon, DeRubeis, & Shelton, 2005). In this study, the most common drugs were compared with cognitive behavioral therapy in 240 patients with moderate to severe depression. Although the medication group got better quicker, after about 4 months, 57% of patients in each group had improved. During the yearlong follow-up period of those people who had showed improvement, cognitive therapy patients fared much better: Three quarters of them remained symptom-free, compared with 60% of patients on medication and 19% on a placebo. DeRubeis et al. (2005) concluded that those people treated with cognitive behavioral therapy improved and are more likely to stay "well" because of the skills they have learned to help them deal with their depression.

In addition to these efficacious treatments, there is also some interesting work around helping people who report feeling depressed to come to terms with and find the individual meaning in and make sense of their experience of depression (Smale, 2000; Styron, 1991). When considering this approach within this debate, it should not be couched in the form of an Aristotelian "either–or"; a person experiencing depression can make use of numerous interventions while simultaneously exploring the meanings in and making sense of their depression. Bound up with such "meaning-making work" is the pivotal developmental task and immense experiential value of accepting the limitations of life and learning that life can never be perfect. Maltsberger (1992) made this point most poignantly when he stated,

> Successful adulthood demands that one must passively endure disappointment over and over again...Maturity demands that one must accept passive suffering without flying into rages against life or against one's body.

CONCLUSION

It is difficult to argue with the compelling evidence that shows how rates of prescription for antidepressants, and more notably SSRIs, have risen dramatically over recent years. At the same time, there is a significant corresponding rise in rates of diagnosis for depression. These dramatic increases are difficult to justify given that that we are still unable to identify any biological markers (i.e., external validating criteria) for depression (see, for example, Stevens, 2007). They are more difficult to justify still when one acknowledges the equivocal nature of the evidence regarding the efficacy of SSRIs. However, whether as a product of a remarkably well-designed and operationalized marketing campaign and/or because of the media-perpetuated myth which posits the human experience as one free of any experience of depression, the normative orthodoxy for "helping" depressed people is one where such people need "fixing." It is one where such people have dysfunctional brains and imbalances in neurotransmitters, and thus these "brains in need of a chemical" inevitably need pharmacological treatment.

Table 1. Implications Arising of Accepting the Alternative Discourse

Practice
P–MHN need to be familiar with the evidence base of the full range of nonpharmacological interventions and be able to communicate these options to clients and thus promote client choice.
P–MHN need to be familiar with the evidence base pertaining to side effects, possible iatrogenic effects, and addictive nature of some antidepressant medications, and such information needs to be provided to clients proactively to promote client choice and fully informed consent to treatment.
Education
P–MHN nurses need to consider curricula revisions to ensure that a space is made for including this alternative discourse.
Similarly, PNP programs should include material on the range of interventions captured in this alternative discourse.
Research
P–MHN nurses need to conduct further studies to better understand and explore how they might help and support those individuals who do choose to stop taking their antidepressant medication.
Policy
With reference to their macro role, P–MH nurses need to consider adding their own voice to those already lobbying for more open reporting of all drug trial study data.

NOTE. P–MHN = psychiatric–mental health nurses.

Yet, the equivocal nature of the evidence upon which this discourse is built, as well as the existence of an evidence base that provides some robust support for alternatives, at least creates the space necessary for a parallel, alternative discourse. A significant number and breadth of practice, education, research, and policy implications emerge once the viability and legitimacy of the alternative discourse is accepted; these are highlighted in Table 1 and will form the basis for a follow-up article. In this discourse, we make room for the view that

> There lies in part, one of the great demoralizing features of depression; there is probably no quick solution. (Smale, 2000, p. 278)

Moreover, the discourse acknowledges that in the search for a world where the automatic response to depression is a pharmacological intervention that inhibits the person's chance to explore the meaning of their experience, we are preventing people from individual growth and personal development. Interestingly, in worlds analogous to this pharmacologically induced depression-free state, such as utopias like that in Huxley's *Brave New World*, no "properly conditioned citizen" is depressed or suicidal. Yet, in the same *Brave New World*, no one is free to suffer, to be different, or crucially, to be independent (Maris, Berman, & Silverman, 2000).

REFERENCES

Antonuccio, D. O., Burns, D. D. & Danton, W. G. (2002). Antidepressants: A triumph of marketing over science? *Prevention & Treatment*, *Article 25 5*(1) *http://www.journals.apa.org/prevention/volume5/pre0050025c.html (retrieved 2008).*

Balon, R. (2003). Selective serotonin reuptake inhibitors and suicide: Is the evidence, as with beauty, in the eye of the beholder? *Psychotherapy and Psychosomatics*, *72*, 292–299.

Barrkman, H. (2008). The Prozac revolution. *http://www.wej.com.au/newmoon/features/prozac/prozac.html.*

Bell-Dolan, D. J., Reaven, N. M. & Peterson, L. (1993). Depression and social functioning: A multidimensional study of linkages. *Journal of Clinical Child Psychology*, *22*, 306–315.

Breggin, P. (1994). *Toxic psychiatry—drugs and electroconvulsive therapy: The truth and the better alternatives*. London: Harper Collins.

Breggin, P. R. (2000). *Reclaiming our children*. Cambridge, MA: Peresus Books.

British Broadcasting Corporation. (2009). Secret of the drug trends. *http://news.bbc.co.uk/2/hi/programmes/panorama/16291773.stm.*

Campbell, P. (2005). Book review: Coming off psychiatric drugs: Successful withdrawal from neuroleptics, antidepressants, lithium, carbamazepine and tranquilizers. *Mental Health Practice*, *8*(7), 33.

Cassano, P. & Fava, M. (2002). Depression and public health: An overview. *Journal of Psychosomatic Research*, *53*(4), 849–857.

Chamberlin, J. (2004). Prefaces. In P. Lehman (Ed.), *Coming off psychiatric drugs: Successful withdrawal from neuroleptics, antidepressants, lithium, carbamazepine and tranquilizers* (pp. 1–2). Shrewsbury, UK: Peter Lehman Publishing.

Craft, L. L. & Landers, D. M. (1998). The effect of exercise on clinical depression: A meta-analysis. *Medicine Sports Science Exercise*, *30*(Supplement, 5), S117.

Currie, J. (2005). The marketization of depression: The prescribing of SSRI antidepressants to women. *Women and Health Protection http://www.whp-apsf.ca/pdf/SSRIs.pdf.*

DeRubeis, R. J., Hollon, S. D., Amsterdam, J. D., et al. (2005). Cognitive therapy vs medications in the treatment of moderate to severe depression. *Archives of General Psychiatry*, *62*, 409–416.

Ener, R., Meglathery, S., VanDecker, S. W., et al. (2003). Serotonin syndrome and other serotonergic disorders. *Pain Medicine*, *4*(1), 63–74.

Godlee, F. (2008). Reputations for sale? *http://news.bbc.co.uk/2/hi/programmes/panorama/6298269.stm.*

Goldney, R. (2005). Risk factors for suicidal behaviour. In K. Hawton (Ed.), *Prevention and treatment of suicidal behaviour: From science to practice* (pp. 161–182). Oxford: Oxford University Press.

Gregorian, R., Golden, K., Bache, A., et al. (2002). Antidepressant induced sexual dysfunction. *Annals of Pharmacotherapy*, *36*, 1577–1589.

Haddad, P. M. (2001). Antidepressant discontinuation syndrome: Clinical prevalence, prevention and management. *Drug Safety*, *24*(3), 183–197.

Healthcare Commission. (2007). *Community mental health services—views of mental health service users: Key findings from the 2007 survey.* London: Healthcare Commission.

Healy, D. (2003). Lines of evidence on the risk of suicide with selective serotonin reuptake inhibitors. *Psychotherapy and Psychosomatics*, *72*, 71–76.

Hemels, M., Koren, G. & Einarson, T. (2002). Increased use of antidepressants in Canada: 1981–2000. *Annals of Pharmacotherapy*, *36*, 1375–1379.

Hollon, S. D., DeRubeis, R. J. & Shelton, R. (2005). Prevention of relapse following cognitive therapy vs medications in moderate to severe depression. *Archives of General Psychiatry*, *2005*, 417–422.

IMS Canada (2008). Retail prescriptions grow at record level in 2003. *http://www.imshealthcanada.com/vgn/images/portal/cit_40000873/0/37/78325962retail_ prescriptions_grow_record_level.pdf.*

Kahn, A., Kahn, S. R., Leventhal, R. M. & Brown, W. A. (2001). Symptom reduction and suicide risk in patients treated with placebo in antidepressant clinical trials: An analysis of the Food and Drug Administration database. *International Journal of Neuropsychopharmacology*, *4*, 113–118.

Kahn, A., Warner, H. A. & Brown, W. A. (2000). Symptom reduction and suicide risk in patients treated with placebo in anti-depressant drug trials: An analysis of the Food and Administration database. *Archives of General Psychiatry*, *57*, 311–317.

Katon, W. & Ciechanowski, P. (2002). Impact of major depression on chronic medical illness. *Journal of Psychosomatic Research*, *53*(4), 859–863.

Kirsch, I., Deacon, B. J., Huedo-Medina, T. B., Scoboria, A., Moore, T. J. & Johnson, B. T. (2008). Initial severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. *PLoS Medicine*, *5*(2), e45, doi:10.1371/journal.pmed.0050045.

Kirsch, I., Moore, T. J., Scoboria, A. & Nicholls, S. S. (2002). The emperor's new drugs: an analysis of antidepressant medication data submitted to the U.S. Food and Drug Administration. *Prevention and Treatment* 5. article 23. Available: *http://www.journals.apa.org/prevention/volume5/pre0050023a.html (retrieved 2008).*

Kripke, D. (1998). Light treatment for non-seasonal depression: Speed, efficacy, and combined treatment. *Journal of Affective Disorders*, *49*(2), 109–117.

Lahti, P. (2004). Prefaces. In P. Lehman (Ed.), *Coming off psychiatric drugs: Successful withdrawal from neuroleptics, antidepressants, lithium, carbamazepine and tranquilizers* (pp. 2–3). Shrewsbury, UK: Peter Lehman Publishing.

Laurance, J. (2008, February 26). Antidepressant drugs don't work—official study. *Independent*.

Lehman, P. (2004). *Coming off psychiatric drugs: Successful withdrawal from neuroleptics, antidepressants, lithium, carbamazepine and tranquilizers*. Shrewsbury, UK: Peter Lehman Publishing.

Maio, H. A. (2008). Do-it-yourself withdrawal. *Ragged Edge Online http://www.ragged-edge-mag.com/reviews/maio-lehmann.html.*

Maltsberger, J. (1992). cited in Maris, R. W., Berman, A. L., Silverman, M. M. (2000). *Comprehensive textbook of suicidology.* New York: Guildford Press.

Maris, R. W., Berman, A. L. & Silverman, M. M. (2000). *Comprehensive textbook of suicidology.* New York: Guildford Press.

Medawar, C. & Hardon, A. (2004). *Medicines out of control?—antidepressants and the Conspiracy of goodwill*. Amsterdam: Aksant Academic Publishers.

MIND. (2008). MIND news, policy and campaigns—MIND releases latest drugs report Coping With Coming Off. *http://www.mind.org.uk/News+policy+and+campaigns/Press+archive/CWCO0905.htm.*

Moncrieff, J., Hopker, S. & Thomas, P. (2005). Psychiatry and the pharmaceutical industry: Who pays the piper? *Psychiatric Bulletin*, *29*, 84–85.

Moncrieff, J. & Kirsch, I. (2006). Efficacy of antidepressants in adults. *British Medical Journal*, *331*, 155–157.

Moncrieff, J., Wessely, S. & Hardy, R. (1998). Meta-analysis of trials comparing antidepressants with active placebos. *British Journal of Psychiatry*, *172*, 227–231.

Moore, T. (1998). *Prescription for disaster.* New York: Dell Publishing.

Mosher, L. (1999). Soteria and other alternatives to acute psychiatric hospitalization: A personal and professional review. *Journal of Nervous and Mental Disease*, *187*, 142–149.

Mosher, L. (2004). Non-hospital, non-drug intervention with first-episode psychosis. In L. Read, L. R. Mosher & R. P. Bentall (Eds.), *Models of madness* (pp. 349–364). London: Routledge.

Munoz-Arroyo, R., Sutton, M. & Morrison, J. (2006). Exploring potential explanations for the increase in antidepressant prescribing in Scotland using secondary analyses of routine data. *British Journal of General Practice*, *56* (527), 423–428.

National Institute for Health and Clinical Excellence. (2007). *Quick reference guide—amended—depression: Management of depression in primary and secondary care*. London: National Institute for Health and Clinical Excellence.

National Institute for Mental Health. (2008). Results for Sequenced Treatment Alternatives to Relieve Depression (STAR∗D) study. *http://www.nimh.nih.gov/science-news/2007/in-second-try-to-treat-depression-cognitive-therapy-generally-as-effective-as-medication.shtml.*

North, T. C., McCullagh, P. & Tran, Z. V. (1990). Effect of exercise on depression. *Exercise Sports Science Review*, *18*, 379–415.

Paluska, S. A. & Schwenk, T. L. (2000). Physical activity and mental health: Current concepts. *Sports Medicine*, *29*(3), 167–180.

Service User Research Enterprise. (2007). *Service user priorities for research*. London: Institute of Psychiatry/Kings College.

Sharfstein, S. S. (2006). Presidential address: Advocacy as leadership. *American Journal of Psychiatry*, *163*, 1711–1715.

Smale, R. (2000). Peering through the darkness: The subjective experience of clinical depression. *Journal of Psychiatric and Mental Health Nursing*, *7*, 277–283.

Stevens, L. (2007). The myth of biological depression. *www.antipsychiatry.org.*

Storosum, J. G., Van Zwieten, B. J., Van den Brink, W., Gersons, B. P. & Broekmans, A. W. (2001). Suicide risk in placebo-controlled studies of major depression. *American Journal of Psychiatry*, *158*, 1271–1275.

Styron, W. (1991). *Darkness visible*. London: Cape Publishing.

Szasz, T. (1961). *The myth of mental illness: Foundations of a theory of personal conduct*. New York: Harper Collins.

Szasz, T. (2007). *The medicalisation of everyday life—selected essays*. Syracuse, NY: Syracuse University Press.

Thase, M. E., et al. (2007). Cognitive therapy as a second-step treatment: A STAR∗D report. *American Journal of Psychiatry*, *164*.

United States Food and Drug Administration. (2004) Worsening depression and suicidality of patients being treated with anti-depressant medications Public Health Advisory March 22.

Van Praag, H. (2005). Why haven't antidepressants reduced suicide rates? In K. Hawton (Ed.), *Prevention and treatment of suicidal behaviour: From science to practice* (pp. 239–260). Oxford: Oxford University Press.

Van Praag, H. M. (2004). Stress and suicide: Are we well-equipped to study this issue? *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *25*(2), 8–85.

Walcraft, J. (2003). *The mental health service user movement in England*. London: The Sainsbury Centre for Mental Health.

Westgate, C. E. (1996). Spiritual wellness and depression. *Journal of Counselling and Development*, *75*(1), 26–35.

World Health Organization. (2008). Mental health—depression. *http://www.who.int/mental_health/management/depression/definition/en/.*

Young, A. H. & Haddad, P. (2000). Discontinuation symptoms and psychotropic drugs. *Lancet*, *355*(9210) correspondence.