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Editorial

Charles Medawar's paper "The Antidepressant Web", which appears in this issue, represents a courageous attempt to spark a genuine and broad discussion of a phenomenon in modern health care which is intensely worrying. The astonishing growth in the use of Selective Serotonin Reuptake Inhibitors as "antidepressants" in western society during the last decade is the starting point for this study. Why has it happened? What real or imagined need does it reflect? And what will its ultimate consequences be – for the individuals concerned or for society as a whole?

It is not the first time that a society has taken into its head the notion that it cannot survive without some form of ongoing medical or pharmacological support for a large proportion of its members – including many who can hardly be conceived as "ill" in the usual sense of the term. There was a time when any self-respecting American intellectual was thought to benefit from periodic psychoanalysis; some communities have for generations lived with khat, cola or ginseng; in the fifties, millions of city workers cocooned themselves from reality with benzodiazepines; and in parts of Europe there is a such a deeply rooted belief that any worker should be sent annually at public expense to a spa to take the waters that any attempt to scale back the practice would threaten to spark a revolution. But nothing of this quite equals the manner in which a fair part of the community has currently, over a short period of time, embraced the use of SSRI's; for Prozac® and its fellows do not merely provide a crutch with which to hobble through a period of adversity – here is Aldous Huxley's *Soma* in supposedly optimal form; here – to quote many a newspaper headline – is "The Happiness Pill" at last. So why should we worry? Should we not merely take our Prozac® and be content?

Charles Medawar is worried, and many with him. Concerned essentially because we seem to be facing here a phenomenon which is capable of expanding exponentially – a headlong rush into the unknown, propelled by forces on which society as a whole has little grip. One does not need to have an anti-establishment mentality to argue that medical authorities and governments are sometimes insufficiently far-sighted in such matters; nor does concern about commercial influences reflect any objection of principle to the manner in which drug are customarily advertised; to question the role which the mass media have sometimes played in catalyzing a particular fashion does not mean that one would wish to stifle the free press. The essential problem here however is that these factors and others seem variously to awaken and catalyze a public desire for new experiences and to pooh-pooh whatever reservations are raised. Mere change is mistaken for progress and innovation for improvement. There indeed comes a moment when society may back-pedal as necessary, but by that time avoidable harm may have been done.

Charles Medawar deliberately sets out to present a paper without conclusions, for what he provides is the starting shot for a discussion which is overdue and which should be conducted in as broad a possible forum. This Journal, similarly, will refrain from drawing conclusions at this point; it is an issue to which one will need to return again and again as the debate develops. What needs to be said however is that some of the concerns which the SSRI story raises go well beyond its own field.

One is the medicalization of life – a process which transforms aspects of everyday existence into pathological conditions requiring diagnosis, medical involvement and treatment; that happened with pregnancy and the menopause, it happened with unusually active children who were supposed to require amphetamines, and it has happened over the last thirty years with that broad spectrum of

depressive states which in part represent a normal reaction to the stresses of life. There are various reasons why life gets medicalized. In the case of the benzodiazepines it was the notion that life can and should be lived entirely on an even keel on a calm sea, and that every time the boat is rocked it must be firmly righted by the doctor. Where the SSRI's are concerned, much of the demand for medication seems to reflect the idea that life can and should be essentially a self-centred hedonistic ("have-a-nice-day") quest, and that a pill is one means of attaining this. More general factors promoting medicalization include the still sometimes pronounced tendency of the medical profession to look down upon mere people as the objects rather than the subjects of its work – and the presence of a commercial element which renders some forms of therapy so profitable for shareholders that the motives for treatment must be extended and stressed wherever possible.

A second aspect is the valiant attempt of science to categorize the unclassifiable; however convenient it may be for purely practical purposes to pigeonhole everything and provide it with a name and number, there are states which do not lend themselves to such detailed analysis. In art, such an analytical approach can be helpful in determining whether an ancient portrait is truly by Albert Dürer or a fragment of music was penned by Beethoven, but the eye and the ear are likely to be at least as reliable a guide; in the case of psychiatric illness we have proceeded beyond Hippocrates' concept of "melancholy" attributable to black bile and understand that melancholy takes various forms, but whether we have been consistently aided rather than misled by classifying it into 307 types is at least an open question. Leo Hollister in his wisdom, writing in 1978, appeared to believe that it was sufficient for medical practice to recognize three types of depression and nine sub-types [1]. Attempts at more detailed classification indeed need to be made, but one should be prepared to admit that compartmentalization has on occasion gone too far; there is such a thing as pseudo-exactness.

The value to be attached to randomized controlled trials is another issue. At their best they are the finest instrument we have for assessing the benefit of alternative forms of treatment, and the Cochrane Collaboration has correctly taken them as its primary tool in re-assessing a large volume of therapeutic knowledge. But a trial built on dubious measures, betrayed by spontaneous unblinding or skewed by a biassed approach to patient selection is a house built on sand. Particularly in psychiatry, where almost every measure is open to challenge, one must know exactly what one is doing before embarking on an experiment.

A final general concern illustrated by the Medawar paper is the manner in which medical authority sometimes judges a new situation as if it were simply an extension of one encountered earlier. It most certainly happened twenty years ago with initial reports of AIDS cases and more recently with the medical view on supposed cases of "Desert War Syndrome"; these things were initially dismissed because they did not fit into any existing category, lacked absolute consistency, and therefore could not be. Something similar may be happening where the risk of dependence to Selective Serotonin Reuptake Inhibitors is concerned; something unpleasant and potentially dangerous seems to be going on, perhaps on a very large scale, but if it does not fit some current definition of dependence (and goodness knows the definitions have been juggled a great deal in the past in order to label the problems experienced in the past with the opiates, the amphetamines or the benzodiazepines, or merely to compromise with some emergent view) it is temptingly easy to deny that it is a concern at all.

Charles Medawar's paper is particularly unusual in that, once it has been put before the medical world in this Journal, it will be opened up to the widest possible discussion on the Internet. That is a commendable step towards conducting in public a debate which may otherwise be too heavily coloured by medical paternalism, commercial manipulation and political *laissez faire*. At that point it will be particularly necessary to follow the debate calmly, critically and constructively, looking for

whatever inputs appear helpful, irrespective of their origin, and setting cautiously aside those which in the first instance seem less so. If one can manage that, without falling into the errors of prejudice and backward thinking which we have just discussed, we may be on the way to understanding what is going on, and perhaps to averting a disaster.

Graham Dukes

Reference

[1] L. Hollister, *Clinical Pharmacology of Psychotherapeutic Drugs*, Churchill Livingstone, New York, Edinburgh and London, 1978, pp. 72–73.