

THE MYTH OF THE MAGIC PILL

BY

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Shelley fights back the tears as she utters in a voice barely audible to her family physician, “things have just gotten to be too much—at first I didn’t want to get up for work and now I don’t want to get up at all.” Shelley feels hopeless, desperate, and fragile. In times gone by, she rallied during tough times and met obstacles head on. But this time is different; no last minute heroics or rising to the occasion, no platitudes or pep talks that have always worked for her in the past. The doctor looks at the 10-item questionnaire Shelley completed in the waiting room; it accurately reflects her poor appetite and loss of pleasure in sex or anything else for that matter. Her physician explains that such “neurovegetative symptoms” are a sign of “clinical depression,” a *medical* illness resulting from a chemical imbalance in the brain. She also tells Shelley that while the problem is serious, there is no need to despair because the illness is now treatable. The doctor gives Shelley a brochure that says treating depression is just like using insulin for diabetes. By taking an antidepressant, Shelley will increase a critical chemical that is in short supply in the brain. As the examination nears completion, the physician suggests that Shelley seek out the support of a “talk therapist” as combining medication with psychotherapy can sometimes enhance the chances of recovery. She nods her agreement. Prescription in hand and samples in her purse, Shelley leaves the office feeling comforted: her problem has a name, a cause, and a known cure.

The practice of attributing emotional suffering to chemical imbalances in the brain is now commonplace and embraced by the public and mental health professionals alike. So popular is it, in fact, that since the antidepressant Prozac--the first SSRI or selective serotonin reuptake inhibitor--was introduced in 1988, over 300 million prescriptions have been written for the drug and its two chemical cousins, Paxil and Zoloft. Pharmacological treatment is not only popular for adults but also the fastest growing form of intervention for children. In 1996, 600,000 prescriptions for Prozac alone were written for kids under the age of 18 and 203,000 for children between the ages of 6 and 12. Three thousands scripts were written for infants under the age of one!

So ubiquitous have these drugs become that almost everyone has either taken or knows someone who is taking medication and reporting feeling better as a result. Sure, the pharmaceutical companies can be criticized for excessive promotion and marketing. Learning that Eli Lilly long ago created a peppermint

flavored version of Prozac even though it is not approved for use with children and even requires a warning label (“safety and effectiveness in pediatric patients has not been established”) is enough to make most people temporarily uncomfortable. By now though, most Americans have come to expect occasional excesses from businesses competing for market share in the capitalistic society in which we live. And while most mental health professionals would acknowledge that the explanation given to clients is a gross oversimplification of actual brain functioning, few reject the biochemical model altogether. Fewer still question the effectiveness of the drugs, and virtually no one challenges the idea that combining medication with therapy is the best of all treatment options. At least it includes what talk therapists have to offer. The problem with these common beliefs and practices emerges, however, when they are examined in the light of scientific research. Empirically, there is *little support* for:

- the idea that emotional suffering is caused by a biochemical imbalance in the brain;
- the superiority of drug treatment over psychotherapy (even for “severe” depression); or
- better outcomes when therapy is combined with drugs.

Let’s start with the mantra of American psychiatry: the biochemical imbalance. What our culture calls “depression” is a complex condition of mind, body, life, and heart. Yet, in the past 10 years, we have been subjected to a simplistic version of a medieval morality play extensively (and expensively) promoted by pharmaceutical companies and rarely critically examined. Replayed endlessly in magazine ads, radio announcements and television shows, endorsed by federal agencies and mental health organizations, this drama always shows some poor soul possessed by a “Chemical Imbalance Demon” being exorcised by a high priest with a prescription pad. Never mind the fact that standard medical textbooks say there is no such thing as a simple “biochemical imbalance” which accounts for emotional problems. Indeed, as neuroscientist Elliot Valenstein points out in his excellent book, *Blaming the Brain*, the arguments supporting biochemical imbalances are unconvincing and the research rudimentary at best. Valenstein suggests that psychotropic drugs create, not cure, biochemical problems because of the brain’s plasticity and rapid adaptation to pharmaceuticals. And yet, the message continues to be broadcast to the American public: emotional suffering is a medical disease and one should run, not walk, to the nearest Church of Pharmacology for a cure. “Biochemical imbalance” is as much a part of American vernacular as “Did somebody say McDonalds?”

Consider, for example, the following excerpt from a *60 minutes* documentary that aired in 1993 at the beginning of the SSRI's meteoric rise to power:

Host: For 10 years, D has been suffering from depression, a serious illness. Sometimes she spends weeks on an unmade bed in a filthy apartment. She told us that she didn't care about anything, and she often thought of suicide.

D: I've sometimes been afraid to take the subway home because I might throw myself in.

Host: Most doctors believe chronic depression like D's is caused by a chemical imbalance in the brain. To correct it, the doctor prescribed Prozac.

Host: . . . and two weeks later, we paid her another visit. I can't get over it. You're smiling.

D: Yeah.

Host: How do you feel?

D: Great. I feel great. I feel like--like a different person. Somebody else. Somebody--something left my body and another person came in.

Host: She no longer spends her days in a filthy apartment. *So two weeks* after you started on this drug, whammo.

D: Right.

Host: You stopped being depressed . . .

D: I stopped being depressed . . .

Host: . . . got out of bed . . .

D: Mmm, hmm.

Host: . . . fixed your apartment, fixed yourself . . .

D: Fixed my life.

Host: . . . and you're losing weight.

D: Yeah. Mmm, hmm. Yep. I'm happy about it. I think it's great.

In this narrative, depression is not a bundle of miseries shaped by many forces, weak and strong: a sedentary, lonely, dishonest, impoverished or selfish life; perhaps the loss of love, health, beauty or community; feelings of powerlessness arising from unsatisfying work, oppressive socioeconomic factors, addicted children or a difficult relationship; frustrated ambitions; difficulties in knowing, speaking and

meeting one's needs or in getting along with one's family or other people. No, D on *60 minutes* is suffering from a purely biological illness, a "chemical imbalance." Its resolution does not require her to get meaningful support from others, to establish a collaborative relationship with a good psychotherapist, to change her attitudes and actions or to make any personal effort. There is only one solution needed, and only one offered: the passive consumption of a pill.

For decades, pharmaceutical companies and their handmaidens have spent billions of dollars promoting this simplistic message, and it has only intensified since the introduction of the "miracle SSRIs." Trumpeting these drugs' supposedly vast advantage over earlier antidepressants and therapy, drug company representatives rent booths at psychiatrists' conventions; buy advertising in medical journals; hand out manufacturers samples to M.D.'s; talk to journalists; and fund the seemingly incontrovertible drug research that provides the intellectual undergirding for this miracle play. More recently, the pharmaceutical industry has bypassed these traditional "middle men of mental health" and marketed their wares directly to the general public. Antidepressants are now as normal and pervasive as aspirin--like VISA, it's everywhere you want to be. Zoloft's logo smiles from plastic pre-paid phone cards, coffee mugs, luggage tags, and complimentary pens and pencils. A commercial during the World Series asserts the powers of Paxil to cure social anxiety. A colorful tissue box in a physician's office proclaims: "Sue's playing with her kids again" on one side and "Walter's fishing again" on the other. The reason for the turnaround? "Just like normal—thanks to Prozac!"

Then there's the National Depression Screening Day (NDS). All across the country, hospitals, mental health clinics, physicians offices, and even libraries, grocery stores, and shopping malls are helping people suffering with depression, many of whom apparently do not even know they are suffering. Sponsored by the American Psychiatric Association and National Institute of Mental Health (NIMH) and supported by mental health organizations and patient groups, this project has grown to include over 3000 sites. In 1998 it screened a record 90,000 people. Over the radio and on television, the message is the same: depression, the silent killer, is a treatable, physical disease, like high blood pressure. "Help" is just a phone call away.

At the screening sites, the message continues: mild forms of depression can be helped with counseling; however, moderate or severe forms of the disease require medication. Never mind that no

depressed person we know of would ever describe his or her own suffering as “mild.” It’s like “I’m mildly pregnant.” But, of course, that is precisely the point. Why? Because in spite of being jointly *sponsored* by the American Psychiatric Association and the NIMH, NDS is actually almost completely *funded* by drug companies. In fact, six of the seven major funders are pharmaceutical companies. Kathleen Day reported in her 1995 article “Depression Awareness—or a Prozac Pitch?” in the *Washington Post*, that Eli Lilly alone provides 50% of the funding! The same article reported student and parent complaints that the project, extended into schools, seemed little more than a plug for Prozac. Say no to drugs, but say yes to Prozac. Perhaps Prozac needs a cool image for maximum impact—perhaps something like Joe Camel.

Primary care physicians, who write most prescriptions for antidepressants, are prime targets for this national marketing extravaganza disguised as a public awareness project. For example, after a recent Depression Day, the managed mental health care firm, Pacificare, reported that the typical physician in its plan, with the help of the quick and dirty questionnaire administered to Shelley, now identifies two to four depressed patients a day and prescribes medication. The message is well-crafted, and it works. If Prozac, Paxil and Zoloft were books, they would be runaway best sellers: \$7 billion was spent on them last year.

Finally, consider the recent White House Conference on Mental Health. Leading luminaries in the field of medicine gathered together to discuss “cutting edge” discoveries in the treatment of emotional problems. As columnist Adrianna Huffington later pointed out in a June 1999 article (Adrianna Online), however, the whole affair was, “mainly a cheerleading session for drug manufacturers,” with the plenary sessions looking like “infomercials.” Adrianna’s take on the conference message was that, contrary to the first lady’s suggestion, it doesn’t take a village to raise a child, just a pill. Adrianna’s conclusion notwithstanding, this “historic” conference provides commentary on the pervasiveness of the bad chemicals on the brain theory of human suffering and the belief in the myth of the magic pill.

This widespread popularity suggests that antidepressants, especially SSRIs, are not merely one good therapeutic tool among many, but miracle drugs, manna from the gods, universal panaceas. They have no serious side effects, so the conventional wisdom goes. They supposedly work for everybody, and far faster and more effectively than therapy for serious depression, making them the obvious treatment of first resort. They help a profoundly depressed sufferer get out of bed and walk and have “proved”, so the

popular wisdom goes, that the causes of depression and other forms of human suffering lie not in our stars or our relationships, but in our cells.

The message behind the miracle play is demoralizing and disempowering to both clients and therapists--to say nothing of its being utterly unrealistic. Yet professional associations representing therapists seem to have believed the drug companies' publicity and accepted their second class status, assuming the primacy of pharmaceuticals is based not on great marketing, but good science. They have become acolytes, worshipping before the altar on which the magic pill is displayed. For example, having apparently resigned themselves to a "if you can't beat psychiatry, then join them" philosophy, the American Psychological Association is fighting for prescription privileges for psychologists. At the same time, the American Association for Marriage and Family Therapy (AAMFT) is funding their campaign for wider recognition as a legitimate provider organization by seeking grants from various pharmaceutical companies. AAMFT recently joined Glaxo-Wellcome (a drug company) to produce a brochure called "Intimacy and Depression: The Silent Epidemic." Drugs are spotlighted as the treatment of choice for depression. Curiously, family therapy is never mentioned, and therapy of any kind becomes a poor second cousin to medication--"antidepressants are usually effective, [but] psychotherapy can also be useful," the brochure condescendingly points out. It also laments about the many sexual side effects of antidepressants, but suggests that other choices exist *without* sexual side effects. Luckily, Glaxo-Wellcome makes Wellbutrin, an antidepressant whose major marketing distinction is its lack of sexual side effects. Wellbutrin is not mentioned in the brochure, allowing the AAMFT to maintain its posture of never endorsing products, but a veiled and ghostly endorsement nonetheless hovers around the entire production, whatever the high-minded denials. Family therapists and other non-medical therapists can either accept a second class status, or face daunting odds in protesting the erosion of valued traditions in their professional organizations.

While most people first became aware of our concerns about medication when we protested the AAMFT and Glaxo-Wellcome relationship, we actually began questioning the veracity of the magic pill many years ago. While a graduate student, Barry worked in a residential treatment center for troubled adolescents. When the psychiatrist was on vacation, 16 year old Ann was admitted and assigned to Barry. Ann was like many of the kids, abused in all imaginable ways, drop kicked from one foster home to

another, attempted suicide on a number of occasions, and been in numerous hospitals and runaway shelters. In spite of all that, Ann was a pure delight—creative, funny, and hopeful for a better future. Therapy went great, Barry and Ann hit it off famously, and Ann settled in and attended high school for the first time in several months.

Three weeks later the psychiatrist returned. Though Ann was adamantly opposed to medication—she said she had been down that path already--the doctor ordered an antidepressant and lithium. Barry protested citing evidence of how well Ann was doing, but to no avail—he was only a mental health grunt and a student to boot. Ann soon ran away and went on a three-day binge of alcohol and drugs. A carload of older men who picked her up while hitchhiking ended the ride with a gang rape. Adding insult to injury, Ann was forcefully injected with an antipsychotic when the police brought her back to the center. When Ann described this experience to Barry, she saw the horror on his face and reassured him that she had suffered far worse indignities than being forcefully tranquilized. It was little solace for either though.

When Ann persisted in her ardent protests of the drugs, Barry encouraged her to talk to the center director. Rather than listening, however, the director defended the psychiatrist. Later on, the director admonished Barry for putting ideas into Ann's head and told him to "drop it." Instead, Barry spent days researching the literature. What he found surprised him. In contrast to what most clients were told, little was actually known about how psychotropic drugs actually worked. There were drugs like cocaine, for example, which blocked the reuptake of the brain chemicals believed critical to depression in exactly the same way as antidepressants but did not have any "therapeutic effect." Furthermore, while increases in these "critical" neurotransmitters resulting from antidepressants were actually present within hours of the first dose they did not result in any therapeutic benefit for 4 to 6 weeks! Moreover, there was no empirical support for prescribing these drugs to children--let alone multiple drugs.

Finally, Barry was shocked to find that the actual effectiveness of the drugs was suspect. He found a 1974 review of 91 studies that reported that tricyclic antidepressants had no better effect than a sugar pill in nearly one third of the published reports. Though largely overlooked, this finding is particularly noteworthy because participants who showed rapid improvement to the fake pill (called, "place

bo responders”) were eliminated from these studies! Furthermore, as research with negative results is less likely to be published, one can safely assume that the extent of the placebo response rate was considerably underestimated in this review. Simply put, Barry had unexpectedly discovered that the emperor had no clothes. What did Barry get when he confronted the psychiatrist with these facts? He got fired. Ann survived as usual, resisting when she could, and unfortunately viewed this experience as just another cog in her wheel of abuse from her “helpers.” Barry left demoralized but determined never to be in the dark again, complicit by virtue of ignorance.

Despite the saturation of the message and the bottomless pit of money that supports it, it cannot succeed without our cooperation. They need talk therapists to promote their message. Increasing their market share requires that everyone come to believe that chemicals are both the cause and the cure to emotional difficulties. As Barry discovered, raising a voice of concern is risky. As the old saying goes, there’s not much difference between holding up your head and sticking your neck out. However, continuing to acquiesce to the biological perspective and prostituting ourselves for whatever is leftover after the “real doctors” have finished eating will only insure our permanent placement at the “kiddies” table. This doesn’t mean simply closing our mouths and refusing to take the medicine we’re being told is good for us. Rather, it means looking at what the research literature really says and then using that information to help clients navigate the many choices available to them. In particular, in order to stay the rising tide of biological fundamentalism, clinicians need to be aware of several serious shortcomings in the research.

To begin with, SSRIs do not work for everybody, not even for those who are desperate to believe in them. Just consult The Physician’s Desk Reference. It reports that adverse reactions cause 15-16% of people to discontinue treatment and that little is known about their effectiveness or consequences beyond 12 weeks of use. A 1999 report issued by the Agency for Health Care Policy and Research (AHCPR) found that in spite of being marketed as having “fewer side effects,” those actually taking the new and improved drugs didn’t think so. In fact, they were just as likely to drop out of research studies because of side effects as those who took the older tricyclic drugs. Patients on SSRIs are more likely to complain of diarrhea, nausea, insomnia, agitation, headache, and sexual problems. The tricyclic antidepressants are more likely to cause dry mouth, constipation, dizziness, blurred vision, tremors, and adverse cardiovascular effects. Pick your poison.

Unfortunately, dropping out of a research study is among the least problematic side effects of these pharmaceuticals. Adverse drug reactions are in fact the third leading cause of death in the United States! In a 1995 study published in the prestigious *Archives of Internal Medicine*, pharmacists Lyle Bootman and Jeffrey Johnson investigated 3.1 million hospital admissions and estimated that 200,000 people die per year from drug complications. This figure is equivalent to a 757 packed full of passengers crashing every eight hours every day of the year! The same study set the cost of such “reactions” at \$77 billion annually.

The adverse effects getting the most coverage lately, especially since the Columbine shootings and the death of Phil Hartman, is the increased chance of violence. According to psychiatrist outcast Peter Breggin, in his 1999 book *Your Drug May Be Your Problem*, “there is substantial evidence that...SSRI’s can cause or exacerbate depression, suicide, paranoia and violence.” Psychologist Ann Blake Tracy investigated 32 murder/suicides in her book *Prozac: Panacea or Pandora?* She found that 24 of these 32 cases were taking SSRI’s. Is this just the raving of lunatics? Yes according to spokespersons like Frederick Goodwin, former director of the NIMH, who boldly asserts that the question of psychotropic drug safety and effectiveness “has long been settled by a mass of scientific evidence and by the testimonies of hundreds of thousands of patients, their families, and caregivers.” When this “mass of scientific evidence” is considered, however, the supposed superiority of biological intervention is exposed as a house of cards built on a foundation of sand.

First, consider the report of the AHCPR, which reviewed more than 300 randomized trials of the SSRIs for depression. The report concluded that the SSRI’s were no more effective in treating depression than the older and much less costly tricyclic antidepressants. Moreover, in contrast to the 75-80% success rates frequently touted in promotional literature by drug companies, the AHCRP reported a much more modest 50% response rate to the drugs. In other words, only half of those given an antidepressant actually experienced some benefit. While at first glance this figure may still seem impressive, the researchers found that 32% of people in the studies they reviewed responded just as well to an inert, inactive placebo! This means that the newer anti-depressants only outperformed sugar pills by 18%--a finding hardly worth writing home about. Responding to similar data published by AHCPR in 1993, psychiatrist Walter Brown

ironically stated, “That’s not an astonishing effect,” and provocatively proposed that placebo should be the first line of treatment with depression.

Recall the stunning changes in D in the *60 minutes* broadcast. Her changes occurred in just 2 weeks although prevailing guidelines for Prozac are 4-6 weeks. Which did she respond to? The active drug or placebo factors? Blinded by expensive marketing, Americans have been led to believe that the virtually universal effectiveness of antidepressants is a matter of scientific record, conclusively demonstrated in strict, controlled, double-blind, placebo studies--the gold standard in medical research. But, in fact, the exaggerated claims from mediocre results are not based on empirical proof but on relatively flimsy data and flawed experimental designs.

In their provocative tour de force, *From Placebo to Panacea*, Professors Roger Greenberg and the late Seymour Fisher demonstrate that the validity of controlled studies, in which a placebo is compared to the “real” drug, depends upon the participants and the raters who measure the effects not knowing who is getting the real drug and who is getting the placebo. They point out, however, that the use of inert sugar pills as the placebo in the vast majority of drug studies actually makes it possible for everyone involved to tell who is taking the real drug. Simply put, those taking the active medication will be more likely to experience the standard side effects--dry mouth, weight loss or gain, dizziness, headache, constipation, nausea, insomnia, etc.--clear signals that they are taking a powerful drug--while those taking the sugar pill will not. As a result, the “double-blind” study is immediately “unblinded.”—a fact which seriously compromises any conclusions that can be drawn.

Paradoxically, side effects *by themselves* likely account for the effect seen in antidepressant studies. A review that examined 13 (*all* available at the time) studies on Prozac by Roger Greenberg and his associates in a 1994 issue of the *Journal of Nervous and Mental Disease* found that side effects were themselves positively correlated with improvement. They reported that the greater the experience of side effects, the better the outcome was judged to be by both patient and clinician. A meta-analytic review of drug treatments for obsessive compulsive disorder similarly found judgements of therapeutic benefit rose as the experience of side effects increased. These studies suggest that a sudden nudge to clients’ physical perceptions seemed to jump-start their own capacity for emotional regeneration.

Psychologists and respected scientists Irving Kirsch and Guy Sapirstein make a persuasive case that antidepressants may have no effect on depression other than that produced by the perception of side effects and the power of placebo. Their meta-analytic review of 19 studies involving 2318 patients showed that the 75% of the beneficial effect of antidepressants can be ascribed to the placebo effect. The remaining 25% of the positive effect of antidepressant is attributable to the side effects. This review demonstrates that antidepressants are equivalent to credible, but non antidepressant drugs; in other words, when an *active* placebo is used (one that mimics the side effects of the real drug), the advantage for the antidepressant disappears--there is no difference in discernible effect between the placebo and the drug being tested. Several other recent meta-analytic studies from independent research groups have validated the finding that placebo accounts for most of the antidepressant effect.

Finally, drug studies often look better than they are because they rate improvement by looking to clinicians' perceptions, not clients'. They usually rely on clinician-rated measures of depression (the Hamilton Depression Rating Scale or the Global Assessment Scale, for example) rather than client-rated measures (like the Beck Depression Inventory or the Lambert and Burlingame Outcome Questionnaire). But clinicians and clients differ substantially in their reading of how much improvement in emotional well being the drugs bring about. In 1986, outcome researcher Michael Lambert and colleagues discovered in their meta-analysis of antidepressant studies that clients reported significantly less improvement on drugs than did their therapists. Six years later, in 1992, Greenberg and colleagues published another more extensive meta-analysis of 22 antidepressant studies involving 2230 patients--and compared the effects of a placebo with both "old" (Elavil, for example) and "new" (Prozac) antidepressants. They found that [both old and new] antidepressants showed an advantage [about 18%] over the placebo on *clinician-rated* measures, but **none** on *client-rated* measures.

In short, when clients rate their *own* responses, they usually experience no improvement on antidepressants beyond what can be attributed to hope and expectation. If clients don't feel "better" after taking medications, how meaningful is any "improvement" their therapists think they see? As a final example of the exaggeration of meager findings, consider a study recently showcased as "the one" that finally demonstrates the benefit of Prozac with children. Set aside the problem of the inert placebo and compromise of the double blind. This study showed *no differences* between the Prozac and placebo groups on all measures,

both clinician and client rated, (totaling five) *except one*. One clinician rated measure of improvement showed superior performance of the Prozac over the placebo condition at the end of the study. The conclusion published in a major journal:

“Fluoxetine was superior to placebo in the acute phase treatment of major depressive disorder in child and adolescent outpatients with severe, persistent depression.”

You be your own judge.

Antidepressants are heavily marketed as more effective than therapy for severe depression, and as the pharmaceutical bubble continues to swell, managed care plans have inexorably pruned therapy to a bare minimum in favor of medications. But research has for years demonstrated that drugs are no more effective than therapy--and there is growing evidence that they may even be *less* effective. As just one example of such research, consider the largest and most methodologically sound study conducted to date comparing psychotherapy with drug treatment: The Treatment of Depression Collaborative Research Project or TDCRP, led by psychologist Irene Elkin. This 1989 NIMH project, which involved psychiatrists and psychologists in multiple cities, randomly assigned 250 participants to four groups: Aaron Beck's cognitive therapy, Gerald Klerman and Myrna Weissman's interpersonal therapy, antidepressant treatment, and finally placebo. Overall, the four treatments--including the placebo--worked with about the same effectiveness!

Since the study was first published, there is now research evidence that changes brought about by therapy are more likely to persist over time. In 1992, researcher Tracie Shea and colleagues published an 18-month follow-up study of clients in the original 1989 NIMH multi-site project. The psychotherapies outperformed the medications and placebo on almost every outcome measure. More therapy clients than drug clients recovered without a subsequent major depressive relapse, while those receiving the antidepressants sought treatment more often during the follow-up period, showed a higher probability of relapse, and experienced fewer weeks of minimal or no symptoms than either the two therapy groups or the placebo group.

Over the decades, generations of therapists have come to suspect it isn't so much *what* they do--what theory, what model, what technique or even what medication--that helps people, but *who* they are and who their *clients* are, as well as the idiosyncratic personal *fit* between themselves and the people who come

to see them. Now, there is a growing body of solid evidence for this widespread intuitive wisdom. A study conducted by Sidney Blatt and colleagues based on the same massive data pool comprising the 1989 NIMH project, reinforced evidence that has been emerging in other studies for years: the difference in outcome was related more to differences among clients and therapists than to treatment methods. Blatt found, however, that some therapists were more effective than others. Who were they? The researchers learned that the clinicians most successful in treating depression were more likely to use psychotherapy alone--they rarely used medications at all. "More effective therapists have a psychological rather than a biological orientation in their treatment approach," Blatt concluded.

But wouldn't the best of all possible worlds be one in which medications were *combined* with therapy, for a kind of double whammy treatment effect? This idea that both together must be better than either one alone for treating depression has become the newest orthodoxy among many professional groups. In fact, this sensible-sounding "compromise" solution actually promotes the use of medications, by implicitly suggesting that virtually anybody who enters therapy for any reason could usefully take them, and many managed care funded practices now routinely require all therapy clients to undergo medical evaluations as a prerequisite to treatment. And yet, there is little evidence in favor of the two-is-better-than-one approach. In 1998, Larry Beutler, researcher and senior editor of *The Journal of Consulting and Clinical Psychology*, challenged anyone to find current scientific literature supporting this now-conventional belief. No one can. Consider a meta-analytic study by Yale psychiatrist Bruce Wexler who concluded his review of seven well-controlled studies of 513 patients with this simple comparison: out of 100 patients with major depression, 29 would recover if given drugs alone, 47 would recover if given therapy alone, and 47 would recover if given combined treatment. On the other hand, drop out or poor response can be expected in 52 drug patients, 30 therapy patients, and 34 combined patients. Further, a 1995 *Consumer Reports* study concurs that medication plus psychotherapy contributed no more benefits than psychotherapy alone. These findings suggest that therapy alone should usually be the initial plan rather than expose clients to unnecessary costs and side effects of combined treatments.

Reality check: The preponderance of scientific evidence shows that therapy is as effective or more effective than medications in the treatment of depression, even if severe, especially when client-rated measures and long-term follow-up are considered. In all of the healing arts, there is no single explanation

nor simple, infallible remedy for any of the problems that beset humankind. And yet, the growing focus on biological determinism in mental health with the accompanying pharmaceutical hard-sell suggests not only that there are always solely biological explanations, but perfect, fail-safe biological solutions as well-- simple pills that mark *fini* to everything from mild depression and nervous tension to panic attacks and bipolar disorder, to full-blown psychosis and schizophrenia. How did this medically anomalous, weirdly simplistic point of view come about? If the science behind the alleged superiority of psychotropic drugs is so lacking, how did medications come to hold almost unchallenged sway over both public and professional opinion?

In the days of the Watergate investigation, the chief informant known as “Deep Throat” advised investigative reporters to “follow the money” to discover the source of illegal behaviors, which eventually led them to the president of the United States. Something like the same advice helps explain why psychotropic medications have permeated every aspect of our culture. Follow the money, and you will begin to understand the logic behind the growth of the pharmaceutical behemoth. Last year, a piece of investigative journalism in *The Wall Street Journal*, for example, reported that 96 percent of the research studies of a drug funded by its manufacturers turn out favorable results, while only 37 percent of such drug studies *not* funded by the manufacturer find in favor of the new drug. Like a flower opening itself to the sun, the research results tend to be skewed in the direction of the money source. Similarly, a study just published in October, 1999 in *The Journal of the American Medical Association (JAMA)* by Mark Friedberg concluded that drug company sponsorship is associated with reduced likelihood of reporting unfavorable results. In a scientific version of the piper calling the tune, the drug company paying for the research tends to get the kind of research its leaders want.

Given this bias, it is even more distressing to consider how many pro drug articles are published that *fail* to disclose ties to drug companies. The American Medical Association provides ethical prohibitions against physicians accepting payments, funding, reimbursements, or inducements of any kind without disclosing their relationships to drug companies. But it happens anyway, all too often. A recent investigation by Terence Monmaney of the *Los Angeles Times* found that the renowned *New England Journal of Medicine* published articles by researchers with drug company ties who did not identify potential conflicts of interest. In an analysis of 36 articles since 1997, eight articles were found with undisclosed financial

links to drug companies that marketed treatments evaluated in the articles. Another recent example is provided by an article in the *JAMA* that reported the sorry state of affairs of American sexuality, saying that as many as 43% suffer from sexual dysfunction. *JAMA* belatedly disclosed that the authors of the study were paid consultants to Pfizer, makers of Viagra, and may possibly had a conflict of interest in pronouncing the nations libido in such a dysfunctional condition.

While the AMA takes conflicts of interest seriously, it cannot apparently keep up with all the violations. With so much drug company funding, it is impossible to police. In addition, there is a major loophole in the guidelines. While disclosure is mandated in medical journals, it is not required in any publications that go directly to the general public. It is almost like the AMA is saying that is important for doctors to know about potential breaches in objectivity but not the general public. A physician can write an article in *a magazine with widespread circulation or author a book that sells millions* and never have to breathe a word about their affiliations. Add to this disclosure deficit the many TV appearances made that implicitly support drug company interests.

Just as bad money drives out good, heavy marketing seems to blunt or even nullify the effects of good, but negative research when it does occur. *Consumer Reports* estimated in a 1992 issue that the 65 billion-dollar drug industry spends 5 billion dollars a year on promotion and publicity for its products--the "educational" and "public service" efforts and multimedia advertising blitz already discussed, for example. Psychotherapy cannot begin to compete with the billion dollar drug industry when it comes to promoting the value of therapy even though the data are clear: psychotherapy is hands down as good or better when head-to-head comparisons with medication are made.

Psychiatrist gadflies Peter Breggin and Loren Mosher have documented the powerful influence of drug company money on continuing education and psychiatric journals. Mosher, in a 1999 *Psychology Today* article, estimates that drug companies pay an average of \$10,000 per physician, per year, on "education." Fully, 30% of the American Psychiatric Association budget is underwritten by drug advertising and pharmaceutical companies substantially support psychiatric conferences through displays and unrestricted grants. How does all this money impact the psychiatric profession? As Abraham Lincoln once said, "Moral principle is a looser bond than pecuniary interest."

Mosher calls the relationship between drug companies and psychiatry an “unholy alliance” that “is dangerous because researchers and psychiatrists...remain biased in favor of drug cures, downplay side effects and seldom try other types of intervention.” It is understandable that biological psychiatry is now embraced almost exclusively in medical schools and residency training programs. “Biochemical imbalance” is the battle cry of the profession. In interviews with the media, psychiatrists often resemble the brainwashed soldiers in the *Manchurian Candidate* (starring Frank Sinatra), robotically espousing the ubiquitous biochemical imbalance as the cause for a plethora of problems.

And therapists of all stripes are joining them as drug companies expand their influence—and the potential conflicts of interest—to other mental health professions. For example, with the help of an unrestricted grant from GlaxoWellcome, the 1998 conference of the AAMFT highlighted the Intimacy and Depression campaign at its opening session—a session generally reserved for one of the real movers of the family therapy field. Instead, without disclosing GlaxoWellcome’s involvement, the session, using “Party of Five” clips and an Oprah style format presented an hour and a half commercial for Wellbutrin without, of course, ever mentioning the drug specifically. The tragedy of the sexual side effects of antidepressants was repeated 11 times and 6 times the point was pummeled into the audience of 2000 therapists that treating depression need not include depriving clients of a sex life. Therapists were encouraged to inquire about side effects and inform clients that alternatives exist to help them.

Two of the presenters are affiliated with GlaxoWellcome. The psychiatrist who drove home the point about sexual side effects of antidepressants is on Glaxo's advisory board, speaker's bureau, and has had her research funded by them. She, with the psychologist on the panel, wrote GlaxoWellcome's own brochure about the IDC. By depriving the audience of the consideration of any possible conflicts of interest, AAMFT violated the standards of the Accreditation Council for Continuing Medical Education (ACCME) in two ways. AAMFT did not acknowledge Glaxo’s support in the conference brochure (Standard 5c) and did not disclose the faculty relationships with Glaxo (Standard 7b).

With all this largesse and publicity raining benevolently down, is it any wonder that people and therapists tend to become hypnotically fixated on the brouhaha about a “revolution” in psychopharmaceuticals and overlook the boring fine print of the drug studies with their more negative implications? Importantly, the fact that drugs do not live up to their miracle status does not discredit those

that have been helped. Medication has its place—if only it would stay there! To give the devil his due, we believe that antidepressants can be very helpful at times--especially for those who believe in them. Because they've gotten good press, they can positively harness the placebo effect, reinforcing Sir William Osler's dictum that "One should treat as many patients as possible with a new drug while it still has the power to heal." They sometimes do help free people from paralyzing self-doubt, obsessions and bulimic cravings--people who have conscientiously tried therapy with no results. Because they're widely touted as simple and effective, they encourage people who might otherwise be too ashamed and reluctant, to talk to another human being about their unhappiness and pain. Because they offer concrete, immediate action, they hearten people with the thought that at least someone is doing *something* to help them. Finally, some people find it easier to begin contemplating their distress when they can attribute it to their biochemistry rather than to circumstances in their personal lives. So they should not be banished from the sanctuary of psychotherapy; rather, therapists and consumers should get a grip, stop kowtowing to their supposedly superior powers, and think of them as one valid choice among many--and certainly not as the treatment of first resort.

But where does this sobering evidence about psychiatric drugs leave us when we are face to face with smothering despair? Consider Alina. At the first session, her therapist listened with growing concern as Alina talked about her fourth attempt to live apart from her abusive husband—the sense of having failed, failed her husband, her marriage, her children, and herself. She spoke of her financial desperation, the humiliation of her new job with a boss who berated her Spanish accent in front of customers, and her guilt at not being able to make a better life, pick a better partner, or make a bad marriage better. "I can hardly get up in the morning. It's just no use. I'm no good to anyone. I really have nothing to live for, to look forward to. If I had the guts, I'd just crash my car into a tree and be done with it." Her tears, her anguish, her despair were so palpable during the session that her therapist found herself having to fight her own feelings of hopelessness and fear for Alina.

Such riveting situations are, if not routine, expected fare in our line of business. It is the "burned out" therapist, indeed, who cannot resonate with the suffering and seemingly inescapable dilemmas our clients present. And it is this resonance that permits the connection and, therefore, the possibility that we can be part of some kind of change. It is also this resonance that makes us vulnerable to finding ourselves, like our clients, in the land of no alternatives. And when, in that place, a voice appears speaking of the

miraculous wonders of a biological cure, the superiority of “modern science” over primitive “talk” or “self-help,” the sky brightens and a gleam of hope shatters the darkness. With no other equally attractive, powerful voice around, it’s not difficult to see that, when facing the hard issues (like life or death), therapists with a heart naturally, inevitably reach for something they believe can give their clients (and themselves) hope and relief.

Our culture, our “mental health” mythology, speaks the following: “It’s fine to go to self-help groups, talk to a therapist, try yoga, or take St. John’s wort when you’re just having a down time—the “blues.” We’re talking about a different animal; we’re talking about the can’t eat, can’t sleep, can’t not sleep, can’t think, can’t work, can’t love kind of debilitation that threatens one’s livelihood, indeed, one’s very life. We’re talking *major* depression—MD.” How has such a climate flourished, where one option shines out above all others in such a compelling and irresistible way, virtually assuring it’s prominence in the lives of people in severe distress? How is it that forty years of research that confirms the preeminence of client resourcefulness, resiliency, and the healing capacity of the therapeutic relationship are dwarfed by a pill? How has it come to be that therapists, when put to the test, so readily abandon their beliefs in hard-won, professional skills and instincts in favor of a medical solution?

Just to set the record straight, these are the very situations we most challenge therapists and clients to re-examine and to question the knee-jerk reaction to seek prescription. We challenge the belief that such depressive conditions, while undoubtedly fraught with pain, despair, and fear, universally require medication. In fact, we challenge therapists and clients to consider personal and social options on at least an equal footing—and to rebuild a faith in themselves and the inevitability of change.

Sitting there, facing Alina, the therapist found herself wondering about the best way to be of help. She began to think about medication, and the implications of the fact that 70% of all antidepressants are prescribed to women. Would medication augment Alina’s sense of failure or provide the boost she needed to find hope and pleasure in her life once again? One path was predictable—referral to someone who could prescribe would inevitably focus on Alina’s mental state, her fragility, and potential suicide. Other paths were far more uncertain. As the therapist struggled with the uncertainty, Alina talked about her past relationships, sharing some sad, and even some humorous, memories. As the conversation unfolded, Alina mentioned that she didn’t like pills, and wanted “to do it on her own.” Knowing that various plans,

including medication, could be introduced at any time, the therapist trusted in Alina's direction and in the power of two people inhabiting an intimate moment of the tragedies and triumphs of Alina's life. It seemed natural, at the end of the visit, for the therapist to comment on what Alina had done to extricate herself and her children in the past from unbearable situations. Alina ended the discussion by emphatically stating that she had no plans to hurt herself. Three weeks later, after weekly meetings, the worst seemed to be *over*. Alina had managed to hang in with her new job and was quietly putting money away as her "escape plan" for an independent future. The therapist and Alina had weathered the storm together, with Alina, not medication (or the therapist), at the helm.

To be trigger happy to bring medication into the discussion automatically in "scary" sessions is to be under the influence of bad science and great marketing. When clients are stuck or desperate, the medication solution is easy to whip up—like ready-made dinners, it takes the work and anxiety out of "What's for supper?" However, consider also that in most therapy, therapists hold more power than clients. Consequently, therapist suggestions, for better or worse, immediately garner a particular status in clients' minds. The introduction of medication at a particular point in the therapy conversation carries with it numerous messages, none of which is "Here's just one of many options to consider." Instead, the uninvited introduction of medication into the therapy conversation, even when framed as an option, is likely to communicate "Your problem is so severe, we have to look at something other than what we are doing here, or something other than what you can do to deal with it," or "Medication is the best thing for what you are telling me." These messages serve to abort the natural search for answers that is the heart of change.

In a moment of crisis, of wanting to help or seeking help, if the option to try something different is not as least as attractive, doable, and potentially effective as the medical option, the magic pill will win. What is required is a shift, or, more likely, a reconnection with what therapists know and have experienced over and over, both in their clients and in themselves—that most people can and will develop solutions to even the most daunting dilemmas given support and encouragement, that the impetus to health has many avenues and sometimes takes unorthodox routes, and that change will and does occur naturally and universally. This is not a "just snap out of it" or "grin and bear it" approach to either "character weakness" or moodiness. It is an effective, all-out assault on the sometimes terrifying and almost always destructive

experience of depression. At its core is a faith in change and the human tendency to find a way even out of the heart of darkness.

We privilege this stance as way to “level the playing field,” to compete with the powerful and boisterous medical ideologies promoted by profiteers and championed by factions within our own professions. When we can hang onto these beliefs in our hearts, emboldened by personal, anecdotal, and empirical evidence, we, and our clients, can hear, loud and clear, other possibilities in times of crisis where once there was only the seductive chant to medicate. Recall, once again the NIMH Treatment of Depression Collaborative Research Project found that clinical improvement was unrelated to the type of treatment received (e.g., psychotherapy, drug treatment). Researcher Janice Krupnick and colleagues, using the same data (reported in *The Journal of Consulting and Clinical Psychology*), have shown that the quality and strength of the therapeutic relationship was the *primary* determinant of successful outcome across treatments--including medication! The type of treatment administered didn't matter. The type of relationship formed mattered most. Indeed, the massive size of the NIMH study means that the best, most empirically supported treatment for depression is a good relationship with a therapist.

For most of the history of the field, therapists have been trained and research conducted “as if” treatment models and their associated techniques explained and caused change. Like the anesthetic before surgery, “building an alliance” or “establishing rapport” has routinely been thought of as the procedure therapists must do *prior* to the “real” treatment (e.g., confronting dysfunctional thinking, prescribing drugs, etc.). In contrast to common perception, the therapeutic relationship is not another vague, unquantifiable, “feel good” technique from the field of therapy. Neither is it the latest in a long line of miraculous technique to be hyped on the lecture circuit. Rather, a virtual mountain of studies conducted over the last 40 years consistently find that therapies in which the *client's* goals, ideas about the problem and change process, and perceptions of a helpful therapeutic interaction are the most successful. Note the emphasis on the client's perception.

Here is where we differ than those that would apply the aggregate data about drugs and psychotherapy without considering the client's own views of what could be helpful. It is true that the data suggest that psychotherapy should be the first line of treatment for people with experiences of depression, then if change is not forthcoming, medication can be considered. However, such an assumption does not

integrate the unique aspects of what our work entails, nor does it include the most potent contributors to the change process in the decision-making process—our clients. Listening to and exploring their stories, experiences, and interpretations of the problem and the change process, what we have come to call the client's theory of change, over time, evolves to an approach that is tailored to the unique qualities of the individual client. . In short, treatment is client-directed. Depending on the client's views of what effectively produces change, this could include anything from physical exercise and dietary changes to assertiveness training, cognitive-behavioral therapy, volunteering, St. John's Wort, restructuring family hierarchies or learning how to get along better with others--all of which have been shown to sometimes have a positive impact on depression We would, for example, never stand in the way of a client considering medication if they believed their problems were of biological origin and thought the drugs might be helpful. It is up to therapists to privilege clients' wishes in the therapy conversation, including their trains of thought, their brainstorming, and their talk. When clients put medication on the table, then therapists can naturally help them explore it as an option. When clients believe medication will help, feel more hopeful at the possibility of trying medication, and are "in the driver's seat" in making an informed choice (including information about side effects, length of treatment, and possibilities of relapse), then medication can be beneficial. To follow the client's lead is to maximize client participation, strengthen the therapeutic bond, and enhance therapeutic outcomes.

In a country that has come to expect, even demand miracles from the pharmaceutical companies, it is little wonder that the chronic problems of drug therapy and the excesses of corporate marketing have been largely ignored. We hope against hope that some pill, some simple and painless solution, will be the cure-all for our emotional and familial woes. Finally realizing that psychiatric drug therapy is a profit-driven industry, built on a flimsy science, may be the bad tasting medicine we've needed. Although it may be hard to swallow, it is time for therapists to learn the data, reinvigorate their belief in therapy, and offer clients real choices for addressing their concerns. Ultimately, therapists and consumers need to just sit back, take a deep breath, and accept the truth about depression and other human travails: there is no better medicine than enlisting your own strengths in a good therapeutic relationship.

This article is adapted from Barry Duncan and Scott Miller's latest book *The Heroic Client: Doing Client Directed Outcome Informed Therapy*. Barry and Scott are co-founders of the Institute for the Study of Therapeutic Change (ISTC) and co-authors of several books including *The Heart and Soul of Change*, *Escape from Babel*, and *Psychotherapy with "Impossible" Cases*. Barry is an Associate Professor in the School of Social and Systemic Studies at Nova Southeastern University (NSU) and Scott is an internationally acclaimed workshop presenter. Jacqueline Sparks collaborated on the *Heroic Client* project and is a member of the ISTC team, as well as a Doctoral Candidate at NSU. The authors can be reached at the ISTC website (www.talkingcure.com).