

Depression and Iatrogenic Hopelessness

Jaleel Khaja

“That element of tragedy which lies in the very fact of frequency, has not yet wrought itself into the coarse emotion of mankind; and perhaps our frames could hardly bear much of it. If we had a keen vision and feeling of all ordinary human life, it would be like hearing the grass grow and the squirrel’s heart beat, and we should die of that roar which lies on the other side of silence”. (George Elliot)

I wonder what would be the magnitude of the roar on the other side of silence when Depression, as WHO has it, becomes the second most common disabling condition worldwide by 2020¹. I don’t know about others but I myself would be relying on my chronic ailment of selective deafness to remain blissfully unaware of the enormity of emotional pain and ceaseless suffering, if these were to penetrate into the much narrowed range of my sensitivity. I am sure my wise colleagues won’t die of the roar either and would have plenty of effective safeguards to choose from. You might, however, argue that these measures may be gratuitous, as the emotional coldness, which is endemic in our circles, may suffice. You may have a point.

Okay let me cut out the rhetoric and tell you what it is basically about. Depression is a major health problem² and 6% of the population meet the criteria for the disorder or Dysthymia at any one time³. In individuals between 15-44 years Depression accounts for 10% of all DALYS (disability-adjusted life-year), which is projected to rise to 15% by 2020, making Depression second only to Ischemic Heart Disease in terms of worldwide disease burden⁴. The irony is, while the time-bomb is ticking away and the race against time is underway, my learned colleagues seem to be engrossed in an endless duel over Antidepressants. “The term ‘antidepressants’ is a misnomer” and ‘they are not effective at all’⁵ sums up the stand ‘the Critical Psychiatry Network’ takes on this group of medications in particular while others dig their heels and maintain that ‘Antidepressants do work and there is lack of evidence for Cognitive Behavioural Therapy in mild Depression’⁶. The debate has raged on for decades now and this year it really came to a head when a major publication⁷ made a news headline writing off Antidepressants nearly completely and then only three months later we had fresh guidelines by another high impact association⁸ recommending their use.

It might sound alarmist but these days patients would be running a huge risk of getting bogged down by diametrically opposite views if they spend more than a few minutes on the internet only trying to find help. People with Depression may very likely find the College recommendations⁹ on when and why to use Antidepressants as straightforward and easy to follow. But if they push a search engine to full throttle they will soon find themselves on a long and bumpy road that basically leads to nowhere. They may suddenly stumble on a view that ‘meta-analyses show selective serotonin reuptake inhibitors have no clinically meaningful advantage over placebo’¹⁰ after negotiating a number of trials suggesting otherwise. With a couple of further clicks on the keyboard they, like myself, will find

themselves struggling to see any concordance between the argument that the effect of Antidepressants could be exaggerated by their sedative property¹⁰ and the conclusion that ‘Insomnia and REM sleep suppression were reported with all SSRIs’¹¹. Surfing on they may even start to wonder whether the beneficial effects of a whole range of medications like Antihypertensives, Antiepileptics, Antibiotics, Hypoglycaemics etc. could be exaggerated, if they come across a view that ‘unblinding effects’ (for example those due to side effects) ‘may inflate the efficacy of antidepressants in trials using inert placebos’¹². The doubt would be perfectly legitimate because the principle of testing medications against ‘active placebos’ appears to be so neatly applicable right across the board and naturally begs the question whether it is applied generally in actual practice. Unfortunately, after a while the answer to the question whether the Antidepressants are beneficial or not will start to appear ever so elusive and it won’t be long afterwards that a deep sense of disappointment will set in, making these desperate searchers to log off from the Net as well as hope.

Dividing the whole of Psychiatry into two warring parties is not what I have intended to do in the above lines. That would be too simplistic. My attempt is only about trying to get a couple of messages across to all of us who claim to have patients’ best interest at heart. I cannot think of any other way to convey the crux of my first message than to take a quote from ‘War is a Racket’¹³. The author says in the book, ‘For a great many years, as a soldier, I had a suspicion that war was a racket; not until I retired to civil life did I fully realize it’. So while we maintain a high quality of our research studies about treatments in Psychiatry by employing rigorous methods, observing scientific detachment and keeping every enquiry dispassionate, it is imperative that we remain on guard against the possibility of us turning into inadvertent racketeers for those who are only driven by their monstrous appetite for profiteering.

My second message is specifically for ‘the Critical Psychiatry Network’ and to those of similar persuasion. I have had an honour to work with one of your main proponents and I can safely claim that you are a group of exceptionally talented Psychiatrists. You are doing a great job of saving Psychiatry against a potential risk of it simply degrading into some kind of quackery. However, I am not entirely comfortable with the unidirectional nature of your works, which appear to be mainly focussing on disproving positive claims made about the efficacy of treatments. It is about time that an equal amount of your energy and time is devoted towards establishing what can effectively treat Depression and help rekindle hope.

CONFLICT OF INTERESTS

None Declared

AUTHOR DETAILS

JALEEL KHAJA, MRCPsych, Staff Grade Psychiatrist,
Northamptonshire Healthcare NHS Trust
CORRESPONDENCE: 90 Heathfield Park Drive, Essex RM6 4FJ
Email: jkhaja@yahoo.com

REFERENCES:

1. Murray, C. & Lopez, A. (1996) *The Global Burden of Disease*. Cambridge, MA: Harvard University Press.
2. Greenberg, P., Stiglin, L., Finkelstein, S., *et al* (1993) The economic burden of depression in 1990. *Journal of Clinical Psychiatry*, 54, 405–418.
3. Keller, M., Lavori, P., Mueller, T., Keller, M., Lavori, P., Mueller, T., *et al* (1992) Time to recovery, chronicity and levels of psychopathology in major depression: a 5 year prospective follow-up of 431 subjects. *Archives of General Psychiatry*, 49, 809–816.
4. Murray, C. & Lopez, A. (1996) *The Global Burden of Disease*. Cambridge, MA: Harvard University Press.
5. Joanna Moncrieff *Canadian Journal of Psychiatry* Feb. 2007;52,2; Pro Quest Medical Library pg 96.
6. SAGE Press Release in connection with BAP guidelines published in May 2008.
7. Irving Kirsch *et al*, *Initial Severity and Antidepressant Benefits: A Meta-Analysis of Data Submitted to the Food and Drug Administration*; PLoS Medicine, Feb. 2008, Vol. 5, Issue 2.
8. Anderson *et al*, *Journal of Psychopharmacology* May 2008
<http://jop.sagepub.com/cgi/rapidpdf/0269881107088441v2>
9. www.rcpsych.ac.uk
10. Joanna Moncrieff *Canadian Journal of Psychiatry* Feb. 2007;52,2; Pro Quest Medical Library pg 96.
11. Mayers A G, Baldwin D S, *Antidepressants and their effect on sleep*; *Human Psychopharmacology: Clinical and Experimental* 2005 Vol. 20(8), (Database of Abstracts of Reviews of Effects (DARE)).
12. Moncrieff J, Wessely S, Hardy R, *Active placebo versus antidepressants for depression*; January 2004 Systematic Review (Cochrane).
13. Major General Smedley D Butler (1898-1931), United States Marine Corps, author of *War is a racket*.
<http://www.lexrex.com/enlightened/articles/warisaracket.htm>