

Antidepressant Medications Are Ineffective And Claims Are Misleading

Practitioners in psychology are ethically bound to remain conversant with and informed about the scientific foundations for our interventions, and to adapt our techniques to those proven conceptualizations of disorder and appropriate interventions. Using scientific findings and practices, the psychologist must first assess patients in such a way so as to establish an accurate diagnostic picture, which are based on specific scientific findings and aid in the selection of the most appropriate treatment.

Psychologists have long been the leaders in the development of a broad range of diagnostic tools, understanding of brain physiology, psychopharmacological agents, learning, social, and behavioral skills based on scientific bodies of evidence and related theories and techniques. As the premier diagnosticians, providers of behavioral healthcare, and compilers of scientific evidence in the behavioral health fields, psychologists have a duty to speak out and make the public aware of effective treatments, choice of treatments, the limitations of certain treatments, and of the risk/benefit analysis of certain treatment choices.

Psychologists have a moral, ethical, scientific, public service, and legal (informed consent) interest in complying with these duties. Unfortunately, our colleagues in medicine, who also share these same ethical considerations, have allowed drug manufacturers to obscure and manipulate the science behind the use of psychotropic medications. Clearly, no physician explicitly prescribes medications they do not believe will help their patients. We make no such claim or imply that they do. Nevertheless, on a whole-scale and widespread basis, physicians routinely prescribe psychotropic medications despite the evidence that the underlying science is absent, contradictory and, in some cases, clearly manipulated by the drug companies.

Antidepressant Medications

We start our discussion with antidepressants because they are the most widely prescribed psychotropic medications; yet few studies have comprehensively analyzed the conditions for which these medications are prescribed. Depression is a disorder that affects millions of Americans and people around the world, robbing them of their productivity, creativity, ability to function effectively in their families; in some studies, one in five people, directly or indirectly, die due to depression. The disorder

increases the likelihood of addiction, shortened life span, and of divorce and disability. Biologically based imbalance theories have long been posited as a basis for antidepressant medications. Followed and joined by genetic etiologies, these theories, although largely unfounded, untested, and unproven, provide the foundation for medications sold by the millions of doses. The science is clear: There is no scientific substantiation that depression is caused by biological, chemical imbalances, defective genes, or that it is remedied in any significant way by available medications.¹⁵⁹ Psychopharmacology interventions for depressive illness are not an effective stand-alone or first line treatment plan. On the other hand, there are effective behavioral interventions for the various types of depression.

With respect to antidepressants, the scientific evidence shows that this class of medication is not appreciably more helpful in treating depression than placebo^{8,9,12,139,142,146,151,157,158,159,162,168,169,170,171,174,177,178,183,179,181.}

The research on antidepressant medications shows they only work in a small minority of the most severely depressed patients, and then only on a minority of the depressive symptoms and syndromes.^{164,182,185} Research scientists and psychiatrists in Canada, Germany, Britain, the Netherlands, the U.S.A., as well as a host of other countries, have chronicled the limits of these medicines in the treatment, eradication, and prevention of future episodes of depression.^{155,161,170}

As early as 1990, NIMH joined researchers and psychiatrists in the world to finally conclude that patients treated with antidepressants relapse rapidly upon cessation of the drug, and that cognitive therapy-treated depressed patients fare better in the long term and have the highest “stay well rate.”^{167,172,175} Antidepressants are therefore not curative of even the minority of symptoms they affect, with most relapsing within a short period of discontinuing the drug. Moreover, taking the medication actually builds up less and less ability to function without the drug, and the condition becomes chronic.^{148,149,153} In other words, the longer one stays on this type of drug, the higher the likelihood of relapse.¹⁸⁴

Leaders in the psychiatric field have noted that they, the government, and the industry are not really interested in the problems that these data point out, and is not likely to vigorously investigate them.¹⁶⁰ The scientific data regarding the efficacy of antidepressants has been so poor that world leaders in psychiatry have publicly stated in major scientific journals and publications, calling the first-line use of these drugs everything from unscientific to magical thinking, myth, and wishful thinking. Others have looked at the data and concluded that the elevation of antidepressants to the level of the first-line

treatment for depression is a hoax.^{5,6,22}

Further, the side effects of these drugs include cardiac complications, metabolic complications due to significant changes in body weight, withdrawal, akathisia and motor abnormalities, sexual side effects, drug-induced violence, neuropsychiatric effects including insomnia, apathy, and mania. Serotonin Syndrome is a life-threatening side effect that can be caused by drug interactions with other antidepressants. The long-term side effects of antidepressants include the induction of brain adaptations which may be depressogenic (cause depression) and pathogenic.^{154,161,184} Some animal studies tend to show that antidepressants modulate the expression of genes,^{141,164} providing a basis for suspecting that permanent effects the long-term administration of antidepressant medications can have a negative effect on the glial cells of the brain or the brain in general. These drugs are therefore very much in the high-risk category of interventions.

Psychotherapy Is Effective And Without Side Effects

Psychotherapy approaches for depression are now well-established as effective first line treatments for depression and just as effective and, in many cases, more effective than antidepressants without the risk of side effects.^{143,144,145,161} In a review of the published research on psychotherapy and depression,^{159 p2}, the author concludes, “The results of these clinical trials, meta-analyses and reviews point to one inescapable conclusion: Psychotherapy works for the treatment of depression, and the benefits are substantial.” In fact, when psychotherapy is compared to antidepressant interventions on the long-term, it outperforms antidepressants for both the severely and non-severely depressed patients¹⁵⁶.

Medications Can Control Only Some Symptoms Some Of The Time

Medication interventions as first-line treatments are potentially effective in controlling some symptoms in a minority of patients, but all have significant risk of dangerous side effects and drug interaction effects. Depressive spectrum disorders are disorders that have psychological, social, physiological, chemical, family and relational, occupational, self-regulation, and financial components. It is unrealistic and misleading to assume that an antidepressant can change and control all of these components and produce relief or a cure. When a person recovers from depression using skills learned in psychotherapy, neuroplasticity produces changes in the central nervous system from learning, and literally changes his brain structure and response pattern. Changes in self-esteem, self identity, and decision-making should not be attributed to an external element like a drug. Again, there is no scientific

basis to conclude otherwise.

According to Kirsch ^{159 p. 162}, “It is like learning to read, write, or ride a bicycle.” He notes that patients have changed and have new skills that they can reuse as needed. Antidepressants only dampen or partially control some symptoms of the disorder and in a minority of patients, and therefore do not qualify as a “stand-alone” or a “first-line treatment.” When such changes are attributed to a medication, they are misleading. Medications can only represent an adjunctive or second-line intervention, or a minor component of a realistic treatment plan. Antidepressant research shows the medicine only works in a small minority of the most severely depressed patients, and then only on a minority of the depressive symptoms and syndromes.

There are No Laboratory Tests That Can Show A Chemical Imbalance

The basis for using medications to treat behavioral disorders rests upon a foundation that has yet to be scientifically established. When a medication is prescribed for depression, there is an implicit assumption that the brain is lacking a significantly less amount serotonin, for example. How does the physician know this? Does the physician have a test to substantiate this? Presently, there are no laboratory tests that can indicate any amount of neurotransmitters, which form the basis for prescribing antidepressant medications. In fact, there are no established parameters that indicate what is the "normal" amount of serotonin, or any other neurotransmitter that psychotropic medications are based upon. All of this is assumed and helps explain why different people react differently to these medications. It's a guessing game that is costly, ineffective, and sometimes harmful. Nevertheless, some advocates ask: Why do some patients respond to these medications? One factor that has been established is the placebo effect. Some people respond positively to anything even something that has absolutely no value, such as an inert starch.

Antidepressant medications represent the most frequent treatment for major depressive disorder. However, there is little scientific evidence, if any, that they have a specific pharmacological effect relative to pill placebo for patients with less severe depression.¹⁵⁰ Leuchter¹⁶³ and his researchers at UCLA examined the brain functioning of responders to selective serotonin reuptake inhibitors (SSRIs) compared to a placebo. After nine weeks of treatment for major depression using quantitative electroencephalography, they concluded that placebo responders showed a significant increase in prefrontal concordance (i.e., a measure of cerebral perfusion), whereas medication responders showed a

decrease in this area. In an article published in Newsweek, the author concluded that the news about depression was "depressing" because the evidence is clear that they work no better than placebos and there was a "moral dilemma" in that how can 32 million people who suffer from depression be told that their medications simply didn't work? ¹⁴⁰

The question, of course, is do we continue to engage in and collude with drug companies and "morally conflicted" physicians simply to keep patients from learning their medications may be worthless? NAPPP thinks we should not. To do so is misplaced and harmful to patients, particularly when there are effective treatments available. The problem is that drug companies cannot make a profit on psychotherapy. Moreover, insurers, who really do know that these medications are essentially ineffective, go along with the ruse and are part of the collusion because medications are cheaper than behavioral intervention.

With all the data pointing to the ineffectiveness of antidepressant medications, some might wonder: Why not simply give patients a placebo? Would it not be safer and less expensive to do so? If one is relying strictly on economic arguments, yes, placebos would be less expensive. However, depression is a serious disorder and can kill. Many people suicide because they are depressed. Placebos will not and cannot cure depression -- they just perform as well or better than medications.

To relieve or cure depression, the scientific data shows that:

1. Most people will respond positively to behavioral intervention. Typically, 13 sessions of cognitive-behavioral intervention will do it.
2. A smaller number will respond positively to medication along with behavioral intervention.
3. A smaller number of patients, a minority of about 12-15%, respond solely to medications.

The challenge is to discern who will respond best to which treatment. The most important factor is to obtain an appropriate evaluation and diagnosis. If a patient is going to be treated for depression, would it not be important to know that they actually are experiencing depression? Herein lies the real

dilemma, both clinical and moral. The vast majority of patients are not evaluated or receive an appropriate diagnosis from a doctoral psychologist or psychiatrist before medications are prescribed. It is clear that those patients who do best with behavioral intervention do so relatively quickly. They do so because they have been correctly diagnosed and treated appropriately. Non-responders, who also have been appropriately evaluated and prescribed a medication and followed by a psychologist also do well for the same reasons, plus the addition of the placebo response. The minority of responders who do well on medications do so for many reasons. First, their response is simply a matter of luck -- a chance occurrence. Second, they may in fact be one of the group that do have a genetic variation. Last, this group may be the most responsive to the placebo effect. Nonetheless, the key issue for all of these patients is to have an appropriate evaluation and diagnosis before any treatment plan is implemented. This ensures the best outcome and becomes the most cost effective in the long run.

Feelings Are Not A Diagnosis

Diagnosing feelings such as anxiety, depression, anger is not defining a psychiatric disorder or diagnosis, and often leads to inappropriate medication selection and application. To use the knowledge and findings of the available and updated science base, one must first start with accurate diagnoses. General medical personnel are ill-equipped and ineffective in accurately identifying, diagnosing, and effecting linkages with mental health services and specialists.^{4,6} No psychopharmacological intervention has ever demonstrated efficacy in changing personality or eradicating mental illness. The effectiveness of antidepressants diminish quickly, and the vast majority of patients treated with these drugs relapse soon after treatment. There is evidence that the longer the treatment with antidepressants alone, the more significant the relapses.¹⁵⁹

The brain has scientifically demonstrated autoplaticity and can change with training, experience, and specialized interventions, such as psychoeducation and behavioral intervention. Every patient and family suffering from serious mental illness deserves an accurate diagnosis from a doctoral-level psychologist and a comprehensive treatment plan to include behavioral intervention, family therapy and psychoeducation, behavioral case management, and appropriately selected and monitored palliative techniques such as medications (where indicated), crisis intervention, and psychiatric hospitalization (when indicated). Every hospital, primary care center, nursing home, and other healthcare facility should be required to staff doctors of psychology for the purpose of specialty diagnoses and treatment planning, and mental health service design and delivery.

