

## HEAD TO HEAD

## Are antidepressants overprescribed? Yes

**Des Spence** believes that the rising prescription rates for antidepressants reflect overmedicalisation, but **Ian Reid** (doi:10.1136/bmj.f190) argues that prescribing is cautious and appropriate

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Antidepressant prescriptions in the UK jumped by 9.6% in 2011, to 46 million prescriptions.<sup>1</sup> As a generalist prescribing antidepressants daily in primary care, I think that we use antidepressants too easily, for too long, and that they are effective for few people (if at all). But even questioning current care is considered “stigmatising” towards mental illness and “populist” anti-medicine rhetoric.<sup>2</sup> The arguments put forward for using antidepressants are simple: depression is an important, often stigmatised, illness, for which antidepressants work; prescribing is supported by national guidelines; and long term treatment prevents relapse.<sup>2,3</sup> But, regrettably, the argument is not that simple, and psychiatry’s defensiveness is stifling legitimate discussion.

### Question of definition

Depression is indeed an important illness; few of us are untouched. But the current definition of depression is too loose and is causing widespread medicalisation. The *Diagnostic and Statistical Manual of Mental Disorders* (both DSM-IV and the proposed DSM-5) suggests defining two weeks of low mood as “clinical depression,” irrespective of circumstance. Depression is depression. It even proposes that being low two weeks after bereavement should be considered depression. But with 75% of those who write these definitions having links to drug companies,<sup>4</sup> is this a story of a specialty being too close to industry? **Mental illness is the drug industry’s golden goose: incurable, common, long term, and involving multiple medications.** This relation with industry has engrained a therapeutic drug mindset to treat mental illness. Today the Centers for Disease Control and Prevention reports that 25% of US citizens have a psychiatric illness.<sup>5</sup> Isn’t this medicalising normality?

The National Institute for Health and Clinical Excellence guidelines do not support the use of antidepressant medication in mild depression, nor necessarily as first line treatment of moderate depression.<sup>6</sup> Guidelines promote the use of psychological talk based interventions. Paradoxically, therefore, any increase in prescribing of antidepressants may reflect non-adherence to these guidelines. Indeed, some meta-analyses

suggest antidepressants may not work at all in mild to moderate depression.<sup>7,8</sup>

But even if we accept that antidepressants are effective, a Cochrane review suggests that only one in seven people actually benefits.<sup>9</sup> Thus millions of people are enduring at least six months of ineffective treatment. People who do not respond fare worse, with switches of medications and often multiple drug combinations. How often do we tell patients these undisputed facts?

### What does the evidence show?

We are assured that depression is undertreated, but this research dates to the 1990s and is no longer relevant.<sup>10</sup> Other observational research reassures us that antidepressants are being used appropriately, but this research merely demonstrates that antidepressants are used in people with depressive symptoms, not whether they are used appropriately—that is, only in those with more severe symptoms.<sup>11</sup> Although it has been suggested that the increase in prescriptions could be due to longer duration of treatment,<sup>2</sup> this isn’t plausible. Since this research was published in 2006, prescriptions in England have increased by 17.3 million, a 59% increase.<sup>12</sup> The only explanation is that we are prescribing more antidepressants to ever more people.

Even if longer prescribing does contribute to increasing prescription totals, there is no evidence to support this policy. The major systematic review of randomised trials of antidepressant drugs to prevent relapse in depression had only 500 patients taking selective serotonin reuptake inhibitors for up to three years.<sup>13</sup> Another systematic review concludes that research “provides no guidance” to support long term treatment.<sup>14</sup> A policy of ever lengthening courses of antidepressants is a product largely of “expert” opinion, not evidence.

Before we continue with this policy the psychiatric community must produce evidence of benefit. The internet is awash with harrowing patient stories of side effects such as gastrointestinal disturbances, hypersensitivity, anxiety, insomnia, tremor, hallucinations, drowsiness, sexual dysfunction, hypomania, and

suicidal behaviour.<sup>15</sup> Research also suggests that half of patients experience a withdrawal syndrome.<sup>16</sup> Patients are reluctant to stop antidepressants, assuming these symptoms mark a return of their depression. Some even believe they will never feel “happy” without medication.

The antidepressant approach is used to validate the “biochemical model”—depression is a mere chemical imbalance. This seems counterintuitive, reductionist, and dismissive of the human condition and is not supported by robust evidence.<sup>17</sup> Lastly, it has been suggested that increased use of antidepressants is linked to a fall in suicide rates.<sup>18</sup> But this doesn’t seem credible: suicide has increased sharply since the economic recession despite increasing antidepressant use.<sup>19</sup> Ian Reid wrote of depression: “work, purpose, faith, family, friends and security can’t make it better.”<sup>20</sup> I fundamentally disagree. Improving society’s wellbeing is not in the gift of medicine nor mere medication, and overprescribing of antidepressants serves as distraction from a wider debate about why we are so unhappy as a society. We are doing harm.

Competing interests: I have read and understood the BMJ Group policy on declaration of interests and declare that I am involved in No Free Lunch, an organisation seeking to limit the influence of Big Pharma over drug promotion and education. I receive no payment or expenses for this. I advocate that healthcare professionals should not see representatives of the pharmaceutical industry.

Provenance and peer review: Commissioned; not externally peer reviewed.

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