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Oy vay syndrome

How a dumbed-down form of psychiatry has been a boon for the drug companies

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Christopher Lane
SHYNESS
How normal behaviour became a sickness
272pp. Yale University Press. £18.99 (US $27.50).
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In 2000, an enterprising reporter on the Boston Globe, aware that the patent for the billion-dollar-selling anti-depressant drug Prozac was soon to expire, checked to see if an application had been filed for a new version and found that it had. Such applications have to state what the improved benefits of the new drug will be. Among them was this claim: “It will not produce several existing side-effects, including suicidal thoughts and self-mutilation . . . one of its [Prozac’s] more significant side-effects”. This story is related in Let Them Eat Prozac: The unhealthy relationship between the pharmaceutical industry and depression (2004) by the British psychiatrist David Healy. It also appears in Christopher Lane’s Shyness, which draws heavily on Healy’s book. What makes it worth retelling is that Eli Lilly, the manufacturers of Prozac, had consistently denied that there was any evidence that the drug raised suicide risks, claiming that it was “safe and well tolerated”.

Launched in 1989, at a time when there was growing concern over the addictive properties of tranquillizers such as Valium and Librium, which could also be lethal in an overdose, Prozac was promoted as virtually side-effect free and proved hugely popular; by 1999, it accounted for 25 per cent of Eli Lilly’s $10 billion revenue. Prozac was the first of a new type of drug known as SSRI’s (selective serotonin reuptake inhibitors) which targeted the neurotransmitter serotonin in the brain. The widely accepted theory, supported by very little evidence, was that low levels of serotonin caused depression, so that the drugs were simply correcting a biological deficiency. But, by the end of the 1990s, almost drowned out by reports of their beneficial effects – depression lifted, personalities transformed – voices started warning of a darker side.

The most persistent of these was that of David Healy, who had acted as an expert witness in two American court cases involving claims that an SSRI had caused outbreaks of violence and suicide. As such, he had had access to unpublished studies held by the manufacturers, showing that the drugs doubled or tripled the risk of suicide. He also claimed that their effectiveness had been greatly exaggerated. At the time of the Boston Globe story, Healy, who heads an NHS psychiatric clinic in North Wales, was regarded as an unreliable maverick for making such claims. Today, however, they are widely accepted. In 2000, a large study, published in the Archives of General Psychiatry and based on 5,200 pages of documents submitted to the FDA over ten years for SSRI licence applications, concluded that not only were the drugs no better than the older anti-depressants, but they were less than 10 per cent

more effective than placebos, which produced an average of a 30.9 per cent improvement in depression.

Three years later the UK's drug regulatory body, the MHRA, which had assured Healy many times that there was no cause for alarm, warned that these drugs doubled the risk of suicide in children, based on research data dating back to 1996. The evidence involved three trials of an SSRI called Seroxat, only one of which had been published. An analysis of all three found that 6.5 per cent of children on the drug showed "emotional liability" (which includes suicidal thinking) compared with 1.4 per cent of those on the placebo. SSRIs now come with a suicide warning. The result of these and similar findings has been to create a crisis of confidence among GPs and mental-health professionals over the best way to treat depression, anxiety and simple unhappiness. Between 1991 and 2001, antidepressant prescriptions in the UK rose from 9 million to 24 million a year; but now questions are being asked about whether such a heavy reliance on the pharmacological approach is wise.

The achievement of Christopher Lane's book Shyness is to chart for the first time the events preceding the rise and fall of the SSRIs. Just as Healy used unpublished drug-company data to highlight the suicide problem, so Lane has marshalled a cache of unpublished data to explain the academic framework that allowed the rise to happen.

When diagnosing mental health problems, American psychiatrists rely on the Diagnostic and Statistical Manual of Mental Disorders, which classifies disorders and lists their symptoms. First published in 1952, it was revised in 1968 and again in 1980. It is that third revision, known as DSM III, that Lane focuses on. Drawing on previously unpublished documents held in the archives of the American Psychiatric Association, he reveals the inner workings of the committee that sat for seven years and drastically revised the manual, creating 112 new disorders, including Social Phobia – later changed to "Social Anxiety Disorder" – the "shyness" of Lane's title.

Officially, that revision transformed the manual and, by extension, psychiatry into a "pristine scientific entity". This was done partly by removing virtually all traces of the psychoanalytic model of mental functioning from the definitions and symptoms. Out went all the unprovable speculations about psychosexual dramas of the ego and the id, and in their place an "atheoretical" system was created that listed only symptoms and was agnostic about cause; a system that could be quantified and standardized much more easily.

However what actually happened, according to the raw material of the archives, was quite different, and Lane tells the complex story with impressive clarity. Far from being the distillation of new research and scientific studies, the new disorders emerged from rounds of bureaucratic infighting and the sort of wheeler-dealing that produces the manifestos of political parties. On one occasion, during a forty-minute meeting, Professor Robert Spitzer, the chairman of the revising committee, together with two other psychiatrists, apparently decided that the old diagnosis of "hysterical psychosis" should be split in two. One was to be characterized by "short episodes of delusion", the other by "showing up in an emergency room without authentic cause". The first they called "brief reactive psychosis", the second "factitious disorder". Spitzer typed out the list of symptoms for each, then and there.

So how did Spitzer and his committee decide on a new disorder? "We'd ask how logical it was", he said. "Whether it would fit in. The main thing was that it should make sense. It was the best thinking of people who seemed to have expertise in that area." In fact the process

could be even vaguer. Some disorders were included on the basis of just one patient, treated by the same clinician who was putting the disorder forward. In other cases the symptoms wouldn't have seemed out of place in a saloon-bar discussion. Signs of "chronic complaint disorder" include grumbling too much about the weather or saying "Oy vay" too many times.

The closest that shyness had come to being pathological prior to DSM III was in a condition called social phobia that was regarded as very rare. In an interview with Lane, Spitzer explained why it was necessary to distinguish severe anxiety over social situations from other phobias: "Well, with specific phobias there are things that scare people like snakes or heights. And then some people avoid people so let's call that social phobia". Symptoms of this new affliction could be experienced by almost everyone; they include "Fear of sounding foolish" and "Being stumped when asked a question in a social setting". Despite the bar for diagnosis being set so low, it was described by the National Institute for Mental Health as "one of the worst neglected disorders of our time". Later on psychiatric experts would regularly claim that the new disorder affected 18 per cent of the American population. But, as Lane shows, the only evidence for this was a single telephone survey of 500 Canadians; using only slightly more stringent criteria could reduce the prevalence to 1 per cent. As one of the consultants to the revising committee, Theodore Millon, conceded in an interview in 2005: "There was very little systematic research, and much of the research that existed was really a hodgepodge – scattered, inconsistent and ambiguous".

On such a flimsy underpinning was the new disorder launched – one of seven new anxiety disorders that were often hard to distinguish, including Schizoid Personality Disorder and Avoidant Personality Disorder. But as soon as they appeared in DSM III, such shortcomings were all forgotten, and the new disorders rapidly became targets for aggressively promoted drug treatments.

Early in its deliberations the committee had stated that the manual should only diagnose conditions that caused one of the 4Ds – acute distress, dysfunction, deviance, or danger. This didn't last long, however, not least because the checklists of symptoms cast their net so wide. Some clinicians thought it fine to gauge impairment by whether a person with a supposedly avoidant personality preferred travelling to work by car or on public transportation. The pharmaceutical companies reinforced this confusion by stressing that Social Phobia was a serious medical condition and a lifestyle issue. The drugs, the American advertisements claimed, could help you regain "emotional balance"; they featured models and catchlines like "Your life is waiting". But not only did the drug treatments replicate the confusion over severity found in DSM III, they also mirrored the lack of clear distinction between the newly created disorders; it seemed the revision had created distinctions without a difference. Whether your problem was generalized anxiety, Social Phobia, major depression, Obsessive Compulsive Disorder or Premenstrual Dysphoric Disorder, the treatment was always the same – antidepressant SSRIs, dispensed in far greater numbers than any psychotropic drugs had been before. The "pristine scientific entity" had contributed to a giant uncontrolled experiment in mass-medicating.

For Lane, the real tragedy of DSM III was that it produced a dumbed-down form of psychiatry that takes little account of the complexities of the unconscious, and its influence on our behaviour, as identified by Freud. The checklists of behavioural symptoms used to diagnose disorders in DSM III take no account of a patient's personal history. And concentrating on externals in psychiatric diagnosis takes little account of how symptoms are experienced by

the patient. Maybe that wouldn't matter if the medical drug model had been successful. This postulates that certain behaviours indicate a neurochemical deficiency – analogous to, say, low insulin – which can be returned to a healthy level with a drug. Quite apart from its shaky biochemical basis – both Healy and Lane demolish it – the results of applying it have not been impressive.

Resent research has raised serious doubts about the safety and efficacy of drug treatments for young people with either depression or ADHD; hundreds of thousands of demented elderly patients in the UK are currently treated with antipsychotics that have been shown to be both damaging and ineffective in this patient group. The problem is that the pharmaceutical dominance of psychiatry has pushed the profession into a corner: drug treatments are virtually all that is available. NICE guidelines recommend that depression be treated with some form of psychotherapy but it is estimated that 10,000 more therapists would be needed to implement the policy. Lane has done a valuable job in tracing the roots of the current crisis and he certainly isn't calling for a reinstatement of Freudianism; what is needed now is another map to indicate a way out.

Jerome Burne is a science and medical journalist. His book Food Is Better Medicine than Drugs, written with Patrick Holford, was published last year.

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