Letters

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Antidepressant prescribing

The two papers by Middleton and Moncrieff,[1] and Anderson and Haddad[2] published in the January edition of the Journal highlight a fundamental fault line that runs under the concept of depression: the current conventional rationale for treatment of depression with antidepressant medication is increasingly untenable. It has been recognised for some time that the serotonin hypothesis that provides the explanatory model for the supposed action of selective-serotonin reuptake inhibitors is not supported by current evidence.[3] Despite this the model remains dominant, largely through the efforts of the pharmaceutical industry to cultivate a profitable sector of the market. As a result we have a pseudoscientific myth that pervades our approach to human distress.[4]

There is now substantial evidence to suggest that antidepressant drugs exert their effects through mechanisms such as an active placebo response[5] and by inducing non-specific abnormal mental states rather than by any specific 'antidepressant' action.[6] Although many clinicians and patients report improvements in depressive symptoms associated with the use of antidepressants, it is ethically questionable to justify treatment based on a naïve and misleading hypothesis.

A critique of the use of antidepressants would necessarily involve a reappraisal of our understanding of the concept of depression itself. There is growing concern that the term is increasingly used inappropriately to medicalise normal human experience.[7,8] Such a strategy, if pursued to its logical conclusion — as currently seems to be the case with the development of DSM-V — would effectively convert much of human experience into overly simplistic technical problems, to be addressed by biomedical solutions that are likely to be ineffective and possibly harmful.[9]

The widespread use of these agents needs to be reconsidered particularly within primary care where they are least likely to be of benefit. It is time for us to rise to Middleton and Moncrieff's challenge and to recognise that antidepressants are 'unlikely to do any good and may do some harm.'

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Antidepressant prescribing

Middleton and Moncrieff[1] make a good case for being cautious about prescribing antidepressants in primary care. The discussion is, however, somewhat one sided. The responsible GP will be aware that there is always a suicide risk if a severely depressed patient is sent away without an antidepressant. Being on the waiting list for cognitive behavioural therapy will not necessarily prevent suicide. Patients who commit suicide have a low concentration of serotonin in the brain.[2] An experienced GP will also know of patients who have been symptom free on antidepressants who experience breakthrough symptoms when they try to wean themselves off the drug.

The old RCGP dictum that every diagnosis should have a physical, social, and psychological component is especially relevant to treatment of depression. The physical component must surely be serotonin deficiency in many cases but it would be wrong to treat this deficiency and ignore the psychological and social components which might be more important.

Recent evidence suggests a link between the physical component of depression and nutritional deficiencies.[3–5] The evidence for omega-3 and antidepressants working synergistically is especially convincing.[6] Recently, when a patient reported breakthrough depression symptoms, I doubled her selective-serotonin reuptake inhibitor dose and added an over-the-counter high dose omega-3. At follow-up, she told me: 'I feel normal for the first time in over 3 years'. Could this be just a placebo effect?

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