NO

James Mauro

AND PROZAC FOR ALL . . .

The year 1993 proved a big one for Eli Lilly & Co., makers of Prozac. *Listening to Prozac,* a testimonial to the drug's healing powers, make the best-seller list, while Peter Kramer, its author, touted his tiny benefactor on various talk shows. Again and again the pill popped up in endless *New Yorker* cartoons, computer-network discussions, even David Letterman jokes. In February, the pill itself graced a cover of *Newsweek.*

Slowly, stealthily, Prozac is slithering into more and more of our lives and finding a warm place to settle.

Even the most casually aware citizen can feel the shift in thinking brought about by the drug's ability to "transform" its users: We speak of personality change, we argue over the drug's benefits over psychotherapy (all those expensive hours of parent-bashing as compared to a monthly dash to the pharmacy); and we let ourselves imagine a world in which our pain is nullified, erased as easily and fully as dirty words on a school blackboard.

Most of all, we envision a race of people both frighteningly bland and joyously healed as the ultimate double-edged sword. While Prozac may indeed be our gift horse of the decade, at least we're staring it straight in the jagged molars.

Of all the fears and concerns, the one barely spoken of but no less valid apparently has more to do with the good news than the bad: It seems the drug is *more* effective, and works to relieve *more* symptoms, than previously imagined.

Without a doubt, Prozac is exiting the realm of clinical depression and entering the murkier world of subclinical, subsyndromal, sub-"sick" disorders. Clinicians in particular are worried that the definition of "subsyndromal" disorders (psychological complaints that fail to meet the criteria for a specific illness) is expanding to include more of what were once thought of as ordinary life stresses. (The unofficial term for this is "bracket creep.")

And as this illness invitation list grows, so, of course, do the numbers of patients who now fall into this category—people somewhere short of being honest-to-God sick but who are nevertheless in some sort of pain.

Robert Trestman, M.D., director of the outpatient program at Bronx VA Medical Center, sums up the dilemma: "There are many situations where people do not meet the minimum criteria for a disorder. Where a specific diagnosis may require five criteria, for instance, some people will have only two, perhaps even one. And yet they're suffering."

And receiving psychiatric medication when once they were shipped off to a therapist's couch. Trestman neatly breaks down the dividing lines between the sick and the uncomfortable:

- Traditional patients, who say, "Doc, can you fix me? I'm hurting."
- Nontraditional patients, who say, "I'm not broken, but make me better. I want to be more assertive, I want to feel better, I want to accomplish more."

In the past, both groups would be recommended for therapy. Now, more and more are being tried on Prozac. Because of its fewer side effects and lower toxicity, the risk-to-benefit ratio is a lot lower.

"It's lower," agrees Trestman, "but it's not zero. There are side effects, risks that raise concern in the medical community."

GOOD NEWS OR BAD?

Historically, the use of drugs as fixers of the world's private ills has run into serious, if unanticipated, snags. At the turn of the century, the medical community thought that cocaine was a completely appropriate, nonaddictive drug, and widely prescribed it. In the 1950s and '60s, first barbiturates and then amphetamines were doled out for various psychological maladies. We now know that each of these drugs came with significant risks. So what yet-to-be imparted knowledge may cause scienc once again, to admit sheepishly that th exuberance over Prozac was somewh premature, if not wholly overblown?

While much remains to be learne about Prozac, so far the bad news ma be that there's no bad news. If, aft all, it does turn out to have no seriot drawbacks, what are the implications a drug that is a shortcut to healing?

It is a concern that potentially affects a psychologists, who may find themselv short of angst-laden clients in the comir years; that places dubious power i the hands of primary care physician who may prescribe the drug without fully articulated understanding of the patients' distress; and that strikes a chor of defensive fervor in the hearts an minds of everyone raised with the Judec Christian ethics—that nothing in life ca be worthwhile, or effective, unless yo *work* for it.

There's more to the story. Questior abound regarding the drug and its chem ical cousins, Zoloft and Paxil: What othe types of disorders, aside from clinical di pression, are they being prescribed for Do the medications work? What other op tions exist? What are the potential risks t individuals and to society?

I'M DYSTHYMIC, YOU'RE DYSTHYMIC

Of all the distresses, ailments, and infir mities patients complain of nowaday perhaps none is so broad or so muddl in definition as "dysthymia"—a chroni discontent involving either depressio (but not *clinical* depression) or irritabi ity. Its symptoms—not eating or eatin too much, not sleeping or oversleepin poor concentration or difficulty makin decisions—reveals the unexclusivity c

its rank and file. In terms of requirements for diagnosis, dysthymia may be the only club that would have Groucho Marx for a member.

According to a recent survey, approximately 48 percent of Americans—almost half the population—has experienced some form of dysthymic disorder. And all of them may qualify for Prozac. Robert Millman, M.D., professor of psychiatry and public health at Cornell, sees the irony of it: "There's *nobody* nonsyndromal. You can give Prozac to anyone you want."

Which is anathema to what medical science is supposed to be about. "We try to convince people there's some specificity to what we do," says Millman. "But this is embarrassing."

And the list doesn't stop there. Simon Sobo, M.D., director of psychiatry at New Milford Hospital, reports that "Prozac has been successfully used for obsessive hair-pulling, panic disorder, eating disorders, and social and other phobias. It has proven useful to people to free themselves from addictive relationships; to dispel doubts about performance; to overcome obstacles that once seemed impossible. I have even added it to my watering can and found geraniums grow better on it."

He's joking, of course, but only about the geraniums. Add obesity, gambling addiction, and PMS to the spectrum of complaints now being helped by Prozac.

BETTER RECEPTION?

If little is known yet of just how effective these drugs are for psychological distress, even less clear is the actual impact they have on those who benefit from them. Are they simply mood brighteners or are they re-regulating systems that are out of balance? Do they actually *change* personality, making you feel better than normal, or merely fine-tune it? Do people say, "Gee, I feel more myself on this drug" or "Gee, I'm a different person now"?

Some clinicians, such as Larry Siever, M.D., director of the Outpatient Psychiatry Division at Mt. Sinai School of Medicine in New York, offer an opinion between the two: "If you have a staticky, bland picture on your TV set, you can fix the reception by adjusting the tuning and contrast. Or simply change the channel. My understanding of the medications personally is more the former than the latter."

Of course the big fear surrounding the "channel-changing" aspect of the drugs is that society will evolve into a battalion of "happy soldiers." Exhumed by Kramer himself, the specter of Aldous Huxley's soma—*Brave New World's* fictional drug that anesthetized citizens into a content unawareness—continues to haunt us and cloud the argument surrounding Prozac. Yet to many, the analogy seems false.

"The drugs, if properly used," says Siever, "shouldn't dampen normal signals of anxiety, not even normal depression. It should not snow under in the way that a hypnotic does a person's normal level of arousal or awareness, but should allow all of these signals to emerge more clearly."

And, he continues, extending the argument, "If depression or other symptoms emerge, whether from psychological or social stresses, aren't people entitled to treatment for these conditions, just as they would get if they had an ulcer in relation to the stresses in their lives?"

Siever's example inadvertently reveals yet another controversy surrounding the use of drugs—any drugs—in fighting these disorders: the contention that pharmacology focuses on the individual rather than examining the larger societal problems that lie behind depression and other ills. Epidemiological studies have shown that more people are suffering from major depression that ever before—at ever-younger ages. Prozac, some argue, puts a Band-Aid on individual symptoms rather than addressing why people are seeking help in ever-increasing numbers.

The response of clinicians is to answer the question with a question: Why must one solution preclude any other?

The fundamental error, they argue, is to assume that the use of Prozac as a therapeutic tool equals an interest only in the biological causes of depression (or sub-depression, or just plain old feeling lousy). Those who can prescribe medication are, by profession, at least partly invested in biological *solutions*. And since Prozac is usually recommended along with some form of psychotherapy, the conclusion that interpersonal relationships are somehow ignored—or that individual brain chemistry is the one and only root being addressed—seems erroneous.

"We're not saying this is the *only* way to help," insists Trestman. "We're saying, 'This is one way, but of course there are others.' Many more people can be helped by changing the structure of society than through medicine. But we also have the ability apparently to help many more people with medication than before. Now we have to figure out should we? And for whom? And where does it stop?"

OUT OF THE WOODWORK

Other concerns stem from the staggering numbers of people for whom Prozac would prove beneficial. In 1991, this

advertisement appeared in New York *Times* and *Village Voice*.

"ARE YOU DEPRESSED? DO YOU SU FFER FROM FATIGUE? INABILITY TO CONCE TRATE? HAVE TROUBLE SLEEPING OR EA ING? IF SO, CONTACT..."

The ad was placed to gather subjec for a study of the effectiveness of Proz in treating dysthymia. The respons according to researcher Jesse Rosenth M.D., Director of psychopharmacology Beth Israel Medical Center in New Yor was "literally thousands of phone calls. was amazing—all these bright, educate hardworking people just came out of th woodwork. We found a mother lode nice people who were able to functio but who were quite literally the walkin wounded of New York."

After selecting a core group who m the criteria for dysthymia, Rosenthal an his team divided them up and gave on half Prozac, the other half a placeb Results? An astonishing 62 percent the Prozac group showed significar improvement after only eight weeks opposed to 18 percent given placebos Other studies conducted by Rosenth have shown a more than 70 percer success rate.

The number of people who responde to the advertisement is evidence widespread, if low-level, depression– and in greater numbers than were pre viously imagined. But what struck Ros enthal was that, while their averag age was 36, almost 80 percent of them were single, and another 9 percent wer divorced. Nearly 90 percent of them ha been in therapy on and off over the years

"They had a lot of insight," report Rosenthal. "But they still had symp toms."

Which begs the question: Were thes people dysthymic (read "unhappy") be

cause they couldn't get themselves involved romantically, or were their persistent blues preventing them from successfully interacting with others?

The distinction is an important one, and crucial in the argument of a "drugs vs. societal change" approach to combating low-level depression. Romantic courtship may be more difficult now than ever before—which may lead many to remain single and unhappy. If so, working toward easier social interaction would benefit. If, however, the reverse were true, and the subjects' dysthymia was what prevented them from dating, then focusing on the individual—*in order to correct the social*—seems justified. "And that focus is not to be dismissed," stresses Trestman.

DOES PROZAC = LEARNING?

Whatever the root, one can see them, sipping Cranzac (Prozac and cranberry juice—a popular cocktail for those unable to tolerate full doses of the drug), nuzzling up to potential mates at the local singles' bar, smiling, their psychological wounds successfully sutured. Given time, wouldn't a more positive outlook lead to better interactions, and the potential relationships that developed continue to promote good cheer once Prozac is tapered off?

"Of course," agrees Trestman. "If people start responding differently to you, and you start feeling different about yourself, you set up new habit patterns that reinforce your changed state of affairs. It may be that Prozac resets the adjustment in the brain after a number of months, and that afterward people would be at this new point and could taper off without relapse."

In other words, first the drugs make you better, happier, more in control—then you do the rest of the work on your own. Cornell's Robert Millman concurs: "The drugs change a person's emotional reward system. Your sense of acceptance increases. Your feeling state is changed. Then hopefully you take this new ammunition and go out and use it on your own."

Wait a minute. What are we saying here? That "real learning" occurs on Prozac? That the drug does not simply solve your problems medically, but requires you to do half the legwork yourself? Yes, believes Millman, "So that even when you take away the medication, the same situation in life may create different responses in an individual. Where once the thought of initiating romance seemed too stressful, it now seems possible. Where once life seemed sad, lonely, and defeating, it now appears worthwhile and conquerable."

SYNDROME VS. CHARACTER

Still, there are fears. Is Prozac bringing to light the frightening number of people who suffer from some sort of distress? Or is it that what were once called "character traits" are now being reclassified as "syndromes"—because they can be smoothed out by medication? And, if such a trend continues, will there be anyone left who *isn't* "disordered"? Who *doesn't* need drugs?

Some doctors bristle at the distinction between syndrome and character. "It's a false and meaningless boundary," insists Steven Roose, M.D., of Columbia University. "People implicitly cross the border from, well, it's a syndrome, that means there's something wrong with the brain, to, well, that's just their character, their personality, so that's psychology."

Such dualism is destructive, believes Roose: "If somebody has a bad temper and works to control it, we don't say they're altering who they are. But there's a paranoia that somehow with medication, we're trying to control the essence of individuality, that we're manipulating someone."

No doubt the moral arguments about character altering are being applied more severely when treatment involves medication as opposed to psychotherapy. Consider one recent *New Yorker* cartoon: "If they had Prozac in the 19th century." One panel features Karl Marx saying, "Sure, capitalism could work out its kinks!" In another, Edgar Allen Poe is on friendly terms with the raven. A third shows Nietzsche outside a church with his mother, saying, "Gee, Mom, I like what the priest said about the little people."

The implicit message is that, without suffering, without the character quirks that made Poe poetic, for example, we would be deprived of his brooding masterworks. True, perhaps, but if suffering is so enlightening, if it is part of what makes us "us" and we should try our best to preserve it rather than medicate it away—isn't that also an argument against *any* kind of treatment? Shouldn't we then avoid seeking *any* kind of relief, for fear that we may be damaging, even destroying, the human spirit, the creative urge, that which defines all of us, the brilliant and the dullard?

"The notion that suffering is good is paternalistic and, at worst, sadistic," says Roose. But even if we take that moralistic, almost religious view, why point our swords only at the dragons marked "take as directed"? Why not apply the same questions and concerns to p chotherapy? "The use of psychother in this country has been grandfathe in," points out Bob Trestman. "It's b accepted already for many years, firs terms of counseling from religious le ers, and more recently in the prac of formal therapy. So that we no lor question either its intrusiveness on v we are or its relative safety."

Does psychotherapy have side effe Is it intrusive? Does it change essence of who we are? The answe yes to all. "If psychotherapy coul manipulate or effect change, ther wouldn't work," states Roose. "The i that therapy isn't intrusive, that don't alter behavior or control peop thoughts is fundamentally untrue."

What about side effects? "By def tion, if a treatment is powerful enou to work, it's powerful enough to h adverse effects. Every journal on p chotherapy will talk about people v regress in treatment, people who h psychotic reactions, people for wh therapy has caused deterioration rat than progress.

"Still," Roose continues, "beca these so-called nonsyndromal disord are considered to be in the realm of p chology, we don't think there's anyth wrong in treating them with psychoth apy. We believe that *isn't* manipulat while medication is—regardless of c come."

MANIPULATION VS. CHANGE

Yet what if the brain reacted, readjus itself in the same way, whether response to a pill or a therapeu directive?

Last year, in the *Archives of Gen Psychiatry*, a research team headed

UCLA's Lewis Baxter, M.D., reported a study of two groups suffering from obsessive-compulsive disorder (recurrent, unwanted thoughts accompanied by ritualized acts, such as excessive handwashing). In treatment, one group was given Prozac with no formal therapy, the other behavior therapy, in the form of exercises designed to prevent their compulsiveness, with no drugs. After 10 weeks, scans of their brains were compared with those taken at the beginning of treatment.

Approximately two-thirds of each group improved. More important, for those who did improve, rates of glucose metabolism (an indicator of brain activity) decreased in *exactly* the same areas of the brain, in statistically similar amounts, regardless of treatment. The behavioral techniques actually altered brain function —and did so no differently, no less intrusively, than Prozac.

"Some may wonder," writes Baxter et al, "how behavior therapy could produce brain-function changes similar to drugs. [But] the possibility of both having the same neural effects is not as farfetched as it might seem."

The brain is the organ of the mind, and its function affects personality. So how far do we go in treating its disorders and distresses, its syndromes and its character flaws? By all accounts, the resounding answer seems to be: as far as it is safe to go. The unanimous opinion among professionals is that more information is needed.

Yet what about the concern that we are entering an age when even the slightest wrinkle in character can be defined as a "disorder." Will we become a Prozac nation? Hardly, thinks Robert Millman, who does not believe the whole of society is going to became dependent upon these drugs. The reason? Evolution, which, over the course of time, has created in us the brain functions that dictate the way we deal with thoughts and emotions. That intricate interplay, he offers, is way beyond the primitive effects of any of these drugs.

"The system is so refined," believes Millman, "and drugs are so primitive, that one can never really replace the other. With drugs, you're always giving away more than you're getting—if you're not really debilitated. You're giving away sensitivity, receptivity, some capacity for pleasure. But it's a reasonable trade-off if you're in pain."

The only question, then, is for what degree of pain do we seek medical treatment. And, as Bob Trestman puts it, where will it end?