review

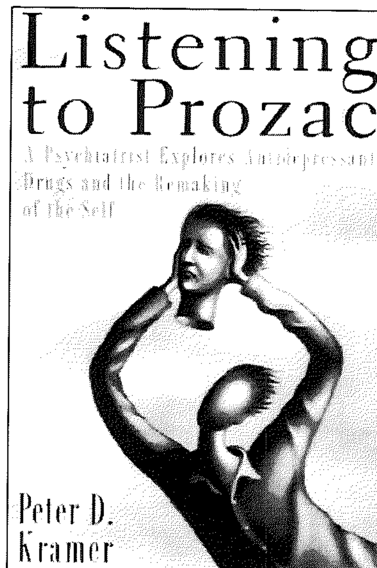
Cosmetic Pharmacology:

the false promise of feel-good drugs

Listening to Prozac
by Peter D Kramer
Fourth Estate, London, 1994
409 pages, $39.95, ISBN 1 85702 233 5

Reviewed by
Beatrice Faust

As I was nodding off over that long-winded and insipid book, *Listening to Prozac*, I received a letter from a more or less marginalised manic-depressive who had once been a student of mine. 'I was keen to read *Listening to Prozac*,' he wrote, 'but into the book, I began to feel I was reading Television, reading the Oprah show. Middle Class malaise, over-achievers, over-eaters, obsessive compulsive disorder, anxiety... Prozac the ad break, the sponsor.' He is right. Dr Kramer discusses patients of his who are on drugs other than Prozac. He includes a variety of responses to Prozac, including one patient who did not like the drug, and another who did not benefit from it. Nevertheless, Prozac dominates the rest like a shining grail. 'Prozac' is Eli Lilly's brand name for fluoxetine and whatever is true of Prozac is also true of the fluoxetine look-alikes now on the market, but *Listening to Fluoxetine* would not roll off the tongue so easily – and would not help sales. The book pretends to be about a theory of personality but it is, as its title says, about Prozac. The author is ostentatiously even-handed but his infatuation with Prozac is inescapable – like the director who sneaks his mistress into the chorus line and then insists on turning the spotlight on her.



Nevertheless, we must separate the book and the drug. The book might be valuable and the drug not. Or vice versa. Apparently Eli Lilly has warned doctors that it does not endorse Kramer's extravagant claims for Prozac which, they say, should be used only for depression. I have no evidence that Lilly secretly encouraged Dr Kramer to write a book that would inspire people to talk about Prozac. However, we don't need a conspiracy theory to explain *Listening to Prozac*. Events happen around great corporations because they are big and they are there – just as mountain ranges influence the weather. George Bush had been on the board of directors of Eli Lilly and held $180,000 worth of Lilly stock when he took office as Ronald Reagan's vice-president. As head of the Task Force For Regulatory Relief, Bush managed to reduce Food and Drug Authority law enforcement actions by two-thirds in the first six months of the Reagan administration (Mokiber 1988:333-334). I shall watch Dr Kramer's career with morbid interest.

Psychiatrists seem agreed that Prozac is just another anti-depressant, but satisfied patients talk about it the way Freud talked about cocaine: it makes them feel better than well. Meanwhile, the Prozac Survivors' Support Group, with twelve chapters across the United States, held its national convention in April 1994 in Wenatchee, Washington, described as the Prozac capital of the world (McConnell & Harlor 1994). The Prozac controversy is not hurting Lilly's sales. What is that vaudeville saying... 'when they don't talk about you, you're dead!'

Kramer uses detailed case histories and research evidence to illustrate his theory. He argues that personality and mental illness are not acquired but born with us. Beginning with studies of the psychobiology of well-known condi-

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tions such as obsession/compulsion, depression, stress, and anxiety, he then extends the argument to take in more problematic miseries including sensitivity, timidity, low self-esteem, sluggishness of thought, and inhibition of pleasure – Woody Allen's anhedonia. So far so good. Then he discusses definitions of mental illness: should we draw the line at serious malfunctioning or should we extend it to include anything less than perfect bliss? In passing, he introduces the notion of 'cosmetic pharmacology' to describe improvements in people who are functioning quite well but can become better than well on a drug – in this case Prozac. He touches on the ethics of using Prozac for people who are not sick in any traditional sense but who still benefit dramatically from it. So far, no further: he never seriously engages the rights and wrongs of cosmetic pharmacology.

He proceeds as if he were tip-toeing between land mines but psychobiology is hardly new and only the politically correct fringe find it controversial. Psychosurgery and electro-shock therapy only make sense if they are based on a belief in physical bases for personality and behaviour in the brain. Concerning the biology of behaviour, Kramer is just taking up where these therapies leave off. He fudges the conflict between chemistry and the talking therapies. Although there is a theoretical conflict between drugs and talking, most doctors use both. Using Ritalin and amphetamines for attention deficit in children is not new: Eysenck was talking about drug treatments for neurotics, criminals, and children with learning difficulties in the 1960s (Eysenck 1965:90, 284). The real issue is not biology versus environment but whether, taking the biological basis of mental ailments as given, Prozac is the remedy.

Kramer's evidence for Prozac is as scant as his evidence on biochemistry is prolix. The book is as bland as a waiting room decorated in restful pastels and hard to open up to criticism. We may as well start with evidence. Although most of Kramer's evidence on the biology of mental illness comes from the laboratory, most of his evidence on the excellence of Prozac comes from personal stories – a handful of his own patients. Reviewers have criticised *Listening to Prozac* because the author's clinical data is not much better than 'nine out of ten film stars use Lux'. Case histories illustrate an argument but do not clinch it. Patients can get a placebo effect from the doctor, feeling better because of qualities in the doctor-patient relationship when nothing else has changed. Kramer briefly refers to before and after tests but his evidence is too vague to be believed. To prove his claims, he would need to measure what a large series of patients was like before and after Prozac or, at a minimum, correlate qualitative reports by independent assessors.

When Kramer does cite research, he usually neglects to evaluate it scientifically: how many people took what dosage for how long and why? How many had unwanted effects of what kind and how does this compare with other drugs? Theoretically, Prozac is a clean drug because it effects only one body system; in practice, it has pretty much the same range of side effects as other drugs although both tricyclic antidepressants (TCAs) and selective serotonin re-uptake inhibitors (SSRIs) avoid the 'cheese effect' of monoamine oxidase inhibitors (MAOIs). (Patients on MAOIs may have a stroke if they eat certain foods, including cheese.)

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The idea of a 'clean' drug only works if we take it narrowly to mean 'limited to one system' – but this is impossible. The family of drugs to which Prozac belongs – the SSRIs – are specific to serotonin in the brain. However, the brain does not work like an Apple Mac in which one icon governs one function. No drug, neurotransmitter, or hormone works in isolation from the physiological environment that is the person taking the drug. The efficacy of neurotransmitters depends on the size, number and healthy functioning of the neuro receptors. The efficacy of drugs depends on the quantity and interactions in a broth of other chemical substances. A person whose liver and brain have been affected by alcohol or one whose adrenals are enlarged following years of stress will react differently from an unhappy but otherwise healthy individual. There is enough biochemical difference between individuals to make prescribing of psychotropics very much hit and miss.

Brain chemistry works on a series of feedback mechanisms: any change is likely to cause compensatory correc-

tions elsewhere in the system. Although Prozac is advertised as producing anti-depressant effects, in some patients it induces drowsiness and fatigue, while others experience anxiety and insomnia, and still others report the famous Prozac high; 5% of all patients in pre-marketing clinical trials experienced side effects severe enough to stop taking the drug (Micromedex: 1974 -1994). It must be prescribed only after careful diagnosis: it is a stimulant that is appropriate for depression but can be disastrous for manic depression. Manic-depressives high on Prozac are likely to sign mortgages they can't afford.

Lilly's marketing is inconsistent with its expressed concern for rational prescribing. In 1991, Norway and Sweden refused to license fluoxetine because the firm did not satisfactorily answer questions about dosage. One study reported good anti-depressant effects on 5mg daily whereas the drug was manufactured only in 20mg, the recommended dose (Medawar 1992:234-235). Kramer himself is meticulous in prescribing – even to showing his patients how to dissolve their Prozac capsules to get a lower dose but he does not explain the rationale: he is compensating for Lilly's misguided marketing.

Prozac has been implicated in some sensational murder cases as defence lawyers, anxious to win acquittals for their clients, look for a plausible excuse. Just as we had the 'Clockwork Orange' defence during the '70s, when lawyers hopefully asked rapists whether they had seen Kubrick's film, now lawyers look for a drug to implicate. Kramer successfully explains some offences that have been blamed on Prozac and also attacks by the Church of Scientology, but discrediting the lunatic fringe is much easier than refuting reasonable criticisms. Although two inquiries have decided that there is no proof that fluoxetine causes suicide, absence of proof cannot be taken as proof of absence. We do not have all the data yet. Research that has been paid for by a pharmaceutical corporation is often designed to produce results favourable to that corporation. Unfavourable results may be suppressed or even manipulated (Faust 1993:69-90).

Lilly has an unenviable record of dud drugs: DES (diethylstilboestrol) – a synthetic hormone that deforms foetuses and causes second-generation cancer; Oraflex (Orpren, benoxaprofen) – an anti-arthritic drug causing many and varied side-effects including death; Darvon (propoxyphene) – a highly addictive analgesic, said to be less efficacious than aspirin in killing pain and more effective than heroin in killing people.

Kramer's soporific style and apparent disinterestedness function like the smooth patter of the man with the pea and thimble. The performance is suspiciously perfect. The question is not whether we are being fooled, but how?

What about tolerance and addiction? Patients are tolerant of a drug when they need to increase the dose to get the same effect. They are addicted when they suffer withdrawal symptoms on giving up the drug. (In the USA, suffering withdrawal symptoms is called 'physical dependence' and 'addiction' is dependence plus drug-seeking behaviour.) He acknowledges in the appendix that tolerance occurs with lithium, Prozac and, most seriously, with MAOIs but he does not discuss this in its proper place. He explores whether healthy people who take Prozac to improve their personalities and enjoyment of life should take it for the rest of their lives but dodges the crucial question: what is the point of taking a drug that is only effective for a few months or possibly only weeks? And when tolerance sets in, can addiction be far behind?

Kramer mentions addiction in the appendix as an aside to the claim that patients on Prozac do not crave the drug and stopping it does not cause withdrawal symptoms. He offers no evidence to support his claim. Professor Malcolm Lader, a psychopharmacologist at the Institute of Psychiatry in London, gives it the benefit of the doubt, saying that fluoxetine has been so widely prescribed that if it were addictive, there would have been straws in the wind by now (Lader: 1994). Except for addiction to excitement, sex, and shopping, Prozac does not seem to cure the symptoms of other addictions – a quick early warning test for addictive capacity – but this only means that it is not addictive in the same way as known addictive drugs. Alcoholics can be switched to benzodiazepines and vice versa but morphine is not interchangeable with cocaine. Only time will tell whether the Prozac Survivors Support Group are right and the drug is addictive in its own way.

Let us forget whether Prozac is addictive and ask where it fits into the ecology of feel-good drugs. For two hundred years, successive psychotropic drugs have been welcomed as non-addictive and have created generations of pitiful, resentful, and sometimes angry addicts. The most recent of these, the benzodiazepine family of tranquillisers, was identified as addictive almost immediately on its market debut but doctors generally ignored the discovery. Weaker members of the family were tested in low doses for brief periods and the results were passed off as conclusive (Faust 1993:37). After twenty years of controversy, the World Health Organisation listed a group of BZDZs as drugs of addiction and doctors are only now learning to prescribe them with discretion. One must question why Kramer omits benzodiazepines from his history of drugs and mental illness when the BZDZs are the biggest embarrassment of twentieth-century pharmacology. Listening to Prozac was written at a time when the

BZDZ sessions of the American Society of Addictive Medicine were packed out with doctors trying to learn how to detoxify their patients.

His Introduction asks 'was Prozac another Miltown or Librium, the 'mother's little helper' from which we expect too much and about which we know too little?' (p.xvii). He slides past the question of addiction. He does not discuss the benzodiazepines as a family of drugs at all – although they appear in a footnote (p.369). Kramer's attempt to by-pass the benzodiazepine scandal suggests he is over-optimistic about psychotropic drugs and insulated from both research and broader community discussion. Is that all? His analysis of Xanax (pp.85-86, 209) is absurd and seriously irresponsible, considering that this drug is notorious as the benzodiazepine most likely to cause epileptic seizures and the hardest to discontinue (Medawar 1992: 185 - 186; Benzer 1994). Xanax was a best-seller in the US but historically, Valium and Librium were the epoch-making drugs. Xanax was marketed to fill a niche only when the addictive capacities of Valium became embarrassingly obvious. Xanax, Librium, Valium, Dalmane, and Halcion were not in a group of 'currently popular anxiolytics and sedatives' in the early 1990s – they were (and still are) abhorred as notoriously addictive drugs that are well past their use-by date. An American psychiatrist writing in the 1990s who doesn't know this has no intellectual credibility. A psychiatrist who knows it and doesn't acknowledge it has no moral credibility.

Research clearly shows that Prozac is no better than other anti-depressants for major depression and no safer than tricyclics for side effects (Micromedex 1974 - 1994). It is safer than monoamine-oxidase inhibitors – but so are the tricyclics. A new drug, or any other new product, breaking into an already well-served market, needs a unique selling proposition. This may be achieved overtly by advertising or covertly by public relations – not necessarily generated by the manufacturer. Prozac seems to be a PR triumph: its niche is the healthy but unhappy and its unique selling proposition is that it makes you better than well. The whole tenor of Kramer's book is to create an infinitely wide net of conditions, to justify them by demonstrating a biological foundation for personality, and to show that Prozac improves it. In other words, the book removes the drug from competition with established anti-depressants and sets it in a new market niche.

It is true, as Kramer says, that fashionable drugs create fashions for the diseases they treat but this is a marketing phenomenon and does not mean that the drug is particularly good for the disease – or even that there is a disease. Many states of unhappiness are not diseases. Much unhappiness has clearly social origins in poor living or working conditions, bad diet, divorce, single parenthood and poverty. They represent a waste-paper basket of misery that doctors cannot effectively treat. They can, however suppress the patients' symptoms and render them less demanding. Waste–paper basket syndrome requires a waste-paper basket drug. For thirty years, benzodiazepines were the drug of choice for psycho-somatic-socio-economic problems but today they are on the way out. The SSRIs appeared just when doctors needed an all-purpose feel-good drug to replace Mother's Little Helper.

KRAMER'S ATTEMPT TO BY-PASS THE BENZODIAZEPINE SCANDAL SUGGESTS HE IS OVER-OPTIMISTIC ABOUT PSYCHOTROPIC DRUGS AND INSULATED FROM BOTH RESEARCH AND BROADER COMMUNITY DISCUSSION.

The success of Prozac can be explained by its timing: it appeared just as doctors were feeling the lack of a not obviously unsafe drug to treat waste-paper basket syndrome.

Kramer wants to go beyond that syndrome – the bulk of his patients are, after all, middle class. He wants to redefine illness to take in a wider range of conditions than at present, curing not just ills but lack of sense of well-being, which is more likely to trouble people whose basic needs are already met. Kramer hardly acknowledges other ways of achieving a sense of well-being: sensible diet, aerobics, Rational Emotive Therapy, behaviour therapy, (both of which have proven effective), meditation, and sex. He mentions L-tryptophan as an essential amino acid from which the body makes serotonin (p.87) but does not explore its therapeutic value. Many people buy it from health food-shops for use as a safe, effective, and relatively cheap sleeping pill that also contributes to well-being.

Kramer knows about the data on learned helplessness as a cause of depression but he neglects to mention that Martin Seligman, who named the condition and did most of the original research, also devised an effective, quick,

inexpensive treatment routine which he calls 'learned optimism' (Seligman 1991). Seligman would certainly point out to patients who fear that they will revert to their shabby selves without Prozac, that this is what happens with all the psychotropic drugs. They are not cures – they simply blanket the symptoms: when the drug is removed, the symptoms reappear.

Kramer's reinterpretation of mental illness may not be intended to benefit Eli Lilly but it is not obviously in the best interests of the patient and clearly increases the mental set that promotes feel-good pills. The choice is not between pharmacological Calvinism and abandoning unhappy people to their sufferings or cosmetic pharmacology, compassion and Prozac. Pharmacological Calvinism could quite well leave patients free to pursue happiness by other means.

References

Benzer, D. 1994, Paper to AMSAM (American Society of Addictive Medicine), 25th Annual Conference, New York, 17 July.

Eysenck, H. J. 1965, *Fact and Fiction in Psychology*, Penguin, Harmondsworth.

Faust, B. 1993, *Benzo Junkie: More Than a Case History*, Penguin, Melbourne.

Lader, M. 1994, Paper to benzodiazepine withdrawal conference, Glan Clwyd Hospital North Wales, 17 March.

McConnell, G.E. & D. Harlor, 'Prozac Survivors Support Group Go To Wenatchee, Washington', *Dendron* 35 (Summer 1994).

Medawar, C. 1992, *Power and Dependence*, Social Audit, London.

Micromedex Inc 1974-1994, *Drug Evaluation Monographs* Vol 79 (CD-ROM).

Mokiber, R. 1988, *Corporate Crime and Violence: Big Business Power and the Abuse of Public Trust*, Sierra Club Books, San Francisco.

Seligman, M. E. P. 1991, *Learned Optimism*, Random House, Sydney.

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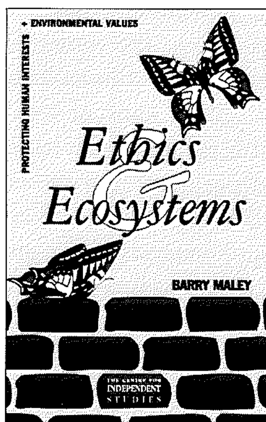

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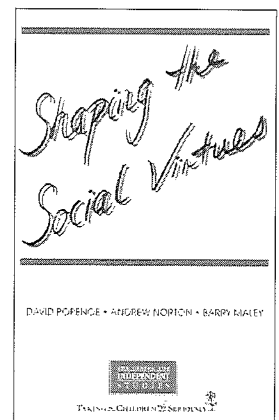

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