Exposing the Mythmakers

How soft sell has replaced hard science

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Author: Duncan, Barry; Miller, Scott; Sparks, Jacqueline
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There was a time when therapists, and much of our larger culture, saw depression and other human troubles as complex conditions of mind and heart, influenced by many subtle inner and outer forces. But in the last decade, a vast intellectual and emotional sea change has taken place. We now inhabit a culture where many people hold the view that their emotional pain is "biochemical" and can be cured by simply taking a pill.

Emotional suffering, according to this new view, is a genetic glitch, successfully treatable by drugs. Depression is no longer thought to be shaped by such diverse forces as a sedentary, lonely or impoverished life;

the loss of love, health or community; "learned helplessness" or feelings of powerlessness arising from unsatisfying work or an abusive relationship. Its resolution no longer requires anyone to get meaningful support from others, to establish a collaborative relationship with a good psychotherapist, to draw on community resources, or for communities to address conditions that breed depression. No, depression is now publicly defined as a purely biological illness, treatable--thank heaven--by the miracle antidepressants.

Consider, for example, this interview, which ran on the CBS news program *60 Minutes* in 1991, three years after Prozac began its meteoric rise to therapeutic dominance:

Lesley Stahl: [voice-over]... For 10 years, Maria Romero has been suffering from depression, a serious illness. Sometimes she spends weeks on an unmade bed, in a filthy apartment. She told us that she didn't care about anything, and she often thought of suicide. . . . Most doctors believe chronic depression like Romero's is caused by a chemical imbalance in the brain. To correct it, the doctor prescribed Prozac . . . and two and a half weeks later, we paid her another visit.

Stahl: I can't get over it. You're smiling.

Romero: Thank you. Yeah.

Stahl: How do you feel?

Romero: Great. I feel great. I feel like--like I'm a different person, somebody else. Somebody--something left my body and another person came in.

Stahl: She no longer spends her days in a filthy apartment. So two weeks after you started on this drug, whammo? . . . You stopped being depressed?

Romero: I stopped being depressed.

Stahl: Got out of bed . . . fixed your apartment, fixed yourself, and are losing--

Romero: --Fixed my life --

Stahl: --weight.

Romero: Yeah. Mmm-hmm. Yep. I'm happy about it. I think it's great.

In the eight years since this segment was broadcast, hundreds of stories like Romero's have been whispered between close friends, described by journalists and repeated in books like Peter Kramer's bestseller, *Listening to Prozac.* They have become our culture's conventional wisdom. The grinding despair and helplessness of depression is, these stories imply, just a "chemical imbalance" somewhat like diabetes or high blood pressure. The treatment of choice, we are told, is always a drug: Prozac, another Selective Serotonin Reuptake Inhibitor (SSRI) like Zoloft or Paxil, or perhaps another, newer antidepressant like Wellbutrin or Serzone. These miraculous drugs, the story goes, are effective with 75 to 85 percent of the people who take them. In this prevailing cultural script, therapy, like an old character actor, is sometimes ignored altogether, and never given more than a minor supporting role. Only one solution, apparently, is needed, and only one is offered: the passive consumption of a pill.

These views have taken on the luster of scientific truths. But they are not truths. They are myths. They have not been confirmed by the latest discoveries of neuroscience, nor are they supported by outcome research. They seem true

because they have been repeated and reinforced by mass-market advertising intended to make taking antidepressants seem as normal and pervasive as swallowing aspirin: Zoloft's logo smiles from long-distance calling cards, coffee mugs, luggage tags and complimentary pens and pencils. A commercial during the World Series trumpets Paxil's power to cure social anxiety disorder. And the sides of colorful tissue boxes in physicians' offices proclaim: "Sue's playing with her kids again," "Walter's fishing again" and "Just like normal--thanks to Prozac!" SSRIs, these advertising campaigns imply, are simply the best first choice for treating depression.

The message is seductive and it works: if these drugs were books, they would be runaway bestsellers. More than 130 million prescriptions were written for them last year alone, and more than $8.58 billion was spent on them. And while most mental health professionals would acknowledge that the explanation given to clients is a gross oversimplification of actual brain functioning, few reject the biochemical model altogether. Fewer still question the effectiveness of the drugs, and virtually no one challenges the idea that combining medication with therapy is the best of all treatment options. At least it includes what talk therapists have to offer. The problem with these common beliefs and practices emerges, however, when they are examined in the light of scientific research.

On a level playing field, antidepressants would be regarded as one valid therapeutic choice among many--one with risks far more grave than those usually attendant on therapy. The awareness of many side effects is just beginning to make it into mainstream consciousness, and the future may reveal further unanticipated consequences: witness the silent epidemics of drug addiction among American women in the 1950s, produced by the widespread prescribing of "mother's little helpers"--amphetamine diet pills and Librium.

Not only are side effects underrated and underreported, outcome research does not confirm the miracle status these drugs have been accorded in the popular imagination. Our culture's exaggerated faith in these psychiatric medications rests not on science, but on brilliant marketing by a profit-driven industry. Outcome research--even outcome research funded by the companies that manufacture pharmaceuticals--has not found these drugs to be any better than therapy, and only marginally better than placebos. Knowing what the research really says will empower therapists to challenge the myths our culture holds about psychoactive medications, reinvigorate their belief in therapy and offer their clients choices based on fact, not superstition masquerading as science.

The first and perhaps most pervasive myth about SSRIs and other newer antidepressants is that their effectiveness is a matter of scientific record, conclusively demonstrated in strict, controlled, double-blind, placebo studies--the gold standard in medical research. According to this myth, the development of SSRIs was a pharmaceutical watershed and the drugs are "magic bullets" far more effective than the older tricyclic antidepressants like Elavil. This message is not only retailed by drug companies, but by the mass media and professional journals: in October 1995, for instance, the American Association for Marriage and Family Therapy's (AAMFT) *Family Therapy News* cited "overwhelming evidence" in support of antidepressants and their undisputed effectiveness with all but 25 percent of people suffering from unipolar depression.

This is a gross overstatement. Last year, a federal research review of hundreds of clinical trials found that the newer antidepressants were effective with only half of the depressed people who took them and outperformed placebos by only 18 percent. The finding came from the federal Agency for Health Care Policy and Research (AHCPR), a branch of the Public Health Service that promotes "evidence based" health care practices. The AHCPR reviewed all 338 relevant clinical trials of antidepressants conducted between 1980 and 1998, including 206 that directly compared SSRIs and other new antidepressants with older tricyclic antidepressants like Elavil. It found "no difference in overall efficacy" between SSRIs (costing about $66.41 a month) and tricyclic antidepressants (costing less than a tenth as much, or about $5.50). About 50 percent of trial subjects responded well to either drug, while 32 percent responded equally well to placebos; thus, all drugs helped only 18 percent more people than did sugar pills (plus hope and regular contact with a researcher or clinician).

Even at the anecdotal level, miracle stories like Maria Romero's are more rare than we have been led to believe: an online survey of 1,400 depressed people by the National Depressive and Manic-Depressive Association (NDMDA) in November 1999 found that 25 percent reported that antidepressants had no effect on their symptoms, 40 percent reported no improvement in fatigue and loss of energy and 35 percent reported no increase in their ability to experience pleasure.

Leaving aside the question of effectiveness, we turn to another major myth about Prozac and other newer antidepressants: that clients are more likely to tolerate them because their side effects are relatively mild compared with older tricyclic antidepressants like Elavil. In reality, the SSRIs' advantages are marginal; it's more a question of picking your poison. According to the AHCPR review, takers of tricyclics complained more of dry mouth, constipation, dizziness, blurred vision and tremors. SSRIs and other new antidepressants, on the other hand, produced more diarrhea, nausea, insomnia and headaches. Another side effect well known to clinicians went unmentioned by the AHCPR: SSRIs cause sexual problems, including pain during intercourse and difficulty reaching orgasm, in somewhere between 30 and 70 percent of the men and women who take them. SSRIs are also associated with rarer, but much graver, side effects, including bleeding, liver damage, seizures and *akasthisia,* an almost unbearable jitteriness that can escalate into suicidal thoughts and violent impulses: more than 200 lawsuits have been filed against pharmaceutical companies contending that SSRIs helped precipitate murders and suicides (see the *Networker,* September/ October 1999).

A third widely held myth is that tolerating even severe sexual side effects is worthwhile, because SSRIs are so much more effective than therapy for depressed people. This myth, too, is junk science, and is not supported by any large-scale methodologically sound study. According to the AHCPR review, the only known, well-controlled research study directly comparing antidepressants and therapy gave a slight edge to therapy. The 1996 study, involving 31 subjects and published in the journal *Depression,* found that Prozac and cognitive therapy were both effective, with no statistically significant differences between them. But a full third of the Prozac group dropped out of treatment or were unavailable for a final assessment, while only 3 of the 13 who received cognitive therapy dropped out.

The myth that SSRIs have proven their superiority to therapy echoes the belief held earlier about tricyclic antidepressants, which were also, in their heyday, thought to be a therapeutic watershed. But in 1989, another large federal study found that therapy was just as effective in the short run, and more effective in the long run, than tricyclics. This finding came from the landmark Treatment of Depression Collaborative Research Project (TDCRP), a National Institute of Mental Health (NIMH) study led by psychologist Irene Elkin. The four-month project involved psychiatrists and psychologists in Washington, D.C., Pittsburgh and Oklahoma City who treated 239 patients diagnosed with major depression. Patients were randomly assigned to one of four groups: Aaron Beck's cognitive therapy; Gerald Klerman and Myrna Weissman's interpersonal therapy; treatment with the tricyclic antidepressant imipramine; and, finally, treatment by placebo. After four months of treatment, the talk therapies had narrowly outperformed the drug: 39 percent of those receiving cognitive therapy, 34 percent of those receiving interpersonal therapy and 32 percent of those receiving drug therapy were rated as recovered. (In the placebo group, 16 percent had recovered.)

In the 18 months following the conclusion of the study, however, the people who had taken part in talk therapy did much better than those who had been given drug treatment. Psychologist Tracie Shea, of Brown University, and her colleagues found that about 24 percent of the therapy clients had recovered without a subsequent major depressive relapse, compared with only 16 percent of the pharmacotherapy clients and an equal percentage of the placebo group. Those receiving the antidepressants did worse on practically every outcome measure: they sought treatment more often during the follow-up period, were more likely to relapse and experienced fewer weeks of minimal or no symptoms than members of either of the two therapy groups. Shea did not speculate on why this was so. But her provocative findings dovetail with the findings reported by outcome researchers Michael Lambert and Allan Bergin in 1994, that clients who attribute change to their own efforts are more likely to maintain positive changes. One plausible hypothesis is that the therapy clients gained the tools and confidence to draw on when other life problems arose, while those who had been given drugs had nothing new to draw on.

But wouldn't the best of all possible worlds be one in which medications were combined with therapy, giving clients enough stability to make use of therapy and creating a sort of double-whammy treatment effect? The idea that both together must be better than either one alone for treating depression has become the newest orthodoxy among many professional groups. In fact, this sensible-sounding "compromise" solution actually promotes the use of medications, by implicitly suggesting that virtually anybody who enters therapy for any reason could usefully take them. Many managed care funded practices now routinely require all therapy clients to undergo medical evaluations as a prerequisite to reimbursement for treatment. But neither outcome studies nor clients themselves offer much support for applying this two-is-better-than-one approach.

In one of the broadest surveys ever conducted of therapy under real-life conditions, *Consumer Reports* in 1995 tabulated the responses of 4,000 members who filled out a questionnaire on their experiences with therapy. On the whole, their self-reports of both therapy and drug treatment were positive: 54 percent of those who said their state of mind had been "very poor" said treatment made things "a lot better." But people who received only psychotherapy reported as much improvement, on the whole, as people who tried drugs-plus-therapy. Given the additional expense of medication and the risks of side effects, we think therapy alone should be the treatment of first resort rather than drugs-plus-therapy.

The *Consumer Reports* survey has obvious limitations: those who filled it out had sought therapy for many problems besides depression; the results were based on self-reports by a self-selected group of members willing to discuss therapy on a questionnaire; and the sample was not randomized or demographically balanced. But its conclusions echo those of a research metareview by Yale University psychiatrist Bruce Wexler published in the *Journal of Nervous and Mental Diseases* in 1992. Wexler examined seven well-controlled outcome studies of 513 patients treated for depression. Therapy alone, he found, helped as many people as therapy-plus-drugs, with fewer dropping out of treatment. The review concluded with this simple summary: out of 100 patients with major depression, 29 would be expected to recover if given drugs alone, compared to 47 given therapy alone and 47 given combined treatment. On the other hand, 52 drug-only patients would be expected to drop out or have a poor response to treatment, compared to 30 therapy-only patients and 34 patients getting therapy-plus-drugs.

In all of the healing arts, there is no single explanation or simple, infallible remedy for any of the problems that beset humankind. Yet the growing power of the biological perspective in mental health discourse and practice suggests not only that there are solely biological explanations, but perfect, fail-safe biological solutions as well--simple pills that mark finis to everything from mild depression and nervous tension to panic attacks, bipolar disorder and full-blown psychosis and schizophrenia. How did this scientifically anomalous, weirdly simplistic point of view come about? If the science behind the advertised superiority of psychotropic drugs is so lacking, how did medications come to hold almost

unchallenged sway over both public and professional opinion?

In the days of the Watergate investigation, the government informant known as "Deep Throat" met with *Washington Post* reporters Carl Bernstein and Bob Woodward in an underground garage and advised them to "follow the money" if they wanted to find who was really behind the break-in at Democratic National Committee Headquarters. The same advice can help explain why psychiatric medications have permeated every aspect of our culture. Follow the money, and you will begin to understand the growth of the pharmaceutical behemoth.

In March 1992, *Consumer Reports* estimated that the $63 billion drug industry spent $5 billion a year on promotion and publicity, and it spends at least as much today: advertising in medical journals, on television and in women's magazines; helping fund "public awareness" efforts like the National Depression Awareness Day; giving grants to organizations like the Anxiety Disorder Association of America (ADAA), the National Depressive and Manic Depressive Association (NDMDA) and even the American Association for Marriage and Family Therapy (AAMFT.) The American Psychiatric Association confirms that at least 30 percent of its budget is now underwritten by drug companies through grants, glossy paid advertisements in its journals and paid exhibits at professional conferences. Psychotherapy organizations cannot begin to compete with this billion-dollar promotional machine, even though the data upholding the value of therapy are clear.

Drug companies also fund much of the drug research that supports, however weakly, the myths that have taken hold of almost everyone from psychiatrists and journalists to therapists and the average client in the street. Because of the shrinking of federal grants and the privatization of research funding that began in the Reagan years, pharmaceutical companies now pay for the majority of clinical trials of drugs. The AHCPR metareview, for example, noted that out of 315 published clinical trials of 29 antidepressant drugs, every study that identified a sponsor had been funded by a drug company. The ubiquity of drug company funding may also help account for the dearth of research comparing the effectiveness of therapy and medication: why would drug companies fund research that might prove a competing product (such as therapy) was equally or more effective?

In the broader field of nonpsychiatric medical research, those who pay the piper tend to enjoy the tune: researchers with financial ties to drug companies usually publish results friendly to their funders, and friendly researchers, likewise, tend to get funded. An October 1999 study of 44 journal articles on anticancer drugs, for instance, published in *The Journal of the American Medical Association* (*JAMA*), reported that only 5 percent of drug-company funded research found that the drugs were not cost-effective, while 38 percent of the research sponsored by universities, foundations and other nonprofit organizations found the drugs not cost-effective. A study in the January 1998 *New England Journal of Medicine* produced similar results: of researchers whose published studies supported the use of calcium channel blockers to treat high blood pressure and angina, 96 percent had financial relationships with the manufacturers; only 37 percent of researchers whose work did not support the use of calcium channel blockers, on the other hand, had received drug company funding. Thus, like a flower opening itself to the sun, published research results tend to be skewed in the direction of the money source.

Our exaggerated sense of the efficacy of psychiatric drugs may also be colored by the fact that drug companies are under no obligation to publish the results of failed clinical trials. Thomas J. Moore, a health policy analyst at George Washington University, for example, recently found, in a search of FDA files, the results of two identical trials of the antidepressant Serzone. The one showing a marginally positive result was published, but Moore found no indication that the other trial, showing no measurable drug effect, was ever published.

While drug-neutral and drug-negative research is underplayed, drug-friendly research is sometimes overplayed and made to serve the purposes of marketing. In February 1999, for example, *JAMA* published a study showing that as many as 40 percent of American women and 30 percent of men suffered from some form of sexual dysfunction. "I think it gives us a base for explaining why we had this enormous response to Viagra," one of the coauthors, sociologist Edward Laumann, told *The New York Times* at the time. The article, widely reported in the popular media, was actually a recalculation of data first published in 1994. The *JAMA* article did not disclose that two of the coauthors, Laumann and Raymond Rosen, had served as paid consultants to Pfizer, the makers of Viagra.

Closer to home, the American Association for Marriage and Family Therapy (AAMFT) recently took part in a major public relations campaign focusing on depression, intimacy and antidepressants. The campaign was primarily funded by Glaxo-Wellcome, makers of Wellbutrin, an antidepressant notable for its lack of sexual side effects. With the help of a $50,000 grant from Glaxo-Wellcome, the AAMFT 1998 national conference in Dallas featured a panel on intimacy and depression at its opening plenary--a session historically reserved for one of the real movers of the family therapy field. The slick, Oprah-style session featured clips from the television series *Party of Five* and a five-member panel that included three speakers with financial relationships with Glaxo-Wellcome: psychologist Martha Manning; her husband, social worker Brian Depenbrock; and psychiatrist Anita Clayton, associate professor in the University of Virginia's Department of Psychiatric Medicine.

Over the next hour and a half, the audience of 2,000 therapists was reminded 11 times of the tragic sexual side effects of some antidepressants. Although Wellbutrin was never mentioned by name, Clayton mentioned several times that some antidepressants don't deprive clients of a sex life. She did not disclose that she is a member of Glaxo-Wellcome's

advisory board and speakers bureau, nor that Glaxo-Wellcome has funded her research. Nor did Manning, who has written widely about her own depression, disclose that she has sometimes acted as a paid consultant to Glaxo-Wellcome and has cowritten a brochure for them on intimacy and depression.

The plenary was part of a larger public relations effort funded by Glaxo-Wellcome and cosponsored by AAMFT and the National Depressive and Manic Depressive Association (NDMDA) a private non-profit "public education" organization that gets the bulk of its funding from pharmaceutical companies. The campaign included a brochure for the public on intimacy and depression, bearing the AAMFT and NDMDA logos, but copyrighted by Glaxo-Wellcome and written from the point of view that drugs are the treatment of choice for depression. Nearly four full pages are devoted to the nuances of antidepressants, while individual and couples therapy rate a few sentences. ("Antidepressants are usually effective . . . psychotherapies developed specifically for the treatment of depression can be useful. . . .") Wellbutrin is not mentioned by name, but the point is prominently made that consumers should consult their physicians about medications free of sexual side effects. The campaign also took a panel that included two AAMFT officials, plus Manning and her husband (and on occasion, actors from *Party of Five* and John Gray of *Men Are from Mars, Women Are from Venus* fame) to three well-publicized and advertised "town hall meetings" on intimacy and depression held in New York, San Francisco and Seattle.

Psychiatrist Anita Clayton told the *Networker* that her airfare and lodging expenses for her participation in the AAMFT 1998 plenary had been paid, but she had not received an honorarium. She also noted that she has received research funding from, and is on the speakers' bureaus of, other pharmaceutical companies beside Glaxo-Wellcome.

We the authors were so concerned about AAMFT's involvement in the depression and intimacy campaign that we organized an e-mail protest to AAMFT before the plenary, leafleted the event and spoke in opposition to it at an AAMFT "town meeting." Although AAMFT did not violate the ethical standards of any group with which it is affiliated, the failure to prominently disclose the speakers' relationships to Glaxo-Wellcome at an event presented for continuing education credit would violate the standards of other professional groups, including the American Psychiatric Association and the Accreditation Council for Continuing Medical Education.

Manning says that she routinely discloses that she is sometimes a paid consultant to Glaxo-Wellcome, but was never asked by the AAMFT to do so for the 1998 plenary; her involvement with the drug company's campaign, she says, resulted in far more focus on therapeutic and relational issues. "We cannot afford to isolate ourselves from the medical approach to depression, which has been enormously useful in my own experience, as has psychotherapy," she said. "Depression is such a horrible thing that we have got to be involved in all kinds of cross-fertilization." We do not argue that her views, and those of other consultants, aren't sincerely held. But what therapeutic school can afford to fund its advocates to put on an equivalent national public-relations road show?

This magazine, likewise, has never routinely asked its authors to disclose financial ties to pharmaceutical companies. In March 1999, the *Networker* published "Rx for Passion: Antidepressants Needn't Depress the Libido," about the sexual side effects of antidepressants, by Valerie Davis-Raskin, M.D, in which she recommended Wellbutrin. The editors were not aware that Davis-Raskin was also a member of Glaxo-Wellcome's speaker's bureau. The ubiquity of nondisclosure of financial ties, like these, makes it impossible for the general public, including therapists, to critically evaluate the objectivity of so called medical experts.

Marketing masquerades not only as research, but as public education. Take National Depression Screening Day, for example, a public relations and marketing extravaganza riding on the back of a public service campaign. On October 7 every year, volunteer mental health workers offer simple screening tests for depression (as well as counseling and referrals), at more than 3,000 hospitals, mental health clinics, doctors' offices, libraries, grocery stores and shopping malls across the country. Public service radio spots publicize the day. The American Psychiatric Association and the National Institute of Mental Health (NIMH) lend their names to the event, which is administered by a private, not-for-profit organization called the National Mental Illness Screening Project (NMISP) of Wellesley Hills, Massachusetts. NMISP also sponsors screening days for other mental illnesses.

According to information provided by NMISP to the IRS, Eli Lilly, the makers of Prozac, gave the group $1.75 million between 1993 and 1997--nearly half of the organization's $3.6 million income for those years. Almost all of Depression Day's largest funders (giving $50,000 or more) are pharmaceutical companies, as are six of the seven major funders named on the web site for the event. The director of NMISP told the *Networker* that revenue from other sources has since increased, and that only 25 to 30 percent of Depression Day's funding now comes from pharmaceutical companies.

Some marketing connected with Depression Day has been directed specifically at children. In 1995, for example, *The Washington Post* reported that several students at Walter Johnson High School in Bethesda, Maryland, complained after sales representatives of Eli Lilly spoke at a school assembly on Depression Day and then passed out free pens, pads and brochures touting Prozac. One student said she had been forced to listen to "a 45 minute plug for Prozac," and her mother told the *Post* that no other alternative treatment for depression, such as counseling, had been presented. These campaigns have a predictable effect: more than 453,000 prescriptions for Prozac alone were written last year for kids under the age of 18. Another recent Depression Day initiative focused on primary care physicians,

teaching them how easily their patients could take screening tests in the waiting room, to be later scored by staff without imposing on the doctor's time.

Adrift in this cultural sea of overprescription and overpromotion, what is the responsible therapist to do? The solution is not to dismiss SSRIs and other antidepressants out of hand, but to put them in their place. Therapists should stop kowtowing to their supposedly superior powers and think of them as one choice among many--and certainly not as the treatment of first resort.

In our own practices, we never suggest medication as the treatment of first resort. Instead, we begin therapy on the assumption that if we follow the client's lead, ask about the client's own theory of how change takes place and strengthen the therapeutic bond, we will enhance therapeutic outcomes of all kinds--with and without medication. When clients believe that medication will help and are "in the driver's seat" in making an informed choice, we have found that SSRIs can be helpful at times. Whatever approach evolves from the dynamic, moment to moment synthesis of ideas, it is the client who judges its helpfulness. Finding something that fits is facilitated by routinely inviting each client's feedback about the treatment he or she is receiving. Whether the approach is medication or one of the 400 available therapy methods and techniques, we think therapy should be a partnership that involves the client's voice at every juncture and in every decision. And if talk therapy has not produced results in three to six weeks, we brainstorm options with our clients; one of them may be antidepressants, while others include switching to another therapist or another approach. But SSRIs are never our first choice unless the client suggests them.

Guidelines like these don't make the treatment of depression simple. Nor can guidelines--or any drug--fully prepare any of us for those horrible moments when we sit face to face with the smothering despair of our clients. Not long ago, one therapist at our clinic at Nova Southeastern University worked with a weeping, financially desperate woman named Alina. The therapist listened with growing concern as Alina talked about her inability to leave her emotionally abusive husband, her worry about her four children and her humiliation at her new job, where her boss mocked her Spanish accent in front of customers. "I can hardly get up in the morning. If I had the guts, I'd just crash my car into a tree and be done with it," she said. Her tears, anguish, and despair were so palpable during the session that the therapist found herself having to fight her own feelings of hopelessness and fear for Alina.

It was this painful resonance that permitted the therapist to connect with her client, and that helped create the possibility that Alina and she could be part of some kind of change together.

But this very resonance also made the therapist vulnerable to finding herself, like Alina, in momentary despair. For many therapists, this is the moment when the voice of bad research and great marketing emerges, whispering of the superiority of "modern science" over primitive "talk therapy." It leads many therapists to reach for what looks like a sure thing to give their clients (and themselves) hope and relief. The medication solution is like fast food: it takes the work, time and anxiety out of answering "What's for supper?" But the introduction of the topic of medication in therapy carries numerous messages, among them, "Your problem is so severe, and you are so biologically damaged, that we have to look at something other than what we are doing together, or what you can do on your own." These messages serve to abort most clients' naturally occurring search for solutions and to block access to their own innate resourcefulness that lies at the heart of good therapy.

Reaching for that sure thing, the therapist thought as she faced Alina, would have predictable results. She would refer Alina to a physician who could prescribe drugs, and he or she would inevitably focus on Alina's mental state, her fragility and her potential for suicide. The therapist also considered the implications of the fact that 70 percent of all antidepressants are prescribed to women. Other paths were far more uncertain. As the therapist struggled internally, Alina volunteered that she didn't like pills, and wanted to solve her problems herself. Knowing that other options could be introduced at any time, the therapist trusted in Alina's direction and in the power of the therapeutic relationship.

At the end of the first visit, the therapist pointed out Alina's strengths and all she had done to extricate herself and her children from unbearable situations. Alina concluded the session by emphatically stating that she had no plans to hurt herself. Over two months of therapy, the therapist met with Alina every week, encouraging her concrete efforts to deal with the circumstances that were distressing her, and Alina's life and mood slowly improved. When federal funding for the therapy program ended, Alina was no longer desperate, validating the therapist's faith in her client's innate resourcefulness. Alina was going out with girlfriends more, she had conquered her job and was getting praise there and she had much more confidence in herself. She had even begun saving money for an independent future without her abusive husband. She and the therapist had weathered the storm together, with Alina, not medication or the therapist, at the helm.

Some people, like Alina, struggle with despair and oppressive life circumstances over time; others, including the severely depressed, sometimes make stunning turnarounds within the course of a single therapy hour. If the option to try something different is not at least as attractive as the medical option, the magic pill will win every time. What is required is a reconnection to what good therapists already know: that most people can and will develop solutions to even the most daunting dilemmas, given support and encouragement.

At the core of this approach is our faith that change occurs naturally and almost universally: the human organism,

shaped by millennia of evolution and survival, tends to heal and to find a way, even out of the heart of darkness. When we hang on to this belief in our hearts, we level the playing field and can compete with the noisy medical ideologies promoted by profit-making drug companies and championed by factions within our own professions.

Every good therapist knows that each case is as different as the faces we greet each hour. Each experience of depression will take its own course. Rather than being hostage to the notion that "it's all biochemical," we can remind ourselves that every emotional human experience--including hope, reassurance, trust, love, faith and rapport--affects the body's chemistry and has neurochemical correlates in the brain. Rather than turning to the magic pill, therapists can access the real magic: the connection created by listening to and exploring their clients' stories, experiences and interpretations of their problems. That rapport, as the sustained power of the much misunderstood and underrated "placebo effect" suggests, can positively affect not only clients' bodies and brain chemistries, but their willingness to act and their sense of who they are and who they can become. A mountain of outcome studies conducted over the last 40 years has shown that forming a therapeutic alliance is not a *prerequisite* to successful treatment--it *is* the real treatment. In study after study, therapies in which the client perceives a helpful therapeutic bond and a mutual agreement on goals are the most successful. Finally realizing that psychiatric drug therapy is a profit-driven industry, built on flimsy science, may be the bad tasting medicine we've needed. Although it may be hard to swallow, empowered with the knowledge, therapists can regain their voices, trusting what they have known all along about depression and other human travails: there is no better medicine than a good therapeutic relationship.

Barry Duncan Psy.D., is an associate professor at the School of Social and Systemic Studies at Nova Southeastern University in Fort Lauderdale, Florida, and Scott Miller, Ph.D., is a therapist and an international workshop presenter based in Chicago, Illinois. They are cofounders of the Institute for the Study of Therapeutic Change (ISTC). Jacqueline Sparks is a member of ISTC and a doctoral candidate at Nova Southeastern University. This article is adapted from Duncan and Miller's latest book, The Heroic Client: Doing Client Directed Outcome Informed Therapy*. The authors can be reached at: www.talkingcure.com*

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