In Gail Bell's essay, *The Worried Well*, I have been the suicidal "surly boy in the next street" that Bell assumes "is the patient for whom the mood-enhancing drugs were invented" (p 5). Although her candid and thoughtful essay goes some way towards correcting the widespread misinformation about depression, her analysis does not quite go far enough and her own bio-reductionist bias is revealed in cases of so-called Major Depression.

Bell claims that "about 15% of major depressions proceed to suicide" (p 42), echoing another frequently heard assertion that depression is the major *cause* of suicide. One prominent suicide expert, Professor Robert Goldney from Adelaide university, uses a "real estate analogy" that the "most important contributing factors to suicidal behaviors are depression, depression, depression"[1]. All these assertions rest on the assumption that depression is a medical illness, an assumption that Bell correctly questions for the worried well but not for major depression.

Bell reminds us that since the 1950s depression has been reconceptualised and 'relabelled' as a disease, rather than a symptom, in order to "render it visible to medicine's gaze" (p 16). Her essay exposes how Big Pharma was instrumental in this though she herself maintains the view that "depression is what depression has always been … a cluster of symptoms" (p 49). Indeed, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the Bible of modern psychiatric diagnosis, defines depression solely in terms of a cluster of symptoms. No aetiology, cause or explanation is offered, but this is sufficient for the American Psychiatric Association (the authors of the DSM) to declare depression as a psychiatric disorder. With this 'decree' from the APA, depression acquires the status of a 'mental illness'.

The phrase 'mental illness' is a metaphor. It uses the language of biological medicine to describe and explore the psychological and emotional pain of mental suffering. But the mind is not a biological organ. There is no mind 'thing' that can get ill in the way that a liver or a kidney can. To speak of mental illness is to speak metaphorically. Although it may be of use as a metaphor (though personally I think it's a weak one), it is a serious mistake when a metaphor is taken as a literal truth. This serious mistake, a category error that confuses the psychology of the mind with the biology of the brain, has in recent decades become the status quo in psychiatry and, in turn, in the general community. But the consequences of this selling of depression as a medical illness extends beyond the commercial excesses of Big Pharma.

A clear example from my own story is that once I was 'diagnosed' with Major Depression, this became the *explanation* for my suicidal feelings and behaviour, and anti-depressants were prescribed. I tried a couple of different SSRI drugs and although I didn't have the nasty side-effects that some people report (the commonly experienced 'sexual dysfunction' is not much fun though), neither did they help much. The response from the psychiatrist was to bring out the heavy guns and an anti-psychotic drug was added to my drug diet to 'augment' the anti-depressant. Psychosis or schizophrenia was never part of my story, so this was an 'off-label' use of this potent drug, a practice that has been increasing alarmingly in recent years. For the year I took this drug, I became a fat zombie couch potato, watching daytime TV,

[1] Goldney, R. D. (2003). Depression and Suicidal Behavior: the real estate analogy. *Crisis, 24*(2), 87-89.

eating ice-cream and doing little else. But even this dulling of my brain didn't work – my last major suicide attempt occurred while I was on this heavy drug diet. The last and biggest gun in the armoury of psychiatry – and still seen as the 'gold standard' – for 'treatment resistant' depression is electroconvulsive therapy (ECT). Fortunately I escaped the clutches of psychiatry before this was inflicted on me. With the current controversies around SSRI drugs in the US, concerns are already being expressed that ECT, which psychiatrists admit to having no explanation for why 'it seems to work', will be resorted to more frequently for depression.

My story has some parallels with that of William Styron's in *Darkness Visible* that Bell refers to. The use of increasingly aggressive medical interventions is not an uncommon story, with sometimes devastating consequences. The failure to look beyond the symptoms and the excessive reliance on medical interventions all rest on the *assumption* that depression is a medical illness. The reconceptualisation of depression as an illness rather than a symptom is part of the colonisation of what it is to be human by medicine and psychiatry, which Bell recognises when she admits that "allopathic rhetoric has colonised my thinking" (p 5). She also cites a "rebel cry" from an unnamed psychiatrist who dared to challenge his/her colleagues that "mainstream psychiatry is now limited to a radical materialist ideology" (p 41). This radical ideology is now the intellectual foundation of modern psychiatry which, supported by Big Pharma and extreme economic rationalism (see below), completes the conquest of this colonisation.

Depression is best understood as psychological *pain*. We do not think of physical pain as an illness but as an indication or symptom of some underlying physical illness or injury, which may require medical attention. A distinguished pioneer in the field of suicide prevention, Professor Edwin S. Shneidman, understood this when he coined the term *psychache* as the central feature of suicidal thinking and behaviour. Disenchanted with the DSM and its "specious accuracy built on a false epistemology"[2], Shneidman defines psychache as psychological pain due to frustrated or thwarted psychological needs – the 'specious accuracy' is the DSM's statistical clustering of symptoms and the 'false epistemology' is the assumption that it is a medical illness. Shneidman is now in his 80s and laments, as I do, the increasing medicalisation of human suffering. His notion of psychache, however, remains a much more useful starting point for understanding 'depression' than the broken brain, radical materialist ideology of modern psychiatry.

In a similar way, anti-depressants are best understood as psychological or emotional pain-killers. If you break your leg then it's a good idea to have some morphine. But it's a big mistake to think that the morphine will heal the broken bone. Taking drugs to ease extreme emotional pain can also serve a useful purpose, such as helping to create some time and space to think about maybe not killing yourself. I would argue, though, that if the anguish is severe enough to warrant potent drugs like anti-depressants then it is severe enough to warrant hospitalisation – but preferably the "benign detention" and "sequestration" that Bell refers to as the keys to William Styron's recovery from suicidal depression. Continuing the broken leg analogy, and further similarities with Styron's story where "the real healers were seclusion and

[2] Shneidman, E. S. (2001) 'Suicidology and the University: A Founder's Reflections at 80' *Suicide and Life-Threatening Behavior, 31*(1), 1-8

time" (p 54), drugs can ease the pain while the real healing takes place. But with the broken leg we don't simply take morphine forever and nothing else. The break in the bone has to be identified, reset and immobilised and then other supports put in place while the healing takes place. Likewise with 'depression'. Except that under the broken brain school of psychiatry, someone with a history like mine will likely be told, as I was, that I would need to take anti-depressants for the rest of my life – and that no other 'treatment' was relevant. Once more, this response to psychache such as mine rests entirely on the ideological assumption that depression is a medical illness, and specifically an illness of the brain.

Although I acknowledge a place for medications to ease extreme mental anguish, there are many complex questions about the suitability of the current SSRI drugs for this purpose. Bell covers most of these but we can continue our analogy with morphine to briefly summarise them. Morphine is a relatively 'clean', benign, reliable and rapid-acting drug. Apart from the risk of addiction with long-term use, there are few risks associated with it if used in the correct way for pain relief. In contrast, modern SSRI emotional pain-killers are decidedly peculiar. First, their efficacy is problematic – they seem to help some people but not others (and no-one has an explanation for this). Next, they take at least a few weeks to 'kick-in', which can be a problem if suicide is a concern. Then they have a peculiar side-effect profile. With morphine, the main side-effect is constipation and perhaps some nausea. With SSRIs probably the most common side-effect, as mentioned, is 'sexual dysfunction' (of varying kinds) but agitation, sleep disturbances (including nightmares) and problems with appetite are also quite common. We are also hearing now, as Bell reports, that these drugs can induce depression and suicidal feelings in some people, especially when first going on them, when the dose is changed, or when coming off them. And although the popular myth is that these drugs are not addictive, we are also now learning of many who suffer quite extreme 'discontinuation syndrome' symptoms, to use the psychobabble of psychiatry Big Pharma. These are decidedly peculiar drugs, which is hardly surprising as they are complex, potent synthetic chemicals carefully designed to get pass our protective 'brain barrier' but which, unlike opiates, alcohol and other psycho-active drugs (or 'intoxicants'), are totally foreign to our evolutionary, biological history. As Bell says, careful control, management and supervision of these drugs is essential – but this rarely occurs. Her plea that "you can't just give an adolescent a prescription and send them on their way" (p 59) is not only the exception to current practice, it should also applies equally to adults.

Mention must also be made of another reconstruction of depression that works hand in hand with the medical reconceptualisation of depression. A succinct description of this is found in the special federation (January 2001) issue of the Medical Journal of Australia on 'Defining Moments in Medicine'. The section on psychiatry's defining moments was written by Professor Gordon Parker, Head of the School of Psychiatry at the University of New South Wales who describes one of psychiatry's defining moments under the heading of "Formulation of clinical depression as an economic malaise":

> *The number of people with depression is not growing substantially, despite historical formulations of depression as a response, a disorder, an illness and a*

disease. Its recent reformulation as a major economic cost due to its disabling effects, endorsed by the World Bank, Harvard University and the World Health Organisation, provided the spin, attracting public, media, health department and political attention.

The leading proponent in Australia of this economic rationalist 'reformulation' – and of the political spin – is the *beyondblue* organisation chaired by former Victorian premier, Jeff Kennett. If you visit the *beyondblue* website you find little to distinguish it from the depression pages on the websites of Big Pharma. The many controversies surrounding depression and its treatment, such as those raised by Gail Bell and others, are barely mentioned. On the contrary, the few times these issues have appeared in the popular media it is often Professor Ian Hickie, the former CEO of and now consulting psychiatrist to *beyondblue*, who you will hear reassuring us of the 'efficacy and safety' of the SSRI drugs. My own attempts to raise these issues with *beyondblue* have so far met with firmly closed doors. Indeed, in my first meeting with Professor Hickie some years ago when I argued that these controversies were a relevant and important part of the public debate on depression, his response was "What controversies?" I have since learned many times that *beyondblue* does not welcome dissenting voices to their public relations spin. Given that it has about $100 million of public funding (at last count) to sponsor a national 'depression awareness' public debate on depression, this is tantamount to censorship in my view, censorship in the service of the 'reformulation' that Professor Barker describes above.

The economic rationalist motivation of *beyondblue* is, as Professor Barker describes, the growing realisation of the economic costs of the so-called 'low prevalence' mental illnesses of depression and anxiety. Too many people are either unable or unwilling to work – taking too many 'mental health sickies' – because of what should properly be called *psychosocial distress*. The World Bank, which is where the much touted figure of 1-in-5 people suffering from depression comes from, expresses this in terms of the 'global burden' of depression. In Australia, *beyondblue* is a major player in this disease mongering that captures more and more people in the mental illness net. This can be seen in a special supplement to the July 2001 issue of the Medical Journal of Australia in which *beyondblue* proposes a screening tool of twelve questions to assist doctors in the detection of mental illness.

An elaborate argument, and a large amount of data, is presented in this MJA supplement to justify the SPHERE-12 instrument as a reliable predictor of mental illness. Space does not allow a full critique of all the flaws in this screening tool, but they can be illustrated with a simple example. One of the twelve questions of the questionnaire asks whether, "in the last few weeks", you have been "Feeling constantly under strain?" According to SPHERE-12, if you answer this question with "most of the time", then you probably have a mental illness. The supplement is careful to say that the tool "is not a diagnostic system that will immediately lead to the delivery of specific treatments" but its purpose is "to recognise a common mental disorder in a patient whose responses to the 12 items … show sufficient symptoms to justify a diagnosis". Feeling constantly under strain most of the time for the last few weeks meets the SPHERE-12 criteria to justify a diagnosis. If you look at all twelve questions and the scoring system that comes with them, then many other very common situations that people find themselves in would "justify a diagnosis" – such

as caring for young children, work stresses or being sacked from your job or your boss is a bully, to mention just a few . One odd feature of this 56 page supplement in the MJA is that the twelve questions that make up the SPHERE-12 questionnaire were not actually published in the supplement, which makes me wonder about the editorial responsibilities of the MJA editors. Even more odd is that when the tool later appeared on the *beyondblue* website for us to anonymously screen ourselves, the threshold for risk of mental illness was very much higher than the advice to doctors in the MJA supplement.

The extremely wide net of diagnostic tools like SPHERE-12 is consistent with the wide net of the diagnostic criteria of the DSM. Few people, when tested by such criteria, would escape the label of a psychiatric diagnosis – I don't know anyone who does not qualify for at least one psychiatric diagnosis according to the criteria of the DSM. This is disease mongering, the colonisation of the human psyche by medical ideology in partnership with the marketing of Big Pharma and the economic rationalism of organisations like the World Bank and *beyondblue*. Or, as the title of the recent book by Ray Moynihan and Alan Cassels aptly describes it, it is *Selling Sickness: how drug companies* [and I would add, psychiatry and politicians] *are turning us all into patients*.

Finally, and perhaps to pre-empt my critics, if you doubt the argument here then I simply urge you to 'follow the money'. By an overwhelming proportion, the vast bulk of spending on mental health in Australia assumes the medical model of 'mental illness'. Governments and other policy-makers have bought the ideological myth of the medical, pharmaceutical and economic rationalist colonisation. Despite a clamour from mental health consumers, and also many non-clinical workers in mental health, for something more than the simplistic 'diagnose and drug' approach of psychiatry, the insatiable appetite of medicine for expensive resources, combined with its political clout, means that few resources are available for non-medical responses to psychosocial distress. Follow the money and you will see the colonisation at work.

I'm no longer the "surly boy in the next street". Today I'm the middle-aged man angry and frustrated that my suicidal soul-mates are still dying from the neglect of – and sometimes as a direct consequence of – the shallow, narrow and soulless medical response to the mental and emotional anguish that so often accompanies the human journey. Bravo, Gail Bell, for daring to speak of this. But the sickness in Australia (metaphorically speaking) indicated by the current 'anti-depressant epidemic' goes very much deeper than even your fine and challenging essay suggests.