Rachel’s head was spinning; the shock and despair so crushing, she struggled just to breathe. Yet, there Jack sat, coolly telling Rachel that although he still loved her, he wasn’t “in love” with her and had found someone else he wanted to be with. She doesn’t remember whether she yelled and screamed or just went numb. Jack’s pronouncement was a month ago, and in an instant, he was gone. Every day since then seemed a struggle for survival to Rachel. She barely slept, hardly ate, and was finally convinced by her best friend she needed to get on an antidepressant. Should she?

Skills or Pills?

What MFTs Can Do Better Than Antidepressant Medications

Michael D. Yapko, PhD
The use of antidepressant medications (ADMs) as a means to manage mood altering life challenges has reached a level of acceptance that probably surprises no one anymore. According to 2005 figures (the most recent available) from the U.S. Centers for Disease Control and Prevention, ADMs are now the most frequently prescribed class of drugs in the U.S., making up about 5% of all prescription medications. For most people, it seems, the fact of the widespread use of ADMs has made it seem unnecessary to question their merits, what’s the point of questioning something already so deeply woven into the fabric of our society? It’s too much like questioning whether the barn door should be closed after the horse has already escaped.

Many marriage and family therapists (MFTs) routinely encourage medication evaluations for their depressed clients, assuming with little foundation that drugs are the primary intervention, while their psychotherapy is merely secondary. But, several things have happened this year in regard to ADMs that should make every MFT stop in his or her tracks and reconsider the key issues raised by these events. I want to state clearly and explicitly to all MFTs that there are plenty of sound reasons to unapologetically emphasize the merits of teaching skills over taking pills.

My intention is to address some of the legitimate concerns about ADMs and provide some supportive data in order to make one key point: We shouldn’t let the marketing of drugs overshadow the science of sound clinical practice. Specifically, I want to draw your attention to the nine domains of concern about ADMs that should make every MFT stop in his or her tracks and reconsider the key issues raised by these events. I want to state clearly and explicitly to all MFTs that there are plenty of sound reasons to unapologetically emphasize the merits of teaching skills over taking pills.

Table 1. Concerns about Antidepressant Medications

1. The one-dimensional nature of a purely biological perspective
2. The limited defined of client role
3. Economic corruption: Greed, undue influence on the healthcare system
4. Pseudoscientific false advertising
5. Conflicting data regarding their safety and use
6. Over- and under-prescribing issues
7. Side effects undermining their effectiveness
8. Therapeutic Efficacy: Do they really work?
9. Ecological issues

The social side of depression, a sensible focus for MFTs, has received too little attention despite the massive attention paid to biological and drug solutions. I hope to help remedy that with my forthcoming book, due out in September 2009 from W.W. Norton, called Depression is Contagious.

What ADMs Can Do Better: View and treat depression from a multidimensional, systemic perspective.

Concern #2: The Passive Definition of the Client’s Role
Depression is a disorder built on a foundation of passivity. “Why bother?” is the unofficial motto of depression. It is no coincidence that the therapies with the greatest empirical support all emphasize taking purposeful and sensible action. To treat depression, in order to make one key point: We shouldn’t let the marketing of drugs overshadow the science of sound clinical practice. Specifically, I want to draw your attention to the nine domains of concern about antidepressants in Table 1.

For the purposes of our limited space here, I will provide a greatly distilled essence of the various concerns.

Concern #1: The One-Dimensional Nature of a Purely Biological Perspective
Consider your answer to this seemingly simple question: What causes depression? How you answer this question is the single most important determinant of how you will design and deliver treatment... and how you will relate to the points raised in this article.

Is depression caused by:
- Genetics?
- A biochemical imbalance in the brain?
- Psychosocial stressors?
- Cognitive distortions?
- A lack of environmental and social rewards?
- Social inequities?
- Cultural and/or familial influences?
- Mishandling key vulnerable situations?
- Dietary issues?
- A lack of physical exercise?

If you were to review the clinical and research literature, you would find that each of the factors above, as well as many others not listed, play significant roles in the onset and course of depression.

Thus, the best and most realistic answer to the question of what causes depression is that depression is caused by many contributing factors that will vary in degree across individuals. Biology ran amok has been overemphasized as the principal causal factor in depression when psychological and social factors have been shown to play an even greater role in its onset and course.

Concern #3: Economic Corruption and Undue Influence of Pharmaceutical Companies
Researchers, journal editors and clinicians are met without greed. Let’s start with physicians, too many of whom have allowed the medical establishment to spell out their specific roles. Dr. Catherine DeAngelis, JAMA’s editor-in-chief, said, “The manipulation is disgusting. I just didn’t realize the extent...the ones who have allowed this to happen. Now we’ve got to make it stop.” (2008)

What ADMs Can Do Better: Actively resist self-serving forces that attempt to control or manipulate how you do research or provide therapy.

Concern #4: Pseudoscientific False Advertising
The “shortage of serotonin” is a heavily touted hypothesis regarding the cause of depression that has little empirical basis but a growing mass of contradictory evidence. All of us have seen the advertising blitz with ads declaring that “depression may be caused by chemical imbalance and (our drug) corrects this imbalance.” The decline of the serotonergic hypothesis of depression was well captured in a recent article in the science magazine 

Concern #5: Conflicting Data That Confuses Almost Everyone
Be afraid, we’re told, be very afraid. But, we’re also told, there’s really nothing to be afraid of...”

Consider the issue of how long the patient should be on medication. This is a hotly debated issue. Government guidelines say 4-9 months after remission. Some experts say 1 year, some say 5 years, some say forever. Confused by conflicting data? How do you think your clients feel?

What ADMs Can Do Better: Recognize the subjective biases of “experts” in areas where no such expertise can exist, simply because conclusive data aren’t available yet.

Concern #6: Drugs are Over-prescribed and, Paradoxically, Under-prescribed
Despite the overall increase in the number of people seeking help for depression, estimates are that only half of depressed people receive any form of SSRI for young people was exaggerated and recommended that the “black box” warning be lifted. A “black box” warning is the strongest warning placed on medication packaging. In the case of ADMs, the warning was about the increased risk of suicidal ideation and behavior in children receiving ADMs.)

On May 2, 2007, just 2 weeks later, the U.S. FDA required drug manufacturers to expand their black box warnings! The original warning was for children and adolescents up to age 18. It is now for young adults up to age 24, as well.

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Concern #6: Drugs are Over-prescribed and, Paradoxically, Under-prescribed
Despite the overall increase in the number of people seeking help for depression, estimates are that only half of depressed people receive any form of antidepressant, the brain is flushed with excess serotonin. Yet, nothing happens; the patient is no less depressed. Weeks pass drearily by. Finally, after a month or two of this agony, the torpor begins to lift. But why the delay...a range of antidepressants trigger a molecular pathway that has little, if anything, to do with serotonin. Instead, this chemical cascade leads to an increase in the production of a class of proteins known as trophic factors. Trophic factors make neurons grow.

It is unknown how antidepressants work.

What the new neuroscience highlights, though, is that psychotherapy changes brain, just as medication does, though in different ways (Siegel, 2007).

What ADMs Can Do Better: Resist being swayed by misleading advertising by staying current with the scientific literature.

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to develop a realistic sense of what the lectures, national depression screening and participate in outreach programs. Peter Kramer promised people they'd be away, and there are people who take doctors instantly writing a prescription

*Nervous* (in this drug company, it was highly likely (94% professionals and the general public. The are published and released to both and how the results of research studies *implies for how science is done* (Turner et al.) that was staggering in

Concern #8: The Arguable Therapeutic 

• Stay in love
• Choose a mate
• Bone fractures in over 50s
• Sedation or agitation/insomnia
• Headache
• Dizziness
• Fine tremor
• Sexual disturbance
• Bone fractures in over 50s
• Mood changes
• Changes in appetite
• Changes in weight

Concern #7: Drug Side Effects Can Be

• Mental confusion
• Physical change
• Sexual side effects
• Dry mouth

Concern #6: The Cost of ADMS

• Loss of income
• Lost time

Concern #5: The Effectiveness of ADMS

• Modest benefits over placebo treatment,
• Analyses of ADMS have reported only effect
• After including these omitted data
• The authors concluded, “Meta-
• The most
• selective publications related to Rofecoxib: A case
• Psaty, B., & Kronmal, R. (2008). Reporting
• A prospective multicenter study of 1022
• PLoS Medicine, 5(2), 20.


