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ANTIDEPRESSANTS AND IATROGENIC SUICIDALITY

Disturbing arguments in the politics of the supplement

L. Paul Strait

UNIVERSITY OF SOUTHERN CALIFORNIA, USA

G. Thomas Goodnight

UNIVERSITY OF SOUTHERN CALIFORNIA, USA
SENIOR SCHOLAR AWARD WINNER

In this essay, we review a case in which disingenuous interlocutors created a public scientific controversy and invested it with enough ambiguity to delay the reformation of consensus for decades. Specifically, we examine the controversial link between antidepressant medication and suicidality. We read the antidepressant–suicidality controversy in two interconnected ways: first, as an instance where tactical institutional discounting of arguable effects produced state-of-the-art rationales for needed research while publically stigmatizing criticism and its engagement; second, as the strategic management of the ambiguous tensions between depression and sadness, lifestyle-enhancing drugs and disease-treating medication, and the division of risk-management labor entailed in a system in which prescription-only medication is directly marketed to potential patient-consumers.

Accordingly, our inquiry examines the dynamics of pseudo-controversy within a constellation of concerns we label the *politics of the supplement,* by which we mean a field of contestation concerning the risks and benefits of new technologies of the self aimed at redressing defects in one's human nature. *Supplements* are material and symbolic surpluses that promise to: overcome lack through improving the security of living, aid in coping with chronic impairment, or retard undignified outcomes of mortality. The politics of the supplement fit into the larger category of what Giddens (1991) calls life politics, "a politics of self-actualization in a reflexively ordered environment, where that reflexivity links self and body to systems of global scope," in which the meaning of risk and its associated burdens of proof are contested, and where market forces, scientific expertise, and other intersecting institutional influences "intrude deeply into the reflexive project of the self" as it is carried out at the material level (p. 214). We argue that the politics of the supplement rhetorically entwine

desire, risk-engagement, and satisfaction in individual and collective contexts of morbidity and mortality. In the following section, we provide an overview of the antidepressant-suicidality controversy and the historical and institutional contexts in which it developed. We then take up the question of whether the debate should be understood as an example of pseudo-controversy. Finally, we resituate the (pseudo-)controversy in terms of the politics of the supplement and show that the peculiar dynamics of the controversy are structured around a logic of risk-management that appears in a wide variety of contemporary argumentative contexts.

Antidepressants and Iatrogenic Suicidality

When antidepressants were discovered, it was well known in the medical community that antidepressants could induce suicidal thoughts, but this was not seen as especially problematic because the patients were all severely ill and closely monitored (Loomer, Saunders, & Kline, 1957). Indeed, the behavioral side effects were documented before the antidepressant main effects were discovered. Before medical researchers noticed the antidepressant effects of isoniazid (a tuberculosis medicine), a case report appeared describing a patient who became violently suicidal. There was "unequivocal evidence" of a causal relationship, "including a fairly sudden onset after a period of drug therapy . . . [that] rather quickly cleared up as soon as the drug was discontinued" (Pleasure, 1954, pp. 315-316). In the paper announcing the discovery of the first tricyclic antidepressant imipramine, Roland Kuhn (1958) warned of an "increased risk of suicide" during the early stages of treatment, leading him to suggest as a reasonable precaution that psychiatrists "commit [their patients] to an institution" before beginning treatment (p. 464). Four months before the first commercially successful antidepressant (amitriptyline) was approved by the Food and Drug Administration (FDA), William Sargant (1961) presciently raised concerns about the "intensive advertising of the new antidepressant drugs for cases of depression in which they may be quite unsuitable, and if used can only increase the grave risks of suicide always present in severe depressive illnesses" (p. 225).

Institutional amnesia about this link 30 years later coincided with the immense popularity of the selective serotonin reuptake inhibitor (SSRI) fluoxetine (branded Prozac). Noted for its relatively favorable side-effects profile, Prozac quickly achieved superstar status, appearing on the front covers of *Newsweek*, *Time,* and *New Yorker*, in the play *Prozac Sisters,* the video game *Virtual Prozac*, and in psychiatrist Peter Kramer's (1993) best-selling *Listening to Prozac: A Psychiatrist Explores Antidepressant Drugs and the Remaking of the Self.* Celebrated in the popular press as a "happy pill," a "wonder drug," and "the feel-good pill," Prozac had by the mid-1990s become the most well known brand name in psychiatric medicine (Montagne, 2001, p. 1267). The emerging concept of "cosmetic pharmacology," by which psychiatric medication could be used to change patients "not just away from illness but toward some desirable psychological state," inspired suggestions that all sorts of non-depressed people might benefit from trying Prozac as a "personality enhancer" (Cowley & Springen, 1990, p. 38).

Physicians generally do not try to conceal or downplay the risks of modern pharmaceuticals. Far from threatening the institutional legitimacy of modern medicine, these risks provide a justification for prescription-only arrangements that make physicians into the exclusive gatekeepers of regulated pharmaceuticals. Surprisingly, then, psychiatrists were quick to discount the reports (Gorman, Liebowitz, & Fyer, 1987; King et al., 1991) of suicidality as an adverse effect of fluoxetine. The first paper establishing a pattern of suicidality over multiple cases described patients with relatively mild symptoms of depression suddenly fantasizing about "killing themselves with a gun . . . [or dying] in a gas explosion or car crash," leading

the clinical psychologists who authored the study to comment that "it was remarkable how violent these thoughts were" (Teicher, Glod, & Cole, 1990, pp. 209–210). In response, a *Time* magazine story in July 1990 quoted Paul Leber, director of the FDA's neuropharmacology division, arguing that people should not be "scared away" from this "wonder drug," as "the evidence linking Prozac to suicidal behavior is tenuous and relies mostly on anecdotal histories" (Toufexis & Purvis, 1990, p. 54). The *British Medical Journal* published a large meta-analysis of data involving thousands of patients, in which all mentions of suicide were recoded as symptoms of a depressive episode; having made this methodological move, the authors concluded that there was no link between fluoxetine and suicide (Beasley et al., 1991). After pontificating that evidence-based medicine should trump anecdotal clinical wisdom, one of the study's authors remarked: "I doubt if there is any study that could be done that could possibly demonstrate a relationship between fluoxetine and suicidality" (*Deposition of John Heiligenstein*, 1994). This hypothetical epistemic limitation stems from the apparent difficulty in distinguishing suicidality caused by depression from suicidality caused by treatment. Similarly, several defenders of fluoxetine argued that by effectively treating depression, fluoxetine lowered the overall risk of suicide (Jick, Dean, & Jick, 1995; Nakielny, 1994).

Against this entrenched view, evidence to the contrary slowly began to emerge over the following decade. For example, David Healy (2000) conducted a study with sertraline, another SSRI, on healthy volunteers, two of whom became suicidal within two weeks, a finding that is statistically significant at the level of $p = 0.0000005$. After more studies of this nature began to accumulate, the FDA in October 2004 issued a public warning about the risk of suicidality (in children and adolescents) being treated with SSRIs. Inverting the epistemic priority of quantitative data over clinical observation established by Leber and Heiligenstein, the institutional response was to suggest that research protocols are complicated and that this was "an instance where clinical wisdom surpasses evidence-based medicine" (Rihmer & Akiskal, 2006, p. 10). Not persuaded, the FDA in 2007 completed its own meta-analysis of data from trials conducted between 1988 to 2006, concluding that while the benefits of SSRI therapy most likely outweigh the risks, recipients of SSRIs (vs. placebo) were twice as likely to exhibit suicidality. Consequently, the FDA (2010) required that prescribing and patient information sheets for all antidepressant medications carry an expanded "black-box warning" disclosing information about an increased risk of suicidal symptoms in young adults aged 18 to 24.

Pseudo-Controversy?

Pseudo-controversy, characterized by the false representation of expert dissensus in the public sphere, is a burgeoning area of research in argumentation studies (Banning, 2009; Ceccarelli, 2011; Dreier & Martin, 2010; Fritch, Palczewski, Farrell, & Short, 2006; Kelly & Hoerl, 2012; Murray, 2007). In a typical pseudo-controversy, "commercial and political entities labor to generate a perception of widespread debate among a scientific community where instead there is a strong agreement" (Banning, 2009, p. 287). One might see this case as the same phenomenon in reverse. But as we have shown, the antidepressant-suicidality link was first documented in the 1950s and did not become controversial for more than three decades. When the link was first contested, the new controversy was immediately characterized as a pseudo-controversy by the same disingenuous actors who were responsible for its existence. That they were disingenuous is now beyond question, as investigators have published internal memos between pharmaceutical executives and the scientists who contested the link, revealing that Eli Lilly was aware of the side-effect years before Prozac came to market, and that the

various data-analysis strategies and talking-points that were deployed to discount concerns about the risks were planned in light of legal liabilities and PR imperatives (Healy, 2004).

Yet in contrast to a pseudo-controversy in which an asymmetrical debate is made to appear symmetrical, this debate actually became asymmetrical and remained so until the evidence became overwhelming, illustrating perhaps the extent of influence the pharmaceutical industry maintains with psychiatric opinion-leaders. The ambiguities and paradoxes inherent in the politics of the supplement help to explain the peculiar trajectory of this pseudo-controversy. A risk society manages the anxieties that it creates by identifying perceived deficiencies that can be ameliorated through supplementation. When supplementation fails, there is uncertainty about whether the supplementation was insufficient or excessive. The anxieties of risk management are only intensified by an awareness that the most serious risks we face as a society are those we created (e.g., nuclear war, climate change, economic depression). As serious as these impersonal risks are, the risks entailed in the reflexive projects of the self pose existential threats to the individual person in a way that is uniquely and profoundly disturbing.

The discursive framework in which individual subjects regard their own human nature as incomplete is a distinctive feature of late modernity. As Lyotard (1991) argued, "[that] children have to be educated is a circumstance which only proceeds from the fact that they are not completely lead by nature, not programmed. The institutions which constitute culture supplement this native lack" (p. 3). The self is always an incomplete reflexive project. As a "surplus or supplement whose political force derives from the sense in which it evades recuperation by instrumental use or determinate meaning" (Carroll, 2008, p. 178), the antidepressant transcends the technical milieu in which its use is managed by experts, becoming a technology of the self. The signifier 'anti-depressant' contains a referent to yet another supplement, the diagnosis of depression, by which psychiatry medicalizes human misery. Yet the meaning of 'depression,' as with that of the implied non-depressed healthy state, is no less elusive. The spontaneous emergence of violent fantasies, sometimes leading to suicidal acts, activates the deepest anxieties one can have concerning a mood supplement. As Derrida (1974) explained:

> When the supplement accomplishes its office and fills the lack, there is no harm done. The abyss is the chasm which can remain open between the lapse of Nature and the delay of the supplement . . . The play of the supplement is indefinite. References refer to references . . . This play of the supplement [entails] the always open possibility of a catastrophic regression and the annulment of progress.
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> *(p. 298)*

The reflexive project of the self is not simply side-tracked, but completely derailed with the auto-destruction of the self. This is why iatrogenic suicidality is so profoundly disturbing.

All state-of-the-art institutional practices involve a balance of risk and uncertainty. The contested framing of the risks of state-of-the-art practices occurs at "a crucial nexus between the scientific and public spheres [which] exists precisely at those points where scientific theories and research programs have implications for prevalent world views, ideologies, and practical social policies" (Czubaroff, 1997, p. 52). Despite the pervasive presence of antidepressant drugs in the popular imaginary, the public is woefully misinformed about their mechanisms of action and the array of potential benefits and risks (Blease, 2013; Glazer, 2013; Lacasse & Leo, 2005). If judgments about the risks and benefits of medication are to be informed by public deliberation, the potential for that deliberation to be distorted by pseudo-controversy

constitutes a threat to public health. But the politics of the supplement call into question the categories of health and illness in the first place. With approximately 70% of people in the United States consuming at least one prescription medication every day (Zhong et al., 2013), health is not the normal or typical condition of the body but rather an ongoing but incomplete project that always ends in failure. The antidepressant-suicidality controversy arises from the ambiguities, tensions, and slippages in the meanings assigned to diagnostic and therapeutic concepts, which together constitute the polysemic grounding for the neurotic fascination with the possibility to reshape our human nature pill-by-pill. Even its status as a (pseudo-) controversy is ambiguous. Health controversies get hashed out in this discursive environment, and the semiotic ambiguity that runs through the biomedical conceptual corpus also permeates our words for contesting uncertainty and risk.

Our reading of the antidepressant-suicidality controversy reveals the techniques of institutional self-protection manifested by the discounting of standing research and by associating criticism with illegitimate, non-scientific research. The linguistic turn in this kind of argument thwarts the transparent practice of science through subordinating uncertainty to the interests of money and power. By linking a biomedical technology to the reflexive project of the self, disingenuous scientific actors were able to convert consensus into controversy and finally pseudo-controversy, as concerns about the safety of a commercial product were experienced as disturbing threats to the self-identity of both the psychiatrist as physician and the patient as health consumer. Antidepressants treat a disease defined (in part) by an elevated risk of suicide and suicidal ideation. By packaging depression as a risk disorder and marketing Prozac as its remedy, the terms of the debate were so infused with doubt that it became difficult to discuss the increased risk of suicidality as an adverse effect without a high degree of causal uncertainty. Consequently, it took nearly two decades to untangle the risks that had actually been well documented decades before the first Prozac prescription was ever filled.

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