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The Pharmaceutical Industry and the Construction of Psychiatric Diagnoses

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Abstract

Psychiatry is fertile ground for the disease mongering activities of the pharmaceutical industry. Over the last few decades, industry influence has helped to create new psychiatric conditions and transform old ones. The modern concept of depression, for example, was established alongside the marketing of antidepressants in the 1950s and 1960s. More recently the label of depression has been applied to an even wider section of the population, associated with intense marketing of SSRIs. Bipolar disorder has also been transformed from a very rare to a relatively common condition in parallel with the promotion of antipsychotic drugs for its treatment. Schizophrenia has also been expanded into the more vague concept of psychosis, and concepts such as "early intervention" and preventive treatment allow more people to be started on potentially life-long antipsychotic drug treatment. Thus marketing has shaped the very nature of psychiatric concepts and psychiatric knowledge. It also distorts service priorities and focuses attention on mass markets in the general population rather than people with the most severe disorders and the greatest needs.

Key Words: pharmaceutical industry; pharmaceutical marketing; medicalisation; disease mongering; antidepressants; antipsychotics; bipolar disorder; early intervention in psychosis

People have always hoped to find a quick fix to difficult social and personal problems. Quacks of past centuries sold potions that promised success, love and happiness as well as ones that were supposed to help physical ailments. Alternative medicines still offer hopes of improving creativity and concentration and reducing depression, stress and troublesome behaviours. But until recently these activities lay at the fringes of medicine and commanded no real legitimacy. Over the last few decades this has changed. The pharmaceutical industry, have spied a market in persuading people to see all sorts of troubles as medical illnesses in need of a chemical remedy. The rising tide of prescriptions of psychiatric drugs confirms that the message has been thoroughly absorbed. In the process the industry has changed perceptions about what it is to be human, with people increasingly likely to view their behaviour as chemically driven (Rose, 2004). It has also shaped our understanding of what psychiatric disorders are and how they should be treated.

Several recent commentators have drawn attention to this process of disease mongering (Moynihan *et al*, 2002). Sexual dysfunction, osteoporosis and irritable bowl syndrome have also been targets of such marketing, but psychiatry represents by far the most lucrative area. In recent years, it has been shown that pharmaceutical companies orchestrated the promotion of previously little known disorders such as panic disorder (Healy, 2004) and social anxiety disorder (Koerner, 2002), such that they are now household names. But the role of the industry goes back much further and has shaped the nature of conditions that are viewed as fundamental psychiatric disorders. Depression, for example, now an undisputed psychiatric disorder, barely existed prior to the appearance of drugs designated as antidepressants (Moncrieff, 2008a) and in recent years conditions like manic depression have been changed beyond recognition (Healy, 2006).

In this paper, I will argue that psychiatrists need to be aware of the commercial influences on the development of psychiatric classification, and should be prepared to resist the direction in which the pharmaceutical industry is driving psychiatry. Otherwise, psychiatrists risk becoming lackeys of an industry whose motivation is to persuade almost everyone to view themselves as sick. Not only do industry activities expose many people to unnecessary, unhelpful and potentially harmful chemicals, they distort health care priorities, leading to neglect of the needs of those with the most severe forms of mental disturbance.

The construction of depression

In the 19th century and early part of the 20th century, psychiatry was mostly concerned with severe psychiatric disorders that required hospitalisation. Indeed, up until 1930 in the United Kingdom, it was impossible for someone to be admitted to a psychiatric hospital on a voluntary basis. Psychiatric classification, following Kraeplin, divided these severe conditions up into schizophrenia and manic

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depression, the latter category including cases of "involutional melancholia." Descriptions of depressive conditions were brief, and they were considered rare and not particularly important in their own right. There was a further category of disorders referred to as "neuroses" which commonly included alcohol disorders, anxiety and neuraesthenia, but not depression (Braude, 1937;Henderson and Gillespie, 1927;Mayer-Gross *et al*, 1954).

Depression as a category of psychiatric disorder, was only introduced into psychiatric textbooks after the acceptance of the idea that some drugs could be considered as "antidepressants". The principle British textbook of the 20th century introduced a general category of disorder called depression in 1962 (Henderson and Gillespie, 1962). Depression differed from previous diagnoses in that it covered a range of problems in a variety of settings, from the mute, psychotic or stuporous hospitalised "melancholic" to the private practice office patient. Although the first reports of the antidepressant properties of imipramine emphasised that it was most effective in severe forms of melancholic depression (Kuhn, 1958), the idea that depression might be a common disorder was soon proposed. An eminent American psychopharmacologist, Frank Ayd wrote a book called "Recognising the depressed patient", which suggested that a much higher proportion of the general population suffered from depression than was previously thought, and recommending ways for General Practitioners and general hospital physicians to identify the condition (Ayd, Jr., 1961). Millions of copies of this book were bought by Merck, the makers of one patented form of the antidepressant amitripyline, and distributed to medical practitioners worldwide (Healy, 1997).

In recent years the transformation of the concept for commercial ends has become even more apparent. From the late 1980s, Prozac and other SSRIs were marketed again alongside the notion that depression was a widely under-recognised condition. Campaigns such as the Defeat Depression Campaign in the UK and the Depression Awareness Recognition and Treatment (DART) campaign in the US were run by the psychiatric profession, but part funded by pharmaceutical companies (Healy, 2003). Their message aimed to encourage GPs to diagnose people as depressed and to persuade the general population not to be concerned about receiving the diagnosis or taking antidepressants.

Hence the emergence of the modern concept of depression was linked with the introduction of a drug that could be marketed to treat it. The pharmaceutical industry was not solely responsible for the construction and promotion of depression. The psychiatric profession undoubtedly also saw advantages in the promotion of a disorder linked to a simple medical remedy, that allowed it to claim supremacy over other professions in the treatment of people outside the hospital setting (Moncrieff, 2008b;Moncrieff, J., 2008a). However, in recent years at least, the industry has been the main driving force in the expansion of the diagnosis to cover a significant proportion of the population. During 2002 for example, 11% of women and almost 5% of men in the United States were prescribed antidepressants (Stagnitti, 2005).

The influence of the pharmaceutical industry does not necessarily mean that the concept of depression itself is problematic. It is possible that commercial motivations have helped to identify real problems that would otherwise have languished unrecognised and untreated. However, revealing the involvement of the industry should make us wary of accepting the modern notion of "depression" at face value. Probing scientific research on depression makes it apparent that there is little support for the premise that people who are currently labelled as depressed suffer from a specific biological abnormality that gives rise to their symptoms and that can be rectified by the use of antidepressants (Moncrieff and Cohen, 2006). Instead it appears that the diagnosis of depression may simply follow from the decision to prescribe antidepressants. This is supported by the recent transition from depression to bipolar disorder as antidepressants have gone off patent and atpyical antipsychotics have become the main focus of drug company marketing for psychiatric disorders.

The transformation of bipolar disorder

David Healy and colleagues have charted the rise and transformation of bipolar disorder over recent years (Healy, D., 2006; Healy, 2008). The well characterised but rare condition known as "manic depression" has somehow metamorphosed into a vaguely defined, supposedly common disorder, which is being applied to ever greater numbers of people. These changes co-incide with the marketing of the highly profitable atypical antipsychotics, such as Zyprexa (olanzapine). Healy has shown how Abbot laboratories, the makers of semi-sodium valproate (Depakote) popularised the concept of a "mood stabiliser" in the mid 1990s and the rapidly increasing use of Depakote seemed to confirm that there was a large potential market for such a product (Harris *et al*, 2003). In the last 10 years Eli Lilly have conducted a small number of trials of olanzapine in people with classical manic depression or bipolar 1 disorder, including just one placebo controlled trial which appeared to show that olanzapine is superior to placebo in prevention of relapse (Tohen *et al*, 2006). Although there were obvious methodological problems with this trial, which make it likely that the results reflect a discontinuation effect rather than a genuine prophylactic effect, olanzapine was recommended as one of the first choices for prophylaxis and acute treatment of bipolar disorder in the UK's National Institute of Clinical Excellence (NICE) Bipolar Disorder treatment guidelines published in 2006 (National Institute for Clinical Excellence, 2006).

Prior to the publication of this trial, Eli Lilly launched an advertising campaign designed to persuade people to diagnose themselves as bipolar and seek treatment from their doctors. In one advertisement, a young woman is portrayed one minute dancing at a nightclub, or shopping to excess, the next minute looking glum and depressed. The voice over says: "That fast talking, energetic, quick tempered, up all night you never shows up in the doctors office" and it concludes "That is why so many people with bipolar disorder are being treated for depression and aren't getting any better- because depression is only half the story" (Lilly 2002, cited Healy, 2008, P 190). The advert goes on to advise people to complete a mood disorder questionnaire, offered on a Lilly sponsored website. Several other company websites offer questionnaires that encourage people to assess themselves and monitor their moods, and advise people to visit their doctor if they score above a certain level.

Not only has bipolar disorder come to rival depression as a label

for the discontent and disaffection felt by adults, it has also come to be applied increasingly frequently to children. Until recently manic depression was not thought to occur in children at all and only very rarely in adolescents. Over recent years, however, certain prominent academics have sanctioned the idea that bipolar disorder occurs in children, even though the supposedly characteristic behaviour patterns are non specific and occur in other childhood disorders (Biederman *et al*, 2003). Although the concept of childhood bipolar disorder has yet to have official approval in diagnostic manuals like the DSM, it has helped to justify a massive increase in prescribing of antipsychotic drugs to children.

The case of paediatric bipolar disorder illustrates how disorders can be constructed without direct marketing campaigns, through the activities and influence of academic psychiatrists. The role of the drug industry in this case is to promote the views of those psychiatrists who are telling a story that suits its purposes. The industry does this by funding research studies and whole research centres, by setting up and funding symposia at academic conferences and through payments to the academics concerned for consultation and other activities. Healy reports that 30% of symposia at the 2003 annual meeting of the American Psychiatric Association, the largest psychiatric event in the United States, concerned bipolar disorder, almost all of which were funded by drug companies (Healy, D., 2008). The research group in Boston who have have promoted the concept of childhood bipolar disorder and its treatment with drugs were funded to set up a research centre by Janssen-Cilag, makers of risperidone. Moreover, some of these researchers recently revealed that they had received income of over a million dollars each from drug companies over the last few years (Harris and Carey, 2008).

From schizophrenia to psychosis

There has been a subtle change in perceptions of the most severe psychiatric disorders over recent years, in which the pharmaceutical industry have also had a hand. Like the transformation of manic depression into bipolar disorder, the vague concept of psychosis has increasingly replaced the more clearly defined disorder called schizophrenia. Although the concept of psychosis has gained popularity partly because it avoids the stigma associated with schizophrenia, it also helps to pave the way for the extension of drug treatment normally reserved for schizophrenia. Twenty years ago, the grave implications of labelling someone with schizophrenia, with its association with life-long disability, made professionals cautious about making the diagnosis. The normal procedure for anyone thought to be displaying psychotic symptoms for the first time was to wait and observe, in order to be certain of the nature of the symptoms and to give them time to resolve spontaneously. Drug treatment would not be started until after this observation period.

Since then, a concerted campaign to promote Early Intervention in Psychosis has changed this approach completely. Early intervention undoubtedly brings benefits such as support for the family, and yet there is little evidence that it alters the long-term outcome of schizophrenia or a psychotic episode (Marshall and Rathbone, 2006). Claims for the benefits of Early Intervention rest on the observation that people who are ill for a longer prior to receiving treatment have a worse outcome (Marshall *et al*, 2005). However, it has long been known that a gradual onset of psychotic symptoms was a characteristic of a more severe disorder, and conversely that people whose symptoms came on suddenly were more likely to make a full recovery, regardless of treatment. However, this knowledge has been ignored in the burgeoning literature on "duration of untreated psychosis," or DUP as it is often referred to. The small number of trials that have evaluated early intervention services have not found positve results on long-term outcome and have not addressed the particular impact of early drug treatment (Marshall, M. and Rathbone, J., 2006).

Despite the dearth of evidence for its benefits, information about early intervention makes repeated claims that "the evidence for early intervention in psychosis is overwhelming" (Care Services Improvement Partnership North West and Care Services Improvement Partnership, 2007) and Early Intervention services have been introduced throughout the western world. Much of the literature on Early Intervention from the UK has been produced by the National Institute for Mental Health in England, which is a partnership between the government and private companies. Drug companies have also funded conferences on early intervention and sponsored the publication of journal supplements on the topic. Two randomised trials of drug treatment for young people thought to be at risk of developing psychosis have been funded by drug companies (McGorry *et al*, 2002;McGlashan *et al*, 2006).

The result of the publicity on Early Intervention is that there is greater proclivity to start prescribing antipsychotics to people who exhibit strange or difficult behaviours, including young people and children. The emphasis placed on the notion that treatment can help prevent deterioration more or less demands that practitioners start prescribing at the earliest signs of a possible problem. The knowledge that many people can recover from psychosis without antipsychotics has been forgotten (Bola and Mosher, 2003). Therefore, many people are being exposed to these drugs who would never have had a full blown episode of psychosis, or who would have recovered without drug treatment. Moreover, once started these drugs are often continued for years, as professionals are often reluctant to stop them.

Psychiatric diagnosis and commercial interests

Despite the seemingly objective appearance of systems like the current Diagnostic and Statistical Manual, diagnosis in psychiatry has always been a movable feast. Conditions like hysteria, neurasthenia and neurotic depression have gone in and out of fashion. This is why psychiatry represents a soft target for disease mongering activities.

The pharmaceutical industry is not the only interest group to shape psychiatric classification to further its own ends. As described earlier, the psychiatric profession has had its own reasons for wanting to promote disorders that can be treated outside the asylum. Similarly, psychologists may have interests in promoting the existence of disorders that appear to be amenable to psychological interventions. However, the resources at the disposal

of drug companies, and the intense competition they are now engaged in, mean their level and sphere of influence goes well beyond the means of professional groups.

The commercial influence on psychiatric diagnosis is important for several reasons. The levels of prescribing we are currently witnessing provoked an outcry in the 1980s when it was revealed that benzodiazepines were being doled out indiscriminately and used to drug millions of women who had genuine complaints about their lives. However, if complaints are framed in terms of a diagnosis, which automatically implies the presence of an underlying neurological disease or dysfunction, and if drug treatment is presented as being able to rectify the underlying abnormality, then it is more difficult to oppose the mass prescription of psychotropic drugs. Many people currently diagnosed as having depression, bipolar disorder, psychosis and other conditions are almost certainly taking toxic psychoactive drugs for no proven benefit, with all the harms that may entail. But to challenge that situation is to risk being accused of denying the reality of emotional suffering and abandoning the mentally ill.

Diagnoses take on lives of their own. Once a diagnosis is established, or even suggested, it is difficult to challenge its validity, and such challenges are usually ignored. Adult Attention Deficit Hyperactivity disorder (ADHD), for example, which barely existed a few years ago, and is still regarded with scepticism by many, is now routinely employed to justify the prescription of stimulant drugs to adults. The United Kingdom National Institute for Clinical Excellence (NICE) guidelines endorsed the diagnosis of adult ADHD, with little consideration of evidence for its validity (National Institute for Health and Clinical Excellence, 2008). In this way, the interests that produce a diagnosis are buried within it, and become invisible in the process. The whole system of psychiatric knowledge and the practices that flow from it both embody and obscure the influences that formed them. Most practising psychiatrists and general practitioners are unaware that many of the concepts they use to denominate problems and to justify treatment have been constructed for them with commercial interests in mind.

Diagnosis has also become an important tool in resource allocation, especially in countries with managed care systems like the United States, but increasingly in other countries as well. The designation of a particular diagnosis determines the amount of specialist care that the state will fund, it gives access to sickness benefits and justifies sickness absence from work. Apart from the costs of drug treatment, inappropriately labelling people as mentally ill uses scarce resources that may be better employed elsewhere. People who suffer from the most severe and long-lasting mental disorders are some of those who are losing out from this distortion of priorities. In the United Kingdom, policy makers have been persuaded to fund large increases in psychological treatments in primary care (Layard, 2008) while at the same time endorsing the contraction of specialised rehabilitation services for the severely mentally ill.

The debate around the nature of psychiatric diagnosis stimulated by the development of DSM V represents an opportunity to refocus psychiatry back on severe mental disorder and to curb the disease mongering activities of the pharmaceutical industry. However, this is not possible until the financial relations between the profession and the industry are severed. At present the psychiatric profession is far too ready to accept diagnostic justifications for prescribing potentially toxic drugs to adults and children on a mass scale. The profession must disentangle itself from the clutches of the industry to salvage its own credibility and in order to represent the real interests of its patients.

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