**The illusion that antidepressants are more effective when the depression is severe**

By Peter C Gøtzsche

Institute for Scientific Freedom

Psychiatrists sometimes admit that depression drugs are rather ineffective in mild or moderate depression, but most psychiatrists believe that the drugs are effective in severe depression, which is reflected in guidelines all over the world.

They also believe that psychotherapy doesn’t work for severe depression. Both beliefs are wrong, and the misconceptions are dangerous for the patients because the drugs double the risk of suicide whereas psychotherapy halves the risk of suicide.

A Danish textbook of psychiatry illustrates these issues.1 The book advises that SSRIs or tricyclics could be used instead of psychotherapy for moderate depression or in combina-tion with it. For severe depression, psychotherapy was not advised, but hospital admission, tricyclics, tricyclics plus psychosis pills, and electroshock were.

This is a familiar theme in psychiatry. The worse the disease, the more the patients will be harmed by treatments that don’t help them.2-4 It is not evidence-based medicine.

New Zealand has the highest suicide rate in the world among teenagers between 15 and 19, double that of Sweden and four times higher than Denmark.5 When Robert Whitaker, founder of the *Mad in America* website, and I visited John Crawshaw, Director of Mental Health and Chief Advisor to the Minister of Health in New Zealand, in February 2018, I asked him to make it illegal to use these drugs in children to prevent some of the many suicides.

He responded that some children were so severely depressed that depression pills should be tried. When I asked what the argument was for driving some of the most depressed children to suicide with pills that didn’t work for their depression,2,4 Crawshaw became uncomfortable, and the meeting ended soon after.

**Mathematical artefacts contribute to the illusion**

The misconception that the drug effect is related to the severity of the depression is due to two mathematical artefacts. I explained one of them in a letter to the editor in 2010,6 in reply to a meta-analysis of trials based on individual patient data. The authors concluded that:7

“The magnitude of benefit of antidepressant medication compared with placebo increases with severity of depression symptoms and may be minimal or nonexistent, on average, in patients with mild or moderate symptoms. For patients with very severe depression, the benefit of medications over placebo is substantial.”

The authors had regressed change in symptoms on initial symptom severity. Thus, they looked at (x − y) = ax + b, where x is the initial value and y the final value. Since x appears on both sides of the equation, 50% of the variation is already explained. This means that even when two factors are unrelated, the analysis will show a relation, which, however, is spurious.

The other mathematical artefact is caused by bias in assessment of the treatment effect. Due to the conspicuous side effects of the drugs, the placebo-controlled trials have not been adequately blinded.2 This introduces a bias, which can be quite large, e.g. 68% on average when the observers had not been blinded compared to blinded observers in the same trials in a review that included all diseases.8

The bias need not be large to explain the results in meta-analyses that have reported that the effect of depression drugs is larger if the patients are severely depressed.7,9,10 Since the baseline scores for severe depression are larger than for mild depression, a bias will influence the measured result more in patients with severe depression than in those with mild depression.

I have given an example of this.11 If we assume that the unblinding bias is 10% when estimating the effect in the drug group, and that for the simplicity of the example there is no bias in the placebo group and nothing happens between baseline and the final visit, then a Hamilton baseline score of 25 would still be 25 after treatment in the placebo group, but because of the bias, there would be a 2.5-point difference between drug and placebo. If the baseline is 15, the difference would only be 1.5.

These results are close to those reported in a large meta-analysis10 that found that the effect was 2.7 for patients with a baseline Hamilton score above 23, which is considered very severe depression,7 and 1.3 for milder degrees of depression.

Even if we assume that the reported results are unbiased (which is clearly not correct2,12), the measured effect in patients with very severe depression, 2.7, is considerably lower than the smallest effect that can be perceived on this scale, which is a Hamilton score difference of 5-6.13

We may therefore conclude that depression drugs are ineffective for all degrees of depres-sion. It is therefore wrong to call them antidepressants.

**The misconception about psychotherapy**

The misconception about psychotherapy is equally profound. Preventing suicide is para-mount in treating depression, and psychotherapy achieves this effectively. It halves the risk of a new suicide attempt in people acutely admitted after a suicide attempt.11 This is a dramatic effect in patients at high risk of suicide, many of whom must have had very severe depression.

In contrast, antidepressants double the risk of suicide, both in children2,4 and adults.14-16

It is bizarre that when a Danish textbook noted that the suicide risk is increased at the start of treatment with depression pills, it falsely claimed the same is true for psychotherapy.17 It looks like an excuse for using harmful pills to postulate that therapy also increases the suicide risk. There was no reference to this statement, but the fact is clear: Psychotherapy *decreases* the risk of suicide.11

**Conclusions**

Psychiatrists recommend the opposite of what they should recommend for treatment of severe depression. So-called suicide experts also recommend depression drugs for people at risk of suicide,18 even though these drugs double the risk of suicide. It is therefore not surprising that suicides among US adults have been steadily increasing from 23,575 in 2001 to 41,484 in 2022,19 a 76% increase. The suicide rate in the United States has risen steadily since the creation of a national strategy to prevent it.20 In other countries, improved access to psychiatric services and psychiatric drugs have also been associated with an increase in national suicide rates.21

Will this insanity ever stop? Guidelines need to be changed urgently.

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