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Psychotropic drugs and the 'anti-depressed' personality

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Not anxious but not at ease; not incapable of working but not capable of working well; not tormented by the children, but not able to enjoy them; willing to be made love to, but not actively loving; neither tense nor relaxed, neither cheerful nor tearful, neither ill nor well, more depressing than depressed, the bland, tranquillized, 'anti-depressed' personality of our time. This is not a fanciful description but one that seems to me to fit an increasing number of people with whom I am acquainted both inside and outside my consulting room. It has become rare to have a patient referred to me who has not already been on psychotropic medication for the preceding weeks, months or years.

For many if not most physicians, including both psychiatrists and general practitioners, there is a chemical answer to most of their patients' worries, fears and unhappiness. Increasingly this is true not only of such symptoms as are clearly neurotic but also of those reactions which are quite appropriate to the circumstances. This clinical impression is given support by a recent article in the *British Medical Journal* (1974). During the year 1970, 17·2 million prescriptions for tranquillizers or sedatives were dispensed by the National Health Service, and this did not include drugs prescribed in mental hospitals. During that year 9 per cent of all people in the United Kingdom had used such a drug every day for at least a month. During the years from 1965 to 1970 the use of these drugs had increased 60 per cent and the upward trend was continuing. According to Balter *et al.* (1974), who made a study of the use of these drugs in nine European countries, the above figures put the United Kingdom in the middle group of users. This study was concerned only with sedatives and tranquillizers. Parish (1971), in a study on all psychotropic drugs from 1965 to 1970, found that there was an increase of 59 per cent in prescribing tranquillizers and of 83 per cent in prescribing anti-depressives. Was this striking increase due to the fact that more people were being given psychiatric diagnoses? It seems not from the second part of his study which examines in detail the prescribing of such drugs in a large, representative group practice in the Midlands. Psychotropic drugs accounted for 12·6 per cent of all their prescriptions. Less than 50 per cent of the patients for whom these drugs had been prescribed had been diagnosed as suffering from psychotic, neurotic or psychopathic illness. Why then had these drugs been prescribed? Two rather ordinary examples, from my own experience, may throw some light on the question.

1. A university student went to his doctor because of a sore throat. When asked how things were going, he admitted that he was rather troubled about his final examinations; now that they were only a fortnight away he realized that he should have studied harder. 'Yes,' he was 'a bit anxious.' He left the surgery with two prescriptions. One was for penicillin to treat the infection for which he had sought help; and one was for Librium to treat the anxiety, which was not inappropriate, and with which he had been coping reasonably well.

2. A middle-aged woman, whose husband had recently died of a coronary thrombosis, went to her doctor because of palpitation. Asked about herself, she wept and said that she felt lonely and miserable. She went away with the reassurance she had sought about her own heart condition, and with tryptizol for her depressed feelings, although these had seemed quite natural to her.

These examples may seem as innocuous as they are ordinary. Why should people have to endure anxiety if there are anxiolytic drugs available? Why should anyone have to endure depression

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if it can be avoided by swallowing enough anti-depressive pills? Doctors who do not immediately prescribe psychotropic drugs are often accused, or may even accuse themselves of being unenlightened, or puritanical, or so unrealistic that they are unaware that the relief of symptoms is what the patient wants and is generally as much as the doctor can offer. How then can one justify the withholding of drugs which alleviate pain and unhappiness? This rhetorical question can only be answered by asking two other very specific questions: first, how effective are these drugs in the relief of suffering; and, secondly, if they are effective, at what cost?

Let us look first at the effectiveness of psychotropic drugs. To listen to the adherents of a chemical etiology for psychic pain one would think that we are now capable of removing symptoms at will (Sargant, 1974); and that the psychotropic drugs are so specific and so successful that the only treatment problem is that of finding the most appropriate drug, or combination of drugs, for the correctly diagnosed patient. Since the use of these drugs is now so widespread one would have a right to expect that anxiety and depression, like tuberculosis or mastoiditis, would be, if not rare, at least becoming rarer. I shall not insist on my own conviction that both of these conditions are on the increase; but I do not think anyone is likely to assert that they are decreasing either in incidence or in severity.

Some psychiatrists, faced with this paradox, have a ready explanation. Although treatment with these drugs is very common, it is often ineffective because it is not properly administered, the principal mistakes being under-prescribing on the part of general practitioners and drug-defaulting on the part of patients. Johnson (1974) in a very large and meticulous study of the use of anti-depressive medication in general practice, has no fault to find with the drugs prescribed but believes that they are generally given in insufficient dosage. He says (of imipramine and other tricyclic drugs) 'Most psychiatrists would agree that 75 mg is the minimum dose likely to be therapeutic and that this dose should be increased to 150 mg or more per day if the lower dose fails.' Most psychiatrists probably would so agree, but on what basis? In this same paper the author deplores the fact that a high proportion of general practitioners owe such knowledge as they have of psychopharmacology to drug companies. He implies that a more respectable source would lead to better prescribing. One is less sure when one looks at the available evidence. Johnson supports his assumption by pointing out recent research showing that, in the use of amitryptiline and nortryptiline, a certain critical blood plasma level has to be achieved for the drugs to be therapeutically effective. That is the finding of Braithwaite *et al.* (1972) in a recent study of 15 patients over six weeks. It is a quite different inference from that drawn by Äsberg *et al.* (1971) on 29 patients for two weeks. Porter (1970) did a placebo-controlled double-blind study of the use of imipramine on 60 patients in a general practice in Surrey. Patients were started out on 75 mg a day and, where this was not effective, it was increased to 150 mg a day. The dosage thus was in accordance with what 'most psychiatrists' would approve. He found no evidence that imipramine was superior to placebo in inducing remission from depression. On the contrary, there was slight but not statistically significant evidence that placebo was more effective. Porter points out that between 1958, when imipramine came on the market, and 1970 some 24 placebo-controlled trials were published. Of these, five returned adverse verdicts. The rest were either generally favourable or uncertain. Morris & Beck (1974) in a review of research on anti-depressives from 1958 to 1972, found that of a total of 93 double-blind studies on the use of tricyclics for depression 61, or about two-thirds, considered them to be more effective than placebo. Of 13 such studies of two widely used monoamine oxidase inhibitors, eight found them to be more effective than placebo.

Any physician conscientious enough to sift through the available evidence must be struck by its ambiguity. In talking of physicians I include general practitioners, psychiatrists and doctors in other specialities. Without conclusive proof, and we have no such proof, there is no reason to suppose that the use of drugs as the sole or main therapy is any more successful in the hands

of psychiatrists than in those of other doctors. One has, perhaps, a right to assume that the psychiatrists will be more familiar than other physicians with the results of recent psychiatric research. However, as is obvious from the studies cited above, research findings are so equivocal that one can get support for any point of view about psychotropic medication depending on which studies one reads or which research workers one believes. There are widely divergent and even contrary assessments on the comparative value of different drugs, on the amounts of drugs which should be used, on the length of time necessary for optimum effect and, far more importantly, on whether or not any particular drug is more effective than placebo in treating non-psychotic illness. Considering the variability of the evidence, it is hardly surprising that physicians tend to give credence to such studies as support their own convictions; nor, in a field where the doctor's expectation is likely to influence the patient both directly and indirectly, is it astonishing that our clinical experience tends to confirm our own prejudices. And this is so whether we are against all psychopharmaceuticals or whether we agree with Professor Mills (1974) who suggests, only half jocularly, that we would all be happier if nortryptiline were put in the drinking water.

Rather than argue about the relative efficacy of drugs, let us assume that drugs have at least moderate success in the alleviation of some forms of distress and suffering. We can then go on to the further question of whether or not there are dangers in their widespread and ever-increasing use. I think that there are such dangers and that they are threefold: (1) The increase in iatrogenic disease, (2) the loss of the protective function of unpleasant feelings, (3) the dehumanization resulting from the loss of emotional experience.

The first of these dangers is so well documented that the point need not be laboured. Whitfield's (1972) statement that 'The history of therapeutics abounds with records of drugs thought at first to be wholly innocuous and later shown to have devastating potentialities,' is peculiarly applicable to pharmacology (Johnson, 1972). One need only to be reminded of thalidomide, LSD, the amphetamines, certain monoamine oxidase inhibitors, etc. to realize how willing doctors are to accept exaggerated claims, to forgo long-term trials, and to minimize possible dangers in the treatment of emotional disorders. We seem willing to try anything on our patients. Indeed, it often takes more courage to withhold than to give medication. Let me illustrate:

Peter, a nine-year-old boy, was admitted to a residential school for maladjusted children. His diagnosis was severe behavioural disorder due to post-meningeal brain damage. He had been unmanageable at home and at a day school for ESN children. He came to us on a dosage of chlorpromazine so large that he was asleep most of the time. In his brief, wakeful moments he was hyperactive and indiscriminately aggressive, hitting out at whatever and whomever crossed his path. After a few weeks I suggested cutting out his morning medication to see if he could be kept awake long enough to learn anything. Although this advice caused general concern, it was, rather reluctantly, adopted. It was soon noted that Peter was not only more wakeful but rather less aggressive in the morning than later in the day. Soon after this, and for extraneous reasons, Peter was hospitalized and his neurological state re-evaluated. Because of my letter about his response to chlorpromazine, the final paediatric report advised substituting ritalin. If, after a trial of a few weeks, ritalin proved unhelpful we should change to haloperidol and, if that did not work, to amphetamine.

The staff noted that, while Peter was on ritalin, he seemed less aggressive but rather more bizarre and more infantile than when he had been on chlorpromazine. He was less likely to strike out, but more likely to suck or bite both people and objects.

Before switching to the next drug in the above popular triad, I had the opportunity to go over his complete file which had at last reached us. It was apparent from this that there had been no time, since the original illness at age four, that Peter had not been on some sort of psychotropic medication. How could anyone evaluate a series of drugs without having a base line? It was with serious misgivings that the other people involved in his care, the general practitioner, the teachers, his parents, the child care staff, agreed to what felt like the great risk of taking Peter off all tablets. It was decided that it could only be tried in the secure environment of the school; that it was too much to ask of his parents that they should

not medicate him on his weekends and holidays at home.

The experiment was tried, first at school and later on at home. It is now more than a year since Peter has been on any medication. I cannot say that he has become a normal child. But doctors, the school staff and his parents all agree that he is much improved. He is less aggressive than he used to be and such aggression as he shows is more likely to be the result of provocation or of 'testing the limits' with a new person. He is rather naughtier than he was but also more amenable to ordinary discipline. He has learned to read and to do simple arithmetic, skills once thought to be far out of his reach. He has become less rather than more bizarre.

What seems to me so striking, and so pernicious, about this case was the general assumption that it was more of a risk to try Peter without medication than to put him on one dangerous drug after another, dangerous in the sense that every one of them is known to have unpleasant and sometimes serious side-effects.

This problem of iatrogenic disease is becoming increasingly urgent. According to a report in *World Medicine* (1973) drug-induced disorders account for 5–10 per cent of hospital admissions in the EEC countries, as well as in Switzerland and the United States. Psychotropic drugs, often prescribed for their usefulness in preventing suicide, are more and more often being used as the agent in suicidal attempts (Hershon, 1968; Lawson & Mitchell, 1972).

The second group of dangers is less obvious and more controversial, that of losing the protective function of unpleasant affect, especially anxiety and depression. These horrid sensations are not often thought of as protective, but I think they can be perceived as comparable to physical pain in connexion with injury or bodily illness. In prescribing analgesics physicians are taught to discriminate between pain which has a useful function and pain that is excessive and/or superfluous. To prescribe analgesia for the occasional headache, muscle pain or toothache is not unreasonable. To prescribe it regularly for such chronic conditions would be bad medical practice, not only because of the side-effects of the medication but because elimination of the pain might prevent discovery of the underlying pathology. The protective value of pain is, of course, most easily demonstrable in those illnesses such as tabes or syringomyelia where the absence of pain is a prominent feature. In such diseases minor injuries occur more frequently and are far less likely to heal because, without the warning sensation of pain, the patient will be unaware of the need to protect a small lesion from further insult and progression to serious infection. I suggest that suffering which, like physical pain can need relief if it is excessive or superfluous, has analogous value to pain in enabling man to cope with environmental and psychological stress.

If we return now to the example quoted earlier, we will recall that the student's anxiety, although disagreeable, had not been crippling, nor had it been more than he felt he could endure. What would have been its natural history in the days before the advent of anxiolytic drugs? He might have suffered rather more, but he might also have learned that taking appropriate action, such as studying, would have lessened his suffering. When the crucial test was imminent the physiological concomitants of anxiety, the increased blood pressure and heart rate and the speeded-up metabolism would have taken over, providing the energy required for maximum performance. Once action, in this case sitting the examination, had begun the sensation of anxiety would have disappeared. What he would have gained from having lived through his anxiety would have been an increase in performance and in self-confidence and an enhanced ability to face future tests. I am not, of course, talking about that small minority whose anxiety is so neurotic that they are unable to endure or eventually to benefit from it. Drug treatment, especially if psychotherapy is not available, may be helpful in enabling this small group to tolerate stress. What they will have learned from this experience, however, is a lessening in self-confidence and the likelihood that, as time goes on, they will need more and more medication for smaller and smaller crises. To put it in more analytic terms, such a student will have survived the crisis with lessened rather than enhanced ego strength.

One need not, however, be analytically orien-

ted to appreciate the importance of living through rather than of evading anxiety. Kurt Goldstein, a distinguished neurophysiologist of an earlier generation, was bitterly opposed to Freudian, or other psychoanalytic theory. In his book, *The Organism* (1939), he emphasizes the importance of anxiety, which he sees as a kind of shock occurring whenever a person is confronted by a task which seems essential for existence and with which he cannot immediately cope. The normal person undergoes such shocks over and over again in his encounters with the environment, continually learning to reduce anxiety by action and thus enabling him to accomplish his 'twin tasks...conquest of the world and...self-realization'.

Irving Janis, a contemporary social psychologist with a more 'down to earth', behavioural approach comes to rather similar conclusions in his book on stress (1958). He sets out to test the hypothesis that worrying serves a useful purpose as a method of dealing with anticipated trauma. His research concerned a group of patients in hospital for major surgery. Intensive interviews were conducted before and after surgery. He found that those patients who showed moderate anxiety in the pre-operative period were far better off emotionally in the post-operative period than those who had not experienced overt anxiety. That is, those patients who gave themselves the equivalent of a trial run in experiencing the pain, the fear, the loss and the physical limitations in anticipation were better able to handle these feelings and events when they actually occurred. Those, however, who showed excessive anxiety were equally, but not more disturbed than those who had shown no anxiety.

The findings of Stacey *et al.* (1970) in a study of hospitalized children lend support to the view that anxiety can be useful. The subjects in this study were three-year-old tonsillectomy patients, and their mothers. They too were studied both pre- and post-operatively. It was found that the children whose mothers had been moderately anxious before surgery showed fewer symptoms of maladjustment after the event than either the children of mothers who had shown no anxiety or the children of mothers who showed excessive anxiety. There is supporting evidence then that what Janis calls 'the work of worrying' (p. 375) is useful in dealing in anticipation with at least one sort of traumatic situation, that of a surgical operation. One can, however, think of many other examples, situations where a certain amount of anxiety is helpful or even essential in order to survive in a dangerous world. The child who has not experienced anxiety about possible consequences is unlikely to exercise due caution in walking near a river, or across railway tracks, in putting things in his mouth, in crossing the road.

These examples may seem as self-evident as they are banal. What I want, however, to focus on is the role of subjective feeling in the development of a person's sense of himself in relation to the rest of the world. And, from the first pangs of hunger onward, the unpleasant feelings are quite as important and at least as instructive as the pleasant ones. Children tend to express these feelings more simply and directly than adults. We no longer teach them that such expression is wrong, that it is almost as 'naughty' to express feelings of fear, anger, envy, jealousy as it is to act on them. There is a general acceptance of at least that part of Freudian doctrine which teaches that suppression of bad feelings does not do away with them but only drives them underground to reappear in other forms such as neurotic symptoms.

And yet as physicians we cursorily prescribe medicines to great numbers and all manner of patients, medicines which chemically alter, distort and, more especially, stifle feelings. It is sometimes said that medication makes patients more amenable to psychotherapy. In my experience it merely makes them more amenable. In psychotherapy one works primarily with feelings. Whatever one's theoretical stance and however much controversy there may be about the as yet unsolved problem as to exactly what is therapeutic about the 'therapeutic relationship', no one who has experienced it as either therapist or patient would deny the importance of engaging the emotions. Intellectual understanding can be interesting and intriguing but it does not lead to personality or behavioural

change. Some patients, in order to make life bearable, have found their own neurotic or psychotic devices for stifling feeling. Such patients cannot be helped by psychotherapy unless and until the emotional barrier can be broken down. Attempted psychotherapy with a patient whose feelings are dulled is a sterile exercise; and the fault is not entirely in the patient.

My own interest in this subject was aroused when I found myself unable to respond, on an emotional level, to certain patients whom I liked and respected. I have now learned that when there seems an unbridgeable distance between me and a non-psychotic patient it is wise to ask whether he or she has been on long-term medication. Sometimes such medication is so taken for granted that neither the patient nor the referring doctor has thought it worth mentioning.

Miss K., for example, was an admirable young woman. Attractive and intelligent, she had overcome serious obstacles in becoming educated and in entering a useful profession. I should have expected my initial liking to have deepened and yet, after three months of therapy, I felt no closer to her than I had at our first appointment. One day she told me of an appalling incident that had occurred on her fourth birthday. She related it, however, so blandly that I felt less moved than if I had read about it in a newspaper. I pointed out that she had left something out of her story, i.e. the feelings that belonged to it. She replied, with a little smile, that some years back she would have been unable to keep back the tears. But that was before she had learned about Librium and Tofranil. She had been taking what is 'generally considered' an optimum dose of both of them for the past three years.

It was not easy to persuade this 25-year-old girl first to cut down and later to cut out her medication; but it was not until she had done so that she began to express feelings in her therapy hours and to begin to make progress with the problem for which she had sought help. That problem, appropriately enough, was sexual frigidity.

For the patient who seeks help not like this one for a particular neurotic problem but in order to cope with the traumas of ordinary life, medication can sometimes undermine confidence and interfere with the chance of resolving difficulties in a constructive way. Let us return now to the second example, that of the widow given Tryptizol to allay her grief. For it is nowhere so clear as in the case of mourning that we can harm ourselves by an unwillingness to put up with suffering. The very word mourning is out of date in ordinary parlance. People are not supposed to mourn. Even at funerals one sees few tears. The bereaved are praised for being 'brave' in not showing distress, presumably because to do so would embarrass other people. Gorer (1965) in an introduction to his book on death and mourning, describes poignantly a death in his own family. He tells how, soon after the death of his brother, he refused an invitation to a cocktail party, explaining that he was in mourning. He was made to feel that he had committed a social sin. 'The people who had invited me responded to this statement with shocked embarrasment as if I had voiced some appalling obscenity...I suspect they were frightened lest I give way to my grief, and involve them in a distasteful upsurge of emotion' (p. 14). And yet thirty years have elapsed since Lindemann (1944) wrote his now classical paper on the effects of bereavement. It will be remembered that his study was based on 101 people who had been recently bereaved, including 13 close relatives of persons who had been burned to death in a Boston night club. He found that those people who were able to mourn in the weeks immediately following the event were in a far better psychological state later on than those who had been unable or unwilling to give vent to their grief. Parkes (1972) came to a similar conclusion in his study of 44 London widows. Deutsch (1937) in a paper entitled 'Absence of grief', discusses the history and pathology of four of her analytic patients each of whom had been unable to mourn the death of a parent. She concludes that it is essential, for normal development in a child and for emotional health in an adult that 'the process of mourning as reaction to the real loss of a loved person *must be carried to completion*' (her italics). Deutsch's concern in this paper is to explore the fate of the unexpressed grief. Lindemann and Parkes are more interested in the related problem of the distinction between normal and pathological mourning. These can be difficult to distinguish

because of the many ways in which clinical depression seems to mimic ordinary mourning. It was Freud (1917) who first called our attention to this similarity in *Mourning and Melancholia*; and Freud, too, who emphasized the importance of the 'work of mourning'. His dictum that this is a task that must be 'carried through bit by bit, under great expense of time and cathectic energy' (p. 154) has not been superseded. It has, in fact, been repeatedly confirmed by other students of human behaviour, some of whom have deepened and expanded our understanding of the normal mourning process and also of its various pathological forms.

Bowlby (1961) has analysed mourning in terms of the paradigmatic experience of loss (usually only temporary absence) of the mother in early childhood. He describes three overlapping stages of mourning: the first is one of shock, yearning and despair; the second of disorganization and depression; the third of reorganization in which the loss is gradually accepted and new adaptation is made. Concerning the second stage, the one in which anti-depressants are so often described, Bowlby says: 'Since the patterns of behaviour which have grown up in interaction with the lost object...have ceased to be appropriate, were they to persist they would be maladaptive; only if they are broken down is it possible for new ones, adapted to new objects, to be built up. Although such disorganization is painful...it seems clear that it is an indispensable preliminary to new adaptation...Although unwelcome such phases are a necessary part of being alive' (p. 335).

Pollock (1961), like Bowlby, is mainly concerned with mourning as an adaptive process, seeing it as essential in order to integrate the experience of loss and to enable 'life activities' to go on.

Parkes (1972) in his brilliant and comprehensive book on bereavement, utilizes a number of earlier studies of cohorts of bereaved persons. He draws attention to the crucial reciprocal relationship between the bereaved individual and the society in which that individual must often find a new role. He too emphasizes the importance of the bereaved person's being able to express his grief; and the corollary importance of society's willingness and ability to accept such expression.

The mounting evidence on the need to mourn has not, however, had any modifying influence on our society's increasing reluctance to tolerate it or to think of it as other than aberrant. This reluctance is well illustrated by a paper on depression by Bornstein *et al.* (1973). A group of widows was interviewed one month and again 13 months after bereavement. On the basis of their answers to specific questions they were divided into two groups, those who were and those who were not depressed. To be classified as depressed the widow had to say that she felt sad and, in addition, had to have any four of eight other symptoms: loss of appetite, fatigue, insomnia, restlessness, loss of interest, feelings of guilt, difficulty in concentrating, and suicidal thoughts. Interestingly enough all but the last of the above symptoms are included in Lindemann's description of normal grief. All are described and poignantly illustrated by Marris (1958) in his study of 72 'unselected' London widows. And here, although suicidal thoughts are not mentioned as such he quotes several such remarks as: 'I didn't even cook myself a bit of food. I wouldn't care if I died tomorrow'; 'I wouldn't care if a bomb fell on the house' (p. 17). And yet, in Bornstein's study the group of widows who had less than four of the above symptoms, even after only a month, are labelled the *well* group, as compared with the *depressed* group. Might one not look at it the other way around? Might one not consider that the woman who did not feel sad and who did not have symptoms of depression in the year following her husband's death was not well but either pathologically inhibited or else callous and insensitive? If one lives in a society where one is expected to react to bereavement in an emotionally neutral way most people will try to conform. They will do so even if it means using such neurotic defences as denial and repression, defences which, in so far as they are successful, result in delayed, distorted and displaced grief reactions, or else in a generalized restriction of the personality. Another alternative is, of course, that they continue to live out their lives on

anti-depressants which dull their senses and often their capabilities. Rather than accept the fact that the death of a loved one is a personal disaster, one from which it takes time to recover, we are willing to turn ourselves and our patients into automata. The capacity to suffer for other than physiological trauma is one of the distinguishing traits of humanity, or at least of the higher mammals (although some ethological studies cast doubt even on this assumption (Lorenz, 1952; Bowlby, 1961)). That it is inhuman not to suffer is implicitly recognized in descriptions of the kind of disorder formerly called 'psychopathic personality'. Although other labels such as 'personality disorder' are now more commonly used, the disorder has not changed. A dictionary definition reads, 'Pathological development in personality structure with little or no anxiety or sense of distress' (English & English, 1958). These are people who have no deep bonds with their fellows. Whether their incapacity to feel anxious or distressed is considered psychopathic, psychotic or defensive their lack of feeling precludes any but the most superficial relationships. And yet, according to the dictionary, it is only unpleasant feelings of which they are incapable. I think it is tacitly understood that people who lack the capacity to feel sad or anxious must also lack the capacity to experience warmth, sympathy, love, those feelings which attach us to others.

And it is the same with drug-induced curtailment of feeling. Even the most selective drugs cannot cut down 'bad' feelings without also cutting down 'good' feelings. Moreover, in relieving, or perhaps we should say in depriving, people of the experience of suffering we also deprive them of the chance of facing and coming to terms with reality. Parkes writes, 'The pain of grief is just as much a part of life as the joy of love; it is perhaps the price we pay for life, the cost of commitment' (1972, pp. 5–6).

There are, of course, times when the cure is not worse than the disease, times in the lives of some people when their suffering is more than they can bear. At such times medication can be helpful. But where it is continued, not to get over a crisis but for months or years or even indefinitely, the drugs, in so far as they are effective, tend to create people who do not feel deeply or, to put it more accurately, people who are alienated from their feelings. The end result is that artificial flattening which I have called the 'anti-depressed personality'.

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