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Critiquing the Critique: Resisting Commonplace Criticisms of Antidepressants in Online Platforms

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Abstract

Critiques of antidepressants in public spaces such as print media, blogs, social media, websites, and radio and television programs are now commonplace. Such critiques typically center on issues such as the side effects and risks of antidepressants, overblown claims of effectiveness, the fallacy of the chemical imbalance hypothesis, overprescribing, and the availability of equally or more effective nonmedication interventions for depression. In this article, we employ a discursive analysis to show how online commenters fashion a particular counter-argument to these critiques. Prominent in this counter-argument is that only "real" depression benefits from antidepressants, and that a "one-size-does-not-fit-all" understanding of these medications is needed. We argue that, while this nuanced counter-critique contains features that make it difficult to undermine, it simultaneously embeds many unanswered questions.

Keywords

antidepressants; counter-critiques; depression; discursive psychology; online comments; qualitative

Antidepressants are among the most widely prescribed and used medications in many industrialized countries. Canadians and Americans, in particular, are among the world's largest consumers of this class of medications. In a 2020 report from the Organisation for Economic Co-Operation and Development (OECD), Canada ranked second in the world in its daily per capita use of antidepressants, behind only Iceland. Data from the National Health and Nutrition Examination Survey also indicate that antidepressants are among the most frequently used medications in the United States (Martin et al., 2019). Both of these countries show a similar trend over the past couple of decades: a rapid increase in use in the early part of the century, followed by a leveling off for a few years and then a subsequent increase (Brody & Gu, 2020; OECD, 2020).

Components of the Critique

A popularized narrative about the use of antidepressants to treat depression is that they are safe, effective, and work according to the chemical imbalance hypothesis, that is, by altering the neurochemistry of the brain (Deacon & Spielmans, 2017). However, in the late 1990s and the first two decades of the 2000s, concerns (such as those listed below) surfaced in the research literature concerning antidepressants and their use to treat depression (e.g., Healy, 1997; Kirsch, 2010). In addition, these concerns have been reproduced as stories in mainstream newspapers, in interviews that have aired on radio and television programs, and as blogs and posts on social media.

Negative Side Effects and Difficulty Discontinuing Antidepressants

Negative side effects of using antidepressants have been documented in the research literature for years. These side effects include insomnia; drowsiness; dry mouth; excessive sweating; dizziness; sexual dysfunction; gastrointestinal distress such as nausea, vomiting, and diarrhea; and weight changes (e.g., Bet et al., 2013). While newer antidepressants such as selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs) are thought to have better tolerability than older versions such as tricyclic antidepressants (TCAs), the reporting of side effects from the use of newer versions continues (e.g., Wang et al., 2018). This link between antidepressant use and negative side

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effects has also been taken up in other spaces, such as in articles on websites (e.g., "Antidepressants Carry Weight Gain Years Into Treatment"[1]; "What's the Harm in Taking an Antidepressant?") and in blogs affiliated with national newspapers (e.g., "Why We're Afraid of Antidepressants—Even When We Take Them").

However, despite the existence of negative side effects, discontinuing antidepressants also presents problems. What has been labeled "discontinuation syndrome" by pharmaceutical companies can include symptoms such as sleep disturbance, gastrointestinal problems, flu-like symptoms, balance problems, brain "zaps," and agitation (Renoir, 2013). Fear of experiencing such symptoms has the potential to result in long-term use of antidepressants that, in some cases, might not be warranted (Leydon et al., 2007). In addition, despite not being addictive, difficulty in discontinuing antidepressants has been compared with nicotine withdrawal and has spawned headlines such as "Antidepressants—The New Tobacco."

Overprescribing and Overuse of Antidepressants

Increasing rates of prescribing and using antidepressants have led to concerns that this medication is being overprescribed and overused. Two explanations for what is seen as the overprescribing and overuse of antidepressants are typically cited in the research literature and in popular media. One explanation is that antidepressants are often prescribed and used off-label, that is, outside of their approved indications, including for conditions such as migraine headaches, diabetic neuropathy, fibromyalgia, and premature ejaculation (Stone et al., 2003). A second explanation is that antidepressants are prescribed too readily for what could be deemed mild to moderate depression or even for problems that are closer to normal sadness, despite there being little evidence of their effectiveness (Horwitz & Wakefield, 2007). Such concerns have been reproduced in newspaper articles with headings such as "A Pill's No Cure for the Summertime Blues" and have led to antidepressants being publicly constructed as "almost becoming the antibiotic of this century" (see Kirkey, 2017, in Supplemental File).

Antidepressants Are, At Best, Only Modestly Effective

A long-standing concern about antidepressants is that claims of their effectiveness are overblown. For example, in a review of research studies, Moncrieff (2007) concluded that there is no empirical evidence that antidepressants have a clinically significant effect and that they reverse the complex and diverse problems associated with depression. From a more recent assessment of reviews of the effects of antidepressants, Jakobsen et al. (2020) again concluded that, while antidepressants appear to produce statistically significant effects on depressive symptoms, their clinical significance is minimal. These authors cited shortcomings in the evidence produced by clinical trials, including the use of outcome measures of low clinical relevance, the risk of bias due to the reliance on industry-sponsored research, and low generalizability. Such concerns have been echoed in the popular press in articles with titles such as "Antidepressants Don't Work as Well as Reported, Study Says" and "Antidepressant Meta-Analyses Biased by Industry" in which the validity of the conclusion that antidepressants are highly clinically effective was challenged.

Antidepressants Work Not According to the Chemical Imbalance Hypothesis, but as Placebos

Although the notion that depression is caused by a chemical imbalance in the brain, specifically from a deficiency of serotonin or norepinephrine, has been widely promulgated, critics argue that this understanding of depression began as, and remains, an unsupported hypothesis. For example, Wong and Licinio (2001) wrote that there are "serious gaps and limitations in the monoamine hypothesis" (p. 347) and pointed to research indicating that there is increased (not decreased) norepinephrine output in depression and that antidepressant drugs affect neurotransmitters within hours but that treatment of depression takes weeks. In addition, the search for a biological marker of depression, such as depleted monoamines or a defective serotonin or norepinephrine system, has remained elusive. Concerns about the validity of the chemical imbalance hypothesis—both as an explanation for depression and for how antidepressants work to alleviate depression—have appeared on websites and in newspaper articles under titles such as "Depression: It's Not Your Serotonin" and "Do 'Happy Pills' Work Like People Say?" and have led to public claims that this hypothesis is not only a gross oversimplification but a myth introduced by pharmaceutical companies as a strategically planned marketing campaign (see Pies, 2011, in Supplemental File).

Suspicion of the chemical imbalance "explanation" of depression raises doubts as to the mechanisms of effect of antidepressants. If there is no definitive evidence that depression is caused by a chemical imbalance in the brain, how, then, can or does a medication which is said to target this imbalance work? Kirsch et al. (2008) concluded on the basis of analyzing data from published and

unpublished clinical trials that drug–placebo differences in antidepressant efficacy are relatively small, even in the case of persons suffering with severe depression. In a subsequent televised interview, Dr. Irving Kirsch again stated that the difference between the effect of the placebo and the effect of the antidepressant is quite minimal for most people, and that taking the medication itself creates a powerful expectation of healing that actually alleviates depressive symptoms. Reports of this conclusion also appeared in a magazine under the heading "Are Antidepressants Just Placebos With Side Effects?," in a newsletter from a professional organization as "Placebo Duplicates Antidepressant Effects for All but the Most Severely Depressed," and on a website as "Antidepressants Can Work, but Only if You Believe They Will."

Nonmedication Alternatives Are Equally or More Effective than Antidepressants

As concern over the use of antidepressants has mounted and their effectiveness has been challenged, several alternative options for treating depression have been promoted in the research literature and in public fora. These options typically include psychotherapy, exercise, and changes in diet. Cognitive-behavioral therapy (CBT), in particular, has been extensively empirically researched and promoted as an equally effective alternative to taking antidepressants (Gartlehner et al., 2016). Similarly, exercise has also been found to reduce symptoms, and to be as effective as psychotherapy or antidepressants, particularly in cases of mild to moderate depression (e.g., Netz, 2017). Research on dietary interventions (e.g., increasing the intake of healthy foods) has also provided evidence of the reduction of symptoms of depression (Firth et al., 2019). Such empirical findings have been readily translated as reports and commentaries in a variety of media. For example, articles on nonmedication options for treating depression have commonly appeared in mainstream media and on websites and blogs under headlines such as "New Study Shows Mindfulness Therapy Can Be as Effective as Antidepressants," "Can Your Diet Shape Your Mental Health?," and "Exercise Can Be a Very Effective Way to Treat Depression. Why Isn't It Prescribed?"

Present Study

Given the extensive and very public critiques of antidepressants that have appeared over the past few decades, it is not surprising that empirical accounts of decision making as to whether to begin a course of antidepressants or to stay on antidepressants, as well as experiences of using an antidepressant, are replete with dilemmas, contradictions, and paradoxes (see, for example, Garfield et al., 2003; Grime & Pollock, 2003; Liebert & Gavey, 2009; Malpass et al., 2009; Verbeek-Heida & Mathot, 2006; Wills et al., 2020). However, in comparison with the research on what people have to say about their decision-making processes and experiences with using an antidepressant, we know little about how they counter the very public critiques of antidepressants. In recent studies, Ridge et al. (2015) argued that antidepressant users often engage in a process of legitimizing their use of this medication, typically alone and while distressed, and Hughes et al. (2020) contextualized users' public reviews of antidepressants in terms of the macro-landscape of conflicting research evidence and powerful interests of the pharmaceutical industry. We sought to bring these two foci together by investigating how people publicly counter critiques that threaten to delegitimize the popularized narrative that antidepressants are safe, effective, and work according to the chemical imbalance hypothesis.

Methodology and Methods

Methodology

We adopted the methodology of discursive psychology (Wiggins, 2016), which is a way of analyzing and conceptualizing language with an emphasis on what talk is doing and achieving (Wood & Kroger, 2000). With this approach, we analyzed what people were saying online in response to critiques of antidepressants that appeared in mainstream media and online, how they were saying it, what social actions they were performing, and the possible implications of such actions. In particular, we paid attention to how people structured counter-arguments to the critiques and to the strategies they employed to limit the possibility of these counter-arguments being undermined and to enhance their persuasiveness.

Methods

Data collection. We conducted an online search for print media articles, public interviews, blogs, websites, and Facebook posts that contained critiques of antidepressants. Sources relevant to our focus included articles published in local, national, and international newspapers; stories in magazines; interviews aired on television or radio; blogs affiliated with newspapers; and personal blogs and websites. Data relevant to our focus on these critiques were derived from the comment sections attached to these sources. On the Facebook platform, Erin Sthamann used the website's search engine to find public posts critiquing antidepressants. While Facebook posts include a comment section where users have the ability to write responses to the critique, most users attached a website link in their post which redirected people to an

online article critiquing antidepressants. These online articles often included a comment section that served as another source of potential data.

Erin Sthamann read all entries in the comment sections from these relevant sources and then identified and selected only those responses that were clearly counter-critiques, that is, arguments that were counter to those in the source. The initial selection of counter-critiques was reviewed by Linda M. McMullen which resulted in only one comment deemed irrelevant to our focus. In total, we collected 145 counter-arguments from 37 sources, which resulted in 38 single-spaced pages of data. All data sources were published between 2009 and 2019, with 84% appearing between 2014 and 2019.

Although the data we present in this article are in the public domain (and our project was deemed exempt from review by our University's Research Ethics Board), we have endeavored to lessen the ease with which our data sources and commenters can be identified by omitting the sources of the data and the names used by the commenters from this article. Our data sources are included in the Supplemental File.

Data analysis. After selecting comments from the data set that we deemed relevant to our focus, we read the selected material several times and continually asked ourselves how these counter-critiques were being constructed, what commenters were doing in their responses, and what the consequences and implications were of what was being done. We relied on several analytic strategies such as considering how the comment was structured, being alert to multiple functions and variability, and adopting a comparative and questioning stance (Wood & Kroger, 2000). Throughout the analysis, we focused on how commenters employed discursive devices in the online posts (e.g., extreme case formulations, qualifiers) and strategies (e.g., defensive rhetoric), and to what ends. Specifically, we isolated linguistic devices and strategies that commenters used to construct key notions such as depression and antidepressants and to formulate their arguments and defend against the critiques, and then made claims about the social actions being performed, that is, what people were doing with language (e.g., positioning themselves, blaming, justifying), and the possible consequences of the counter-arguments.

Analysis

In this article, we focus on one particular pattern of qualified and nuanced argumentation that was evident in our data—that the use of antidepressants is justified in cases of "real" or serious depression and is not "one size fits all."

Negative Side Effects and Difficulty Discontinuing Antidepressants

How do people counter the critique that antidepressants are known to produce negative side effects and other health risks and that discontinuing their use can actually produce some of the same symptoms they are designed to eliminate? One way that commenters justify their decision to start using, or to continue to use, antidepressants is by constructing the state of their suffering and/or the outcomes from having taken antidepressants in extreme terms. For example, commenters use terms and phrases such as "horrible," "hideous," "horror," "torture," and "cannot physically do anything" to characterize their depression, and, conversely, phrases such as "saved my life" and "life changing" to characterize the outcomes from using antidepressants. Such words and phrases were sometimes used in the context of commenters constructing a risk–benefit analysis as a way to counter this critique, as is evident in Extract 1, which is in response to a blog on the fears of taking an antidepressant:

Extract 1:

> After years of hesitation, the weight of my suffering all at once seemed heavier than the weight of all my doubts combined. Although I was aware of the many health risks, I knew I would continue to suffer and I felt as though I had nothing to lose. I felt as though I was already hit rock bottom. I was very accepting (to begin antidepressant treatment), it was just an overall battle to keep going each day, a struggle.

In this extract, the commenter employs extreme terms ("nothing to lose," "hit rock bottom," "just an overall battle to keep going") in the context of personal testimony to justify their decision to start using antidepressants in the face of this critique. They also construct themselves as an informed and knowledgeable decision maker ("Although I was aware of the many health risks") who has engaged in a nonrash ("After years of hesitation") risk–benefit analysis ("The weight of my suffering all at once seemed heavier than the weight of all my doubts combined"). In so doing, the commenter acknowledges the critique regarding "health risks" and builds a nuanced and credible counter-critique: In extreme cases, and after having assessed the possible benefits as outweighing the risks, the taking of antidepressants can be justified.

A similar use of extreme terms and invoking of risks versus benefits was evident in a response to a story on the difficulties associated with discontinuing antidepressants:

Extract 2:

> After reading a number of comments, I feel compelled to comment myself. I took antidepressants for about 7 years. When I thought I didn't need them, I weaned myself off

> them slowly on my doctor's advice. No discontinuation syndrome. Then I spent two years being extremely irritable and angry, with no appetite, incapable of managing my emotions and having occasional suicidal thoughts. I am happy with my decision to begin taking them again, despite all the judgement from holier-than-thous. Antidepressants are certainly not for everyone. But many of us who take them do so because the benefits far outweigh the risks.

In this extract, the commenter also casts their suffering while not taking antidepressants ("*extremely* irritable and angry," "*no* appetite," "*incapable* of managing my emotions"; emphasis added) and the outcome of taking antidepressants ("benefits *far* outweigh the risks"; emphasis added) in extreme terms, and presents themself as a responsible actor who followed recommended practice ("When I thought I didn't need them . . . on my doctor's advice"). The short declaration "No discontinuation syndrome" serves both to show that the commenter is aware of the critique regarding symptoms that can occur from discontinuing antidepressants and to summarily dismiss it in their case. In addition, they make a nuanced "Yes, but" statement ("Antidepressants are certainly not for everyone. But . . .") in which they acknowledge and then counter the critique in a qualified way ("many of us"), thereby lessening the possibility that the counter-critique will be taken as extreme and not justifiable. This commenter also makes explicit the social consequences ("all the judgment from holier-than-thous") of taking antidepressants in the context of critiques about their safety. What Extracts 1 and 2 suggest is that one way to reduce the judgment produced by deciding to take, or to continue taking, antidepressants given their negative side effect and risk profile is to cast one's suffering as extreme and to show oneself as being cognizant of the critique and as having conducted a risk–benefit analysis to arrive at a reasoned decision.

Overprescribing and Overuse of Antidepressants

Counter-critiques to the criticism that antidepressants are overprescribed and overused took a variety of forms, but common to many of the online responses was the proffering of explanations for these trends. In the following extract (edited for length), the commenter responds to a blog post in which the author makes claims that depression is overdiagnosed and antidepressants are overprescribed. Here, the focus is on invoking the diagnostic criteria for depression as a possible explanation for what is constructed as the overuse of antidepressants.

Extract 3:

> I'm puzzled by the judgmental and almost puritanical tone used by so many in disparaging the use of SSRIs to treat depression . . . I work as a psychotherapist and have seen these drugs both work spectacularly and fail miserably. (I cannot prescribe so I am not involved in that process.) Medication is a complicated issue and one size does not fit all, but these drugs can, and do, help some people out of a rut, over a hump . . . . Perhaps the fault, if there is such a thing, lies in the diagnostic criteria itself and not in the treatment . . . [These pills] are a tool, nothing more and nothing less. Sometimes, they are useful, even dramatically so, and they can improve the lives of many who do not "fit" the necessary diagnosis. What's wrong with that?

By claiming the identity of a psychotherapist who "cannot prescribe" and as someone who has "seen these drugs both work spectacularly and fail miserably," this commenter positions themself as an unbiased arbiter of firsthand evidence regarding the range of effectiveness of antidepressants and as not having a professional stake in the argument about overuse. Here again is the use of extreme terms ("work *spectacularly* and fail *miserably*") to construct the outcomes of using antidepressants. In this case, however, both negative and positive outcomes are cast in these terms. Doing so can work to establish the wide range of possibilities from the use of antidepressants and can provide a basis for the nuanced construction of medication as "a complicated issue" where "one size does not fit all." As in Extract 2, the qualifying of outcomes ("these drugs can, and do, help *some* people"; emphasis added) can also work to enhance the reasonableness of the commenter's argument and reduce the ease with which it can be undermined as being extreme. The crux of the counter-critique is that the overuse of antidepressants might be explained by the diagnostic criteria for depression. Although the commenter is not explicit about what is problematic with these criteria, the claim that antidepressants "can improve the lives of many who do not 'fit' the necessary diagnosis" focuses their argument on the mismatch between diagnostic criteria and potential benefits from using antidepressants.

The commenter's counter-critique is bookended by the opening declaration ("I'm puzzled by the judgmental and almost puritanical tone . . . to treat depression") and by the rhetorical question at the end ("What's wrong with that?"), which frame the argument in-between as a moral counter-point to the critique about overdiagnosis of depression and overuse of antidepressants. In addition, the commenter explicitly references "fault," but then immediately casts doubt on this notion ("if there is such a thing") as applying to the use of antidepressants. Constructing antidepressants as "a tool, nothing more and nothing less" further serves to emphasize their pragmatic utility over their moral currency.

Antidepressants Are, At Best, Only Modestly Effective

Public critiques of what are sometimes characterized as overblown claims of the effectiveness of antidepressants typically occur in the context of media reports of empirical studies in which the authors conclude that antidepressants are ineffective or, at best, only modestly effective. Counter-critiques in this context question the validity of such studies and their applicability to practice, as in the following two extracts.

Extract 4:

> Personal experience is that this study is flawed. Some antidepressants work wonders, though each uses different mechanisms and each are not equally effective on all patients. Also, perhaps the patients where the medicine did not work didn't have clinical depression to begin with?

In this extract, the commenter alludes to "personal experience" as the basis for warranting their counter-critique, in this case that the study cited in the newspaper article "is flawed," the implication being that its conclusion that the effects of antidepressants are mostly modest is, therefore, suspect. Although the commenter presents no details on how this "personal experience" warrants their claim, they make a declarative pronouncement about the effectiveness of antidepressants that is highly qualified ("*Some* antidepressants work wonders; *each uses different mechanisms; each are not equally effective*; on *all* patients"; emphasis added). In opening a space for so many possibilities, such a nuanced construction of antidepressant effectiveness is difficult to undermine. The last sentence of the comment provides one possible answer to what about the study might be "flawed," that is, some patients in the study might not have had "clinical depression," the implication being that it is only in these cases where antidepressants work.

Other respondents add to the counter-critique regarding the applicability of conclusions reached from research studies by contrasting such studies with what is constructed as actually transpiring in clinical practice. For example, in response to an online article in which the author makes claims that antidepressants are ineffective, one commenter says the following:

Extract 5:

> A couple of problems with this argument: studies look at average effect sizes, meaning that individually, some will have less effect than whatever is represented by the average and some will have more. Additionally, each study generally only involves one antidepressant. In real practice, different antidepressants have different effects and often it is not the first choice that it [*sic*] found to have the clinically satisfactory effect. It is evident from clinical practice that antidepressants help some people in a clinically relevant way—it's not all placebo.

In this case, the commenter uses the title of "Dr." which can carry a self-proclaimed position of authority from which to speak about the effectiveness of antidepressants. The first two sentences in this extract serve not only to explicate the "problems" with the argument in the article but to set up the contrast between research and clinical practice that follows. In differentiating research that relies on average effect sizes and that uses only one antidepressant from what is constructed as "real practice," the commenter is able to cast doubt on the applicability of the former for the latter. Once again, antidepressants are constructed in nuanced terms ("different antidepressants have different effects"). In addition, in "real practice," the use of antidepressants might involve some trial and error ("often it is not the first choice that it [*sic*] found to have the clinically satisfactory effect"), a contingency that would not typically be found in research. The pronouncement that clinical practice produces evidence ("It is evident from clinical practice") places such practice as a source of knowledge. In addition, as seen in previous extracts, the commenter not only presents a qualified take on effectiveness ("antidepressants help *some* people in *a clinically relevant way*—it's *not all* placebo"; emphasis added) but also acknowledges the critique regarding mechanisms of effect and does not rule out the placebo response as an explanation for some instances of effectiveness. Such discursive moves have the potential to cast the commenter as speaking from an informed and reasonable position.

The arguments in these extracts challenge the conclusion that antidepressants are, at best, modestly effective by implying that the research upon which this conclusion rests might not have included appropriately diagnosed cases of depression and that clinical research does not mimic clinical practice. Specifically, they keep space open for the particularized and nuanced use of antidepressants to produce effectiveness.

Antidepressants Work Not According to the Chemical Imbalance Hypothesis, but as Placebos

Antidepressants have been purported to work by restoring the levels of neurochemicals in the brain. This widely reported hypothesis now has the public status of an explanatory theory and to suggest that it is inaccurate or largely discredited is often taken as undermining the status of depression as an illness and the very foundation of the use of antidepressants to treat depression. In the

following extract, which comes in response to an online article, a commenter's rejection of the premise that this hypothesis has been de-bunked is justified by constructing a case for particularity and uniqueness:

Extract 6:

> The article says, "if depression was due to a chemical imbalance, then increasing the levels of chemicals in the brain would make us all get better." But this isn't rational. You can't lump everyone together, everyone is different and each antidepressant affects the brain differently. There is no "one pill fits them all" answer.

In this extract, the commenter frames their counter-argument as a rebuttal to what is presented as a direct quote from an article ("if depression was due to a chemical imbalance . . ."). The totalizing form of the critique about the chemical imbalance hypothesis in this quote (". . . make us all get better") serves as fodder for the commenter's counter-critique. By constructing each person as "different" and "each antidepressant as affect[ing] the brain differently," the commenter can open up the possibility that the chemical imbalance hypothesis might still be operative in certain cases. That is, if "no 'one pill fits them all,'" then the reason a person might not benefit from an antidepressant is not that the chemical imbalance hypothesis is necessarily incorrect but rather that the right antidepressant for a particular person has not been found.

In our data set, most of the counter-critiques of claims that the effects of antidepressants, particularly for mild to moderate cases of depression, are due not to the restoration of a chemical balance in the brain but to the placebo effect were voiced in response to interviews with Dr. Irving Kirsch. As part of these counter-critiques, commenters use powerfully evocative terms and phrases to characterize the message (e.g., "garbage," "madness," "*** and bull story") and its consequences (e.g., "reckless," "insulting"), to discredit the messenger (e.g., "[has] not experienced real depression," "full of shit," "quack"), and to criticize the decision to air the interview (e.g., "irresponsible, potentially dangerous reporting"). Apart from out-rightly dismissing this critique with the argument that antidepressants work for those who are "*actually* mentally ill," one form of counter-critique consisted of providing personal testimony of having tested the placebo hypothesis, as in Extract 7:

Extract 7:

> If the efficacy of medication were due solely to placebo effect, then every trial of a medication should result in a positive effect. I have taken antidepressants that has no benefit whatsoever despite my hopefulness and desire for relief. I have tried discontinuing medications (under medical supervision), hopeful that I was well enough to do without them, only to find that after several weeks I needed to go back on them. The placebo effect may be a real phenomenon, but we can't chalk up all successes on antidepressants to placebo effect.

Here, the commenter lays out the logics of an argument that rests on the premise that "If the efficacy of medication were due solely to placebo effect, then every trial of a medication should result in a positive effect." Invoking personal testimony, they then proceed to show how, in their case, the presence of "hopefulness"—a core component of the placebo effect—was not operative in some instances in which they desired antidepressants to work or in which they desired to remain free of them. While this disentangling of hope from a positive outcome could have enabled the commenter to conclude that they have presented a foolproof case against the notion that antidepressants work according to the placebo effect, they provide a much more balanced and nuanced message. Specifically, they acknowledge the possibility of this effect (i.e., it "may be a real phenomenon"), and conclude that it cannot account for "all successes on antidepressants." In doing so, space is carved out for the mechanisms of effects of antidepressants to be something other than the placebo response in certain (unspecified) circumstances.

Another type of counter-critique consisted of unraveling the research paradigm upon which the studies that led to the critique were based and questioning the conclusions that can be made from it, as is evident in the following extract.

Extract 8:

> The research reported in the . . . segment on the effects of placebos vs. antidepressants would more than likely have been performed using statistical analysis based on data from all subjects grouped together under each condition . . . It is possible, therefore, that overall results did not represent the actual data of ANY ONE particular subject in the study. There are patients who respond with highly clinically significant improvement following treatment with antidepressants. There are patients who have no response whatsoever. Some respond with only mild success. Antidepressants have NEVER been regarded as "one size fits all" . . . it is possible that for a minority of subjects the medication was far more effective than a placebo.

The introductory sentences of this comment work to position the commenter as having some knowledge of research design and to establish the basis for their counter-critique, specifically, that group data might not tell us anything about an individual person's response to antidepressants. Arguing and emphasizing (placing ANY ONE

in capitals) that it is possible the results from such research might not apply to a single person casts doubt on the validity of the conclusions of the research. Constructing the variability of individual responses to antidepressants as covering a wide range (i.e., from "*highly clinically significant* improvement" to "*no response whatsoever*," to "*mild* success"; emphases added) further establishes the difficulty in drawing conclusions about individual persons from group data. The commenter's subsequent declaration (i.e., that "Antidepressants have NEVER been regarded as 'one size fits all'") definitively (placing NEVER in capitals) casts the understanding of the use and effectiveness of antidepressants as not being a "one size fits all" approach. While "who," specifically, has never regarded antidepressants in this way remains unspecified, this declaration could be read as a challenge to globalizing narratives about antidepressants or as an allusion to the gulf between the standardization of research protocols and the contextualized, individualized focus of clinical practice. This commenter indirectly acknowledges the placebo effect, but does so to advance the possibility that "for a minority of subjects the medication was far more effective." As seen in extracts oriented to other critiques of antidepressants, this commenter constructs a qualified and nuanced argument as to the scope and extent of effectiveness of antidepressants.

Nonmedication Alternatives Are Equally or More Effective than Antidepressants

Counter-arguments to the critique that safer alternatives can produce comparable or greater effects than antidepressants focused on constructing this message as too "simple" and "a bit naïve"; on the inappropriateness of these alternatives for alleviating "severe," "actual," "real" depression; and on the argument that "everyone is different." The following extract is in response to an online article in which claims of the proven effectiveness of alternatives are made:

Extract 9:

> Vigorous exercise is easily done by people who are not TRULY suffering from deep depression. But the mere thought of getting out or exerting that much energy makes most depression sufferers want to even go further into a shell and hide. Depression is very real and it is an illness. I cannot argue that it would help to get out and vigorously exercise, I am saying it is near impossible for depression sufferers to DO IT . . .

In Extract 9, the commenter uses sharply contrasting terms to set up two distinctions: between those who are "*TRULY* suffering from *deep* depression" (emphasis added) and those who are not, and between the "*mere thought* of getting out or exerting that much energy" (emphasis added) and the *ease of doing* "vigorous exercise" to argue that truly depressed persons cannot take advantage of an alternative such as exercise. As in previous extracts, they concede that the critique might have validity ("I cannot argue that it would help to get out and vigorously exercise"), but rule out this alternative as "near impossible" for those suffering from "deep" depression. Capitalizing "DO IT" emphasizes that it is the very absence of the capacity to engage in vigorous exercise, perhaps not desire or will, that makes this alternative unrealistic for those who are legitimately (TRULY) depressed, thereby minimizing blame.

In responding to the critique that alternative therapies can be more effective than antidepressants, commenters argued that "what works for one individual does not work for another" and that there is not a "one size fits all" cure, as in the following extract which comes from an online article on natural depression therapies:

Extract 10:

> For some patients, medication, despite being full of side effects and not always as effective as we would like, is necessary to bring them to a place where they are then able to incorporate therapy, or exercise, or dietary changes. Depression is a complex and multi-faceted illness, just as the individuals who suffer from depression are each unique and complex in their own ways. Medication may not cure depression but neither can any of the above methods in isolation. Such black and white thinking only harms those who are most vulnerable. It is not a matter of what is better.

In this extract, the commenter acknowledges two critiques of antidepressants ("full of side effects and not always as effective as we would like") and presents a qualified case ("for *some* patients"; emphasis added) for their use as a necessary first step in facilitating the use of other treatments. Constructing depression as "a complex and multifaceted illness" and sufferers as "unique and complex in their own ways" implies the need for treatment to be responsive to such complexity and uniqueness. Although the nature of such complexity is not stated explicitly, the implication from the assertion "Medication may not cure depression . . . in isolation" is that no one approach to treating depression, in and of itself, is sufficient, and that medication is on an equal footing with other treatments. Constructing the isolated use and privileging of one intervention over another as "black and white thinking" and dismissing the focus on "what is better" casts the notion that certain interventions are categorically better

than others as wrongheaded. Constructing the possible outcomes of such thinking as "harm[ing] those who are most vulnerable" again invokes the moral consequences of an absolutist stance.

Discussion

Critiques of antidepressants are both wide-ranging in focus and wide-spread in academic literatures and in a variety of media. Statements attesting to the validity of these critiques, often in the form of online comments to newspaper articles, radio and television interviews, blogs, and websites, are also readily available. For example, many responders in the comments sections we accessed constructed accounts of having had negative experiences on antidepressants, or of knowing family members or friends who had similar experiences. These accounts included declarations of being pleased that criticisms of antidepressants had surfaced in the media, and exhortations of the need for more people to be educated and made aware of the risks of antidepressants prior to consumption. It is clear that these critiques have been important in reshaping the popularized public narrative of antidepressants that was so pervasive in the latter part of the 20th century and in informing clinical guidelines regarding the treatment of depression (e.g., see National Collaborating Centre for Mental Health [NCCMH], 2010).

However, we were interested in the voices that construct counter-critiques, particularly for what the discursive work involved in these counter-critiques might be able to tell us about what is at stake. Previous research (e.g., Malpass et al., 2009) has highlighted how the current climate of critique has the potential to add to the shame, judgment, and stigma that can be experienced by those who decide to use, or to continue to use, antidepressants. Similar concerns were echoed in the comments in our data set. In addition, some of the strategies used by commenters to resist the critiques, such as justifying the use of antidepressants in grim circumstances and constructing them as the only option for some people, have also been highlighted in previous research (e.g., Ridge et al., 2015). Our in-depth analysis adds to this literature by showing how certain counter-arguments have the potential to lessen the likelihood of their being undermined and by enabling us to unpack issues in addition to shame, judgment, and stigma that are at stake.

The Counter-Critique and Ensuing Questions

In the discursive pattern highlighted in this article, commenters who constructed arguments against the critiques used various discursive moves that lessened the possibility of their arguments being undermined. These moves included inserting personal testimony about their own or others' use of antidepressants, acknowledging the critiques, and positioning themselves as informed, reasoned, responsible, or unbiased actors. Hand-in-hand with these moves was the construction of nuanced counter-critiques. The use of qualifying words and phrases such as "some people," "not for everyone," "sometimes," and "one size does not fit all" has the potential to cast these counter-critiques as encompassing complexity, particularity, and context, and, by contrast, the critiques as more extreme and overly inclusive. While the persuasiveness of these counter-critiques can be enhanced by such nuancing, we also see these counter-critiques as embedding additional issues.

Antidepressants work for whom? In countering the critiques, commenters in our data set justified the use of antidepressants and claimed its benefits for those who are "truly" suffering from "real," "actual," or "clinical" depression. This argument is consistent with statements that antidepressants can be effective for moderate to severe depression but should not be the first line of treatment for mild depression (World Health Organization [WHO], 2020). Clinical researchers and practitioners similarly make use of categories such as mild, moderate, and severe, or less severe and more severe, to characterize the range of severity of depression. However, as noted in the literature (e.g., Zimmerman et al., 2018) and as referenced in some of the extracts in the present study, there is little agreement as to how such categories should be operationalized, despite the existence of diagnostic criteria and cutoff scores on measures designed to assess depression. Such lack of agreement among professionals as to what constitutes a particular degree of depression is likely also present among nonmedical laypersons (and between professionals and laypersons). This definitional imprecision renders the justification for the use of antidepressants in cases of "serious" or "real" depression not as straightforward as it first appears, and could pose challenges during consultations regarding whether a course of antidepressants is warranted.

In addition, there is no clear sense as to how these categories of severity map onto persons' suffering. It is possible, for example, that a person experiencing what might be deemed "mild" depression could be suffering considerably, or that a person scoring high on a scale measuring depression might not consider their suffering as extreme. This counter-critique also raises questions about what it might mean to have to establish that one is suffering from "real," "clinical," or "severe" depression to justify the use of antidepressants, or, conversely, how one might characterize one's level of depression if benefits from using antidepressants ensue. As Ridge (2018) argued, depression is currently "being actively constructed along multiple,

fragmented lines" and "there are increasing claims and counterclaims about depression and treatment, many of which are difficult to reconcile." McPherson and Armstrong (2012) reached a similar conclusion from their systematic review of studies on the management of depression by general practitioners, specifically that their findings highlighted "the very issue of definition and the contested nature of depression" (p. 1157). While it is likely, then, that the counter-critique regarding who benefits from antidepressants highlighted in this article is only one set of contingencies among many, its real-life consequences remain unknown.

Antidepressants work how and to what extent? Qualified claims about how antidepressants work and to what extent were also clearly evident in these counter-critiques. The idiom "one size does not fit all" effectively summarizes these claims: Antidepressants work via "different mechanisms," including via "placebo" or "in a clinically relevant way," and "each is not equally effective" for all persons. In our data set, commenters acknowledged the placebo response as a mechanism of effect, but ruled it out as accounting for all instances of positive responses to antidepressants. This discursive move not only creates space for possibilities but also raises questions. For example, given that there is no physical test for determining the effectiveness of an antidepressant, how would one know, outside of a randomized controlled trial and for any particular individual, whether a positive response to an antidepressant is attributable to the placebo effect or to a "clinically relevant" effect? Under what circumstances might these differential effects be operative? For whom does it matter? Again, such questions have no easy answers (see Hardman et al., 2019, for an analysis of the "competing and confusing discourses that underpin the understanding of placebo treatment," p. 6, and for a discussion of the challenges posed by various ways of constructing placebos and their uses).

The notion that each antidepressant "is not equally effective" for all persons, while serving as an effective counter-critique, raises the possibility that finding an antidepressant and a specific dosage that is beneficial for a particular person is, at least to some extent, a matter of trial and error (see Brijnath & Antoniades, 2017, for an exploration of the concept of experimenting or "playing" with antidepressants). The challenges of matching a particular antidepressant to a particular person's suffering have been widely recognized in the academic literature, but, to date, the development of protocols for precision or personalized medicine largely remains elusive (e.g., Tomlinson et al., 2020). This state of affairs raises unanswered questions about the extent to which, and how, various forms of practice-based evidence, such as physicians' observations about individual patient responses to a particular antidepressant, actually shape future evidence-based practice. So, while constructions of clinical practice as bearing witness and being responsive to the complexities of antidepressant use can serve as a convenient foil in the critique of clinical research as not being applicable in individual cases, the intricacies of what transpires in clinical practice remain largely undocumented.

Conclusion

Given the contexts from which our data were derived, that is, articles and interviews in mainstream media, websites, and blogs, the nuanced counter-critique that we have highlighted in this article is perhaps not surprising. Claims about antidepressants in these contexts are often headlined with provocative titles followed by an accompanying focus on a singular (or near singular) storyline. While counter-critiquing through nuancing and qualifying is consequently made possible by such titles and storylines, these discursive moves also underscore the thorniness of, and uncertainties involved with, diagnosing depression and treating such forms of distress with antidepressants. As such, this pattern of counter-critique might be thought of as a double-edged sword: It lessens the likelihood of being easily undermined by qualifying for whom, how, and to what extent antidepressants are effective, but simultaneously opens up questions with no easy answers, thereby illustrating the limitations of our collective knowledge.[2]

However, despite the uncertainties embedded in the rhetorical pattern foregrounded in this article, we can also ask how this counter-critique might contribute to the shaping of ongoing narratives about the use of antidepressants for depression. From the once popular narrative that antidepressants are safe, effective, and work according to the chemical imbalance hypothesis, to the numerous critiques of this narrative, we have now provided evidence from what Fosgerau and Davidsen (2014) called the "voice of society" (p. 650) of yet another counter-narrative. Questions for future research might include "to what extent, and how, is the counter-narrative that only 'real' depression benefits from antidepressants, and that the use of antidepressants is not 'one-size-fits-all' actually taken up by professionals and patients in consultations?, and what are the outcomes when it is or is not taken up?" Addressing such questions might assist in fleshing out the consequences—both positive and negative—of this counter-narrative.

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Notes

1. A detailed reference list of all media sources identified by title or author in this article is available in the Supplemental File.
2. We thank one of the reviewers for supplying the phrase "illustrat[ing] the limitations of our collective knowledge."

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