Good Science or Good Business?

by DAVID HEALY

In the 1950s, estimates of the incidence of depression were fifty people per million; today the estimate is 100,000 per million. What was once defined as "anxiety" and treated with tranquilizers in the wake of the crisis of benzodiazipine dependence and the development of selective serotonin reuptake inhibitors became "depression." And as SSRIs have been shown to be effective for treating other nervous conditions, such as panic disorder, estimates of their frequency have increased markedly as well. Disease increasingly means whatever we have a reimbursable treatment for.

When *Listening to Prozac* emerged in 1993, it was one of the few books dealing with psychiatry to become an international best-seller since Freud's and Jung's works and the only book on psychopharmacology ever to do so. The book dealt with the effects of an "antidepressant" on conditions that often looked more like states of alienation than classic depressions. For many, this was their first awareness that antidepressants were drugs distinguishable from minor tranquillizers. For others, Peter Kramer's book and the notion of cosmetic psychopharmacology that it introduced raised interesting ethical and philosophical dilemmas. But the argument here is that the attraction of the book has depended on a series of engineered transformations in the way we think about mental well-being. The "alienation" Prozac and similar therapies "treat" has very commonly been defined in terms of the interests of the medico-pharmaceutical complex, and the arguments on offer about the merits of Prozac look more like descriptions of the interests of their proponents than dependable accounts of reality.

The interface between mental health and alienation traces to the emergence of psychodynamic therapy at the turn of the century, but this new industry remained at one remove from psychiatry until the 1950s. While the therapists took charge of such problems as alienation, psychiatrists dealt with those suffering from full-blown psychoses. In the interim, there was considerable recourse to do-it-yourself pharmaco "therapy" that employed alcohol, opiates, bromides, and barbiturates to manage community nervousness (that is, nervous conditions that do not lead to hospitalization), but this use, unconstrained by a therapy establishment, gave rise to little talk of alienation among philosophers. Indeed one can wonder whether many philosophy departments would be able to function without alcohol to facilitate social intercourse.

When imipramine, the first antidepressant, was introduced, clinicians and pharmaceutical company executives could see little rationale for it. The frequency of affective disorders appeared vanishingly low and these conditions responded to antipsychotics or ECT. Clinicians used the antidepressants sparingly,[1] and the very word "antidepressant" only begins to appear in dictionaries in the mid-1980s. Unlike the antipsychotics, the antidepressants had no clear niche. However, they did seem capable of making some difference to a large number of people, even if those people might have to be persuaded that they needed this difference in their lives. As early as 1958, Roland Kuhn, the discoverer of imipramine, had noted that some sexual perversions responded to imipramine and that many patients, when they recovered, felt better than well.[2] Such transformations opened up significant philosophical and ethical issues—claims now strongly suggestive of Kramer's agenda. But whereas Kramer's book became a runaway best-seller, Kuhn's speculations had minimal impact. The philosophers who were excited by the new psychotropic compounds in the 1950s and are now interested in neuro-

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好的科学或好生意?

by DAVIDHEALY

在 20 世纪 50 年代，抑郁症的发病率估计为每百万五十人；如今，估算为每百万 100,000。曾经被定义为“焦虑”并用镇静剂治疗的危机后苯二氮䓬类药物依赖的余波和选择性 5-羟色胺再摄取的发展抑制剂变成了“抑郁”。并且，SSRIs 已被证明对治疗其他神经系统疾病有效。条件，如恐慌症，其频率的估计也显著增加。疾病不断增加意味着我们有什么可报销的治疗方法。

《烦所百忧解》于 1993 年问世，它是自弗洛伊德和荣格的作品以来，为数不多的涉及精神病学并成为国际畅销书的书籍，也是第一部关于精神药理学的书籍。该书探讨了“抗抑郁药”对那些看起来更像是异化状态而非典型抑郁症的条件的效应。对于许多人来说，这是他们第一次意识到抗抑郁药是不同于轻微镇静剂的药物。对于其他人来说，彼得·克莱默的书籍以及它所引入的“美容精神药理学”概念引发了有趣的伦理和哲学困境。但这里的论点是，这本书的吸引力取决于我们对心理健康思考的一系列工程化转变。《百忧解》和类似疗法“治疗”的“异化”通常被定义为医药品复杂体的利益，关于百忧解优点的论点看起来更像是其支持者利益的描述，而不是可靠的现实描述。

心理健康与疏离感的界面可追溯到世纪初心理动力学疗法的出现，但这个新兴行业直到 20 世纪 50 年代才与精神病学有所距离。当时，治疗师负责处理疏离等问题，而精神科医生则处理那些患有严重精神病的患者。在过渡期间，人们大量采用自制药剂“疗法”，使用酒精、鸦片、溴化物和巴比妥酸盐来管理社区紧张情绪（即不导致住院的紧张状况），但这种使用，不受治疗机构的约束，在哲学家之间几乎没有引起异化的讨论。事实上，人们可以质疑许多哲学系是否能够在没有酒精促进社交互动的情况下运作。

当三环类抗抑郁药首次被引入时，临床医生和制药公司高管对其合理性几乎一无所知。情感障碍的频率似乎极低，这些状况对抗精神病药或电休克疗法有反应。临床医生很少使用抗抑郁药，而“抗抑郁药”这个词直到 20 世纪 80 年代中期才开始出现在词典中。与抗精神病药不同，抗抑郁药没有明确的细分市场。然而，它们似乎能够对大量的人产生一些影响，即使这些人可能需要被说服他们需要这种改变。早在 1958 年，三环类抗抑郁药的发现者罗兰·库恩就注意到一些性变态对三环类抗抑郁药有反应，而且许多病人在康复后感觉比健康时还要好。这种转变引发了重大的哲学和伦理问题——现在强烈暗示了克莱默的议程。但是，尽管克莱默的书成为畅销书，库恩的推测影响甚微。20 世纪 50 年代对新型精神活性化合物感到兴奋的哲学家们，现在对神经-

David Healy，《好科学还是好商业？》，Hastings Center Report 30，第 2 期（2000 年）：19-22。

science and Prozac were not interested in imipramine.

Market Development

The developmental trajectory for the antidepressants was largely determined by a critical external event—the thalidomide disaster. The public reaction to the birth defects caused by thalidomide, which had been taken by pregnant women to combat "morning sickness," led to the 1962 Food and Drug Act amendments, which channeled drug development toward clear diseases. Drug availability was restricted to prescription-only medicines, placing it in the hands of individuals who supposedly would make drugs available for problems stemming only from diseases rather than for those stemming from other sources. These developments radically changed psychiatry, first by putting a premium on "categorical" rather than "dimensional" models of disease, so that psychiatrists were more likely to treat diseases as conditions that patients either have or lack rather than have to some degree, and second because prescription-only status brought nervousness within the psychiatric ambit.

Initially, the straitjacket of the 1962 amendments had the outcomes intended. But if drugs are made available only for diseases, it was perhaps predictable that there would be a mass creation of disease. There has been, and these developments shape our perceptions of how alienation is being managed. In the 1950s, it was thought that only fifty people per million were depressed. Nowadays no one blinks on being told that depression affects over 100,000 per million and that it leads to more disability and economic disadvantage than any other disorder.[3] But this change plainly requires a major change in our view of what constitutes disease. If 10 to 15 percent of the population is depressed, the label "disease" does not make sense if understood in terms of the biological disruption that bacterial infections produce. What is meant can be grasped only if the "disease state" is framed in terms of temperamental factors and only if what is aimed at is a state of comparative well-being rather than cure.

Oddly enough, the widespread acceptance of our views of depression conceals the process by which they were changed. When first faced with the question of what community nervousness is, the psychiatric profession and the pharmaceutical industry understood it in terms of anxiety, and they resorted to Valium and other anxiolytics to treat it. This led to the first debates about the ethics of treating "problems of living" in this way.[4] In the West, however, the 1980s crisis surrounding benzodiazepine dependence led to the eclipse of both the minor tranquilizers and the whole notion of anxiolysis. This ushered in the antidepressant era. In contrast, in Japan, where dependence is less of a problem, the anxiolytics remain the most widely used drugs for nervousness and the antidepressant market remains small—in fact, Prozac is unavailable.

Depression as it is now understood by clinicians and at street level is therefore an extremely recent phenomenon, largely confined to the West. Its emergence coincides with the development of the selective serotonin reuptake inhibitors (SSRIs), which in the mid-1980s appeared capable of development as either anxiolytics or antidepressants.[5] Since their initial launch as antidepressants, various SSRIs have been approved for the treatment of panic disorder, social phobia, post-traumatic stress disorder, obsessive-compulsive disorder, and other anxiety-based conditions. In a number of these disorders, the SSRIs are more effective than they are in depression. Indeed, it has not been possible to show that Prozac is effective in classic depressive disorders. Worse, there is some evidence that far from reducing rates of suicide and disability associated with depression, antidepressants may actually increase them. Prozac and related drugs are prescribed to over four million children and teenagers per annum in the United States, yet a preponderance of evidence suggests that such prescriptions are not warranted.[6]

The designation of Prozac as an antidepressant means that some efficacy in some milder depressions can be shown for this compound and it is accordingly not illegal to market it as a treatment for depression, but the fact that Prozac "works" for some people does not mean that they have classic depression. That it was marketed this way stems from business rather than scientific calculations.[7]

Changes in the way we think about problems of living are not restricted to depression. The research demonstrating that SSRIs could be useful for treating other nervous conditions has been associated with marked increases in estimates of their frequency as well.[8] Obsessive-compulsive disorder has increased a thousand-fold in apparent frequency. Panic disorder, a term coined in the mid-1960s and first appearing in diagnostic classification systems in 1980, has become one of the most widely recognized psychiatric terms at street level. Social phobia, all but invisible until the 1990s, now appears to affect the population in such epidemic proportions that the launch of Paxil as an anti-shyness agent was a media event.

These changes have very likely been brought about by the pharmaceutical industry itself, through its highly developed capacities for gathering and disseminating evidence germane to its business interests. The methods that might have this effect include convening consensus conferences and publishing the proceedings, sponsoring symposia at professional meetings, and funding special supplements to professional journals. The industry may also establish and support patient groups to lobby for treatments. The claim here—though defended elsewhere—is that these and other techniques for marketing information are sufficiently well developed that significant changes in the mentality of both clinicians and

科学与百忧解对丙咪嗪不感兴趣。

市场开发

抗抑郁药的发育轨迹在很大程度上是由一个关键的外部事件——沙利度胺灾难所决定的。公众对沙利度胺引起的出生缺陷的反应，这种药物曾被孕妇用来对抗“晨吐”，导致了 1962 年食品和药物法案的修正案，将药物开发引导到明确的疾病上。药物的可获得性被限制为仅限于处方药，将其交到了那些据说只会为仅由疾病引起的疾病提供药物的人手中，而不是那些由其他原因引起的疾病。这些发展从根本上改变了精神病学，首先是通过重视“分类”模型而不是“维度”模型，使得精神科医生更有可能将疾病视为患者要么有要么没有的条件，而不是某种程度上的条件，其次是因为处方药的地位使得神经质成为了精神病学领域的一部分。最初，1962 年修正案的紧身衣达到了预期的效果。但如果药物仅限于用于疾病，那么大量创造疾病的可能性可能是可以预见的。 过去一直如此，这些发展塑造了我们对于如何管理疏离感的看法。在 20 世纪 50 年代，人们认为每百万人口中只有 50 人患有抑郁症。如今，当被告知抑郁症影响每百万人口超过 10 万人，并且它导致的残疾和经济劣势比任何其他疾病都要多时，没有人会感到惊讶。但这种变化显然需要我们对于构成疾病观念的重大转变。如果 10%至 15%的人口患有抑郁症，那么从细菌感染引起的生物破坏的角度来看，“疾病”这个标签就没有意义了所指的是什么，只有当“疾病状态”以气质因素来界定，并且所追求的是一种相对良好的状态而不是治愈时，才能理解。

奇怪的是，我们关于抑郁症的观点被广泛接受，却掩盖了它们改变的过程。当首次面对“社区紧张”这个问题时，精神病学界和制药行业都将其理解为焦虑，并求助于安定和其他抗焦虑药来治疗。这导致了关于以这种方式治疗“生活问题”的伦理问题的第一次辩论。然而，在西方，20 世纪 80 年代围绕苯二氮䓬类药物依赖的危机导致了小剂量镇静剂和整个抗焦虑概念的衰落。这迎来了抗抑郁药时代。相比之下，在日本，由于依赖性较小，抗焦虑药仍然是治疗紧张最广泛使用的药物，而抗抑郁药市场仍然很小——实际上，百忧解不可用。

抑郁症如今在临床和街头层面上的理解因此是一种极其近期现象，主要局限于西方。其出现与选择性 5-羟色胺再摄取抑制剂（SSRIs）的发展相吻合，这些药物在 20 世纪 80 年代中期显示出既能作为抗焦虑药也能作为抗抑郁药开发的潜力。自从它们最初作为抗抑郁药推出以来，各种 SSRIs 已被批准用于治疗恐慌症、社交恐惧症、创伤后应激障碍、强迫症和其他基于焦虑的条件。在这些疾病中，SSRIs 的效果比在抑郁症中更有效。事实上，尚未证明百忧解对经典抑郁症有效。更糟糕的是，有证据表明，抗抑郁药不仅没有降低与抑郁症相关的自杀和残疾率，反而可能实际上增加了这些比率。

氟西汀及其相关药物每年在美国被处方给超过四百万名儿童和青少年，然而大量证据表明，此类处方并无依据。

将 Prozac 定为抗抑郁药意味着该化合物在某些轻度抑郁中显示出一定的疗效，因此将其作为抑郁症的治疗方法进行市场推广并不违法，但 Prozac 对某些人“有效”并不意味着他们患有典型的抑郁症。这种市场推广方式源于商业而非科学计算。

我们对生活问题的思考方式的改变并不仅限于抑郁症。证明 SSRIs 可能对治疗其他神经系统疾病有用的研究，也与它们频率估计的显著增加有关。强迫症在明显频率上增加了千倍。恐慌症，一个在 20 世纪 60 年代中期创造的术语，首次出现在 1980 年的诊断分类系统中，已成为街头最广泛认可的心理学术语之一。社交恐惧症，直到 20 世纪 90 年代几乎看不见，现在似乎以如此流行的比例影响着人口，以至于 Paxil 作为一种抗羞涩剂的推出成为了一场媒体事件。

这些变化很可能是由制药行业本身引起的，通过其高度发达的收集和传播与其商业利益相关的证据的能力。可能产生这种效果的方法包括召开共识会议并发布会议记录、在专业会议上赞助研讨会、资助专业期刊的特别增刊。该行业还可能建立并支持患者团体以游说治疗。这里的说法——尽管在其他地方得到了辩护——是，这些以及其他营销信息的技术已经足够发达，足以在临床医生和

the public can be produced within a few years.[9] In effect, the industry has educated prescribers and the public to recognize many other kinds of cases as depression.

These changes are facilitated by a broader social shift. When dynamic therapies occupied the citadels of orthodoxy in psychiatry, their terminology leaked out into popular language. A variety of terms were used in ways that technically were wholly inaccurate but that nevertheless became part of the way in which we thought of ourselves and conceptualized alienation. Recently, the psychobabble prevalent during much of the century has begun to give ground to a newly minted biobabble. A rootless patois of biological terms—"low brain amines," for example—has settled into the popular consciousness, with consequences for our self-conception that can only be guessed at.[10]

Possibly, Prozac's success has also depended partly on a lack of information. Prozac has been shown to "work" using clinician-based disease-specific rating scales, but when patient-based, nonspecific quality of life instruments have been used, it has not been shown to work for depression—although this information has not seen the light of day.[11] Current methods to estimate the side effects of drugs in clinical trials actually underestimate them, according to some tallies, by a sixfold factor.[12] Finally, the SSRIs have been sold on the back of a claim that the rate of suicide is 600 per every 100,000 patient years. But this is the rate for people with severe depression, for which Prozac does not work. The rate for primary care depression is on the order of 30 out of every 100,000 people. Yet in these populations, suicide rates of 189 for every 100,000 on Prozac have been reported.[13] Thus there are good grounds to believe that Prozac can trigger suicidality. The pharmaceutical companies are not investigating, however; one wonders whether they are receiving legal advice echoing that given to the tobacco companies, that any investigation of these issues may increase product liability. From this vantage point, Prozac might seem better cast as a symbol of the alienation that large corporations can visit on people rather than as a symbol of the "treatment" of alienation that a psychotropic agent can bring about.

Lifestyles and the Disease Model

The public perception of Prozac, as shaped by *Listening to Prozac*, was that the drug had been rationally engineered, in the sense that it had been developed so as to achieve highly reproducible clinical outcomes. If it is important that a drug be rationally engineered, it seems clear that Kuhn's discovery of cosmesis, in contrast to Kramer's, could not have gone anywhere.

However, Kramer's mythic account of the development of Prozac was mistaken. It was perhaps prophetic, since neuroimaging technologies, pharmacogenetic techniques, and other novel strategies will make the development of psychotropic drugs increasingly rational in this industrial sense, but none of this applied to Prozac. While Prozac works for some people, it has not been possible to offer any guarantees as to the quality of clinical outcomes when using it. Lacking such guarantees does not matter as much in treating genuine disease, since when patients are in danger, even doing something risky is by consensus preferable to doing nothing. But poor outcomes are much less tolerable in the management of less severe conditions. Thus a disease model offers pharmaceutical companies and clinicians a valuable escape from quality standards.

A disease model offers other advantages to pharmaceutical companies. It acts powerfully to legitimate drug-taking, allowing Prozac, for example, to escape the flak that Valium drew in the 1970s. And it can function as a means of resolving problems about equitable access to health resources, since it is widely accepted that there are greater difficulties with inequities in health care than with inequities in the access to computers or digital televisions.

Prozac is of course only one of a growing number of agents that modulate lifestyles rather than cure diseases. Viagra is another good example of this trend. Viagra's designation as a lifestyle agent depends in good part on the reliability with which the intended responses can be elicited. What is interesting about Viagra is that we have had other drugs for two decades now that have comparable effects on sexual function. The SSRIs may have weak and unpredictable effects on depression, but they can reliably delay orgasm, and other antidepressants can advance it.[14] Thus we have had the capacity to "engineer" sexual performance for some time; the pharmaceutical companies have simply not marketed pills for such uses, presumably because they were uncertain about the acceptability of a "lifestyle market" for their wares.[15] Seen against this background, the promotion of Viagra marks an important turning point in the way drugs are developed.

Arguments in favor of Prozac look more like descriptions of the interests of their proponents than dependable accounts of reality.

In general, clinical therapeutics is increasingly comprised of a series of domains removed to varying degrees from the management of bacterial infections. The provision of oral con-

公众可以在几年内产生。实际上，该行业已经教育了处方者和公众，使他们能够识别出许多其他类型的病例为抑郁症。

这些变化是由更广泛的社会转变所促进的。当动态疗法占据了精神病学正统的堡垒时，它们的术语就渗透到了流行语言中。各种术语被用于技术上完全不准确的方式，但无论如何，它们成为了我们思考自己和概念化疏离的方式的一部分。最近，在整个世纪的大部分时间里盛行的心理学术语已经开始让位于新铸成的生物学术语。一种无根的混杂生物学术语——“低脑胺”等——已经深入人心，对我们自我认知的影响只能猜测。

可能，Prozac 的成功也部分依赖于信息不足。研究表明，Prozac 在使用基于临床医生、针对特定疾病的评分量表时“有效”，但当使用基于患者、非特异性的生活质量工具时，并未显示出对抑郁症的有效性——尽管这些信息尚未公之于众。根据一些统计，目前估计临床试验中药物副作用的方法实际上低估了它们，低估了六倍。最后，SSRIs 的销量是基于自杀率每 10 万人中有 600 人的说法。但这是针对重度抑郁症患者的数据，对于 Prozac 无效。初级护理抑郁症的比率约为每 10 万人中有 30 人。然而，在这些人群中，Prozac 的自杀率每 10 万人中有 189 人。因此，有充分的理由相信 Prozac 可能引发自杀倾向。然而，制药公司并未进行调查；人们不禁要问，他们是否在接收与烟草公司所收到的法律建议相呼应的建议。

任何对这些问题的调查都可能增加产品责任。从这个角度看，百忧解可能更像是大型企业对人们施加异化的象征，而不是作为精神活性剂能带来的异化“治疗”的象征。

生活方式与疾病模型

公众对百忧解的认知，由《倾听百忧解》塑造，认为该药物经过理性设计，即在达到高度可重复的临床效果方面进行了开发。如果一种药物需要经过理性设计很重要，那么显然库恩对美容学的发现，在...

赞成百忧解的论点看起来更像是

描述其支持者的利益

与 Kramer 的相比，不可能有任何进展。

然而，克莱默对百忧解发展过程的神话般描述是错误的。这或许具有预言性，因为神经影像技术、药代遗传学技术和其他新颖策略将使精神药物的开发在工业意义上越来越理性，但这都不适用于百忧解。尽管百忧解对某些人有效，但使用它时无法提供任何关于临床结果质量的保证。在治疗真正疾病时，缺乏这样的保证并不那么重要，因为当患者处于危险之中时，即使做一些冒险的事情，根据共识也比什么都不做更可取。但在管理较轻的疾病时，不良结果则难以容忍。

因此，疾病模型为制药公司和临床医生提供了一个宝贵的摆脱质量标准的途径。

疾病模型为制药公司提供了其他优势。它有力地证明了药物使用的合理性，例如，使氟西汀避开了 1970 年代瓦利姆所吸引的炮火。并且它可以作为一种解决关于健康资源公平获取问题的手段，因为普遍认为，在医疗保健中的不平等比在计算机或数字电视的获取中的不平等更具困难。

Prozac 当然只是越来越多调节生活方式而非治愈疾病的作用剂之一。Viagra 是这一趋势的另一个良好例子。Viagra 被指定为生活方式作用剂在很大程度上取决于其可靠性的程度。

可靠的现实描述。

倾向于引起反应。关于伟哥有趣的是，我们现在已经有其他两种药物在性功能方面有相似的效果已经二十年了。SSRI 可能对抑郁症有弱且不可预测的影响，但它们可以可靠地延迟高潮，而其他抗抑郁药可以提前它。因此，我们已经有能力“设计”性表现一段时间了；制药公司只是没有为这种用途推广药片，可能是因为他们对“生活方式市场”的接受度感到不确定。在这种背景下，伟哥的推广标志着药物开发方式的一个重要转折点。

一般来说，临床治疗学越来越多地由一系列与细菌感染管理程度不同的领域组成。口服给药的提供

traceptives on a prescription-only basis is notionally underpinned by a disease model. Hormone replacement therapy is likewise presented as treatment for a disease. "Treatments" for baldness, age-induced skin changes, obesity, and a range of other lifestyle agents wait in the wings. All of these raise the question of what qualifies as a disease. In recent history, a disease has been thought of as an entity established by an underlying biological lesion. Previously, illnesses were anything that made the individual feel less well, a definition which potentially included halitosis. Latterly, the emergence of agents that can modify natural variations in hair loss or ejaculatory latency push us closer to making explicit one of the currently implicit but increasingly important definitions of disease, which is that it is, in practice, something that third-party payers will reimburse on.

Before 1962, tonics flourished along with treatments for halitosis and other problems of living. Cyproheptadine, an imipramine-like agent, which reliably improves appetite and sleep and less reliably cures depressions, was on sale as a tonic. The 1962 amendments required redesignation of agents like this as antidepressants rather than tonics, but in many ways they might have had greater public acceptability if classified as tonics, a usage hallowed by centuries of practice, rather than as antidepressants, since as drugs they quickly became associated with risks of addiction. Would we be talking about alienation if it were over-the-counter tonics rather than prescription-only antidepressants that were involved—or if we were, would the public take our debate seriously? Could it be that much of the current debate is predicated on a combination of pseudoscientific mystique and regulatory artifact? Consider in this connection one of the dilemmas raised by Kramer: because of its prescription-only status, Prozac raises special moral problems for the physician, who is now called on to decide whether it would be a good thing to reduce the general level of melancholy in the community, with the consequent loss of spirituality or creativity that might go with that.

These dilemmas would be transformed if the power to make these decisions were returned to the consumer. We may be unwittingly alienated choosing to purchase automobiles, but we would certainly feel alienated if it were the prerogative of the automobile salesmen to decide which brand of vehicle we should get.

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处方药特性在概念上由疾病模型支撑。激素替代疗法同样被呈现为疾病的治疗方法。“治疗”秃发、年龄引起的皮肤变化、肥胖以及一系列其他生活方式因素在幕后等待。所有这些都引发了关于什么算作疾病的问题。在最近的历史中，疾病被认为是由潜在生物学病变确立的实体。以前，疾病是指使个体感觉不适的任何事物，这个定义可能包括口臭。最近，能够改变自然头发脱落或射精潜伏期变化的药物的出现，使我们更接近明确目前隐含但越来越重要的疾病定义之一，即在实践中，它是第三方支付方将报销的事物。

在 1962 年之前，补药与治疗口臭和其他生活问题的治疗方法一样繁荣。西替利嗪，一种类似三环类抗抑郁药的药物，能够可靠地改善食欲和睡眠，但治愈抑郁症的效果不太可靠，曾作为补药出售。1962 年的修正案要求将这类药物重新归类为抗抑郁药而不是补药，但就许多方面而言，如果被归类为补药，它们可能具有更大的公众接受度。

一个被数百年实践所神圣化的用法，而不是作为抗抑郁药，因为作为药物，它们很快与成瘾风险相关联。如果是非处方补药而不是仅限处方的抗抑郁药涉及其中，我们是否在谈论异化——或者如果我们是在谈论，公众是否会认真对待我们的辩论？是否可能，当前的许多辩论是基于伪科学神秘主义和监管文物的结合？考虑这一点，考虑 Kramer 提出的困境之一：由于其仅限处方状态，Prozac 为医生提出了特殊的道德问题，现在医生被要求决定是否降低社区普遍的忧郁水平是好事，这可能导致随之而来的精神或创造力的丧失。

这些困境将得到转变，如果做出这些决定的权力回归消费者。我们可能在不经意间因为选择购买汽车而感到疏远，但如果决定我们应购买哪个品牌汽车的权力在汽车销售员手中，我们肯定会感到疏远。

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