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Prescription of antidepressant medication by general practitioners: total social reality?

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We shall discuss what anthropology brings to the analysis of certain problems that are currently treated medically.

Precisely because medical issues are necessarily broached by many other disciplines, we feel that anthropology is situated at the vanguard of many questions, and is obliged to redefine its objects and demonstrate the heuristic value of its approach. In this undertaking, medical anthropology, which has often borrowed from various theoretical currents, puts the whole of anthropology to the test unless it seeks to define its originality from within.

Here we will outline only a partial and empirical illustration of this vast project, by analysing general practitioners' discourse about their practices in terms of prescriptions and treatment for with patients that describe themselves, or that the physicians diagnose, as being depressive.

1. French epidemiological data on depression in general. medical practice and issues

The "depression" that has been largely examined by Anglo-Saxon anthropologists (Kleinman 1986; Kleinman and Good 1985) is estimated to be the second-ranking cause of invalidity, according to the World Health Organisation. According to Ehrenberg, depression in France has become «our main form of intimate unhappiness» (Ehrenberg 1998). In the psychiatry of the early 20th century, depression was one symptom associated to others but has now come to constitute a separate pathology that can be apprehended without theory, which is subject to symptomatic diagnosis and which non-specialist physicians can establish using the appropriate manuals (DSM

IV, CIM 10). But the pathological entity called "depression" as it is manipulated in practice by general practitioners, and even more so the popular entities loosely differentiated in France under the headings "*dépression*" and "*déprime*", do not correspond exactly to the set of symptoms listed under this designation in diagnostic handbooks. Epidemiological surveys like the one published in 1999 by CREDES must use tools to reveal the existence of these afflictions, independently of spontaneous declarations. In this case it was the *Mini International Neuropsychiatric Interview* (MINI). It is now proposed to furnish general practitioners with this type of tool in order to diagnose and treat major depressive episodes that would otherwise go unnoticed [4]. In the CREDES survey, the rate of 6.3% of individuals declared to be depressive rose to 12% with the MINI questionnaire alone. Earlier surveys by the same organisation (1994), however, underscored that consumption of antidepressant medication was two to four times higher than in neighbouring countries. This means that the 1999 results concluding that the French population is insufficiently treated are something of a paradox. The majority of these afflictions are treated by general practitioners, just as they see 11% of their patients for "life events" (Pouchain *et al*., 1966), so we realise that a good share of what in our society is called the "depression" syndrome is handled during office visits to general practitioners.

We observe a significant increase in cases of depression reported over the last 30 years. In surveys on health and medical care in France four times as many people claimed to be depressive between 1970 and 1980, and seven times as many between 1980 and 1996. The epidemiological data cited show that «all things being equal», «situations of unemployment, divorce, living alone are highly associated with risk of depression» (*op. cit.*, 1999). This type of morbidity can be understood in two ways. There is a growing medicalisation of the «pain of being» (Jaeger, 1998), just as much as an embodiment of social suffering and inequalities, insofar as management level employees, and those exercising higher intellectual occupations (men and women), and farmers (women) «seem to be protected from the most active forms of this pathology», even though paradoxically «they declare it more frequently» (*op. cit.*, 1999). Biological models of depression describe it as being a deregulation of cerebral neuromodulation systems, or of the biological mechanisms that allow the individual to adapt to the environment. So, we are confronted with a type of reality «in which the social nature is very directly connected to the biological nature of man» (Mauss 1926). The author continued: «In addition, these facts are also "total" facts that I believe merit study. Consideration of the psychic realm, or better

still of the psycho-organic realm is not enough to describe the entire complexes. The social sphere must be taken into consideration. Inversely the study of just the fragment of our lives constituted by life in society is not sufficient.» So we can see more precisely how Durkheim's "*homo duplex*" is situated, and how this "double nature" can be contemplated.

We will touch upon only one of the facets of this task, but one that in our view is revealing of the perception that the main actors – the general practitioners – have of the nature of the reality they have to treat.

2. Survey and methodology

The subject emerged from the peculiar turn taken by our study (funded by MILDT) of the "differentiated management of dependencies by general practitioners" in the region of France which, on an epidemiological level, is known as one of the most heavily areas affected by alcoholism [(5)] and suicide among the young [(6)]. The instructions were to place each patient's visit during one day within the history of the therapeutic relationship, specifically mentioning all known problems of dependence. This interview was recorded in full and transcribed for analysis. The day of the interview was chosen from the days of the preceding week of activity. In this week the practitioners had been asked to note, the reasons for each patient's visit their diagnoses and prescriptions. In this way, we would have an idea of the practice and clientele of each practitioner. The interviews were carried out using charts to summarize the practitioner's present activity. The comments were an account. We interviewed 10 general practitioners in the region. Five belong to a private practice/hospital network for treating addicts. The other five are practitioners who work in residencies, taking in residents for periods of 3 to 6 months a year [(7)]. For the purposes of analysis, the interviews had to be anonymous so the authors who also participated in teaching and training activities interviewed the subjects. Practitioners are credited with a minimum of current knowledge concerning psychotropic substances (Tamblyn *et al*., 1996). For the group of practitioners that includes residents, it goes without saying that they teach, and therefore know, the most recent recommendations made by the accepted conferences in the field. This only makes the following discussion all the more pertinent. The survey was completed with five more practitioners, chosen at random this time. As the interview was to last no more than two hours, we restricted ourselves to one day. However, our first practitioner was not satisfied with the day he was asked to comment upon, and he made

a point of telling us, in addition, about all the patients he had seen in the week, who in his view were interesting for our inquiry. We then suggested to the next physicians to do the same. We thus have interviews in two parts, one day totally covered (whatever the pathology of the patient was) and an overview of the other days of the week in relation to "dependences". It is remarkable that the physicians chose to tell us about a great many visits that did not refer to past or present dependencies, but to "psy" problems in the expression of one respondent [8]. In these cases, suffering was expressed by functional disorders, or by psychiatric disturbances. They fell into the category of antidepressant treatment, harking back to depression or "depressive states", which the physicians sometimes refused to medicalise as such. These problems run through the entire corpus and are very rich in information about the physicians' practices. For this communication, we have taken extracts dealing with depression or the prescription of antidepressants [9].

By analysing the practices of the physicians in both groups, we can compare their prescriptions of antidepressants with data gathered in studies of populations who consult general practitioners. According to a 1996 WHO study cited in Le Pen (Le Pen 1998), 10.4% of patients were diagnosed as depressive, whereas this figure rises to 13.7% of the population at the Parisian centre of this study. Our physicians in the first group, all practising in cities, prescribe an antidepressant every 14.7 visits of to patients aged 15 and older (6.77%). The physicians in the second group, practising in towns or in the country, prescribe an antidepressant every 9 visits of patients' aged 15 and older (9%). Diagnoses, including Manic-Depressive Psychosis (MDP) and anxiety-depressive syndromes, are 5.7% and 9.5%, for patients aged 15 and older, respectively. Indeed antidepressants are prescribed for disorders such as alcoholism, or for "senile dementia" [10]. While some of these prescriptions do not correspond to the diagnosis of depression, this diagnosis does not always result in a prescription.

In the survey, in which no models or diagnostic criteria whatsoever for depression were asked for, this disorder is most often evoked in the life history, in a family or social context known to the practitioner through various sources. The practices of these practitioners, as reported, appear to run counter to the hegemony of symptomatic diagnosis. Indeed, if for the reasons given above we exclude a lack of information that is assumed by MINI proponents, then the experience that these physicians have reconstructed of their encounters with patients whose suffering is qualified as depression must refer to something else. This is exactly what we will attempt to analyse by studying in detail what the prescription or non-prescription of antidepressants refers to.

3. The diagnosis of "depression" as related in interviews with general practitioners

In the comments about visits that we have gathered, there is little mention of the search for symptoms. When insomnia or other symptoms are referred to as such, it is often a confirmation (we would say a rationalisation) or an answer to a question from the investigator, as in the following example:

> Q – *«mais quand elle est venue là pour sa dépression, elle est venue en disant qu'elle faisait une dépression ou c'est vous qui l'avez diagnostiqué ? Comment ça s'est passé ?»*
>
> M – *«'ben' elle est venue en pleurant»*
>
> Q – *«ah elle est arrivée en pleurant»*
>
> M – *«elle est venue en pleurant en disant que ça allait pas du tout et elle m'a pas demandé qu'est-ce qui lui arrivait mais elle est venue en me disant ce qu'elle avait et qu'elle le vivait très mal et donc le diagnostic de dépress d'état dépressif réactionnel a 'quand même' été posé sur les troubles du sommeil et y'avait pas de troubles physiques mais y'avait un manque de goût à tout ce qu'elle faisait enfin bon etc. hein c'est comme ça que le diagnostic a été posé. Mais y'avait une demande, y'avait une demande hein.»* (733) [11]

The massive obviousness of the «well» («*ben*») commenting the reality of crying precedes the confirmation «even so» («*quand même*») by the «sleep problems.»

Depending on his or her personality, the physician "rationalises" to a greater or lesser extent. These elements are never presented as the initial analysis. They emerge to support a feeling based on a perception of the patient's life experience and on the knowledge of the patient's history.

> *«...et il est dépressif, pour moi il est dépressif »* [12]
>
> Q – *« il a des insomnies, il a... ?»*
>
> M – *«il se réveille fatigué, il est fatigué toute la journée, il a mal partout, il a envie de rien faire, il a pas envie de lire. Il a les signes cardinaux de la dépression.»* [13]

Clearly the physician masters these technical terms and will use them later:

> *«manque peut-être, peut-être l'insomnie du matin hein et encore je crois qu'il se réveille assez tôt, mais ce qui domine surtout ce sont les troubles somatiques, l'anhédonie et la fatigue hein ça c'est les trois tableaux»* [14].

However, in most instances the mirroring discourse of the patient clearly shows that we are dealing with the proximity of empathy, and not with the distance of diagnosis of symptoms.

Some physicians told us about their clinical criteria. Nevertheless, this is not the case in the majority of comments where the diagnosis appears to

be built on the physician's feeling about the patient's mood.

> *«c'est une petite dame qui n'est jamais bien dans sa peau… J'arrive à ce qu'elle ressorte d'ici avec le sourire alors qu'elle est rentrée toujours très triste»* (682) [15].

This state is linked to known events in the patient's life:

> *«Bon c'est un très vieux monsieur de 83 ans qui a toujours été un peu dépressif. C'est moi qui l'ai mis aux antidépresseur y'a 16 ou 17 ans quand je suis arrivé ici, parce que lui et sa femme étaient bien tristes. Ils venaient d'arriver en retraite et ils étaient bien tristes tous les deux.»(870)* [16]

> *«C'était un monsieur qui était fermé parce qu'il était dépressif, dépressif parce qu'à son boulot on veut le virer» (343)* [17]

Or more serious still:

> *«Elle prend depuis la mort de son fils qui a été longtemps malade avant de mourir enfin pendant un an elle a il a été assez malade et puis il a été suivi après si tu veux il a été dans un coma pendant presque trois mois enfin ça a été très très pénible pour elle et depuis un prend un antidépresseur»* (728) [18].

Yet again:

> *«C'est une dame que je connais très bien, qui, que j'ai eu quand je l'ai connue y'a vingt ans, elle était je dirais alcoolique mondaine, femme de notable, s'ennuyant un peu toute seule, consommation d'alcool largement supérieure à ce qu'on peut admettre. Son fils s'est tué en voiture, ce qui n'a pas arrangé les choses […] je pense que maintenant elle ne boit plus, elle ne fume plus, bon ça ça date de dix douze ans hein, mais par contre elle a ce fond dépressif auquel moi j'associe la consommation d'alcool, ce fond dépressif ressort de manière cyclique, donc là je l'avais, au début de l'année je l'avais mis sous Deroxat* et ça c'est bien passé, elle était plutôt positive»* (693) [19].

We become aware that the general practitioner, who has the qualification of family doctor, reacts to all that s/he grasps of the patient's history, through all that has been said in consultation naturally, but also through things learned by participating in the social life of the neighbourhood or town.

> *«Lorsque son mari est décédé elle était très triste apparemment mais en fait elle a commencé à dépenser de manière compulsive tout ce qu'ils avaient mis de côté et donc j'ai eu l'occasion de la voir chez elle et je lui ai posé la question à plusieurs reprises hein et je lui disais que si, elle était très triste bien sûr par rapport aux événements mais que sans doute si elle avait tendance à abuser un peu des des apéritifs le soir notamment, bon c'est à cause de la solitude, le lendemain matin elle devait être encore plus triste quoi, et là, à chaque fois elle minimisait alors que les voisins me disaient qu'elle débarquait à 22 heures 23 heures dans un état qui laissait pas de doute hein.»* (678) [20]

Likewise, very few semiological elements are given with reference to manic-depressive psychosis (MDP). The utilisation of this concept by general practitioners turns it into an entity for psychiatric treatment, which they cannot get a grip on. Some of the prescriptions for antidepressants (15 out of the whole corpus) are repetitions of treatments started during psychiatric hos-

pitalisation or prescribed by a specialist. The hospitalisation reports, which sometimes present different diagnoses for the same patient, including diagnosis of MDP (155), do not give them much help. In the prognosis, it emerges that this entity, more than depression, belongs to the register of "psychosis" in the sense of a "very serious" illness requiring periodic hospitalisation (716) in a familial context that is sometimes tragic, such as those of the manic depressive *«qui a pété les plombs, dont l'oncle s'était pendu»* (who went off his rocker, the uncle hanged himself). Looking at the succession of psychiatric diagnoses, it seems that general practitioners prefer that of MDP, perhaps because it is less of a stigma for the patient, if it is presented as a sort of depression, and treated with antidepressants, among other medication. Nonetheless, like other psychiatric entities, it reveals the gravity of the disturbance and the inability to resolve it (806), the character of chronic illness that antidepressants regulate without hope of a cure.

> *«Elle a un fils qui a, qui est très dépressif un petit peu, un petit peu maniaco-dépressif, célibataire à plus de 60 ans aussi enfin»* (844) [21]

In general, in practitioners' practice related to "psychiatric" afflictions, it seems that the diagnosis is confirmed by the efficacy of the product administered, in this case a neuroleptic:

> *«Alors là pff j'en sais rien, c'est une dame, une psy d'un grave, bon elle prend des médicaments pour dormir aussi. Mais elle est psy hein, moi j'ai marqué paranoïa sensitive, ça c'est c'est moi qui fait ce genre de diagnostic mais, dans le sens où elle est elle est toujours en train de pleurer, elle a, toujours en train de se plaindre, elle, elle parle en pleurant, sans larme tu vois? donc elle a vraiment un problème, et et d'après ses enfants, elle est quand même mieux depuis qu'elle est sous Tercian*, ça l'a un petit peu enfin (?), bon ben elle a pas eu de chance non plus hein elle a elle a eu un ou deux de ses enfants qui sont morts jeunes»* (844) [22].

However, the comment that ends the presentation of this case shows that the physician finds it hard not to read some meaning into suffering treated in this way.

4. Prescription of antidepressant medication

Not all sadness lends itself to treatment, however, and some states, such as bereavement, are left to take their natural course «*Donc sur son problème de tristesse on a discuté, mais y'a pas eu de traitement*» (So we talked about her problem of sadness, but there wasn't any treatment). This was also the case of a female patient whose husband had abandoned her upon learning of her breast cancer and who was «not feeling well», *«n'est pas bien dans sa*

peau». She came to talk to the physician. Yet this is a case where prescription would be possible, for the general practitioner concludes: «*pour l'instant' il n'y a pas de traitement*» (for the time being there is no treatment). In these cases, some physicians give «*Guronsan® et puis des Oligosols® pour éviter des antidépresseurs ou des trucs comme ça, avec des bonnes paroles. Sans compter que la visite a duré au moins une heure...*» (Guronsan® and then Oligosols® to avoid antidepressants and things like that, with some good words. Not to mention that the visit lasted at least an hour). They gave their time. They also give their energy «*en fait elle avait une grosse inhibition anxieuse, mal de chien à lui arracher trois mots*» (in fact she had a major anxious inhibition, and I had a tough time getting three words out of her).

An extremely bad family situation requiring antidepressants (see below), such as the possible rape of a child, or the situation of a young woman who is described as «completely stressed out, she was off her rocker» (*complètement stressé, elle pétait les plomb),* were "treated" by prescriptions for an anxiolytic. The physician who had asked whether this woman felt suicidal (*si elle avait des idées suicidaire),* received the reply that she felt more like running away abroad. Likewise, the grief of bereavement that the patient drowns in a frenzy of compulsive purchases and alcohol is not even treated with medication, like the grief of a woman who at age 86 had lost her husband:

> *«qui a perdu son mari et qui s'en sort toute seule… c'est assez rare en général, la plupart des personnes âgées sont souvent sous anxiolytiques, antidépresseurs en ce qui les concernent… elle avait largement de quoi s'en sortir toute seule»* [(23)]

In all these situations, treatment involving psychotropic medication is not similar to other circumstances.

Antidepressants are prescribed when the disturbances are qualified as "psychosomatic", manifestations of a non-verbalised suffering that the physician tries to understand.

> *«On a beau se dire que c'est une colopathie. Bon. C'est psychosomatique mais est-ce vraiment psychosomatique en même temps, hein? c'est, on est on est dans. D'un autre côté, des examens Dieu sait qu'elle en a eu, alors est-ce qu'il faut aller encore plus loin? Je sais pas… Là je suis un petit peu emmerdé, parce que je je comprends pas trop non plus quoi, je comprends pas trop pourquoi maintenant. Mais en même temps, en même temp, c'est peut-être parce que y'a une souffrance qui qui qui qu'on comprend pas et qu'on touche pas et, bon on va voir hein. Et donc elle, sur le plan médicament, / cette femme n'a jamais eu de traitement psychotrope, pour autant que je me souvienn… Ça c'est un truc , problématique, qui va poser des problèmes, qui est pas résolu, je suis même pas certain que ça sera résolu un jour.»* (142) [(24)]

If the antidepressant mitigates the disturbance or if stopping the medication worsens the symptoms, then the diagnostic is confirmed. As in the case of a man who had a stomach ache every time he had worries, *«mal au*

ventre chaque fois qu'il avait des soucis» and for whom the antidepressant was effective, «*c'était donc bien un syndrome anxio-dépressif*» [25] (808) or a widow whose digestion problems are attributed to grief, «*c'était vraiment psychosomatique complet*» [26] (542), because they start up again when treatment is stopped. But for some doctors the relevance of this type of treatment seems to be like a step towards achieving verbalisation. For example, an elderly woman was treated for stomach troubles. The doctor said: «*Donc je lui avais mis un antidépresseur qui marchait bien*» [27], which the patient welcomed, «*tous les mois ou les deux mois je la vois avec les même doléances, donc je l'écoute et lui renouvelle son traitement de façon à changer*» [28]… «*bon, elle vient se plaindre, vider son sac un petit peu j'ai l'impression*» [29]. In more severe cases, like fibromyalgia, which resists treatment with antidepressants, the same physician is at a loss, convinced that the woman's extremely reserved attitude hides a secret that the pain irradiates. However, he is unable to make her talk;

> «*si j'essaie de lui suggérer qu'elle a des soucis qui pourraient… pof, le blocage tout de suite, donc , j'arrive à rien avec elle… Donc je pense qu'il y a quelque chose derrière dont elle ne veut pas parler, consciemment ou inconsciemment*» [30]

Backgrounds of alcoholism, prevalent in certain neighbourhoods, are sometimes associated with a tendency to depression, "*un fond dépressif*", and encourage this recourse.

> «*… ça c'est un grave, un grave aussi, c'est un diabétique qui a un comportement très très compulsif , avec ee des cuites phénoménales, qui ferme quelques fois la porte aux infirmiers, je je quasiment suicidaire, quasiment suicidaire…, il est très agressif… Donc il a fait également un infarctus, il est sous Effexor… voilà*» [31]

5. Effects of treatment

The pertinence of the prescription and the effects of treatment are reinterpreted, or at least related, in the same framework as the diagnosis. It is not easy to give an account of how treatment is experienced. The comments are repeated, briefly, but no details of the resolution of symptoms are given: «*il est sous antidépresseur et ça lui va bien, voilà*.» [32] «*elle est correcte voilà*» [33] «*c'est vraiment le médicament qu'il lui fallait, et elle est d'ailleurs sensiblement mieux*» [34] «*finalement elle a trouvé que c'était pas mal*» [35] «*ça semblait être un peu mieux*» [36] «*il a l'air d'avoir retrouvé le moral*» [37]. Concluding their accounts of office visits, the general practitioners position themselves more in the register of overall care for the person, than in the register of curing the disease. This is supported by expressions such as «*je voudrais l'aider mais à mon avis pour l'instant, 'je ne la tiens pas' quoi, je ne la tiens pas*» [38] or « '*contact' très*

intéressant, on cause bien ensemble» [39] evoked by the same physician referring to another patient. Another doctor theorises this for his practice, «*J'essaie d'avoir une relation très proche avec le patient, si je le connais trop, je l'envoie chez un psychiatre*» [40]. The physicians keep the patient away from a possible breakdown («*effondrement*») with its recognised fatal risks by staying in contact and maintaining the patient sufficiently within the framework of a therapeutic relationship to achieve this, but at a proper distance; – a symptomatological focus does not suffice for these ends.

These situations in which these family doctors diagnose "depression" show that they attempt to establish a real contact («*arriver à établir un vrai contact*») so as to bring out («*faire exprimer*») the unspoken that is revealed by the symptoms. The same is true for situations in which they justify prescriptions of antidepressants, whether for "depressions" linked to drug or alcohol abuse, elderly people, the ill, or for any other problem associated with bereavement, work relationships, or antidepressants prescribed in organic affections analysed as somatisation. When the contact has not yet been established with patients whose treatment was started by another doctor the recent nature of the relationship is put forward as the explanation:

> *«Et alors, bon alors en plus, mais j'ai pas trop creusé parce que malheureusement normalement, c'est vrai quand je les vois pour la première fois, je prends plus de temps et puis là c'était un peu sur le fil donc j'ai pas pu, mais on va se revoir, on va en parler ... et puis visiblement le (praticien de médecine douce) qui la suit il l'a mise sous Séropram* et Lexomil* depuis peu de temps et que, mais ça j'ai pas trop fouillé, savoir quel était la raison de son état dépressif alors qu'elle est amoureuse, m'enfin bon. Donc voilà».* [41]

There may or may not be a "reason" and if it is hidden, the antidepressant can help «to get things moving», «*ce qu'au moins quelque chose bouge*».

Through their experience these physicians are well aware that sometimes those that they readily qualify as "true depressives"– because they do not know the "reason" for their illness, or do not believe in the socially acceptable reason that is advanced- might collapse and reveal tragic family histories. For instance, a young mother, who seemed to have no real problems until she collapsed sobbing and spoke of a deep conflict between brother and sister, and their mother,

> *«sans soucis a priori, sauf que en grattant un peu ... était venue pour trois fois rien, on commence à parler ... s'effondre brutalement. Vraiment j'étais sidéré, et en fait elle me parle d'une histoire familiale, gros conflit entre frère et soeur et la mère ... dans un sanglot permanent»* [42]

She did not, however, reveal the underlying problem («*le fond du problème*»). Likewise, the third depression of a young woman, related to work difficul-

ties (job loss), *«un problème de travail, elle avait perdu son poste»*, reactivates the circumstances that had led her to consult the doctor at an earlier time, after the suicide of her father who was known to be an exhibitionist. The discussion turns to worries about the anorexic granddaughter. The palpable unspoken side of this family does not respond to attempts at psychotherapy, which are rapidly abandoned. Sometimes a patient recognises only sleep problems, and an antidepressant is given as a substitute for hypnotics, to try and "unblock" the situation, as in the following unsuccessful case:

> *«alors ça c'est un type qui est très très introverti, y'a de très gros problèmes de couple dont il n'arrive absolument pas à parler. Ça c'est la femme qui m'a dit hein?(RIRES) / il a eu des épisodes, il a encore, j'crois c'est un type qui profondément est dépressif. / mais qui n'arrive pas à exprimer quoi que ce soit. Sa femme m'a dit, qu'il il avait eu des pulsions suicidaires. J'en ai parlé avec lui mais il n'a jamais reconnu. / il a eu des troubles du sommeil, un mauvais sommeil qui était très très important, il ne dormait plus du tout, il/, mais bon il n'a jamais voulu, je n'ai jamais réussi à le f…, enfin il n'a jamais réussi à exprimer quoi que ce soit, il a toujours refusé de se faire aider, que ce soit par / par moi ou par un/, un un thérapeute, la seule chose qu'il acceptait un moment donné, parce que bon il voulait dormir et moi je lui ai dit écoutez, les troubles du sommeil sont liés vraisemblablement à une dépression, je ne vous donnerai pas d'hypnotique, et puisque bon, la situation était bloquée, je veux bien vous donner un antidépresseur pour voir et puis après si ça débloque la situation on pourra peut-être en reparler, parce qu'évidemment il a mieux, mais il n'est pas allé plus loin, et, et, il a arrêté au bout de deux mois, deux trois mois, et puis, . Alors je le voyais régulièrement tous les quinze jours, mais ça, c'est un mur, quoi. Il disait oui ça va mieux, je dors mieux. Bon ben alors / ben rien. Et puis voilà. La vie a continué, il prend pas de médicament mais / il est pas bien, sa femme non plus d'ailleurs.»* (43)

For the physician as well as for the patient, the illness "depression" is a «syndrome of signification and experience» (Good, 1998); together they seek to "encircle" in order to contain it. In our view this is how the term "reason" should be understood. Rather than sticking to a «linear causality» (Dardennes, 1999), for the physician, it could be a question of finding a meaning, an intelligibility, perhaps fictive but operational, that gives the doctor the capacity to initiate and support the care process for the patient.

6. Social suffering thus embodied

For the general practitioners in our study, the depressive episodes take place in a context that gives them meaning; a familial, social, even political context related in the interviews, rather than the symptomology of depression. By reflecting the closeness that they seek to have with their patients,

their discourse unfolds the manifestations of social suffering, as seen by the patients.

They naturally mention bereavement and separation, but in contexts that make them more difficult. For example, when a patient requires intensive family care:

> *«elle est dépressive la dame. Elle est dépressive mais elle est dépressive donc elle est sûrement accrochée à son temesta pour dormir, mais bon elle a des raisons hein, elle a elle a sa fille qui est hémiplégique qui vient de débarquer, enfin qui vient, qui est qu'ils ont pris en charge chez eux depuis deux ans et donc, la cohabitation est très difficile et son fils qui est mort subitement cette année, donc elle a un peu des raisons de bouffer du temesta hein. Et du prozac»* (44)

When the absence of a diagnosis makes it hard to accept the death of a spouse, doctors say: *«elle me dit 'je m'en sort pas'… son mari est mort on n'a jamais su de quoi, même à l'autopsie. C'est difficile à lui expliquer»* (45), the physician eventually suspects new diseases that are not analysed in routine autopsies.

The accumulation of family or marital conflicts and pathological or delinquent behaviour of children exhaust the patient's capacities: *«la mère en a fait une dépression, elle a tenu le coup un certain temps et puis voilà …»* (46). The antidepressant means an alternative :

> *«traitement antidépresseur parce qu'elle était vraiment pas bien … maintenant ça va mieux, parce qu'elle a aussi retrouvé une accroche sociale, elle travaille … le problème du fils n'est pas réglè … c'est vrai qu'on reparle un peu de tout ça au cours des consultations …»* (47)

The physician tried to use the same approach to break down a dependence on benzodiazepines that began with a divorce, but the woman absolutely refused to talk about it (48).

As some of the doctors handle substitution treatment for substance-abuse patients (8 out of 10, not necessarily in the private practice/hospital network), personal separations that occur while stopping drug use lead to prescription of antidepressants when the pathology is recognised.

> Q: *«C'était avec vous le sevrage ou bien il avait été en cure?»*
>
> M: *«Il avait été pour le sevrage de la toxicomanie? Non non il avait arrêté en même temps que l'alcool et il était pas très dépendant, il commençait vraiment, avant que son épouse lui dise bon ben ça suffit arrête-moi tout ça maintenant. Donc, il a tout arrêté, malheureusement elle a … pour d'autres raisons elle est partie. Donc là, il est plutôt dépressif donc avec prozac et un puis un traitement pour sa bronchite. Et là pour le moment, j'ai pas rajouté d'antidépresseur, non, d'anxiolytiques, plus un suivi aussi, un soutien psychothérapeutique, surtout pour faciliter»* (49)

Beyond this context, invalidity due to a multiple pathology, dependence on family and particularly on a spouse, the breaking off of professional

relationships at retirement and, for sailors, confinement with a spouse who is not used to living with her husband, incite the physician to propose medication as help.

> *«Il est obligé de se taper sa femme toute la journée ... comme il est assez fragile ... là maintenant, il est sous antidépresseurs parce qu'elle est insupportable quoi ...»* (50)

Nevertheless, once again, this assistance, which is intended to "manage the anxiety" of a serious disease such as breast cancer, is given as necessary only when the husband is not supportive but defective or hostile.

> *«et puis bon, je crois qu'il ne parle pas trop de la maladie de sa femme, mais il la supporte à mon avis très mal parce qu'il connaît le pronostic ... et puis il sent qu'un jour ou l'autre il va se retrouver tout seul»* (51)

The physicians link the prescription of anti-depressants to elderly patients (between 70 and 90 years old) to the anxiety of solitude or a fear of death that the elderly must confront alone during the long nights in retirement homes. The doctors think that the elderly have to combat this by hypnotics. Of course these patients are often also sick and bereaved, but their main problem is solitude, *«le handicap majeur, se retrouver seule dans la vie sans perspective autre qu'une vieillesse très handicapante»* (52). So when an 88-year old woman seems «much improved» (*«sensiblement améliorée»*) with medication and a stay in a rest home, this improvement can either be ascribed to the treatment (*«est-ce la raison?»*), or to playing dominoes with her companions.

Pressure encountered in the workplace, moral harassment of a union militant, or working conditions requiring mobility, which are the cause of depressions that are sometimes called "reactive", do not necessarily lead to a prescription.

In the region studied, which is not propitious for migrations but welcomes refugees, the suffering of expatriation may be surmounted for a while, and then people spill it all out one day in the doctor's office. This is the case of two young women; one who «drags through life» (*«traîne sa vie»*) with the impossible mourning for a father who was killed, undoubtedly in obscure circumstances, in the Balkan war, and the other who wears herself out trying to protect her children from a loss of social status and supporting her husband through the difficult period of professional reinsertion.

But the clear "reasons" behind these "breakdowns" should not mask the fact, hinted at by the physicians, that the recourse to medication is deemed necessary only as a release, to disembody suffering that is so massive that it is unspoken, or that cannot be spoken about under prevailing conditions.

Conclusion

For the family doctors who were asked to situate the prescription of antidepressant medication in an account of their therapeutic relationships with patients, the meaning of this practice extends far beyond the treatment of depressive entities as defined by various diagnostic handbooks. While these criteria may provide a framework, and justify the practice, they are very rarely the first aspects mentioned in this context. In the "culture" of these general practitioners on the front lines of social and even psychiatric suffering, it is difficult to detach the illness from the patient who experiences it. Like the patient, the doctors look for meaning in the illness and seek to place it in a personal context. Antidepressants emerge as tools in the care relationships, useful for "unblocking", "getting things moving", so as to make patients intelligible and possible to treat. The practitioners neither belong to the domain of psychotherapy, nor to the practice of psychiatry, but they follow fluctuating diagnoses and frequently renews highly complex psychiatric treatments; their analyses, however, apply to the familial and social context of their patients. Faced with psychic suffering, depression and problems in coping with life, the general practitioner does not pose as a clinical worker tracing the pathway from the analysis of pathological signs to clinical diagnosis and then to the drawing up of a therapeutic strategy. The approach is both more detailed and more complex. Clearly the prime concern is the patient's well being and the preoccupation is to "take care" of the patient. The family Doctor has indeed a caring function.

We have seen that the physicians put emphasis not so much on "life events", no matter how tragic, but rather the lack of outlets and a deficit of expression stemming from these events, as underpinning the "biologisation" in the form of illness. This is the case when the symptom is one of the "cardinal symptoms" of depression or any other symptom that they analyse as being a somatisation. Prescription of antidepressants, rather than the explicit diagnosis of depression, thus appears to be central for an analysis of "the interactions of social and biological aspects" in the framework of the system of signification which is the medical system, according to medical anthropology. This analysis would be but one contribution to a broader anthropology of medication (Van der Geest, Whyte and Hardon 1996), which would have to cover other actors, including the consumers themselves. This will be the next stage in our work. It would also be interesting to have physicians explicitly discuss the problems they encounter in handling depression, through focus group discussions. Analysing discussions from this type of consultation, while diffi-

cult, and would shed light on the subject of this culture-specific idiom of psychological distress (Massé 1999).

While the prescription of antidepressants can be analysed as a ritual, which the organisers understand in the meaning given to it by an interactionist perspective, we have analysed only the exegetic version, according to V. Turner, of one set of actors. This version suggests, however, that the rupture that this ritual tries to introduce, breaking with the anomie, the lack of purpose, meaning and direction in a situation and a society without communication, would be that which the patient can only embody via illness. The "social fact" named by Mauss harks back to Durkheim, and leaves us with our initial question, which is certainly a French preoccupation, regarding the specificity of anthropology with respect to sociology, two historically distinct disciplines in our country.

Notes

(1) Anthropologist and pharmacist, Faculté de Médecine de Brest / CESAMES.

(2) Psychiatrist, Service Alcool Toxiques CHU Brest.

(3) General practitioner, associate professor at the Faculté de Médecine de Brest.

(4) A prevalence of 9.1% in France according to the European survey "Depression Research in European Society (DEPRES) which used precisely this questionnaire.

(5) Respectively 126.2 (Finistère) and 108.3 (Côtes d'Armor) cases of mortality due to liver cirrhosis, alcoholic psychosis, VAD cancers, per 100,000 men between the ages of 25 and 64 for the period 1995-1997 (sources INSERM SC8 INSEE reference population France RGP 1999).

(6) 21.5 men and 8.4 women per 100,000 between the ages of 15 and 24 (sources *ibid.)*

(7) 903 visits, of which 401 elicited comments, 92 of which mentioned depression, MDP or prescription of antidepressants in one way or another.

(8) Regarding the comments on the rest of the week: 2 problems of dependency/10 for GP1, 3/3 for GP2, 5/14 for GP3, 4/8 for GP4, 8/20 for GP5, 10/18 for GP6, 4/8 for GP7, 23/36 for GP8, and 5/8 for GP9 (GP10 did not comment upon the patients seen during the week).

(9) 92 occurrences.

(10) It goes without saying that these figures are purely indicative, and serve only to put these physicians in context.

(11) [«Question: But when she came in for her depression, she was the one who said that she was depressed or were you the one that diagnosed it? How did it go?»

Practitioner: «Well, she came in crying»

Q: «Ah, she came in crying»

P: «She came in crying and saying that she wasn't at all well. She didn't ask me what was happening to her, but she came in saying what she had and that she was doing very poorly and so the diagnostis of depression, of a reactional depressive state was established for the sleep problems and there weren't any physical problems but there was a lack of enthusiasm in everything she did and so on, heh and that's how the diagnosis was established. But there was a demand, there was a demand, heh». (733)]

(12) [«... and he was depressive, for me he was depressive».

Q: «He had insomnia, he had...?»

P: «He wakes up tired, he's tired all day long, he has pains everywhere and he doesn't feel like doing anything, he doesn't want to read. He has the cardinal signs of depression.»]

(13) (735) concerning *«une maladie de parkinson, très peu évolutive bien contrôlée par le traitement mais qu'il vit très mal psychologiquement...»* «a Parkinson's disease, very little progression well controlled by treatment but psychologically he's very badly off».

(14) [«maybe, maybe the morning insomnia is missing, um, and even so I think he wakes up fairly early, but what is dominant are the somatic disorders, anhedonia and fatigue, um, those are the three tableaux»].

(15) [«She's a little lady who never feels good with herself... I sometimes manage it so that she leaves here smiling whereas she always comes in feeling very sad.»]

(16) [«Well, he's a very old man of 83 who has always been a bit depressive, I put him on antidepressants 16 or 17 years ago when I first came here, because he and his wife were very sad. They had just retired and they were right sad both of them.»]

(17) [«He was a man who was closed up because he was depressive, depressive because at work they wanted to get rid of him.»]

(18) [«She has been taking since the death of her son who was ill for a long time before dying so for a year she was he was rather sick and then he was in care, later if you will he was in a coma for nearly three months so it was very very hard for her and since then she takes an antidepressant.»]

(19) [«She's a lady that I know quite well, who, whom I have had since I met her twenty years ago when she was, I'd say, a social alcoholic, wife of a prominent citizen, somewhat bored all by herself alcohol consumption way over what one can accept. Her son was killed in an automobile accident, which didn't help any... I think now she doesn't drink any more, she doesn't smoke anymore, right that goes back ten, twelve years, um, but in contrast she has this depressive nature with which I associate consumption of alcohol. This depressive nature comes out cyclically, so there I had her, at the beginning of the year I put her on Deroxat* and it went well, she was rather positive.»]

(20) [«When her husband passed away she was very sad apparently but in fact she began to spend compulsively all they had saved up and so I had the occasion to see her at her home and I asked her about it several times and I told her that if, she was very sad of course about the events but that no doubt she had a tendency to abuse a little the drinks in the evening notably, well it's because of the loneliness, the next morning she must be even sadder what, and there, every time she minimised whereas the neighbours were telling me that she got home at 10 or 11 in the evening in a state that left no room for doubt.»]

(21) [«She has a son who has, who is very depressive a little bit, a little bit manic-depressive, a bachelor who is over 60 also.»]

(22) [«Now there pff I have no idea, she was a lady, a very serious psycho. Well she takes medication to sleep as well. But she's psycho, um, me I wrote down sensitive paranoia, that's me who makes that kind of diagnosis but, in the sense that she's always crying, she has, always complaining, she cries as she talks, without tears you see? so she really has a problem and according to her children she's nonetheless better off since she's been on Tercian* that (?) her a little bit, and well she wasn't lucky either she had she had one or two children who died young.»]

(23) [«who had lost her husband and who is coping all by herself... that's fairly rare in general, most old people are often on anxiolytics, antidepressants as far as they were concerned... she had largely the ability to cope on her own.»]

(24) [«It's all good and well to say that it's a colopathy. Fine. It's psychosomatic but at the same time is it really psychosomatic, eh? It's, we are we are in. On the other hand, the tests. God knows she had had tests, so is it necessary to go even further? I don't know... Now I'm a bit bothered because I don't really understand much anymore, I don't understand why now. But at the same time, at the same time maybe it's because there is suffering which which which isn't understood and nobody touches it and, well OK we'll go see. And so she, with medication, this

woman had never had psychotropic treatment, as far as I recall ... That's a thing, problematic, that is going to pose problems, that isn't resolved, I'm not even sure that it will be resolved someday.»]

(25) [«It was therefore really an anxio-depressive syndrome»].

(26) [«It was truly totally psychosomatic»].

(27) [«So I gave her an antidepressant that worked well»].

(28) [«Every month or two I see her with the same complaints, so I listen to her and renew her treatment so it changes»]

(29) [«Well, she comes to complain, get it off her chest a little is my impression»].

(30) [«If I try to suggest that she has worries that could ... pof, locked up right away, I can't do anything with her ... So I think there is something behind that she doesn't want to talk about, consciously or unconsciously»]

(31) [«... that it's a serious one, a serious one as well, a diabetic who has very very compulsive behaviour with incredible drunken sprees, who sometimes closes the door on the nurses, I I practically suicidal, practically suicidal ..., he is very aggressive ... So he also had a heart attack, he is on Effexor ... so there you have it.»]

(32) [«He is on an antidepressant and that suits him, so there»].

(33) [«She's OK, so there»].

(34) [«That's really the medication that she needed, and indeed she's much better»].

(35) [«Finally she found that it wasn't bad»]

(36) [«It seemed to be a bit better»].

(37) [«He seems to have gotten his good spirits back»].

(38) [«I'd like to help her but in my opinion for the time being 'I don't have a hold on her', what, I don't have a hold on her»].

(39) [«Very interesting 'contact', we have good chats together»].

(40) [«I try to have a very close relationship with the patient, if I know the patient too well I send him to a psychiatrist»]

(41) [«And so, well so in addition, but I haven't really dug down because unfortunately usually, it's true when I see them for the first time, I take more time and so here it was a bit acrobatic so I couldn't, but we will get together again, we'll talk about it ... and then clearly the (gentle medicine practitioner) who has been following her put her on Séropram* and Lexomil* not long ago and that, but I haven't really gotten into this, to know what was the reason for her depressive state since she is in love, but so there. There you have it.»]

(42) [«No real worries on the surface, except that when you scratched down a bit ... came for insignificant reasons, we start to talk ... broke down suddenly. Really I was flabbergasted, and in fact she tells me about a family affair, big conflict between the brother and the sister and the mother ... sobbing all the time»].

(43) [«Now this was a very very introverted fellow, there are very big conjugal problems that he is absolutely unable to talk about. It was the wife who told me that eh? (laughter) and he had episodes, he still does, I think he's a fellow who is profoundly depressive. But who can't express anything whatsoever. His wife told me, that he he had had suicidal impulses. I talked with him about it but he never recognised it. He had sleep problems, poor sleep patterns that were very very major, he didn't sleep at all, he, but well he never accepted, I never managed to get him ... I mean he never succeeded in expressing anything whatsoever, he always refused to be helped, whether by me or by a, a a therapist, the only thing that he accepted at one time, because well he wanted to sleep and me I said to him listen, the sleep problems are in all likelihood related to a depression, I'd like to give you an antidepressant to see and then afterwards if that unblocks the situation we can maybe talk about it again, because obviously he is better, but he didn't go any further, and and he stopped after two months, two three months, and then. So I saw him regularly every two weeks, but that, it was a wall, what. He said yes, he was better, I sleep better. So now what, well nothing. So

there you have it. Life goes on, he doesn't take medication but he isn't well, neither is his wife for that matter.»]

(44) [«She is depressive, this lady. She is depressive but she is depressive so she is surely addicted to her temesta for sleeping, but then she has reasons, eh, she has she has her daughter who is hemiplegic who has just shown up, I mean who is there, who is that they have cared for at their home for two years and so, it's very difficult to live together and her son died suddenly this year, so she has some reasons to gobble temesta, eh. And prozac.»]

(45) [«She said to me 'I can't cope'... her husband died no one ever knew what of, even after the autopsy. It's hard to explain to her»]

(46) [«The mother had a depression, she managed for a while and then there it is»].

(47) [«Antidepressant treatment because she really wasn't well... now she's better because she has also found a social connection, she is working... the problem of the son isn't settled... it's true that we talk a little about all that during the visits.»]

(48) *«/ et puis bon, on est un peu dans une impasse parce que je lui ai dit, bon du coup on a mis les choses à plat, je lui ai dit écoutez pour moi c'est, je lui ai déjà dit mais je pense que vraiment c'est dépressif, et que/ bon il faut, il faut essayer de comprendre ce qui va pas, pourquoi ça va pas, ça fait six sept ans huit ans que ça dure , vous allez pas vous en sortir comme ça, quoi. Je m'en fous, je veux pas. Bon. (RIRES) c'est pas facile hein, parce que on est un petit peu coincé, enfin coincé ou pas coincé, on peut continuer comme ça hein, y'en a des tas qui font.. Mais si on veut faire bouger les choses, là on est, on, on a créé en fait, on, on les a amenés là où ils sont, quoi, enfin en tout cas on les a accompagnés, solidement accompagnés (SOURIRE) et puis /, on fait machine arrière, c'est pas facile. Alors, bon, / là encore je lui dit écoutez on fait l'essai, prenez un traitement anti-dépresseur, au moins bon. Elle a accepté, elle dort mieux. (SOURIRES) ben c'est déjà bien. c'est déjà bien parce que / au moins ça l'a amenée à se poser la question, au moins ça, quoi hein. Je dors mieux, / indéniablement je dors mieux qu'avec tout ce que j'ai eu jusqu'à maintenant avec mon deroxat. Ça c'est clair. Alors qu'est-ce que ça veut dire hein ? puisque ça, c'est facile d'expliquer un cas où ça, c'est pas un hypnotique un truc-là, hein ? si ça marche, c'est que quelque part il y a un fond dépressif, y'a quelque chose quoi. Bon alors on va essayé de travailler là-dessus quoi. / peut-être que/ elle finira par accepter»*

«And so then, we are sort of at a dead-end because I said to her, so then we put everything on the table, I said to her listen for me it's, I had already told her but I think it is really depressive, and that well we have, we have to try to understand what is wrong, why it is wrong, this has been going on for six seven eight years you aren't going to make it this way, what. I don't care, I don't want to. OK. (LAUGHTER) it isn't easy, heh, because we are sort of stuck, at any rate stuck or not stuck, we can keep on this way, heaps of people do... But if you want to get things moving, there you are, one, one has created in fact, one has led them to the point where they are, what, at least in any event one has accompanied them, solidly accompanied (SMILE) and then, we backslide, it isn't easy. So well, once again I said listen let's give it a try, take an antidepressant medication, anyway. She accepted, she sleeps better (SMILES) so that's already something. that's already something because at least it made her ask herself the question, at least that, what. I sleep better, undeniably I sleep better than with everything I had up to now with my deroxat. That is clear. So what does that mean heh? because that, it's easy to explain a case where that, it isn't a hypnotic that thing, heh? if it works, it's that somewhere there is a depressive nature, there's something there. Good so we are going to try to work on that, what. Maybe she will accept in the end.»

(49) [Q: «Was the cut-off with you or had he been in treatment?»

"P: «Had he been in treatment to get off drugs? No no he stopped at the same time he stopped alcohol and he wasn't very dependent, he was starting really, before his wife told him OK that's enough, stop it all right now. So, he stopped it all, unfortunately she... for other reasons she left. So there, he was more or less depressive so with Prozac and then treatment for his bronchitis. And for the moment I haven't added on an antidepressant, no, anxiolytics, plus follow-up also, a psychotherapeutic support, above all to make it easier.»]

(50) [«He has to put up with his wife all day long ... since he is rather fragile ... so now, he is on antidepressants because she is impossible to live with, what.»]

(51) [«And then, I think he doesn't talk about his wife's illness too much, but he can't accept it in my opinion at all because he knows the prognosis... and then he realises that one day he will find himself all alone.»]

(52) [«The main handicap, to find oneself all alone in life with no perspective other than a very debilitating old age.»]

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