

The Use of Anti-Depressants

Clay Tucker-Ladd, Ph.D.
Author of *Psychological Self-Help*

Anti-depressants have been a major part of the pharmacological era in psychiatry. In the last twenty years, psychiatric practice has changed in major ways, namely, the shift from talking to giving pills. Many factors have contributed to this treatment revolution:

- The development of safer drugs with fewer side effects, especially the SSRI anti-depressants. These medications may not reduce depression better than older drugs but they are less likely to kill you when an over-dose is taken.
- The pharmaceutical companies have advertised intensely, turning consumers into drug advocates and permitting drug sales representatives to target primary care physicians rather than the much more rare psychiatrists.
- Moreover, HMOs have realized their profit-margins can be greatly increased when the drugs are dispensed by a family physician requiring only brief and occasional follow-up visits rather than by expensive psychiatrists. The distribution of drugs got much easier: just tell your regular doctor that you have been feeling down or tired and have had some crying spells, and you immediately get a prescription for anti-depressants paid for without question by your health insurance.

Millions have started taking anti-depressants and while they may have shifted from one brand to another, many have been satisfied. Nevertheless, it is generally recognized that anti-depressants take about 30 days to work and about 30% of depressed patients get little benefit from anti-depressants.

During the last two decades, the stigma against taking psychiatric drugs seems to have been considerably overcome but the stigma against "seeing a shrink" (psychological or psychiatrist) is still strong. Moreover, while Cognitive-Behavioral therapy has developed during this period, it hasn't had a breakthrough in terms of highly publicized effective techniques or in terms of cheap or easy treatment. In other words, anti-depressant drugs haven't had a lot of competition. Also, most people do not realize how little training and experience primary care doctors, in general, have in dealing with serious psychological disorders, including depression. Yet, as you know, if you have read the rest of this chapter, depression is a very complex and potentially dangerous disorder. It isn't something to be diagnosed in a few minutes. Since anti-depressants take 30 days before having full impact, a significantly depressed person needs frequent and careful monitoring immediately and during the first several weeks. The treating physician needs to get a detailed mental health history (mental problems or illness often accompany depression) and he or she should strongly encourage the patient to also get psychotherapy as well as drugs. Depression is not an easily treated disorder. The doctor/therapist should be expected to maintain long-term contacts with their depressed patients, at least every week for a few months and maybe much longer. Depression frequently comes back.

Ideally, a health care service for depression would have enough coordinated psychiatric and psychological specialists to carefully diagnose each case of depression, assessing the possible psychological, personal, circumstantial, interpersonal and physiological or genetic causes of the disorder. As a part of this

evaluation there should be a careful assessment of the risk of self-injury (see earlier sections of this chapter). This initial evaluation is not a trivial frill; it is crucial. This process should usually involve psychological testing and a detailed history as well as medical tests. The general practitioner is not this kind of specialist. (Light cases of depression could, I suppose, be handled more casually--but how can anyone identify a light case just by talking to a person for a few minutes?)

Another serious problem is that the general public has NOT understood or paid close attention to the research about the frequency of suicide and the obvious connection between depression and suicide. For instance, we often don't like to think about suicide as being an integral part of depression. Suicide is the eighth leading cause of death in the US. It is the third leading cause in 15 to 24-year-olds and the fourth most common cause of death between ages 10 and 14. This is serious--60% of high school students have had thoughts about killing themselves, 9% have tried. At every age, especially in old age, depression must not be dismissed and taken lightly. The "just take these pills and call me in three months" is not acceptable treatment. See the [Suicide section](#) of this chapter for a comprehensive review of this field of research

Not only has the risk of suicide underlying depression been taken too lightly, the generally positive public opinion about the effectiveness and safety of anti-depressants seems to have a major disconnect with the scientific evidence. There have been many, many studies. Of course, some of the studies have shown anti-depressants to be effective, sometimes. These drugs, however, are big sellers--among the best-selling medicines in the world, with such names as Prozac, Serzone, Wellbutrin, Zoloft, Remeron, Celexa, Effexor, Lovox, Paxil, and others--all similar in chemical composition. The total sales world-wide are about 20 billion dollars per year. In 2002 alone about 11 million prescriptions were written just for children and teens in the US. Let's think about why is it difficult to honestly know the effectiveness of anti-depressants (or any other treatment).

People come to see doctors and therapists because they are feeling badly, often their discomfort has gotten gradually worse, and they are seeking help at the height of their depression. If so, the chances are (for a variety of reasons) that the problem will later get better rather than staying awful or getting worse. This amelioration process is observed so often when scientists re-assess unusually high or extreme conditions; this going back towards normal (for you) is called "regression to the mean." So, you see a doctor with a bad cold, an aching back, a tension headache, etc., and soon in the natural course of things you begin to feel better (closer to average for you).

There is another process that also makes it hard to evaluate the effectiveness of a treatment method--the suggestion or placebo effect. It is well known that a sugar pill can help many people feel better (if the doctor suggests it is very effective medicine and will take care of the problem in a couple of days or weeks). If such a suggestion is made or just implied when actual medication is given, then the placebo effect and the drug effects combine together and both may be working. To prove the effectiveness of a drug (or any treatment) the amount of improvement shown to be due to the drug alone has to be significantly greater than the placebo effect by itself.

Note: according to testimony given in the fall of 2004 to the Congressional Energy and Commerce Committee, about half of all studies of anti-depressants have not shown in adults that the SSRI drugs are significantly

more effective than a placebo alone. Even worse, insignificant results were found in two thirds of the studies in which children were given anti-depressants and compared to children given a placebo. This is not well understood by the general public. Please note that these research findings certainly do not prove that anti-depressants are entirely ineffective (in fact, half the studies may suggest anti-depressants yield some benefits), but these results cast considerable doubt on the effectiveness of the drugs. Psychiatrists know the effectiveness of anti-depressants is limited; they commonly point out that anti-depressants do not help about 1/3 of their depressed patients.

In addition to these difficulties interpreting the results of research, more recently there is a new and very disturbing possible problem with using anti-depressants, especially with children and teens. Over several years, there have been occasional clinical reports of suicide and violence associated with taking anti-depressants. For instance, it was reported that Eric Harris, one of the suicidal shooters in Columbine High School, had been taking an anti-depressant (Luvox). Parents have described the sudden, out-of control suicide of a college student after taking a regular dose of anti-depressants (<http://www.nypost.com/news/nationalnews/30505.htm>). Britain prohibited prescribing anti-depressants to children and teenagers in late 2003 (a year before the US considered such action). Even more alarming, Shankar Vedantam of the Washington Post reported on September 10, 2004, that testimony was given at a congressional meeting that two internal **FDA analyses showed that anti-depressants, given to children and teens, were associated with increased suicidal thoughts, actual self-harm, and hostile behavior.** How much of an increase? FDA recently estimated that these drugs might double the risk of suicide in children. While the rate of suicide at that age is low, this sounds very serious. Other analyses by FDA reportedly indicated that the risk of suicide in children taking anti-depressants was only 2% or so greater than in children given a placebo. However, FDA also reported that children taking Effexor had almost 9 times the risk of suicidal behavior or thinking (also reported in Washington Post). These are much higher risks than most families would be willing to run, until science tells us more about identifying the children most at risk taking anti-depressants. We lack the accurate useable facts that we need. Any treatment causing deaths or near deaths is a serious matter that will probably have far-reaching effects on the treatment of depression. So, much more research is needed.

The difficulty of predicting suicide is discussed in some detail in the earlier [Suicide section](#). The suicide prediction problem is an important part of the decision to use anti-depressants or not. Also, the patient and his/her parents, if a child or teen, should be involved in the tough decision-making about the use of drugs. It isn't just a question of what approach offers the most hope for improvement but also what methods have helped and not helped before and how desperate the situation is. If I am feeling terribly miserable, I'd be willing to take more chances with a risky drug-- just the same as when risky surgery is an option.

Please remember I am not a physician. I have no expertise concerning drugs. My review is just a summary of the relevant available research which suddenly seems very important. The data and my comments should in no way be interpreted as opposing the use of anti-depressants. There probably are many circumstances in which it is a very good judgment to give anti-depressants to children and teens. This new information about anti-depressants with children just makes it critical that case

studies and treatment plans are done at the highest level of professional competence.

I strongly recommend each depressed patient (and his/her parents, if the patient is a minor); with the help of his/her physician (the prescription writer) explore the pros and cons of taking anti-depressants. It is not a simple decision. If the prescribing physician is not a psychiatrist or a psychotherapist, then a therapist (Psychologist or Social Worker) should permanently join the team. At this time (fall of 2004), only about 15% of children and teens being treated for depression are prescribed anti-depressants. If research continues to find suicide risks are associated with anti-depressants, surely a number of changes are likely to be made in the treatment of depression. What will change is hard to know until we get better research. For instance, we need to know the rate of suicide in certain types of patients in specific circumstances depending on whether they are taking anti-depressants or not. Science needs to map the high risk points for depressed patients on and off medication. Certain dangerous times have been known for many years, but we need to know more. For instance, Wessely, Kerwin & Kaye (2004) found that the most dangerous times for adults and children taking anti-depressants were in the first nine days of treatment (a four-fold increase in non-fatal suicide behavior). The risk is three-fold higher during days 10 to 29. What if they were not taking anti-depressants? Another high risk time for children and adults is when anti-depressants are suddenly stopped. It is important that the doctor and the patient know the high risk times so both can be especially vigilant.

In summary, moderate or serious depression carries with it a threat of self-injury. This risk requires special precautions. Taking anti-depressants must be considered carefully because the drugs may slightly increase the risk of agitation and suicide in some young people while the drug may effectively relieve depression in other people. The prescribing doctor, the collaborating psychotherapist, the patient, and the parents of a child or teen should be involved in making the treatment plans. The prescriber and/or the psychotherapist must see the patient frequently, probably weekly for an hour, especially during high risk or high stress or high agitation times. The FDA's concern is high enough that the drug manufacturers and the FDA are now considering adding a suicide warning on every package for children or teens. For unexplained reasons, the news reports describe the manufacturers as being more eager to have a blunt, rather scary label placed on their medications than is the FDA.

This article is excerpted with permission from the online self-help book, [Psychological Self-Help](#) by Clay Tucker-Ladd, Ph.D. Copyright © 2004 Clay Tucker-Ladd.