

Depression: Ask the Doctor

With Ken Duckworth, MD, NAMI Medical Director

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When is electroconvulsive therapy needed?

Electroconvulsive therapy (ECT) is a very unique treatment for severe depression. Like all treatments, it has risks and benefits. Medications and psychotherapy are considered the first line of treatment for major depression, yet ECT can be a life-saving intervention for the right people.

For many, ECT still carries negative associations due to Hollywood portrayals of the intervention. Depression accompanied by profound body symptoms (e.g., weight loss, sleep disturbance) is one example of a clinical picture that might respond to ECT. A person with depression accompanied by psychosis (e.g., a fixed, false belief that the person's internal organs are stolen or rotted) also can respond to ECT, sometimes in a dramatic way. ECT can impact memory, which is an important consideration. If you feel that your or your loved one's depression isn't responsive to other treatments, ECT is another option to investigate.

Recent research indicates that a combination of ECT and antidepressants may be helpful for some individuals. See Kitty Dukakis' book, *Shock*, available at [Amazon.com](https://www.amazon.com). Also read more about the book [here](#).

How will I know when my antidepressant is working?

Antidepressant medications typically address the "body" symptoms of depression first,--such as energy, sleep and appetite--along with reducing the intensity of the sadness and anxiety accompanying depression. Antidepressants often take several weeks to show an effect. Psychotherapy, such as cognitive behavioral therapy (CBT), can help address the negative thinking that accompanies depression and research shows that therapy combined with medication is more effective than either one alone. We know from the **NIMH funded STAR*D study** that if one antidepressant does not work, it is important to persevere and try another.

What can I do for treatment-resistant depression?

Treatment-resistant depression is a term for depressive symptoms that persist in the face of good intervention. I encourage people to review their care and see if they have had the best interventions before they conclude that they are unresponsive to treatment.

For example, are they engaged in psychotherapy? If they have a substance abuse issue (e.g., alcohol acts as a depressant), is that fully addressed? If they are taking medicines, what have been the doses and duration of treatment?

Adequate dosing and duration is required to assess a medication. We know from the STAR*D study that one medication may be more helpful even after several others have failed--so sticking to the treatment program is important.

Also, I encourage people who feel "stuck" to seek expert consultation to assess the treatment and offer suggestions to improve the problem.

Be sure to organize your efforts of treatment, the symptoms you live with and what you have tried in the past to help the consultant obtain a full picture and give you better information. You may also want to [read more about treatment-resistant depression](#).

How do I know if I really need antidepressants?

First, it is very important that to receive a thorough evaluation to ensure the correct diagnosis of any illness you are addressing with medications. The severity of the impact of the symptoms on your functioning or safety also plays part in the decision. If you have struggled with symptoms for weeks and have tried other interventions, such as psychotherapy, talking with your doctor is good idea.

Targeting key symptoms, such as sleeping problems and energy, can be a way to assess the impact of the medications. Finally, if you have a strong family history of depression, assess if your relatives have benefited from medications (or a specific medication) to help inform your choice.

How do antidepressants work?

In the past five decades, more has been learned about the biochemical aspects of depression. The first antidepressants were observed to be helpful as doctors were trying to treat other medical conditions. Over time, the idea that key neurotransmitters (chemical messengers in the brain) were altered in the symptoms of people with depressive symptoms led to treatments to address this. Serotonin, norepinephrine and dopamine are the most commonly impacted neurotransmitters in antidepressant treatment. Different medicines impact different neurotransmitters and therefore may have different effects and side effects. Talk these options over with your doctor before beginning a course of antidepressant medications.

What other conditions could be causing these feelings besides depression?

A good evaluation is important to sorting out the best treatment. Medical conditions can mimic depressive symptoms and have different treatment approaches. For example, anemia can cause fatigue and weakness. Thyroid disorders can cause slowed metabolism and can look like a clinical depression.

Medications you may be taking for other conditions, such as high blood pressure, can cause a depressive syndrome. Alcohol and street drugs can generate depressive symptoms as well, so exploring at that aspect is important. Finally, human grief after the loss of a loved one can look like a major depression; with love and support, this grief typically resolves in time. If symptoms persist for months or safety concerns arise during grief, then an evaluation with a professional is needed.

What is bipolar depression? Is it treated differently than major depression?

People who live with bipolar disorder actually spend more time in the depressed phase rather than the manic phase of the illness. The STEP-BD study, the largest study of individuals with bipolar disorder, demonstrated the challenges of treating bipolar depression. Antidepressants were not found to be very beneficial for bipolar depression in this study, which challenged some prior studies and clinical experience. There are several medications recommended or approved for the treatment of bipolar depression. For more information, visit [NAMI's BPD page](#). The psychosocial aspects of treatment like psychotherapy, family psycho-education and cognitive behavior strategies were found to be more helpful than previously thought. The field continues to learn more in this important area, so be sure to talk with your doctor about this evolving field.

I have been told I can't be treated for depression because I am still dealing with my alcohol addiction. Is that really true?

The mental health and substance abuse fields each have a very different history and culture, and this unfortunately leads to statements like this from both sides of the equation. People require both concerns to be addressed in real time. In some cases, these are the highest-risk individuals and the systems of care have a particular responsibility to serve the riskiest people. NAMI advocates for full and complete integration of co-occurring substance abuse and mental illness treatment. Learn more about [dual diagnosis](#).

I am worried about suicide for my depressed relative. What should I do?

Suicide is a central risk in depression. "Safety first" is a good rule of thumb. Be sure to talk with your relative if you have this concern and strongly encourage him or her to get an evaluation as soon as possible. Untreated depression can lead to suicide. Fortunately, most people with depression respond to treatment.