

Depression and Medication

Laura Pinsky, LCSW

Columbia University Counseling and Psychological Service

What is depression?

In the language of clinical psychology, depression is a syndrome, a cluster of emotional, physical, and behavioral symptoms characterized by sadness, low self esteem, loss of pleasure, and, sometimes, difficulty functioning. If these problems persist for more than two weeks, cause real suffering, and interfere with the business and pleasure of daily life you may have a clinical depression.

In everyday conversation people say they are depressed when they are feeling unhappy, down, blue, sad, or hopeless. Almost everyone has experienced these emotions, and many people eventually suffer some adversity or loss that could give them reason to be anxious or depressed at times. These feelings are just one part of everyday life for most people.

However, if the feelings are overwhelming or persistent, you may benefit from psychological evaluation and treatment. Depression of this type can be effectively reduced or even eliminated with treatment that is often relatively simple. Professional intervention in serious depression can reduce suffering and improve the quality of life.

What is the psychiatric definition of depression?

In the United States today, psychological symptoms are organized into diagnostic categories written by the American Psychiatric Association (APA) and known as DSM-IV criteria. These categories are pragmatic constructs and do not capture the richness of mental and emotional life. However they are useful in determining whether medication might reduce your symptoms and, if so, which medications should be tried.

There are several sub-categories of depression. The most common are **major depression** and **dysthymia**.

Basic criteria for **major depression** are (literally) one symptom from column A and four symptoms from column B, lasting for at least two weeks.

Criteria for Major Depression

One from Column A	Four from Column B
<ul style="list-style-type: none"> • Feeling depressed most of the day and almost every day. (Down, sad, blue, hopeless.) It can evolve gradually over a few weeks or suddenly after great stress, or • Loss of interest and pleasure in things that are usually interesting and pleasurable; this can be partial or complete. Some people may not be able to feel better no matter what the circumstances; others may periodically respond to positive things by feeling better. 	<ul style="list-style-type: none"> • Loss of appetite and/or weight loss without dieting or medical cause, or increase in appetite and/or undesired weight gain. • Insomnia (Waking up early and not being able to fall back asleep; difficulty falling asleep). Sleeping too much. This happens to everyone at some point. It can be a symptom of depression if it is persistent. • Being slowed down physically or mentally. You and other people notice that it takes you longer than usual to accomplish activities. • Being agitated (restless, can't sit still, pacing, wringing hands, rubbing head). • Fatigue, loss of energy. • Feeling excessively guilty or worthless. • Difficulty in concentrating. Feeling that your thinking is slowed down. Increased difficulty in making small decisions. • Persistent thoughts about death and/or suicide.

What other problems might I notice if I'm depressed?

You may experience some of the following problems if you are depressed:

- Criticizing, attacking, and berating yourself.
- Skipping days of work or not going to work.
- Inability to study or pursue serious intellectual or creative interests.
- Loss of interest in sex.
- Avoiding friends or usual social activities, hobbies, or recreations.
- Inability to enjoy activities or events in which you normally take pleasure.
- Neglecting yourself physically (in terms of grooming and hygiene).

- Forgetfulness.
- Crying a lot or feel like crying without knowing why.
- Feeling irritable and getting into arguments easily.
- Increased and excessive use of alcohol or other recreational drugs.

One of the common symptoms of depression is a feeling of hopelessness. If you are seriously depressed, you may feel that it is impossible to get help and that you will never feel better. You may feel that you have always been in this mental state. This hopelessness can lead to failure to get help. If friends comment on your depression or suggest that you get professional help, take them seriously.

Major depression can be a harmful, incapacitating, or even dangerous disorder. You may have difficulty attending class, completing academic work, or fulfilling other responsibilities. You may take risks, which in a non-depressed period of time would be unacceptable to you, including risks with alcohol, drugs, or unsafe sexual activity. At its worst, depression can lead to suicide.

If someone in your immediate family has had an episode of severe depression, studies indicate that you probably face an increased risk of developing this kind of depression.

I feel depressed most of the time but I manage to function on a daily basis. Is there help for this kind of depression?

Yes. **Dysthymic disorder** is a term used in psychiatry to describe an ongoing depression that may not be as severe as a major depressive disorder, but is chronic, often lasting for years—and, for some people, as long as they can remember.

The symptoms may be similar to that of major depressive disorder, but milder—that is, fewer and less severe symptoms. The diagnosis is usually made when the symptoms have lasted for at least two years.

Following are the DSM-IV criteria for dysthymia:

Criteria for dysthymia

Feeling unhappy or "down" most of the time on most days

AND

While depressed, at least two of the following symptoms are present:

- Poor appetite or overeating
- Difficulty sleeping or sleeping too much
- Low energy or fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Feeling hopeless
- Excessive use of alcohol or other recreational drugs

People with dysthymia are able to work and generally conduct their lives but often feel irritable, are chronically unhappy with themselves, unable to enjoy things, and may feel that life is not very worthwhile.

When should I get help with depression?

Major depressions often do get better on their own but this can take at least six months or a year and some symptoms may persist for months or even years. Adequate treatment can often shorten the period of time that you are suffering to a few weeks or less. Getting help may keep you from losing a job, a relationship, or even your life. Dysthymia can be life-long, and many people who have episodes of major depression also suffer from dysthymia.

If depression is intense and interferes significantly with your daily life for a period of time (major depression), or if you are functioning adequately but feeling depressed for months at a time (dysthymia), you should seek help from a mental health professional. You should always seek help if you are suicidal or neglecting necessary medical care.

Can other medical problems or medications cause symptoms of depression?

Yes.

This is one of the reasons that your psychiatrist needs to take a careful history. A number of medical problems can lead to symptoms identical to those of depression. However, these illnesses are unusual in a University-aged population. Additionally, some prescription and recreational drugs may cause depressive symptoms. For some women, the use of some types of birth control pills may cause depression. If the start of a depression coincides with beginning birth control pills, this should be considered as a probable cause and birth control pills should be changed or discontinued.

What are the possible treatments for depression?

Psychotherapy is helpful in treating depression. If you are depressed it is crucial that you have someone to listen to your feelings, provide support, and help you understand what is troubling you. Although friends, lovers, and family may serve some of these functions, it is best to have a well-trained and more objective mental health professional to provide you with help. Supportive talk therapy need not be lengthy.

Medication with antidepressants is the quickest way to relieve major depression and is helpful for severe depression associated with suicidal thoughts and/or major disruption of functioning. It relieves symptoms and allows you to go on with your life. In general, two thirds of patients with a major depressive disorder will respond positively to the use of medication within two weeks to two months. Most of the rest will get better when they try a different antidepressant. Major depression is one of the most treatable of medical conditions.

Medication also works for dysthymia. Although the improvement may look less dramatic than in major depression, it can lead to a meaningful improvement in your life.

The best treatment for both major depression and dysthymia is a combination of medication and talk therapy. Numerous studies show that both psychotherapy and medication are very effective in treating depression. A recent study (and a great deal of clinical experience) indicates that a combination of the two is most effective in treating depression.

Aren't antidepressants just "happy pills" that will cover up the real problem and keep me from solving it?

No. If you are not depressed and take antidepressants, they will not improve your mood or functioning. People who are significantly depressed often lack the perspective and energy to understand and deal with underlying problems. Many therapists report that patients who are treated with antidepressants make more progress in talk therapy because they have the ability to grapple with emotional and practical problems when the depression is lessened with medication.

Aren't psychiatric drugs only for people with severe mental illness?

It is a common fear that taking medication means you are "crazy," or that medication will sedate you into being a zombie, change your identity as a person, or disarm appropriate anger at social injustice. These fears are unrealistic. Psychoactive drugs are useful for people with a wide range of problems, not just people who are "crazy." People who are generally well functioning psychologically can have transient periods of depression. There is no reason why you should suffer such distress when safe, effective medication can reduce the burden you have been forced to carry.

When a major source of stress is present such academic problems, medical illness, family problems, or difficulty in a relationship, you may tend to accept depression as inevitable, understandable, and unchangeable, and therefore inappropriate for medication-oriented treatment. However, just because a stressor is known, medical treatment is not invalidated. We understand an arm can be fractured because of the stress of a fall; but we still set the bone in a cast. Understandable and proportionate sadness and worry should be distinguished from depression.

While some drugs used to treat severely disturbed people are sedating, the drugs normally prescribed for milder problems are not. Drugs used to treat depression generally restore you to normal mood rather than blunting or blurring all feelings or robbing you of emotion or passion. A small number of people do experience a sense of apathy or flatness on some antidepressants. In this case a different antidepressant may not have the same effect.

Like other drugs, psychoactive medications have some side effects. Many of these side effects are typically noticeable at the beginning of a course of medication and diminish or disappear after a few weeks, though some may be more persistent. When prescribed correctly, psychoactive drugs do not dull your intelligence or your ability to perceive reality. Depression inhibits your ability to see the world clearly and act effectively. By reducing anxiety and depression, drugs help some people clarify their thinking and become more active.

What medications are used to treat depression?

A number of different drugs, referred to as antidepressants, are used to treat depression. Antidepressants belong to several different categories. They affect the function of certain neurotransmitters in the brain, although the process is not completely understood.

The medications that currently are most widely used to treat both major depression and dysthymia belong to categories referred to as SSRIs, “selective serotonin reuptake inhibitors” or SNRIs “serotonin/norepinephrine reuptake inhibitors. They take their name from the effect they have on a neurotransmitters in the brain known as serotonin and norepinephrine, which are believed to play a role in causing depression. There are currently six SSRIs (drugs that affect serotonin) available in the United States:

- **Prozac** (fluoxetine)
- **Paxil** (paroxetine)
- **Zoloft** (sertraline)
- **Luvox** (fluvoxamine)
- **Celexa** (citalopram)
- **Lexapro** (escitalopram oxalate)

Three SNRIs (drugs that affect both serotonin and norepinephrine) are currently available. They are

- **Effexor** (venlafaxine)
- **Remeron** (mirtazapine)
- **Cymbalta (duloxetine).**

An additional drug that is widely used to treat both major depression and dysthymia is **Wellbutrin** (bupropion). This drug directly affects chemicals in the brain other than serotonin, mainly noradrenaline and dopamine.

For reasons that are not understood, some people respond to one drug and do not respond to another drug in the same class. Additionally, the severity of side effects of each drug varies from person to person. Therefore, if you do not get better after a therapeutic trial of one drug or have unacceptable side effects, you are still likely to respond well to another antidepressant. Occasionally people respond best to a combination of medications and may, paradoxically, have fewer side effects.

These antidepressants are generally the first choice for treating both dysthymia and major depression. They are as effective as the older drugs used to treat depression and have fewer and less serious potential side effects.

How safe are these drugs medically?

Generally these drugs are very safe. The antidepressants listed above have not been used long enough to study very long-term side effects, but they have already been in use for more than ten years with no long-term side effects. In addition, these drugs are safer for people who may have suicidal impulses; it is very hard to kill yourself with an overdose of these drugs alone.

How do the above antidepressants differ?

All of these drugs appear to be equally effective in treating both major depression and dysthymia, though there are insufficient data available to make a clear-cut comparison. They vary primarily in terms of side effects, and you and your psychiatrist will make the decision on which drug to use based largely on these side effects.

What are the side effects of these drugs?

Almost all medications have a wide variety of possible side effects, and this is true of the SSRIs and Wellbutrin. As with other drugs, only a few of these side effects are common. However, there is tremendous variation in response to medication. Do not hesitate to report any possible side effects to your psychiatrist, even if they are not typical of the drug you have been given.

The following description is intended to be a general overview of side effects and is not complete.

Sexual side effects

The most common side effect of **Prozac, Zoloft, Paxil, Celexa, Effexor,** and **Luvox** is sexual dysfunction. People are highly variable in how they respond to these sexual side effects. The most common sexual side effect is delayed orgasm. The next most common is decreased libido, or sexual desire. A small proportion of men develop problems getting an erection. Delayed orgasm can range anywhere in severity from a slight delay to a complete inability to achieve orgasm. Its impact on sex varies. It may prolong sex in a pleasurable way, or it may significantly inhibit pleasure. The orgasm itself may feel different.

Consequently, some people find the sexual side effects of these drugs tolerable while others find them extremely disturbing and discontinue medication or switch to another drug. These side effects reverse when the medication is stopped.

Sexual side effects occur in both women and men, although most of the clinical studies have been done on men. There is disagreement over what percentage of patients develops these side effects; possibly up to 75% of patients who take these drugs develop some sexual side effects. In some people the side effects disappear after a few weeks on the drug. Some people report a decrease in sexual desire, which may be secondary to the difficulty in achieving orgasm. Although inadequate data are available, **Wellbutrin** and **Remeron** appear to have fewer sexual side effects and **Wellbutrin** in combination with other antidepressants may even decrease the sexual side effects of those antidepressants.

The impact of these side effects on the individual and his or her partner(s) varies tremendously. Sometimes delayed orgasm can be an advantage if premature orgasm has been a problem in the sexual activity. For others, substantial delay in orgasm can be a major problem.

Sexual desire may be diminished, or absent. Sometimes spontaneous thoughts of sex lessen or disappear, while sexual response to external stimulus is well maintained.

Erectile problems, when they do occur, generally respond well to treatment with **Viagra**, **Cialis**, or **Levitra**.

Information regarding the sexual side effects of these drugs in women is somewhat limited. Because of cultural prejudices, discussions (especially with male doctors) about sexual side effects are often omitted, insufficiently detailed or followed up in subsequent visits, or considered unimportant.

Sometimes people don't care about sexual function when depressed. Since loss of sexual desire is a symptom of depression, some people who start these medications report an improvement in their sex lives despite delayed orgasm. Remember however, that as your depression lessens, sex may become more important and sexual side effects more bothersome. At this point you should feel free to raise this issue with your doctor.

Insomnia and agitation

All SSRIs and SNRIs and **Wellbutrin** (especially) may cause mild to moderate insomnia or restlessness, agitation and nervousness. Occasionally these side effects may be severe. Again, occurrence of this side effect varies from person to person. It usually gets better after a few weeks and some psychiatrists prescribe sleep or anti-anxiety medication to use until these symptoms remit. With some

people, the agitation may be severe enough to lead to discontinuation of the drugs.

Sedation

All of these medications occasionally cause sleepiness in some people. With **Remeron** this is a frequent problem.

Weight gain and loss

All SSRIs and SNRIs may cause weight gain in some people; this has been frequently observed in clinical practice, though research data are limited. This appears to be most frequent with **Remeron** and least common with **Lexapro**. At the same time, **Prozac, Zoloft, Paxil, Luvox, and Wellbutrin** may cause temporary loss of appetite and consequent weight loss when they are started.

Other side effects

- **Prozac, Zoloft, Paxil, Luvox, Celexa, Effexor, and Wellbutrin** all may cause temporary nausea, stomachache, diarrhea, or headache. Generally these symptoms are mild and disappear after a few days or weeks.
- **Remeron** and **Zoloft** may increase cholesterol levels.
- **Effexor** may cause constipation and dry mouth, and it causes high blood pressure in a small number of people who take the drug. This happens in the higher dose range and is usually minimal, but should be monitored. This may be true of **Cymbala** as well.
- **Wellbutrin** can cause seizures. This has occurred in less than 1% of people who take the drug and can be avoided by taking the correct dosage of medication. Discuss the right way to take Wellbutrin with your psychiatrist. If you have a previous history of seizure disorders, significant head trauma, or an eating disorder, you should not take Wellbutrin at all.
- All SSRIs **may** cause anticholinergic side effects (dry mouth, constipation, difficulty urinating) and orthostatic hypotension (low blood pressure)

How fast do these drugs work and how long should I take these them?

Antidepressants are usually started at low dosage and then increased. Significant improvement should occur in two to six weeks after taking a therapeutic dose of the drug; do not expect it to work immediately, although some people feel better within a few days. If one antidepressant does not work,

another may be effective. Inadequate dosage or inadequate length of time on the drug is the most common cause of treatment failure.

Antidepressant medications are usually taken for four to six months. If depression recurs when the medication is stopped, these antidepressants may be taken on an indefinite basis.

What if I want to stop taking my antidepressant?

It is best to consult with your physician about how best to terminate medication. It is usually best to taper off medication. This is especially true of **Paxil** and **Effexor** which may cause extremely uncomfortable side effects if terminated abruptly.

Are these drugs used to treat other problems?

The SSRI drugs are also used to treat a number of other psychiatric problems including panic disorder, social phobia, and obsessive-compulsive disorder.

Some people who are depressed treat themselves with **St. John's Wort** (*hypericum perforatum*), an herbal supplement available without prescription in health food stores. You may consider this preferable to one of the prescribed medications because of the ease of obtaining it and because it is seen as "natural". It is probably an effective antidepressant for some people and has been widely used in Europe. However, recent studies show that **St. John's Wort** is less effective than SSRIs and SNRIs in treating depression. Additionally, the strength of pills varies from manufacturer to manufacturer, and, like other medications, it has side effects. Discuss the use of St. John's Wort or any other over-the-counter medication with your psychiatrist.

What if SSRIs don't work?

A group of drugs referred to as **cyclic antidepressants** are also commonly used for treating major depressive episodes. They are extremely effective; their efficacy equals that of the newer antidepressants and in some situations they may be preferable. In past years they were the first line of treatment for major depression, however, they have more side effects than SSRIs and now are usually used for patients who do not respond to SSRIs.

Cyclic antidepressants

- **Tofranil** (imipramine)
- **Norpramin** (desipramine)
- **Elavil** (amitriptyline)

- **Aventyl** or **Pamelor** (nortriptyline)
- **Sinequan** or **Adapin** (doxepin)
- **Surmontil** (trimipramine)
- **Vivactil** (protriptyline)
- **Ludiomil** (maprotiline)
- **Asendin** (amoxopine)
- **Anafranil (clomipramine)**

These cyclic antidepressant medications vary primarily by side effects. Some are more sedative than others—that is, they make you feel sleepy or fall asleep. This can be useful if you are suffering from insomnia, or troubling if it interferes with your daily activities.

These drugs have, to various degrees may have side effects include dry mouth, constipation, blurred near vision, and difficulty in urinating. (These are referred to as “anticholinergic” side effects). Dry mouth is the most frequent symptom. Sucking on hard candies, especially citrus-flavored ones (preferably sugar-free ones for the sake of your teeth) can alleviate it.

Sometimes cyclic antidepressants cause a drop in blood pressure associated with change in posture that can lead to fainting or dizziness. This is referred to as orthostatic hypotension. Standing up slowly after being in a prone or squatting position can help prevent this.

- **Norpramin** (desipramine) and **Tofranil** (imipramine) are two of the most widely prescribed cyclic antidepressants. Norpramin is one of the least sedating of the cyclic antidepressants and causes fewer anticholinergic side effects (dry mouth, etc.) than most other cyclic medications. It can be monitored in the blood with blood tests to determine if a therapeutic level is being reached. Norpramin causes fewer anticholinergic symptoms than Tofranil but some psychiatrists believe that it is less effective than Tofranil.
- **Elavil** (amitriptyline) is very sedating and causes severe anticholinergic side effects (such as dry mouth).
- **Vivactil** (protriptyline) has the advantage of possibly being energizing and not causing weight gain. However, it has severe anticholinergic side effects and can cause anxiety and insomnia.
- **Ludiomil** (maprotiline), **Sinequan** or **Adapin** (doxepin), **Surmontil** (trimipramine), and **Asendin** (amoxopine) are antidepressants that are currently not widely used. They have no major advantages, and they have problems that make them generally less desirable than other drugs. **Ludiomil** can increase the possibility of developing seizures. **Sinequan** is believed by many psychiatrists to be less effective than other cyclic antidepressants but is often used as an effective and non-addicting sleeping pill. **Asendin** can

cause a serious and sometimes irreversible side effect known as tardive dyskinesia, an involuntary movement of muscles.

All of the cyclic antidepressants except Vivactil may cause weight gain. They may cause fewer sexual side effects than the SSRIs.

People with narrow angle glaucoma or certain heart rhythm irregularities may not be able to take certain cyclic antidepressants.

Monoamine oxidase inhibitors (MAOIs)

MAOIs are antidepressants generally used for patients who have not responded to other antidepressant drugs. They are not usually the first choice but can be very effective and seem to work well in certain patients who are considered to have atypical depressions (depression with overeating and too much sleeping). They are particularly useful for people who have depression combined with panic disorder, although other antidepressants work for this purpose also. The following MAOIs have comparable effectiveness and similar side effects.

- **Parnate** (Tranylcypromine)
- **Nardil** (Phenelzine)
- **Marplan** (Isocarboxazid)

MAOIs have significant side effects. They provoke dangerously high blood pressure when combined with a substance known as tyramine, which is contained in some food, beverages, and drugs. If you take MAOIs you must avoid liver, cheese pizza, Chianti wine, certain beers and cheeses, herring, bologna and some other sausages, and a number of other foods as well as many cough and cold medications. Any meat you eat must be fresh. Coffee and chocolate should be consumed only in small amounts. If you take MAOIs you must get a dietary restriction list from your doctor. If you eat a “forbidden” food with no problem, you may still develop a severe reaction if you eat that food again because the amount of tyramine may vary in these foods.

Are there other types of depression besides major depression and dysthymia?

Yes. One of these is **bipolar affective disorder**. Mania, like depression, is a disorder of mood, an affective disorder. It often presents itself as a state of extreme excitement, euphoria, or intense irritability. Some patients who have serious depressions may at other times have manic episodes. This is referred to as a manic-depressive illness, or **bipolar affective disorder**. Mania is a much less common problem than depression. Bipolar affective disorder, like other affective disorders, seems to be inheritable.

Symptoms include:

- Elevated, expansive, or irritable mood
- Extreme talkativeness, racing thoughts, a decreased need for sleep, increased activity, agitation, distractibility, poor judgment about spending money, unrealistic planning, grandiosity, and hypersexuality

When these symptoms are severe, interfere on an extended basis with work or daily life, or require hospitalization, the disorder is classified as mania. If the symptoms are less severe, it is classified as hypomania.

Use of antidepressants during a depressed period may trigger a bout of mania in a small percentage of people. This does not mean that you cannot use antidepressants. Rather, it means that you must be monitored closely by a psychiatrist, and may need to take a second medication in order to prevent the development of an episode of mania

A number of medical problems and medications can cause mania and hypomania. Some drugs that cause mania or hypomania are amphetamines, cocaine, and steroids. Any infection or cancer that affects the brain and causes organic mental disorder can manifest itself as mania or hypomania. Treating the illness or discontinuing the medication that causes the symptoms is the first order of business. As with depression, your ability to assess the need for treatment may be impaired.

Drugs that are used to treat mania: For people who have a pattern of manic and depressive episodes known as bipolar disorder, drugs referred to as “mood stabilizers” work to prevent recurrence of the illness. The most effective mood stabilizers are **lithium**, **Tegretol** or **Trileptil** (carbamazepine), **Depakote** (divalproex sodium) and **Lamictal** (lamotrigine). **Neurontin** (gabapentin), and **Topomax** (topiramate) are most effectively used in combination with other mood stabilizers.

Mood stabilizers can be used in combination with antidepressants to help someone in the depressed state of bipolar illness. **Lamictal** shows promise for treatment of the depressed stage of bipolar disorder, as well as being a mood stabilizer. Acute mania is treated with other tranquilizing medication and many people do not need to take medication for the hypomanic phase of their bipolar disorder.

Where should I get medication for depression?

It is best to get antidepressants from a psychiatrist. If this is not possible, your regular physician can prescribe antidepressants. Effective medication depends on correct diagnosis. Diagnosis of psychological symptoms requires specialized training and prescribing psychoactive drugs optimally requires experience.

Proper dosage can be critical, and the choice of effective drugs can be subtle. Therefore, a psychiatrist is the best physician to prescribe antidepressants.

It is important to see a psychiatrist who is well trained and up-to-date on the use of psychoactive drugs. You may want to consult a psychiatrist who specializes in the use of such medications, called a psychopharmacologist.

Psychopharmacologists are more likely to choose the most suitable drug for you and are more likely to prescribe appropriate doses. They are trained to have an organized strategy for trying different drugs if the first is not successful. The psychiatrists at the Columbia Counseling and Psychological Service are expert at treating depression. Because they are familiar with the particular problems of University students, they will help you deal with side effects of medication (such as fatigue) that may impede academic work. A CPS psychiatrist can evaluate you and provide follow-up for a period of time. Your Health Service fee covers such treatment. If additional follow-up is required, CPS will make an affordable and reliable referral. Although anti-depressant medications can be somewhat costly, the cost is generally covered by your student medical insurance.

If you are unable for any reason, financial or otherwise, to see a psychiatrist, you may get antidepressants from your regular physician. Often this is a successful approach, since many people respond well to the first drug they are given for depression and have few complications. This has become less problematic, as SSRIs are usually less complicated to prescribe than older antidepressants. However, your regular doctor may lack the expertise and the time to make a careful assessment. Physicians (and even some psychiatrists) inexperienced with medication sometimes prescribe antidepressant or anti-anxiety drugs at doses that are not ideal. Non-specialists may also give up if the first medication does not work. If you are treated for depression by your regular physician and do not respond, you should make every effort to see a psychiatrist rather than give up.

If you are in therapy with a well-trained psychologist or social worker, s/he will be able to make a preliminary diagnosis of depression and refer you to a psychiatrist. At that point the therapist and psychiatrist will consult and work with you collaboratively. If you are not already in therapy, the psychiatrist should refer you to a non-medical therapist for talk therapy. Some psychiatrists provide both medication and talk therapy.

Consultation for medication with a psychiatrist for medication generally involves several closely spaced visits (usually weekly) with a psychiatrist while you start medication, and then occasional, more widely spaced visits to monitor your progress on the drug. Your contact with the psychiatrist will not be as frequent or regular as visits for psychotherapy.

What is the relationship between recreational drug use and depression?

Many recreational drugs can cause depression or anxiety; these include alcohol or alcohol withdrawal, amphetamines, cocaine, ecstasy, crystal, and ketamine. We lack adequate scientific data about the relationship between depression and recreational drug use but do have significant understanding based on clinical experience.

Depression may lead you to seek relief in the use of alcohol or other recreational drugs. In turn, these drugs may cause or exacerbate depression. If you are taking antidepressants and extensively using recreational drugs, it will decrease your chances of getting better. You need to seek help in reducing drug use as well as getting direct treatment for the depression.

It is important to be honest with your psychiatrist about the extent of your recreational drug use. You have a need and right to report this without receiving a morally judgmental response.

The drug Ecstasy affects the serotonin system, the same neurotransmitters that are affected by antidepressants. There is growing reason to fear that Ecstasy may have very long-term effects which may ultimately bring on depression and anxiety problems. For some individuals, it may not take much Ecstasy use for this to occur.

“Crystal” (methamphetamine) is likely to lead to periods of depression and anxiety. In addition, its use may lead to the development of paranoid psychotic symptoms.

Both alcohol and marijuana, when used on a regular and frequent basis for an extended period of time, tend to lead to depressive symptoms in some people. If you are depressed and are smoking pot or drinking alcohol regularly, you may be able to decrease your depression by abstaining from substance use for a period of time.

Should I seek psychotherapy for depression? If so, what kind?

It is emotionally helpful to understand your psychological state and to identify current sources of stress and the influence of your own particular history and conflicts in depression. Therapy helps lessen depression and may prevent its recurrence. Psychotherapy provides you with a chance to talk about upsetting feelings, to experience the comfort of being understood, and to alleviate anxiety and depression at times of particular stress. We encourage all students who are receiving medication at the Columbia Counseling and Psychological Service to see a non-MD therapist at CPS at the same time. Short-term treatment is available through CPS and is paid for by your Health Service fee. If longer-term treatment is indicated, CPS will work with you to find affordable and effective psychotherapy.

Suggested reading:

"The Essential Guide to Psychiatric Drugs, 3rd Edition", Jack M. Gorman, MD, St. Martin' Griffin

A different version of this article appears on the web site AIDSmeds.com.

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