Pearls

Jeffrey L. Anders, MD, on

Seven common myths about depression and antidepressant therapy

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Some of the problems we face and solutions we employ in clinical practice run contrary to what we were taught in psychiatry rotations. I've found this to be particularly true regarding depression diagnosis and treatment.

Throughout my career, I've seen many truisms concerning depression that were passed on in medical training and later contradicted through clinical experience. Witness the following seven "myths" about depression therapy:

1. Early morning awakening and suppressed appetite with weight loss are cardinal symptoms of major depression. Sleep and appetite disturbances remain core DSM-IV symptoms of major depression, but depressed patients seldom present with "classic" terminal insomnia and significant anorexia. So-called "atypical" neurovegetative changes involving hyperphagia and hypersomnia or initial/middle insomnia are common in outpatients.

2. Patients with major depression face a 15% lifetime suicide risk. The American Foundation of Suicide Prevention says that "30% of all depressed patients attempt suicide and half of them succeed."[1] More recent data have shown the lifetime suicide risk in depression to be only 2 to 6%.[2]

Most suicide victims do have a depressive illness, and depression remains a disturbingly under-recognized and under-treated disorder with a high degree of morbidity. The absolute suicide risk for outpatients with nonpsychotic depression is probably lower than previously thought, however.

3. The risk of suicide increases when response to antidepressant therapy begins. The assumption is that patients in the initial stages of response to medication experience a preferential increase in energy and motivation with persistence of hopelessness, helplessness, or worthlessness. This supposedly predisposes them to follow through with a suicide plan they did not have the energy to complete before starting antidepressant treatment.

There is no firm evidence that this occurs normatively. In fact, many patients exhibit diminished hopelessness and helplessness after an initial mental health intervention and less suicidality even early in antidepressant treatment.

4. Patients with dysthymic disorder respond poorly to antidepressants. Many patients with low-grade, longstanding depression or dysthymic disorder respond well to appropriate antidepressant medication. There is no valid evidence that patients with acute depressive disorders respond more favorably to chemotherapy than do those with dysthymia.[3]

5. A patient's subjective response to antidepressants lags behind more noticeable improvements. No research has borne this out. In the course of response to antidepressants, patients typically realize improvements in subjectively experienced symptoms (e.g., hopelessness, dysphoria, and amotivation) that tend to parallel, not lag behind, more observable somatic and interpersonal improvements (e.g., in sleep and social interaction).

6. A slim adolescent female typically requires a lower antidepressant dose than a burly adult male does. Many complex factors determine response to and tolerability of antidepressant medications. But age, gender, and body type do not appear to be consistent determinants. Male endomorphic adults can be highly sensitive to low doses of medications, while petite younger females may require and tolerate relatively high doses—and vice versa.

7. A patient's response to one SRI predicts his or her response to another. Responses to different medications in the same class are highly individual and unpredictable. A patient may have identical responses to several SRIs, or may tolerate them similarly. More commonly, individual patients experience varying types and degrees of side effects and disparate responses to different agents.

References

1. American Foundation for Suicide Prevention: http://www.afsp.org/index-1.htm.
2. Blair-West GW, et al. Lifetime suicide risk in major depression: sex and age determinants. *J Affective Disord* 1999;55(2-3):171-8.
3. McCullough JP, et al. Comparison of DSM-III-R chronic major depression and major depression superimposed on dysthymia (double depression): validity of the distinction. *J Abnormal Psychol* 2000;109(3):419-27.