An Ounce of Prevention

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Why Antidepressants Don't Live Up to the Hype

By John Cloud

In the '90s, Americans grew fond of the idea that you can fix depression simply by taking a pill — most famously fluoxetine (better known as Prozac), though fluoxetine is just one of at least seven selective serotonin reuptake inhibitors (SSRIs) that have been prescribed to treat hundreds of millions of people around the world.

But in the past few years, researchers have challenged the effectiveness of Prozac and other SSRIs in several studies. For instance, a review published in the *Journal of Affective Disorders* in February attributed 68% of the benefit from antidepressants to the placebo effect. Likewise, a paper published in *PLoS Medicine* a year earlier suggested that widely used SSRIs, including Prozac, Effexor and Paxil, offer no clinically significant benefit over placebos for patients with moderate or severe depression. Meanwhile, pharmaceutical companies maintain that their research shows that SSRIs are powerful weapons against depression. (Here's a helpful blog post that summarizes the debate.)

Now a major new study suggests that both critics and proponents might be right about SSRIs: the drugs can work, but they appear to work best for only a subset of depressed patients — those with a limited range of psychological problems. People whose depression is compounded with, say, substance abuse or a personality disorder may not get much help from SSRIs — which is unfortunate for the 45% to 60% of patients in the U.S. who have been diagnosed with a common mental disorder like depression and also meet the criteria for at least one other disorder, like substance abuse. (Multiple diagnoses are known in medical parlance as comorbidities.)

The new study, published online in April by the *American Journal of Psychiatry*, was conducted using data from a large, government-funded trial called Sequenced Treatment Alternatives to Relieve Depression, which usually goes by the moniker STAR*D. The STAR*D project, which collected data from 2001 to 2004 at 41 U.S. psychiatric facilities, was one of the most ambitious efforts ever to understand how best to treat people with major depression. STAR*D participants comprise a powerful research sample because they are highly representative of all depressed Americans. Very few depressed people were excluded from STAR*D; only women who were pregnant, those with seizure disorders and a few others with acute conditions were kept out. All other psychiatric and medical co-morbidities were allowed.

The authors of the new paper, a team of 11 researchers led by University of Pittsburgh professor of epidemiology Stephen Wisniewski, were curious how the STAR*D group would compare with a typical group of patients selected for a run-of-the-mill drug-company trial for a new antidepressant — the very trials on which the Food and Drug Administration bases its decisions regarding new drug approval. Drawing on their own experiences in helping to conduct such trials, which have far more stringent inclusion criteria than the STAR*D group, Wisniewski and his team divided the STAR*D patients into two groups — an "efficacy" sample of patients who would normally be included in a typical Phase III clinical trial for a new antidepressant and a "nonefficacy" sample of patients who would normally be rejected.

Depressed STAR*D patients who were classified for inclusion had no more than one general medical condition (like, say, heart disease) and no more than one additional primary psychiatric disorder besides depression. All patients with multiple comorbidities — along with anyone whose depression had lasted more than two years — were excluded. Once the authors crunched all the numbers, they found that only 22% of STAR*D patients met entry criteria for a conventional antidepressant trial.

All the STAR*D patients were taking citalopram, an SSRI marketed in North America as Celexa. Not surprisingly, those who met standard inclusion criteria for a clinical trial had significantly better outcomes on the drug. In the efficacy group, 52% responded to Celexa vs. 40% of the nonefficacy group. Patients in the latter group also took longer to respond and had to be readmitted to psychiatric settings more often. "Thus," the authors conclude, "current efficacy trials suggest a more optimistic outcome than is likely in practice, and the duration of adequate treatment suggested by data from efficacy trials may be too short."

To bolster their findings, the authors cite a smaller 2002 study that arrived at similar results: in that paper, published in the *American Journal of Psychiatry*, Dr. Mark Zimmerman of Brown University and his colleagues found that of 315 patients with major depressive disorder who sought care, only 29, or 9.2%, met typical criteria for an efficacy trial. Similarly, psychologist Ronald Kessler of Harvard co-authored a 2003 paper in the *Journal of the American Medical Association* that concluded that most "real world" patients with major depression would be excluded from clinical trials because of comorbidities. Such findings help explain why antidepressants haven't quite lived up to their promise.

But the University of Pittsburgh's Wisniewski, the lead author of the new study, cautions against interpreting the results as an indictment against greedy drug companies eager to exclude difficult patients in order to show better results. "If the population in a [clinical] trial were more representative, that would come at a cost," he says. Researchers expect a certain number of bad reactions during clinical trials; some of these reactions can cause serious medical problems. If patients enter a trial with multiple complications — if they are, say, not only depressed, but also cocaine-addicted, hypertensive and diabetic — you dramatically increase the chances of adverse side effects. "That's why trials to determine efficacy are done on a relatively homogeneous population," Wisniewski says.

That's understandable, but the new study does shed light on the limitations of antidepressants. Conducting clinical trials with representative samples would undoubtedly be more complex — and expensive — since patients with multiple risk factors would have to be monitored more carefully. But for a future generation of antidepressants to be truly effective for most patients, more-inclusive trials may be the best answer.

For the online article please visit:
http://www.time.com/time/health/article/0,8599,1895672,00.html

Change One Thing

Sometimes we don't make changes because they are too difficult of daunting or we are "fixin' to get ready," as my friend Helen says. One way to get change going is to consider the smallest change you can make and begin. Often inertia will continue to take you in the direction of change once you start. If not, at least you are moving forward a little. As Milton Erickson used to say, "If you fall on your face, at least you are heading in the right direction."

Identify the smallest change you can make and begin
If you want to write a book and aren't getting it done, try writing one word a day. I used to recommend five minutes a day (which is fine if that works for you), but if even five minutes seems too much, start with one word a day. Clean up, organize, or toss one piece from that stack of papers/mail/magazines cluttering your house or office.

Commit to a limited period of time for the change
You could commit to walking for five minutes a day for the next week. Or de-cluttering that pile of papers for the next three days. Forever is too daunting for most. Time-limited often works better.

Focus on only one thing at a time
Stop multi-tasking and experiment with doing only the thing you are doing. Or attend only to the person or experience you are with at the moment. Listen to and watch the person you are conversing with (rather than texting, glancing at the television, thinking about what you will do or say next, etc.). Eat when you are eating. Drive when you are driving.

Build a new habit one day at a time
Do the new habit for 5 minutes each day until it becomes ingrained, then expand the time or effort you put in.

Dismantle an old, unhelpful or unhealthy habit one piece at a time
Change one small thing about the old habit. Drink half a soda and half a glass of water with a meal instead of a soda. Park a little farther away from the store or your workplace and walk a little. Eat everything that is unhealthy with your non-dominant hand.

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Children of Alcoholics: Important Facts

- One in four children in America under the age of 18 is growing up with alcohol abuse or alcoholism in the family.
- Children of alcoholics (COAs) are four times more likely than non-COAs to become alcoholics.
- Alcohol is the third leading lifestyle-related contributor to death in the U.S. after tobacco and diet/activity patterns.
- Alcohol-related traffic crashes make up the fifth leading cause of death for Americans of all ages.
- Research suggests alcoholism is more strongly related to child abuse than other disorders, such as parental depression.
- Alcohol and/or drugs are very likely involved in at least 81% of reported cases of child abuse in this country, according to state welfare records.
- Children of alcoholics are more likely than non-COAs to develop disruptive behavioral problems, anxiety, depression, and poorer school performance.
- Children of alcoholics experience greater physical and mental health problems and higher health care costs (32% higher) than children from non-alcoholic families.
- **Only one in 20 children of alcoholics gets any help. Yet, there is growing evidence that with help, these children can learn to thrive, become resilient, and change their lives.**

Sources:
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
National Association for Children of Alcoholics
National Institutes of Health
Journal of the American Medical Association

Net News

Here are some web sites you & your family may find helpful.

A video from Alberta Family Wellness Initiative changes minds by informing Canadians about effects of toxic stress on kids' brains:
http://www.albertafamilywellness.org/resources/video/how-brains-are-built-core-story-brain-development
Website: http://acestoohigh.com/category/community-prevention-programs/

TED talks: childhood trauma and how it can affect your health across a lifetime:
http://www.ted.com/playlists/1/how_does_my_brain_work

Self- Help Corner:

Alcoholics Anonymous: 780-424-5900
www.alcoholics-anonymous.org
Al-Anon/Alateen: 780-433-1818
Support Network / Referral Line: 211
Distress Line: 482-4357
Cocaine Anonymous: 780-425-2715

Informative Links:

Is Alcohol a Form of Depression?
http://well.blogs.nytimes.com/2015/09/25/ask-well-alcoholism-and-depression/?_r=0

Are you in a dangerous relationship?
http://www.oprah.com/oprahshow/Abusive-Relationship-Red-Flags

How Much Alcohol Is Too Much?
http://time.com/3896238/drinking-alcohol-heart/?xid=newsletter-brief