MANAGEMENT FILE

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the ME association

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DEPRESSION AND ANTIDEPRESSANTS AND OTHER FORMS OF TREATMENT

AM I DEPRESSED? OR JUST FED UP?

In common with many other chronic disabling conditions, some people with ME/CFS will experience a degree of clinical depression at some stage in their illness.

Although feeling fed up and frustrated are extremely common reactions to having an illness like ME/CFS, and emotional lability/instability can sometimes form part of ME/CFS, this is not the same as having true clinical depression.

The two key symptoms of clinical depression are:

- Persistent sadness or low mood
- Marked loss of interest or pleasure in things that were previously enjoyed (= anhedonia)

Other characteristic symptoms include:

- Early morning wakening or disturbed sleep
- Poor concentration, memory or indecisiveness
- Fatigue or loss of energy
- Loss of self-esteem and/or feeings of worthlessness/hopelessness
- Inappropriate guilt
- Decreased or increased appetite and/or weight
- Feeling sad and tearful
- Agitation or slowing of movements
- Self-neglect
- Suicidal thoughts or intentions

The first three symptoms in the second list do, of course, overlap with ME/CFS symptomatology. So this has to be taken into account when assessing whether someone has clinical depression.

WHAT CAUSES DEPRESSION?

The causes of depression can be both internal and external. Often there's a combination of both.

Internal causes refer to changes in the levels of what are called neuro-transmitters – chemicals in the brain such as noradrenaline and serotonin that help to control mood, sleep, motivation and mental activity.

External causes relate to life events that can sometimes trigger and perpetuate an episode of depression. In the case of ME/CFS, this might include problems with relationships, living conditions and social isolation, finances/benefits, work, or the failure to obtain appropriate medical help.

If you've experienced depression in the past, before ME/CFS occurred, you are probably more likely to develop depression.

HOW DO DOCTORS CLASSIFY DEPRESSION?

Depression can be mild, moderate or severe – depending on the number of symptoms present, type of symptoms and the effect that depression is having on your ability to function as an individual.

Doctors also refer to subthreshold depression where there are warning signs of depression present.

HOW IS IT TREATED?

In the past doctors would often rely on the almost automatic use of anti-depressant drugs to treat depression. However, there has been a welcome and significant shift towards the use of non-drug treatments such as guided self-help, cognitive behavior therapy (CBT) and counselling – especially for people with mild depression.

A rough rule-of-thumb for assessing and treating depression relates to the number, duration and severity of symptoms, along with consideration of the other components – such as a past history of depression – and the effect that depression is having on a person's ability to function.

Mild depression is normally managed by non-drug approaches such as guided self-help and/or CBT.

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Moderate depression is normally treated with an antidepressant, often in combination with other approaches.

Severe depression is normally treated with drugs but may well need require regular input from a hospital-based mental healthcare team, or even admission to hospital for a programme of multi-professional healthcare.

Where depression is accompanied by anxiety, which it sometimes is, the first priority is usually to treat the depression.

WHAT ARE ANTIDEPRESSANTS?

This is a group of drugs that can help to relieve depression by correcting the imbalance in one or more of the chemical (neuro) transmitters in the brain.

Antidepressants are divided into three main groups – the older tricyclic antidepressants (TCAs), the newer selective serotonin re-uptake inhibitors (SSRIs) and the mono-amine oxidase inhibitors (MAOIs).

The mode of action for each group is different and depends on which chemical transmitter system/s they affect.

There are several other anti-depressants that don't fit neatly into these three categories. As a result, doctors now have over 40 different commercial brands of antidepressants to choose from – some of them very similar.

CHOOSING AN ANTIDEPRESSANT

Unfortunately, there's no simple way of knowing which type of anti-depressant is going to be the most effective one to use in any individual patient. And when it comes to effectiveness, there are no major differences between the different groups. There are, however, some significant differences in the type of side-effects that are likely with different groups of antidepressants.

So the choice of drug will depend on a number of factors:

- Severity and duration of depression
- What sort of depressive and other mental health symptoms (eg anxiety, suicidal intentions) are present
- What ME/CFS symptoms are present – eg postural hypotension (low blood pressure on standing) could be made worse by a tricyclic drug
- Whether you have had depression in the past and which drugs were helpful/unhelpful
- Whether other drugs are being taken – because antidepressants can interact with other medications
- Which other illnesses are also present – heart disease and conditions such as epilepsy, diabetes and liver disease in particular.

For most people with ME/CFS, the choice lies between an SSRI and a tricyclic because MAOIs can produce dangerous interactions with some types of food (especially those rich in tyramine), drugs (eg decongestants) and caffeine. So their use has steadily declined.

The older tricyclic drugs are sub-divided into those that have sedating properties (which may be useful for people with anxiety as well) and those which are more stimulating.

The best known sedating tricyclic is amitriptyline – a drug that many people with ME/CFS find helpful for pain relief and sleep disturbance when used at a lower dose than is taken for depression. In fact, sleep disturbance can often be one of the first symptoms to improve on starting a tricyclic.

However, tricyclics have a number of side-effects that people with ME/CFS may find troublesome. They are also more likely to cause problems if taken as an overdose.

So an SSRI such as citalopram or fluoxetine (which has a higher risk of drug interactions) may be the more appropriate first choice.

Other antidepressant drugs

These tend to be reserved for more severe or unusual/atypical types of depression. Examples include:

- duloxetine/Cymbalta
- flupenthixol/ Fluanxol
- mirtazapine/Zispin and
- venlafaxine/Efexor.

Specific problems related to the use of these drugs include sedation and weight gain with mirtazapine; heart problems and a higher risk of withdrawal complications with venlafaxine.

In some circumstances more than one type of antidepressant drug is used in combination – but this should only be done in with great care and in consultation with a consultant psychiatrist.

PRACTICAL POINTS

People with ME/CFS are often very sensitive to drugs that act on brain chemical transmitter systems – so it may be better to start off with a low dose and gradually increase over a period of several weeks.

Research findings also indicate that disturbances in serotonin levels occur in ME/CFS – which may help to explain that, whilst some people benefit from an SSRI drug, others are extremely sensitive to even very low doses. The use of SSRI drugs along with research involving ME/CFS, is covered in more detail in the MEA purple booklet.

So it's important to have a regular review with your doctor, especially during the first few weeks of treatment. Treatment should normally continue for at least four weeks before deciding that a drug isn't effective and it's worth trying another anti-depressant. However, the evidence of advantage of switching to another drug, either in the same group, or in

another group, is weak. If a switch is going to be made, a drug-free period may be necessary because some antidepressants interact with each other.

Following remission, doctors now recommend that antidepressant treatment should continue at the same dose for at least six months, and for considerably longer, up to two years, where there is a history of depression – as this will help significantly to reduce the chance of a further episode occurring.

Side-effects

All antidepressants come with a long list of potential side-effects – some of which can be very similar to the symptoms that occur in ME/CFS. Side-effects tend to be worse at the beginning of treatment and tend to diminish over time.

Common problems with tricyclic drugs include drowsiness, dry mouth, blurred vision, constipation and dizziness (due to a fall in blood pressure). Tricyclics can also cause heart rhythm disturbances and weight gain.

SSRIs tend to be less sedating than tricyclics and have less potential to cause side-effects involving the heart. But they may cause gastric side-effects such as nausea and vomiting, dyspepsia, stomach pain and diarrhoea.

SSRIs are associated with an increased risk of gastric bleeding, especially in older people and in people taking drugs that have a potential to cause damage to the lining of the gut (eg non-steroidal pain killers such as ibuprofen/Brufen and aspirin) or interfere with blood clotting mechanisms.

Other SSRI side-effects include sexual problems, sweating, feelings of depersonalisation, feeling tense or nervous, insomnia. They have also been linked to suicidal intentions.

The drug information leaflet from the pharmacist that comes with a prescription provides a more detailed description of possible side-effects and what to do if they occur.

All drugs, including antidepressants, should be used with great caution during pregnancy, especially the first few months, and some not at all unless absolutely necessary. The same caution applies to people who are at risk of getting pregnant, or are trying to get pregnant.

Withdrawal

Stopping an antidepressant, especially when this is done suddenly and the drug has been used for eight weeks or more, can result in a range of distressing withdrawal symptoms.

Discontinuation symptoms can include increased mood change, restlessness, difficulty sleeping, unsteadiness, sweating, and altered sensations. So the dose should normally be gradually reduced over a period of time, several weeks, or even months. This will depend on individual circumstances and may need to be extended if withdrawal symptoms start to occur.

MIND has produced an excellent guide on withdrawing from psychiatric medication.

Are antidepressants addictive?

With people now remaining on anti-depressants for quite long periods of time concerns are often raised about the risk of addiction. So it's worth noting that antidepressants are not addictive.

ARE THERE ANY OTHER OPTIONS?

Practical coping strategies and guided self-help

There are a number of simple measures that can often be helpful in the management of any type of depression. However, some of them are clearly going to be of limited value in ME/CFS:

- Problem solving – especially where external life events are involved
- Taking regular physical exercise, possibly done as a group – something that people with ME/CFS are unlikely to cope with
- Avoiding excess eating, smoking and cutting down on alcohol – likely to be the case already
- Establishing a good sleep pattern

St John's Wort
(Hypericum perforatum)

This is a popular over-the-counter herbal remedy that is sometimes used by people to treat mild to moderate depression.

It has an effect on enzymes in the liver that are used to deal with a number of common conventional drugs inside the body – so it can alter their concentration and activity if taken together. Examples include conventional antidepressants (which should **not** be used with this herb), anti-convulsants, antivirals, and oestrogen and progestogen in the contraceptive pill. So always check with your pharmacist about potential drug interactions if you are going to try using St John's Wort.

Doctors are now advised by NICE not to prescribe or recommend St John's Wort due to these potential drug interactions.

Cognitive behaviour therapy (CBT) and Counselling

Talking therapies such as CBT can be as effective as antidepressants in some types of depression – especially where life events, and your response to them, are playing a role in either triggering or maintaining the depression.

So many doctors are now advising that a talking therapy, possibly in combination with an antidepressant, is the best form of treatment for mild and moderate depression, especially where life events appear to be involved.

Computerised CBT is another option that could be discussed.

There are also more complex

talking treatments called 'high intensity psychological interventions' for people with more severe depression.

Counselling may be available at a GP surgery and can be helpful for some cases of mild to moderate depression.

An initiative called IAPT (Improving Access to Psychological Therapies) means that talking therapies no longer have to be accessed via a hospital. They should be far more accessible. Visit www.iapt.nhs.uk

Electroconvulsive therapy (ECT)

This is usually reserved for people with more severe depression that fails to respond to any other form of treatment.

CAN ANTIDEPRESSANTS BE USED TO TREAT ME/CFS?

The simple answer here is 'no'.

Important research findings show that ME/CFS is biologically different to depression – in particular, the finding of decreased blood flow to the brain stem in ME/CFS along with the fact that levels of cortisol tend be higher than normal in depression and lower than normal in ME/CFS.

USEFUL CONTACTS

DEPRESSION ALLIANCE
www.depressionalliance.org

MIND
www.mind.org.uk

FURTHER INFORMATION

- Pages 231 - 245 of *Living with ME* covers the subject of depression and management of depression in more detail.
- MEA Management Files on Amitriptyline, CBT and Counselling
- Sections 7:3 and 7:4 of *ME/CFS/PVFS: An Exploration of the Key Clinical Issues* covers research into the use of antidepressants in ME/CFS and summarises clinical trials that have assessed their value.
- MIND *Making sense of coming off psychiatric drugs*
- NICE *CG91 Depression with a chronic physical health problem: Understanding NICE guidance*
  https://tinyurl.com/yxus3vxdh

COMMON ANTIDEPRESSANTS

Chemical/generic names are listed first, followed by commercial brand names:

MAOIs

Phenelzine – Nardil
Isocarboxazid
Moclobemide – Manerix
Tranylcypromine

SSRIs

Citalopram – Cipramil
Escitalopram – Cipralex
Fluoxetine – Prozac
Fluvoxamine – Faverin
Paroxetine – Seroxat
Sertraline – Lustral

TRICYCLICS

Amitriptyline*
Clomipramine* – Anafranil
Dosulepin hydrochloride* – Prothiaden *(not normally recommended)*
Doxepin - Sinepin
Imipramine
Lofepramine – Gamanil
Nortriptyline – Allegron
Trimipramine* – Surmontil

* = sedating tricyclics

OTHERS

Duloxetine – Cymbalta
Mirtazapine - Zispin
Venlafaxine - Efexor

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