

Patient information from the BMJ Group

Depression in adults

In this section

[What is it?](#)

[What are the symptoms?](#)

[How is it diagnosed?](#)

[How common is it?](#)

[What treatments work?](#)

[What will happen?](#)

[Questions to ask](#)

Depression in adults

Everyone gets low from time to time. But if you feel down a lot of the time you may be depressed. Depression is an illness and there are some good treatments which can help you feel better.

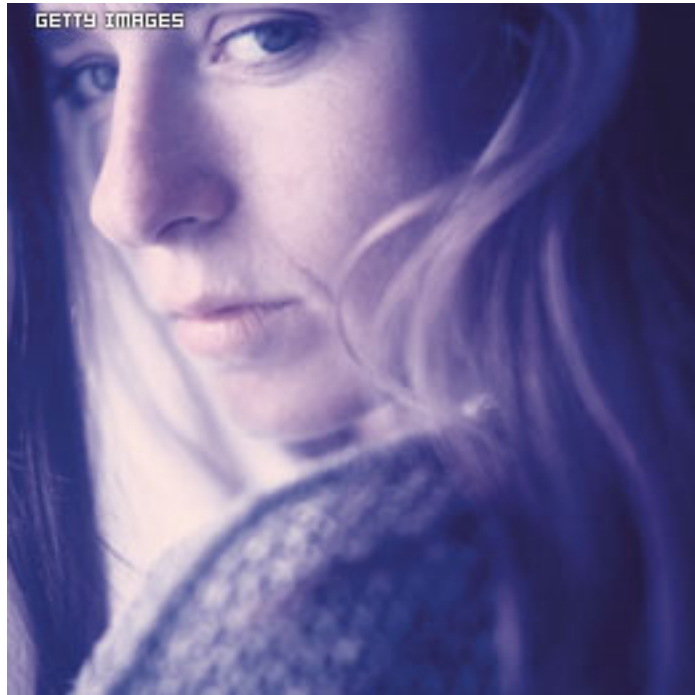
Depression can also affect children and teenagers. See our articles on [Depression in children](#) .

We've brought together the best research about depression in adults and weighed up the evidence about how to treat it. You can use our information to talk to your doctor and decide which treatments are best for you.

What is depression?

Depression is so misunderstood that some people don't even realise it's an illness. That's understandable. Doctors don't know exactly what goes wrong, and the symptoms are not always obvious. People with depression often hide their illness instead of looking for help.

Depression in adults



Everyone feels down sometimes, but depression is more than feeling unhappy.

Yet for people who are diagnosed with depression and given help, the results can be very good. Many people have big improvements in their mood.

Key points for people with depression

- Depression can be treated; you don't have to suffer.
- Depression is common. It affects about 1 in 7 people at some time.
- If you think you may be depressed, it's important to talk to your doctor. Your doctor can tell you whether you are depressed and give you treatment.
- Antidepressants and talking treatments, such as [cognitive therapy](#), can help treat depression.
- It can take as long as six weeks for antidepressants to make you feel better, so it is important not to stop taking them too soon.

How you feel

Everyone feels down sometimes, but depression is more than feeling unhappy.

If you have depression you may be irritable, tired, unable to sleep, unable to eat and unable to make decisions. You may also feel dissatisfied, guilty, hopeless, helpless and you may want to cry all the time. And as much as you try, you can't make yourself feel better.

Depression in adults

Although everyone can have these feelings from time to time, if you have depression, they accumulate and don't go away. They can last for weeks or months. They can affect your sleep, relationships, job or school work, hobbies, sex drive and appetite. To learn more, see [What are the symptoms of depression?](#)

Some people with depression have symptoms that are not typical. If you're a man or a child, you may be anxious or irritable. If you're an older adult, you may suddenly lose your memory or concentration. ^[1]

You can have depression at the same time as other illnesses, such as **diabetes**, cancer, or **heart disease**. Depression could also happen after a traumatic event, such as the death of someone close to you. Some people can become depressed after they've been drinking alcohol or using illegal drugs. ^[2]

Many people with depression don't ask for help. About half of all depression isn't properly treated. ^[2]

Depression is not just a state of mind or something you can will away. With depression, the most important thing is to recognise that you may have it and to see someone qualified to give you the right diagnosis and treatment.

It's also good to remember that the hopelessness you may feel is a symptom of your depression, and it doesn't mean that there really is no hope. It may help to confide in someone you trust, and to keep busy and meet up with people rather than stay at home on your own.

Men, in particular, are at risk of not being treated. They may not recognise their anger or feelings of hopelessness as depression, and they are less likely than women to tell someone how they feel. Also, doctors are less likely to suspect depression in men than in women. Men's depression is often covered up by drinking or drug-taking, or lots of overtime at work. ^[3]

Understanding what goes wrong

No one knows for certain what causes depression.

Doctors and researchers think that personal experience can often play a role in the development of depression. For example, it can be triggered by the death of a loved one, the break-up of a relationship, financial trouble or a stressful change in your life. A difficult childhood also can mean that you may be more at risk of getting depression. ^[3]

Depression is also linked to changes in how the brain works. This makes sense, given that our emotions, thoughts, sleep, appetite and behaviour are regulated by our brain. ^[3]

The brain sends signals from nerve to nerve using special chemicals called **neurotransmitters**. But the levels of certain neurotransmitters in your brain called **noradrenaline** and **serotonin** are abnormal if you have depression, and they don't work properly. ^[3] ^[4]

Depression in adults

Family history also appears to play a part in depression. In some cases, depression seems to run in families, suggesting that it may be caused by **genes**. In other cases, however, it can occur in people with no family history of depression. ^[3]

What's more, **hormones** may contribute to depression, especially in women, who are more likely than men to be depressed. Depression in women is sometimes linked to changes in their **menstrual cycle**, pregnancy, miscarriage, having just had a baby (postnatal depression) and the **menopause**. ^[3]

Different types of depression

The word depression is used to describe a range of emotions. We often say we're depressed when we're down in the dumps or feel a bit sad. Depression is also used to describe feelings of utter hopelessness and withdrawal that stop you doing things you used to enjoy or getting on with life. Doctors often use other words to describe different types of depression.

In what's called **major depression**, you feel depressed or uninterested in doing anything nearly every day for at least two weeks. You also have several other symptoms, including changes in sleep, appetite and concentration. Major depression is also called clinical depression or unipolar depression. ^[1]

Dysthymia is a less severe illness that lasts at least two years. Some people with dysthymia have episodes of major depression as well as low-grade depression. This is sometimes called double depression. ^[1]

Another kind of depression is **bipolar disorder**, in which a person swings between high and low moods. This is also called **manic depression**.

If you get big mood swings in different seasons of the year, it is known as **seasonal affective disorder** (SAD). People with SAD usually get more depressed in winter. If you have SAD you may also have unusually high moods (mania) in spring.

Some women have **postnatal depression** soon after childbirth. This may be because having a baby leads to changes in a woman's hormones, as well as her lifestyle and responsibilities. ^[3]

Depression in adults: why me?

A stressful situation, such as losing someone close to you or being in a difficult relationship, can trigger depression. Some people are prone to depression and find that other people in their family have had it too. This suggests that the **genes** we inherit from our parents may have something to do with whether we get depressed or not.

The exact causes of depression are often complicated. However, there are some things that increase your chances of becoming depressed. Doctors call these **risk factors**.

Here are some of the things that can increase your chance of becoming depressed. ^[5]

Depression in adults

- **Going through upsetting life events.** It's normal to feel down after a distressing event, such as the death of a loved one, divorce, being sacked, or getting into serious financial trouble. But sometimes the feelings of sadness get worse and lead to depression.
- **Lacking social support.** Not having supportive friends or family around, or a friendly listener to discuss things with, can increase your risk of getting depressed.
- **Having a physical illness.** People who've had a **stroke** or a heart attack, or have a long-term and painful illness, can get depressed.
- **Having a certain personality type.** For some reason, some people tend to get more down about things than others. Although anyone can have depression, some people do seem to be more vulnerable because of the way they see the world and how they respond to it.
- **Being a woman.** Women are twice as likely as men to get depressed. It may just be that more women see a doctor about depression because they are more willing to talk about how they feel. Or it may be that women have more stresses to deal with than men, such as having to juggle different roles in and out of the home.
- **Having a history of depression in your family.** Depression can run in families. You are more likely to get severely depressed if one of your parents had depression.
- **Having difficult experiences as a child.** Adults who had a poor relationship with their parents when they were children, or who were neglected as children, are more likely to get depressed than those who had a strong and supportive relationship with their parents. If you were physically or sexually abused as a child, you may also be more prone to depression later in your life.

What are the symptoms of depression?

Being depressed is more than feeling down for a day or two. It usually goes much deeper and affects the things you do as well as how you feel. You may find it hard to cope with everyday life.

You may have depression if you: ^[5]

- Feel sad most of the time for at least two weeks (you may feel a little better in the evenings). You may be tearful a lot of the time
- Lose interest in doing things you used to enjoy
- Find it harder to concentrate or make decisions
- Feel you can't cope with things the way you used to

Depression in adults

- Have no energy
- Feel restless and agitated
- Lose your appetite and lose weight (or the reverse happens, and you put on weight)
- Have trouble sleeping. For example, it may take you one to two hours to get to sleep, and then you wake up earlier than usual
- Lose interest in sex
- Lose your self-confidence
- Feel useless or worthless
- Feel guilty for no reason
- Avoid other people
- Feel irritable
- Feel worse at a particular time each day, usually in the morning
- Think about suicide. If you have suicidal thoughts or feelings it's important to get medical help straight away.

You don't need to have all of these symptoms to be diagnosed with depression. But if you have five or six, it may mean you have depression. If you think you may have depression, you should talk to your doctor. There are treatments that can help.

How do doctors diagnose depression?

If you think you may have depression, you should see your doctor. Some medicines, along with some medical conditions and infections, can cause the same symptoms as depression. Your doctor will probably ask you some questions, and may do some blood or urine tests to check for other conditions and infections.

If your doctor can't find a physical cause for the depression, he or she will want to ask you in more detail about your feelings. Doctors call this a psychiatric assessment. It can also be carried out by a [psychiatrist](#), a [psychologist](#) or a psychiatric nurse.

There is no laboratory test for depression. To find out whether you're depressed, and to see how depressed you are, your doctor will ask you questions about your feelings and how you are coping with life.

Depression in adults

Your doctor may also ask about your alcohol and drug use, whether you've thought about death or suicide, whether family members have had any type of depression and how it was treated.

Often, people with depression see their doctor with other, physical problems such as difficulty sleeping or headaches. If your doctor suspects you may be depressed, he will ask the following questions: ^[5]

- During the last month, have you often been bothered by feeling down, depressed, or hopeless?

During the last month, have you often been bothered by having little interest or pleasure in doing things?

If you answer yes to either question, your doctor will ask more questions to find out whether you have depression, or another mental health problem.

How bad is it?

To find out how bad your depression is, your doctor first looks for any of the three key symptoms: ^[5]

- Feeling sad or low most of the time
- Losing interest in things you used to enjoy
- Having no energy or feeling really tired.

A depressed person will have had at least one of these symptoms on most days, most of the time, for two weeks or more.

If you have a key symptom, your doctor will consider how many, if any, of the following symptoms you also have:

- Problems sleeping, or sleeping too much
- Poor concentration or difficulty making decisions
- Low self-confidence
- Poor or increased appetite
- Thoughts of suicide
- Agitation or sluggishness
- Feelings of guilt for no reason.

Depression in adults

If you have five symptoms, your doctor may say you have **mild depression**. If you have most of the symptoms on the list, and they interfere with your ability to get on with life, your doctor may say you have **severe depression**. If you are somewhere between the two, your doctor may say you have **moderate depression**.

But a doctor won't just count the number of symptoms. He or she should also look at how your symptoms affect your life, and how long your symptoms have lasted. ^[5]

Referral to a specialist

Most people with depression are treated by their GP. However, if you have had depression more than once in a year, or the treatments your doctor has tried haven't worked, then he or she may refer you to a psychiatrist or psychiatric team. Psychiatrists specialise in helping people with mental health problems. You may be able to see one at a local doctor's surgery, but some are based in hospitals.

How common is depression?

Depression is fairly common. It's one of the most common reasons for people to visit their GP.

- About 1 in 7 adults get depression serious enough to need treating at some point in their lives. ^[6]
- About 5 in 100 to 10 in 100 of people who visit their doctor have depression. ^[7] Two to three times this number have some symptoms of depression, but not severely enough for them to be diagnosed.
- Up to 1 in 7 older people (over 65 years old) get some of the symptoms of depression. But depression that needs treating is relatively rare in this age group. ^[8]
- Overall, depression is the fourth biggest cause of disability worldwide. ^{[9] [10]}

What treatments work for depression?

There are many treatments that work well for depression. The most difficult thing can be admitting you have a problem and asking for help. But once you get help, you may soon start to feel better.

Key points about treating depression

- Some talking treatments work well for depression. There's often a waiting list for these treatments.
- Drug treatments also work well. But they have side effects.

Depression in adults

- Once you feel better, carrying on taking antidepressants can stop you getting depressed again. If you get depression for a second time it's called a relapse.
- If you are severely depressed, taking antidepressant drugs and having a talking treatment works better than having just one of these treatments.
- A herbal treatment, St. John's wort, can help people with mild or moderate depression.
- Electroconvulsive therapy (ECT) works for severe depression. But it is used only for people who need to be treated in hospital and only when all other treatments haven't helped.

There are national guidelines on how doctors should treat depression. The treatment you get will depend on whether your depression is mild, moderate or severe. To learn more, see [NICE guidance on depression](#) .

NICE guidance on depression

We can't tell you exactly what type of treatment you'll get if you have depression. But we can give you some idea about what to expect.

The National Institute for Health and Care Excellence (NICE) is the government body that decides which treatment should be available on the NHS. Here's what NICE says about depression. ^[5]

If you have mild depression

Your doctor may offer you one of the following treatments. He or she will take account of your preferences, and what services are available locally:

- A self-help programme based on a talking treatment called [cognitive behaviour therapy](#) . You'll probably be given some leaflets or books about this, and your doctor or a nurse will see you regularly to find out how you're getting on. Programmes usually last about six or nine weeks.
- A group exercise programme, where you take part in exercise with other people
- A computer course based on cognitive behaviour therapy.

Your doctor may suggest you delay starting treatment for a couple of weeks, to see how you feel. If you agree, your doctor should arrange to see you after two weeks. If you're having problems sleeping, your doctor should offer you advice on how to sleep better.

Not everyone with mild depression will need treatment with **antidepressants** . For mild depression, the side effects may outweigh the benefits.

Doctors are advised to consider antidepressants for people with mild depression if they've had bad depression before, or if they've had symptoms of mild depression for two years

Depression in adults

or more. People who have not been helped by the initial treatments may also be offered antidepressants, or other types of talking treatment.

If you have moderate or severe depression

- Your doctor may advise you to take an **antidepressant** and have a talking treatment. This is likely to be [cognitive behaviour therapy](#) or [interpersonal therapy](#) .
- You'll probably be given a type of antidepressant called a [selective serotonin reuptake inhibitor \(SSRI\)](#) . Your doctor should discuss with you the risks and benefits of the antidepressant before you start taking it.
- Your doctor will ask to see you a week or two after you start drug treatment, and at regular intervals after that, to see how you're getting on. People under 30, or those thought to be at high risk of suicide, should be seen after a week of taking an SSRI.
- If your antidepressant doesn't seem to be helping after four weeks, or if it's causing side effects, your doctor will talk to you about trying another one.
- If an antidepressant is helping only a bit, your doctor may increase the dose.
- Your doctor will advise you to keep taking antidepressants for six months after you feel better. This can make it less likely you'll get depressed again.
- You may get some **withdrawal symptoms** when you stop taking antidepressants. You may also get these symptoms if you miss a dose or when you reduce your dose. Your doctor should talk to you about this.
- To reduce the chances of getting withdrawal symptoms when you stop taking antidepressants, your doctor will gradually reduce your dose over several weeks.

If these treatments don't work, you may be offered other types of talking treatment, including couples therapy if you have a partner, or psychodynamic psychotherapy.

If you've been depressed for more than two years

- You should be treated with both [cognitive behaviour therapy](#) and **antidepressants** , probably a [selective serotonin reuptake inhibitor \(SSRI\)](#) .
- Men who've been depressed for more than two years and haven't been helped by a SSRI may be offered treatment with [tricyclic antidepressants](#) . Men don't seem to get as many side effects from these drugs as women.
- You may be asked if you'd like to take part in a [befriending scheme](#) . This is where a trained volunteer gets in touch with you at least once a week for two months to six months.

Depression in adults

- If you've lost your job or feel too depressed to take part in social activities, your doctor may ask if you want to join a rehabilitation programme. This is where you work with a therapist to see if you can get back into your work and social life.

If you have depression that's difficult to treat

If you've tried at least two different **antidepressants** and they haven't helped, you will probably be referred to a specialist. You may be offered:

- [Lithium](#) . This drug would probably be added to your usual antidepressant. But this drug causes heart problems in some people. You should have tests on your heart before you take this drug
- [Venlafaxine](#) . Doctors consider using this antidepressant only if other drugs haven't worked. It can lead to heart problems in people with **heart disease** . You should have your blood pressure checked before taking this drug. You should also have regular blood pressure checks while taking it^[12]
- Two different antidepressants together. For example, mianserin or mirtazapine may be used alongside a [selective serotonin reuptake inhibitor \(SSRI\)](#)
- Phenelzine. This drug belongs to a group called [monoamine oxidase inhibitors \(MAOIs\)](#) . You have to avoid food and drinks that contain **tyramine** while taking phenelzine, and for two weeks after you stop taking it. This means not drinking alcohol (or even alcohol-free lager), and not eating cheese, sauerkraut, yoghurt, raisins, bananas, sour cream, pickled herring, liver, dry-cured sausage, canned figs, avocados, soy sauce, turkey, yeast extracts, papaya products, fava beans, and broad bean pods. You should have only small amounts of caffeine and chocolate.

An antidepressant called dosulepin isn't recommended. It can cause heart problems and is easy to overdose on.

If you've had several bouts of depression

If you've had more than two bouts of depression in the last few years, you may have some of these treatments to reduce your chances of getting it again.

- You may need to carry on taking an **antidepressant** for two years.
- If an [antidepressant plus lithium](#) has helped you, you may need to carry on taking this combination for six months. You shouldn't take lithium on its own.
- [Cognitive behaviour therapy](#) may be useful.
- You may be offered a treatment called mindfulness-based cognitive behaviour therapy. This is a talking treatment which you will probably have in a group.

Depression in adults

If you need hospital treatment

- You may need to go to hospital if your depression is very bad.
- If other treatments haven't helped, you may be offered [electroconvulsive therapy](#) (ECT). This treatment involves being given electric shocks while under a [general anaesthetic](#). A course of treatment usually lasts four to six weeks, with two to three sessions of ECT each week. The most serious side effect from ECT is memory loss.

St. John's wort

- Your doctor won't advise you to take [St. John's wort](#). It's a herbal treatment for depression that you can buy in pharmacies. But the amount of the herb used is different in different brands, and no one really knows how much you should take.
- St. John's wort can also cause some dangerous side effects if it's used with some medicines, including the contraceptive pill, [anticoagulants](#) and some drugs for [epilepsy](#).

Treatment Group 1

There are many different treatments for depression. But which treatments work best? We've looked at the best research and given a rating for each treatment according to how well it works.

For help in deciding which treatment is best for you, see [How to use research to support your treatment decisions](#).

Treatments for depression

Treatments that work

- [Cognitive therapy](#) : This talking treatment aims to change people's negative views about themselves and the world. It is often used on its own for mild and moderate depression. [More...](#)
- [Interpersonal therapy](#) : This talking treatment focuses on improving how you deal with social occasions and relationships. It is used for mild and moderate depression. [More...](#)
- [Selective serotonin reuptake inhibitors \(SSRIs\)](#) : These are newer kinds of antidepressants and doctors often prescribe them first. Examples of SSRIs (and their brand names) include fluoxetine (Prozac), paroxetine (Seroxat), citalopram (Cipramil), and sertraline (Lustral). [More...](#)
- [Tricyclic antidepressants \(TCAs\)](#) : Doctors usually prescribe one of these older antidepressants only if other drugs haven't worked. Examples (with brand names)

Depression in adults

include imipramine, nortriptyline (Allegron), amitriptyline, and doxepin (Sinepin).
[More...](#)

- [Monoamine oxidase inhibitors \(MAOIs\)](#) : You'll probably only be given one of these antidepressants if you have an unusual sort of depression. Examples include phenelzine (brand name Nardil) and tranylcypromine. [More...](#)
- [Venlafaxine](#) : This is a newer kind of antidepressant drug. The brand name is Efexor. [More...](#)
- [Electroconvulsive therapy \(ECT\)](#) : This treatment uses electrodes to deliver electric pulses to your brain while you're under anaesthetic. It is used only for people with severe depression who need to be treated in hospital. [More...](#)

Treatments that are likely to work

- [Antidepressants plus a talking treatment](#) : This combination of drugs and a talking treatment is used for people who have more severe depression. [More...](#)
- [Counselling](#) : In this talking treatment, therapists don't give advice but suggest new ways for people to think about their problems. [More...](#)
- [St. John's wort](#) : Extracts of this plant are sometimes used to treat people who have mild or moderate depression. [More...](#)
- [Having a care plan](#) : This is when a team of health professionals agrees on a written care plan, to make sure you get the treatment you need. [More...](#)

Treatments that need further study

- [Exercise](#) : Regular exercise is thought to help mild and moderate depression. [More...](#)
- [Befriending](#) : In this treatment, you get together with a volunteer who gives you support, if you have mild or moderate depression. [More...](#)
- [Problem-solving therapy](#) : In this talking treatment, people with mild or moderate depression are taught to use their own skills and resources to cope with their problems. [More...](#)
- [Antidepressants plus lithium](#) : This treatment is for people with severe depression who do not get better with antidepressants. [More...](#)
- [Antidepressants plus pindolol](#) : This treatment is for people with severe depression who do not get better with antidepressants. [More...](#)

Depression in adults

- [Regular check-ups after you're better](#) : Once you are better, you may have regular check-ups with a specialist. The check-ups can be face-to-face or by telephone. [More...](#)

Treatments that are likely to be ineffective or harmful

- [Reboxetine](#) : This is a newer kind of antidepressant drug. The brand name is Edronax. [More...](#)

What will happen to me?

Lots of people recover from an episode of depression on their own, without treatment. But getting the right treatment can speed up your recovery.

What will happen to you depends partly on how bad your depression is.

About half the people who have one bout of major depression will have more symptoms of depression within the next 10 years. ^[11]

This may sound bleak. But you may find it helpful to have this information. It means you can be prepared, and use treatments and your own ways of coping if you feel you are becoming depressed again.

Even though depression is a serious illness, many people are able to manage their condition and live fulfilling and rewarding lives. A bout of depression can feel overwhelming, but there are good reasons to be hopeful. Treatments are getting better all the time, and many thousands of people in a similar position to you have gone on to make a good recovery from depression.

Where to get more help

The Depression Alliance is a UK charity that runs self-help groups for people with depression. You can visit its website (<http://www.depressionalliance.org>) or call 0845 123 2320.

Questions to ask your doctor

If you've been diagnosed with depression, you may want to talk to your doctor or psychiatrist to find out more.

Here are some questions you may want to ask. You may find it helpful to have someone with you, to help you find out everything you want to know.

- I feel very down. How do I know if I'm depressed?
- Do I need treatment?
- What treatment do you recommend?

Depression in adults

- Does the treatment have any side effects?
- When will I start to feel better?
- How long will I need to have this treatment?
- What will happen to me if I don't have this treatment?
- What kind of talking treatments (**psychotherapies**) are available? Would any of them help me?
- Are there any alternative therapies or complementary therapies that may help?
- Is there anything I can do to avoid getting depressed again?

Treatments:

Cognitive therapy

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

[How does it work?](#)

[Can it be harmful?](#)

[How good is the research on cognitive therapy?](#)

This information is for people who have depression. It tells you about cognitive therapy, a treatment used for depression. It is based on the best and most up-to-date research.

Does it work?

Yes. If you have mild or moderate depression, cognitive therapy can help you. It may even work better than antidepressants, but the research isn't good enough to be certain. (To read about different antidepressants, see [Treatments for depression](#) .)

Having cognitive therapy on its own may not help you if you have severe depression.

What is it?

Cognitive therapy is a kind of talking treatment (**psychotherapy**). During cognitive therapy you talk to a therapist about your problems. Most people with mild or moderate depression see a therapist six to eight times over about 10 weeks. But you can see a therapist more often, or for longer, if you need to. ^[13] ^[5]

Each meeting with the therapist lasts about an hour. Your therapist could be a **psychologist** , a **psychiatrist** , a psychiatric nurse, a **psychotherapist** , or a GP.

Cognitive therapy is based on the idea that the thoughts you have and certain assumptions you make about life automatically make you think the worst of yourself. This can make

Depression in adults

you depressed. You may automatically think the worst about yourself and the world without realising it. The aim of cognitive therapy is to change this way of thinking to help you look at things more positively.

To learn more, see [More about cognitive therapy](#) .

Cognitive therapy isn't always easy to get on the NHS. In some areas there aren't enough trained therapists to go round. ^[13]

Cognitive behaviour therapy is similar to cognitive therapy. A therapist helps you change how you behave as well as how you think. It's recommended as a treatment for depression in national guidelines. ^[5] To learn more, see [NICE guidance on depression](#) .

How can it help?

If you have mild or moderate depression, cognitive therapy can:

- Improve your symptoms. This could mean that you start to feel happier, more relaxed or less tired. You may have more energy and a better appetite than before ^[16]
- Increase your chances of getting completely better. About half the people who try cognitive therapy recover completely during treatment. Doctors call this remission. ^{[13] [17] [18]}

Cognitive therapy is likely to help your depression even if you're older. ^{[19] [20]}

But depression often comes back again sooner or later after you stop having treatment. This can happen whether you have drugs or a talking treatment. It's called a **relapse**. Cognitive therapy may be better than antidepressants at preventing relapses. But we need more research to be certain. ^[16]

In studies, 3 in 10 people got depressed again after they stopped cognitive therapy. But 6 in 10 people got depressed again after they stopped taking antidepressants. ^[16]

Carrying on with cognitive therapy can help you stay well for longer. In one study, two years of cognitive therapy was better at preventing relapses than two years of treatment with antidepressants. ^[21]

Cognitive therapy has been compared with other types of talking treatments, including [interpersonal therapy](#) and [problem-solving therapy](#) . One review of the research says they all work about the same. ^[22]

How does it work?

Cognitive therapy changes the way you think. So if the way you think is making you depressed, cognitive therapy should help. If, say, you assume that you're no good at anything, or your family doesn't need you any more, cognitive therapy will help you stop

Depression in adults

thinking that way. You learn to look more positively at yourself and your life, so your mood gets better.

Can it be harmful?

None of the research we found reported any harmful effects from cognitive therapy.

We know that people are better at sticking with talking treatments than with drugs such as antidepressants. About 2 in 10 people drop out of talking treatments, compared with 5 in 10 who drop out of other treatments. ^[17]

How good is the research on cognitive therapy?

There's lots of research showing that cognitive therapy works for people with mild or moderate depression. There isn't enough research to say whether it works for people with severe depression.

The research comparing cognitive therapy with antidepressants isn't good enough to tell us for certain which treatment is better.

We found seven large summaries of research (called systematic reviews) testing different kinds of psychotherapy, including cognitive therapy. Altogether, these summaries looked at more than 100 good-quality studies, which included thousands of people with depression. ^{[13] [16] [17] [23] [24] [25] [26]}

The summaries found that symptoms improved more for people who had psychotherapy compared with those who:

- Stayed on a waiting list
- Had a dummy treatment (a placebo)
- Had standard treatment by a nurse, GP or specialist (standard treatment could include antidepressants, but not a talking treatment)
- Had help and support, but no treatment.

More people who had psychotherapy also found that their symptoms went away completely. Some of the summaries looked separately at cognitive therapy. ^{[13] [16] [24]}
They found:

- People who had cognitive therapy did better than most of the people who had a dummy treatment ^[16]
- Cognitive therapy worked better than antidepressants about two-thirds of the time ^[16]

Depression in adults

- People who had cognitive therapy were more likely to get completely better than people who had standard treatment ^[13]
- A talking treatment known as [interpersonal therapy](#) worked as well as cognitive therapy. ^[24]

One study said that interpersonal therapy worked better than cognitive therapy. ^[26]

We found another summary of eight studies looking at what happened to people after they got better and stopped treatment. About 6 in 10 people who got better with antidepressants got depressed again within a year. People who had cognitive therapy were half as likely to get depressed again. About 3 in 10 got depressed again within a year. ^[16]

The last studies we found looked at how long-term treatment with cognitive therapy compared with treatment with antidepressants. People who carried on with cognitive therapy were less likely to get depressed again than people who carried on with antidepressants. ^{[21] [27] [28]}

One summary of the evidence looked at different types of talking treatments. It found they all worked about as well as each other. ^[22]

Interpersonal therapy

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

[How does it work?](#)

[Can it be harmful?](#)

[How good is the research on interpersonal therapy?](#)

This information is for people who have depression. It tells you about interpersonal therapy, a treatment used for depression. It is based on the best and most up-to-date research.

Does it work?

Yes. If you are a younger adult with mild or moderate depression, interpersonal therapy can help. If you're an older adult (over 55), it's not clear that interpersonal therapy works any better than just having someone helpful to talk to.

There isn't enough research to know if this treatment can help people with severe depression.

We don't know how this treatment measures up against other good treatments such as [antidepressants](#) or [cognitive therapy](#) . (To read about different antidepressants, see [Treatments for depression](#) .)

What is it?

Interpersonal therapy is a kind of **psychotherapy** designed for people with depression. It aims to improve your relationships with other people and help the social side of your life.

It's based on the idea that depression is often linked to things like a fight with your partner or a problem with a workmate. These types of events can trigger depression. But the depression may also come first, and your mood may make fights or work problems more likely. Either way, during interpersonal therapy, your therapist encourages you to learn new and better ways of relating to people.

Most people meet their therapist once a week for three or four months. ^[13] ^[29]

Interpersonal therapy is recommended for people with depression in national guidelines for doctors. To learn more, see [NICE guidance on depression](#) . ^[5] But it can be hard to get on the NHS. In many places there aren't enough trained therapists to go round.

How can it help?

If you have mild or moderate depression, you're more likely to get better if you have [interpersonal therapy](#) than if you don't. ^[13]

One review that looked at several types of talking treatments reported that interpersonal therapy was as good as [cognitive therapy](#) , [counselling](#) , [problem-solving therapy](#) and some other types of talking treatments, if not better. ^[22]

How does it work?

Interpersonal therapy teaches you how to relate better to the people in your life, including family, friends and workmates. So the therapy should help if your depression was triggered by interactions with other people or is causing problems with other people.

The therapy can help you make up after arguments or assert yourself at work. It can also help you build stronger friendships or family ties so you have better social support.

The idea is that you're less likely to get depressed and more likely to recover from depression if you have stronger, more supportive relationships. ^[29]

Can it be harmful?

None of the research we found reported any harmful effects from interpersonal therapy. The main problem is that it's not always available.

How good is the research on interpersonal therapy?

There's a reasonable amount of good research showing that interpersonal therapy can help if you're a younger adult with mild or moderate depression.

Depression in adults

The research in older people (over 55) is much more patchy. And there's very little good research comparing interpersonal therapy with antidepressants or with [cognitive therapy](#).

Younger adults

We found three big summaries of research (called [systematic reviews](#)) testing types of [psychotherapy](#), including interpersonal therapy.^{[13] [17] [23]} The summaries found that psychotherapy worked better than usual care for people with mild or moderate depression. Usual care involves standard treatment by a nurse, doctor or specialist. It could include antidepressants, but not psychotherapy.

Nearly half the people in these studies got better after psychotherapy. Only a quarter of the people who didn't have psychotherapy got better.^[17]

We found one summary of research comparing interpersonal therapy with cognitive therapy. But the research wasn't good enough to tell which treatment was better.^[13]

Another summary of research said interpersonal therapy was better than cognitive therapy, and as good as antidepressants.^[26]

Very few of the people in these research summaries had severe depression. So we still don't know if interpersonal therapy works for severe depression.

We found one more study (a [randomised controlled trial](#)) that looked at group therapy.^[30] The study found that people in Uganda who had interpersonal therapy in groups were much less likely to be depressed than those who didn't have any treatment.

Older adults

We found one summary of three studies testing interpersonal therapy in people over 55. In this summary, interpersonal therapy didn't work. The people who had it did no better than those who had no treatment.^[19]

Compared with other talking treatments

One big review of the evidence looked at all the studies on seven types of talking treatment. It showed all the treatments worked, and interpersonal therapy tended to work better than the others.^[22]

However, a study that directly compared interpersonal therapy with cognitive therapy said that cognitive therapy may work better for severe depression.^[31]

Selective serotonin reuptake inhibitors (SSRIs)

In this section

[Do they work?](#)

[What are they?](#)

[How can they help?](#)

Depression in adults

[How do they work?](#)

[Can they be harmful?](#)

[How good is the research on selective serotonin reuptake inhibitors?](#)

This information is for people who have depression. It tells you about selective serotonin reuptake inhibitors (SSRIs), a treatment used for depression. It is based on the best and most up-to-date research.

Do they work?

Yes. There's good research showing that these antidepressant drugs work for people with more severe depression. But selective serotonin reuptake inhibitors (SSRIs) can cause unpleasant side effects.

We don't know for certain how antidepressants compare with another good treatment called [cognitive therapy](#). But if you have mild or moderate depression, cognitive therapy may work slightly better.

What are they?

Selective serotonin reuptake inhibitors (SSRIs) are a newer type of antidepressant. Your doctor will probably prescribe an SSRI if you need drugs to treat your depression. ^[5] ^[32] Examples of SSRIs (and their brand names) include:

- fluoxetine (Prozac)
- fluvoxamine (Faverin)
- paroxetine (Seroxat)
- sertraline (Lustral)
- citalopram (Cipramil).

Your doctor will probably talk to you about what treatment you would like, if any.

You'll probably need to take antidepressants for more than six weeks before you start to feel better. So it's important not to stop taking them early.

There are national guidelines for doctors on how to treat depression. ^[5] You may find them useful when discussing your treatment with your doctor. To learn more, see [NICE guidance on depression](#).

How can they help?

SSRIs can help you with the symptoms of depression.

Between 5 in 10 and 7 in 10 depressed people feel much better after treatment with SSRIs. ^[33] ^[34] ^[35]

Depression in adults

Taking an antidepressant can mean:

- You feel less sad, hopeless, worried, or guilty
- Your appetite improves
- Your sex drive comes back
- You can concentrate better
- You no longer think about suicide.

Antidepressants work better the more depressed you are.^[36] If you have fairly mild depression, you may not get much benefit. The benefits are larger if you have more severe depression.

SSRIs seem to work as well as older kinds of antidepressants (known as [tricyclic antidepressants](#)).^{[34] [37] [38] [39] [40]} They also work as well as an antidepressant called mirtazapine.^[41]

But a newer antidepressant called [venlafaxine](#) (brand name is Efexor) may work slightly better than SSRIs in people with mild or moderate depression.^{[39] [41] [42]}

Antidepressants may not work as well as cognitive therapy at treating depression and preventing it coming back.^{[16] [43]}

One summary of the evidence compared all the studies about SSRIs and other newer antidepressants. It concluded that there were no major differences between how well they worked.^[44]

How long should I stay on SSRIs?

We don't know for certain how long you should stay on antidepressants. But specialists recommend that you take antidepressants for at least four to six months after you start to feel better.^[45] That's because:

- Depression often comes back sooner or later after you stop treatment. This is called a **relapse**
- About 6 in 10 people who stop taking their antidepressants after a few months get depressed again within a year
- Staying on antidepressants for at least six months after you start to feel better can reduce your chances of a relapse

Depression in adults

- In studies, only 2 in 10 people who stayed on antidepressants got depressed again during treatment. People in these studies stayed on antidepressants for six months to three years after they felt better. ^[45] ^[46] ^[47] ^[48]

Long-term treatment with antidepressants works. But any side effects you get will most likely continue for as long as you take the treatment. About 1 in 5 people have to stop long-term treatment because of side effects. ^[45]

How do they work?

Antidepressants affect chemicals called **neurotransmitters** which help carry messages from brain cell to brain cell. As their name suggests, selective serotonin reuptake inhibitors increase the amount of a neurotransmitter called **serotonin** in your brain. This gradually causes changes in how your brain cells behave. It can take several weeks before you can tell if the drugs are affecting your mood.

The problem is that the drugs also affect other brain cells, disrupting nerve signals and causing side effects.

Can they be harmful?

No one knows how likely you are to get side effects. Different studies say different things. But in general:

- The side effects of selective serotonin reuptake inhibitors (SSRIs) don't bother people quite as much as the side effects of another group of antidepressants called [tricyclic antidepressants \(TCAs\)](#). ^[49]
- You can get withdrawal symptoms if you stop taking an SSRI drug suddenly or reduce your dose. You may feel dizzy and have a runny nose ^[50]
- Treatment with SSRIs may make you more likely to think about suicide when you first start taking them. ^[51] But not all studies show this. ^[52]

In the UK, there is government advice for doctors on how to safely prescribe SSRIs (and a similar drug called [venlafaxine](#)). It says that people taking these drugs should be carefully checked in the early stages of treatment or when their dose is changed, especially if they have symptoms such as agitation and restlessness, or if their depression gets worse. People should also be on the lowest dose that works. ^[53]

All antidepressants can cause side effects. It's important to find the drug that suits you best.

Older people may be more likely to get side effects than younger people, whatever antidepressant they take. This is because of changes in the body that happen as people

Depression in adults

get older. Older people are also often on other medicines, so there's more chance of side effects from taking more than one drug.

Common side effects of SSRIs

Selective serotonin reuptake inhibitors (SSRIs) can make you feel tired, dizzy or generally unwell. ^[54] There doesn't seem to be much difference in side effects between the drugs in this group. ^[55]

A study looked at the side effects that people got when taking an SSRI. The study compared people taking an SSRI with people taking a dummy treatment (a placebo). Of the people taking an SSRI: ^[56]

- 13 in 100 said it made them sweat more than usual
- 14 in 100 said it affected their sex life
- About 25 in 100 said it stopped them sleeping properly
- About 20 in 100 said it gave them a dry mouth.

SSRIs can cause older people to have low levels of sodium. If your sodium levels drop very low, you can get confused, sleepy or even have convulsions. ^[32] If you get any of these problems see your doctor as soon as you can.

Comparing different antidepressants

One study compared the side effects of SSRIs and TCAs in people with depression. ^[49]

- SSRIs such as fluoxetine, fluvoxamine, paroxetine, sertraline, and citalopram caused slightly more people to have stomach upsets, anxiety, sleeplessness and headaches than TCAs.
- TCAs such as amitriptyline, nortriptyline, imipramine, trimipramine, and doxepin caused twice as many people to have a dry mouth, constipation, and dizziness, compared with SSRIs.

Here are the numbers from the study. Each column shows the number of people who got each side effect, in every 100 people.

Side effect	TCAs	SSRIs
Dry mouth	55 in 100	21 in 100
Constipation	22 in 100	10 in 100
Dizziness	23 in 100	13 in 100
Feeling sick	2 in 100	22 in 100

Depression in adults

Diarrhoea	5 in 100	13 in 100
Anxiety	7 in 100	13 in 100
Agitation	8 in 100	14 in 100
Trouble sleeping	7 in 100	12 in 100
Nervousness	11 in 100	15 in 100
Headaches	14 in 100	17 in 100

Overall, people taking SSRIs were a bit less likely to stop taking the drug because of side effects than people taking TCAs. ^[37]

TCAs are more dangerous than SSRIs if you take too much (this is called an overdose). An overdose of a TCA can cause life-threatening damage to your heart.

Withdrawal symptoms

SSRIs can cause withdrawal symptoms if you stop taking them suddenly or if your dose is reduced. The most common symptoms are dizziness, sickness, headaches, a feeling that the room is spinning, and numbness or tingling feelings. ^[50] Other withdrawal symptoms are sweating, anxiety and problems sleeping. ^[53]

Paroxetine seems more likely than some other SSRIs to cause these problems. ^[50] In one study, nearly two-thirds of people taking paroxetine had withdrawal symptoms when they stopped taking it. ^[57]

Venlafaxine can cause similar withdrawal symptoms. Although venlafaxine isn't an SSRI, it is a similar type of drug. ^[53]

In one study, 10 in 100 people who stopped taking fluoxetine said they got a runny nose, and 4 in 100 felt sleepy during the day. About 3 in 100 women said they got painful periods. ^[58]

Talk to your doctor if you want to stop taking an antidepressant. And never stop your treatment suddenly. Your doctor can help you reduce your dose gradually over several weeks to reduce the risk that you'll get withdrawal symptoms. ^[53]

Self-harm and suicide

Research has found that children, teenagers and young adults taking antidepressants of all kinds are more likely to think about suicide or try to harm themselves. ^[59]

The risk of suicidal thoughts is highest if you're under 18. ^[59] Among people under 18 who are taking an antidepressant, an extra 14 in 1,000 thought about suicide.

The researchers also found that there's a risk for young adults up to the age of 24. ^[59] But their risk wasn't as big as the risk for people under 18. An extra 5 in 1,000 people between the ages of 18 and 24 thought about suicide.

Depression in adults

The research doesn't seem to show an increased risk of suicidal thoughts or self-harm for people over the age of 24.^[59] But doctors and caregivers are advised to keep a careful check on anyone taking antidepressants for signs of suicidal thoughts. You are more likely to get these thoughts in the early stages of your treatment, or if the dose of the antidepressant you're taking is changed. You may also be at risk if you have had thoughts about harming or killing yourself before.^[60]

If you're taking an antidepressant and are worried about any thoughts or feelings you have, **see your doctor or go to hospital straight away**. You may also find it helpful to tell a relative or close friend about your condition. You could ask them to tell you if they think your depression is getting worse or if they are worried about changes in your behaviour.^[60]

Serotonin syndrome

If you take too much of an SSRI, you could get a condition called serotonin syndrome. This happens when you get too much serotonin in your body. It causes serious side effects and can be fatal. To learn more, see [Serotonin syndrome](#) .

Can I take antidepressants if I'm pregnant?

There isn't much research on taking antidepressants if you're pregnant. Doctors are advised to avoid prescribing them to pregnant women, or to use them with care if the benefits are likely to outweigh the risks.^[61] This is because of concerns that drugs taken during pregnancy may harm the baby.^[62] However, some research shows that pregnant women who stop taking their antidepressants are more likely to become depressed again.^[63]

To learn more, see [Antidepressants and pregnancy](#) .

How good is the research on selective serotonin reuptake inhibitors?

There is lots of good research on antidepressants. Most of it shows that antidepressants work for people with depression, regardless of whether their depression is mild or severe. Studies have found that selective serotonin reuptake inhibitors (SSRIs) improve people's depression as much as most other kinds of antidepressants.

But some experts are concerned that many of the studies have been paid for by companies that make antidepressants. This could affect the way that findings are reported.^[74] Also, the studies don't really look at whether the improvements in symptoms last. And there's not enough research to show how much these drugs may affect the way you live and your health.

We found hundreds of studies comparing antidepressants with a dummy treatment (a placebo). They all found that SSRIs helped more than half the people who took them.^{[75] [34] [76] [77] [78] [79] [35]} Studies in people over age 55 found that SSRIs worked for

Depression in adults

this age group too. ^[80] ^[81] ^[82] But the studies also found that depression improved in about a third of people who took a placebo.

Other studies compared SSRIs with other treatments.

- Many studies have looked at how well SSRIs work compared with other antidepressants. ^[34] ^[83] ^[38] ^[40] ^[39] These found that SSRIs work as well as older antidepressants known as [tricyclic antidepressants \(TCAs\)](#) . They may also work as well as an antidepressant called mirtazapine. ^[84] ^[85] But SSRIs may not work as well as a drug called [venlafaxine](#) . ^[39] ^[42] ^[41]
- A summary of 155 studies showed that all SSRIs and newer drugs like mirtazapine, venlafaxine, and bupropion worked about as well as each other. However, there are differences in how fast they start working, and in the side effects. ^[44]
- A summary of 31 studies found that taking antidepressants, including SSRIs, for a long period can cut by half the risk of getting depressed again. The benefits were biggest in the first year, but they lasted for up to three years. ^[45] ^[86] ^[87]
- Studies in older people are less clear. One found that people who took citalopram for up to two years were less likely to get depressed again than people who stopped their treatment after a few months. ^[48] But another study found that continuing to take an SSRI didn't prevent more bouts of depression any better than taking a placebo. ^[88] However, these studies were small, with just over 100 people in each. More research is needed to say whether continuing to take SSRIs helps older people.
- Nearly 50 studies, which involved more than 3,000 people, found that [cognitive therapy](#) may work better than antidepressants for treating depression and preventing depression coming back. ^[16] ^[43] But the summary that looked at most of the studies has been criticised for the way it grouped together treatments that were different. ^[89] So these findings may not be reliable.

Tricyclic antidepressants (TCAs)

In this section

[Do they work?](#)

[What are they?](#)

[How can they help?](#)

[How do they work?](#)

[Can they be harmful?](#)

[How good is the research on tricyclic antidepressants?](#)

This information is for people who have depression. It tells you about tricyclic antidepressants, a treatment used for depression. It is based on the best and most up-to-date research.

Do they work?

Yes. There's good research showing that these drugs work for people with more severe depression. But they may cause more unpleasant side effects than some newer kinds of antidepressants.

We don't know for certain how antidepressants compare with another good treatment called [cognitive therapy](#) . If you have mild or moderate depression, cognitive therapy may work slightly better.

What are they?

Tricyclic antidepressants (TCAs) are an older type of antidepressant.^[90] Your doctor will probably prescribe a newer type of antidepressant known as a [selective serotonin reuptake inhibitor \(SSRI\)](#) if you need drugs to treat your depression. You may get a TCA if the newer type of antidepressant doesn't help you, especially if you're a man and have been depressed for more than two years.^[5] Men don't seem to get as many side effects as women from these drugs.

Examples of TCAs (and their brand names) include:

- amitriptyline (Elavil)
- dosulepin (Prothiaden)
- doxepin (Sinequan)
- imipramine
- nortriptyline (Allegron)
- trimipramine (Surmontil).

Your doctor will probably talk to you about what treatment you would like, if any.

You'll probably need to take antidepressants for more than six weeks before you start to feel better. So it's important not to stop taking them early.

There are national guidelines for doctors on how to treat depression.^[5] You may find them useful when discussing your treatment with your doctor. To learn more, see [NICE guidance on depression](#) .

How can they help?

Tricyclic antidepressants (TCAs) can help you with the symptoms of depression.

Between 5 in 10 and 7 in 10 depressed people feel much better after taking one of these drugs.^{[33] [91] [76] [34] [35]}

Depression in adults

Taking an antidepressant can mean:

- You feel less sad, hopeless, worried or guilty
- Your appetite improves
- Your sex drive comes back
- You can concentrate better
- You no longer think about suicide.

Antidepressants work better the more depressed you are.^[36] If you have fairly mild depression, you may not get much benefit. The benefits are larger if you have more severe depression.

TCA's work as well as selective serotonin reuptake inhibitors (SSRIs).^{[34] [92] [38] [39] [40] [93]} But SSRIs may cause fewer side effects.^{[38] [93]} The commonly used TCA amitriptyline may work for more people than SSRIs.^[93]

How long should I stay on antidepressants?

We don't know for certain how long you should stay on antidepressants. But specialists recommend that you take antidepressants for at least four to six months after you start to feel better.^[45] That's because:

- Depression often comes back sooner or later after you stop treatment. This is called a **relapse**
- About 6 in 10 people who stop taking their antidepressants after a few months get depressed again within a year
- Staying on antidepressants for at least six months after you start to feel better can reduce your chances of a relapse
- In studies, only 2 in 10 people who stayed on antidepressants got depressed again during treatment. People in these studies stayed on antidepressants for six months to three years after they felt better.^{[45] [94]}

Long-term treatment with antidepressants works. But any side effects you get will likely continue for as long as you take the treatment. About 1 in 5 people have to stop long-term treatment because of side effects.^[45]

How do they work?

Antidepressants affect chemicals called **neurotransmitters** which help carry messages from brain cell to brain cell. In particular, tricyclic antidepressants boost the amounts of the chemicals **serotonin** and **noradrenaline**. This gradually causes changes in how your brain cells behave. It can take several weeks before you can tell if the drugs are affecting your mood.

The problem is that the drugs also affect other brain cells, disrupting nerve signals and causing side effects.

Can they be harmful?

No one knows how likely you are to get side effects when you take antidepressants. Different studies say different things about how common side effects are.

These are some common side effects you may get from tricyclic antidepressants: dry mouth, constipation, dizziness, nervousness, and headaches.

It looks as if you're slightly more likely to get side effects with tricyclic antidepressants (TCAs) than with selective serotonin reuptake inhibitors (SSRIs).^[38] ^[49]

One study compared the side effects of TCAs and SSRIs in people with depression.^[49]

Here are the numbers from the study. Each column shows the number of people who got each side effect, in every 100 people.

Side effect	TCAs	SSRIs
Dry mouth	55 in 100	21 in 100
Constipation	22 in 100	10 in 100
Dizziness	23 in 100	13 in 100
Feeling sick	2 in 100	22 in 100
Diarrhoea	5 in 100	13 in 100
Anxiety	7 in 100	13 in 100
Agitation	8 in 100	14 in 100
Trouble sleeping	7 in 100	12 in 100
Nervousness	11 in 100	15 in 100
Headaches	14 in 100	17 in 100

TCAs can be dangerous if you take too much (this is called an overdose). An overdose of a TCA can cause life-threatening damage to your heart. An overdose of a TCA is more dangerous than an overdose of an SSRI.

Studies looking at other side effects of tricyclic antidepressants found:

- 17 in 100 people got blurred vision^[95]

Depression in adults

- 17 in 100 people got **low blood pressure** ^[96]
- 10 in 100 people got a fast heartbeat ^[96]
- 10 in 100 people got trembling. ^[96]

The TCA dosulepin (brand name Prothiaden) has been linked to an increased risk of **heart disease** in older adults. ^[97]

It's impossible to tell who will and who won't get side effects. But you may be less likely to get side effects if you take a lower dose of a TCA. ^[91]

All antidepressants can cause side effects. It's important to find the drug that suits you best.

Older people may be more likely to get side effects than younger people, whatever antidepressant they take. This is because of changes in the body that happen as people get older. Older people are also often using other medicines, so there's more chance of side effects from taking more than one drug.

Withdrawal symptoms

You can get **withdrawal symptoms** if you stop taking antidepressants suddenly or if your dose is reduced. If you stop taking TCAs you can get headaches, nausea, and an overall feeling of discomfort. ^[98]

Talk to your doctor if you want to stop taking an antidepressant. And never stop your treatment suddenly. Your doctor can help you reduce your dose gradually over several weeks to reduce the risk that you'll get withdrawal symptoms. ^[90]

Self-harm and suicide

Research has found that children, teenagers and young adults taking antidepressants of all kinds are more likely to think about suicide or try to harm themselves. ^[59]

The risk of suicidal thoughts is highest if you're under 18. ^[59] Among people under 18 taking an antidepressant, an extra 14 in 1,000 thought about suicide.

The researchers also found that there's a risk for young adults up to the age of 24. ^[59] But their risk wasn't as big as the risk for people under 18. An extra 5 in 1,000 people between the ages of 18 and 24 thought about suicide.

The research doesn't seem to show an increased risk of suicidal thoughts or self-harm for people over the age of 24. ^[59] But doctors and caregivers are advised to keep a careful check on anyone taking antidepressants for signs of suicidal thoughts. You are more likely to get these thoughts in the early stages of your treatment, or if the dose of the

Depression in adults

antidepressant you're taking is changed. You may also be at risk if you have had thoughts about harming or killing yourself before. ^[60]

If you're taking an antidepressant and are worried about any thoughts or feelings you have, **see your doctor or go to hospital straight away**. You may also find it helpful to tell a relative or close friend about your condition. You could ask them to tell you if they think your depression is getting worse or if they are worried about changes in your behaviour. ^[60]

Can I take antidepressants if I'm pregnant?

There isn't much research on taking antidepressants if you're pregnant. Doctors are advised to avoid prescribing them to pregnant women, or to use them with care if the benefits are likely to outweigh the risks. ^[61] One large study found that women who took tricyclic antidepressants for depression during pregnancy had an increased risk of a condition called [pre-eclampsia](#) than depressed women who did not. ^[99] There are also concerns that drugs taken during pregnancy may harm the baby. However, some research shows that pregnant women who stop taking their antidepressants are more likely to become depressed again. ^[63]

To learn more, see [Antidepressants and pregnancy](#) .

How good is the research on tricyclic antidepressants?

There's lots of good research on these drugs. Most of it shows that all kinds of antidepressants work for people with depression, regardless of whether their depression is mild or severe. But some experts are concerned that many of the studies have been paid for by companies that make and sell antidepressants. This could affect the way that findings are reported. ^[74]

We found more than 50 studies comparing antidepressants with a dummy treatment (a placebo). Some of the studies involved tricyclic antidepressants (TCAs). They found that TCAs helped more than half the people who took them. ^{[33] [91] [76] [34] [35]} Studies of people over age 55 found that these drugs helped people in this age group too. ^[80]

Taking a low dose of a TCA may work just as well as taking a high dose. One review of six studies found just as many people got better after taking either a high or low dose of a TCA for six to eight weeks. But we don't know how reliable these results are. The studies may not have been well-designed. ^[91]

There's a lot of research comparing TCAs to other types of antidepressants. Here's a summary of the research.

- Summaries of the research (called [systematic reviews](#)) have found that TCAs work just as well as the group of antidepressants known as [selective serotonin reuptake inhibitors \(SSRIs\)](#) and just as well as a drug called [venlafaxine](#) . ^{[34] [100] [38] [39]}

Depression in adults

[40] [93] [42] These reviews looked at hundreds of studies involving many thousands of patients.

- A review of 55 studies found that TCAs work better than [monoamine oxidase inhibitors \(MAOIs\)](#) for people with severe depression. [101] But TCAs may not work as well as MAOIs for some unusual types of depression that cause people to eat more or sleep more.
- Two studies compared [reboxetine](#) with TCAs. The results of the studies were mixed. So we're still not sure which drug is better. [95] [102] Reboxetine is a newer kind of antidepressant.
- A summary of 31 studies found good evidence that continuing to take antidepressants for a long period can cut by half the risk of getting depressed again. The benefits lasted for up to three years but were biggest in the first year. [45]

Nearly 50 studies, which involved more than 3,000 people, have found that [cognitive therapy](#) may work better than antidepressants at treating depression and preventing depression coming back. [16] [43] But the summary that looked at most of the studies has been criticised for the way it grouped together treatments that were different. [103] So these findings may not be reliable.

Monoamine oxidase inhibitors (MAOIs)

In this section

[Do they work?](#)

[What are they?](#)

[How can they help?](#)

[How do they work?](#)

[Can they be harmful?](#)

[How good is the research on monoamine oxidase inhibitors?](#)

This information is for people who have depression. It tells you about monoamine oxidase inhibitors (MAOIs), a treatment used for depression. It is based on the best and most up-to-date research.

Do they work?

Yes. There's good research showing that these drugs work for people with more severe depression, but possibly not as well as some other antidepressants. Monoamine oxidase inhibitors (MAOIs) aren't used very often because of dangers when they're taken with certain other drugs and types of food.

We don't know for certain how antidepressants in general compare with another good treatment called [cognitive therapy](#). But if you have mild or moderate depression, cognitive therapy may work slightly better.

What are they?

Monoamine oxidase inhibitors (MAOIs) are a kind of antidepressant. Examples of MAOIs include:

- phenelzine (brand name Nardil)
- isocarboxazid
- tranylcypromine.

MAOIs aren't used very much any more. But your doctor may suggest you try one of these drugs if other antidepressants haven't worked^[104] or if you have an unusual type of depression (for example, you eat or sleep more than normal, or you are very moody or sensitive).

Your doctor will probably talk to you about what treatment you would like, if any.

You'll probably need to take antidepressants for more than six weeks before you start to feel better. So it's important not to stop taking them early.

There are national guidelines for doctors on how to treat depression.^[5] You may find them useful when discussing your treatment options with your doctor. To learn more, see [NICE guidance on depression](#).

How can they help?

Monoamine oxidase inhibitors (MAOIs) can help you with the symptoms of depression.

More than half of depressed people feel much better after treatment.^[34] Taking an antidepressant can mean:

- You feel less sad, hopeless, worried or guilty
- Your appetite improves
- Your sex drive comes back
- You can concentrate better
- You no longer think about suicide.

Antidepressants work better the more depressed you are.^[36] If you have fairly mild depression, you may not get much benefit. The benefits are larger if you have more severe depression.

Depression in adults

MAOIs probably work as well as most other types of antidepressants. ^[33] ^[56] Some studies show [tricyclic antidepressants \(TCAs\)](#) may work a bit better than MAOIs if you have severe depression. ^[101]

MAOIs aren't used very often, but they may work better than other antidepressants in people whose depression has unusual symptoms. Doctors call this **atypical depression**. For example, some people eat or sleep more than usual, or are very sensitive or moody. ^[101] ^[105]

How long should I stay on antidepressants?

We don't know for certain how long you should stay on antidepressants. But specialists recommend that you take antidepressants for at least four to six months after you start to feel better. ^[90] That's because:

- Depression often comes back sooner or later after you stop treatment. This is called a **relapse**
- About 6 in 10 people who stop taking their antidepressants after a few months get depressed again within a year
- Staying on antidepressants for at least six months after you start to feel better can reduce your chances of a relapse.

Long-term treatment with antidepressants works. But any side effects you get will most likely continue for as long as you take the treatment.

How do they work?

Antidepressants affect chemicals called **neurotransmitters** which help carry messages from brain cell to brain cell. Monoamine oxidase inhibitors (MAOIs) block a chemical called monoamine oxidase. ^[104] This causes amine neurotransmitters to collect, which gradually makes changes in how your brain cells behave. It can take several weeks before you can tell if the drugs are affecting your mood.

The problem is that the drugs also affect other brain cells, disrupting nerve signals and causing side effects.

Can they be harmful?

The biggest problem with monoamine oxidase inhibitors (MAOIs), such as phenelzine (Nardil) and tranylcypromine, is that they react with lots of other medicines, foods and alcoholic drinks.

If you take an MAOI, eating foods containing the natural chemical **tyramine** (such as mature cheese and Marmite) can dangerously raise your **blood pressure**. ^[104] The first sign of very high blood pressure is usually a throbbing headache. If this happens, **see**

Depression in adults

your doctor straight away. People taking these drugs have to be careful about what they eat.

If you take an MAOI, you should avoid:^[104]

- Meat extracts or yeast extracts such as Bovril, OXO, or Marmite
- Soy sauce
- Broad beans, especially the pods
- Pickled herring
- Any game, such as pheasant or hare
- Any meat, poultry, fish or offal that you think may be a bit old or stale
- Cough, cold and flu remedies containing a decongestant
- Alcoholic drinks (even low-alcohol drinks such as alcohol-free lager).

Make sure to ask your doctor for a full list of foods, drinks and medicines to avoid.

MAOIs also react dangerously with most other antidepressants.^[104] The combination of tranylcypromine with clomipramine (Anafranil) is particularly dangerous.^[104] Clomipramine is a [tricyclic antidepressant](#) .

If you stop taking an MAOI, you should not start taking another antidepressant for two or three weeks.

Common side effects of MAOIs

In studies, the most common side effects reported by people taking MAOIs were:^[101]

- **Low blood pressure** , causing faintness
- Dizziness
- Blurred vision
- Goose bumps
- Difficulty sleeping
- Trembling
- Problems with sex, including being unable to have an orgasm.

Depression in adults

All antidepressants can cause side effects. It's important to find the drug that suits you best.

Older people may be more likely to get side effects than younger people, whatever antidepressant they take. This is because of changes in the body that happen as people get older. Older people are also often taking other medicines, so there's more chance of side effects from taking more than one drug.

Withdrawal symptoms

You can get **withdrawal symptoms** if you stop taking antidepressants suddenly.

Talk to your doctor if you want to stop taking an antidepressant. And never stop your treatment suddenly. Your doctor can help you reduce your dose gradually over several weeks to reduce the risk that you'll get withdrawal symptoms. ^[104]

Self-harm and suicide

Research has found that children, teenagers and young adults taking antidepressants of all kinds are more likely to think about suicide or try to harm themselves. ^[59]

The risk of suicidal thoughts is highest if you're under 18. ^[59] Among people under 18 taking an antidepressant, an extra 14 in 1,000 thought about suicide.

The researchers also found that there's a risk for young adults up to the age of 24. ^[59] But their risk wasn't as big as the risk for people under 18. An extra 5 in 1,000 people between the ages of 18 and 24 thought about suicide.

The research doesn't seem to show an increased risk of suicidal thoughts or self-harm for people over the age of 24. ^[59] But doctors and caregivers are advised to keep a careful check on anyone taking antidepressants for signs of suicidal thoughts. You are more likely to get these thoughts in the early stages of your treatment, or if the dose of the antidepressant you're taking is changed. You may also be at risk if you have had thoughts about harming or killing yourself before. ^[60]

If you're taking an antidepressant and are worried about any thoughts or feelings you have, **see your doctor or go to hospital straight away**. You may also find it helpful to tell a relative or close friend about your condition. You could ask them to tell you if they think your depression is getting worse or if they are worried about changes in your behaviour. ^[60]

Can I take antidepressants if I'm pregnant?

There isn't much research on taking antidepressants if you're pregnant. Doctors are advised to avoid prescribing them to pregnant women, or to use them with care if the benefits are likely to outweigh the risks. ^[61] This is because of concerns that drugs taken during pregnancy may harm the baby. However, some research shows that pregnant

Depression in adults

women who stop taking their antidepressants are more likely to become depressed again.
[63]

To learn more, see [Antidepressants and pregnancy](#) .

How good is the research on monoamine oxidase inhibitors?

There's lots of good research on all kinds of antidepressants. Most of it shows that antidepressants work for people with depression, regardless of whether their depression is mild or severe. But some experts are concerned that many of the studies have been paid for by companies that make and sell antidepressants. This could affect the way that the findings are reported. [74]

We found three summaries of the research (known as [systematic reviews](#)) which included some studies of monoamine oxidase inhibitors (MAOIs). In these summaries researchers looked at the results of many hundreds of studies involving thousands of people

The summaries found that MAOIs worked better than a dummy treatment (a [placebo](#)).
[33] [34] [76] More than half of the people taking an MAOI got better. Getting better meant people's symptoms improved by 50 percent or more.

We also found some summaries looking at how well MAOIs worked compared to other antidepressants. [56] [106] [105]

One review found that MAOIs worked about as well as other types of antidepressant. [56]

Another review found that MAOIs didn't work as well as antidepressants called [tricyclic antidepressants \(TCAs\)](#) for people with severe depression. [106] But this review, and another one, showed that MAOIs worked better than other types of antidepressant for people with unusual depression symptoms. [105]

Venlafaxine

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

[How does it work?](#)

[Can it be harmful?](#)

[How good is the research on venlafaxine?](#)

This information is for people who have depression. It tells you about venlafaxine, a treatment used for depression. It is based on the best and most up-to-date research.

Does it work?

Yes. There's good research showing that venlafaxine works as well as other antidepressants for people with more severe depression. Venlafaxine may work slightly

Depression in adults

better than [selective serotonin reuptake inhibitors \(SSRIs\)](#) for people with mild or moderate depression.

But venlafaxine can cause unpleasant side effects.

We don't know for certain how antidepressants compare with another good treatment called [cognitive therapy](#) . But if you have mild or moderate depression, cognitive therapy may work slightly better.

What is it?

Venlafaxine (brand name Efexor) is a fairly new antidepressant. It is a **serotonin and noradrenaline reuptake inhibitor** (or SNRI). This drug is similar to selective serotonin reuptake inhibitors (SSRIs). Venlafaxine is usually used after other antidepressants haven't worked. ^[107]

Your doctor will probably talk to you about what treatment you would like, if any.

You'll probably need to take antidepressants for more than six weeks before you start to feel better. So it's important not to stop taking them early.

There are national guidelines for doctors on how to treat depression. ^[5] You may find them useful when discussing your treatment with your doctor. To learn more, see [NICE guidance on depression](#) .

How can it help?

Venlafaxine can help you with the symptoms of depression.

One study found that up to 8 in 10 people felt much better after treatment with venlafaxine. ^[108]

Taking an antidepressant can mean:

- You feel less sad, hopeless, worried or guilty
- Your appetite improves
- Your sex drive comes back
- You can concentrate better
- You no longer think about suicide.

Antidepressants work better the more depressed you are. ^[36] If you have fairly mild depression, you may not get much benefit. The benefits are larger if you have more severe depression.

Depression in adults

Venlafaxine seems to work as well as other kinds of antidepressants.^{[42] [109] [110] [44]}
It may work slightly better than selective serotonin reuptake inhibitors (SSRIs) for people with mild or moderate depression.^{[42] [41] [39]}

How does it work?

Antidepressants affect chemicals called **neurotransmitters** which help carry messages from brain cell to brain cell. In particular, venlafaxine boosts the amounts of the chemicals serotonin and noradrenaline. This gradually causes changes in how your brain cells behave. It can take several weeks before you can tell if the drugs are affecting your mood.

The problem is that the drugs also affect other brain cells, disrupting nerve signals and causing side effects.

Can it be harmful?

In the UK, there is government advice for doctors on how to safely prescribe venlafaxine (and SSRI drugs). It says that people taking these drugs should be carefully checked in the early stages of treatment or when their dose is changed, especially if they have symptoms such as agitation and restlessness, or if their depression gets worse. People should also be on the lowest dose that works.^[107]

Venlafaxine causes heart problems in some people. You need to have your blood pressure checked regularly when you're taking it.^[111] You shouldn't take venlafaxine if you have certain heart problems or high blood pressure.

Studies show that up to 7 in 10 people treated with venlafaxine have side effects.^[108]
^[109] This is similar for people taking an SSRI drug.

Venlafaxine can cause sexual problems, such as problems with erections or difficulty having an orgasm.^[112] You may also feel sick, tired or dizzy, or lose your appetite if you take this drug.

Here's what happened to people with depression who took venlafaxine in studies:^[108]
^[109]

- 4 in 10 people had stomach problems
- More than a quarter had a dry mouth
- More than a third sweated more than normal
- Two-fifths lost weight.

All antidepressants can cause side effects. It's important to find the drug that suits you best.

Depression in adults

Older people may be more likely to get side effects than younger people, whatever antidepressant they take. This is because of changes in the body that happen as people get older. Older people may also be on other medicines, so there's more chance of side effects from taking more than one drug.

Withdrawal symptoms

Venlafaxine can cause withdrawal symptoms if you stop taking it suddenly or if your dose is reduced. The most common symptoms are dizziness, sickness, headaches, a feeling that the room is spinning, and a feeling of numbness or tingling.^[113] Other withdrawal symptoms are sweating, anxiety and problems sleeping.^[107]

Talk to your doctor if you want to stop taking an antidepressant. And never stop your treatment suddenly. Your doctor can help you reduce your dose gradually over several weeks to reduce the risk that you'll get withdrawal symptoms.^[107]

Self-harm and suicide

Research has found that children, teenagers and young adults taking antidepressants of all kinds are more likely to think about suicide or try to harm themselves.

The risk of suicidal thoughts is highest if you're under 18.^[59] Among people under 18 who are taking an antidepressant, an extra 14 in 1,000 thought about suicide.

The researchers also found that there's a risk for young adults up to the age of 24.^[59] But their risk wasn't as big as the risk in people under 18. An extra 5 in 1,000 people between the ages of 18 and 24 thought about suicide.

The research doesn't seem to show an increased risk of suicidal thoughts or self-harm for people over the age of 24.^[59] But doctors and caregivers are advised to keep a careful check on anyone taking antidepressants for signs of suicidal thoughts. You are more likely to get these thoughts in the early stages of your treatment, or if the dose of the antidepressant you're taking is changed. You may also be at risk if you have had thoughts about harming or killing yourself before.^[60]

One study found that venlafaxine was more strongly linked to suicide attempts than SSRI antidepressants. But this could be because people taking venlafaxine were more likely to have severe depression, and were therefore more likely to have attempted suicide before starting the drug.^[114]

If you're taking an antidepressant and are worried about any thoughts or feelings you have, **see your doctor or go to hospital straight away**. You may also find it helpful to tell a relative or close friend about your condition. You could ask them to tell you if they think your depression is getting worse or if they are worried about changes in your behaviour.^[60]

Serotonin syndrome

If you take too much venlafaxine or another SNRI, you could get a condition called serotonin syndrome. This happens when you get too much serotonin in your body. It causes serious side effects and can be fatal. To learn more, see [Serotonin syndrome](#) .

Can I take antidepressants if I'm pregnant?

There isn't much research on taking antidepressants if you're pregnant. Doctors are advised to avoid prescribing them to pregnant women, or to use them with care if the benefits are likely to outweigh the risks.^[61] One large study found that women who took serotonin and noradrenaline reuptake inhibitors for depression during pregnancy had an increased risk of a condition called pre-eclampsia than depressed women who did not.^[99] There are also concerns that drugs taken during pregnancy may harm the baby. However, some research shows that pregnant women who stop taking their antidepressants are more likely to become depressed again.^[63]

To learn more, see [Antidepressants and pregnancy](#) .

How good is the research on venlafaxine?

There's lots of good research on all kinds of antidepressants. Most of it shows that antidepressants work for people with depression, whether their depression is mild or severe.

We found three summaries of the research (known as [systematic reviews](#)) and more studies that show that venlafaxine (brand name Efexor) works as well as other antidepressants.

- Venlafaxine works as well as [tricyclic antidepressants \(TCAs\)](#) . TCAs are an older kind of drug used to treat depression. A review of eight studies included more than 1,000 people with mild or moderate depression. It found just as many people taking venlafaxine got better as people taking a TCA. People in the studies took the antidepressants for at least a month and up to a year.^[42] Getting better meant at least a 50 percent improvement in people's symptoms. Another smaller study also found both types of drugs worked equally well.^[115]
- Venlafaxine may work slightly better than [selective serotonin reuptake inhibitors \(SSRIs\)](#) for people with mild or moderate depression. Three reviews covering 28 studies found slightly more people got better if they took venlafaxine than if they took an SSRI.^[42] ^[41] ^[39]
- Venlafaxine works as well as mirtazapine (brand name Zispin SolTab). Mirtazapine is a newer antidepressant. One study found both drugs improved symptoms of depression after eight weeks for people in hospital.^[116]

Electroconvulsive therapy (ECT)

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

[How does it work?](#)

[Can it be harmful?](#)

[How good is the research on electroconvulsive therapy?](#)

This information is for people who have depression. It tells you about electroconvulsive therapy (ECT), a treatment sometimes used for depression. It is based on the best and most up-to-date research.

Does it work?

Yes. Electroconvulsive therapy (ECT) is a quick way to help some people with severe depression. It may work better than antidepressants for some people. (To read about different antidepressants, see [Treatments for depression](#) .)

What is it?

Electroconvulsive therapy is a series of electric shocks given to your brain through **electrodes** placed on your scalp. The shocks cause a brief fit, or **seizure** . You won't be awake during the treatment (you'll be given a **general anaesthetic**).

ECT is controversial. In the past it was probably used too much and on some people who didn't need it. It also has side effects. It's normally used only after treatment with drugs hasn't worked, or when a patient is so ill (suicidal perhaps, or refusing to eat or drink) that quick treatment is needed. ECT is given only in hospital.

You can have ECT to one side of your brain, or both sides. And doctors can increase or decrease the power of the electric shocks depending on how ill you are.

Your doctor will probably recommend ECT only if you are in hospital for depression and other treatments haven't helped. ^[5] A course of treatment usually lasts four to six weeks, with two or three sessions a week. To learn more, see [NICE guidance on depression](#) .

How can it help?

In studies, people with severe depression who were given ECT got much better than people who were given a dummy treatment for comparison (a **placebo**). ^[117] It also seems to work better than antidepressants for people with very bad depression.

The effects of ECT do not last forever, though. As with other treatments for depression, many people eventually become ill again. And we don't know if it works for older people. ^[118]

How does it work?

Experts don't know exactly why ECT works. Most think that the electric shocks increase the amount of chemicals in the brain called **neurotransmitters**. These chemicals help carry signals between nerves.

Can it be harmful?

The main side effect is that your memory becomes hazy. You may have trouble remembering things or recognising words. This effect can last for a few weeks or sometimes for as long as two months. But depression can affect memory too, so it's difficult to know just how much of the memory loss is because of the treatment.

Having ECT on both sides of your brain seems to affect memory more than having it on just one side. And the more powerful the ECT, the more likely you are to get a hazy memory. ^[117]

How good is the research on electroconvulsive therapy?

We found a large summary of the research (a **systematic review**) that summarised 73 studies with slightly more than 1,000 people in total. ^[117]

The review found that:

- Electroconvulsive therapy (ECT) worked better than a dummy treatment (a **placebo**)
- ECT worked better than one month to three months of treatment with **antidepressants**
- ECT to both sides of the brain worked better than ECT to one side only. But ECT to both sides caused more side effects
- The more powerful the ECT, the better it worked. But the more powerful ECT also caused more side effects
- An extra treatment each week (three instead of two) made no difference to people's symptoms.

We also found another review looking at ECT in older adults. It included three small studies, but they weren't good enough to tell us anything for certain about the effects of ECT in people over 55. ^[118]

Antidepressants plus a talking treatment

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

Depression in adults

[How does it work?](#)

[Can it be harmful?](#)

[How good is the research on antidepressants plus a talking treatment?](#)

This information is for people who have depression. It tells you about antidepressants plus a talking treatment, a treatment used for depression. It is based on the best and most up-to-date research.

Does it work?

Probably. If you're depressed, having a talking treatment ([psychotherapy](#)) and taking antidepressants is likely to work better than having either treatment on its own.

What is it?

If your doctor thinks you need drug treatment for your depression, you'll probably be given a type of antidepressant called a [selective serotonin reuptake inhibitor \(SSRI\)](#) .^[5] You may also have a talking treatment along with the antidepressant. There are several kinds of talking treatments, including [interpersonal therapy](#) and [cognitive therapy](#) .

This combined treatment is recommended for people with moderate or severe depression by national guidelines for doctors.^[119]

To learn more, see [NICE guidance on depression](#) .

How can it help?

You're more likely to become less depressed or recover if you have a talking treatment as well as taking an antidepressant.^[120] ^[121] However, there may be waiting lists to see a therapist.

Longer periods of treatment (at least 12 weeks) seem to work better than shorter ones.^[120] In one study, people who had both antidepressants and a talking treatment were more likely to stick with treatment than people just taking antidepressants.^[122]

The two treatments together also seem to work better for people who have a personality disorder as well as depression.^[123] People with personality disorders have fixed ways of thinking about themselves or others, and of how to behave, which stops them fitting in with society. They may not know that how they think or act is unusual, but they do know that this causes them problems in their day-to-day life.

Having a course of a talking treatment called cognitive therapy when you start taking antidepressants may help more than just taking antidepressants alone.^[124]

Research also shows that adding cognitive therapy to antidepressants can help if antidepressants alone don't work well enough.^[125]

How does it work?

Antidepressants and a talking treatment seem to combine well with each other and work better than either of them on their own.

Can it be harmful?

Antidepressants all have a risk of side effects. Depending on the drug, these can include a dry mouth, constipation, dizziness, nausea, diarrhoea, anxiety, agitation, sleeplessness, nervousness and headaches.

Antidepressants can also cause unpleasant withdrawal symptoms if you stop taking them or reduce your dose too quickly. And doctors are advised not to give some antidepressants to children and teenagers because these drugs may make them more likely to harm themselves or think about committing suicide.

To learn more about these side effects, see [Selective serotonin reuptake inhibitors \(SSRIs\)](#), [Tricyclic antidepressants \(TCAs\)](#), [Monoamine oxidase inhibitors \(MAOIs\)](#), [Venlafaxine](#), and [Reboxetine](#).

There's no evidence that talking treatments can be harmful.

One study found that people having antidepressants and a talking treatment had similar complaints and side effects as people who were treated only with antidepressants. ^[126]

How good is the research on antidepressants plus a talking treatment?

There's some good evidence that having a talking treatment as well as taking antidepressants helps people with depression. But there's not as much evidence for using both of these treatments as there is for using either of these treatments on its own.

We found two systematic reviews that summarised around 30 studies. The studies found that using antidepressants plus a talking treatment worked better than using either treatment on its own. ^[122] ^[127] They found that:

- Having antidepressants and a talking treatment (such as [interpersonal therapy](#) or [cognitive therapy](#)) worked better than just taking antidepressants
- People having treatment for a longer amount of time were less likely to drop out if they had a talking treatment as well as antidepressants.

However, we also found two studies (randomised controlled trials) that found that having a talking treatment plus antidepressants didn't help more than having each treatment on its own. ^[128] ^[129] But the quality of the first study was not very good. In the second study people who had a personality disorder as well as depression did better if they had the two treatments together. ^[129] (People with personality disorders have fixed ways of thinking about themselves or others, and of how to behave, which stops them fitting in with society.)

Depression in adults

Another study looked at adults who were older than 60 and had depression. ^[130] The researchers found that taking an antidepressant and having cognitive therapy worked better than just taking an antidepressant. But the combination didn't work better than cognitive therapy alone.

One study looked at almost 400 people starting antidepressant treatment. Half had cognitive therapy, over the telephone, for several weeks at the start of the study. After six months, they were less depressed than the people who just had antidepressants alone. ^[124]

Another study looked at 469 people with depression whose symptoms weren't helped enough by antidepressants alone. Those who started having cognitive therapy as well as taking antidepressants improved more than those who continued to just take antidepressants. ^[125]

Counselling

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

[How does it work?](#)

[Can it be harmful?](#)

[How good is the research on counselling?](#)

This information is for people who have depression. It tells you about counselling, a treatment used for depression. It is based on the best and most up-to-date research.

Does it work?

Probably. If you have mild or moderate depression, counselling may help, at least at first. But the benefits may not last very long.

In studies, people who had counselling did better than people who were treated by their doctor but did not have any counselling. But after six months, the additional benefits of counselling wore off.

We don't know whether counselling works for people with severe depression.

What is it?

Counselling involves talking to someone about your problems. Talking helps you think more clearly. It also helps you express your feelings.

Most people talk regularly to a trained counsellor at their doctor's surgery. If you have this treatment, you'll probably have one session a week for a few weeks. ^[131] The counsellor will listen carefully then encourage you to solve your own problems. The counsellor won't tell you what to do.

Depression in adults

How can it help?

About a third of people who have counselling for one to six months feel much better afterwards.^[131] It seems to help people who have symptoms of anxiety as well as depression.^[132]

Feeling much better means having fewer or milder symptoms of depression. For example, you may be able to concentrate more, and you may feel less sad and less anxious. Your appetite may improve and your sex drive may come back.

Counselling may not work as well as other types of talking treatment.^[22]

How does it work?

Counselling is based on the idea that sharing your problems with someone else helps you work out a way round them. So if your problems are making you depressed, talking to someone could help.

Counsellors are trained listeners. They don't tell you what to do, but they help you to find your own answers.

Can it be harmful?

Counselling isn't likely to harm you. We didn't find any reports of unwanted effects from this treatment.

How good is the research on counselling?

There's some research to show that counselling can help people with mild or moderate depression. We found one summary (a **systematic review**) of nine studies.^[131] The studies included more than 1300 people.

The summary found that counselling can improve symptoms for the first six months. But in the long run, people who have counselling are likely to be just as depressed as those who get only the usual care. Usual care means standard treatment by a nurse, doctor or specialist. It could include **antidepressants** but not **psychotherapy**.

Another study (a **randomised controlled trial**) found that women were less anxious and depressed after eight weekly sessions of counselling.^[133]

A study comparing different types of talking treatment showed counselling may not work as well as other types of talking therapy.^[22]

St. John's wort

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

[How does it work?](#)

Depression in adults

[Can it be harmful?](#)

[How good is the research on St. John's wort?](#)

This information is for people who have depression. It tells you about St. John's wort, a treatment used for depression. It is based on the best and most up-to-date research.

Does it work?

Probably. St. John's wort is likely to help you if you have mild or moderate depression. However, the research on St. John's wort isn't as good as the research on antidepressants. (To read about different antidepressants, see [Treatments for depression](#).)

What is it?

St. John's wort is a plant. Its scientific name is **Hypericum perforatum**. It's been used as a herbal remedy for depression in parts of Europe for many years.

It comes as a tablet containing concentrated extracts from the plant, but exactly how much is in the tablets varies from brand to brand. ^[134]

In the UK, St. John's wort is sold as a food supplement, not as medicine. This means it hasn't been tested for safety in the same way as medicines.

Your doctor probably won't advise you to take St. John's wort. It isn't recommended as a treatment for depression in national guidelines. ^[119]

To learn more, see [NICE guidance on depression](#).

How can it help?

The research on St. John's wort isn't very good. But we do know: ^[135]

- If you have depression, there's a good chance that St. John's wort will help you feel better
- Feeling better means you may feel less sad or anxious, and more able to concentrate. You may sleep better and have a better appetite
- It seems to work about as well as selective [serotonin reuptake inhibitors \(SSRIs\)](#) and [tricyclic antidepressants](#).

How does it work?

No one knows for certain. Extracts of St. John's wort contain at least 10 kinds of chemicals that may affect your health. It's not clear which of these chemicals helps treat depression, or which combination works best.

Although St. John's wort tablets are often described as 'standardised', this usually means that the amount of one of the ingredients is fixed, not that they all are.

Depression in adults

Here are two theories about how St. John's wort may work. ^[136]

- It may increase the level of chemicals called **neurotransmitters**, such as **serotonin**, which help carry signals between brain cells. These don't work properly if you're depressed.
- Depressed people have more of some **hormones**. St. John's wort may reduce the supply of a protein called interleukin 6, which in turn reduces levels of these hormones.

Can it be harmful?

Most studies don't look properly at side effects. The most common side effects seem to be stomach problems (such as sickness or **diarrhoea**), dizziness or confusion, tiredness, and a dry mouth. People in some studies also said St. John's wort gave them headaches or reduced their enjoyment of sex. ^[137]

Some people get an **allergic skin reaction** if they take St. John's wort, but this is rare. ^[138] There have also been reports of people becoming manic possibly because they took St. John's wort.

The biggest problem with St. John's wort is that it interferes with lots of other medicines. ^[138] ^[139] ^[140] For example, you shouldn't take St. John's wort if you are taking: ^[141]

- The contraceptive pill. St. John's wort makes the pill less effective, so there is a higher chance you'll get pregnant
- A drug called simvastatin (brand name Zocor). This is a medicine used to treat or prevent **high cholesterol** and **heart disease**.
- Drugs for **migraine** called triptans, such as sumatriptan (brand name Imigran) and eletriptan (brand name Relpax)
- Drugs for **epilepsy**
- Warfarin, and similar drugs used to prevent blood clots
- A drug for **eczema** called tacrolimus (brand name Protopic)
- Drugs for **HIV** called indinavir, efavirenz, and nevirapine
- **Antidepressants**.

St. John's wort interferes with many other drugs too. You should **always tell your doctor if you are taking St. John's wort**.

How good is the research on St. John's wort?

We found a big summary of research (called a [systematic review](#)) that looked at the evidence from lots of studies of St. John's wort.^[135] The summary found that St. John's wort:

- Improved symptoms more than a dummy treatment (a [placebo](#)) for people with depression (the treatment lasted one to three months). More than half the people treated with St. John's wort got better.
- Worked just as well as some antidepressant drugs ([tricyclic antidepressants](#) and [selective serotonin reuptake inhibitors](#)).

But some of the studies weren't run very well, so their results may not be reliable.^[142]

The findings don't mean you should rely on this treatment. Here's why.

- The people in the studies may not be typical, either of most people or of people who have depression. So it's hard to know whether these findings will apply to you.
- Most of these studies didn't compare the same St. John's wort tablets. Instead, there was a lot of variation in what the tablets contained and how they were made. So it's difficult to say whether most of the studies apply to the products you can find in health food shops and pharmacies. Different brands contain different amounts of St. John's wort.
- The studies were short, usually less than six weeks long. No one knows what happened to the people later on.
- There was a lot of variation in how well St. John's wort worked in different studies.

Having a care plan

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

[How does it work?](#)

[Can it be harmful?](#)

[How good is the research on having a care plan?](#)

This information is for people who have depression. It tells you about having a care plan, a treatment used for depression. It is based on the best and most up-to-date research.

Does it work?

Probably. If you're depressed, it's important to get the right treatment. Having a written care plan can mean you get treatment when you need it. Support to help you see treatment

Depression in adults

through can help you get better faster. It can also help you stay well for longer once you are better.

What is it?

A care plan outlines all of the things that should happen in order for you to get the best care possible. It's usually written by the team of health professionals treating you, including doctors, nurses, social workers and **psychologists**. Then they all work together to follow the plan. But since every patient is different, they make changes to the plan if they need to.

By following a set plan, it's less likely that important steps in your care will be left out. Also, by having a team of people looking after you, you are more likely to get all of the care you need.

Lots of different things can go into a care plan. Here are a few examples. ^[143]

- You may have regular check-ups by your doctor or nurse. These could be face-to-face or over the phone, or you may fill in a questionnaire about your symptoms.
- You may have a team of people looking after you, instead of just your doctor. The team could include your doctor, your **psychiatrist**, a **psychologist** and a social worker.
- You may have your own case manager. This person checks on you regularly during your treatment and lets your doctor know how you're doing. He or she also makes sure that you get any support you need from other professionals such as a psychiatric nurse or a social worker. Some case managers can teach you more about depression or even help treat you.
- You may learn more about depression in group lessons.
- Your doctor and nurse may also learn more about depression by going to classes or doing homework.
- A pharmacist may give regular feedback to your doctors about the treatments they use for depression.

How can it help?

Studies have shown that care plans help people with depression get the best from their treatment. People who have a care plan: ^[144] ^[145] ^[146] ^[147]

- Have fewer symptoms
- Get better faster

Depression in adults

- Stay better for longer.

In one study, three-quarters of the people who had a case manager got better and stayed better for up to two years. ^[148]

In another study, a care plan that included group classes and regular check-ups helped 7 in 10 people to get better. Only 3 in 10 people got better without a care plan. ^[149]

How does it work?

Having a care plan means you're more likely to get the right treatment at the right time, and less likely to stop your treatment early. This means you should get better faster and stay well for longer.

- Having someone check on you probably makes it easier to spot when your treatment isn't working properly and your depression is getting worse. Your doctor or health care team can then look for other ways to help you, such as by changing the dose or type of your antidepressant.
- Being looked after by a team of people instead of just one person means much more knowledge and experience is used to help you get better.

Can it be harmful?

It's unlikely that having a care plan could do any harm. But these plans can be expensive and difficult to organise, so they may not be available where you live.

How good is the research on having a care plan?

There's good research showing that having a care plan can reduce your symptoms and help you stay well.

We found five large summaries (called **systematic reviews**), and several more high-quality studies (called **randomised controlled trials**). ^{[145] [150] [146] [151] [147] [152] [149] [153] [154]}

^{[155] [156] [157] [158] [159] [160] [161]} The studies looked at lots of different care plans.

Most of the studies found that care plans helped people with depression. Some studies involved older people being treated by community nurses and mental health teams working together. These too found that care plans were helpful. ^{[145] [150]}

But the research doesn't tell us what sort of care plan works best.

Reboxetine

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

Depression in adults

[How does it work?](#)

[Can it be harmful?](#)

[How good is the research on reboxetine?](#)

This information is for people who have depression. It tells you about reboxetine, a treatment used for depression. It is based on the best and most up-to-date research.

Does it work?

Reboxetine can help people recover from **severe depression**, but it doesn't seem to help people with mild to moderate depression.

What is it?

Reboxetine (brand name Edronax) is a fairly new antidepressant. It may be used after other antidepressants haven't worked. It's a type of antidepressant known as a **selective inhibitor of noradrenaline reuptake**.

Your doctor will probably talk to you about what treatment you would like, if any.

You'll probably need to take antidepressants for more than six weeks before you start to feel better. So it's important not to stop taking them early.

There are national guidelines for doctors on how to treat depression.^[5] You may find them useful when discussing your treatment with your doctor. To learn more, see [NICE guidance on depression](#).

How can it help?

Reboxetine can help people recover from **severe depression**, but it doesn't seem to help people with mild to moderate depression.

Several studies have compared reboxetine with a dummy treatment (a **placebo**).^[162] The studies found that about 5 in 10 people recovered from severe depression when they took reboxetine, compared with about 4 in 10 people who took the dummy treatment. However, the studies also found that reboxetine did not help people recover from mild to moderate depression.^[162]

Studies have also compared reboxetine with other antidepressants, such as [selective serotonin reuptake inhibitors \(SSRIs\)](#).^[163] In these studies, about 46 in 100 people taking reboxetine recovered from depression. This compared with 52 in 100 people taking SSRIs.

How does it work?

Antidepressants affect chemicals called **neurotransmitters** which help carry messages from brain cell to brain cell. In particular, reboxetine boosts the amounts of the chemical **noradrenaline**. This gradually causes changes in how your brain cells behave. It can take several weeks before you can tell if the drug is affecting your mood.

Depression in adults

The problem is that antidepressants also affect other brain cells, disrupting nerve signals and causing side effects.

Can it be harmful?

In studies, around 8 in 10 people who took reboxetine got at least one side effect. ^[163]
This is similar to the amount of side effects caused by other antidepressants.

About 1 in 10 people got side effects that were bad enough to stop them taking reboxetine. ^[163]

Here's what happened to the people with depression who took reboxetine in studies. ^[164]
^{[95] [102] [165]}

- Between 13 in 100 and 57 in 100 people said they got a dry mouth.
- Up to 25 in 100 had trouble sleeping.
- Between 4 in 100 and 18 in 100 had blurred vision.
- Between 10 in 100 and 21 in 100 got constipated .
- About 20 in 100 said they sweated more than usual.
- About 17 in 100 got headaches or migraines .
- About 14 in 100 got trembling hands.
- About 14 in 100 felt sick.
- Between 10 in 100 and 19 in 100 had low blood pressure .
- About 10 in 100 said they found it harder to pass urine.

Older people may be more likely to get side effects than younger people, whatever antidepressant they take. This is because of changes in the body that happen as people get older. Older people are also often taking other medicines, so there's more chance of side effects from using more than one drug.

Withdrawal symptoms

If you stop taking antidepressants suddenly you can get withdrawal symptoms , such as feeling sick, vomiting, getting headaches and having problems sleeping. To avoid these effects, your doctor should reduce your dose gradually over a few weeks.

Depression in adults

Self-harm and suicide

Research has found that children, teenagers and young adults taking antidepressants of all kinds are more likely to think about suicide or try to harm themselves. ^[59]

The risk of suicidal thoughts is highest if you're under 18. ^[59] Among people under 18 taking an antidepressant, an extra 14 in 1,000 thought about suicide.

The researchers also found that there's a risk for young adults up to the age of 24. ^[59] But their risk wasn't as big as the risk for people under 18. An extra 5 in 1,000 people between the ages of 18 and 24 thought about suicide.

The research doesn't seem to show an increased risk of suicidal thoughts or self-harm for people over the age of 24. ^[59]

But doctors and caregivers are advised to keep a careful check on anyone taking antidepressants for signs of suicidal thoughts. You are more likely to get these thoughts in the early stages of your treatment, or if the dose of the antidepressant you're taking is changed. You may also be at risk if you have had thoughts about harming or killing yourself before. ^[60]

If you're taking an antidepressant and are worried about any thoughts or feelings you have, **see your doctor or go to hospital straight away**. You may also find it helpful to tell a relative or close friend about your condition. You could ask them to tell you if they think your depression is getting worse or if they are worried about changes in your behaviour. ^[60]

Can I take antidepressants if I'm pregnant?

There isn't much research on taking antidepressants if you're pregnant. Doctors are advised to avoid prescribing them to pregnant women, or to use them with care if the benefits are likely to outweigh the risks. ^[61] This is because of concerns that drugs taken during pregnancy may harm the baby. However, some research shows that pregnant women who stop taking their antidepressants are more likely to become depressed again. ^[63]

To learn more, see [Antidepressants and pregnancy](#) .

How good is the research on reboxetine?

There's some good research suggesting reboxetine mainly helps people with severe depression.

One review of the research was done by the Medicines and Health Regulatory Agency for the UK (MHRA), which is the government agency responsible for regulating medicines and medical devices. It looked at studies that compared reboxetine with a dummy treatment (a **placebo**), and included around 2,000 people in total. ^[162] Some studies found that reboxetine helped people recover from severe depression compared with the

Depression in adults

placebo, but didn't work any better than the placebo for people with mild to moderate depression. ^[162]

Some studies compared reboxetine with other antidepressant drugs. Other drugs, such as [selective serotonin reuptake inhibitors](#), worked better for people with mild to moderate depression. ^[162]

Exercise

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

[How does it work?](#)

[Can it be harmful?](#)

[How good is the research on exercise?](#)

This information is for people who have depression. It tells you about exercise, a treatment sometimes used for depression. It is based on the best and most up-to-date research.

Does it work?

It's hard to know. You may find that exercise helps lift your mood. But there haven't been enough good studies for us to say for sure that it works.

What is it?

Regular exercise (for example, walking, swimming, weight training or jogging) may help improve your mood.

Taking part in an exercise programme is recommended for people with mild depression in national guidelines for doctors. ^[5] To learn more, see [NICE guidance on depression](#).

How can it help?

Some studies have found that regular exercise of any type can make people feel happier. But these studies haven't always been very high-quality, so their results may not be reliable. ^[166] ^[167] ^[168]

Other studies have looked at yoga and at aerobic exercise. ^[169] ^[170] They found that both these types of exercise can be helpful. But again, the studies were not very high quality. So it's hard to rely on the results.

A study looking at people over 75 found that a home exercise programme and social visits both reduced depression by the same amount. ^[171]

How does it work?

There are several reasons why exercise may help.

Depression in adults

- Being good at something, feeling successful and achieving new goals can all boost your mood.
- You may be distracted from your day-to-day worries.
- Exercise may boost the levels of chemicals in your brain that help improve your mood (such as [endorphins](#)). ^[166]

Can it be harmful?

None of the studies mentioned any problems because of exercise. It's possible you could strain a muscle or injure yourself if you overdo it or don't warm up properly.

How good is the research on exercise?

We found two big summaries of the research ([systematic reviews](#)) that looked at the results of several smaller studies. ^[166] ^[168] Both reviews found that exercise may help improve the symptoms of depression but the improvements may not be very large.

The reviews included studies that weren't very high quality. This makes it hard for us to know whether the results are reliable.

Other research has focused just on older adults, showing that exercise may also help depression in this group. ^[172]

Befriending

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

[How does it work?](#)

[Can it be harmful?](#)

[How good is the research on befriending?](#)

This information is for people who have depression. It tells you about befriending, a treatment used for depression. It is based on the best and most up-to-date research.

Does it work?

There's too little evidence to know if befriending works.

What is it?



Is befriending an effective treatment for depression?

Your doctor arranges for someone, probably a volunteer, to meet you every week for friendly conversation or trips out.

You may be asked if you would like to take part in this type of scheme if you've been depressed for two years or more.^[5] The volunteer should keep touch with you at least once a week, over a period of several months.

How can it help?

Having someone to talk to or go out with once a week helps some people feel less depressed.^[173]

How does it work?

People with lots of friends are less likely to get depressed. So doctors think that having someone befriend you could work as a treatment.

Can it be harmful?

The one study we found didn't mention any harms.^[173]

One drawback to befriending could be that some people don't want to participate in this type of treatment. They may want to make friends, but just not in this way.

How good is the research on befriending?

There's too little research to say whether befriending helps people with depression. We only found one small study.^[173] It looked at 86 women with long-term depression.

It found that, after about one year, the women who had been befriended were more likely to have fewer symptoms than the women who didn't have this treatment.

Problem-solving therapy

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

Depression in adults

[How does it work?](#)

[Can it be harmful?](#)

[How good is the research on problem-solving therapy?](#)

This information is for people who have depression. It tells you about problem-solving therapy, a treatment used for depression. It is based on the best and most up-to-date research.

Does it work?

There's not enough evidence to be certain. Some people with mild or moderate depression feel better after problem-solving therapy. But the effects don't seem to last very long. In the long run, problem-solving therapy may be no better than the usual care from your doctor. (Usual care could include antidepressants, but not [psychotherapy](#).)

We don't know if this treatment works for people with severe depression.

What is it?

Problem-solving therapy is a fairly short and simple treatment. You may have six sessions over three months. It can be provided by a doctor or a trained nurse or counsellor. You'll be taught how to cope with problems in your life.

Problem-solving therapy helps you take small steps towards coping. You work out what the problem is, discuss ideas about how to solve it, choose a solution and work out the steps you can take to get there. ^[174]

How can it help?

In one study, people who had problem-solving therapy were less likely to be depressed after six months than people who didn't. But the extra benefits wore off over the next six months. ^[175]

In another study, people who had problem-solving therapy did no better than people who were treated in the usual way by their doctor. ^[176]

One summary of the research looked at seven talking treatments, including problem-solving therapy. It said all of them worked about the same. ^[22]

How does it work?

Everyone has problems in their lives. Most of the time we get over them and carry on. But if a problem gets too big or goes on for too long, it can make you depressed. Problem-solving therapy teaches you how to solve problems in an easy, step-by-step way. With these new skills, you should cope better with life's problems. Your mood should improve, and you may be less likely to get depressed again

Can it be harmful?

Problem-solving therapy isn't likely to harm you. We didn't find any reports of unwanted effects from this treatment.

How good is the research on problem-solving therapy?

The research on problem-solving therapy is mixed. It may help people with mild or moderate depression, but more research is needed to be certain. There is very little research on problem-solving therapy for people with severe depression.

We found one large study of 452 people with mild or moderate depression. People who had problem-solving therapy were more likely to get better than people who didn't. But a year or so later, the difference had worn off. ^[175]

We found one large summary of research (called a [systematic review](#)) that included four studies on problem-solving therapy. Two of them, which looked at 439 people with mild depression, found that problem-solving therapy was no better than a dummy treatment (a [placebo](#)). ^[23]

Another, smaller study looked at 70 people. It found that problem-solving therapy was no better than usual treatment. ^[176] (Usual treatment could include antidepressants, but not [psychotherapy](#).)

A comparison of seven different types of talking treatment, including problem-solving therapy, which covered 53 studies in total, said they all worked about the same. ^[22]

Antidepressants plus lithium

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

[How does it work?](#)

[Can it be harmful?](#)

[How good is the research on antidepressants plus lithium?](#)

This information is for people who have depression. It tells you about antidepressants plus lithium, a treatment used for depression. It is based on the best and most up-to-date research.

Does it work?

We don't know. This treatment is for people who don't get better when they take antidepressants. There isn't enough good research to say for certain whether it works.

Depression in adults

What is it?

You'll be offered this treatment only if you've tried antidepressants for at least four weeks and found that they don't work on their own. Your doctor may then add lithium to your treatment. You don't stop taking your antidepressants.

You can take lithium as a tablet or a liquid. It's normally used to treat a serious mental illness called bipolar disorder (sometimes known as manic depression), in which a person swings between high and low moods. It can also be used as an extra treatment for people with other types of depression. ^[177]

Most people get lithium from a psychiatrist, not from their GP. You'll have tests before you take this drug to make sure your heart is working properly. This is because lithium can cause heart problems in some people.

You'll also need regular blood tests to check you're having the right dose. Too much lithium can be dangerous. And too little could mean the treatment won't work. Most people need blood tests every week for about four weeks, then one every three months. ^[178]

You'll need to carry a card with you that tells you:

- How to take this treatment
- What your blood test results are
- What to do if you miss a dose
- What side effects to expect
- What other drugs to avoid.

Lithium has several brand names, including Camcolit, Liskonum, and Priadel. You can take it several times a day or as one big dose before you go to bed. ^[179]

You can take lithium with any kind of antidepressant. ^[180] There are three main types of antidepressants.

- [Selective serotonin reuptake inhibitors \(SSRIs\)](#) . These include fluoxetine (brand name Prozac), fluvoxamine (Faverin), paroxetine (Seroxat), sertraline (Lustral), and citalopram (Cipramil).
- [Tricyclic antidepressants \(TCAs\)](#) . Some examples of TCAs are amitriptyline, doxepin (Sinepin), imipramine, nortriptyline (Allegron), and trimipramine (Surmontil).
- [Monoamine oxidase inhibitors \(MAOIs\)](#) . Examples of MAOIs are phenelzine (Nardil) and tranylcypromine. This type of antidepressant isn't used very much any more.

Depression in adults

Other antidepressants include [venlafaxine](#) (Efexor) and [reboxetine](#) (Edronax). Venlafaxine is sometimes described as an SSRI.

How can it help?

We don't know for certain that this treatment can help.

- Some research found that 4 in 10 people taking lithium plus antidepressants got better. ^[181]
- But in another study only 1 in 10 people having this treatment got better. ^[182]

In studies, getting better usually means having at least a 50 percent improvement in symptoms. Symptoms include feeling down, not being able to concentrate, losing your appetite and having sleep problems.

How does it work?

We don't know exactly how lithium may work. Both lithium and antidepressants alter chemicals in your brain called [neurotransmitters](#). These chemicals take messages between brain cells. They also affect your mood. ^[183]

Lithium and antidepressants affect the neurotransmitters in your brain in different ways. So having both together may be better than having antidepressants on their own.

Can it be harmful?

Yes. Lithium can cause an upset stomach. It may make you feel sick, put you off your food or give you mild [diarrhoea](#). It can also make you want to drink more fluids and go to the toilet more than usual. ^[184]

Lithium can also cause:

- [Kidney](#) problems ^[177]
- An underactive or enlarged [thyroid gland](#) ^[178]
- Slight trembling in your hands. ^[178]

Too much lithium can have serious and dangerous effects, including [seizures](#) (fits). Warning signs include: ^[178]

- Blurred vision
- Feeling sleepy

Depression in adults

- Feeling giddy
- Having trouble walking straight
- Trembling hands.

Regular blood tests to check your dose should prevent any problems. But if you notice any of these symptoms, **contact your doctor straight away**. You may need emergency treatment in hospital.

Lithium's side effects are made worse by low levels of sodium in your body, and by **dehydration**. Salt is a form of sodium, so don't make any changes to your diet that may reduce the amount of salt you eat. Dehydration happens when your body doesn't get enough fluid. So make sure you drink enough.

Other drugs can interfere with the way your body handles lithium. Some drugs increase, and others decrease, the amount of lithium in your blood. Tell your doctor if you take any other medicines, especially if you bought them over the counter at a pharmacy.

Antidepressants also have side effects.

- TCAs can cause side effects including a dry mouth, **constipation** and dizziness. ^[185]
- SSRIs can cause stomach upsets, anxiety, sleeplessness and headaches. ^[185]
- MAOIs react with a natural chemical called **tyramine**. This is found in some foods, including mature cheese, pickled herrings and yeast extracts. The reaction can cause **high blood pressure**. You need to avoid these foods if you're taking these drugs. ^[178]

Antidepressants may also cause unpleasant **withdrawal symptoms** if you stop taking them or reduce your dose. And doctors are advised not to give some antidepressants to children and teenagers because these drugs may make them more likely to harm themselves or think about committing suicide. ^[186]

To learn more about these side effects, see [Selective serotonin reuptake inhibitors \(SSRIs\)](#), [Tricyclic antidepressants \(TCAs\)](#), [Monoamine oxidase inhibitors \(MAOIs\)](#), [Venlafaxine](#), and [Reboxetine](#).

How good is the research on antidepressants plus lithium?

There isn't much good research on this treatment.

We found one summary (called a **systematic review**) of two studies, and one further study. Together they included only 85 people with severe depression. ^[181] ^[182]

Depression in adults

All the people in these studies had tried antidepressants and found they didn't work. Half the people then added lithium to their antidepressants. The other half were given a dummy treatment (a [placebo](#)) to take with their antidepressants.

- The summary of two studies found that lithium can help. Of the people who took lithium, 42 in 100 got better, compared with only 17 in 100 of the people who took a placebo. ^[181]
- The other study found that lithium didn't work. ^[182]

Antidepressants plus pindolol

In this section

[Does it work?](#)

[What is it?](#)

[How can it help?](#)

[How does it work?](#)

[Can it be harmful?](#)

[How good is the research on antidepressants plus pindolol?](#)

This information is for people who have depression. It tells you about antidepressants plus pindolol, a treatment used for depression. It is based on the best and most up-to-date research.

Does it work?

We don't know if adding pindolol to antidepressants helps. This treatment is for people who don't get better when taking antidepressants on their own. There isn't enough good research to say for certain whether it works.

What is it?

You'll be offered this treatment only if you've tried antidepressants for at least four weeks and found that they don't work. You don't stop taking your antidepressants. Instead, pindolol is added to your treatment.

Most people get this treatment from a [psychiatrist](#), not from their doctor. You take pindolol as a tablet. Its brand name is Visken.

Pindolol is usually used to treat [high blood pressure](#). It's called a **beta-blocker**. Pindolol can boost the effects of antidepressants.

Antidepressants are medicines designed to lift your mood. There are three main types.

- [Selective serotonin reuptake inhibitors \(SSRIs\)](#). Examples (with brand names) include fluoxetine (Prozac), fluvoxamine (Faverin), paroxetine (Seroxat), sertraline (Lustral), and citalopram (Cipramil).
- [Tricyclic antidepressants \(TCAs\)](#). Some examples of TCAs are amitriptyline, doxepin (Sinepin), imipramine, nortriptyline (Allegron), and trimipramine (Surmontil).

Depression in adults

- [Monoamine oxidase inhibitors \(MAOIs\)](#) . Examples of MAOIs are phenelzine (Nardil) and tranylcypromine. This type of antidepressant isn't used very much any more.

Other antidepressants include [venlafaxine](#) (Efexor) and [reboxetine](#) (Edronax). Venlafaxine is sometimes described as an SSRI.

How can it help?

We're not sure that it can help. This is a new treatment, and there isn't much good research on it.

In studies, people taking antidepressants plus pindolol did no better than people who just took antidepressants. ^[181] ^[187] But the studies were very small, so we can't rely completely on the results.

How does it work?

Antidepressants alter some of the chemicals in your brain. These chemicals, called [neurotransmitters](#) , carry messages between brain cells. They also affect your mood.

Pindolol boosts the effects of antidepressants by helping them increase the level of a neurotransmitter called [serotonin](#) in your brain. ^[188]

Can it be harmful?

Both antidepressants and pindolol can cause side effects.

Pindolol can: ^[178]

- Slow down your heartbeat; if your heartbeat slows down too much, you can faint
- Lower your [blood pressure](#) ; if your blood pressure gets too low, you may feel dizzy or faint, especially if you get up from a chair too fast
- Cause side effects including tiredness, stomach upsets and problems with sex.

Antidepressants also have side effects.

- TCAs (such as amitriptyline, nortriptyline, and imipramine) can cause side effects including a dry mouth, [constipation](#) and dizziness. ^[185]
- SSRIs (such as fluoxetine, fluvoxamine, and paroxetine) can cause side effects including stomach upsets, anxiety, sleeplessness and headaches. ^[185]
- MAOIs react with a natural chemical called **tyramine**. This is found in some foods, including mature cheese, pickled herrings and yeast extracts. The reaction can

Depression in adults

cause **high blood pressure** . You need to avoid these foods if you're taking these drugs. ^[178]

Antidepressants can also cause unpleasant withdrawal symptoms if you stop taking them or reduce your dose. And doctors are advised not to give some antidepressants to children and teenagers because these drugs may make them more likely to harm themselves or think about committing suicide. ^[186]

To learn more about these side effects, see [Selective serotonin reuptake inhibitors \(SSRIs\)](#) , [Tricyclic antidepressants \(TCAs\)](#) , [Monoamine oxidase inhibitors \(MAOIs\)](#) , [Venlafaxine](#) , and [Reboxetine](#) .

How good is the research on antidepressants plus pindolol?

The research on this treatment isn't very good.

We found one summary (called a **systematic review**) of three studies. ^[181]

- The summary included only 106 people. They all had severe depression and had tried antidepressants for at least four weeks.
- Half added pindolol to their antidepressant. The other half were given a dummy treatment (a placebo).
- The people who took pindolol did no better than the people who took a placebo.

We found one other study. It also found no difference between the people who took pindolol and the people who just took antidepressants. ^[187]

Regular check-ups after you're better

In this section

[Do they work?](#)

[What are they?](#)

[How can they help?](#)

[How do they work?](#)

[Can they be harmful?](#)

[How good is the research on regular check-ups after you're better?](#)

This information is for people who have depression. It tells you about regular check-ups after you're better, a treatment used for depression. It is based on the best and most up-to-date research.

Do they work?

We don't know. Once you're feeling better, regular check-ups are meant to help you stay well for longer. We're not sure if they do. The research isn't good enough to give a clear answer.

Depression in adults

We also don't know how regular check-ups compare with other ways of helping you stay well, such as carrying on taking [antidepressants](#) or having [cognitive therapy](#) . (To read about different antidepressants, see [Treatments for depression](#) .)

What are they?

If your treatment worked and you're now better, there's still a chance that your depression will come back. This is called a **relapse**. About 6 in 10 people get depressed again when they stop taking antidepressants. ^[189] About 3 in 10 people get depressed again after they stop cognitive therapy. ^[16]

Regular check-ups are one way of trying to prevent relapses. Doctors sometimes call regular check-ups a **relapse prevention programme**.

There are lots of different ways of having regular check-ups. People in studies had: ^[190]
^[191]

- Visits to a depression specialist (such as a [psychologist](#) , a [psychiatric nurse](#) or a social worker)
- Phone calls from the same depression specialist
- Occasional group or individual therapy sessions
- Questionnaires to fill in about how they were feeling
- A chance to learn more about depression by attending an education programme.

How can they help?

Having regular check-ups once you feel better may mean you'll have fewer symptoms of depression. But it may not reduce the risk that you'll get depression again (have a relapse). ^[190] ^[191]

How do they work?

Regular check-ups:

- Help you and your doctor spot early warning signs of depression
- Help you stick with any treatment you're still having, such as antidepressants
- Give you a regular time to talk about how you're feeling.

All these things should help you stay well for longer.

Can they be harmful?

It's unlikely that regular check-ups will harm you. But none of the research we found looked for unwanted effects.

How good is the research on regular check-ups after you're better?

There isn't much research on this treatment. One summary of the research (a **systematic review**) found that the research wasn't good enough to say whether regular check-ups helped stop depression coming back. ^[191]

One high-quality study in the review included 386 people with depression who were feeling better after taking **antidepressants** for eight weeks. ^[190]

For one year, half of them had regular check-ups with a depression specialist, attended an education programme about depression and received telephone calls to check on how they were doing. The other half had some follow-up appointments and could see their doctor if they needed to. But they weren't telephoned at home and they did not attend an education programme about depression.

- Slightly more than one-third of the people in both groups got depressed again at least once.
- But overall, those who had regular check-ups had fewer symptoms of depression than the others.

Further informations:

More about cognitive therapy

There are different kinds of cognitive therapy. But all of them involve trying to change the way you think. You work with a therapist to do this. Cognitive therapy involves: ^[14]
^[15]

- Finding out which thoughts make you depressed and ill. These are sometimes called **automatic thoughts**. For example, every time your boss asks you to do something new you might think, "I can't do that, I'm no good at it." Or when someone wants to get close to you, you might think, "What's the point; they won't like me"
- Figuring out what therapists call your **rules for living**. These are the assumptions you make about life. Most people form these rules when they're young, and they might not even know they have them. Examples of unhealthy rules might be, "I'll never be any good at anything, so what's the point in trying?" or, "I make people unhappy. So I'm better off on my own"

Depression in adults

- Getting rid of bad rules and thoughts so you can replace them with better ones. The first step is to list your bad thoughts and ask yourself whether they are true. For example, you might ask yourself, "Am I really no good at anything?"
- Learning and practicing ways to be more positive. For example, you might learn to change the thought, "I'll never be any good at anything" to "I must be good at my job. I've never been fired, my co-workers like me and I always meet my deadlines".

Some types of therapy use techniques based on meditation. You might hear this called **mindfulness-based therapy**.

Each session with a therapist lasts about 50 minutes. At the start of each session, you and your therapist decide what you want to achieve. At the end, your therapist gives you homework. Your homework could be to:

- Make a daily diary of your thoughts
- Do a simple task that you would normally avoid.

Homework is important. It means your treatment carries on between sessions.

Helping yourself

Treatment doesn't end when you stop going to a therapist. Cognitive therapy is meant to teach you how to treat yourself. If your old ways of thinking come back, you can use your training. This is a good approach for people who want to help themselves get better.

A short course of cognitive therapy usually lasts about 10 weeks. ^[5] It's important that you feel comfortable with your therapist. If you're unhappy with your therapist for any reason, talk to your doctor. Your doctor might be able to refer you to a different therapist.

It's also important to finish the treatment.

Serotonin syndrome

If you take too much of certain antidepressants, you could get a condition called serotonin syndrome. This happens when you get too much serotonin in your body. Serotonin syndrome is rare but very serious, and can be fatal.

The main antidepressants that increase serotonin include the following (with brand names):

- citalopram (Cipramil)
- duloxetine (Cymbalta)

Depression in adults

- escitalopram (Cipralex)
- fluvoxamine (Faverin)
- fluoxetine (Prozac)
- paroxetine (Seroxat)
- sertraline (Lustral)
- venlafaxine (Efexor).

The **symptoms of serotonin syndrome** are:

- Feeling restless
- Having rapid changes in blood pressure (you may not notice when this happens)
- Having a rise in your body temperature
- Feeling jittery
- Feeling as if you may be sick
- Vomiting
- Having diarrhoea .

The chance of getting serotonin syndrome may be higher if the dose you are taking is increased or if you switch from one medicine to another.^[64] Taking these antidepressants with certain medicines (for example, some other antidepressants and triptans for migraine) may also increase the chance of getting serotonin syndrome, particularly when you start taking the other medicine or if the dose of one of the medicines is increased.

If you get any of the above symptoms you should see your doctor or go to an accident and emergency department straight away.

Antidepressants and pregnancy

It can be very difficult to decide whether to continue taking antidepressants if you're planning to get pregnant or have recently become pregnant. The research doesn't always give a clear picture of how antidepressants affect women who are pregnant.

Depression in adults

If you take antidepressants late in your pregnancy, your baby may get withdrawal symptoms soon after birth. In one study, some mothers who took the [selective serotonin reuptake inhibitor](#) (SSRI) fluoxetine (brand name Prozac) late in their pregnancy had smaller babies. ^[65]

Another study looked at more than 3,500 women who took antidepressants during the first three months of pregnancy. It found that women who took the SSRI paroxetine (brand name Seroxit) were more likely to have a baby with birth defects than women who took other antidepressants. The babies mainly had heart defects. ^[66] Earlier studies didn't show a higher risk of birth defects from paroxetine or other SSRIs. But a later review of the evidence suggests fluoxetine may have the same effect. ^[67]

Some research suggests that taking antidepressants while you are pregnant could make you more likely to have a premature birth. ^[68] ^[69] ^[70] However, one study found that severe depression also made a premature birth more likely, even for women who didn't have treatment.

Some research suggests that taking an SSRI in the second half of pregnancy may increase the risk of your baby getting a serious lung condition called persistent pulmonary hypertension (PPH) soon after they are born. Babies with PPH have high blood pressure in the blood vessels in their lungs. This makes it difficult for them to get enough oxygen into their blood. One study found that babies whose mothers took an SSRI after the 20th week of pregnancy were six times more likely to get PPH than babies whose mothers did not take one of these antidepressants. ^[71] However, some studies have found no increase in risk. ^[72]

If you've had major depression in the past you're more likely to have a relapse while pregnant if you stop taking your antidepressants. ^[73] In one study, researchers followed 201 women who'd had major depression in the past. Some women stopped taking antidepressants when they became pregnant, while others chose to continue taking their antidepressants. Out of the 82 women who carried on taking their antidepressants, 21 (26 percent) had a relapse. Out of the 65 women who stopped taking antidepressants, 44 (68 percent) relapsed. (The numbers of women don't add up to 201 because some women dropped out of the study.)

Talk to your doctor if you take antidepressants and are pregnant or planning to get pregnant.

Glossary:

diabetes

Diabetes is a condition that causes too much sugar (glucose) to circulate in the blood. It happens when the body stops making a hormone called insulin (type 1 diabetes) or when insulin stops working (type 2 diabetes).

heart disease

You get heart disease when your heart isn't able to pump blood as well as it should. This can happen for a variety of reasons.

noradrenaline

Depression in adults

Noradrenaline is a neurotransmitter, which is a chemical that helps to send information between nerve cells. It is similar to adrenaline. Your body produces adrenaline when you're in stressful situations, which increases your blood pressure and heart rate.

serotonin

Serotonin is a neurotransmitter, which is a chemical that helps to send information from a nerve cell to other cells. It is thought to play a role in learning, sleep and control of mood.

genes

Your genes are the parts of your cells that contain instructions for how your body works. Genes are found on chromosomes, structures that sit in the nucleus at the middle of each of your cells. You have 23 pairs of chromosomes in your normal cells, each of which has thousands of genes. You get one set of chromosomes, and all of the genes that are on them, from each of your parents.

hormones

Hormones are chemicals that are made in certain parts of the body. They travel through the bloodstream and have an effect on other parts of the body. For example, the female sex hormone oestrogen is made in a woman's ovaries. Oestrogen has many different effects on a woman's body. It makes the breasts grow at puberty and helps control periods. It is also needed to get pregnant.

menstrual cycle

The menstrual cycle is the regular monthly process that causes an egg to be released from the ovaries so that a woman can get pregnant. The menstrual cycle causes her period, the bleeding that happens if she does not get pregnant.

menopause

When a woman stops having periods, it is called the menopause. This usually happens around the age of 50.

stroke

You have a stroke when the blood supply to a part of your brain is cut off. This damages your brain and can cause symptoms like weakness or numbness on one side of your body. You may also find it hard to speak if you've had a stroke.

psychiatrist

A psychiatrist is a doctor who specialises in psychiatry. Psychiatry is the branch of medicine that covers mental, emotional or behavioural problems.

psychologist

A psychologist is trained to study the human mind and human behaviour. A clinical psychologist provides mental health care in hospitals, clinics, schools or to private patients.

psychotherapy

Psychotherapy is a talking treatment. It is given by trained therapists (such as a psychiatrists, psychologists or social workers). Psychotherapy usually consists of regular sessions (often weekly) between the therapist and the patient. There are many types of psychotherapy, including cognitive behavioural therapy and interpersonal therapy.

antidepressant

Antidepressants are medicines used to treat depression and sometimes other conditions. They work by changing the levels of chemicals in your brain called neurotransmitters. There are three main types of antidepressants, which work in different ways: selective serotonin reuptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants (TCAs).

withdrawal symptoms

Withdrawal symptoms are when you get unpleasant physical or mental symptoms because you stopped taking a drug you were physically dependent on. You can become physically dependent on a drug if it alters the level of certain chemicals in your body. This makes your body produce less of those chemicals or change how it responds to them. Also, some drugs work in a similar way to chemicals that naturally occur in your body. This may mean your body stops making its natural versions. If either of those things happens, your body will need the drug to function normally and you will feel or become ill if you suddenly stop taking the drug. You can get withdrawal symptoms from some prescription medicines, as well as some illegal drugs.

general anaesthetic

You may have a type of medicine called a general anaesthetic when you have surgery. It is given to make you unconscious so you don't feel pain when you have surgery.

anticoagulants

Anticoagulants are medicines that prevent your blood from clotting. In certain cases, they are given to people to prevent them from having a stroke. Anticoagulants are also called blood-thinners.

psychotherapist

A psychotherapist is a health professional who treats mental disorders by talking with their patients, rather than by prescribing medicines. There are many types of psychotherapy, including cognitive behavioural therapy and interpersonal therapy.

systematic reviews

A systematic review is a thorough look through published research on a particular topic. Only studies that have been carried out to a high standard are included. A systematic review may or may not include a meta-analysis, which is when the results from individual studies are put together.

Depression in adults

placebo

A placebo is a 'pretend' or dummy treatment that contains no active substances. A placebo is often given to half the people taking part in medical research trials, for comparison with the 'real' treatment. It is made to look and taste identical to the drug treatment being tested, so that people in the studies do not know if they are getting the placebo or the 'real' treatment. Researchers often talk about the 'placebo effect'. This is where patients feel better after having a placebo treatment because they expect to feel better. Tests may indicate that they actually are better. In the same way, people can also get side effects after having a placebo treatment. Drug treatments can also have a 'placebo effect'. This is why, to get a true picture of how well a drug works, it is important to compare it against a placebo treatment.

randomised controlled trials

Randomised controlled trials are medical studies designed to test whether a treatment works. Patients are split into groups. One group is given the treatment being tested (for example, an antidepressant drug) while another group (called the comparison or control group) is given an alternative treatment. This could be a different type of drug or a dummy treatment (a placebo). Researchers then compare the effects of the different treatments.

constipated

When you're constipated, you have difficulty passing stools (faeces). Your bowel movements may be dry and hard. You may have fewer bowel movements than usual, and it may be a strain when you try to go.

blood pressure

Blood pressure is the amount of force that's exerted by your blood on to your blood vessels. You can think of it like the water pressure in your home: the more pressure you have, the faster and more forcefully the water flows out of the shower. Blood pressure is measured in millimetres of mercury (written as mm Hg). When your blood pressure is taken, the measurement is given as two numbers, for example 120/80 mm Hg. The first, higher, number is called the systolic pressure, and the second, lower, number is the diastolic pressure. The systolic number is the highest pressure that occurs while your heart is pushing blood into your arteries. The diastolic number is the lowest pressure that happens when your heart is relaxing and is not pushing your blood.

diarrhoea

Diarrhoea is when you have loose, watery stools and you need to go to the toilet far more often than usual. Doctors say you have diarrhoea if you need to go to the toilet more than three times a day.

migraine headaches

These are severe headaches that last four to 72 hours. They often cause other symptoms such as queasiness (nausea) or being extra-sensitive to sound or light.

high blood pressure

Your blood pressure is considered to be high when it is above the accepted normal range. The usual limit for normal blood pressure is 140/90. If either the first (systolic) number is above 140 or the lower (diastolic) number is above 90, a person is considered to have high blood pressure. Doctors sometimes call high blood pressure 'hypertension'.

low blood pressure

If your blood pressure is about 100/60 or less, your doctor may say that you have low blood pressure. Low blood pressure is usually not a problem unless it becomes too low to push blood to your brain and the rest of the body. If you have low blood pressure, you may sometimes feel dizzy when you stand up.

electrode

A wire or disc through which electric current passes.

seizure

A seizure (or fit) is when there is too much electrical activity in your brain, which results in muscle twitching and other symptoms.

anaesthetic

An anaesthetic is a chemical that blocks the ability to feel sensations like pain or heat. A local anaesthetic blocks the feeling in a specific area of the body. For example, your dentist uses a local anaesthetic like lignocaine in your gums so that you don't feel the pain of having a cavity filled. A general anaesthetic makes you completely unconscious and is usually used only in a carefully controlled environment like an operating room.

neurotransmitters

Neurotransmitters are chemicals that help to carry messages between nerve cells. Serotonin, dopamine, and norepinephrine (noradrenaline) are all neurotransmitters.

allergic reaction

You have an allergic reaction when your immune system overreacts to a substance that is normally harmless. You can be allergic to particles in the air you are breathing, like pollen (which causes hay fever) or to chemicals on your skin, like detergents (which can cause a rash). People can also have an allergic reaction to drugs, like penicillin.

high cholesterol

Depression in adults

If you've been told that you have high cholesterol it usually means that your total cholesterol level is 5mmol/l or higher. But doctors also look at the amount of good (HDL) and bad (LDL) cholesterol you have in your blood. Having high levels of bad cholesterol can make it more likely that you'll get certain diseases in your heart and arteries.

Epilepsy

Epilepsy is a condition that affects your brain. If you have epilepsy, the normal electrical activity in your brain gets disturbed from time to time. This leads to seizures (also called fits).

eczema

Eczema is a very itchy rash. It may be dark and bumpy and release fluid. Scratching makes it worse. You can get eczema anywhere on your body, but it is most common on the wrists, the insides of the elbows and the backs of the knees. If you have asthma or allergies you are more likely to get eczema than someone who doesn't have these conditions.

HIV

HIV stands for human immunodeficiency virus. It's the virus that causes AIDS. It makes you ill by damaging cells called CD4 cells. Your body needs these cells to fight infections. You can get HIV by sharing needles for injecting drugs, or by having sex without a condom with someone who has the virus.

endorphins

Endorphins are chemicals that the brain makes. They are the body's own painkillers.

kidney

Your kidneys are organs that filter your blood to make urine. You have two kidneys, on either side of your body. They are underneath your ribcage, near your back.

thyroid gland

Your thyroid gland is a small organ that sits in your neck, just in front of your windpipe. It sends out a hormone called thyroxine. This acts on receptors within cells. By acting on the receptors it gives the cells a message to speed up their metabolism and work harder.

dehydrated

When you're dehydrated, you don't have enough fluid in your blood. This could be because you're not drinking enough or because you're losing water by sweating or having diarrhoea.

psychiatric nurse

A psychiatric nurse is a nurse who specialises in helping people who have mental health problems.

Sources for the information on this leaflet:

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 5th edition, (DSM-5). American Psychiatric Publishing, Washington, DC; 2013.
2. Reus V, Braunwald E, Fauci AS, et al. Mental disorders. In: Harrison TR (editor). Harrison's Principles of Internal Medicine. 15th edition. McGraw-Hill Publishing Co.; 2001.
3. National Institute of Mental Health. Depression. May 2011. Available at <http://www.nimh.nih.gov/health/publications/depression/complete-index.shtml> (accessed on 9 December 2013).
4. Guyton AC, Hall JE. Psychotic behavior and dementia: roles of specific neurotransmitter systems. In: Textbook of medical physiology. 9th edition. WB Saunders, Philadelphia, U.S.A.; 1996.
5. National Institute for Health and Care Excellence. Depression: the treatment and management of depression in adults. October 2009. Clinical guideline 90. Available at <http://www.nice.org.uk/cg090> (accessed on 9 December 2013).
6. Reus V, Braunwald E, Fauci AS, et al. Mental disorders. In: Harrison TR (editor). Harrison's Principles of Internal Medicine. 15th edition. McGraw-Hill Publishing Co.; 2001.
7. Katon W, Schulberg H. Epidemiology of depression in primary care. *General Hospital Psychiatry*. 1992; 14: 237-247.
8. Beekman AT, Copeland JR, Prince MJ. Review of community prevalence of depression in later life. *British Journal of Psychiatry*. 1999; 174: 307-311.
9. Murray CJ, Lopez AD. Regional patterns of disability-free life expectancy and disability-adjusted life expectancy: global Burden of Disease Study. *Lancet*. 1997; 349: 1347-1352.

Depression in adults

10. Murray CJ, Lopez AD. Alternative projections of mortality and disability by cause 1990-2020: Global Burden of Disease Study. *Lancet*. 1997; 349: 1498-1504.
11. Judd LL, Akiskal HS, Maser JD, et al. A prospective 12 year study of subsyndromal and syndromal depressive symptoms in unipolar major depressive disorders. *Archives of General Psychiatry*. 1988; 55: 694-700.
12. Commission on Human Medicines. Updated prescribing advice for venlafaxine (Efexor/Efexor XL): information for healthcare professionals. May 2006. Available at <http://www.mhra.gov.uk/Safetyinformation/Safetywarningsalertsandrecalls/Safetywarningsandmessagesformedicines/CON2023846> (accessed on 9 December 2013).
13. Churchill R, Hunot V, Corney R, et al. A systematic review of controlled trials of the effectiveness and cost-effectiveness of brief psychological treatments for depression. *Health Technology Assessment*. 2001; 5: 1-173.
14. Kaplan HI, Sadock BJ. *Concise textbook of clinical psychiatry*. 1st edition. Lippincott, Williams and Wilkins, Baltimore, US; 1996.
15. Schuyler D. Cognitive therapy for depression. *Primary Psychiatry*. 2003; 10: 33-36.
16. Gloaguen V, Cottraux J, et al. A meta-analysis of the effects of cognitive therapy in depressed patients. *Journal of Affective Disorders*. 1998; 49: 59-72.
17. Casacalenda N, Perry JC, Looper K. Remission in major depressive disorder: a comparison of pharmacotherapy, psychotherapy, and control conditions. *American Journal of Psychiatry*. 2002; 159: 1354-1360.
18. DeRubeis RJ, Hollon SD, Amsterdam JD, et al. Cognitive therapy vs medications in the treatment of moderate to severe depression. *Archives of General Psychiatry*. 2005; 62: 409-416.
19. McCusker J, Cole M, Keller E, et al. Effectiveness of treatments of depression in older ambulatory patients. *Archives of Internal Medicine*. 1998; 158: 705-712.
20. Gould RL, Coulson MC, Howard RJ. Cognitive behavioral therapy for depression in older people: a meta-analysis and meta-regression of randomized controlled trials. *Journal of the American Geriatrics Society*. 2012; 60: 1817-1830.
21. Fava GA, Rafanelli C, et al. Prevention of recurrent depression with cognitive behavioral therapy: preliminary findings. *Archives of General Psychiatry*. 1998; 55: 816-820.
22. Cuijpers P, van Straten A, Andersson G, et al. Psychotherapy for depression in adults: a meta-analysis of comparative outcome studies. *Journal of Consulting and Clinical Psychology*. 2008; 76: 909-922.
23. Van Schaik DJF, Van Marwijk HWJ, Van Der Windt Dawm, et al. Effectiveness of psychotherapy for depressive disorder in primary care: a systematic review. *Tijdschrift voor Psychiatrie*. 2002; 44: 609-619.
24. Leichsenring F. Comparative effects of short-term psychodynamic psychotherapy and cognitive-behavioral therapy in depression: a meta-analytic approach. *Clinical Psychology Review*. 2001; 21: 401-419.
25. Haby MM, Donnelly M, Corry J, et al. Cognitive behavioural therapy for depression, panic disorder and generalized anxiety disorder: a meta-regression of factors that may predict outcome. *Australian and New Zealand Journal of Psychiatry*. 2006; 40: 9-19.
26. de Mello MF, de Jesus MJ, Bacaltchuk J, et al. A systematic review of research findings on the efficacy of interpersonal therapy for depressive disorders. *European Archives of Psychiatry and Clinical Neuroscience*. 2005; 255: 75-82.
27. Klein DN, Santiago NJ, Vivian D, et al. Cognitive-behavioural analysis system of psychotherapy as a maintenance treatment for chronic depression. *Journal of Consulting and Clinical Psychology*. 2004; 72: 681-688.
28. Ma SH, Teasdale JD. Mindfulness-based cognitive therapy for depression: replication and exploration of differential relapse prevention effects. *Journal of Consulting and Clinical Psychology*. 2004; 72: 31-40.
29. Markowitz JC. Interpersonal psychotherapy for chronic depression. *Journal of Clinical Psychology*. 2003; 59: 847-858.

Depression in adults

30. Bolton P, Bass J, Neugebauer R, et al. Group interpersonal psychotherapy for depression in rural Uganda: a randomized controlled trial. *Journal of the American Medical Association*. 2003; 289: 3117-3124.
31. Luty SE, Carter JD, McKenzie JM, et al. Randomised controlled trial of interpersonal psychotherapy and cognitive-behavioural therapy for depression. *British Journal of Psychiatry*. 2007; 190: 496-502.
32. British National Formulary. Selective serotonin reuptake inhibitors. Section 4.3.3. British Medical Association and Royal Pharmaceutical Society of Great Britain. Also available at <http://bnf.org> (accessed on 9 December 2013).
33. Joffe R, Sokolov S, Streiner D, et al. Antidepressant treatment of depression: a meta-analysis. *Canadian Journal of Psychiatry (Revue Canadienne de Psychiatrie)*. 1996; 41: 613-616.
34. Williams JW Jr, Mulrow CD, Chiquette E, et al. A systematic review of newer pharmacotherapies for depression in adults: evidence. *Annals of Internal Medicine*. 2000; 132: 743-756.
35. Arroll B, MacGillivray S, Ogston S, et al. Efficacy and tolerability of tricyclic antidepressants and SSRIs compared with placebo for treatment of depression in primary care: a meta-analysis. *Annals of Family Medicine*. 2005; 3: 449-456.
36. Fournier JC, DeRubeis RJ, Hollon SD, et al. Antidepressant drug effects and depression severity: a patient-level meta-analysis. *Journal of the American Medical Association*. 2010; 303: 47-53.
37. Geddes JR, Freemantle N, Mason J, et al. Selective serotonin reuptake inhibitors (SSRIs) for depression (Cochrane review). In: *The Cochrane Library*. Wiley, Chichester, UK.
38. Anderson IM. Selective serotonin reuptake inhibitors versus tricyclic antidepressants: a meta-analysis of efficacy and tolerability. *Journal of Affective Disorders*. 2000; 58: 19-36.
39. Cipriani A, Brambilla P, Furukawa T, et al. Fluoxetine versus other types of pharmacotherapy for depression (Cochrane review). In: *The Cochrane Library*. Wiley, Chichester, UK.
40. Barbui C, Guaiana G, Hotopf M. Amitriptyline for inpatients and SSRIs for outpatients with depression? Systematic review and meta-regression analysis. *Pharmacopsychiatry*. 2004; 37: 93-97.
41. Hansen RA, Gartlehner G, Lohr KN, et al. Efficacy and safety of second-generation antidepressants in the treatment of major depressive disorder. *Annals of Internal Medicine*. 2005; 143: 415-426.
42. Smith D, Dempster C, Glanville J, et al. Efficacy and tolerability of venlafaxine compared with selective serotonin reuptake inhibitors and other antidepressants: a meta-analysis. *British Journal of Psychiatry*. 2002; 180: 396-404.
43. Fava GA, Rafanelli C, Grandi S, et al. Prevention of recurrent depression with cognitive behavioral therapy: preliminary findings. *Archives of General Psychiatry*. 1998; 55: 816-820.
44. Gartlehner G, Gaynes BN, Hansen RA, et al. Comparative benefits and harms of second-generation antidepressants: background paper for the American College of Physicians. *Annals of Internal Medicine*. 2008; 149: 734-50.
45. Geddes JG, Carney SM, Davies C, et al. Relapse prevention with antidepressant drug treatment in depressive disorders: a systematic review. *Lancet*. 2003; 361: 653-661.
46. Rapaport MH, Bose A, Zheng H. Escitalopram continuation treatment prevents relapse of depressive episodes. *Journal of Clinical Psychiatry*. 2004; 65: 44-49.
47. Schmidt ME, Fava M, Robinson JM, et al. The efficacy and safety of a new enteric-coated formulation of fluoxetine given once weekly during the continuation treatment of major depressive disorder. *Journal of Clinical Psychiatry*. 2000; 61: 851-857.
48. Klysner R, Bent-Hansen J, Hansen HL, et al. Efficacy of citalopram in the prevention of recurrent depression in elderly patients: placebo-controlled study of maintenance therapy. *British Journal of Psychiatry*. 2002; 181: 29-35.

Depression in adults

49. Trindade E, Menon D. Selective serotonin reuptake inhibitors differ from tricyclic antidepressants in adverse events. Selective serotonin reuptake inhibitors (SSRIs) for major depression. Part 1. Evaluation of the clinical literature. Canadian Coordinating Office for Health Technology Assessment 1997. Evidence-Based Mental Health. 1998; 1: 50-51.
50. Stahl MM, Lindquist M, Pettersson M, et al. Withdrawal reactions with selective serotonin re-uptake inhibitors as reported to the WHO system. European Journal of Clinical Pharmacology. 1997; 53: 163-169.
51. Fergusson D, Doucette S, Glass KC, et al. Association between suicide attempts and selective serotonin reuptake inhibitors: systematic review of randomised controlled trials. BMJ. 2005; 330: 396-399.
52. Gunnell D, Saperia J, Ashby D. Selective serotonin reuptake inhibitors (SSRIs) and suicide in adults: meta-analysis of drug company data from placebo controlled, randomised controlled trials submitted to the MHRA's safety review. BMJ. 2006; 333 :30.
53. Medicines and Healthcare products Regulatory Agency. Report of the CSM expert working group on the safety of selective serotonin reuptake inhibitor antidepressants. December 2004. Available at <http://www.mhra.gov.uk/home/groups/pl-p/documents/drugsafetymessage/con019472.pdf> (accessed on 24 September 2014).
54. Mackay FJ, Dunn NR, Wilton LV, et al. A comparison of fluvoxamine, fluoxetine, sertraline and paroxetine examined by observational cohort studies. Pharmacoepidemiology and Drug Safety. 1997; 6: 235-246.
55. Price JS, Waller PC, Wood SM, et al. A comparison of the post-marketing safety of four selective serotonin re-uptake inhibitors including the investigation of symptoms occurring on withdrawal. British Journal of Clinical Pharmacology. 1996; 42: 757-763.
56. Lima MS, Moncrieff J. A comparison of drugs versus placebo for the treatment of dysthymia (Cochrane review). In: The Cochrane Library. Chichester, Wiley, UK.
57. Rosenbaum JF, Fava M, Hoog SL, et al. Selective serotonin reuptake inhibitor discontinuation syndrome: a randomized clinical trial. Biological Psychiatry. 1998; 44: 77-87.
58. Zajecka J, Fawcett J, Amsterdam J, et al. Safety of abrupt discontinuation of fluoxetine: a randomized, placebo-controlled study. Journal of Clinical Psychopharmacology. 1998; 18: 193-197.
59. US Food and Drug Administration. Antidepressant use in children, adolescents, and adults. August 2010. Available at <http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/UCM096273> (accessed on 24 September 2014).
60. Medicines and Healthcare products Regulatory Agency. Implementation of warnings on suicidal thoughts and behaviour in antidepressants. February 2008. Available at <http://www.mhra.gov.uk/NewsCentre/CON2033960> (accessed on 9 December 2013).
61. British National Formulary. Pregnancy. Appendix 4. British Medical Association and Royal Pharmaceutical Society of Great Britain. Also available at <http://bnf.org> (accessed on 30 April 2014).
62. Kieler H, Artama M, Engeland A, et al. Selective serotonin reuptake inhibitors during pregnancy and risk of persistent pulmonary hypertension in the newborn: population based cohort study from the five Nordic countries. BMJ. 2012; 344: 8012.
63. Cohen L, Altshuler LL, Harlow BL, et al. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. Journal of the American Medical Association. 2006; 295: 499-507.
64. National Institute for Health and Care Excellence. Clinical guideline 90. Depression: the treatment and management of depression in adults (partial update of NICE clinical guideline 23). October 2009. Available at <http://www.nice.org.uk/cg90> (accessed on 10 December 2013).
65. Wisner KL, Gelenberg AJ, Leonard H, et al. Pharmacologic treatment of depression during pregnancy. Journal of the American Medical Association. 1999; 282: 1264-1269.
66. US Food and Drug Administration. Safety alert: Paxil (paroxetine HCL), Paxil CR controlled-release tablets. September 2005. Available at <http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm152310.htm> (accessed on 1 September 2014).

Depression in adults

67. Medicines and Healthcare Products Regulatory Agency. Fluoxetine: possible small risk of congenital cardiac defects. March 2010. Available at <http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON091089> (accessed on 9 December 2013).
68. Maschi S, Clavenna A, Campi R, et al. Neonatal outcome following pregnancy exposure to antidepressants: a prospective controlled cohort study. *BJOG*. 2008; 115: 283-289.
69. Calderon-Margalit R, Qiu C, Ornoy A, et al. Risk of preterm delivery and other adverse perinatal outcomes in relation to maternal use of psychotropic medications during pregnancy. *American Journal of Obstetrics and Gynecology*. 2009; 201: 579.
70. Lund N, Pedersen LH, Henriksen TB. Selective serotonin reuptake inhibitor exposure in utero and pregnancy outcomes. *Archives of Pediatrics & Adolescent Medicine*. 2009; 163: 949-954.
71. Chambers CD, Hernandez-Diaz S, Van Marter LJ, et al. Selective serotonin-reuptake inhibitors and risk of persistent pulmonary hypertension of the newborn. *New England Journal of Medicine*. 2006; 354: 579-587.
72. U.S. Food and Drug Administration. Selective serotonin reuptake inhibitor (SSRI) antidepressant use during pregnancy and reports of a rare heart and lung condition in newborn babies. December 2011. Available at: <http://www.fda.gov/Drugs/DrugSafety/ucm283375.htm> (accessed on 10 December 2013).
73. Cohen L, Altschuler LL, Harlow BL, et al. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *Journal of the American Medical Association*. 2006; 295: 499-507.
74. Stewart LA, Parmar MKB. Bias in the analysis and reporting of randomized controlled trials. *International Journal of Technology Assessment in Health Care*. 1996; 12: 264-275.
75. Joffe R, Sokolov S, Streiner D. Antidepressant treatment of depression: a metaanalysis. *Canadian Journal of Psychiatry*. 1996; 41: 613-616.
76. Lima MS, Moncrieff J. A comparison of drugs versus placebo for the treatment of dysthymia (Cochrane review). In: *The Cochrane Library*. Wiley, Chichester, UK.
77. Ballesteros J, Callado LF. Effectiveness of pindolol plus serotonin uptake inhibitors in depression: a meta-analysis of early and late outcomes from randomised controlled trials. *Journal of Affective Disorders*. 2004; 79: 137-147.
78. Lepola UM, Loft H, Reines EH. Escitalopram (10-20 mg/day) is effective and well tolerated in a placebo-controlled study in depression in primary care. *International Clinical Psychopharmacology*. 2003; 18: 211-217.
79. Burke WJ, Gergel I, Bose A. Fixed-dose trial of the single isomer SSRI escitalopram in depressed outpatients. *Journal of Clinical Psychiatry*. 2002; 63: 331-336.
80. Wilson K, Mottram P, Sivanranthan A, et al. Antidepressants versus placebo for the depressed elderly (Cochrane review). In: *The Cochrane Library*. Wiley, Chichester, UK.
81. Rapaport MH, Schneider LS, Dunner DL, et al. Efficacy of controlled-release paroxetine in the treatment of late-life depression. *Journal of Clinical Psychiatry*. 2003; 64: 1065-1074.
82. Schneider LS, Nelson JC, Clary CM, et al. An 8-week multicenter, parallel-group, double-blind, placebo-controlled study of sertraline in elderly outpatients with major depression. *American Journal of Psychiatry*. 2003; 160: 1277-1285.
83. Geddes JR, Freemantle N, Mason J, et al. Selective serotonin reuptake inhibitors (SSRIs) for depression (Cochrane review). In: *The Cochrane Library*. Wiley, Chichester, UK.
84. Behnke K, Sogaard J, Martin S, et al. Mirtazapine orally disintegrating tablet versus sertraline: a prospective onset of action study. *Journal of Clinical Psychopharmacology*. 2003; 23: 358-364.
85. Wade A, Crawford GM, Angus M, et al. A randomized, double-blind, 24-week study comparing the efficacy and tolerability of mirtazapine and paroxetine in depressed patients in primary care. *International Clinical Psychopharmacology*. 2003; 18: 133-141.

Depression in adults

86. Rapaport MH, Bose A, Zheng H. Escitalopram continuation treatment prevents relapse of depressive episodes. *Journal of Clinical Psychiatry*. 2004; 65: 44-49.
87. Schmidt ME, Fava M, Robinson JM, et al. The efficacy and safety of a new enteric-coated formulation of fluoxetine given once weekly during the continuation treatment of major depressive disorder. *Journal of Clinical Psychiatry*. 2000; 61: 851-857.
88. Wilson KC, Mottram PG, Ashworth L, et al. Older community residents with depression: long-term treatment with sertraline: randomised, double-blind, placebo-controlled study. *British Journal of Psychiatry*. 2003; 182: 492-497.
89. Parker G, Roy K, Eysers K. Cognitive behavior therapy for depression? Choose horses for courses. *American Journal of Psychiatry*. 2003; 160: 825-834.
90. British National Formulary. Antidepressant drugs. Section 4.3. British Medical Association and the Royal Pharmaceutical Society of Great Britain. Also available at <http://bnf.org> (accessed on 9 July 2014).
91. Furukawa TA, McGuire H, Barbui C. Meta-analysis of effects and side effects of low dosage tricyclic antidepressants in depression: a systematic review. *BMJ*. 2002; 325: 991-995.
92. Geddes JR, Freemantle N, Mason J, et al. Selective serotonin reuptake inhibitors (SSRIs) for depression (Cochrane review). In: *The Cochrane Library*. Wiley, Chichester, UK.
93. Guaiana G, Barbui C, Hotopf M. Amitriptyline for depression (Cochrane review). In: *The Cochrane Library*. Wiley, Chichester, UK.
94. Old Age Depression Interest Group. How long should the elderly take antidepressants? A double-blind placebo-controlled study of continuation/prophylaxis therapy with dothiepin. *British Journal of Psychiatry*. 1993; 162: 175-182.
95. Ban TA, Gaszner P, Aguglia E, et al. Clinical efficacy of reboxetine: a comparative study with desipramine, with methodological considerations. *Human Psychopharmacology*. 1998; 13 (supplement 1): S29-S39.
96. Berzewski H, Van Moffaert M, Gagiano CA. Efficacy and tolerability of reboxetine compared with imipramine in a double-blind study in patients suffering from major depressive. *European Neuropsychopharmacology*. 1997; 7 (supplement 1): S37-S47.
97. Hippisley-Cox J, Pringle M, Hammersley V, et al. Antidepressants as risk factor for ischaemic heart disease: case-control study in primary care. *BMJ*. 2001; 323: 666-669.
98. British National Formulary. Antidepressant drugs. Section 4.3. British Medical Association and Royal Pharmaceutical Society of Great Britain. Also available at <http://bnf.org> (accessed on 1 September 2014).
99. Palmsten K, Setoguchi S, Margulis AV, et al. Elevated risk of preeclampsia in pregnant women with depression: depression or antidepressants? *American Journal of Epidemiology*. 10 April 2012 [Epub ahead of print].
100. Geddes JR, Freemantle N, Mason J, et al. Selective serotonin reuptake inhibitors (SSRIs) for depression (Cochrane review). In: *The Cochrane Library*. Wiley, Chichester, UK.
101. Thase ME, Trivedi MH, Rush AJ. MAOIs in the contemporary treatment of depression. *Neuropsychopharmacology*. 1995; 12: 185-219.
102. Berzewski H, Van Moffaert M, Gagiano CA. Efficacy and tolerability of reboxetine compared with imipramine in a double-blind study in patients suffering from major depressive. *European Neuropsychopharmacology*. 1997; 7 (supplement 1): S37-S47.
103. Parker G, Roy K, Eysers K. Cognitive behavior therapy for depression? Choose horses for courses. *American Journal of Psychiatry*. 2003; 160: 825-834.
104. British National Formulary. Monoamine-oxidase inhibitors. Section 4.3.2. British Medical Association and the Royal Pharmaceutical Society of Great Britain. Also available at <http://bnf.org> (accessed on 1 September 2014).
105. Henkel V, Mergl R, Allgaier AK, et al. Treatment of depression with atypical features: a meta-analytic approach. *Psychiatry Research*. 2006; 141: 89-101.

Depression in adults

106. Thase ME, Trivedi MH, Rush AJ. MAOIs in the contemporary treatment of depression. *Neuropsychopharmacology*. 1995; 12: 185-219.
107. Medicines and Healthcare products Regulatory Agency. Report of the CSM expert working group on the safety of selective serotonin reuptake inhibitor antidepressants. December 2004. Available at <http://www.mhra.gov.uk> (accessed on 9 December 2013).
108. Montgomery SA, Huusom AK, Bothmer J. A randomised study comparing escitalopram with venlafaxine XR in primary care patients with major depressive disorder. *Neuropsychobiology*. 2004; 50: 57-64.
109. Sauer H, Huppertz-Helmhold S, Dierkes W. Efficacy and safety of venlafaxine ER vs. amitriptyline ER in patients with major depression of moderate severity. *Pharmacopsychiatry*. 2003; 36: 169-175.
110. Guelfi JD, Ansseau M, Timmerman L, et al. Mirtazapine versus venlafaxine in hospitalized severely depressed patients with melancholic features. *Journal of Clinical Psychopharmacology*. 2001; 21: 425-431.
111. Commission on Human Medicines. Updated prescribing advice for venlafaxine (Efexor/Efexor XL): information for healthcare professionals. May 2006. Available at <http://www.mhra.gov.uk/Safetyinformation/Safetywarningsalertsandrecalls/Safetywarningsandmessagesformedicines/CON2023846> (accessed on 9 December 2013).
112. British National Formulary. Venlafaxine. Section 4.3.4. British Medical Association and Royal Pharmaceutical Society of Great Britain. Also available at <http://bnf.org> (accessed on 9 December 2013).
113. Stahl MM, Lindquist M, et al. Withdrawal reactions with selective serotonin re-uptake inhibitors as reported to the WHO system. *European Journal of Clinical Pharmacology*. 1997; 53: 163-169.
114. Rubino A, Roskell N, Tennis P, et al. Risk of suicide during treatment with venlafaxine, citalopram, fluoxetine, and dothiepin: retrospective cohort study. *BMJ*. 2007; 334: 242.
115. Sauer H, Huppertz-Helmhold S, Dierkes W. Efficacy and safety of venlafaxine ER vs. amitriptyline ER in patients with major depression of moderate severity. *Pharmacopsychiatry*. 2003; 36: 169-175.
116. Guelfi JD, Ansseau M, Timmerman L, et al. Mirtazapine versus venlafaxine in hospitalized severely depressed patients with melancholic features. *Journal of Clinical Psychopharmacology*. 2001; 21: 425-431.
117. UK ECT Review Group. Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis. *Lancet*. 2003; 361: 799-808.
118. Van der Wurff FB, Stek ML, Hoogendijk WL, et al. Electroconvulsive therapy for the depressed elderly (Cochrane review). In: *The Cochrane Library*. Wiley, Chichester, UK.
119. National Institute for Health and Care Excellence. Depression: the treatment and management of depression in adults. October 2009. Clinical guideline 90. Available at <http://www.nice.org.uk/cg090> (accessed on 1 July 2014).
120. Pampallona S, Bollini P, Tibaldi G, et al. Combined pharmacotherapy and psychological treatment for depression: a systematic review. *Archives of General Psychiatry*. 2004; 61: 714-719.
121. Friedman MA, Detweiler-Bedell JB, Leventhal HE, et al. Combined psychotherapy and pharmacotherapy for the treatment of major depressive disorder. *Clinical Psychology: Scientific Practice*. 2004; 11: 47-68.
122. Pampallona S, Bollini P, Tibaldi G, et al. Combined pharmacotherapy and psychological treatment for depression: a systematic review. *Archives of General Psychiatry*. 2004; 61: 714-719.
123. Kool S, Dekker J, Duijsens IJ, et al. Efficacy of combined therapy and pharmacotherapy for depressed patients with or without personality disorders. *Harvard Review of Psychiatry*. 2003; 11: 133-141.
124. Ludman EJ, Simon GE, Tutty S, et al. A randomized trial of telephone psychotherapy and pharmacotherapy for depression: continuation and durability of effects. *Journal of Consulting and Clinical Psychology*. 2007; 75: 257-66.

Depression in adults

125. Wiles N, Thomas L, Abel A, et al. Cognitive behavioural therapy as an adjunct to pharmacotherapy for primary care based patients with treatment resistant depression: results of the CoBaT randomised controlled trial. *Lancet*. 2013; 381: 375-384.
126. de Jonghe F, Hendricksen M, van Aalst G, et al. Psychotherapy alone and combined with pharmacotherapy in the treatment of depression. *British Journal of Psychiatry*. 2004; 185: 37-45.
127. Friedman MA, Detweiler-Bedell JB, Leventhal HE, et al. Combined psychotherapy and pharmacotherapy for the treatment of major depressive disorder. *Clinical Psychology: Scientific Practice*. 2004; 11: 47-68.
128. de Jonghe F, Hendricksen M, van Aalst G, et al. Psychotherapy alone and combined with pharmacotherapy in the treatment of depression. *British Journal of Psychiatry*. 2004; 185: 37-45.
129. Kool S, Dekker J, Duijens IJ, et al. Efficacy of combined therapy and pharmacotherapy for depressed patients with or without personality disorders. *Harvard Review of Psychiatry*. 2003; 11: 133-141.
130. Thompson LW, Coon DW, Gallagher-Thompson D, et al. Comparison of desipramine and cognitive/behavioral therapy in the treatment of elderly outpatients with mild-to-moderate depression. *American Journal of Geriatric Psychiatry*. 2001; 9: 225-240.
131. Bower P, Rowland N, Hardy R. The clinical effectiveness of counselling in primary care: a systematic review and meta-analysis. *Psychological Medicine*. 2003; 33: 203-215.
132. Ali BS, Rahbar MH, Naeem S, et al. The effectiveness of counselling on anxiety and depression by minimally trained counsellors: a randomized controlled trial. *American Journal of Psychotherapy*. 2003; 57: 324-336.
133. Ali BS, Rahbar MH, Naeem S, et al. The effectiveness of counselling on anxiety and depression by minimally trained counsellors: a randomized controlled trial. *American Journal of Psychotherapy*. 2003; 57: 324-336.
134. Linde K, Mulrow CD. St John's Wort for depression (Cochrane review). In: *The Cochrane Library*. Wiley, Chichester, UK.
135. Linde K, Berner MM, Kriston L. St John's wort for major depression (Cochrane review). In: *The Cochrane Library*. Wiley, Chichester, UK.
136. National Center for Complementary and Alternative Medicine. St. John's Wort. April 2013. Available at <http://nccam.nih.gov/health/stjohnswort> (accessed on 9 December 2013).
137. Shelton RC, Keller MB, Gelenberg A, et al. Effectiveness of St John's wort in major depression: a randomized controlled trial. *Journal of the American Medical Association*. 2001; 285: 1978-1986.
138. Hammerness P, Basch E, Ulbricht C, et al. St John's wort: a systematic review of adverse effects and drug interactions for the consultation psychiatrist. *Psychosomatics*. 2003; 44: 271-282.
139. Zhou S, Chan E, Pan SQ, et al. Pharmacokinetic interactions of drugs with St John's wort. *Journal of Psychopharmacology*. 2004; 18: 262-276.
140. Mannel, M. Drug interactions with St John's Wort: mechanisms and clinical implications. *Drug Safety*. 2004; 27: 773-797.
141. British National Formulary. St. John's Wort. Also available at http://www.rxlist.com/st_johns_wort-page3/supplements.htm (accessed on 9 December 2013).
142. Hammerness P, Basch E, Ulbricht C, et al. St John's wort: a systematic review of adverse effects and drug interactions for the consultation psychiatrist. *Psychosomatics*. 2003; 44: 271-282.
143. Gilbody S, Whitty P, Grimshaw J, et al. Educational and organizational interventions to improve the management of depression in primary care: a systematic review. *Journal of the American Medical Association*. 2003; 289: 3145-3151.
144. Bijl D, van Marwijk HW, de Haan M, et al. Effectiveness of disease management programmes for recognition, diagnosis and treatment of depression in primary care. *European Journal of General Practice*. 2004; 10: 6-12.
145. Gilbody S, Whitty P, Grimshaw J, et al. Educational and organizational interventions to improve the management of depression in primary care: a systematic review. *Journal of the American Medical Association*. 2003; 289: 3145-3151.

Depression in adults

146. Neumeyer-Gromen A, Lampert T, Stark K, et al. Disease management programs for depression: a systematic review and meta-analysis of randomized controlled trials. *Medical Care*. 2004; 42: 1211-1221.
147. Thota AB, Sipe TA, Byard GJ, et al. Collaborative care to improve the management of depressive disorders: a community guide systematic review and meta-analysis. *American Journal of Preventative Medicine*. 2012; 42: 525-538.
148. Rost K, Nutting P, Smith JL, et al. Managing depression as a chronic disease: A randomised trial of ongoing treatment in primary care. *BMJ*. 2002; 325: 934-937.
149. Araya R, Rojas G, Fritsch R, et al. Treating depression in primary care in low-income women in Santiago, Chile: a randomised controlled trial. *Lancet*. 2003; 361: 995-1000.
150. Bijl D, van Marwijk HW, de Haan M, et al. Effectiveness of disease management programmes for recognition, diagnosis and treatment of depression in primary care. *European Journal of General Practice*. 2004; 10: 6-12.
151. Gensichen J, Beyer M, Muth C, et al. Case management to improve major depression in primary health care: a systematic review. *Psychological Medicine*. 2006; 36: 7-14.
152. Akerblad AC, Bengtsson F, Ekselius L, et al. Effects of an educational compliance enhancement programme and therapeutic drug monitoring on treatment adherence in depressed patients managed by general practitioners. *International Clinical Psychopharmacology*. 2003; 18: 347-354.
153. Finley PR, Rens HR, Pont JT, et al. Impact of a collaborative care model on depression in a primary care setting: a randomized controlled trial. *Pharmacotherapy*. 2003; 23: 1175-1185.
154. Hedrick SC, Chaney EF, Felker B, et al. Effectiveness of collaborative care depression treatment in veterans' affairs primary care. *Journal of General Internal Medicine*. 2003; 18: 9-16.
155. Miranda J, Azocar F, Organista KC, et al. Treatment of depression among impoverished primary care patients from ethnic minority groups. *Psychiatric Services*. 2003; 54: 219-225.
156. Miranda J, Chung JY, Green BL, et al. Treating depression in predominantly low-income young minority women: a randomized controlled trial. *Journal of the American Medical Association*. 2003; 290: 57-65.
157. Simon GE, Ludman EJ, Tutty S, et al. Telephone psychotherapy and telephone care management for primary care patients starting antidepressant treatment: a randomized controlled trial. *Journal of the American Medical Association*. 2004; 292: 935-942.
158. Swindle RW, Rao JK, Helmy A, et al. Integrating clinical nurse specialists into the treatment of primary care patients with depression. *International Journal of Psychiatry and Medicine*. 2003; 33: 17-37.
159. Dietrich A, Oxman T, Williams J, et al. Re-engineering systems for the treatment of depression in primary care: cluster randomised controlled trial. *BMJ*. 2004; 329: 602-607.
160. Smit A, Kluiters H, Conradi H, et al. Short-term effects of enhanced treatment for depression in primary care: results from a randomized controlled trial. *Psychological Medicine*. 2006; 36: 15-26.
161. Richards DA, Hill JJ, Gask L, et al. Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial. *British Medical Journal*. 2013; 347: f4913.
162. Medicines and Healthcare products Regulatory Agency. Reboxetine: a review of the benefits and risks September 2011. Available at <http://www.mhra.gov.uk/home/groups/pl-p/documents/websitesresources/con129107.pdf> (accessed on 9 December 2013).
163. Eyding D, Lelgemann M, Grouven U, et al. Reboxetine for acute treatment of major depression: systematic review and meta-analysis of published and unpublished placebo and selective serotonin reuptake inhibitor controlled trials. *British Medical Journal*. 2010; 341: 4737.
164. Versiani M, Amin M, Chouinard G. Double-blind, placebo-controlled study with reboxetine in inpatients with severe major depressive disorder. *Journal of Clinical Psychopharmacology*. 2000; 20: 28-34.

Depression in adults

165. Massana J, Moller H-J, Burrows GD, et al. Reboxetine: a double-blind comparison with fluoxetine in major depressive disorder. *International Clinical Psychopharmacology*. 1999; 14: 73-80.
166. Lawlor DA, Hopker SW. The effectiveness of exercise as an intervention in the management of depression: systematic review and meta-regression analysis of randomised controlled trials. *BMJ*. 2001; 322: 763-767.
167. Blumenthal JA, Babyak MA, et al. Effects of exercise training on older patients with major depression. *Archives of Internal Medicine*. 1999; 159: 2349-2356.
168. Cooney GM, Dwan K, Greig CA, et al. Exercise for depression (Cochrane review). In: *The Cochrane Library*. Wiley, Chichester, UK.
169. Pilkington K, Kirkwood G, Rampes H, et al. Yoga for depression: the research evidence. *Journal of Affective Disorders*. 2005; 89: 13-24.
170. Dunn A, Trivedi MH, Kampert JB, et al. Exercise treatment for depression: efficacy and dose response. *American Journal of Preventive Medicine*. 2005; 28: 1-8.
171. Kerse N, Hayman KJ, Moyes SA, et al. Home-based activity program for older people with depressive symptoms: DeLLITE--a randomized controlled trial. *Annals of Family Medicine*. 2010; 8: 214-223.
172. Bridle C, Spanjers K, Patel S, et al. Effect of exercise on depression severity in older people: systematic review and meta-analysis of randomised controlled trials. *British Journal of Psychiatry*. 2012; 201: 180-185.
173. Harris T, Brown GW, Robinson R. Befriending as an intervention for chronic depression among women in an inner city. 1: Randomised controlled trial. *British Journal of Psychiatry*. 1999; 174: 219-224.
174. Mynors-Wallis LM, Gath DH. Randomised controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care. *BMJ*. 1995; 310: 441-445.
175. Dowrick C, Dunn G, Ayuso-Mateos JL, et al. Problem solving treatment and group psychoeducation for depression: multicentre randomised controlled trial. *BMJ*. 2000; 321: 1450-1454.
176. Mynors-Wallis L, Davies I, Gray A, et al. A randomised controlled trial and cost analysis of problem-solving treatment for emotional disorders given by community. *British Journal of Psychiatry*. 1997; 170: 113-119.
177. Cookson J. Lithium: balancing risks and benefits. *British Journal of Psychiatry*. 1997; 171: 120-124.
178. British National Formulary. Monoamine-oxidase inhibitors (MAOIs). Section 4.3.2. British Medical Association and Royal Pharmaceutical Society of Great Britain. Also available at <http://bnf.org> (accessed on 7 March 2014).
179. McIntyre RS, Mancini DA, Parikh S, et al. Lithium revisited. *Canadian Journal of Psychiatry*. 2001; 46: 322-327.
180. Nelson JC. Overcoming treatment resistance in depression. *Journal of Clinical Psychiatry*. 1998; 59 (supplement 16): S13-S19.
181. Stimpson N, Agrawal N, Lewis G. Randomised controlled trials investigating pharmacological and psychological interventions for treatment-refractory depression. *British Journal of Psychiatry*. 2002; 181: 284-294.
182. Nierenberg AA, Papakostas GI, Petersen T, et al. Lithium augmentation of nortriptyline for subjects resistant to multiple antidepressants. *Journal of Clinical Psychopharmacology*. 2003; 23: 92-95.
183. Lenox RH, Hahn CG. Overview of the mechanism of action of lithium in the brain: fifty-year update. *Journal of Clinical Psychiatry*. 2000; 61 (supplement 9): S5-S15.
184. Johnson G. Lithium: early development, toxicity, and renal function. *Neuropsychopharmacology*. 1998; 9: 200-205.
185. Trindade E, Menon D. Selective serotonin reuptake inhibitors differ from tricyclic antidepressants in adverse events. Selective serotonin reuptake inhibitors (SSRIs) for major depression. Part 1. Evaluation of the clinical literature. Canadian Coordinating Office for Health Technology Assessment 1997. *Evidence-Based Mental Health*. 1998; 1: 50-51.

Depression in adults

186. Medicines and Healthcare products Regulatory Agency. Report of the CSM expert working group on the safety of selective serotonin reuptake inhibitor antidepressants. December 2004. Available at <http://www.mhra.gov.uk> (accessed on 9 December 2013).
187. Perry EB, Berman RM, Sanacora G, et al. Pindolol augmentation in depressed patients resistant to selective serotonin reuptake inhibitors: a double-blind, randomized, controlled trial. *Journal of Clinical Psychiatry*. 2004; 65: 238-243.
188. Blier P, Bergeron R. The use of pindolol to potentiate antidepressant medication. *Journal of Clinical Psychiatry*. 1998; 59 (supplement): S16-S23.
189. Geddes JG, Carney SM, Davies C, et al. Relapse prevention with antidepressant drug treatment in depressive disorders: a systematic review. *Lancet*. 2003; 361: 653-661.
190. Katon W, Rutter C, Ludman EJ, et al. A randomized trial of relapse prevention of depression in primary care. *Archives of General Psychiatry*. 2001; 58: 241-247.
191. Rodgers M, Asaria M, Walker S, et al. The clinical effectiveness and cost-effectiveness of low-intensity psychological interventions for the secondary prevention of relapse after depression: a systematic review. *Health Technology Assessment*. 2012; 16: 1-130.

This information is aimed at a UK patient audience. This information however does not replace medical advice. If you have a medical problem please see your doctor. Please see our full [Conditions of Use](#) for this content. For more information about this condition and sources of the information contained in this leaflet please visit the Best Health website, <http://besthealth.bmj.com>. These leaflets are reviewed annually.

