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Combining Antidepressants and Psychotherapy

In Treatment for Depression

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ENG2205

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In an article entitled “Multimodel Therapy of Treatment Resistant Depression,” Bannan (2005), a doctor at St. John of God Hospital in Stillorgan, Ireland, presented a case study involving a woman who battled depression for over a year with no relief from antidepressants. The woman, Ann, was 25 years old and was given three different types of antidepressants over the course of 13 weeks, starting with lower doses and receiving higher doses as the weeks went on. During her depression struggle, Ann felt insecure and had trouble making friends at work, thinking “she was boring, unattractive and irritating, which in turn lead to social isolation” (p. 29). Ann lost interest in most of her normal activities, and spent extra time alone or asleep (p. 29). Bannan also noted that Ann was “insightful and keen to try a new approach” and was also “psychologically minded” (p. 30). Ann agreed to participate in cognitive behavioral therapy (CBT) along with taking her antidepressants.

Like Ann, many people—both young and old—struggle with depression. Depression is more than just feelings of sadness or despair—it is a serious illness. Novelist William Styron wrote that, “depression is a true wimp of a word for such a major illness” (cited in Kramlinger, 2001, p. 3). Kramlinger, a doctor at the Mayo Clinic in Rochester, Minnesota, defined depression as “a serious illness that causes memory and thinking (cognitive), mood, physical and behavioral changes. It affects how you feel, think, eat, sleep and act” (p. 3). Kramlinger also stated that depression is a very common illness, with one fourth of all Americans being overcome by a bout of depression at least once during their lifetime. Wolpert (1999), Professor of Biology at University College in London, referred to depression as “soul loss” because of the “extreme sadness” it evokes (p. 3). Kramlinger claimed that in America, almost 18 million people will suffer from depression “at any given time” and that it occurs more frequently among women than among men (p. 7).

Fortunately, there are ways to treat this illness. One approach is to use antidepressants, which are drugs used to treat and prevent depression. It is unknown how these medications specifically work to help people with depression; however, Kramlinger (2001) claimed that doctors assume the antidepressant to do one of three things in the brain: “it may inhibit neurotransmitter reuptake...it may block certain chemical receptors that neurotransmitters act on...[or] it may inhibit monoamine oxidase enzymes that break down neurotransmitters” (pp. 68-69). These different reactions in the brain depend on which antidepressant is used. Another approach to treating depression is through psychotherapy. There are two main types of psychotherapy, or counseling, which can help a depressed patient. The first is through interpersonal psychotherapy (IPT). Sarason and Sarason (2005) claimed that this type of therapy is pointed toward helping patients deal with their interpersonal relationships and any problems they may have with those. Interpersonal psychotherapy is also a way to keep patients from relapsing (p. 350). The other main form of psychotherapy is cognitive-behavioral therapy (CBT). This type of therapy teaches patients to distinguish between events that give them pleasure and events that can trigger mood swings, and how to adapt to them (p. 353).

Finally, the newest approach to managing depression is through a combination of antidepressants and psychotherapy. This method was not used until the early 1990s when studies were done that found that using both approaches proved that there was a better long-term success rate (Kramlinger, 2001). Friedman (2004) stated that many doctors were skeptical of this method, claiming each “alternative therapy would undermine the effects of the initial treatment” (p. 48). For instance, Friedman also said that some doctors thought if antidepressants were added to psychotherapy, that the patient would no longer care to continue in psychotherapy after watching his or her symptoms lessen through the medication. On the contrary, combining the

approaches has proven to actually “enhance the efficacy” of both (p. 48). For example, Friedman noted that the satisfaction of knowing the antidepressants are relieving the patient of his or her physical symptoms may cause the patient to focus more thoroughly on their emotional healing in psychotherapy. Because of the possible side effects of the medications and because of the effectiveness of pairing the treatments, antidepressants should not be prescribed without psychotherapy.

The first reason why antidepressants should not be prescribed without psychotherapy is because of the possible side effects. Many of the new antidepressants are known to have fewer side effects; however, they can still take a negative toll on the depressed person. Sarason and Sarason (2005) listed the following as three main types of antidepressants: tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), and monoamine oxidase inhibitors (MAOIs). Tricyclic antidepressants were created in the 1950s and were widely used until the late 1980s when the new antidepressants were made (“Depression,” 2005). Now, these antidepressants are usually only given out when others have no effect on the depressed patient, because of the higher probability of side effects (Kramlinger, 2001). Side effects for TCAs may include the following: drowsiness, dry mouth, blurred vision, constipation, urinary retention, headaches, low blood pressure, and weight gain (“Depression,” 2005). TCAs have also been known to “trigger or worsen certain medical conditions” such as glaucoma and heart disease (Kramlinger, 2001, p. 72). Anyone taking Tricyclic antidepressants needs to be much more closely monitored because of the dangerous side effects. Regarding TCAs, Sarason and Sarason said, “For some patients, small overdoses were lethal” (p. 343). Because they are an older version of antidepressants, tricyclics have more risk of dangerous side effects and should not be prescribed without psychotherapy.

The second type of antidepressants is selective serotonin reuptake inhibitors (SSRIs), and these were created in the 1980s (Kramlinger, 2001). These new drugs were discovered to be safer and have less risk of side effects (Sarason & Sarason, 2005). Kramlinger (2001) suggested that gastrointestinal and sexual problems have been known to occur in some patients; however, these difficulties are usually easy to care for and are not permanent. Kramlinger also said that SSRIs can have an uncommon but deadly side effect on patients—serotonin syndrome. This can occur when a patient takes another antidepressant medication along with an SSRI, and symptoms can be confusion, hallucinations, seizures, and coma. Sarason and Sarason (2005) indicated that even though SSRIs are proven to be safer, “they have not been shown to be more effective than other antidepressant medications” (p. 344). Murray and Fortinberry (2005) found that “antidepressants (particularly SSRIs) work only as well (or less) than placebos.” Even though it seems SSRIs are safer with their fewer side effects, it does not seem that the drugs are that useful. This is where psychotherapy comes in: to help the patients deal with the physical side effects and to teach them coping skills to prevent relapse.

The third type of antidepressants suggested by Sarason and Sarason (2005) is called monoamine oxidase inhibitors (MAOIs). These were also created in the 1950s (Sarason & Sarason, 2005). This type of antidepressant is also not regularly distributed these days because of the risk of dangerous side effects and because of the other antidepressant choices (Kramlinger, 2001). The most dangerous side effects involved with MAOIs are the “food and drug interactions” (Kramlinger, 2001, p. 73). Patients using MAOIs should exercise caution concerning what they eat and what other medications they use, because if they consume anything with “high levels of the amino acid tyramine,” it can cause “a spike in blood pressure, which can lead to a headache...and possibly a stroke” (Kramlinger, 2001, p. 73). Kramlinger gives

examples of these types of foods: cheese, chocolate, coffee, beer, red wine and pickles. Patients taking MAOIs have to be extremely careful and closely monitored by a psychotherapist because of the dangerous side effects of the medications.

More recently, suicide and suicidal thoughts have become a possible side effect of taking antidepressants. According to Sarason and Sarason (2005), the U.S. Food and Drug Administration (FDA) came out with a “warning that suicidal thinking or behavior may occur” during a patient’s usage of antidepressants (p. 344). Although Sarason and Sarason conclude that this “suicidal thinking” does not happen too often (p. 344), there have been studies done that claim it is happening with children and adolescents taking antidepressants (p. 345). Kramlinger (2001) reported that “researchers found the suicide rate for people receiving treatment for depression varies between 2 percent and 9 percent” (p. 165). Suicide is also known to claim the lives of many elderly people. Depression is “one of the most common conditions associated with suicide in older adults” and is quite often missed by their doctors (“Older Adults,” 2003). Murray and Fortinberry (2005) stated that certain SSRIs are “linked to suicide.” Kramlinger also said, “The more severe the depression...the greater the suicide risk” (p. 165). Although rare, it is still a reality that suicide and suicidal thoughts can be caused by using antidepressants.

Psychotherapy helps patients to identify and work through those suicidal thoughts before acting upon them.

The second reason why antidepressants should not be prescribed without psychotherapy is because of the effectiveness of pairing the treatments. Friedman (2004) suggested that combining antidepressants and psychotherapy would “address a wider range of symptoms” (p. 48). For example, antidepressants target physical symptoms (i.e. drowsiness, loss of appetite, reduced energy, etc.) while psychotherapy targets other cognitive symptoms (worthlessness,

guilt, shame, etc.). Murray (2005) suggested that sometimes antidepressants alone do not work because they are solely for “altering brain chemistry” and do not aide in solving the true reasons behind the depressive feelings.

This is where psychotherapy comes in—to teach the patient to identify those reasons and work through them with their therapist. It seems that using both antidepressants and psychotherapy is the best treatment for the elderly, as “approximately 80 percent” of elderly people struggling with depression were able to overcome it through “combination treatment” (“Older Adults,” 2003). Fava and Ruini (2005), professors at the University of Bologna and the State University of New York at Buffalo, respectively, did a recent study on treatment for mood disorders and found that combining antidepressants and psychotherapy results in a “higher improvement rate” as compared to antidepressants alone (p. 92). Combining the treatments is more effective than using just one.

Some have claimed that there is no long-term research on whether or not the combined approach works. Hegerl, Plattner and Moller (2003) stated that the “Agency for Healthcare Policy and Research” thinks that there is not enough proof that combined therapy works better than antidepressants or psychotherapy alone, and that it should not be used until there is (p. 99). On the other hand, Friedman (2004) reported that “additive models suggest simply that more treatment is better” (p. 48). Even though the combined approach has not been around that long, it seems that it does more good than harm to a patient dealing with depression.

Murray (2005) seems to believe that psychotherapy alone is the answer to treating depression, since he said, “depression is a social disease....it can be treated effectively without the use of drugs.” Kramlinger (2001) stated that the drugs “influence brain activity” to “relieve depression” (p. 68). Although psychotherapy is helpful, it is better when paired with medication

to ensure a full recovery from depression. The drugs help to relieve depression from a medical viewpoint while psychotherapy helps to relieve depression from a psychological viewpoint.

Because of the possible side effects of the medications and because of the effectiveness of pairing the treatments, antidepressants should not be prescribed without psychotherapy. Ann, who suffered from severe depression and failed to respond to antidepressants alone, willingly participated in 12 sessions of cognitive behavioral therapy while still on antidepressant medication (Bannan, 2005). Throughout these sessions, Bannan (2005) claimed that “there were clear improvements in her mood, levels of hopelessness, as well as overall social and occupational functioning” (p. 35). Bannan attributed these “improvements” to the psychotherapy, picking up where the antidepressants had left off (p. 36). Ann grew more comfortable talking about her interpersonal relationships, the problems involved with them, and was able to work through them with her therapist. Ann also spoke positively regarding the psychotherapy, stating that it had “altered her way of thinking,” teaching her how to identify the problems she had and be able to work through them on her own (p. 36). It is important to keep in mind that Ann continued her use of antidepressants during her cognitive behavioral therapy sessions. Her improvements seem to be attributed to the combination of the two treatments since she had not been responding to the antidepressants alone.

References

- Bannan, N. (2005). Multimodel therapy of treatment resistant depression: A study and analysis. *International Journal of Psychiatry in Medicine*, 35(1), 27-39. Retrieved November 7, 2005, from *ProQuest Psychology Journals* database. Through the use of a case study of a woman with an 18-month history of depression, this article demonstrates the application of cognitive behavioral therapy to pharmacotherapy in the treatment of depression.
- Bannan has her MB and is a Member of the Royal College of Physicians of Ireland (MRCPI). She is also a Member of the Royal College of Psychiatrists (MRCPsych) and works at the St. John of God Hospital in Stillorgan, Ireland.
- Depression: Tricyclic antidepressants (TCAs). (2005). Retrieved November 17, 2005, from <http://www.mayoclinic.com/health/antidepressants/MH00071>. This article gives detailed and relevant information on TCAs: how they work and their side effects. It came off of the Mayo Clinic's homepage, created by their doctors.
- Fava, G. A., & Ruini, C. (2005). What is the optimal treatment of mood and anxiety disorders? *Clinical Psychology: Science and Practice*, 12(1), 92-96. Retrieved November 10, 2005, from *ProQuest Psychology Journals* database. This article discusses the optimal treatments for mood disorders using additive models of interaction between pharmacotherapy and psychotherapy. Fava works at the University of Bologna and Ruini works at the State University of New York at Buffalo.
- Friedman, M.A. (2004). Combined psychotherapy and pharmacotherapy for the treatment of major depressive disorder. *Clinical Psychology: Science and Practice*, 11(1), 47-68. Retrieved November 6, 2005, from *ProQuest Psychology Journals* database. This article reports a study done comparing the efficacy of combined psychotherapy and

pharmacotherapy to single treatment. Friedman gives clarification, proof and statistics that combined treatment works better than single treatments. Friedman works in the Rutgers University Department of Psychology and Institute for Health, Health Care Policy, and Aging Research.

Hegerl, U., Plattner, A., & Moller, H.J. (2003). Should combined pharmaco- and psychotherapy be offered to depressed patients? A qualitative review of randomized clinical trials from the 1990s. *European Archives of Psychiatry and Clinical Neuroscience*, 254, 99-107. Retrieved November 10, 2005 from *ProQuest Psychology Journals* database. This article reviews clinical trials from the 1990s comparing the efficacy of the combination of pharmacotherapy and psychotherapy in the treatment of major depressive disorders. Dr. Hegerl is a professor in the Department of Psychiatry and Psychotherapy at Ludwig-Maximilians University in Munich, Germany. Dr. Plattner works in the Head Office of the German Research Network on Depression and also in the Department of Psychiatry and Psychotherapy at Ludwig-Maximilians University in Munich, Germany. Dr. Moller is the Head of the Department of Psychiatry and Psychotherapy at the Ludwig-Maximilians University in Munich, Germany.

Kramlinger, K. (Ed). (2001). *Mayo clinic on depression: Answers to help you understand, recognize and manage depression*. Rochester: Mayo Clinic Health Information. This book gives a great background to depression, antidepressants and how to deal with the illness. It is also filled with relevant statistics and basic information to help understand depression. Dr. Kramlinger is a consultant in Mayo Clinic's Department of Psychiatry and Psychology. He is also an assistant professor of psychiatry at Mayo Medical School.

Murray, B. (2005). Cures for the depression epidemic. Retrieved November 17, 2005, from

http://www.upliftprogram.com/article_curdep.html. This article gives Murray's personal opinion on the cure for the depression epidemic. He provides relevant statistics and information regarding depression, antidepressants and psychotherapies. Dr. Murray is a published psychologist and expert on depression. He is the founder of the Uplift Program, and the author of new book, *Creating Optimism: A Proven, 7-Step Program for Overcoming Depression*.

Murray, B., & Fortinberry, A. (2005). Depression facts and stats. Retrieved November 17, 2005, from http://www.upliftprogram.com/depression_stats.html. This webpage provides several relevant facts and statistics about depression from recent studies and surveys. Dr. Murray, a published psychologist, and his wife Dr. Fortinberry, a psychotherapist, together offer seminars and courses teaching people how to beat depression and improve their self-esteem. Fortinberry is a writer and a Feldenkrais (learning through movement) Practitioner.

Older adults: Depression and suicide facts. (2003). Retrieved November 10, 2005, from <http://www.nimh.nih.gov/publicat/elderlydepsuicide.cfm>. This article gives facts and statistics regarding depression in older adults and the correlation between that and suicides in older adults. This article is off of the National Institute of Mental Health's website.

Sarason, I.G., & Sarason, B.R. (2005). *Abnormal psychology: The problem of maladaptive behavior*, 11th Ed. New Jersey: Prentice-Hall. This college textbook has a full chapter dedicated to mood disorders and suicide, and gives relevant information on the different types of depression treatments and antidepressants. It also provides helpful, recent

statistics about depression. Sarason and Sarason are both of the University of Washington.

Wolpert, L. (1999). *Malignant sadness: The anatomy of depression*. New York: The Free Press.

This book is an autobiography of Dr. Wolpert's own struggle with depression. Wolpert gives great personal input on the struggle with depression and relevant information about the illness. Wolpert is a Professor of Biology as Applied to Medicine at University College in London. He has authored six books, including *A Passion for Science*, *The Triumph of the Embryo*, and *Passionate Minds*.

Combination Psychotherapy and Antidepressant Medication Treatment for Depression: For Whom, When, and How. Article. Literature Review in Annual Review of Psychology 65(1):267-300. January 2014 with 499 Reads. How we measure 'reads'. Physical health resources may also play an important role in treatment response. Preliminary evidence suggests that better overall physical health is related to greater mental health treatment response in individuals with PTSD (Currier et al., 2014; Sofko, Currier, & Drescher, 2016) and depression (Craighead & Dunlop, 2014; Iosifescu et al., 2003; Rossom et al., 2016). Furthermore, greater pain severity may predict worse mental health treatment response (Bartoszek, Hannan, Kamm, Pamp, & Maieritsch, 2017). New research is showing that combining antidepressants with medications for other mood disorders can be effective in helping people manage their depression. People with severe depression symptoms or other conditions, such as chronic illnesses, may be good candidates for this combination. Combination therapy as first-line treatment. Success rates of monotherapy treatment are relatively low. Therefore, many researchers and doctors believe the first and best approach to treating MDD is combination treatments. Treatment-resistant depression refers to depression that doesn't respond to common treatments. Despite the name, there are still treatments that can help. Herbs, Vitamins, and Supplements for Depression. Psychotherapy can be an effective form of treatment for depression because it can help you delve into possible underlying reasons for your depressive feelings and learn new skills to cope. Finding out which type of psychotherapy is best for you will depend on a number of factors, including the severity of your symptoms, your own personal preferences, and your therapy goals. Several studies suggest, however, that the combination of an antidepressant and psychotherapy is the best approach, because of the complex mix of causes of mood disorders like depression. Psychotherapy is the process of treating psychological disorders with verbal and psychological techniques. Depression treatment may involve psychotherapy, medications, or a combination of the two. Medication: Prescription drugs, called antidepressants, help alter mood by affecting naturally occurring brain chemicals. Other classes of antidepressants include serotonin and norepinephrine reuptake inhibitors (SNRIs), Norepinephrine and dopamine reuptake inhibitors (NDRIs), Tricyclic antidepressants, and Monoamine oxidase inhibitors (MAOIs). Several studies have suggested that combining psychotherapy and medication together works best for treating people with severe depression. This study will assess the efficacy of combining antidepressant medication and sleep-focused psychotherapy to simultaneously treat sleep difficulties and depression. Participants in this double-blind study will be randomly assigned to receive either desensitization therapy or cognitive behavioral therapy to target insomnia. All participants will also receive escitalopram oxalate, an antidepressant medication. The study will last 12 weeks. The severity of participants' depression and insomnia will be assessed. Cognitive Behavioral Treatment for Insomnia. Other Name: Cognitive Behavioral Treatment for Insomnia. Active Comparator: MED+CTRL. Escitalopram plus Pseudo-desensitization Therapy for Insomnia.