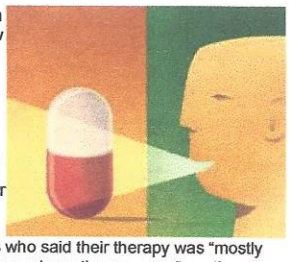
Drugs vs. talk therapy

3,079 readers rate their care for depression and anxiety

A combination of therapy and medication is often the best way to treat depression.



Where people turn for help to combat depression and anxiety can make a critical difference in the type of care they receive and how completely they recover. That's an important finding of a new survey, one of the largest of its kind, of thousands of *Consumer Reports* subscribers who recently sought treatment for those conditions.

The survey results, plus our interviews with patients and experts, offer a compelling snapshot of how people found mental-health care and how they fared given the choices they made. Among our other findings:

• Talk therapy rivaled drug therapy in effectiveness. Respondents who said their therapy was "mostly talk" and lasted at least 13 sessions had better outcomes than those whose therapy was "mostly medication." Therapy delivered by psychologists and clinical social workers was perceived as effective as that given by psychiatrists.

• Drug therapy relieved symptoms faster than talk therapy, and the majority of people who described their therapy as "mostly medication" also had good outcomes. But it can take much trial and error to find the right medication. More than 50 percent of survey respondents who took antidepressants tried two or more drugs; 10 percent tried five or more.

CR Quick Take

With or without drugs, most people who sought care for depression or anxiety gained relief. A survey of thousands of CR subscribers who recently received treatment for those conditions found that:

• A combination of talk therapy and drugs often worked best. But "mostly talk" therapy was almost as effective if it lasted for 13 or more visits.

• "Mostly drug" therapy was also effective for many people. Drugs had a quicker impact on symptoms than talk therapy, but it often took trial and error to find a drug that worked without unacceptable side effects.

• Forty percent of people who took antidepressants complained of adverse sexual side effects.

• Care from primary-care doctors was effective for people with mild problems, but less so for people with severe ones.

• The rates of adverse drug side effects that our respondents experienced were much higher than those noted on the medications' package inserts. Forty percent said they experienced a loss of sexual interest or performance, and almost 20 percent said they gained weight.

• Health-plan restrictions, such as limits on therapy visits, and costs kept some people from getting the best treatment.

• Consumers who did their own research and monitored their own care reported better results.

In recent years, depression and anxiety have come out of the closet, thanks in part to TV and magazine advertising campaigns for prescription drugs that treat everything from depression to "premenstrual dysphoric disorder" and social anxiety ("Hello My Name Is Anxious"). In 2003 alone, $275 million in consumer advertising helped sell $12.4 billion worth of drugs to treat depression and anxiety in the U.S. Even the federal National Institutes of Health has led an advertising campaign on "real men, real depression."

Talk therapy has also gotten off the couch and revitalized its image. The head mobster on HBO's "The Sopranos" sees a therapist. And many states mandate that health plans include at least some coverage for mental-health treatment.

The increased number of treatment options for emotional disorders might improve the odds of recovery for the 9 percent of American adults who suffer from depression and the 11 percent who experience an anxiety disorder in a given year. Indeed, more than 80 percent of our survey respondents said they found treatment that helped.

While more than 4,000 readers answered our two-and-a-half-page questionnaire in 2003, this report focuses on the 3,079 who described themselves as depressed (39 percent), anxious (16 percent), or both (43 percent). The survey did not include people with symptoms who never sought care, and probably also excluded those too ill to complete the questionnaire.

Mushrooming treatment options have made it more problematic for consumers to ferret out the best approaches. Does everyone in emotional distress need prescription antidepressants? Can talk therapy be enough? Where do you start on the path to recovery?

Some of our results confirm those of smaller, placebo-controlled clinical trials. But other findings--such as the effectiveness of specific drugs and talk therapy, and the side effects of antidepressants--capture information that clinical trials cannot and challenge some of their findings.

Therapist vs. Family Doctor

Break an arm, and you head for the emergency room. Nagging cough, you see an internist or family doctor. But where should a depressed person turn for help when, as our questionnaire put it, emotional problems make life "usually pretty tough" or when he or she can "barely manage to deal with things"? The answer is crucial to the type of treatment received and its success.

"People may not go to the doctor and say, 'Hey, I'm depressed.' Often they show up saying, 'I can't sleep, I have stomach problems, my head hurts, my back hurts, " says Michael Schoenbaum, Ph.D., a RAND Corporation health economist whose work focuses on improving the treatment of depression.

If you're not sure what the problem is, a family doctor might be the logical first stop in seeking care, but perhaps not the only stop for those with severe symptoms. While treatment outcomes from primary-care doctors were nearly as good as from therapists for people who said they started out with less severe symptoms, treatment by mental-health specialists yielded significantly better results for people who started out in poor shape.

And indeed, in our study, people who saw only a primary-care physician tended to have milder symptoms, and most had six or fewer treatment visits.

"Mostly drugs" was the type of therapy described by almost half of those who saw only a primary-care physician and 38 percent of those who saw a psychiatrist. The "mostly drugs" group typically received a prescription antidepressant. The few doctor visits they had were probably largely devoted to monitoring how well the medicine was working and checking for side effects. Others who saw only a primary-care physician received a combination of advice and medication.

Experts we interviewed noted that many independent studies have documented the less effective mental-health treatment delivered by primary-care doctors. "Your primary-care doctor has a million things to do and not a lot of time to see you, and in general does not have much training in diagnosing and treating mental illness," Schoenbaum says.

Had trouble getting care

WHO Gale Burstein, 40, Decatur, Ga.

WHAT HAPPENED Burstein, a pediatrician specializing in adolescent health, recognized she had the symptoms of postpartum depression. She says that shortly after the birth of her second child, three years ago, she urgently needed help. But when she called the 800 number on her health insurance plan card, she got a runaround and could not obtain authorization for treatment. Reluctantly, she had to reveal her need to a human resources staffer at her workplace, who informed her that her health plan had turned over mental-heath benefits to another company to administer--using an 800 number not listed on her card. Six months' treatment with Effexor, prescribed by a psychiatrist, brought her to the point where "finally, life was good."

Referral: Friend va. employer

"People are more likely to ask their friends and colleagues who knows a good mechanic than who knows a good psychotherapist," says Gregory Simon, M.D., a psychiatrist and mental-health researcher at Seattle's Group Health Cooperative. "If one can screw up the courage to ask, word-of-mouth recommendations are very good."

Our findings confirm that advice. Only 20 percent of respondents who saw a mental-health therapist got the name from a friend or family member. But that group had a better outcome than those who saw a therapist recommended by their employer or through an advertisement. People who were referred by their medical doctor or another mental-health professional also got good results.

Though psychologists and social workers can't themselves prescribe drugs, some have arrangements with psychiatrists who will prescribe and monitor drugs for their patients. Among our respondents, 66 percent of psychologists' and social workers' patients reported that they received drug treatment as an adjunct to talk therapy.

"Many insurers refuse to allow psychiatrists to do anything but prescribe drugs, except for the most severely ill patients," notes Bruce Schwartz, M.D., associate professor of clinical psychiatry at Albert Einstein College of Medicine, in New York City, and one of two consultants who helped us design our survey and interpret the results.

Regardless of how ill respondents were when going into therapy, their outcomes were virtually identical whether they saw a psychiatrist, psychologist, or social worker. "This shows that if you leave people to their own devices, they're going to come up with a therapist they like and who helps them," says William Sanderson, Ph.D., professor of psychology at Hofstra University, in Hempstead, N.Y., our other consultant.

Meds vs. Talk

Drug therapy has become a more prevalent mode of treatment for emotional problems in the last decade. When we surveyed our readers in 1994, only 40 percent of those who sought care for any type of mental-health problem received drugs compared with 68 percent in the current survey (and 80 percent of those with depression or anxiety)--a number that reflects the fast-growing sales of antidepressant drugs over the past decade.

Still, someone entering treatment today has the same basic choices they would have had a decade ago: talk therapy, drug therapy, or a combination. While our results suggest that all of these options can work for many cases of anxiety and depression, the combination of talk and drugs was the overall winner.

The reason could be that drug and talk therapies work at very different paces. Respondents who took drugs improved substantially within a few visits. Within six visits, those whose treatment consisted of mostly medication had improved as much as those who had 13 or more visits. By contrast, respondents who elected mainly talk therapy improved more gradually. If they had just six visits or fewer, they fared worse than patients on medication. But if they stuck with their therapy for 13 or more visits, their outcome was better than those who relied mainly on medication. The most successful patients of all were those who received a balance of drug and talk therapies. They had the advantage of quick improvement with the drugs, followed by steady

Managing depression

WHO Claudia Meadows, 55, Shoreline, Wash.

WHAT'S HAPPENING To

continuing improvement from the talk.

The number of talk therapy sessions received by people with a mental problem drastically declined over the last decade. In 1994, survey respondents averaged well over 20 visits with a mental-health professional, while in the current survey the average was 10 visits. Since our survey indicates that longer-term therapy is linked to more positive outcomes, that trend is troubling.

Striking the right balance between medications and "enough" talk therapy sessions can be tricky. Asking hard questions of the professional recommending treatment can help people understand their options. These questions should include: What's your understanding of this problem? What kind of treatments would you recommend and why? How long will it take to experience some relief of symptoms? How long will I need to stay on medication and/or continue with talk therapy to get the maximum benefit?

Meadows, managing her chronic major depression is "a full-time job." Because her husband's job provides membership in Seattle's Group Health Cooperative HMO, she has care from a well-coordinated team. "I can get useful therapy, face-to-face psychiatric appointments when I need them, medications at the walk-in pharmacy or by mail, online help, telephone nurse consultations, and my doctor returns phone calls within hours." With this support, Meadows has raised two sons, works part-time as a bus driver, and is developing a photo greeting card business.

drug vs. drug

From 1999 through 2003, drugmakers spent more than $953 million promoting the major antidepressants directly to consumers. Much more is spent advertising to doctors. Antidepressants were the drug category most heavily advertised in medical journals in 2003. Escitalopram (Lexapro), a newer antidepressant, was the most heavily advertised drug of all, according to Medical Marketing & Media, a trade publication that tracks pharmaceutical ad sales.

Published clinical trials have not found meaningful differences in effectiveness for adults among the major antidepressants. When researcher Mark Zimmerman, M.D., director of outpatient psychiatry at Rhode Island Hospital, recently reviewed 24 trials, including 411 drug comparisons, he found that fewer than a dozen comparisons yielded significant differences.

The experiences of our respondents, however, did yield differences in both effectiveness and side-effect ratings for the six top-selling antidepressants, though no single "winner" emerged. Four of the six drugs--citalopram (Celexa), fluoxetine (Prozac), paroxetine (Paxil), and sertraline (Zoloft)--are known as SSRIs, or selective serotonin re-uptake inhibitors. (Lexapro, now also a top-selling SSRI, was introduced in 2002, too late to show up in our survey.) SSRIs increase the brain's supply of available serotonin, a neurotransmitter that plays a central role in mood and alertness. Beginning with the 1987 introduction of Prozac, the first SSRI, this category of drugs has largely supplanted an older class of antidepressants, the tricyclics, which, though effective, caused much more severe side effects.

All of the SSRIs except Celexa have also received regulatory approval for treating some type of anxiety-related disorder. But there has been virtually no clinical testing of these medications on the combined depression and anxiety that is so often found in clinical practice and was common among our survey respondents.

There was a high frequency of anxiety disorders among respondents who took Paxil. That drug was prescribed most often to those who got their treatment from a medical doctor rather than a mental-health therapist. Perhaps not coincidentally, between 1999 and 2003, the year of our survey, Paxil was by far the antidepressant most heavily advertised to consumers, mainly to promote its use as a treatment for "social anxiety disorder."

"That Paxil was effective for the depressed and anxious patient was a great message to send out there," Zimmerman says. "The primary-care physician didn't have to be able to tell the difference." In our survey, a slightly smaller percentage of readers who took Paxil reported that it helped "a lot" compared with readers who took other SSRIs. This percentage was essentially the same among those who took Paxil for depression, or anxiety, or both.

Two other drugs indicated for depression but not anxiety are different from the SSRIs. Venlafaxine (Effexor) is a dual-action drug that affects brain levels not only of serotonin but also of another neurotransmitter, norepinephrine. Effexor's dual action may account for the fact that more of our readers found it effective. In our survey, respondents who took Effexor were likely to have started treatment with more severe symptoms, but even when we controlled for severity, respondents perceived Effexor to be quite effective. In August 2004 the Food and Drug Administration approved a second antidepressant drug in this category, duloxetine (Cymbalta).

Bupropion (Wellbutrin) is an older drug whose precise effect on the brain is not understood, although the drug has been clinically shown to work. Our respondents found it produced a lower level of side effects, but fewer found that it "helped a lot."

There was no clear favorite among the medications, and our findings confirm those of clinical studies that there is no single antidepressant that will work for everyone. "I tell my patients that there's probably one of these medications that's better for you than the others, but unfortunately we can't tell in advance which one it is," says Simon, the Seattle researcher and psychiatrist.

Our survey confirms that it often takes trial and error to find the right drug. Fifty-five percent of respondents who took medications had to try two or more, and nearly 10 percent had taken five or more, aiming to find a drug that helped and had acceptable side effects.

Since all of the drugs can be effective for some people, and there are many factors involved in choosing the one to start with, it's important to work with a healthcare professional who understands you and all the drug options. Some experts recommend starting with whichever antidepressant is the cheapest. Lower-cost generics are available for

Drug-free cure

WHO Robert MacNeill, 62, Hingham, Mass.
WHAT HAPPENED For four decades MacNeill experienced extreme fear, a pounding heart, and intense sweating and nausea when faced with the prospect of traveling for more than an hour's ride. He tried anti-anxiety drugs and a psychiatrist's treatment to quell his severe panic attacks, but found no relief. Finally the prospect of missing his son's wedding in Kansas impelled him to search for another treatment. He found it at Boston University's Center for Anxiety and Related Disorders. The cognitive-behavioral therapy involved deliberately inducing the symptoms of panic attacks and training himself not to fear them. After 11 weeks of intensive therapy, MacNeill passed his final behavioral "exam"--a plane trip to Kansas to visit his son. He now travels

bupropion, fluoxetine, and paroxetine. When starting a new medication routinely. "I wish I had known this 40 years ago," he says.
it's important to have close follow-up with the doctor or therapist to make sure that it's working.

People who take an antidepressant should also be aware of the high risk of side effects, especially a loss of sexual interest or ability and weight gain. (Poor sexual functioning and weight gain can also be symptoms of depression itself.)

The package inserts for antidepressants typically peg adverse sexual side effects as affecting 15 percent of patients or less, based on studies sponsored by drug companies. We found rates about three times that for the four SSRIs and Effexor, from a low of 41 percent for Prozac to a high of 53 percent for Paxil. Our findings are similar to those of the only published comparative study on this subject, headed by Anita Clayton, M.D., of the University of Virginia and reported in April 2002 in the Journal of Clinical Psychiatry. It found rates of adverse sexual side effects ranging from 36 to 43 percent for SSRIs and Effexor.

About 20 percent of people who took SSRIs or Effexor reported weight gain, and 15 to 21 percent noted that those drugs made them feel drowsy or disoriented. Wellbutrin, with its different chemical composition, had noticeably lower rates of side effects. Only 21 percent of the people taking it said they experienced sexual problems, 10 percent complained of sedation, and 12 percent experienced weight gain.

For many people, side effects were more than annoyances. Of the readers who said they stopped taking an antidepressant, 34 percent said they'd done so because the side effects were intolerable.

Insurance vs. Pay your way

Mental-health professionals use apocalyptic language in speaking of their financial arrangements with the managed-care companies that dominate their field. The major targets of their ire are low reimbursement rates and annual limits on the number of mental-health visits patients may make. "It's disgusting," Zimmerman says. "Insurance limits on mental-health treatment are the norm, rather than the exception. If you have difficult-to-control diabetes, you can have as many visits as you need. If you have difficult-to-control depression, you may be limited to 20 visits a year."

A study of mental-health benefits, published in the September-October 2003 issue of Health Affairs, found that though 98 percent of insured employees had some kind of mental-health coverage, 32 percent were allowed no more than 20 outpatient visits per year, and 22 percent had to pay a higher share of the costs for mental-health care than for other types of health care.

Even Medicare treats mental illness differently from other medical conditions, requiring patients to bear half the cost, rather than the usual 20 percent for other types of outpatient care.

In our study, most people did get better in the number of visits for which their coverage paid, but a significant minority ran into trouble. Of the 80 percent who secured treatment through their health plans, 23 percent said they had some type of problem with it. Problems included restrictions on the number of visits, long waits for appointments, hassles with red tape, or difficulty finding a doctor in the plan directory who was willing to accept new patients.

These frustrations, as well as privacy concerns, may lead some people to avoid using their health insurance to pay for mental-health care. Federal privacy laws make it illegal for mental-health professionals to disclose, without the patient's permission, "personal notes" containing the therapists' impressions. But health plans are allowed access to information about diagnosis, drugs prescribed, treatment plan, and prognosis. So a health plan or employer may be able to find out that a person is getting, say, Zoloft for depression, but not the therapist's opinion on the causes of depression.
That's thin protection for people concerned that having an antidepressant prescription on their record might result in insurance or employer discrimination. Whether from lack of coverage or fears about using it, 19 percent of our respondents said their health plan didn't pay for any of their mental-health treatment. As a result, many spent $500 or more out of pocket for therapy over the previous year. And of the 57 percent of respondents who said they had stopped their mental-health treatment, 14 percent said it was because they couldn't afford to continue.

Active vs. Passive

It requires some consumer savvy to get the best results from treatments for depression and anxiety, our research has found. Survey respondents who were most satisfied with their care and had the best outcomes were more likely to:
- Research their problem in advance of seeking help.
- Interview more than one professional.
- Ask therapists whether they had experience treating that problem.
- Bring a family member or friend to an office visit.
- Keep a written record of their treatment and emotional state.
- Apply what they were learning in treatment to their daily lives.

That last step, which involves working hard at therapy and putting suggestions into action, was the best predictor of a good outcome.
Only 1 percent of respondents followed all of the steps listed above, and 18 percent followed none at all.
People with depression and anxiety might need to involve family or friends to help them get the best care and make the best use of it. Restrictive insurance policies, social stigma, and a feeling of "What's the use?" can all present barriers.
But if social and personal barriers are are overcome and appropriate treatment is started, the experience of *CR* readers demonstrates that relief is available.
"My whole life has changed," says Robert MacNeill, speaking of his successful treatment for panic disorder. "It's like being reborn."

To stay safe this summer, you need to learn as much as you can about how to avoid summer's hidden dangers.

If you suspect you are suffering from depression, make an appointment with your doctor soon. Prompt, proper treatment of depression can control symptoms and restore your quality of life. With many drug and nondrug options available, having up-to-date, unbiased information is very important.

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