

Depression & Multiple Sclerosis



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The words **depressed** and **depression** are used so casually in everyday conversation that we tend to forget their true meaning. While often used to describe someone who is blue or has had a bad day, the term more accurately refers to an emotional disorder that may be more specifically called “major depressive disorder,” “persistent depressive disorder” (also known as “dysthymia”) or one aspect of “bipolar disorder,” depending on the exact kinds of symptoms the person is experiencing.

Major depressive disorder will affect about 1 in 5 or 20 percent of Americans during their lifetime, but for people with MS, all the depressive disorders are much more common: major depressive disorder may affect over 50% of individuals with MS.

Diagnosis of these depressive disorders depends on the presence of a set of particular symptoms at a certain level of severity for a specified amount of time. Effective treatment depends on making the correct diagnosis, and doing so as quickly as possible.

A person who is “depressed” may also have symptoms of “depression” that are not severe enough or do not last long enough to warrant a diagnosis of a depressive disorder, but still cause pain and suffering. Some people over-use alcohol or various prescription and non-prescription drugs in an effort to manage their depressive symptoms; however, those approaches are ineffective and can cause significant problems of their own. Regardless of whether a person’s symptoms meet the criteria for a diagnosis of depression, any symptoms that cause suffering and interfere with daily activities and quality of life deserve attention and treatment.

The pull-up-your-socks syndrome

Unfortunately, when “depression” and “MS” are mentioned in the same breath, some people say, “Of course you’d be depressed if you’d been diagnosed with MS,” or “How would you feel if your ability to walk just suffered a major setback?” Such reactions assume that depression is simply a psychological and emotional response to MS. There is a tendency in our

culture to see depression as a weakness or character flaw. It is not. Depression cannot be overcome by simple will power. Treatment with medication and/or psychotherapy (“talk therapy”) is required to help people feel better and get on with their lives.

Cause, effect or both?

Researchers are finding increasing evidence that depressive disorders in people with MS have a complex set of causes including changes in the brain and the immune system due to MS, genetic predisposition, early life experiences and current circumstances.

While the physiology of MS may contribute to depression, many people with MS experience changes in their ability to function and challenges in everyday life that may impact their mood. Regardless of the cause of the depression — as a reaction to MS-related challenges or because of changes in the brain or the immune system — there are effective interventions. Research has shown that the treatments that are effective for

people in the general population are also effective for people with MS.

Disability and depression — a false link

Some people who are severely disabled are not depressed — while others are very depressed but not physically disabled. Research has shown no clear or consistent relationship between depression and an individual's degree of disability or length of time with MS.

The interferon-beta medications

The interferon-beta medications used to treat MS carry warning labels stating that they should be used with caution by anyone who has depressive symptoms or a history of a depressive disorder. Although research has failed to show a strong link between depression and the interferon-beta medications, if you intend to take or now take an interferon-beta medication, let your doctor know if you or a biological relative has had emotional ups and downs, and make a plan for what to do if they occur during interferon treatment.

Is it sadness, grief or true depression?

It can be difficult to determine whether a person's emotional distress is due to grief and sadness in response to the losses MS can produce or a depressive disorder. The reality is that either or both may play a role. Grief and sadness are natural reactions and common among people with MS. These feelings lift a little when something pleasant happens and over days and weeks will gradually improve. They tend to occur at particular times: when someone is told the diagnosis or there is a long delay with unexplained symptoms; with relapses and worsening symptoms and function; when a mobility aid becomes necessary; and with changes in major roles, such as leaving the workforce. By contrast, depressive disorders get worse over time, and things that would normally feel enjoyable or pleasurable have no effect. While situation-specific sadness and grief may turn into depression, depressive disorders can occur at any time in the course of MS. In fact,

people who are depressed often feel there is no reason why they should be feeling so down.

Symptoms of depressive disorders are listed on pages 7–9. They are quite specific, but recognizing them is not always easy because some of the physical and mental symptoms — fatigue, trouble concentrating, slowed thinking, difficulty making decisions, loss of interest, trouble planning and being active — are common in MS as well. Sometimes people with MS, family members and doctors are slow to recognize depression because it may appear so gradually or seem indistinguishable from MS symptoms.

Once depressive symptoms are recognized, specialists agree: don't wait; reach out for professional help. Depression can add to fatigue, increase pain symptoms, reduce function and significantly worsen problems with thinking and memory. In fact, depression makes everything else feel worse. Most importantly, depressive disorders put people at risk of suicide, which is more common in people with

MS than in the general population. Even if you are not sure it is depression, ask for an evaluation by a mental health professional. Treatment is easy, safe and effective, so it's well worth your while to find out if you need it.

Symptoms of depressive disorders

The hallmark of these symptoms is their persistence. They linger. They are not the normal, transient “blues” that everyone experiences in response to a sad or distressing event.

The American Psychiatric Association in its Diagnostic and Statistical Manual of Mental Disorders lists the following criteria for diagnosing depressive and other mental disorders

Major depressive disorder

People with major depressive disorder will have one or more major depressive episodes over their lifetimes. Five or more of the symptoms listed on page 8 — including at least one of the first two symptoms — will occur together

for at least two weeks, most of the day, nearly every day, and represent a significant change in functioning for that individual.

- feeling sad, tearful, empty, hopeless or irritable
- experiencing a loss of interest or pleasure in most activities
- significant weight loss or gain or a decrease or increase in appetite
- sleeping too much or having trouble sleeping
- agitation or slowed movement observed by others
- fatigue or loss of energy
- feeling worthless or excessively guilty without cause
- diminished ability to think, concentrate or make decisions
- recurrent thoughts of death or suicide, or planning or attempting suicide

These symptoms cause distress and impair daily functioning.

The manual notes that symptoms due to a medical condition should not be counted. However, as discussed above,

it is important not to assume that the symptoms that are shared by MS and depressive disorders are all due to MS. A mental health professional can work with you to sort out the causes of the symptoms you are experiencing.

Persistent depressive disorder (Dysthymia)

Persistent depressive disorder or dysthymia is diagnosed when the depressed mood occurs most days, lasts most of the day, and persists for at least two years in an adult or at least one year in a child.

Bipolar disorder

Bipolar disorder, which is also more common in people with MS than in the general population, is characterized by both depressive and manic episodes. A diagnosis of mania is made when a person has an elevated mood (feels 'up' or 'high') and/or irritable mood for at least one week; speaks rapidly, is easily distracted, has racing thoughts, needs little sleep, and is highly energized, over-active and acts impulsively with poor judgment. These symptoms range in severity from mild (hypomania) to

severe enough to impair the person's ability to function, sometimes involving delusions or hallucinations.

OK, I need help

To find help, ask your neurologist or general medical doctor to refer you to a mental health professional — and give permission for all members of your team to communicate and collaborate in your care.

The Society can also give you referrals to mental health professionals who understand MS. Call an MS Navigator® at 1-800-344-4867.

Medication therapy

Many types of antidepressants are available, but none are magic bullets. To avoid side effects, it is wise to start at the lowest possible dose and gradually increase the dose until side effects become intolerable, there is full relief from depressive symptoms, or the maximum dose has been reached. Not only does this initial process take time, but it may take a few weeks to

see an effect at the maximum dose. The important thing is to persist; the only way to know if a medication will be effective is to take the highest recommended or highest tolerated dose for a sufficient length of time to demonstrate that it does or does not work. An antidepressant may be effective for one person, but not another. The only predictor of which one will work for an individual is that it helped a biological relative.

Side effects are no longer a major obstacle with selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SSNRIs). The tricyclic antidepressants (TCAs) are effective but produce more side effects. Because TCAs can cause urinary retention, and thereby increase the risk of bladder and kidney infection, they should be used in people with MS only if other antidepressants have not worked, a TCA has worked well in the past, and if the person is carefully monitored, especially for symptoms of bladder infection.

Because a variety of side effects are possible with antidepressant medications, it is essential to discuss them with your healthcare provider so that they can be effectively managed. Together, you and your provider can make a decision about continuing, modifying or stopping the medication. Almost all antidepressants cause sexual problems ranging from loss of interest (which can be due to the depression itself) to impaired sensation and orgasm. Some antidepressants are reportedly less likely to cause these problems, and other drugs may be added on an “as needed” basis to minimize these effects temporarily. If you experience a change in your sexual feelings or functioning, let your healthcare provider know.

The medications that are effective for treating major or persistent depressive disorder are not used for bipolar disorder. In fact, antidepressants can produce mania in someone whose depression is actually in the depressed phase of bipolar disorder, requiring a change in both diagnosis and treatment.

The medications used for bipolar disorder include lithium and certain anticonvulsants that have been found to stabilize moods.

Talk therapy

Medication alone does not cure depression. Medication therapy should be combined with some form of psychotherapy or counseling.

Psychiatrists (physicians with training and expertise in the diagnosis and treatment of emotional disorders) and — in certain states — advanced practice psychiatric nurses and psychologists, can prescribe medication to treat emotional disorders. Neurologists and primary care physicians can also prescribe antidepressant medication, but typically consult with or ask their patients to see a psychiatrist to confirm the diagnosis and recommend treatment. Psychotherapy can be provided by psychiatrists, psychologists, social workers, psychiatric nurses, licensed professional counselors or other qualified non-physicians. Non-physician mental health professionals

are trained in making psychiatric diagnoses and determining when medication might be indicated and can refer their patients to a psychiatrist for further evaluation, recommendations and possible medication.

Psychotherapy takes several forms. It may be focused on a particular issue or problem (e.g., distress at the time of diagnosis or thinking through how best to talk with children about MS) and last only until the problem or issue is resolved, or it may be ongoing with a change in focus over time. For example, the person who came at the time of diagnosis may want to continue meeting weekly or every other week to talk about ways to adjust to MS, and those discussions may move on to thinking about work, or what and when to tell friends and colleagues, or any of the myriad life issues that people with MS face. Psychotherapists also provide support to families through the life changes that MS may require.

Both supportive and in-depth psychotherapy tend to move away from focusing on MS to addressing any of the personal and interpersonal

issues everyone confronts at some time in their lives. Many people with MS have a long-term relationship with a psychotherapist: some continue to meet regularly and some leave and return when a new problem or issue arises.

There are many models of psychotherapy. Cognitive behavioral therapy (CBT) is a structured, problem-focused, short-term therapy that typically includes exercises and practice between sessions; marital and family therapy is designed to help a couple or whole family work on shared problems; and group therapy led by a psychotherapist provides opportunities for people to share feelings and experiences and problem-solve together. Within each of these broad categories, individual therapists utilize different conceptual and clinical approaches.

Psychotherapy can be supplemented by participating in a self-help group, but support group participation, by itself, is not sufficient for treating depression. An MS Navigator® can provide information about self-help group programs in your area; call 1-800-344-4867.

A good relationship

No matter what form talk therapy takes, a good ‘fit’ between you and your therapist is essential. You should feel that you can bring up any topic. Since not every qualified therapist is right for everyone, you may need to meet a few until you find the right therapist for you. Don’t give up on the concept of treatment just because you don’t ‘click’ with the first therapist you meet. When a comfortable relationship is developed, it can help you understand your emotions and gain more control over your life. While it would be ideal to find a therapist who is familiar with MS and the challenges of living with a chronic illness, this is not often possible. It is up to you to teach your therapist about MS in general and your MS in particular; most experts in the emotional aspects of MS learned what they know from their patients! It is also up to you to encourage your therapist and MS care provider communicate and collaborate with you and each other in your care.

Exercise and mood

The evidence is growing that exercise has a positive impact on mood as well as on a person's physical well-being. An exercise regimen that is tailored to a person's abilities and limitations can significantly improve mood and quality of life.

A final note

Many different factors contribute to the occurrence of a depressive episode in a person with MS, including genetics, inflammatory processes in the brain, immune system changes, the individual's coping style, past and present experiences, and the kinds of family and social supports he or she may have. Although we don't yet know how or why a particular person becomes depressed, we do know how to effectively treat depression — so don't hesitate to consult with a mental health professional even if you're not sure whether you are depressed or need treatment. It's the professional's job to help you figure that out. Sometimes just making this connection can be beneficial and reassuring.

Notes

The National Multiple Sclerosis Society (“Society”) is proud to be a source of information on multiple sclerosis related topics. The information provided is based on professional advice, published experience, and expert opinion, but does not constitute medical or legal advice. For specific medical advice, consult a qualified physician. For specific legal advice, consult a qualified attorney.

The Society does not endorse products, services or manufacturers. Such names appear here solely because they are considered helpful information. The Society assumes no liability for the recipient’s use of any product or service mentioned. The Society does not independently verify whether the information provided by each service provider is accurate. The Society undertakes no responsibility to verify whether the service provider is appropriately licensed and certified and has applicable insurance coverage.

Early and ongoing treatment with an FDA-approved therapy can make a difference for people with multiple sclerosis. Learn about your options by talking to your healthcare professional and contacting the National MS Society at **[nationalMSSociety.org](https://www.nationalMSSociety.org)** or 1-800-344-4867.

The Society publishes many other resources about various aspects of MS. Call 1-800-344-4867 or visit **[nationalMSSociety.org/brochures](https://www.nationalMSSociety.org/brochures)**.

Other popular resources include:

- Multiple Sclerosis and Your Emotions
- Taming Stress in MS
- MS and the Mind

The National MS Society's mission is for people affected by MS to live their best lives as we stop MS in its tracks, restore what has been lost and end MS forever. To fulfill this mission, the Society funds cutting-edge research, drives change through advocacy, facilitates professional education, collaborates with MS organizations around the world, and provides services designed to help people with MS and their families move their lives forward.



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