Depression 'highly treatable,' doctors say

Editor's note: This is the third story in a four-part series on depression by Edward Edelson, science editor of the New York Daily News.

By EDWARD EDELSON
New York Daily News

Gary Goldsmith went through a decade and more of hell with manic-depression before he discovered lithium.

He had his first episode of mania in college, when he suddenly found himself possessed by wild, grandiose ideas and boundless yet futile energy. He had his first crippling bout of depression a few years later, when he worked as a buyer for Macy's.

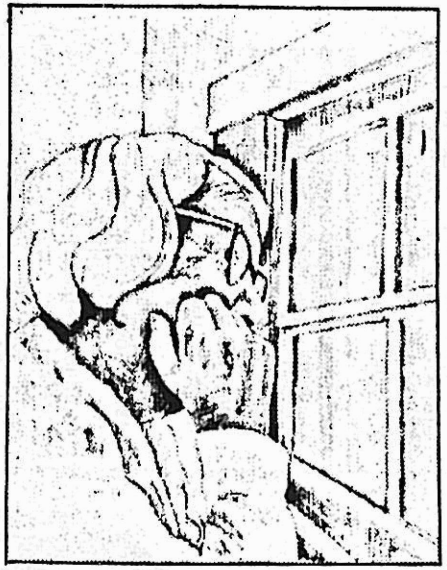
The depression recurred predictably — every September, when pre-Christmas job pressures hit their peak. "I lost my ability to work and my grasp of basic things," Goldsmith said. "I'd just sit there and do nothing all day."

Anti-depressant drug treatment snapped him out of that, but then the mania came back. Now Goldsmith takes lithium regularly — "I'll probably take it for the rest of my life" — and is doing fine.

Florence Gassman leads a near-normal life because her recurrent depression is kept under control by anti-depressant drugs, which are believed to right a chemical imbalance in the brain. She enrolled in a program for elderly depressed persons at New York University Medical Center two years ago and has had only one relapse since then.

Nancy Scheff says electroconvulsive therapy (ECT), a highly controversial treatment in which powerful electric shocks are administered to the brain, saved her life. She had been prescribed "every drug in the book" for recurrent bouts of depression and hadn't been doing that well. "The best I've ever been is in the hospital after ECT," she said.

Three patients, each with a different kind of depressive disorder, with one thing in common: There's a treatment to help



each one.

That's true of almost all depressive patients.

"Depression is a medical illness that is now highly treatable," said Dr. Robert M. Post of the National Institute of Mental Health.

The problem is getting that treatment to the people who need it, something that doesn't happen often enough.

"The data show that only about a third of severely depressed patients get any sort of treatment," said Dr. Donald Klein of the New York Psychiatric Institute. "What most of them get is inadequate."

Patients don't recognize the condition. Doctors often miss the diagnosis, treating the symptoms patients complain about — insomnia and headaches, for example — rather than underlying causes. Society puts a stigma not only on mental illness but also on visiting a psychiatrist.

Any alert doctor can diagnose depression, Klein says, but it takes time — time spent talking to the patient. The doctor has to recognize the symptoms of depression and rule out possible physical causes such as thyroid deficiency.

"The three major signs are interest, energy and pleasure," Klein said. "If patients have lost interest in everything, have no energy and feel no pleasure, the odds that they are depressed are very high."

Klein is a leading proponent of drug therapy. His new book, *Do You Have a Depressive Illness?* ($7.95, NAL), written with Dr. Paul Wender, says, "Medication should be the primary treatment of depressive illness. Psychotherapy often serves only to maintain the patient's morale until medication can work."

They point to well-established statistics showing that better than 80 percent of patients with depression get better with drug treatment. Colleagues don't argue with the effectiveness of anti-depressant drugs, especially for severe depression, but say there's a large role for psychotherapy, too.

But the essential message is that almost everyone can be helped.

There's a basic consensus about drug therapy for depression, Post said: "We've got a series of very highly effective treatments, just as for heart arrhythmias or hypertension. If one doesn't work, another will."

Treatment for depression usually starts with a tricyclic anti-depressant drug (so called because of its molecular structure), Post said.

If the patient doesn't improve in four to six weeks, a different tricyclic can be tried. If that doesn't work, the next step is use of a monoamine oxidase (MAO) inhibitor, a different kind of anti-depressant drug that gets its name from its effect on a specific brain chemical.

For the minority of patients who aren't helped, the next step would be to add thyroid hormone or lithium to the anti-depressant drug. That is effective in about half of all cases, said Post. For those who still don't respond, the doctor can try a variety of drugs, including anti-convulsants, which normally are prescribed for epilepsy.

For manic-depression, lithium is the mainstay, but anti-convulsants also can help, Post says.

Ideally, he says, drug treatment should be accompanied by psychotherapy, weekly sessions at which the therapist helps the patient deal with the symptoms and stresses of the disease.

Somewhere toward the end of the road is ECT, which can help many of those patients for whom all else fails.

Scheff remembers her ECT treatments as providing some of her more endurable times in her long experience with depression.

"The only unpleasant thing is having the IV (intravenous tube) put into your arm," she said. "I would go to sleep, wake up and it would be all over. ECT did a lot of good for me."

But she noticed a memory loss after her last series of ECT treatments.

"Up to the last four treatments, I didn't lose any memory except the day of the treatment," she said. "Then I lost a lot — first everything, then a big block came back. It's scary, but not more scary than the illness itself."

Gassman says she was helped by ECT but wouldn't have it again because of the memory loss.

"Never, never, never," she said. "It was a horror. I visited my son at summer camp and couldn't remember a thing about it. I couldn't even drive around the neighborhood because I couldn't remember the streets."

Even ECT's proponents acknowledge they don't know how it works. But they point out there's the same uncertainty about anti-depressant drugs and other treatments for depression.

There's a consensus that the drugs and ECT produce their effects by altering brain chemistry, but the exact mode of action isn't known. It's in brain biochemistry that most psychiatrists now look for explanations of mental illness, and where they think there's real hope for ultimate answers.

THURSDAY: Trying to find the cause.

Houston Chronicle, December 28, 1988

ECT Timed With Disturbing Thoughts

International Medical News Service

BANFF, Alta. — A way of administering electroconvulsive therapy so that the shock reaches a fully conscious patient at the same time his most disturbing thoughts are present in the "mind's eye" has produced dramatic improvement in some previously hopeless cases, Dr. Richard D. Rubin said at the silver anniversary meeting of the Canadian Psychiatric Association.

His modified technique has been used on 28 volunteer patients, including seven who had earlier received five or more routine ECT treatments without effect. After a single modified treatment, all improved dramatically for periods of 3 months to 10 years. One relapsed after 9 months but recovered after another single treatment, said Dr. Rubin, of Trenton, N.J.

In practice, the procedure is not unlike the routine one. A basic difference with the new method, however, is that the patient is not anesthetized but left purposefully conscious, and he is told to actively think about his most disturbing feelings and imagery. Only when this thought activity is evident, and within seconds of its appearance, is the ECT administered.

Dr. Rubin

Dr. Rubin described the use of the method in two patients:

"One case was that of a fireman whose particular hallucination was that he talked to Jesus Christ. I sat by his bed for 3 hours, waiting for this to occur, while he remained wired up throughout this time, a syringe of succinylcholine inserted in a vein, and my finger resting near the button.

"When his hallucination finally occurred, the 40 mg of succinylcholine was injected to prevent risk of fracture and, at the very instant fasciculation was observed, the ECT was administered."

Patients who are not hallucinatory but have obsessions and compulsions are instructed to act them out.

"In one such case, a female patient was given a rubber knife and told to use it on her enemies. While she was stabbing the air in a frenzy the shock was administered," Dr. Rubin said.

The development of the technique was based on the hypothesis that the most important determinant of success in ECT is what the patient has "in mind" at the time of the treatment.

His theory has stemmed from earlier studies in animals of the effects of ECT on conditioning and memory. The results of such studies showed that the retrograde amnesia produced by ECT had its greatest effects on memories with which it was contiguous. That is, the amnesia for a memory event occurred if the shock was given immediately following it; amnesia did not occur when 24 hours elapsed between the event and the shock.

Further, and particularly significant, the age of the particular memory ablated by the ECT was not a crucial factor. Rather, it was the degree of contemporaneousness of the memory, Dr. Rubin said.

If the memory was active at the time of the ECT it would be inhibited, whether it was an old retrieved memory or a newly acquired one.

Dr. Rubin's current "model" of ECT action in humans considers that "attention" is the effective selector of the contents of consciousness, and that these contents are the "active memory" event that is to be disrupted by ECT.

"Since these active memories have their neural correlates, when you suggest imagery for the person's attention it necessarily activates the neural correlates of that imagery," he said.

Thus, when the main psychopathologic imagery is suggested to the patient for his attention, the neural correlates of that imagery are "selected," and if ECT is given at the same instant then these correlates are disrupted. Retrograde amnesia ablates that particular imagery and the patient thus "forgets" his symptoms.

Dr. Rubin acknowledges that "the model is oversimplified, as most theoretical models are;" however, he believes such models have been useful in early stages of investigation.

In the light of this model, it is understandable why contradictory results have often been obtained from the routine method of ECT, and why it has been beneficial in some conditions and not in others, Dr. Rubin said.

Remedy for Depression

For example, symptoms treated by ECT can be divided into two broad categories: intermittent states and steady states. Intermittent ones, such as hallucinations, delusions, and compulsions may escape the effects of routine ECT because they are already protected in the inactive memory state, by anesthesia or by "attention" being linked to environmental and irrelevant stimuli.

Conversely, routine ECT is a tried and true remedy for depression because the symptoms are primarily in a steady state, he said.

"Predictably, acute schizophrenics also respond well to routine ECT because during the series of treatments the pathological neural correlates are bound to be affected sooner or later."

Using the modified method will increase the probability of successful treatment and reduce the number of treatments necessary for any one patient. It will also increase the number of patients who can benefit from ECT and possibly have application to parapsychiatric conditions, such as habitual criminality and drug addiction, Dr. Rubin said.

(Continued on page 23)

F16 : E27 : Memory 1055

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NEW YORK POST

SPORTS EXTRA

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BESS MESS TRIAL

'MY MIND'S LIKE SWISS CHEESE'

Sukhreet tells of electroshocks

New York Post: Robert Kalfus

PAGE 4

SAN FRANCISCO CHRONICLE 10/18/88

Divorce-Fixing Case

Myerson's Lawyer Rips Into Testimony

Washington Post

New York

When a grand jury began looking into her hiring by Bess Myerson, Sukhreet Gabel testified yesterday, the former beauty queen showed up at her apartment and declared: "You've got to keep your mouth shut. Don't you know you could be dangerous?"

During an hour-long, nighttime walk around the Upper East Side, Gabel said, Myerson told her: "The trouble with you is that you remember too much. You have to learn to forget more. I've forgotten more than you have ever known."

No sooner had Gabel completed that account than the case took a dramatic turn, as Myerson's defense lawyer began a cross-examination that led the witness into a thicket of contradictions and may have seriously damaged her credibility as the prosecution's star witness.

In a particularly devastating moment, attorney Frederick Hafetz read from a 1987 deposition in which Gabel had interrupted herself and said: "Oh dear, am I making this up? I'm not certain. . . . "

Repeatedly mentioning the electroshock treatments that Gabel has undergone for depression, Hafetz pressed the witness about another sworn statement in which she said her memory was "like Swiss cheese with holes in it."

By the time Hafetz finished shouting questions at the 39-year-old woman, the fabric of her testimony was considerably more tattered.

Fourth Day on Stand

These rapid-fire events unfolded during Gabel's fourth day on the stand in the divorce-fixing case. Myerson, the city's former cultural affairs chief; her boyfriend Carl (Andy) Capasso; and Gabel's mother, retired Judge Hortense Gabel, are charged with conspiring to fix Capasso's $15 million divorce in exchange for arranging a city job for Sukhreet Gabel as Myerson's special assistant.

Myerson, who faces up to 30 years in prison if convicted, is also charged with obstruction of justice based on the conversation Sukhreet Gabel recounted yesterday.

Kept Off Balance

In launching his cross-examination, Hafetz attempted to portray Gabel as a mentally unstable witness with a tendency to invent conversations. He kept Gabel off balance by underscoring conflicts between her trial testimony and her voluminous statements to reporters, prosecutors and the grand jury.

Gabel quickly waded into quicksand by misstating the date of her 1985 electroshock treatments, saying they occurred a year later, in the spring of 1986 or during the same period as her nighttime walk with Myerson.

"Are you telling the jury you don't remember those 15 . . . electro-shock . . . treatments . . . to . . . your . . . brain," Hafetz asked, drawing out each word.

Apparent Love of Limelight

Hafetz then opened fire on Gabel's apparent love of publicity, waving a gossip column from yesterday morning's New York Post.

The column quoted Sukhreet Gabel as saying she discussed the case with her mother over dinner Sunday night.

As Hafetz grew louder and the courtroom grew hushed, the witness said she did not recall speaking to the Post columnist on Sunday.

"You don't remember yesterday?" Hafetz asked in a mocking voice.

The attorney then read from 1986 grand jury testimony in which Gabel said, "I'm getting confused between knowing something and thinking something must have been." Gabel said she did not recall making that statement.

Gabel was confronted with a comment that she made when her mother was indicted last October.

"There's the thrill of having worked so hard to testify and to have something come of it," Gabel told the New York Daily News.