

Understanding Antidepressant Medications

What are antidepressants?

Antidepressants are prescription medications that change signaling in brain systems involved in mood, anxiety, sleep, and other functions. They are commonly used for major depressive disorder and some anxiety disorders; certain agents are also prescribed for obsessive-compulsive disorder, PTSD, chronic pain, or insomnia. They are not addictive in the way opioids or benzodiazepines can be, but stopping suddenly can cause withdrawal-like discontinuation symptoms.

What benefits can patients expect?

- Symptoms may improve gradually over 2–6 weeks; a full response can take 6–8 weeks or longer. Sleep, appetite, and anxiety may change sooner.
- Medication plus psychotherapy can be more effective than either alone for some patients, especially with more severe or recurrent depression.
- Finding a good fit may require dose adjustments or trying a different medication. A lack of benefit from one antidepressant does not mean all will fail.
- Once symptoms improve, treatment is often continued for at least 6–12 months; longer maintenance may be appropriate after recurrent or severe episodes.

Major medication families — how they differ

Class	Examples	Common considerations
SSRIs	Sertraline, escitalopram, fluoxetine, citalopram, paroxetine, fluvoxamine	Often first-line; nausea, sexual effects, sleep changes; sodium and bleeding concerns in older adults.
SNRIs	Venlafaxine, desvenlafaxine, duloxetine, levomilnacipran	May also help certain pain syndromes; sweating, nausea, blood-pressure changes.
Atypical / multimodal	Bupropion, mirtazapine, trazodone, vortioxetine, vilazodone	Different effects on sleep, appetite, sexual function and activation.
TCAs	Nortriptyline, amitriptyline, imipramine and others	Anticholinergic effects, orthostasis, conduction abnormalities; often avoided in frail older adults.
MAOIs	Phenelzine, tranylcypromine, isocarboxazid, selegiline patch	Important drug/food interactions; generally specialist-managed.
Newer / specialized	Esketamine nasal spray, dextromethorphan/bupropion, zuranolone	Indication-specific, additional monitoring or restrictions; not interchangeable with standard daily antidepressants.

Important: antidepressants are not interchangeable

Some are energizing; others are sedating. Some can worsen insomnia, raise blood pressure, affect heart rhythm, or interact with other medications. A prescriber chooses based on symptoms, other diagnoses, medication list, and prior response.

Medication Reference List

Informational list of antidepressant medications used in the United States (generic names; brand availability varies). Not every drug is appropriate for every patient, and some older products are rarely prescribed or may have limited availability.

Selective serotonin reuptake inhibitors (SSRIs)

Citalopram (Celexa) • Escitalopram (Lexapro) • Fluoxetine (Prozac) • Fluvoxamine (Luvox) • Paroxetine (Paxil, Pexeva) • Sertraline (Zoloft)

Serotonin–norepinephrine reuptake inhibitors (SNRIs)

Desvenlafaxine (Pristiq) • Duloxetine (Cymbalta, Drizalma Sprinkle) • Levomilnacipran (Fetzima) • Venlafaxine (Effexor XR)

Other antidepressants and multimodal agents

Bupropion (Wellbutrin formulations, Aplenzin, Forfivo XL) • Mirtazapine (Remeron) • Trazodone (generic; older brand Desyrel) • Nefazodone (generic; limited use) • Vilazodone (Viibryd) • Vortioxetine (Trintellix) • Dextromethorphan/bupropion (Auvelity)

Tricyclic and related antidepressants

Amitriptyline • Amoxapine • Clomipramine (Anafranil) • Desipramine (Norpramin) • Doxepin (Sinequan; low-dose Silenor is for insomnia) • Imipramine (Tofranil) • Maprotiline • Nortriptyline (Pamelor) • Protriptyline (Vivactil) • Trimipramine (Surmontil)

Monoamine oxidase inhibitors (MAOIs)

Isocarboxazid (Marplan) • Phenelzine (Nardil) • Tranylcypromine (Parnate) • Selegiline transdermal system (Emsam)

Specialized treatments

Esketamine nasal spray (Spravato): administered under supervision with required observation for eligible patients with treatment-resistant depression; indication and program requirements apply. Zuranolone (Zurzuvae): oral treatment specifically approved for postpartum depression, not general depression. Intravenous brexanolone (Zulresso) was approved for postpartum depression but commercial availability has changed; ask a specialist about current options.

Not included: antipsychotic augmentation medications, lithium, thyroid hormone, and other treatments sometimes used alongside antidepressants; these are not classified here as antidepressants.

Common side effects

- Nausea, diarrhea or constipation; headache; sweating; dizziness.
- Insomnia, vivid dreams, restlessness, or daytime sedation.
- Sexual dysfunction (especially SSRIs/SNRIs); weight or appetite changes (vary by medication).
- Temporary increased anxiety or agitation early in treatment.
- Discontinuation symptoms after missed doses or abrupt stopping, especially with shorter-acting drugs.

Safety, Monitoring & Older Adults

Important but less common risks

- Suicidal thoughts: FDA boxed warnings describe increased risk of suicidal thinking and behavior in children, adolescents and young adults, particularly early in treatment or after dose changes. Monitor all ages for new or worsening mood, agitation, or suicidal thoughts.
- Serotonin syndrome: potentially dangerous combination of fever, confusion, sweating, diarrhea, tremor, stiffness, and rapid heart rate; risk rises with interacting serotonergic medicines.
- Low sodium (hyponatremia): can cause confusion, weakness, falls or seizures, especially in older adults or people taking diuretics.
- Bleeding: SSRIs/SNRIs may increase bleeding risk, particularly with aspirin, NSAIDs, anticoagulants or antiplatelet medications.
- Mania/hypomania: antidepressants can trigger mood elevation in susceptible patients, particularly those with bipolar disorder.
- QT prolongation or heart rhythm concerns with certain drugs and doses; seizures with certain agents or risk factors; rare liver toxicity with nefazodone.

Special considerations in dementia

Depression and anxiety can coexist with dementia, but withdrawal, poor sleep, apathy, pain, delirium, medication effects, and unmet needs may look similar. Evaluation should consider these causes before adding a medication. Evidence that antidepressants improve depression in dementia is mixed, and side effects may outweigh benefits in some patients.

- Start with a clear target symptom and measurable goal; review benefit and adverse effects at follow-up.
- Monitor falls, gait, alertness, appetite, weight, bowel habits, sleep, sodium when indicated, and changes in confusion.
- Avoid high anticholinergic-burden medications when possible (notably paroxetine and many TCAs), because they can worsen cognition, constipation, urinary retention and falls.
- Trazodone or mirtazapine may be used for specific symptoms but are not risk-free: sedation and orthostatic hypotension can increase falls.
- Antidepressants are not established treatments for the core memory loss of Alzheimer's disease or a reliable solution for agitation in dementia. Nonmedication strategies remain essential.

Comparing antidepressants with other approaches

Approach	Potential strengths	Limitations
Psychotherapy / behavioral approaches	No medication adverse effects; teaches coping and problem-solving	Access and participation can be challenging; adaptations may be needed for cognitive impairment
Antidepressant medication	Can reduce depressive and anxiety symptoms; daily treatment	Delayed onset, drug interactions, adverse effects, variable response
ECT or other specialist treatments	May be appropriate for severe, psychotic, suicidal or treatment-resistant depression	Requires specialist evaluation; distinct risks, logistics and monitoring

When to call urgently

Seek emergency care for a seizure, severe confusion with fever or rigidity, fainting with concerning heart symptoms, severe allergic reaction, or immediate danger of self-harm. Call 911 for emergencies; call or text 988 in the U.S. for suicide or mental-health crisis support.

What to Expect & Questions to Ask

Starting a medication

- Before starting: review all prescriptions, over-the-counter medicines, supplements, alcohol use, prior manic episodes, falls, heart disease, kidney/liver disease, and any history of low sodium.
- First 1–2 weeks: mild side effects may occur before mood improves. Do not stop or change the dose without discussing the plan with the prescriber.
- Follow-up: assess symptoms, function, sleep, side effects and safety. Older adults may need more gradual dose changes and targeted laboratory or ECG monitoring.
- When stopping: tapering is often recommended to reduce discontinuation symptoms; timing depends on the medication and duration of use.

Questions for the prescribing clinician

- What symptom are we treating, and how will we know whether it is helping?
- Why this medication rather than another option or psychotherapy?
- Which side effects are most important given age, dementia, falls, heart disease, or other medicines?
- Do we need sodium testing, blood pressure checks, an ECG, or other monitoring?
- When should we expect improvement, and when will we reconsider the plan?
- What should we do if a dose is missed, symptoms worsen, or the medication needs to be stopped?

Family medication review worksheet

Medication / dose	Target symptom	Benefit noticed / side effects

Reliable educational resources

- National Institute of Mental Health (NIMH): Depression and mental health treatments — nimh.nih.gov
- MedlinePlus (National Library of Medicine): medication-specific patient information — medlineplus.gov/druginformation.html
- U.S. Food & Drug Administration: Medication Guides and prescribing safety information — fda.gov/drugs
- National Institute on Aging: Depression and older adults — nia.nih.gov
- Alzheimer's Association: dementia symptoms and caregiver guidance — alz.org | 800-272-3900
- 988 Suicide & Crisis Lifeline — call or text 988 | 988lifeline.org

This handout is educational and is not a substitute for individualized medical advice. Medication availability, labeling and indications can change. Never start, stop or alter prescribed treatment without guidance from the treating clinician.