



## TMS List — Trusted TMS Provider Directory

FREE RESOURCE — UPDATED 2026 EDITION

# TMS vs. Medication: Complete Comparison

*A side-by-side guide to help you understand the differences between Transcranial Magnetic Stimulation and antidepressant medications — so you can make an informed decision with your doctor.*

### TMS Therapy

Non-invasive brain stimulation. FDA-cleared for MDD & OCD. No medications, no anesthesia.

VS

### Antidepressants

Oral medications. First-line treatment for depression. 50+ FDA-approved options available.

### What This Guide Covers

- Side-by-side comparison of effectiveness, side effects, and costs
- Detailed breakdown of side effects — from mild to serious
- Which treatment to choose based on your specific situation
- How TMS and medication can work together
- What happens when one treatment doesn't work
- Real patient experiences with both approaches

**50–60%**

TMS RESPONSE RATE  
(TRD)

**40–55%**

MEDICATION  
RESPONSE

**70%+**

EXPERIENCE SIDE  
EFFECTS (MEDS)

**0%**

SYSTEMIC SIDE  
EFFECTS (TMS)

*"I was on an SSRI for 2 years that worked okay but killed my sex drive and made me gain 20 pounds. When I tried TMS, I was nervous it wouldn't work without medication. It did — and I got my life back in ways the medication never gave me."*

— Lisa R., Denver, CO (TMS patient, 2024)

*"TMS didn't work for me — I tried it twice and got no response either time. Medication is what actually helped. This guide would have helped me understand that TMS isn't guaranteed to work for everyone, and that's okay."*

— Kevin P., Minneapolis, MN (medication patient, 2025)

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# 1 Head-to-Head Comparison

Factor	TMS Therapy	Antidepressants
Primary Indication	Treatment-resistant MDD (failed meds) Primary Use	All depression severity levels First-Line
FDA Status	FDA-cleared for MDD, OCD, smoking cessation	FDA-approved for MDD + many other conditions
Treatment Duration	4–6 weeks (daily sessions), then treatment course ends	Ongoing — months to years, often indefinitely
Session Time	3–37 minutes per session (iTBS to standard) Fastest option	Zero — daily pill, under 5 seconds
Response Rate (TRD)	50–60% Higher for TRD	~30–40% on first med for TRD
Remission Rate	~30–35% full remission	~20–25% on monotherapy
Systemic Side Effects	None — localized to brain only Major Advantage	Common: nausea, weight gain, sexual dysfunction, insomnia, fatigue
Cognitive Effects	No impairment; may improve cognition Cognitive Benefit	Some SSRIs/SNRIs cause "brain fog" or emotional blunting
Drug Interactions	None — no systemic absorption No Interactions	Many interactions: MAOIs + SSRIs (dangerous), SSRIs + blood thinners
Withdrawal / Discontinuation	No withdrawal — stop anytime No Taper	Withdrawal possible (paroxetine, venlafaxine) — requires gradual taper
Daily Compliance Required	No — clinic-administered	Yes — depends entirely on patient taking the pill every day
Anesthesia Required	No — fully awake treatment No Anesthesia	N/A — oral medication
Insurance Coverage	Covered for TRD; prior auth typically required	Widely covered; generic medications often \$0 copay
Out-of-Pocket Cost	\$6K–\$12K self-pay (often \$0–\$500 with insurance)	\$10–\$50/month generics; \$200–\$500/month brand names
Can Be Combined?	Yes — TMS + medication is a valid strategy. TMS does not interfere with medications. Some patients use both simultaneously under psychiatrist supervision.	

## The Bottom Line on Effectiveness

For patients with treatment-resistant depression (2+ medication failures), TMS has a **higher response rate than switching to another medication** (50–60% vs 30–40%). For patients who haven't tried medication yet, antidepressants remain the appropriate first step. The two treatments work through different mechanisms — some patients respond to one but not the other, and some benefit from both together.

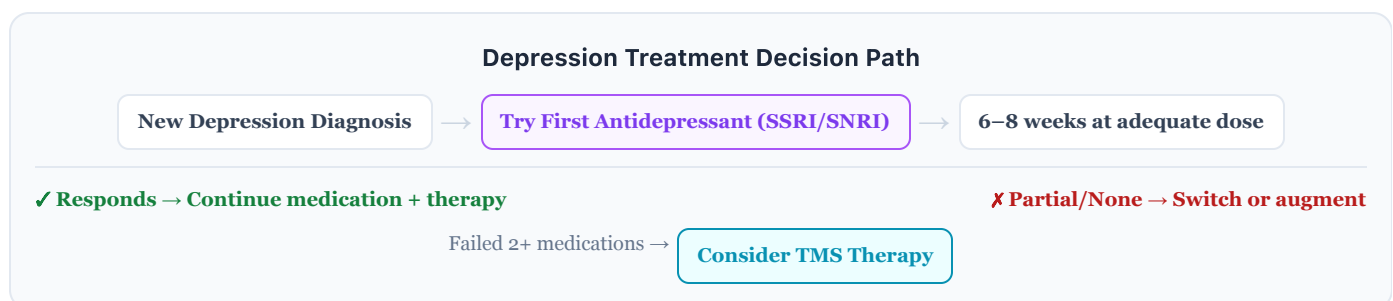
## 2 Side Effects: Detailed Comparison

How each treatment affects your body, mind, and daily life.

<b>Scalp Discomfort</b>	<p><b>~50% of patients</b></p> <p>Mild pain or tingling at coil site during treatment. Resolves within the first week for most patients. Respond well to ibuprofen or acetaminophen.</p>	<p><b>N/A</b></p> <p>No physical sensation from the head with oral medication.</p>
<b>Headache</b>	<p><b>~30% of patients</b></p> <p>Mild headache after session, fades within 30–60 minutes. Transient — improves with continued treatment.</p>	<p><b>~15–25%</b></p> <p>Common during medication initiation (weeks 1–2). Usually transient over 1–2 weeks.</p>
<b>Nausea</b>	<p><b>None</b></p> <p>TMS has no effect on the digestive system. No nausea reported.</p>	<p><b>~25–30%</b></p> <p>Common with SSRIs and SNRIs during first 2–4 weeks. Usually improves with food or time.</p>
<b>Weight Changes</b>	<p><b>None</b></p> <p>TMS has no direct effect on weight, metabolism, or appetite.</p>	<p><b>Common</b></p> <p>SSRIs (especially paroxetine): weight gain. Bupropion: weight neutral or loss. TCAs: significant weight gain.</p>
<b>Sexual Dysfunction</b>	<p><b>None</b></p> <p>TMS does not affect sexual function. May improve sexual desire if depression resolves.</p>	<p><b>~30–70%</b></p> <p>SSRI/SNRIs cause decreased libido, anorgasmia, delayed ejaculation. Leading cause of medication discontinuation.</p>
<b>Emotional Blunting</b>	<p><b>None</b></p> <p>TMS does not cause emotional blunting or flat affect.</p>	<p><b>~20–40%</b></p> <p>SSRI-induced emotional blunting ("feeling like a zombie") — common and a leading reason patients stop taking medication.</p>
<b>Sleep Changes</b>	<p><b>Minimal</b></p> <p>No direct effect on sleep. May improve sleep as depression improves.</p>	<p><b>Variable</b></p> <p>SSRIs can cause insomnia (fluoxetine) or sedation (paroxetine, trazodone). Can go either way.</p>
<b>Long-Term Brain</b>	<p><b>Positive neuroplasticity</b></p> <p>Repeated sessions may strengthen neural circuits involved in mood regulation.</p>	<p><b>Receptor adaptation</b></p> <p>Long-term use leads to receptor downregulation. Brain adjusts to chronic presence of medication.</p>

## 3 Which Should You Choose? Decision Framework

Use this framework to understand which option may be most appropriate for your situation.



**Choose TMS When:**

- You've tried 2+ antidepressants without adequate relief (treatment-resistant)
- You can't tolerate medication side effects (sexual dysfunction, weight gain, emotional blunting)
- You want a non-systemic, non-medication approach
- You've had positive response to TMS in the past
- You're preparing for or recovering from ECT and want to avoid it next time
- You want to avoid long-term medication dependence
- You're pregnant or planning pregnancy (medications carry different risks)

**Choose Medication When:**

- This is your first or second antidepressant trial
- You have mild-to-moderate depression without medication failures
- You prefer the convenience of a daily pill
- Cost is a major factor (generics are often \$0 with insurance)
- You're pregnant or breastfeeding (some SSRIs are considered relatively safe)
- You need a treatment you can take independently without clinic visits
- You have comorbid conditions that medication specifically addresses (e.g., anxiety, OCD)

**4****Medication Classes — What You're Taking**

Understanding the main classes of antidepressants helps you have better conversations with your doctor.

**Common Antidepressant Classes****SSRIs**

Escitalopram, Sertraline, Fluoxetine, Paroxetine, Citalopram

**SNRIs**

Venlafaxine, Duloxetine, Desvenlafaxine

**Atypical**

Bupropion, Mirtazapine, Trazodone

**TCA's**

Amitriptyline, Nortriptyline, Imipramine

**Bupropion + TMS: A Special Case**

**Bupropion (Wellbutrin) + TMS is safe and may be synergistic.** Bupropion works on dopamine and norepinephrine — a different mechanism than SSRIs/SNRIs. Some evidence suggests it may enhance TMS efficacy. Unlike SSRIs, bupropion does not lower seizure threshold in a way that conflicts with TMS. If one treatment failed you, the combination may be worth discussing with your psychiatrist.

**?****Frequently Asked Questions****Q: Does choosing TMS mean I'm "giving up" on medication?**

A: No. TMS is considered when medications haven't worked adequately — it's a next step, not a last resort. Many patients use both: TMS to achieve remission, then medication (or no medication) for maintenance. Think of it as expanding your toolkit, not replacing one treatment with another.

**Q: Can I switch from medication to TMS immediately?**

A: You don't need to stop medication to start TMS. In fact, most TMS clinical trials allowed patients to stay on their current medications. If you want to discontinue, work with your psychiatrist on a tapering plan — stopping certain medications (especially paroxetine, venlafaxine) suddenly can cause withdrawal symptoms.

**Q: I've tried many medications. Is TMS my last option?**

A: No — there are several options beyond TMS: ECT, ketamine/esketamine infusions, vagus nerve stimulation (VNS), and deep brain stimulation (DBS) for severe cases. TMS is actually one of the less invasive options. If TMS doesn't work, it doesn't mean you're out of options.

**Q: Does TMS work better than medication for everyone?**

A: No. TMS works for roughly half of patients. For some patients, medication remains more effective. The two treatments work through different mechanisms — some respond to one but not the other. The goal is to find the right treatment for you, which may take trying multiple approaches.

**Q: How do I know if my medication side effects are "bad enough" to try TMS?**

A: If side effects are affecting your quality of life, relationships, or ability to function — they're bad enough. Sexual dysfunction, emotional blunting, and severe weight gain are particularly cited reasons patients seek TMS. Have an honest conversation with your psychiatrist about what's tolerable vs. what's unsustainable.

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**Take the Candidacy Quiz**

2-minute assessment for TMS eligibility.

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## Glossary of Medication & TMS Terms

Key terms to understand when comparing TMS therapy to antidepressant medications.

### TMS-Specific Terms

**TMS** — Transcranial Magnetic Stimulation. Non-invasive brain stimulation using magnetic pulses to improve mood.

**rTMS** — Repetitive TMS. Standard protocol using repeated pulses at 10Hz (high-frequency) or 1Hz (low-frequency).

**iTBS** — Intermittent Theta Burst Stimulation. FDA-cleared 2018. 3-minute sessions equivalent to 20-minute standard TMS.

**Motor Threshold** — The magnetic dose calibration point. Measured once at the start of treatment to personalize intensity.

**DLPFC** — Dorsolateral Prefrontal Cortex. The brain target for TMS depression treatment, located above the left eyebrow.

**Neuroplasticity** — The brain's ability to form new neural pathways. TMS promotes neuroplasticity in mood-regulation circuits.

**Deep TMS** — TMS using H-coils (BrainsWay) that reach deeper brain structures. FDA-cleared for MDD and OCD.

**CPT 90868** — The billing code for TMS treatment delivery. Medicare reimbursement: ~\$100–\$140/session.

### Medication & Clinical Terms

**SSRI** — Selective Serotonin Reuptake Inhibitor. First-line antidepressants (Prozac/Zoloft/Lexapro/Celexa). Work by increasing serotonin levels.

**SNRI** — Serotonin-Norepinephrine Reuptake Inhibitor. Second-line (Effexor/Pristiq/Cymbalta). Affect both serotonin and norepinephrine.

**Atypical** — Antidepressants that don't fit other categories (Wellbutrin/Augmentor/Remeron). Different neurotransmitter targets.

**Augmentation** — Adding a second medication to boost the effect of an antidepressant. Common: adding Abilify or Wellbutrin to an SSRI.

**TRD** — Treatment-Resistant Depression. Failure to respond to 2+ adequate medication trials. The gateway criterion for TMS insurance.

**PHQ-9** — Patient Health Questionnaire-9. Standardized depression scale (0–27). Most insurers require score  $\geq 10$  for TMS.

**GAD-7** — Generalized Anxiety Disorder 7-item scale. Used alongside PHQ-9 to assess comorbid anxiety.

**Half-life** — Time for a drug's blood concentration to halve. Affects withdrawal risk when stopping (paroxetine/ Effexor: short half-life = worse withdrawal).

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## Which Treatment Is Right For Me?

Use this decision guide to have a focused conversation with your psychiatrist.

### TMS May Be Right For You If...

- You've tried 2+ antidepressants without adequate relief
- Medication side effects are unbearable (sexual, weight, fatigue)
- You want to avoid systemic medication effects
- You prefer a non-drug, targeted treatment approach
- You're able to attend daily clinic sessions for 4–6 weeks

### Key Questions to Ask Your Doctor

- "Based on my history, do I meet TMS criteria?"
- "What's the realistic response rate for someone like me?"
- "Should I continue medication during TMS?"
- "What's your recommendation and why?"

### Medication May Be Right If...

- You prefer a daily pill vs. daily clinic visits
- You respond well to your current medication
- You want to avoid daily travel to a clinic
- Your insurance has limited TMS coverage
- You're comfortable with ongoing medication use

### My Treatment Decision

- 
- TMS — next step: call \_\_\_\_\_
  - Medication adjustment — next step: \_\_\_\_\_

TMS vs Medication Guide — more at

[tmslist.com](https://tmslist.com)

## THE FREE RESOURCES LIBRARY

# Keep going — there's more where this came from.

This guide is one piece of a free library we publish for patients researching TMS and providers running TMS clinics. Every resource below is a full PDF — no fluff, no upsell.

## The Complete TMS Buyer's Guide

PATIENT

Everything to choose the right TMS provider.

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## Insurance Coverage Checklist

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A step-by-step walkthrough to get TMS covered.

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Reimbursement reference for billers and coders.

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