An Investigation of Primary Care Patients Receiving Extended Treatment With Selective Serotonin Reuptake Inhibitors

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Abstract

***Objective*: To determine the psychiatric characteristics of a sample of primary care patients receiving extended treatment with selective serotonin reuptake inhibitors (SSRIs) as well as to assess the appropriateness of extended treatment.**

***Study Design*: A prospective case series of patients (convenience sample) assessed with survey, psychological testing, interview, and medical record review.**

***Methods*: Participants (n = 39) were patients in a health maintenance organization primary care setting receiving treatment with SSRI-type antidepressants for 12 months or longer, with no psychiatric evaluation or treatment immediately before commencement of antidepressant therapy. Each participant completed measures of self-destructive behavior and personality disturbance, underwent a clinical psychiatric interview, and had their medical record reviewed to determine psychiatric diagnoses by the primary care physician at the initiation of antidepressant treatment.**

***Results*: On psychiatric interview, 64.1% of participants were diagnosed with major depression, the majority recurrent (46.2% of the entire sample); 46.2% with dysthymia; and 38.5% with panic disorder. Psychiatric morbidity in this sample was reflected by recurrent depressive episodes, long-standing depression, comorbid psychiatric diagnoses on interview (average of 1.8 diagnoses per participant), self-harm behaviors, and personality pathology. Seventy-seven percent of primary care diagnoses gleaned from medical records reflected depressive diagnoses. The approximate "match" rate for a depression-spectrum diagnosis between psychiatric interviewer and primary care physicians was 90%; however, on psychiatric interview, 16.7% of participants had bipolar disorder and 38.5% had panic disorder, which were not noted in the primary care medical record.**

***Conclusions*: Patients in primary care settings receiving extended treatment with SSRIs may have complex psychopathology for which long-term antidepressant treatment appears appropriate.**

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With the advent of the selective serotonin reuptake inhibitor (SSRI)-type antidepressants, primary care clinicians are able to treat a variety of psychiatric syndromes (eg, depression, panic disorder, and obsessive-compulsive disorder) with potentially fewer clinical complications and risks compared with the older tricyclic antidepressants. Because of these features, the use of SSRIs has dramatically increased among all clinicians, including those in primary care settings. However, one study indicates that, compared with patients in tertiary psychiatric settings, patients in primary care settings appear to have milder clinical symptoms.[1]

Among a subgroup of patients in primary care settings, SSRI treatment is extended (eg, longer than 12 months). Extended antidepressant treatment is indicated for several psychiatric disorders, including recurrent major depression and dysthymia (chronic depression), and may be appropriate in chronic panic disorder or generalized anxiety disorder, as well as premenstrual dysphoric disorder. The current study was undertaken to explore this particular subgroup of patients by examining their psychiatric attributes in an effort to: (1) characterize this subgroup; and (2) retrospectively assess whether extended antidepressant treatment appeared appropriate.

··· METHODS ···

The study candidates were health maintenance organization (HMO) patients receiving treatment with

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SSRIs for longer than 12 months. During the study period, each patient was consecutively recruited either by the family physician investigator when prescribing an SSRI refill or by a pharmacy staff member when filling a prescription for an SSRI (ie, sample of convenience). All patients had initially been prescribed the SSRI by a primary care physician, either 1 of 2 family physicians (1 male, 1 female) or 2 internists (both male) at the HMO site. After recruitment, all candidates were screened by the family physician investigator for exclusion criteria (age older than 55 years or psychiatric consultation at the initiation of, or during treatment with, the current SSRI; prior psychiatric intervention was not a criterion for exclusion). Because the study period lasted for several months, the current study group represents a subsample of all patients prescribed SSRIs in this HMO setting.

Of 73 candidates, 8 had received psychiatric treatment during the current course of SSRI treatment and were excluded; 8 others did not meet the selection criteria. Of the remaining 57 individuals, 56 agreed to participate (one dropped out after initially agreeing to participate, response rate, 98.2%). Of these 56 individuals, 4 failed research appointments and 13 could not subsequently be contacted. Ultimately, 39 individuals completed all measures. Each received $20 for participation.

The participants comprised 33 women and 6 men between the ages of 18 and 51 years (mean ± SD, 39.05 ± 8.12 years). The large majority were married (84.6%). All had completed high school. Twenty (51.3%) participants had attended some college or postsecondary school training, and an additional 9 (23.1%) had completed a bachelor's degree or greater.

On-site, participants completed the following: (1) a research booklet that contained a demographic inquiry and history of self-destructive behavior; (2) a psychiatric interview; and (3) the Millon Clinical Multiaxial Inventory-III (MCMI-III).[2] Self-destructive behavior was assessed using the Self-Harm Inventory,[3] a 22-item, yes/no, self-report questionnaire with the heading, "Self-Harm Inventory." This measure has been developed in populations younger than age 55 years. Each item in the questionnaire is preceded by the statement, "Have you ever intentionally, or on purpose, . . ." Response items include "overdosed on purpose, cut self on purpose," and "attempted suicide." The total score indicates the number of endorsed self-destructive behaviors.

The psychiatric interview consisted of both general Axis I assessment as well as a specific checklist for several disorders associated with extended treatment with antidepressants. Using criteria described by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (*DSM-IV*),[4] the checklist disorders included major depression (recurrent), bipolar disorder, dysthymia, panic disorder, generalized anxiety disorder, and premenstrual dysphoric disorder. For these specific diagnoses, the interviewer, a fourth-year resident in psychiatry, rated individual criteria as "present" or "absent," and diagnoses were assigned according to *DSM-IV* thresholds. The interviewer also explored participants' histories for chronic pain, chronic headaches, fibromyalgia, and chronic insomnia. Interviews ranged in length from 1 to 1.5 hours. The interviewer was blind to the psychiatric diagnoses made by the primary care physician.

Personality assessment was undertaken using the MCMI-III,[5] a 175-item, self-report inventory that generates 14 personality scales. This measure has undergone an extensive process of test development and validation.[5,6] Raw scores on each scale are transformed into base-rate (BR) scores to standardize interpretation across the 14 scales. Although a BR score of 75 or greater is commonly indicative of clinically significant levels of personality psychopathology, we used a more conservative approach of considering BR scores of 85 and above as indicative of notable personality pathology.

Finally, each participant's medical record was reviewed by the family physician investigator for the psychiatric diagnoses determined by the primary care physician (2 family physicians, 2 internists, all at 1 site) at the initiation of antidepressant treatment. These clinicians were not aware of the research endeavor at the time they diagnosed participants. The order of interviews and written materials was alternated with each participant. Each signed a consent form before participation.

··· RESULTS ···

All 39 participants completed self-report measures and the psychiatric interview. However, the medical records of only 35 participants could be located. Among the 39 participants, 19 (48.7%) were prescribed fluoxetine, 17 (43.6%) sertraline, and 3 (7.7%) paroxetine. Throughout the active treatment, each participant had been treated with the same SSRI. Duration of antidepressant treatment ranged from 12 to 96 months (mean ± SD, 36.10 ± 20.75 months). Psychiatric and primary care diagnoses are presented in Table 1.

Of the 30 patients who were given primary care diagnoses of "depression," (including depression and "anxiety attacks") "dysthymia," or "adjustment disorder with depressed mood," 19 (63.3%) were diagnosed on psychiatric interview as having had major depres-

sion, 16 (53.3%) dysthymia, and 5 (16.7%) bipolar disorder (some patients had more than one psychiatric diagnosis). Only three (10.0%) participants receiving a primary care diagnosis of depression did not receive a similar diagnosis from the interviewer (ie, 90% of primary care diagnoses of depression matched with a psychiatric diagnosis of depression). Of these three, none had a psychiatric diagnosis on psychiatric interview, although one indicated chronic pain and headaches.

Eighteen of 25 patients with major depression reported recurrent depression (46.2% of the entire sample). In examining the prevalence of recurrent depression or dysthymia—two psychiatric conditions clearly associated with extended antidepressant treatment—27 (69.2%) participants met criteria for either or both conditions. Indeed, 12 (30.8%) participants reported both major depression and dysthymia, a combination frequently referred to as "double depression." Of the five participants with bipolar disorder, the interviewer did not distinguish between types I and II.

Among the entire sample, the average number of psychiatric diagnoses per participant was 1.8. Specifically, 4 (10.3%) had no psychiatric diagnosis, 11 (28.2%) had one diagnosis, 14 (35.9%) had two diagnoses, 9 (23.1%) had three diagnoses, and 1 (2.6%) had four diagnoses. On psychiatric interview, several participants reported chronic pain (38.5%), chronic headaches (30.8%), fibromyalgia (5.1%), and chronic insomnia (17.9%).

Concerning the prevalence of self-destructive behaviors, endorsements for the entire sample (n = 39) ranged from 0 to 11 with a mean of 2.72 (±SD, 2.89). These endorsement profiles of participants' self-destructive behavior characterize the seriousness and extent of disturbance in the current sample (Table 2). Only 9 (23.1%) participants denied having engaged in any of the 22 listed forms of purposeful self-harm behavior. Among those who endorsed at least one self-destructive behavior (n = 30), the mean number of endorsed behaviors was 4.62 (±SD, 2.73). With regard to the more dramatic self-destructive behaviors—such as overdosing, cutting self, and/or attempting suicide—10 (25.6%) participants acknowledged one or more of these behaviors.

The proportion of respondents (n = 39) who scored 85 or above on each of the personality pathology scales (MCMI-III) is presented in Table 3. Exactly one-third of the sample did not receive any personality disorder diagnosis, exactly one-third received 1 personality disorder diagnosis, and the remaining one-third demonstrated significant elevations on 2 to 4 different personality pathology scales.

Only 13 (33.3%) participants reported having seen a mental health professional at any time in the past.

Table 1. Participant Diagnoses

	n (%)
Psychiatric Diagnoses (interview; n = 39)	
Major depression	25 (64.1)
Bipolar disorder	5 (12.8)
Dysthymia	18 (46.2)
Panic disorder	15 (38.5)
Generalized anxiety disorder	4 (10.3)
Premenstrual dysphoric disorder	1 (2.6)
Eating disorder	2 (5.1)
Primary Care Diagnoses (medical record review; n = 35)	
"Depression"	26 (66.7)
"Depression and anxiety attacks"	1 (2.6)
"Adjustment disorder with depressed mood"	2 (5.1)
"Dysthymia"	1 (2.6)
"Anxiety" and/or "panic attacks"	2 (5.1)
"Premenstrual syndrome"	1 (2.6)
No psychiatric diagnosis	2 (5.1)
Medical chart not available or missing	4 (10.3)

Table 2. Selected Self-Harm Behaviors Endorsed by Participants (n = 39)

Self-Harm Behavior	n (%)
Overdosed on purpose	6 (15.4)
Cut self on purpose	4 (10.3)
Banged head on purpose	3 (7.7)
Scratched self on purpose	3 (7.7)
Attempted suicide	9 (23.1)
Abused prescription medication	6 (15.4)
Abused alcohol	5 (12.8)
Driven recklessly on purpose	9 (23.1)
Been sexually promiscuous	17 (43.6)

··· DISCUSSION ···

In comparing diagnoses made by the psychiatric interviewer and the primary care physicians, there is fair consistency (90%) among depressive-spectrum disorders, although not specific depressive diagnoses. However, diagnoses entered into the medical record by the primary care physician do not appear to reflect this sample's psychiatric comorbidity, including the presence of a subgroup of patients with bipolar or panic disorders. This could have important treatment implications as SSRI therapy may precipitate manic episodes or be poorly tolerated by patients with panic disorder if initiated at standard doses rather than low doses. These data also indicate that a subgroup of depressed primary care patients have significant mental health morbidity as evidenced by self-destructive behaviors and comorbid Axis I and II psychiatric diagnoses. Despite the complex psychopathology of this sample, only one-third of the participants had been previously evaluated or treated by mental health professionals.

With regard to psychiatric diagnoses, this sample of patients demonstrated a high prevalence of both dysthymia (46.2%) and recurrent major depression (46.2%). Dysthymia, or chronic depression, is often characterized by significant morbidity as well as comorbidity.[7-9] Comorbidity can include other Axis I disorders, particularly major depression,[7] as well as personality disorder, especially among those with early-onset dysthymia (onset before 21 years of age).[10,11] This particular study group had both extensive dysthymia as well as personality pathology as measured by the MCMI-III. Dysthymia can be difficult to treat. Treatment outcomes tend to be less robust than in major depression[12,13] and are often tempered by comorbidity. Extended treatment with antidepressants is currently recommended for both dysthymia and recurrent major depression, and efficacy studies in dysthymia support the use of tricyclic antidepressants[14,15] as well as SSRIs.[16,17]

In examining the self-destructive profile of this sample, it is difficult to discern whether the endorsed behaviors reflect affective disorder or personality disorder. Chronic and multiple self-destructive behaviors are characteristic among patients with borderline personality.[18-20] However, it is genuinely difficult to attribute these behaviors to borderline personality, or any other Axis II disorder, without a clinical interview that focuses on personality pathology. The MCMI-III data do not strongly suggest the presence of borderline personality disorder among this particular sample. Therefore, at the very least, it is fair to conclude that many of these self-destructive behaviors could simply be a reflection of long-standing mood disturbance.

Table 3. Prevalence of Personality Pathology According to MCMI-III* Scores (n = 39)

MCMI-III Personality Scale	n (%)
Schizoid	4 (10.3)
Avoidant	7 (17.9)
Depressive	13 (33.3)
Dependent	8 (20.5)
Histrionic	2 (5.1)
Narcissistic	5 (12.8)
Antisocial	0 (0.0)
Aggressive (sadistic)	1 (2.6)
Compulsive	1 (2.6)
Passive-aggressive	1 (2.6)
Self-defeating	8 (20.5)
Schizotypal	0 (0.0)
Borderline	1 (2.6)
Paranoid	0 (0.0)

MCMI-III = Million Clinical Multiaxial Inventory-III.
*Base-rate scores of 85 or above.

With regard to the MCMI-III data, it is important to note that some of these pathological personality styles are not currently formal diagnoses according to *DSM-IV*. It is perhaps more appropriate to view the MCMI-III data as a reflection of overall personality disturbance in the sample, rather than to focus on the specific diagnoses offered by this measure. Viewed in this manner, the prevalence of personality disturbance is fairly impressive, particularly among at least one-third of the sample. Interestingly, among the personality pathologies in this sample with a prevalence of 10% or greater (Table 3), the common psychodynamic thread is "passivity." From the perspective of depression, this dynamic may be interpreted in a number of ways (eg, passive with regard to problem solving, passive in interpersonal relationships resulting in the perception of a lack of autonomy or personal control).

In interpreting the MCMI-III data, it should be emphasized that personality assess-

ment using self-report measures can have potential hazards.[21] These include the issues of construct validity (ie, is the targeted item really being measured?), reliability (eg, trait vs state influences), and the potential impact of comorbid psychiatric diagnoses such as depression (ie, do comorbid psychiatric phenomena affect the assessment of personality?). Therefore, the personality data should be interpreted with caution despite our conservative use of a BR of 85 instead of 75 on the MCMI-III.

This sample and its psychiatric complexity suggest that healthcare utilization might be higher compared with other types of patients with comparable medical morbidity. In terms of cost-effectiveness, whether these individuals are better managed in psychiatric settings or primary care settings remains unknown. However, longitudinal psychotropic medication prescription may be a marker for psychiatric complexity, which would facilitate this type of subsequent research.

There are a number of limitations with these data that warrant caution in generalizing to other samples. First, the sample size reflects the complexity of candidate solicitation and screening, as well as the scheduling of subsequent interviews. Therefore, it is unknown how this sample compares with other samples of primary care patients receiving extended treatment with SSRIs. Second, some patients may have continued with antidepressant treatment by request (ie, this sample may partially reflect patients who choose to remain on extended treatment), thus affecting the ability to generalize to other patients. Third, we do not know the relationship between these data and samples of patients who have been initially evaluated and treated by psychiatrists and then referred to primary care physicians for follow-up care. Fourth, several measures in this study do not constitute bona fide psychiatric diagnoses, including the assessment of self-destructive behavior and the MCMI-III personality profiles.

The current study has several strengths. First, to our knowledge, this is the first study that carefully examined a subpopulation of patients receiving extended treatment with SSRIs who were evaluated and treated by primary care physicians, not psychiatrists. Second, this study entailed a psychiatric interview, which is currently the most convincing format for psychiatric diagnosis, and the interview was administered by a fourth-year psychiatric resident. Third, this study included several general measures of psychiatric status, including the assessment of self-harm behavior as well as personality pathology. Although not diagnoses, these measures provide a genuine clinical impression of this sample. Finally, data collection included an inquiry of past mental health treatment, the results of which indicated that relatively few participants previously sought treatment with mental health professionals.

··· CONCLUSIONS ···

The diagnoses of the psychiatric interviewer and primary care physicians "matched" fairly well for depressive-spectrum disorders. These data suggest that patients in primary care settings who are prescribed extended treatment with antidepressants are characterized by: (1) psychiatric comorbidity, particularly dysthymia and recurrent major depression; (2) self-destructive behaviors; and (3) personality disturbance. Relatively few participants sought mental health treatment, which suggests that primary care physicians need to be alert to this potentially complex population when considering extended treatment with antidepressants (an appropriate intervention). Further research is needed to explore the healthcare utilization of patients receiving extended antidepressant treatment versus those not receiving such treatment.

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