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Short Communication

Depression Treatment Survey of Psychiatrists: Outcome and Side Effects

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Keywords

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- Sexual problems

Abstract

Objective: To explore psychiatrists' opinions on the effectiveness and side-effects of current pharmacological antidepressant treatments in Australia.

Method: A postal survey was sent to all consultant psychiatrists in Australia.

Results: A total of 412 psychiatrists replied. The mean remission rate for depression reported by the sample was 54%. Following a partial but inadequate response to an optimal dose of either a Selective Serotonin Reuptake Inhibitors (SSRI) or Selective Serotonin/Noradrenaline Reuptake Inhibitors (SNRI), 42% (n=172) of respondents reported they would wash out the initial antidepressant and then start another antidepressant, 26% (n=106) would cross- taper antidepressants and 14% (n=59) would add a second antidepressant. Sexual problems, withdrawals, weight gain, perspiration and emotional blunting were reported as significant side-effects.

Conclusion: The psychiatrists surveyed believed that depression in psychiatric practice had a guarded prognosis. Pharmacological agents commonly used for depression are perceived to have inadequate efficacy and a high side-effect burden. With regard to the effectiveness of treatment by family doctors, easier access to psychiatrists and psychologists, and better use of medication were suggested by psychiatrists as likely to improve outcomes for patients.

INTRODUCTION

Depression is associated with personal and family distress, increased utilisation of general medical services, reduced productivity, relationship difficulties, increased risk of dementia, and suicide. In a community follow up over approximately 20 years, only 50% of patients recovered fully from their first episode of depression and had no further episodes [1]. Thirty five percent (35%) had one or more recurrences of depression and 15% developed chronic depression.

While multiple Australian and international guidelines [2-5] exist suggesting various protocols to be followed in the treatment of depression in clinical practice, no reliable information was available describing the realities of clinical practice in Australia. A survey was designed to gain an insight into the current pharmacological treatment of depression by psychiatrists. The survey aimed to explore psychiatrists' perceptions about the effectiveness of current pharmacological treatments and their side-effect burden.

METHODS

A one-page survey was developed by one of the authors (DH) and mailed to 2636 consultant psychiatrists in Australia. The survey consisted of eleven multiple choice questions and one open question. The questions focused on gaining insight into psychiatrists perceptions of the efficacy and tolerability of antidepressant medication classes most commonly used in clinical practice in Australia, namely Selective Serotonin Reuptake Inhibitors (SSRIs), Selective Serotonin Noradrenaline Reuptake Inhibitors (SNRIs) and the relatively newly introduced medication agomelatine. Questions were also asked about personal preference in taking antidepressants in the event of a psychiatrist suffering depression, including the option of using agomelatine, and about improving the treatment of depression in general practice. Doctors were given the option of returning completed surveys via fax, email or mail. Responses were anonymous and no patient identifiable data was collected. As such, ethics approval was not obtained. To more easily express an overview of results, mean values of ranges of percentages were calculated. The mean values were calculated by a statistician by establishing the midpoint of the range [min + (max-min)/2], multiplying the midpoint by the number of psychiatrists, adding all the values together and dividing by the number of responses.

RESULTS

Four hundred and twelve (412) of 2636 (16%) psychiatrists replied to the survey. Of the respondents, seventy-five (18%) worked in public practice, 132 (32%) worked in both public and private practice, and 205 (50%) worked in private practice exclusively.

The perceived mean remission rates (defined as a return of patients to normal self) with current antidepressants was calculated as 54%. Almost 90% (n=367) of psychiatrists reported that fewer than 75% of their patients with depression achieved remission (Figure 1).

When asked specifically about the perceived efficacy of SSRI and SNRI treatments, 25% (n=104) of respondents reported an inadequate response to SSRI and/or SNRI treatment in 50-75% of patients. A further 39% (n=162) and 27% (n=113) of respondents reported an inadequate response in 30-50% and 10-30% of their patients respectively. The majority of respondents (68%; n=278) reported managing inadequate responses to an optimal dose of an SSRI and/or SNRI by switching antidepressant treatment, whilst only 14% (n=59) of respondents reported they would add a second antidepressant (Figure 2).

The most common SSRI and/or SNRI treatment related side effects observed by respondents were sexual side-effects followed by withdrawal symptoms, reported by respondents as occurring in an average of 42% and 33% of their patients respectively (Table 1). Weight gain, excessive perspiration and emotional blunting was reported as occurring in an average of 25%, 23% and 23% of patients treated with SSRI and/or SNRIs respectively.

A number of differences were identified between responses from public and private practitioners. Fewer psychiatrists (12%) working exclusively in public practice reported that 50% or more of their patients have had an inadequate response to treatment with an SSRI and/or SNRI, compared with approximately 25% of those working in private practice (part or full time). Psychiatrists working in public practice also reported fewer side-effects in general, compared with psychiatrists working in private practice. When asked which antidepressants were better tolerated by patients, 51% of private practice psychiatrists nominated the melatonergic antidepressant agomelatine, compared with only

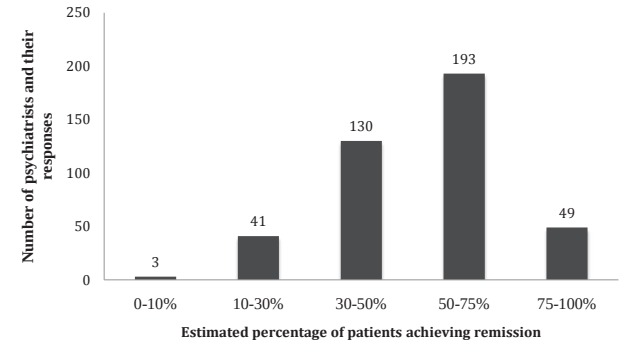

Figure 1 Percentage of patients respondents believed achieve remission with common antidepressants.

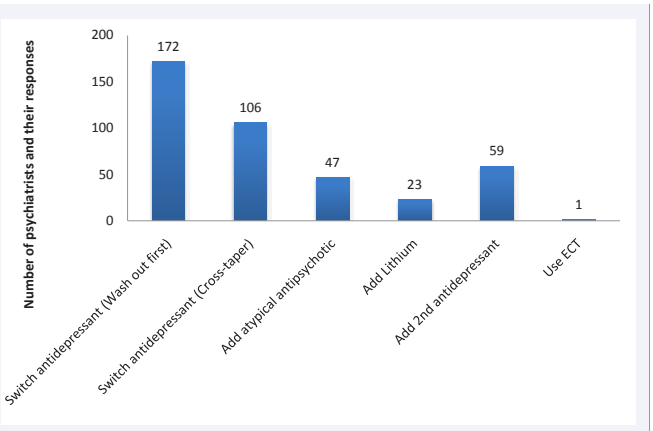

Figure 2 Management approach following partial response to SSRI and/or SNRI.

Table 1: Psychiatrists' responses when asked what percentage of their patients currently treated with SSRIs or SNRIs experience the following.

Results from treatment with SSRIs or SNRIs	Percentage*
Inadequate response rates (as judged by treating psychiatrist)	41%
Weight gain	25%
Sexual side-effects	42%
Excessive perspiration	23%
Emotional blunting	23%
Withdrawal symptoms	33%

*Psychiatrists were asked to rank responses using the following ranges; 0-10%, 10-30%, 30-50%, 50-75%, 75-100%. Mean percentages were calculated by establishing the midpoint of the range [min + (max-min)/2], multiplying the midpoint by the number of psychiatrists, adding all the values together and dividing by number of responses.

33% nominating SSRIs/SNRIs. In contrast, 78% of public practice psychiatrists nominated SSRIs/SNRIs, with only 13% nominating agomelatine. It is unclear why such differences exist. Reduced experience with agomelatine in the public setting as a result of budgetary considerations and pharmaceutical marketing approaches may have contributed to this difference.

When asked which treatment psychiatrists would try first if they themselves required medication for mild to moderate depression, respondents in private practice nominated escitalopram (26%) and agomelatine (20%) as their main treatments of choice. In contrast, those in public practice nominated escitalopram (25%), citalopram (15%), sertraline (12%) and agomelatine (9%). The preference for escitalopram in both private and pubic practice is noteworthy. Higher awareness of agomelatine and its side effect profile at the time of the survey may explain its popularity with psychiatrists in private practice.

Finally, psychiatrists receiving referrals from general practitioners were asked what they felt would improve the outcome for patients treated in general practice. Easier access to psychiatrists and psychologists, and better use of medication were the most common suggestions made (Table 2). There was also general agreement that new classes of antidepressants were

Table 2: What psychiatrists believe would help improve outcomes in the treatment of depression in general practice*.	
Easy access to psychiatrists and psychologists	66
Better use of medication	63
More time with patients, including appropriate Medicare subsidies	51
Increased diagnostic accuracy	51
Better education of general practitioners (GPs)	50
More focus on therapy as distinct from medication	43
The use of increased doses of medication	35
More focus on psychosocial factors	30
Better training in cognitive behavioural therapy (CBT)	19
* Not all respondents provided suggestions. Some respondents made more than one suggestion.	

required, with almost 90% (n=366) of psychiatrists responding that, if a new antidepressant were to become available, a new class of agent would be preferred.

DISCUSSION

Despite the risks of symptom recurrence and suicidal ideation associated with antidepressant washouts, this appears to be the most common approach taken by respondents when switching antidepressant treatment in patients that have achieved an inadequate response. Interestingly, adding a second antidepressant was uncommon, being reported by only 14% (n=59) of responding psychiatrists. These results are in contrast to a 2004 survey, which showed that 72% of consultant psychiatrists in Australia had used combination antidepressants at least once [6]. In the VIVALDI study in Europe, 26% of patients were treated with combination antidepressants [7]. The use of combination antidepressants remains controversial in Australia, not only among psychiatrists but particularly among general practitioners. This was discussed in an editorial in the official journal of the Royal Australian and New Zealand College of psychiatrists, which stated there are a number of antidepressants that, in theory, are safe to add to SSRIs/SNRIs, [8] including mirtazapine, reboxetine, agomelatine and bupropion. Interestingly, very few psychiatrists reported adding lithium or an atypical antipsychotic agent, despite literature support for such steps [9]. Pharmaceutical Benefits Scheme restrictions would have influenced such replies. Only one psychiatrist in this survey advocated the use of electroconvulsive therapy (ECT) in partially responsive patients.

The clinical reality of depression as a resistant illness, especially those cases referred to psychiatrists, has been observed in this survey, with mean remission rates calculated as only 54%. In the STAR*D trial in the United States, remission on a single SSRI was reported as 37%. The cumulative remission rate in those tried on four different levels of the trial was only 67% [10].

The rates of sexual problems and weight gain reported by respondents were in keeping with authoritative sources [11] and naturalistic studies [12]. Rates of emotional blunting were similarly in keeping with rates reported in other studies [13]. Of course, this symptom is complained about by a significant number of patients with depressive illness before medication treatment, making differentiation between the illness and treatment difficult, especially in patients with residual depressive symptoms.

There were a number of limitations with this survey that may have affected the results. Firstly, although a response of almost 16% is common for surveys of this type, the response rate is uncomfortably low. This may reflect a possible selection bias, as psychiatrists with the least or the most satisfaction with antidepressants may have been more likely to respond. Due to the anonymity of the survey, it was not possible to compare the attitudes of respondents and non-respondents. However there is no basis to suggest that the attitudes of non-respondents would have differed significantly to those of respondents. The clinical wisdom of over 400 psychiatrists is of undoubted value. Secondly, the survey questions asked psychiatrists to subjectively rank items like patient response, rates of remission and rates of side-effects. There is a risk of recall bias with this approach, as it is likely that respondents are more likely to recall poor or dramatic results as opposed to other outcomes. However, not only answers to surveys but many clinical choices also are made on the same impression basis presumably, which is what we hoped to clarify in this study. Finally, the role pharmaceutical marketing plays on recall and consequent responses, particularly for agents such as agomelatine, (which is only available as a non-subsidised prescription item in Australia), must be considered. In contrast, the strong preference for escitalopram (and citalopram) as their own antidepressant of choice by psychiatrists if depressed at a time when these medications were not being heavily marketed, may be seen as confirmation of clinicians responding on the basis of clinical experience, regardless of pharmaceutical marketing.

This survey does raise interesting questions about how psychiatrists choose an antidepressant. Proven efficacy, marketing and side-effects all play a role, but individual impressions must also be significant, as evidenced by the popularity of escitalopram. Which of these factors should be emphasised in ongoing education and/ or clinical practice guidelines is a complex question.

CONCLUSION

This survey indicates that psychiatrists perceive the effectiveness of current pharmacological agents for depression to be limited. More research into improving remission in depression is needed, given the known

health, economic and relationship burdens associated with residual depression. This survey also highlights the strong desire among psychiatrists for new antidepressant agents that do not have the high side-effect burden of traditional SSRIs or SNRIs.

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