The Use of Antidepressants in Alcohol-Dependent Veterans

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Background: Although some research reports suggest antidepressants may be an effective treatment for alcohol dependence, their clinical use has been controversial.

Method: By using comprehensive national administrative data from the Department of Veterans Affairs (VA) documenting psychiatric diagnoses and care under natural conditions in both mental health and non-mental health settings, the use of antidepressants was compared in alcoholic and non-alcoholic veterans. Data were collected from April 1, 2000, to Sept. 30, 2000.

Results: Overall, patients with alcohol dependence were significantly more likely to be prescribed antidepressants than individuals without alcoholism (38.9% vs. 31.2%), but multivariate analysis showed that this was attributable to the higher rate of comorbid psychiatric diagnoses in this group. After controlling for diagnosis and other potentially confounding factors, alcoholdependent individuals treated in specialty mental health clinics were in fact less likely to be prescribed antidepressants (odds ratio = 0.95, p < .0001). Of patients treated with antidepressants, those with alcohol dependence were more likely to be prescribed newer antidepressants (odds ratio = 1.22, p < .0001). Among patients treated in non-mental health clinics, there were no significant differences in rate of antidepressant use between alcohol-dependent and non-alcohol-dependent individuals with mental illness after controlling for other factors.

Conclusion: The principal finding is that a diagnosis of alcoholism, independent of other factors, is associated with a decreased likelihood of receiving antidepressant treatment in VA mental health clinics, suggesting that prescribers have not embraced reports of their efficacy in alcohol dependence. In fact, this may reflect a disinclination to use medications to treat alcoholism in specialty mental health clinics but not in non-mental health clinics.

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O ne important unresolved issue in the treatment of alcoholism is the role of pharmacotherapy with antidepressants. It has long been speculated that alcoholism may reflect underlying depression at either a subclinical level or a manifest level, the so-called "selfmedication hypothesis." This speculation has resulted in an interest in the potential role of antidepressant treatment in alcoholism. While several studies have suggested such treatment may be effective,^{1,2} others have had negative findings.^{3,4} Factors other than empirical research, such as the general negative perception of pharmacotherapy in the substance abuse treatment culture, may also influence the use of antidepressant medication treatment in alcoholism.

The use of antidepressants in the treatment of alcoholism, even with manifest depressive symptoms, has been a subject of debate for many years. Symptoms consistent with an underlying affective disorder are often indistinguishable from the negative affective symptoms associated with alcohol withdrawal syndrome, and affective symptoms often resolve with abstinence.⁵ However, recognition that comorbid alcoholism and depression is associated with a worse prognosis,⁶ including an elevated risk of suicide, suggests the potential need for early antidepressant treatment.^{7,8} Empirical evidence from clinical trials with several classes of antidepressants, including the tricyclic antidepressants (TCAs), the 5-hydroxytryptamine-2 antagonist nefazodone, and the selective serotonin reuptake inhibitors (SSRIs), has not yet resolved this debate. The TCAs have had both negative⁴ and positive⁹ results in treating depression in alcoholism and little success in decreasing alcohol consumption in manifestly depressed alcoholics. One study has shown nefazodone to be effective in treating depressive symptoms but not in decreasing alcohol consumption in this population.¹⁰ Studies with the SSRIs have been somewhat promising with some evidence that they may be effective in decreasing alcohol use as well as depressive symptoms.^{7,11,12} However, negative studies have been published as well.²

In individuals without a manifest depressive disorder, treatment with antidepressants has been hypothesized to (1) prevent subclinical depressive symptoms that lead to relapse and (2) reverse common underlying neurobiological abnormalities.¹³ Although the TCAs are sometimes dismissed as ineffective treatment for alcoholism, clinical

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trials with these medications have had both negative and positive results.¹⁴ Further, limitations in the methodology of the clinical trials (e.g., use of inadequate medication dosage) have precluded definitive evaluation of their effectiveness.¹⁴ Similarly, clinical trials with the SSRIs in non–dually diagnosed alcohol-dependent individuals have had both positive² and negative³ results. Recent literature suggests that some of the mixed results may be explained by an interaction between SSRIs and the sub-type of alcoholism.^{15,16}

Other factors may also play a role in the use of antidepressant medications in alcoholism. Historically, the treatment of alcoholism has occurred outside the bounds of traditional psychiatric or medical clinics in self-help groups such as Alcoholics Anonymous, which rejected psychiatric medications on philosophical grounds as unhelpful and even harmful. However, research and popular literature emphasizing the biological nature of alcoholism, along with other changes such as the integration of mental health and substance abuse services and the expansion of services for individuals with dual disorders, have led to changes in patient and clinician attitudes about the use of medications. It is not clear whether this historic and cultural context still affects the practice of prescribing antidepressants to these patients.^{17,18}

While many recent studies have demonstrated that treatments for which there is solid evidence are not used as often as they appear to be indicated, this study asks a different question: To what extent do practitioners employ treatment strategies for which evidence is conflicting or ambiguous? If these medications are widely prescribed, it could be taken as evidence that the strategy has an intuitive appeal to practitioners and perhaps that they have found it effective in their clinical experience. Alternatively, the failure to widely employ treatment strategies may be evidence that they are ineffective or that the cultural bias against the use of pharmacotherapy remains. We thus propose a novel approach to evaluating an incompletely studied pharmacotherapeutic strategydetermining how frequently prescribers elect to use pharmacotherapy in clinical practice.

This study analyzed comprehensive national administrative data from the Department of Veterans Affairs (VA) documenting the care delivered system-wide to patients with alcohol abuse or dependence with and without other psychiatric disorders under natural conditions. We especially focused on the use of antidepressants in alcoholic patients as compared with non–alcoholic psychiatric patients and used multiple regression analysis to control for other factors such as age, race, comorbid psychiatric diagnoses, and service use. Since individuals with these disorders are also treated in primary care clinics,¹⁹ we conducted all analyses both in patients treated in specialty mental health clinics and in patients treated exclusively in non–mental health clinics. Finally, within the group of patients treated with antidepressants, we also evaluated the frequency of use of newer antidepressants.

METHOD

Sample and Sources of Data

All outpatients diagnosed with a mental disorder during a 6-month interval from April 1, 2000, to September 30, 2000, were identified within the VA workload databases. Identification was accomplished using the outpatient encounter file, a national database of information concerning all outpatient services delivered in the VA. Only veterans who had at least 2 outpatient visits 60 days apart were included in the analysis (N = 719,730). A diagnosis of a mental disorder was operationally defined as having at least 1 outpatient encounter in a specialty mental health outpatient clinic or a diagnosis of a mental disorder in any clinic (corresponding to ICD codes 290.00-319.99, excluding 305.1). The group was subdivided into patients seen in a specialty mental health clinic and patients seen in a non-mental health clinic. Patients with alcoholism were defined as individuals who had at least 1 encounter with an alcohol-related diagnosis (ICD-9 codes 303.xx or 305.00).

Measures

Data on patient characteristics such as age, income, gender, ethnicity, receipt of VA compensation or pension, comorbid medical and psychiatric diagnoses, hospital utilization, and zip code of residence were also available from the VA workload databases. By using the zip code of residence and data from the American Hospital Association annual survey, the distances from the centrum of the patient's zip code to the nearest VA and non-VA hospitals were calculated. The patient treatment file, which includes discharge abstracts of all VA hospital care, was used to determine inpatient mental health utilization. Subjects were categorized into 3 groups: those with no inpatient utilization, those with 1-21 days (below the median) of inpatient utilization, and those with > 21 days of inpatient utilization (above the median). Data from the outpatient care file were used to quantify intensity of outpatient mental health service use (those with 1-4 visits and those with > 4 visits in a mental health clinic).

All patients prescribed an antidepressant during this 6-month window were identified using the VA drug benefit management database. These patients were then classified into 2 groups: (1) those who had a prescription for one of the newer antidepressants, defined as bupropion, mirtazapine, nefazodone, trazodone, or venlafaxine, or one of the SSRIs (citalopram, fluoxetine, sertraline, fluvoxamine) and (2) those who had exclusively been prescribed one of the older antidepressants, defined as any of the tricyclic antidepressants or monoamine oxidase inhibitors.

	Total Sample (N = 719,730)			Alcoholics (N = 106,827)			Nonalcoholics $(N = 612,903)$			χ^2/t	
Characteristic	Ν	%	Mean (SD)	Ν	%	Mean (SD)	Ν	%	Mean (SD)	(df = 1)	р
Age, mean, y			58.0 (13.7)			50.7 (9.9)			59.3 (13.9)	193.3	< .01
≤ 40	62,547	8.7		13,502	12.6		49,045	8.0		2,465.1	< .01
41-50	159,460	22.2		41,474	38.8		117,986	19.3		20,207.5	< .01
51-60	210,135	29.2		36,353	34.0		173,782	28.4		1,417.7	< .01
61–70	123,308	17.1		10,355	9.7		112,953	18.4		4,890.1	< .01
≥ 71	164,280	22.8		5,143	4.8		159,137	26.0		23,101.5	< .01
Female	45,343	6.3		3,280	3.1		42,044	6.9		2,213.8	< .01
African American	116,971	16.3		26,869	25.2		90,102	14.7		7,300.3	< .01
Hispanic	36,609	5.1		4,921	4.6		31,688	5.2		59.9	< .01
Mental health diagnosis											
Alcoholism	106,827	14.8									
Drug abuse	78,333	10.9		51,088	47.8		27,245	4.5		176,485.0	< .01
Major depression	132,538	18.4		26,792	25.1		105,746	17.3		3,709.0	< .01
Dysthymia	163,745	22.8		33,278	31.2		130,467	21.3		5,037.0	< .01
Anxiety disorder	99,994	13.9		16,641	15.6		83,353	13.6		297.5	< .01
Posttraumatic stress disorder	144,519	20.1		26,215	24.5		118,304	19.3		1,555.0	< .01
Schizophrenia	87,749	12.2		15,479	14.5		72,270	11.8		618.7	< .01
Organic brain syndrome	54,828	7.6		6,053	5.7		48,775	8.0		679.0	< .01
Personality disorder	30,275	4.2		11,428	10.7		18,847	3.1		13,117.8	< .01
Bipolar	53,798	7.5		13,685	12.8		40,113	6.5		5,164.0	< .01
Treated in specialty mental	546,059	75.9									
Received any antidepressant	232 772	323		41 564	38.0		101 208	31.2		2 471 7	< 01
Received newer antidepressant	177 797	24.7		35 487	33.2		142 310	23.2		4 890 8	< 01
Service use	177,777	24.7		55,407	55.2		142,510	23.2		4,070.0	< .01
Outpatient											
High	286 600	39.8		75 634	70.8		210.966	34.4		50 241 8	< 01
Low	259,000	36.1		23 425	21.9		236.034	38.5		10 851 2	< 01
Inpatient	257,757	50.1		23,723	21.)		230,034	50.5		10,001.2	< .01
High	27 601	38		13 644	12.8		13 957	23		27 169 6	< 01
Low	26.413	3.7		15,048	14.1		11,365	1.9		38,502,6	< .01

Table 1. Baseline Characteristics of Veterans in a Specialty Mental Health Clinic or With a Mental Health Diagnosis

Analysis

Analysis proceeded in several steps. First, chi-square tests were used to evaluate whether veterans with alcoholism had an increased likelihood of being prescribed antidepressants compared with other non-alcoholic patients and whether they differed from other veterans on characteristics that might influence medication prescription. Since the use of antidepressants is influenced by factors other than alcoholism, a series of logistic regressions was performed to evaluate the relationship of alcoholism to antidepressant use controlling for other potentially confounding factors such as age, race, psychiatric diagnosis, and service use (both inpatient and outpatient). Further analyses were conducted to evaluate the use of newer antidepressants versus older antidepressants among those prescribed any antidepressant. Data from patients seen in specialty mental health clinics were analyzed first. The analyses were then repeated for individuals with psychiatric diagnoses who were treated in non-mental health clinics.

RESULTS

A total of 719,730 VA patients were diagnosed with a mental disorder or treated in a specialty mental health

clinic and had at least 2 appointments 60 days apart from April 1, 2000, to Sept. 30, 2000. The sample was overwhelmingly male (93.7%), which is consistent with the characteristics of the veteran population. The mean age was 58.0 years (SD = 13.7) and the mean income was \$16,331.28 (SD = \$26,747.49). Sixty-four percent of the sample were white, 16.3% were African American, 5.1% were Hispanic, and 14.7% were identified as other or race unknown.

As shown in Table 1, 14.8% of the total sample were identified as having alcoholism and 52% were identified as having at least 1 clinical indication for antidepressant treatment; i.e., a diagnosis of major depression (18.4%), dysthymia (22.8%), anxiety disorder (13.9%), or post-traumatic stress disorder (PTSD) (20.1%). Other psychiatric diagnoses included schizophrenia (12.2%), drug abuse (10.9%), organic brain syndrome (7.6%), and personality disorder (4.2%). Patients had a mean of 1.3 (SD = 1.3) clinical psychiatric diagnoses, with a range of 0 to 11. Seventy-six percent were seen in specialty mental health clinics.

There were significant differences between the alcoholic and non-alcoholic patients in age (mean = 50.7 years vs. 59.3 years, respectively), and more specifically alcoholics were more likely to be under the age of 61

		Non-Mental Health Clinics										
	Any Antidepressants (N = 209,981)			New Antidepressants ^b $(N = 167, 125)$			Any Antidepressants $(N = 1237)$			New Antidepressants ^b (N = 736)		
	Adjusted Odds Ratio	$\begin{array}{c} \chi^2 \\ (df = 1) \end{array}$	р	Adjusted Odds Ratio	$\begin{array}{c} \chi^2 \\ (df = 1) \end{array}$	р	Adjusted Odds Ratio	$\begin{array}{c} \chi^2 \\ (df = 1) \end{array}$	р	Adjusted Odds Ratio	$\begin{array}{c} \chi^2 \\ (df = 1) \end{array}$	р
Predisposing factors												
Age, mean, y												
41-50	1.38	850.96	< .0001	0.90	23.15	< .0001	1.50	8.75	.0031	0.50	6.38	.0116
51-60	1.44	1,128.07	< .0001	0.95	5.76	.0164	1.72	16.68	<.0001	0.68	2.02	NS
61-70	1.14	104.68	< .0001	0.80	84.16	< .0001	1.37	5.16	.0231	0.77	0.89	NS
≥ 71	0.79	367.15	< .0001	0.78	103.48	<.0001	0.88	0.88	NS	0.48	6.94	.0084
African American	0.80	671.28	< .0001	0.87	73.62	< .0001	0.68	15.89	<.0001	0.72	2.85	NS
Hispanic	0.94	19.16	< .0001	0.96	3.16	NS	1.17	0.71	NS	0.90	0.10	NS
Alcoholism	0.95	27.96	< .0001	1.21	104.53	< .0001	0.84	2.88	NS	1.48	3.70	NS
Drug abuse	0.94	38.60	< .0001	0.97	2.44	NS	1.02	0.02	NS	0.63	2.77	NS
Major depression	2.14	11,931.55	< .0001	1.58	1,282.54	< .0001	1.78	18.29	<.0001	1.89	6.02	.0142
Dysthymia	1.90	9,438.19	< .0001	1.29	456.93	< .0001	1.49	14.63	.0001	1.76	7.68	.0056
Anxiety disorder	1.19	491.72	< .0001	0.86	126.22	< .0001	1.39	4.88	.0271	1.00	0.00	NS
Posttraumatic stress disorder	2.06	9,581.72	< .0001	1.69	1,388.29	< .0001	1.65	16.71	< .0001	2.44	13.51	.0002
Schizophrenia	0.73	1,128.08	< .0001	0.90	36.68	< .0001	0.86	0.90	NS	1.19	0.28	NS
Organic brain syndrome	1.12	108.67	< .0001	1.10	22.84	< .0001	0.89	1.21	NS	1.04	0.03	NS
Personality disorder	1.03	5.72	.0168	0.99	0.30	NS	1.11	0.24	NS	0.97	0.00	NS
Bipolar disorder	1.19	291.61	< .0001	1.46	326.37	<.0001	0.83	0.75	NS	1.84	1.54	NS
Service use												
Outpatient												
High	1.28	1,386.57	< .0001	1.52	1,145.02	<.0001						
Inpatient												
High	1.43	591.00	<.0001	2.18	532.53	<.0001	1.47	6.08	.0137	3.55	13.43	.0002
Low	1.24	208.05	<.0001	1.61	228.76	< .0001	1.46	6.96	.0083	2.41	9.71	.0018
aVA health convice u	so for the pe	at yoor										

Table 2. Logistic Regression Results of Veterans Treated in Specialty Mental Health Clinics or Non-Mental Health Clinics^a

^aVA health service use for the past year.

^bWithin the group of patients treated with any antidepressant.

Abbreviations: NS = not significant, VA = Department of Veterans Affairs.

years (see Table 1). Alcoholics were more likely to be African American (25.2% vs. 14.7%) but less likely to be Hispanic (4.6% vs. 5.2%). Alcoholics were also more likely to have comorbid anxiety disorder (15.6% vs. 13.6%), bipolar disorder (12.8% vs. 6.5%), drug abuse (47.8% vs. 4.5%), dysthymia (31.2% vs. 21.3%), major depression (25.1% vs. 17.3%), PTSD (24.5% vs. 19.3%), personality disorders (10.7% vs. 3.1%), or schizophrenia (14.5% vs. 11.8%) but were less likely to have organic brain syndrome (5.7% vs. 8.0%). They also were more likely to be high outpatient (70.8% vs. 34.4%) and inpatient (12.8% vs. 2.3%) users of mental health services.

On bivariate analysis, individuals with alcohol dependence treated in a VA clinic (N = 106,827) were more likely to be prescribed an antidepressant than those who were not alcoholics (N = 612,903) (38.9% vs. 31.2%; $\chi^2 = 2471.7$, df = 1, p < .0001). Alcoholic patients prescribed an antidepressant were also more likely to be prescribed a newer antidepressant (33.2% vs. 23.2%; $\chi^2 = 4890.8$, df = 1, p < .0001).

When we examined patients treated in a specialty mental health clinic (N = 546,059), alcoholic patients were more likely to be prescribed antidepressants than nonalcoholic patients (40.8% vs. 37.9%; $\chi^2 = 289$, df = 1, p < .0001) and more likely to be prescribed newer antidepressants (35.1% vs. 29.6%; $\chi^2 = 1176$, df = 1, p < .0001). In the group of patients treated exclusively in a nonmental health clinic, in contrast, there was no greater likelihood that alcoholic patients were treated with antidepressants than non-alcoholic patients (18.3% vs. 17.2%).

Results from the logistic regression of individuals treated in specialty mental health clinics show that after controlling for potentially confounding factors, especially comorbid indications for antidepressants, individuals with alcoholism were in fact significantly less likely to be prescribed any antidepressant (Table 2). Characteristics associated with prescription of antidepressants include, as expected, the clinical indications for these medications: major affective disorders, dysthymia, anxiety disorders, and PTSD. Less expected, those with personality disorders and organic brain syndrome were significantly more likely to be treated with antidepressants, while those with drug use and schizophrenia were less likely to be prescribed these medications. Veterans over the age of 71 and minorities, including both African Americans and Hispanics, were also significantly less likely to be prescribed antidepressants. Thus, the higher use of antidepressants in alcoholic veterans did not reflect enthusiasm for pharmacologic treatment of alcohol dependence but rather a higher prevalence of comorbid psychiatric disorders for which antidepressants are indicated.

Of those who received antidepressants, individuals with alcoholism were more likely to be prescribed the newer antidepressants even after other factors were controlled. Other characteristics predicting a higher likelihood of receiving newer antidepressants included the diagnosis of bipolar disorder, dysthymia, major depression, and organic brain syndrome. The use of newer antidepressants was less likely in individuals with schizophrenia and anxiety disorders. African American veterans were also less likely to be prescribed newer antidepressants.

Data from the logistic regression for veterans treated exclusively in non-mental health clinics are presented in Table 2. The diagnosis of alcoholism was not significantly associated either positively or negatively with the prescription of antidepressants in this group. As expected, individuals with major depression, dysthymia, anxiety disorder, and PTSD were more likely to be prescribed antidepressants but there were no other significant associations with other psychiatric diagnoses. As in the specialty mental health clinics, African Americans were less likely to be prescribed antidepressants but there was no significant association with being Hispanic. Individuals with major depression, dysthymia, and PTSD were more likely to be prescribed the newer antidepressants, but individuals between ages 41 and 50 years and over the age of 71 years were significantly less likely to be prescribed the newer antidepressants.

DISCUSSION

This study used administrative data to examine the rate of prescription of antidepressants in alcoholic veterans receiving care throughout the VA health care system. The principal finding is that a diagnosis of alcoholism independent of other factors leads to a decreased likelihood of receiving an antidepressant in specialty mental health clinics but not in non-mental health clinics. Although there was a higher rate of prescription of antidepressants in alcoholic veterans compared with non-alcoholic veterans on bivariate analysis, this was explained by the higher rate of comorbid psychiatric conditions for which antidepressants are clearly indicated in the group of alcoholic patients. These findings suggest that there is no tendency to favor antidepressant treatment of alcohol dependence and there may be some reluctance to use psychopharmacology in this population, particularly in specialty mental health clinics.

This reluctance may reflect a treatment culture that is suspicious of the use of pharmacotherapy since alcohol counselors still provide much of the direct treatment to alcoholic veterans in specialty mental health clinics,

while physicians and physician extenders provide the vast majority of treatment in non-mental health clinics.²⁰ Specialty mental health clinics also have strong ties to Alcoholics Anonymous since many substance abuse treatment programs include 12-step meetings in their clinics and actively encourage their patients to attend. Patients may themselves be active members of Alcoholics Anonymous, and as a result, may have been discouraged from taking these medications. A recent survey found that almost a third (29%) of Alcoholics Anonymous members had experienced some pressure to stop taking medications of any type.²¹ Other explanations for the reluctance to prescribe include the possibility that clinicians, especially those with less experience prescribing medications, may be more concerned about safety, since actively drinking patients may combine these medications with alcohol.

An alternative explanation for the difference in prescribing rates is a difference between the 2 clinics in access to a prescriber. While patients in specialty mental health clinics may be seen by alcohol counselors, all patients in VA specialty mental health clinics have a prescriber, usually a psychiatrist, overseeing their care. Nevertheless, a suspicion of medication may reflect the culture in the non-medical community and may not extend to the culture in the psychiatric community. Clinicianspecific data were not available for this study, so a direct comparison between psychiatrists and primary care physicians was not possible.

A second finding from this study is that when veterans with alcoholism are prescribed antidepressants, they are more likely to be prescribed one of the newer antidepressants. These medications have a better safety profile than the traditional antidepressants and may have better efficacy in this group of patients.²²

A third notable finding is that minority veterans, particularly African Americans, are less likely than white veterans to be prescribed either any antidepressant or newer antidepressants, in both specialty mental health and non-mental health clinics. There are several possible explanations for this finding. One possibility is that African Americans are less likely to have a psychiatric condition for which there is an indication for antidepressant treatment. However, since we controlled for comorbid depression and anxiety disorders in this study, this explanation is unlikely. Additional explanations may be either that these patients are reluctant to take medications or that clinicians are influenced by some unresolved racial attitudes. Unfortunately, data are not available to allow further explanation of these results.

A strength of this study is the use of information from a large administrative database to examine prescribing practices in a "real world" clinical setting. However, several methodological limitations deserve mention. First of all, in evaluating predictors of antidepressant use in the VA, the available data are limited to diagnostic, sociodemographic, and service use characteristics. Further, the measures used to determine clinical diagnoses were based on administratively reported diagnoses, not on validated structured interviews. Previous research has shown that there can be low agreement between independent evaluators using structured clinical interviews and clinical diagnoses with an underreporting by clinical staff.^{23,24} This factor (i.e., that there is low agreement between independent evaluators and clinical diagnoses and that diagnoses were not validated) is made more complicated by the fact that many patients had multiple psychiatric diagnoses in our study. Other factors that were not measured, such as medical diagnoses, may also influence the use of these medications. Finally, this study was based on a predominantly male VA sample and the results may not be generalizable to other clinical settings.

In spite of these limitations, this study has both methodological and clinical importance. Although other studies have used administrative databases to answer questions about "off label" pharmacotherapeutic interventions,²⁵ to our knowledge this is the first study to assess the utilization of antidepressants in alcohol-dependent individuals in a "real world" clinical setting. Further, it is the first study to raise the question of whether an "off label" pharmacotherapeutic intervention has been adopted even before its value has been definitively established in clinical trials. This study found that the diagnosis of alcohol dependence is not independently associated with an increased use of antidepressants and may actually reflect the opposite in specialty mental health clinics although not in nonmental health clinics. Clearly, definitive clinical trials are still needed to determine the efficacy of antidepressants in alcohol-dependent individuals. However, this study highlights the importance of tracking real world practice among clinicians who are responsible for the psychiatric care of alcoholic patients.

Drug names: bupropion (Wellbutrin and others), citalopram (Celexa), fluoxetine (Prozac and others), fluvoxamine (Luvox and others), mirtazapine (Remeron), nefazodone (Serzone), sertraline (Zoloft), trazodone (Desyrel and others), venlafaxine (Effexor).

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