

More antidepressants for African Americans with coronary heart disease? Maybe—maybe not

Waldman et al¹ reported that African Americans with coronary heart disease (CHD) are less often prescribed antidepressants compared to white patients with similar levels of depressive symptoms. They urged more careful assessment of African American patients to reduce this disparity. Ethnic disparities in health care are well documented, and depression needs to be adequately treated, irrespective of race or ethnicity.

Waldman et al¹ correctly suggested that physician practices may influence less antidepressant use among African Americans. They also suggested that patient stigma, low education, and access may be factors. Rather than simply an issue of mental health literacy or compliance, however, apprehensions of African Americans toward antidepressants may reflect a conscientious decision-making process.² Results from the 1998 General Social Survey confirmed that African Americans are less willing to use antidepressants, largely due to skepticism regarding antidepressant efficacy and beliefs about side effects, controlling for socioeconomic and educational status, religious involvement, medication knowledge, and physician trust.² Similarly, West Indian immigrants to Canada have explained their reluctance to use mental health services in part on a perceived overwillingness of physicians to rely on pharmaceutical interventions.³

The concerns of African American patients seem reasonable. Half of African American patients on antidepressants in Waldman et al¹ had BDI scores <10. A recent study demonstrated that selective publication of positive trials has substantially overestimated the efficacy of antidepressant medications.⁴ There are persistent and troublesome side effects of antidepressants, including sexual side effects, drowsiness, and weight gain, but more than half of patients are not told about potential side effects when therapy is initiated.⁵ A substantial number of patients in primary care settings discontinue depression treatment within 1 month of initiation, and as many as one half discontinue treatment within 3 months.⁶

On the basis of their findings, Waldman et al¹ argue for more careful depression assessment to improve care. We agree that better care is needed. There is no evidence,

however, that depression screening and antidepressant prescription outside the context of sophisticated, multi-faceted, collaborative care interventions would improve outcomes for CHD patients.⁶ More effective strategies are needed to better identify and assess specific problems faced by patients with CHD and to negotiate and mobilize interventions that are acceptable and useful to patients.

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