Patients’ Accounts of
Non-Acceptance and Non-Adherence to
Drug Treatment in Depression

A Scoping Review and Narrative Synthesis of Research Findings
on Patients’ Views on Antidepressants

by
Urzsula Pasterkiewicz

A thesis
presented to the University of Waterloo
in fulfilment or the
thesis requirements for the degree of
Master of Science
in
Health Studies and Gerontology

Waterloo, Ontario, Canada 2017

© Urzsula Pasterkiewicz 2017
AUTHOR’S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.
ABSTRACT

Major depressive disorder (MDD) is a disabling condition with a high frequency of recurrence and non-recovery, resulting in serious morbidity and mortality (Kessler & Bromet, 2013; Stotland, 2012; Alonso et al., 2013). Depressive patients are said to report persistent symptoms and long-term disability despite high primary care utilization and medicines, and this notion is challenging the efficacy of existing models of care (Stirling et al., 2001; Ambresin et al., 2015). Despite increased numbers of issued prescriptions, the prevalence of depression remains static (Ambresin et al. 2015; Baxter et al., 2014; Wittchen et al., 2011), or demonstrates progressive course (Mojtabai et al. 2016; Hidaka, 2012). This striking polarity of findings opens space for further research. Former studies designed to promote medications for the treatment of depression generated rather discouraging findings (Aikens et al., 2008; Kutcher et al. 2002; Brook et al. 2005; Pampallona et al., 2004; Katon et al., 2001). It seems imperative to undertake a careful analysis of reasons, for which the low effectiveness of treatment may result from its low utilization. A better understanding of individual views on antidepressants may help improve adherence as well as patient-centeredness in depression care and suggest innovative, more effective intervention strategies.

Purpose of the study: This review summarises patients’ accounts of experiences with drug therapy in depressive disorder. Perceptions of mood-stabilizing drugs have been explored with the aim to unravel negative treatment decisions. Individual and common beliefs that lead to refusal of antidepressant treatment as well as challenges experienced during initially accepted and initiated treatment have been identified and explained.
Methods: With the help of Arksey and O’Malley’s scoping review methodology as a guide, several databases were searched: MEDLINE through PubMed, Scopus, PsycNET and Google Scholar. In addition, bibliographies and references of relevant studies were searched online. As a result, 41 qualitative research papers remained the core of this work. Design triangulation was used to examine the consistency and reliability of qualitative data with 71 quantitative and mixed-methods studies. Concepts emerging from summarized findings are presented in a thematic analysis. The research was conducted in a manner that will allow this review to be replicable.

Findings: Utilization of antidepressants continues to raise concerns. Existing scholarly evidence concerning attitudes and people’s behavior in relation to mood-stabilizing drugs uncovered a rich spectrum of ethical, racial, cultural and emotional underpinnings of medical treatment. There were accounts of patients who both accepted and refused drug treatment in the process of acceptance or denial of their depressive condition. Pattern of ignorant or dismissive behaviors observed in health care professionals was the cause of major frustration.

Conclusions: depressive patients either fully refuse the medicines or they do not adhere to recommended treatment. The analysed studies provide evidence that adherence to antidepressants is a complex health behavior that is mediated by multiple factors based on patients’ cultural, religious and ethical beliefs. The most serious reasons for non-compliance are adverse side effects and frustration experienced due to lack of efficacy of drug treatment and absence of permanent cure after prolonged use of medications. A major concern is the quick diagnostic procedure based on patient’s self-report and the ease of prescribing antidepressants viewed by patients as unnecessary and harmful. Complains about lack of continuous medical support indicate an urgent need of revision of existing mental-health services and regulations.
I would like to thank all who made writing of this Thesis possible. First of all, I cannot appreciate enough the patience of both my Supervisors, Dr. John Mielke and Dr. Frank Arocha whose presence and availability to discuss my academic as well as personal issues, and their tireless effort to find solutions for all my problems, provided a great encouragement through the most difficult times. The wonderful support and constructive criticism of the two other Committee members, Dr. Veronique Boscart and Dr. Pamela Seeds were invaluable and put me in the right direction in my research. However, my new career and my overall accomplishment in Applied Health Sciences would have not been possible without Dr. Phil Bigelow. The Graduate Officer always found time to listen and to answer all my questions. From day one, he kept encouraging me to continue the journey and strive for excellence. I must also recognize the very special efforts of our wonderful Graduate Studies Coordinators Tracy Taves and Krista Nicol who always solve the most complicated administrative problems with understanding, patience and their unique professional charm.

I must admit that I very much appreciate the great support of my family members. A big thank you goes to my husband Ziggy, my son Konrad and my daughter Madzia for releasing me from my household and babysitting duties. I know, it was extremely stressful at times, but you have always been there for me, making sure that I am doing well and that my brain is free of worries, so I can fully commit myself to the endless reading and writing. Madzia, our weekend retreats in Ayr were absolutely the best time to relax! Piotr and Selam, you inspired me to write on the topic of depression. And finally, my dearest grandchildren Malinka and Joey, thank you so much for your wonderful understanding that Mimi needed to work over the entire summer and for your trust that it will soon be over so we can return to play.
# TABLE OF CONTENTS

AUTHOR’S DECLARATION ii

ABSTRACT iii

ACKNOWLEDGMENTS v

LIST OF TABLES x

LIST OF FIGURES xi

CHAPTER 1. INTRODUCTION 1

CHAPTER 2. BACKGROUND ON DEPRESSION? 5

2.1. What is Depression? 5

2.2. Depression Burden 11

2.2.1. Prevalence and Incidence 11

2.2.2. Economic Cost of Depression 13

2.2.3. Poor Life Performance in Individuals with Depressive Disorders 14

2.2.3.1. Education 15

2.2.3.2. Family Life 15

2.2.3.3. Work 16

2.2.4. Suicidal Ideation 16

2.3. Depression Management 17

2.3.1. Course of Depression and Phases of Treatment 19

CHAPTER 3. METHODOLOGY 21

3.1. Study Rationale 21

3.2. Aims and Scope of the Study 23
3.3. Design

3.4. Search Strategy

3.5. Study Selection

3.6. Data Extraction

3.7. Qualitative Synthesis

3.7.1. What is Thematic Synthesis/Analysis?

3.7.2. Framework Stages

3.8. Triangulation

CHAPTER 4. SUMMARY OF FINDINGS

4.1. Narrative Summary of Previous Reviews

4.2. Qualitative Studies Selected for Synthesis

4.3. Themes Emerging from Qualitative Studies Selected for Analysis

4.4. Beliefs, Views, and Behaviors

4.5. Triangulation of Synthesized Qualitative Data

CHAPTER 5. KNOWLEDGE SYNTHESIS

5.1. Perceived Reasons for Non-Acceptance of Antidepressants

5.2. People’s Identities Feel Affected and Questioned

5.3. Stigma, Blame, and Responsibility

5.4. Seeking and Accepting Help

5.5. Receiving/Obtaining Information about Medications

5.6. Initial Use of Antidepressants

5.7. Views of Antidepressants

5.8. Side Effects
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.9. Personal Control and Perceived Effectiveness of Treatment</td>
<td>99</td>
</tr>
<tr>
<td>5.10. Communication and Relationship Issues with Health Care Specialists</td>
<td>100</td>
</tr>
<tr>
<td>5.11. Timeline and Prediction of Recovery</td>
<td>101</td>
</tr>
<tr>
<td>5.12. Continuation of Treatment</td>
<td>102</td>
</tr>
<tr>
<td>5.13. Discontinuation of Treatment</td>
<td>102</td>
</tr>
<tr>
<td>5.14. Self-Reported Reasons for Nonadherence with Antidepressants</td>
<td>103</td>
</tr>
<tr>
<td>CHAPTER 6. DISCUSSION</td>
<td>105</td>
</tr>
<tr>
<td>CHAPTER 7. CONCLUSION</td>
<td>113</td>
</tr>
<tr>
<td>7.1. Strengths and Weaknesses</td>
<td>119</td>
</tr>
<tr>
<td>7.2. What this Study Adds</td>
<td>120</td>
</tr>
<tr>
<td>7.3. Implications for Further Studies</td>
<td>122</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>124</td>
</tr>
<tr>
<td>APPENDICES</td>
<td></td>
</tr>
<tr>
<td>APPENDIX A Search Strategy</td>
<td>201</td>
</tr>
<tr>
<td>APPENDIX B Description of Selected Studies</td>
<td>204</td>
</tr>
<tr>
<td>APPENDIX C Summary of Content of Selected Qualitative Papers</td>
<td>207</td>
</tr>
<tr>
<td>APPENDIX D Qualitative Narratives (Verbatim)</td>
<td>332</td>
</tr>
<tr>
<td>APPENDIX E Summary of Qualitative Studies Analysed in Previous Reviews</td>
<td>410</td>
</tr>
<tr>
<td>APPENDIX F Summary of Screened Studies</td>
<td>416</td>
</tr>
<tr>
<td>Table</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>Table 1</td>
<td>Process of exclusion in data extraction</td>
</tr>
<tr>
<td>Table 2</td>
<td>Chart of eleven existing review on similar topic</td>
</tr>
<tr>
<td>Table 3</td>
<td>Qualitative studies selected for synthesis</td>
</tr>
<tr>
<td>Table 4</td>
<td>Definitions of 1st, 2nd, and 3rd orders of construct</td>
</tr>
<tr>
<td>Table 5</td>
<td>Themes emerging from selected qualitative studies (excepts)</td>
</tr>
<tr>
<td>Table 6</td>
<td>Patients’ beliefs, rationale, and behavioral patterns</td>
</tr>
<tr>
<td>Table 7</td>
<td>Epidemiological and quantitative studies selected for triangulation</td>
</tr>
<tr>
<td>Table 8</td>
<td>Reported adverse effects of antidepressants</td>
</tr>
<tr>
<td>Table 9</td>
<td>Self-reported reasons for non-adherence</td>
</tr>
<tr>
<td>Table 10</td>
<td>Summary of factors that affect adherence to antidepressants</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

Figure 1. Phases of treatment in depression 20

Figure 2. Flow chart of inclusion procedure 36

Figure 3. Why don’t patients take their medicines? 52
Not the least of the reasons for studying illness meanings, therefore, is that such investigation can help the patient, the family, and also the practitioner: certainly, not every time, perhaps not even routinely, but often enough to make a significant difference” (Kleinman, 2004, p.10).
CHAPTER 1. INTRODUCTION

"[N]ot only are we well or ill, but also, we act or refuse to act, and we can choose to act one way rather than another. And thus we – women and men – must take responsibility for doing things or not doing them. It makes a difference, and we need to take note of that difference”

Amartya Sen, Development as Freedom, 2000, p.190

Few diseases are found to be as troublesome as depression (Sapolsky, video). The World Health Organization (WHO) predicts depression to become the leading cause of global disease burden in 2030 (http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_9-en.pdf). The large number of people suffering from depression contribute to the overall economic deficit by large health care expenditures and production losses. Concerning is not only the economic loss resulting from unemployment, low work performance, absenteeism and premature death, but first and foremost, it is the overall health and individual well-being which is put on risk. Generally, one in five people are believed to suffer from a depressive episode at some point in their lives (Kessler et al., 2009). Frequently misdiagnosed and in many instances undertreated, depressive condition often takes a chronic and recurrent course, leading to increased disability, premature mortality (Lepine & Briley, 2011), and contributes to the global economic burden. Symptoms of depression often show an episodic pattern and may resolve without medical treatment; but the majority of affected individuals experiences multiple episodes or residual symptoms, and some cases take a long-lasting course (Hollon et al., 2002). The severity of illness can differ from “mild disruptions of normal mood to disorders of psychotic intensity” (Hollon et al, 2002; Murray & Lopez, 1997). The burden of unipolar depression is intensified as a result of multiple relapses and the chronic character of the illness (Berwian et al. 2017). More than 50% of people
affected by one episode of depression are said to experience another one, and the majority of them will not be able to escape further episodes (American Psychiatric Association, 2000).

Medicines are found to demonstrate high efficiency in the maintenance of functional activity in depressive patients (McDonald et al., 2002). The intake of antidepressants is also believed to improve self-rated health and life satisfaction. Mood-stabilizers have proven utility not only in treating acute episodes of depression, but also in reducing the risk of relapse (Geddes et al. 2003; Kaymaz et al. 2008; Donovan et al. 2010), and preventing relapses presents as an essential component of treatment in depressive illness. Regretfully, lack of satisfying evidence about significant improvement challenges the belief in efficacy of recommended therapies. While the ultimate goal, such as symptomatic remission, is the only desired and acceptable treatment outcome (McIntyre & O’Donovan, 2004), only 30–40 % of individuals diagnosed with depression are estimated to be reaching full symptom relief after successful treatment with first-line antidepressants (Kessler et al, 2013; Bortolato et al, 2016). Many patients never reach premorbid levels of psychosocial functioning, such that a significant number of patients suffers from residual symptoms (Kessler et al, 2013; Bortolato et al, 2016).

The effort to understand why depressed patients have poor medical care outcomes despite available treatment options may help to determine the extent to which negative results in treatment might be linked to low adherence to treatment recommendations (DiMatteo et al. 2000). During the past 3 decades, patient noncompliance has been of concern in attempts to understand limitations in the process of medical care delivery (DiMatteo et al. 2000). The benefit of effective treatment is particularly important in primary care and the phenomenon of non-adherence is not exclusive to depression. Challenges to efficient utilization of effective
treatments in chronic illnesses have been brought to light by multiple studies (DiMatteo et al., 2000; Brown & Bussel, 2011; Gadkari & McHorney, 2012; Burra et al., 2007).

Patient preferences regarding treatment conditions, type of treatment, or relationship with the physician, are found to have a major influence on therapy outcomes (Winter and Barber, 2013; van Grieken et al. 2014). Controversies exist: some studies indicate higher levels of nonadherence among patients who explain their depression with interpersonal causes (Brown et al., 2001), while contradictory research demonstrates the best clinical outcomes in individuals who perceive their depressive symptoms in nonbiological terms (Sullivan et al., 2003). Also, the disorder itself is believed to be a frequent reason for refusal of medications and noncompliance to treatment (Marazziti et al., 2010).

Treatment guidelines for Major Depression state that it is imperative to collaborate with patients in decision making about therapy and attend to their concerns, preferences and choices (American Psychiatric Association (APA), 2010 in: van Grieken 2014). “With increasing numbers of effective self-administered treatments, the need is apparent for better understanding and management of nonadherence” (Mc. Donald et al, 2002). Gibson, Cartwright and Read (2014) summarized and examined existing research on treatment preferences and individual attitudes toward antidepressants. By constructing a patient centered perspective, they discovered a range of ambivalent feelings about medication use. Many individuals discontinue treatment rapidly (Olfson et al., 2006) or adhere partially (Hunot et al., 2007) because of the adverse effects; some relapse despite regular treatment while others do not relapse despite discontinuation. Also, it is scientifically proven that not all patients will respond to a particular antidepressant treatment with experiencing the same side effects (e.g. Rush et al., 2006). In addition, there are also suggestions that antidepressant treatment itself possibly provokes relapses
after discontinuation through perturbational effects on neuromodulatory systems (Andrews et al. 2011). Finally, patients need to learn how to assess a treatment effect appropriately; if not, they will use their own measures, e.g. may interpret depressive symptoms as side effects of the medication (Dowell & Hudson, 1997). Since treatment preferences result from treatment knowledge, research should further explore the role of educational strategies in motivating depressed patients to actively seek the most effective therapy and adhere to it (Dwight-Johnson et al., 2000). McDonald et al. (2002) imply that full benefits of medication treatment cannot be accurately assessed at current levels of adherence; therefore, more studies of innovative approaches are needed in order to assist patients to follow prescriptions. They also claim that existing methods of improving medication adherence in chronic diseases are “mostly complex, labor-intensive, and not predicably effective” (McDonald et al, 2002). In consideration of inconsistencies in research findings, this thesis sought to clarify the role of patient’s individual perception on use of mood-regulating prescription drugs. This review is a major task undertaken by a single person, leading to the discovery of relevant opinions, recorded verbatim or reflected upon by other scholars. The addition of quantitative data to the extensively analysed qualitative reports is believed to strengthen the results and create a greater understanding of the phenomenon. The review succeeded in identifying relatively large numbers of patients both accepting and refusing the antidepressant therapy and revealed mechanisms that support or hinder medication adherence. It may serve the purpose of identifying meaningful ways of educating the public about symptom detection and treatment motivation. Detecting ways to motivate people to be in charge of their own well-being and become more approving of potentially effective treatment options as well as enhance compliance, could lead to significant cost savings in public health care and improve general mental health condition.
CHAPTER 2. BACKGROUND ON DEPRESSION

2.1. What is Depression?

“There are few diseases out there that are as bad as depression. It is crippling. It is pervasive. It wipes out any capacity for joy, hope or pleasure. Cancer victims will often express gratitude for their disease. It woke them up, gave them a new perspective, helped them rebuild important relationships and get to the meaning of life. This is not depression. Depression destroys perspective, undermines relationships, and steals joy. Depression isn’t a disease that you are grateful for having”.

(Sapolski, video)

It is a commonly occurring, serious, recurrent disorder linked to diminished role functioning and quality of life, medical morbidity, and mortality (Spijker et al., 2004; Üstün et al., 2004). It is generally understood in terms of “a low”; and speaking of the emotional condition, people usually describe feelings of sadness, emptiness, and hopelessness. It is often associated with self-blame or self-deprecation; awareness of the future is impaired (Chapman and Gavrin, 1999). Women are said to more likely have major depression than men, and the average age for clinical depression to set in is 32 years old. Men are reluctant to admit to symptoms of depression, because these symptoms are not the culturally approved idioms for men.

The condition is said not to be a disease sensu stricto as its etiology and mechanisms have not yet been fully unraveled (Dantzer et al., 2011). It is perceived as a disparate and heterogeneous disorder with a varying and modifiable course, with an unpredictable response to treatment, and no explicit mechanism (Belmaker, 2008). Depression induces a far-reaching social and economic burden and negatively impacts people’s lives (Papakostas and Ionescu, 2015). Individuals tormented by depressive prodroms generally refer to experiencing dysphoria.
and anhedonia\(^1\) and a variety of emotional and behavioral symptoms including, but not limited to, deviant sleep pattern, poor appetite or overeating, feelings of worthlessness, and intrusive thoughts of death (www.ncbi.nlm.nih.gov). In addition, cognitive and executive dysfunctions are present in depression, along with fatigue, tiredness and somatic pain (Fava, 2003; Targum & Fava, 2011). The ICD-10 and DSM-5 diagnostic criteria link ‘reduced concentration and attention’ and ‘diminished ability to think’ with Major Depressive Disorder (MDD) (Bortolato et al., 2016). Inflammation is also an important etiologic factor, and thus a potential pharmacological target in depression treatment (Kaster et al., 2016).

Existing studies suggest that a poor prognosis in depression outcome could be linked with patient family history and personal traits, younger age of onset and disease characteristics (longer duration of depressive episodes), but also with the type of treatment and medical service characteristics (e.g., underdetection, undertreatment, limited treatment effectiveness) (van Grieken, 2014; Hölzel et al., 2011 and Cantrell et al., 2006). Researchers try to explore why depression continues to be overlooked or misdiagnosed, and, in frequent cases of comorbidity, simply not identified (McIntyre et al., 2005). In recent times, there have been hefty debates about the efficacy of antidepressants (Fountoulakis & Möller, 2011; Kirsch et al., 2008) and widespread concern about whether they are being overprescribed (Jureidini & Tonkin, 2006) or have harmful effects (Middleton & Moncrieff, 2011). Moreover, some studies openly question the efficacy of antidepressive drugs and compare them with placebo (Moncrieff & Kirsch, 2005; Moncrieff & Cohen, 2006).

---

\(^1\) dysphoria is general state of sadness that includes restlessness, lack of energy, anxiety, and vague irritation; anhedonia is markedly diminished interest and enjoyment in activities that were previously considered pleasurable (www.ncbi.nlm.nih.gov)
The International Classification of Diseases 10 (World Health Organization, 1992) characterizes depression by three core symptoms: “low mood, anhedonia and low energy levels. Other symptoms include reduced concentration and self-esteem, ideas of self-harm, disturbed sleep and diminished appetite, which must persist for 2-weeks minimum”. Variation in symptomatology distinguishes between mild, moderate and severe depression. In regards to management, antidepressants are recommended as first-line treatment for moderate and severe depression, whereas ‘watchful-waiting’, exercise and problem solving are recommended for mild depression (www.ncbi.nlm.nih.gov; Anderson et al. 2008). According to the DSM-5 criteria, “the diagnosis of major depressive disorder can be made in the presence of a distinct change of mood, characterized by sadness or irritability and accompanied by at least several psychophysiological changes, such as disturbances in sleep, appetite, or sexual desire; loss of the ability to experience pleasure in work or with friends; spells of crying; suicidal thoughts; and slowing of speech and action. These changes have to be noticeable for minimum of 2 weeks and interfere considerably with work and family relations” (APA 2013). For an appropriate diagnosis of a major depressive episode, patients need to demonstrate 5 of 9 symptoms during the same 2-week period. Of the following 9 symptoms, a diagnosis of MD must also include either the first or second symptom: 1) depressed mood; 2) loss of interest or pleasure (anhedonia); 3) significant weight loss or gain, or increase or decrease in appetite; 4) insomnia or hypersomnia; 5) psychomotor agitation or retardation; 6) fatigue or loss of energy; 7) feelings of worthlessness (Keller et al., 1998), diminished ability to think or concentrate, or indecisiveness, and 9) suicidal ideation. DSM-5 formulates it as “the presence of a distinct change of mood, characterized by sadness or irritability and accompanied by at least several psychophysiological changes, such as disturbances in sleep, appetite, or sexual desire; loss of the ability to experience pleasure in work
or with friends; spells of crying and suicidal thoughts” (DSM-5). Cognitive symptoms are an emerging clinical focus in patients with major depressive disorder (Bortolato et al., 2016). Deficits in executive function, memory, attention, and processing speed, as well as negative cognitive bias, can contribute to low mood symptoms and reduced occupational and social functioning (Bortolato et al. 2016). Both patient reports and objective measures demonstrate that cognitive symptoms are common in patients with depression. Cognitive dysfunction may be present even before the first depressive episode and may remain after mood symptoms have remitted (www.science.gov)

Depression ‘profoundly and fundamentally’ changes perception of, and interaction with, the environment and “pervasively impacts elementary and complex neurocognitive processes which play a role in these” (Roiser et al., 2012). Furthermore, the effect of depression on cognitive function determines daily function in the long term and also influences the degree to which patients are capable of psychotherapy and psychotherapeutic improvement (Roiser et al., 2012; Bortolato et al., 2016). Persistent cognitive dysfunction decreases coping capacities and influences therapeutic compliance and cooperation (Castaneda et al., 2008). Focus on cognitive symptoms in depression remained for a long time only secondary to mood symptoms, yet impairment of executive functions, varying from symptoms affecting basic neurocognition through concentration and memory problems and inability to control recurring negative thoughts, dysfunctional attitudes and maladaptive schemata, form an important part of depressive symptomatology (Marazziti et al., 2010). The ICD and DSM describe cognitive impairment during depression only in general, but there are studies that explore a wide spectrum of cognitive dysfunctions also during the acute phase of depression. Executive functions, verbal and visual short and long-term memory as well as psychomotor skills and attention, have been found to
negatively affect patients with depression in multiple studies (Hammar & Ardal, 2009; Marazziti et al., 2010; Roiser et al., 2012; Castaneda et al., 2008; Austin et al., 2001).

Despite a vibrant and ever-changing depression research (Beck & Alford, 2009), the illness is increasingly becoming the leading cause of disability worldwide, and it is an alarming fact that deserves focused clinical and research attention (Beck & Alford, 2009). The belief that “more human suffering has resulted from depression than from any other single disease affecting humankind” (Kline, 1964), challenges cohorts of specialists worldwide, inviting them to conduct more effective studies in order to find better answers regarding its phenomena.

Fava (2003) found that eight of ten people experiencing an initial episode of major depressive disorder will suffer at least one additional episode during their lifetime (i.e. a recurrent major depressive disorder). In some patients, the episodes may be separated by many symptom-free years of normal functioning (Fava, 2016). For others, the episodes become increasingly frequent (Panel, 1993), what appears to be the more prevalent, both in psychiatric and primary care settings (Fava 1999; Fava & Kendler 2000; Ormel et al., 1993).

Longer duration of episodes and a history of previous depressive episodes have been found to increase the vulnerability to psychosocial stressors (Kendler et al., 2000), when the self-concept changes, and cognitive skills and coping strategies become weaker (Coyne et al., 1998). While a number of patients may recover from depressive episodes, the majority become chronic (Keller et al., 1998). Partial remission between episodes, and not full recovery, appears to be most common and is associated with ‘residual disability’ (Fava, 1999). As a result, for most people, depression is a lifelong episodic disorder with multiple recurrences, averaging one episode in every 5-year period (Fava & Kendler, 2000) with adverse economic, interpersonal and medical consequences (e.g. work impairment, family dysfunction, co-morbidity) (Judd, 1997).
Major depressive disorder (MDD) represents the classic condition in the group of Depressive Disorders. It is characterized by discrete episodes of at least 2 weeks’ duration or longer, involving clear-cut changes in affect, cognition, and neurovegetative functions and inter-episode remissions. A diagnosis based on a single episode is possible, although the disorder is recurrent in the majority of cases. During a mild episode of MDD, a person feels persistent sadness and a diminished interest in previously enjoyable activities. Insomnia, fatigue, and trouble concentrating negatively influence their daily routine, but the individual still manages to function with some extra effort. A moderate episode in MDD brings constant sadness and anhedonia. The person experiences some difficulty in every day life and abnormal sleep pattern, has trouble concentrating, and sometimes thinks about harming himself (or herself). During a severe episode an individual feels overwhelmed with persistent sadness and functioning in daily life is impaired. The person sometimes loses touch with reality and wants to harm or kill himself (or herself).

Clinical studies show that a substantial proportion of people who seek treatment for major depression have a chronic-recurrent course of illness (Hardeveld et al., 2010; Torpey & Klein, 2008). Major Depressive Disorder appears as a highly heterogeneous category what leads to problems in classification and in specificity of treatment (Paris, 2014). A small percentage of patients with major depression demonstrate manic episodes consisting of hyperactivity, euphoria, and an increase in pleasure seeking (Belmaker & Agam, 2008).

The boundaries to the chronic variant of depression are redefined in DSM-5: a newly introduced category of ‘persistent depression’ combines chronic major depressive episodes and dysthymia into one category; the minimum required duration of symptoms in this new diagnosis is 2 years. Major depression lasting more than 2 years shifts into this new category and no longer
belongs to the category of major depression. A more chronic form of depression, persistent depressive disorder (dysthymia) occurs when the mood disturbance continues for at least 2 years in adults. Studies found that the majority of depressive patients suffer from a persistent condition rather than from an episodic illness (Klein & Santiago, 2003).

2.2. Depression Burden

2.2.1. Prevalence and Incidence

The World Health Organization’s global estimate for 2004 showed that major depression caused disability for 65.5 million people worldwide (World Health Organization. Global Burden of Disease Study: 2004 Updates. Geneva, Switzerland, World health Organization; 2008). The condition is chronic and its recurrent nature is receiving increasing attention (Fava et al., 2003; Judd, 1997). Beck (2009) stated that “[d]epression is second only to schizophrenia in first and second admissions to mental hospitals in the United States, and it has been estimated that the prevalence of depression outside of the hospitals is five times greater than that of schizophrenia”. The NIMH estimates report that in the United States, 16 million adults had at least one major depressive episode in 2012. That’s 6.9 percent of the population. According to the World Health Organization (WHO), 350 million people worldwide suffer from depression. It is a leading cause of disability. Depressive disorders are said to be highly prevalent in the United States (Olfson et al., 2002). Studies suggest that the 1-year prevalence of major depression in the adult population is between 5.0% and 10.3%. Cross-national epidemiologic research further suggests that major depression is common in Europe, Canada, New Zealand, and, to a lesser extent, Taiwan and Korea (Olfson et al., 2002). Depression is often chronic, recurrent, and responsible for a large number of suicide attempts (Burcusa & Iacono, 2007).
In Canada, the lifetime prevalence of Major Depressive Episode (MDE) is 12.2% as determined by the Canadian Community Health Survey, Mental Health and Wellbeing (CCHS 1.2) national survey conducted in 2002 (Patten, 2009). Similar values have been reported by a methodologically comparable European study (Patten, 2009). Higher past values had been reported in the US: 16–18% (Kessler et al., 1994). Lifetime prevalence estimates may substantially underestimate the true population values (Kessler et al., 1997). The lifetime incidence of depression in the United States is said to be more than 12% in men and 20% in women (Kessler et al., 2003). Epidemiological studies link gender, age, and marital status with depression and women are said to have a two-fold increased risk of major depression compared to men (Van de Velde et al., 2010), individuals who are separated or divorced have significantly higher rates of major depression than the currently married (Weissman et al., 1996). This evidence, however, mainly reflects studies conducted in highly developed countries. The limited data available from low-middle income countries suggest that the age pattern might either be non-monotonic or reversed compared to other countries, with depression increasing with age (Kessler et al., 2010). Within high-income countries, the ratio ranged from ≤30% in France, Germany, Italy, and the Netherlands to >40% in the US and Israel. Within low-middle income countries, the lowest ratios were in Colombia (46.7%) and South Africa (49.6%) and the highest (57–58%) in São Paulo, Shenzhen, and Ukraine. Consistent with these results, the 30-day prevalence estimate was somewhat lower in high income (1.8%) than low-middle income (2.6%) countries (Kessler et al., 2013).

A Canadian study by Remick (2002) confirms that mood disorders, and thus depression, are among the most common indispositions that bring patients to doctors. It is believed that almost 20% of adults will have a mood disorder requiring treatment during their lifetime, and
about 8% of adults will have a major depressive disorder during their lives (Murphy et al., 2000). The individual rate of depression prevalence in patients with physical disorders is about two- to three-fold higher than in the general population (6.6%) (Kessler et al., 2005). With respect to specific physical diseases, rates of depression vary according to methodological issues including the differential use of estimated time points and assessment scales (Kang et al., 2015). The individual rate of depression prevalence in patients with physical disorders is about two- to three-fold higher than in the general population (6.6%) (Kessler et al., 2005).

### 2.2.2. Economic Cost of Depression

In 2008, the direct costs (i.e., hospital care, physician care and drug expenditures) associated with mental illness were estimated at approximately $8 billion in Canada (Government of Canada). Indirect expenses associated with mental illness, including costs of disability claims, social and judicial expenditures, lost educational potential and lost or limited productivity at work due to absenteeism and presenteeism, are much higher than direct costs (Lim & Dewa, 2008; Sanderson et al., 2007). According to the WHO, "more working days are lost as a result of mental disorders than physical conditions" (WHO 1998). It has been suggested that workplace impairment may contribute to more than 60% of the MDD-related economic burden (Katon and Ciechanowski, 2002). Several studies attempted to estimate the annual salary-equivalent human capital value of overall lost work performance. These estimates were in the range $30.1 billion (Stewart et al., 2003) to $51.5 billion (Greenberg et al., 2003).

The economic cost of depression introduced through global statistics mainly refers to the economic burden on healthcare systems and society, but we cannot disregard the fact that it also pertains to patient well-being (Berto et al., 2000). Report issued by the Pharmaceutical Research and Manufacturers Association (PhRMA) where prevalence and cost of disease were compared
for several major chronic diseases, including Alzheimer’s, asthma, cancer, depression, osteoporosis, hypertension, schizophrenia, found depression to be one of the most serious diseases, ranked third by prevalence and sixth in terms of economic burden (Berto et al., 2000). Moreover, “in terms of the average cost per patient, depression imposes a societal burden that is larger than other chronic conditions such as hypertension, rheumatoid arthritis, asthma and osteoporosis” (Berto et al., 2000). Depressed individuals’ ability to fit into society is estimated to be worse than in patients with other chronic diseases (Kessler & Bromet, 2013).

It is important to consider patients’ perceptions on their quality of life: people who suffer from depression usually experience as much or even more limitations in multiple aspects of their daily functioning and well-being as is associated with most medical conditions (Berto et al., 2000; Martin et al., 2005). Individuals living with untreated mental illness face an increased risk of suffering from co-morbid chronic medical conditions (Colton & Manderscheid, 2006). Among the 20.7 million adults in the U.S. who experienced a substance use disorder, 8.4 million (40.7%) had a co-occurring mental illness (U.S. Department of Health and Human Services). Approximately 1 in 5 adults in the U.S., 43.7 million, or 18.6%, experience mental illness in a given year (National Institute of Mental Health). According to the World Health Organization (WHO, 2010), major depression carries the heaviest burden of disability among mental and behavioral disorders (US National Institute of Mental Health). Depressive illness is continuously defined as an under-recognized, underreported and undertreated condition (Koenig et al., 1997).

2.2.3. Poor Life Performance in Individuals with Depressive Disorders

Depression comes in different forms and shows an episodic pattern. Major depressive disorder, known for its severity, constrains the ability to work, study, and to enjoy once pleasurable activities (anhedonia). A deep, long-lasting sadness, anxiety, or emptiness are the
characteristic moods, as well as feelings of hopelessness, overwhelming pessimism, guilt and worthlessness; loss of interest in hobbies and sex, persistent fatigue, difficulty concentrating, remembering, or making decisions, changes in sleep pattern and appetite, suicidal ideation and chronic physical pain and discomfort, which do not respond to regular treatment such as headaches, digestive problems, etc. (Wrobel, 2007). Dysthymia is a chronic although less severe and less disabling, form of depression, but is also a condition that makes it difficult to enjoy life, function well, or feel good over the long-term. Individuals with dysthymic disorder may also experience major depressive episodes at some time in their lives (Wrobel, 2007). MDD was one of two- with the other being Bi-polar disorder (BPD)- mental disorders most often rated severely impairing in both developed and developing countries. None of physical disorders considered as severe conditions (cancer, diabetes, and heart disease) have impairment levels as high as those for MDD or BPD (Kessler and Bromet, 2013).

2.2.3.1 Education

Several studies show early-onset mental disorders associated with a high number of school drop-outs (Breslau et al., 2008). MDD is associated with a greater potential risk of failure to complete secondary education in developed countries; however, these adverse effects are believed to be weaker in lower-income countries (Kessler & Bromet, 2013).

2.2.3.2 Family Life

It has long been known that marital dissatisfaction and hostility are strongly related to depressive symptoms (Whisman 1999). “Considerable research documents that both perpetration of, and victimization by, physical violence in marital relationships are significantly associated with depression” (Stith et al., 2004). A growing body of research has more recently suggested
that spousal violence and child neglect/maltreatment might be consequences of pre-existing mental disorders (Kessler et al., 2001).

2.2.3.3 Work

A number of epidemiological surveys in the US have estimated the workplace costs of either MDE or MDD on absenteeism and low work performance (often referred to as presenteeism) (Lerner & Henke, 2008). Studies found that MDE and MDD significantly predicted overall lost work performance. Research analyses have also documented high-risk associations between unemployment rates and suicide (Jones, 1991). Although depression is known to be associated with unemployment, research on this association has emphasized the impact of job loss on depression rather than depression as a risk factor for job loss (Dooley et al., 1996). A recent analysis from the WMH surveys documented the latter association by showing that history of mental disorders as of the age of completing schooling predicted current (at the time of interview) unemployment and work disability (Kawakami et al., 2012).

2.2.4. Suicidal Ideation

Hollon et al. (2002) claim that depression is a leading cause of suicide. Suicidal ideation is said to occur frequently as one of the common symptoms of the disorder (Paykel & Priest, 1992). Major depressive episode is known as the most common current psychiatric diagnosis among suicide victims and attempters (56-87%), thus a successful acute and long-term treatment will drastically reduce the risk of suicidal ideation (Rihmer et al., 2012). People 65 years and older are found to be committing suicide at a higher rate than the national average (Senior Health). High risks of suicide have been found in men between age 20 and 30, over age 50 years and especially very old men and in women between age 40 and 60 with affective illness, poor impulse control, history of previous suicide attempt(s) (believed to be most relevant factor),
family history of suicidal ideation, positive family history of early-onset affective disorder, alcohol abuse, broken marital status (single, divorced or widowed) as well as sudden change in socioeconomic status (loss of job, financial problems, undesired retirement), and finally, lack of support (Blumenthal 1990; Appleby 1992; Nordstrom et al., 1995; Angst ,1999; Bostwick and Pankratz, 2000; Möller, 2003). There is no specific, acutely acting “anti-suicidal” medication known, but some clinicians successfully combine antidepressants with antipsychotics or benzodiazepines (Furukawa et al., 2001).

In recent decades, epidemiological studies have discovered a dual phenomenon: a reduction in the numbers of suicides and increased prescriptions of antidepressants. At the same time, an ongoing debate about antidepressants potentially increasing the risk of suicidal behaviour leads to differentiated findings: studies exist, which suggest that treatment with SSRIs and other antidepressant drug classes may increase the risk of suicidality (suicidal attempts) in some patients (Möller, 2006). This risk is said to be higher in the initial phase of treatment (Jick et al. 2004). Simon and colleagues (2006) showed that the risk of suicide is highest in the month preceding treatment with antidepressants. However, Khan et al. (2000) compared the incidence of suicide and suicide attempts with several of the “newer” antidepressants and placebo and did not find statistically significant differences.

### 2.3. Depression Management

“*When practice guidelines are followed, patient outcomes are quite good*”

*Goldman et al., 1999*

Research findings indicate that in 2012, depression was estimated to affect 350 million people (Marcus et al., 2012), and is predicted to be the second leading cause of disability worldwide by 2020 (second to ischemic heart disease) (Murray & Lopez, 1996). The demand for
reducing the burden of mental health has become a raising global concern (Marcus et al., 2012). World Health Assembly urged the WHO and its member states to take immediate actions in this direction (WHO, 2012). The importance of the doctor–patient relationship in general practice care, the engagement of patients in management decisions, and the role of self-management goes in the direction of ‘patient centredness’ (Williamson, 2014). Ideally, the management of depression should start with the bio-psychosocial model of assessment and continue with successful treatment (drugs, psychological, social), until mental issues have been sucessfully addressed (Hegarty et al., 2009). The available pharmacology is said to be offering very effective forms of treatment (Andrews et al., 2011); however, in general, rather negative attitudes towards antidepressants (Olfson, 2002) are believed to significantly influence poor adherence to treatment (Consumer Reports, 2013, Hollon et al., 2002). At the same time, pharmacology alone is rather rarely offering a complete solution for depression (Whybrow, 2015). In chronic conditions, treatment with antidepressants and psychotherapy in accordance with current depression guidelines is suggested to be most efficacious (Ramasubbu et al., 2012).

This review aims to detect and to share the research findings about the ways people tend to manage their depressive symptoms with or without medications. As lay beliefs seemingly portray depression as a ‘sick self’-image (Kihlstrom & Kihlstrom, 1999), with an apparent fear of being labeled and stigmatized as mentally ill, the majority of people tend to be in denial of their symptoms, trying to avoid the painful realization (Lieberman, 2013). Doctors, patients, and their families must gain a deeper understanding of the illness and a broader knowledge of existing and preferred treatment options (Whybrow, 2015, p.285). The need and importance of new directions in research in this area should not be underestimated and patient perspectives should be considered and validated in new studies. To quote Whybrow (2015), “with the
advances in pharmacology and general knowledge about the nature of [...] severe depression, it is possible for patients to educate themselves about their illness and to help manage it, much as diabetes or asthma can be managed” (p. 288).

2.3.1. Course of Depression and Phases of Treatment

The chart below illustrates a course of an episode of mood disorder and the associated phases of treatment that best illustrate a drug treatment (Kupfer, 1991). The acute phase marks the period from the start of treatment until the reduction of symptoms becomes noticeable. Response to treatment would be then defined as a significant reduction in symptom severity (typically 50%), such that the patient no longer meets criteria for the disorder (Frank, Prien et al., 1991). Remission is the desired and ultimate outcome of treatment, defined as a ‘reduction of symptom intensity to a level within the range of a never-ill population’. Remission is associated with a lower risk of relapse that a response to treatment (Paykel et al., 1995). Relapse refers to the return of symptoms associated with the treated episode (Frank, Prien, et al., 1991). Treatment may suppress symptoms early on, but these symptoms are likely to reemerge if treatment is discontinued before the underlying episode has been resolved. Ending treatment too early is analogous to discontinuing an antibiotic as soon as a fever breaks but before the underlying infection has run its course; the symptoms of the underlying infection are likely to reemerge.
Fig. 1. Phases of treatment and the five “Rs” of depression: response, remission, relapse, recovery, and recurrence. The solid line represents the course of a prototypical episode of depression, the dotted line represents normalization that occurs if the oncoming episode is prevented, and the dashed lines represent the return of symptoms associated with relapse and recurrence. Adapted from “Long-Term Treatment of Depression,” by D.J. Kupfer, 1991, Journal of Clinical Psychiatry, 52(Suppl. 5), p. 28. Copyright 1991 by the Physicians Postgraduate Press.
CHAPTER 3. METHODOLOGY

3.1. Study Rationale

The high global prevalence of depression and the seemingly never-ending need for improving efficacy of therapies shows potential for continuous research. The impact of depressive disorder on our society cannot be overemphasised; especially, since the existing ways to fight depression are not optimal (Frazer et al., 2005). A growing scholarly evidence continues to demonstrate the dichotomy between a rich variety of available treatment options and the disorder of vast dimensions. There is a reported dramatic increase in the incidence and severity of depression, although it is a matter of debate how much of these statistics reflects an increase in the actual incidence of depression, and how much should be assigned to biasing factors such as reduced stigma, better diagnosis, diagnostic procedures, and drug industry pressures (Borch-Jacobson, 2002; Shorter, 1997; Torrey and Miller, 2001). Yet the belief that antidepressants are overprescribed is quite prevalent (Spence, 2013). For example, prescribing of antidepressants in the UK has more than doubled over the last decade (Anderson & Roy, 2013). Especially the newer antidepressants are considered to have a higher clinical efficacy, together with a milder side-effect profile, lower lethality, and increased social acceptance (Khan et al., 2002; Kirsch et al., 2002; Thase, 2002). Numerous studies report that the use of antidepressants, and especially of the selective serotonin reuptake inhibitors (SSRIs), has dramatically increased in recent years, although new analyses suggest that their efficacy for depression may be significantly less than formerly believed (Khan et al., 2002; Kirsch and Antonuccio, 2002; Kirsch et al., 2002; Thase, 2002). I recommend caution in the application of the term “use” within the context of utilization of mood-stabilizing drugs. It can be misleading, because it does not precisely reflect the intake of the medicines, but rather indicates the amount
of issued prescriptions which can be both filled or disregarded. According to the WHO report, the global measures of treatment utilization in depression are alarming: worldwide, not even half of people suffering from the illness, and in many countries, less than 10%, receive treatments [http://www.who.int/mediacentre/factsheets/fs369/en/](http://www.who.int/mediacentre/factsheets/fs369/en/).

It is suggested that the majority of people with prescribed antidepressants do not adhere to recommended treatment (Farinde, 2013). If the potential offered to reduce heavy burden of depression is not properly managed, the issue is becoming bigger than individual choices; it translates into unused therapeutic means as well as financial, societal and environmental losses coming from overproduction of psychotropic drugs and tons of unwanted medications ending in waste disposal. Multiple studies found that negative beliefs and views lead directly to non-treatment or under-treatment in depression. Public views and media create the depression paradigm that has quite significant influence on individual treatment choices. Also, people’s beliefs and patients’ relationships with their physicians are found to play major roles in medication adherence. Refusal of medical treatment might occur due to beliefs that adverse side effects of medications outweigh the benefits, or due to many other cultural, social and religious reasons, still, the patient assumes the central role in making final decisions about the course of his/her illness. There is a great need to explore patients’ views and their life experiences of medication use vs. non-use. My aim is to introduce the depressive patient and his/her reasoning within the treatment process. By exploring the mechanisms of refusal and non-adherence to medications, I argue that the task of fighting depression is presented by research in a such a manner that leaves no doubt about patients’ individual responsibility for treatment outcomes. “The term adherence is intended to be non-judgmental, a statement of fact rather than of blame of the prescriber, patient, or treatment. Compliance and concordance are synonyms for
adherence” (McDonald et al., 2002). Nonetheless, what I have discovered, yet what has not been stressed before, is the following: the task to treat one’s own depression, carried out by the said patient, can become so overwhelming that almost impossible to complete. Moreover, and regardless of reasons provided, the patient who is non-adherent to therapy will sooner or later, but almost always, lose the battle. We should not only be talking about patients’ non-adherence to treatment; we should be reflecting on what makes this non-compliance to persist and see if anything can be done to intervene. The urge of raising public awareness of both, the depressive symptoms and consequences of leaving them untreated, is thought to be the message send across by this work. The results I have summarized in this review are strongly supported by research findings, and also fit within my own personal experience. According to Holliday (2007) the voice and person of the researcher as writer not only become a major ingredient of the written study, but have to be evident for the meaning to become clear (Holliday, 2007). The essence of qualitative writing is very different from an analysis in quantitative studies. Qualitative writing develops like an unfolding story in which the arguments gradually make sense, not only of the collected data, but of the total entity, and in this case, the medication adherence in depression treatment. This review is an interactive process in which I have tried to untangle and make reflexive sense of my own presence and role in depression research.

3.2. Aims and Scope of the Study (adapted version of definitions of purpose of scoping studies (Levac’s, Colquhoun’s & O’Brien’s, 2010) and methodological framework’s elements proposed by Arksey and O’Malley, 2005):

- Extract, summarize and present research findings regarding drug treatment in depression based on views of people living with depression;
- Outline what is already known about adherence and non-adherence to pharmacological treatment in depression;
- Identify the most serious reasons for non-adherence to medical treatment in depressive disorders.

I was made aware that the subject of this study is very broad, therefore both qualitative and quantitative studies would be needed to provide valuable answers to the formulated research goals (Seeds, 2015). This caused the revision of the initial aim to include only qualitative data. The inclusion of quantitative studies in addition to qualitative findings made the assessment of the methodological quality of the papers complicated. Still, the search method, data extraction, synthesis and evaluation of results were implemented as systematically as possible.

Arksey and O’Malley’s scoping review framework outlines a five stage approach with each stage discussed and explained. Adaptations were driven by an intention to develop a feasible approach for reviewing a vast body of literature.

The initial idea to check out as broad selection of existing qualitative and quantitative studies as possible, with the inclusion of reviews and grey literature, as recommended by Gibson et al. (2014), lead to the discovery of a very large amount of data to be extracted by one person within the limited time of thesis completion, and had to be revisited.

3.3. Design

According to Arksey and O’Malley, scoping review methodology is particularly useful for examining a broadly covered topic to comprehensively and systematically map the literature and identify key concepts, theories, evidence, or research gaps (Arksey and O’Malley, 2005). Unlike systematic reviews or meta-analyses, scoping reviews do not narrow the parameters of
the review to research trials and they do not require quality assessment (Enns et al., 2016).

Nonetheless, this type of review is rigorous and methodical in its approach to examining research trends in a particular field (Enns et al., 2016). Scoping studies are used to examine the extent, range and nature of research activity and help in understanding what is already known in the existing literature (Takahashi et al., 2014; Levac et al., 2010). The purpose is the ‘mapping’ of existing scholarly evidence to describe and interpret important issues that may inform the public and invite further research. Gibson and colleagues believe that “while systematic reviews are seen as desirable for very specific research questions, they can be restrictive when a broader focus is required” (Gibson et al., 2014). This view dictates a choice of a narrative review, allowing for the “examination of a range of topics that are related to the phenomenon under consideration” (Collins, 2004) and components of larger studies that are relevant to the author’s focus (Gibson et al., 2014).

3.4. Search Strategy

A computer-assisted search of the databases PubMed, PsychInfo, Scopus and Google Scholar catalogues was carried out without assigning limits on publication dates (this approach was suggested by Dr. Pamela Seeds). The databases were searched using several search terms and keywords related to depression and anxiety disorders, as well as the need for and attitudes to mental health care from the patient's point of view.

Number of studies received through this search combined with all above terms:  \textbf{N} = 520632

Several authors undertaking systematic search for qualitative research have pointed out the difficulty in accessing sought qualitative studies due to imperfections in the setup of the search engines and lack of sensitivity to detect qualitative articles.

Searching by means of the ‘snowball method’ (the reference lists of all relevant studies were
screened for potential articles) resulted in adding a number of articles to those selected from databases. Some articles were found in more than one database. Overall, 1779 articles were retrieved and a thorough study selection was then performed.

3.5. Study Selection

The study selection was performed in several stages:

1. The first selection, resulting in selecting 229 studies from Medline, was based exclusively on titles and abstracts. Step two: after adding articles found in Scopus, PsycNET and Google and through the “snowball method”, the search stopped at the final number of 1779 potentially relevant qualitative and quantitative studies.

2. Again, titles and abstracts were screened in a search of relevant articles and 426 qualitative and quantitative papers were chosen as bearing potential relevance to this thesis. All these papers were read, sometimes more than once, and their thematic application and validity were informally assessed in prediction of further selection.

Qualitative and mixed methods studies  
\[ n = 128 \]

Reviews (incl. minireviews, overviews, commentaries, summaries of literature, etc.)  

\[ n = 32 \]

From these 32 potentially important reviews, 11 studies were chosen as matching the validity criteria for the analysis. Consequently, each of the 11 reviews was read and their content was searched for studies that were the focus of the review analysis. This process presented a major challenge because most of the review articles did not explain the selection process nor did they tabulate or list articles that were reviewed. From 11 papers, only Pampallona 2002, Pound 2005, Malpass 2009 and Britten 2010 included formal tables of the articles that were the subject of their reviews. All other authors presented a summary of references which also included articles
that were reviewed in no specific order and without further indication. No distinction between review publications and secondary literature was made and I searched each bibliography for articles that were on my list of 426 primarily selected studies.

The next step took me closer to the final review as I narrowed the number to selected qualitative articles to be further synthesised. In this process, the following studies were selected to be excluded from the tabulated 426 articles:

   a) eleven systematic and narrative reviews;
   b) 83 articles that have already been reviewed by other authors;
   c) Grey literature, n=3, (search discontinued due to saturation)
   d) Published dissertations, n = 13
   e) Published Master Theses, n = 2

The number of remaining qualitative, quantitative and mixed-methods studies was 326.

From this list, I further selected 41 qualitative papers for the final data extraction, synthesis and narrative analysis. This is my final selection of publications that used qualitative methods only, to obtain data desired for this review. Among the originally tabulated papers, a number of studies were found that had obtained data using qualitative methods, but that also used statistical calculations for their analysis. I am not disqualifying those writings a priori, however, the main focus of this thesis is being put on qualitatively collected and analysed findings. I have used the quantitative and mixed-methods papers in the number of 71 later, in the triangulation phase, summarising research with statistical evidence in support of the qualitative findings that build the core of this work.

I have followed Pound et al. (2005) and the model they used in the synthesis of their (total of 38) papers. I have adopted their model of organising the studies into groups but modified them to
expose the themes and subthemes that emerged from the extracted data, and applied the charting by date of publication for my summary of data. These models proved to be ‘an invaluable organisational aid’ during the entire review process. I have used them in the synthesis process to include comprehensively the findings from all 41 studies. Similarly to what Pound at al. (2005) describe, this involved reading and re-reading each of the selected papers and a thorough deductive reading of extracted primary data (participants’ accounts of their experiences), and analysing and interpreting the data thematically. This created what Noblit and Hare (1988) describe as a ‘line of argument’ synthesis. At this stage, a reconceptualisation and reformulation of the findings is suggested to be possible, which is an attempt to produce concepts that offer explanation for all the data, in a fresh way. At this point, the working title of my thesis was reformulated to better capture the content of studies chosen to be synthetised.

Table 1. Process of exclusion in data extraction:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Papers initially included in synthesis</td>
<td>46</td>
</tr>
<tr>
<td>Papers excluded during synthesis</td>
<td>5</td>
</tr>
<tr>
<td>Total papers finally synthesised</td>
<td>41</td>
</tr>
</tbody>
</table>

Adapted from: Pound et al. 2005

The two following studies were excluded: Janakiraman, Hamilton and Wan (2016) and Lafrance and Stoppard (2006) as, despite providing relevant information, they do not present verbatim transcripts of participants’ accounts, therefore no excerpts could be extracted for the purpose of primary synthesis. Both Egede’s (2002) and Hansen and Cabassa’s (2012) papers were removed due to its focus on patients with type 2 diabetes with accompanying depression, which was beyond the scope of this review. Finally, Stanton and Randal’s (2016) article was
found to contain insufficient information about patient’s perception of antidepressants and was excluded as well.

Description of all scanned papers ($n = 426$) is presented in a table that includes the following information: year of publication, name of the author(s), title, country in which the study was conducted, study design/method, diagnosis and diagnostic instruments, focus of the study, results/conclusion, recommendation for future studies/actions (Appendix F).

**3.6. Data Extraction**

The process of organizing reviewed studies and consequently, data extraction, is often facilitated by the use of tables or charts that summarize key aspects of the studies (Cruzes et al. 2015). Their format may depend on the number of papers, but their validity is measured by the ability to make repeated examination and comparison of the relevant data from each study possible (Pope, Mays & Popay, 2007, p. 43). Data extraction performed for the purpose of this review is grounded in Todres’, Wertz’ and Hartley’s methodology, but has been dictated by the aim of this thesis to present individual beliefs about pharmacological treatment in depressive illness and people’s lived experiences of depression. In this regard, the narratives created here differ from Hartely’s et al. because I am not assigning thematic categories a priori, but let them result from the drafted narratives. I conducted data extraction separately for each of the above listed 41 qualitative studies (Appendix C)

Extracting the 'key concepts' from the qualitative studies on patients' experiences has been performed by Campbell et al. (2003), yet depicting them may often pose difficulty (Thomas and Harden, 2008). Sandelowski and Barroso (2002) discovered that “identifying the findings in qualitative research can be complicated by varied reporting styles or the misrepresentation of data as findings (as for example when data are used to 'let participants speak for themselves')".
They further argue that the findings of qualitative (and all empirical) research are distinct from the data upon which they are based, because of the methods used to derive them and researchers' conclusions and implications (Sandelowski and Barroso, 2004). I have chosen to use a model of the qualitative narrative analysis originally described by Todres (2007, 2008) and used by Wertz et al., (2011) and Hartley et al., (2014). This method has been used for presenting the original data as the most appropriate writing technique in the process of giving accounts of people’s experiences. This serves multiple purposes: first, in order to achieve factographic authenticity and credibility; second, to present a certain clarity of the writing style. According to Hartley et al., the “composite first person narrative provides a reflective story about individual’s experiences by constructing a composite picture from participants’ self-reports” (Hartley et al., 2014). While Todres and Wertz et al. used the narration technique to expose the main findings collected from direct study participants’ accounts, Hartley et al. take it to the next level by generating summaries of the “key messages” coming from the articles under review. By drafting them into narratives, the researchers create a first-person-accounts so the reader gets the impression that study participants directly share their lived experiences and feels invited to enter the lived world of depression. This method is inevitably grounded in the phenomenological perception of reality but serves the purpose of being absolutely true to patients’ and lay persons’ own reflections. It “does not aim to be a mere re-telling of the evidence, but a narrative that reflects a richer and more evocative understanding of the complex experiences” (Hartley et al., 2014).

3.7. Qualitative Synthesis

Synthesis is the point in the review process at which the findings from the included studies are combined in order to draw conclusions based on the studies as a whole (Pope, Mays & Popay,
The synthesis of qualitative research and especially the synthesis of qualitative with quantitative evidence are said to be relatively recent endeavours (Pope, Mays & Popay, 2007, p. 43). There is a growing recognition of the value of synthesising qualitative research in the evidence base in order to facilitate effective and appropriate health care (Thomas and Harden, 2008). Within the qualitative research community there has long been a recognition that writing and presentation of qualitative research is about representing the data and that this representation is influenced by the theoretical and methodological stance of the researcher. Writing up qualitative data needs to be coherent, but also capture the richness of presented information. White et al. (2003) note that this is a real challenge because it is not easy to summarise qualitative findings neatly (by tables or numbers). Qualitative researchers, therefore, have to find ways to order ‘disorderly data’ (White et al., 2003, p. 289). For a synthesis involving any qualitative evidence, a further problem for some of the potential audiences may be lack of familiarity with qualitative research methods. It is therefore important that in presenting the findings the reader is made aware of the types of study included and the kinds of inference and interpretation that are possible (Pope, Mays & Popay, 2007, p.147)

The following is a justification of my choice to present the findings that emerged from reviewed studies as a thematic analysis. The decision is based on theories introduced by Thomas and Harden (2008) and Sandelowski and Barroso (2002, 2004). I tried to apply a rigorous combination of individual truths and review techniques to achieve validation of qualitative data. Retrospective narratives, of which almost all were extracted as citations from the original studies and few created on the basis of secondary text narration, have been summarised in Appendix D and serve the purpose of primary thematic data analysis, presented below. These excerpts are believed to build a true-value foundation that is used to ensure trustworthiness and academic
rigor, with the aim of avoiding second-line interpretation bias. Ridge et al. (2015) propose thematic analysis as the process of identifying important or recurrent themes that become visible in the extracted data. All findings are then summarised under thematic headings. Information is tabulated allowing identification of prominent themes and offering structured ways of dealing with the data in each theme. More recently the method has been refined, such that a new approach – thematic synthesis – has emerged: Thomas and Harden (2008) claim that seeking to synthesise qualitative research means stepping into more complex and contested research area and seeking unique and various ways to support RCTs with data emerging from individual accounts included in a review. They claim that precise methods are much less developed in this area, with fewer completed reviews available to serve as examples, and, the “whole enterprise of synthesising qualitative research” is still debated (Thomas and Harden, 2008). Qualitative research is believed not to be as easy to be generalised as are quantitative findings, due to being specific to a particular context, time and chosen group of often purposefully, rather than randomly, selected participants (Thomas and Harden, 2008). Thus, in acknowledgment of the validity of qualitative research, all the various methods that aim to bring their findings together for a broader audience, need to be recognised as heterogenous and unique, and should not be disregarded a priori as not being able to offer universal application. At the same time, they preserve and respect their original context from which they emerge (Thomas and Harden, 2008). Explanations or theories extracted from individualized concepts may be presented as 'line of argument' bringing the results together but expanding the content of the primary data: “this notion of 'going beyond' the primary studies is a critical component of synthesis, and is what distinguishes it from the types of summaries of findings that typify traditional literature reviews” (Thomas and Harden, 2008). The interpretation will then depend on the range of concepts
depicted in the selected studies, their context, and mainly reflect the researcher’s point of view. However, deciding what to abstract from the published report of a 'qualitative' study is said to be much more difficult. Thomas and Harden (2008) conclude that this stage of a qualitative synthesis can be both, challenging and controversial, since it is dependent on the judgement and insights of the reviewers. The equivalent stage in meta-ethnography is the development of 'third order interpretations' which go beyond the content of original studies (Britten et al., 2002, Campbell et al., 2003). Using Thomas and Harden’s (2008) technique, I also included series of questions, derived directly from the selected studies that were associated with the main topic of the conducted review and applied narrative accounts as the findings of the primary studies: these were new propositions generated in the light of the synthesis. The application of this methodological strategy also shows that it is possible to synthesise data without conceptual innovation (Thomas and Harden, 2008). In studies where the primary analysis is concerned directly with the review question, it is not necessary to go beyond the contents of the original data in order to produce a satisfactory synthesis (Marston and King, 2006).

3.7.1. What is Thematic Synthesis/Analysis?

Pope, Mays and Popay (2007, pp. 96-97) define the ‘thematic analysis’ as one of the most commonly used methods for the synthesis of review findings (p. 96). It is said to be a great tool in organizing and summarizing the findings from a large, diverse body of research. Pope, Mays and Popay (2007) conclude that while thematic analysis is “primarily qualitative in origin”, tabulation of themes, similar to ‘content analysis’ is common. In the following thematic analysis of qualitative findings, I followed the suggestion that the data extraction be performed “without a complete set of a priori themes” (Pope, Mays and Popay (2007). The themes I introduce, were identified by reading and re-reading the included studies, coded by annotating the original papers,
and then extracted and summarized as recommended by the methodologists (Pope, Mays and Popay (2007). Thematic analysis is basically associated with qualitative or text-based data; however, it is potentially possible to include quantitative data. This could be achieved by ‘qualitizing’ data, for example, in the way that Dixon-Woods et al. (2006) extracted themes and findings from quantitative evidence; it is possible, having identified themes, to count the frequency with which they occur. The list of themes that emerged after reading and re-reading the papers, were refined by identifying key themes as recommended by Pope, Mays and Popay (2007, p.96).

3.7.2. Framework Stages

The Framework Method is gaining importance and broad application in contemporary health research as a well-suited approach to the management and analysis of qualitative data (Gale et al., 2013). It is a set of codes organised into categories and designed to help structure the review process. It creates a new structure for the data (rather than the full original accounts given by participants) that is helpful to summarize/reduce the data in a way that can support answering the research questions (Gale et al., 2013). The framework describes the stages as clearly designed steps in developing projects that the researcher/writer takes to gather data, which lead to conclusions.

Framework Stage 1. Familiarization / Identifying Research Question(s)

Questions that emerged in the initial phase of the review were developed through the process of reading the articles. They were ‘a priori issues’ that I was interested in exploring. They formed the basis of the themes formulated later. They fully related to the aims of the study, but were
subject to modification during the reading and further review process as recommended by Arksey and O’Malley, 2005:

- What are the patients’ considerations and decisions in acceptance, maintenance and discontinuation of antidepressant therapy? (van Geffen, 2008).
- What are the patients’ beliefs and lived experiences regarding clinical effectiveness of drugs in the treatment of depression and in the relief of depressive symptoms?
- What are the patients’ beliefs about clinical evidence on the safety of antidepressants for the treatment of patients with major depressive disorder?
- What are the reasons for refusal of pharmacological treatment?
- What are the reasons for non-adherence with the medications after initial decision to start the treatment?

**Framework Stage 2. Identifying Relevant Studies**

At this stage, I decided upon criteria for eligibility, databases to search, and formulated a search strategy and proposed key terms (Appendix A). Arksey & O’Malley (2005) recommend that a saturation point should be set, beyond which no further references would be checked. I was interested in recent findings and unpublished papers; however, termination of this process needed to occur.
Fig. 2. Flow chart of inclusion procedure.

Potentially relevant studies identified through Medline, Scopus and PsychNET and screened on title and abstract (n=1779)

Potentially relevant studies identified through Medline and additional search and screened on full text (n=229)

Potentially relevant studies screened on full text (n=426)

Exclusion criteria for studies excluded after screening on full text:
- Similar studies (reviews) n = 11
- Studies reviewed by others n = 83
- Dissertations n = 13
- Master theses n = 2
- Commentaries and mini reviews
- Focus too broad
- Insufficient data

Qualitative studies selected for data extraction and analysis (final selection) n=41

Epidemiological and quantitative studies selected for transtluation n=71

Adapted from: Prins et al. (2008). Health beliefs and perceived need for mental health care of anxiety and depression- The patients' perspective explored Clinical Psychology Review, 2008, Vol.28(6), pp.1038-1058
Search strategy

Sources that were searched were electronic databases accessed through UW Library (Public Health and Kinesiology Research Guide).

Searching electronic databases

After numerous primary searches that were applied as intensive training practice, the following electronic databases were recommended by the librarian Jackie Stapleton to be searched: MEDLINE through PubMed, Scopus, PsychNet, Web of Science and Google Scholar. The primary search strategy (MEDLINE through PubMed) was developed collaboratively with the help of two University of Waterloo librarians. We have decided that broader terms should be excluded from the search due to a large number of not topic-related articles that were identified by search engines. The search was limited to articles in English. I received detailed instructions to employ various search strategies appropriate for each relevant database that was searched.

With both librarians’ help, I formulated search strategies that were subject to revision and modification before the final review process. Upon completion, the searches from each database were carefully documented and references were imported into database-specific folders in RefWorks, where duplicates were eliminated. The librarians played a key role in determining and testing appropriate keywords, MESH terms and filters to maximize sensitivity and specificity within the search. The exercise process was fundamental in modifying and applying search terms to comply with the various bibliographic databases.

Reference lists

It is recommended (Arksey & O’Malley, 2005) that reference lists and bibliographies included in Internet articles and academic reviews also be checked. There is a possibility of inclusion of the most recent papers not yet accessible through the electronic searches but found
in journals. Therefore, an additional search of relevant bibliographies and references was performed in addition to the electronic search. However, the overall sum of potentially relevant studies was rapidly growing and reached a high number of 1779. The realization that the number of studies is overwhelmingly large forced me to set a saturation point and the decision was made to discontinue reference list checks at some point.

Framework Stage 3. Study selection

Eligibility/inclusion criteria

The exclusion/inclusion criteria introduced in the Review Protocol were subject to change. All types of qualitative as well as epidemiological, quantitative, and mixed method studies (n=426) were included and synthetized in a chart (Appendix F). Studies were also included that introduced data collected from lay persons sharing their beliefs and opinions on drug treatment in depression. Eligible studies included those that mention all kinds of patients diagnosed with unipolar depression or comorbid unipolar depression who were prescribed or recommended medication, including:

1. individuals suffering from depressive symptoms and at risk for major depression who refuse treatment with antidepressants;
2. outpatients with identified depressive disorder who are involved in pharmacological therapy;
3. individuals suffering from depressive symptoms and at risk for major or persistent depression who underwent pharmacological treatment, but decided to discontinue the medication;
4. persons that were pharmacologically treated for depressive illness and where the therapy has ended due to observed and recorded recovery;
5. outpatients with depression present in both single diagnosis and comorbid with other mental disorders or physical diseases.
All types of studies (qualitative, quantitative and mixed methods) have been reviewed with no restrictions on publication dates.

**Specific interventions included in the review:**

Studies of depression that introduced medications with at least one active single treatment (pharmacotherapy) were eligible for inclusion. The included studies address a variety of drugs known as the first and second generations of antidepressant drug development. Treatments can be applied during acute/episodic/ as well as maintenance/recurrent and chronic phases/ of the illness. A priori knowledge of possible side/adverse effects of these medications has been applied. The following inclusion criteria were used to guide the search and were also used during the review process:

- Qualitative, quantitative and mixed method studies including: published scholarly articles, reviews, case studies, narratives and vignettes, book reviews, opinion articles, commentaries or editorial reviews. Due to an overwhelmingly large body of articles, it was recommended by the librarian to exclude examples from the grey literature for the purposes of this scoping review.

Excluded: Books, textbooks, magazines and the grey literature.

Rationale: My focus was on published scholarly papers.

Limitations: Some narrative or biographic material presenting opinions relevant to my study will be lost.

- Published in the English language

Rationale: Due to time constraints, translation of documents published in languages other than English was not considered.

Limitations: Some potentially valuable multi-cultural and ethnic contributions might be lost.

- Research that targets the general adult population (except those listed under exclusion criteria)
Rationale: Research on children’s and adolescents’ depression is beyond the scope of this study because a major difference between adult and pediatric depression is the response to pharmacotherapy (Bridge et al., 2007; Hazell et al., 1995; Kratochvil et al., 2006).

Limitations: The review does not introduce the whole spectrum of human experience of depression.

▸ Research findings that target individuals with depressive symptoms and those diagnosed with unipolar depression or comorbid depression: Major Depressive Disorder (MDD), Dysthymia or mild depression, recurrent depression (without mania), severe melancholic depression, ‘atypical’ depression, treatment-resistant depression.

Rationale: It is very rare for depression to exist without another disorder (especially comorbid anxiety, either before onset or at the same time/after) (Seeds, 2015).

▸ No geographical or ethnic limitations.

Rationale: Various ethnic views, beliefs and lived experiences recorded globally are universal to representatives of these nations, thus apply to some degree to multi-cultural and multi-ethnic societies and minorities in Canada, USA, Australia, UK and any other countries.

Limitations: This review is not specifically addressing Canadian or North-American issues.

**Explicit exclusion criteria have been identified as:**

**Writings:**

▸ Books and textbooks, self-help books, magazines, Web-sites, public forums

**Population:**

▸ Patients remaining in supervised care who are unable to make independent decisions about their treatment;

▸ Children and adolescents
Framework Stage 4: Extracting the data and determination of quality

I included an detailed report on how many papers were selected at each stage of data collection and extraction. A typical way of assessing quality of reviewed studies is the application of ‘hierarchy of evidence’ (Pope, Mays, and Popay, 2007; Dixon-Woods et al., 2006). This approach, commonly used in epidemiological and quantitative research, assigns a higher scientific value to randomized controlled trials than to other designs, i.e. case-control studies (Dixon-Woods et al., 2006). In case of qualitative papers, where no hierarchy of study designs exists, the appraisal can be conducted by using a structured quality checklist, but several challenges will still appear, as stated by Dixon-Woods et al. (2006). In the light of missing definite rules regarding how, or whether at all, should the appraisal of qualitative papers be performed in an interpretive review, I decided to follow Dixon-Woods’ et al. (2006) model of assessment. Neither the quality nor validity of papers chosen for the review have been assessed, however, I reviewed the papers by seeking positive answers to questions presented below. The scheme illustrates Dixon-Wood’s et al. (2006) assessment criteria that should be met during the selection phase and also proposed by the National Health Service (NHS) National Electronic Library for Health for the evaluation of qualitative research.

Appraisal prompts for informing judgements about quality of papers

- Are the aims and objectives of the research clearly stated?
- Is the research design clearly specified and appropriate for the aims and objectives of the research?
- Do the researchers provide a clear account of the process by which their findings were reproduced?
- Do the researchers display enough data to support their interpretations and conclusions?
• Is the method of analysis appropriate and adequately explicated?

Adapted from: Dixon-Woods et al., 2006

Data extraction

Pope, Mays and Popay (2007) state that in the synthesis of qualitative studies, the data extraction depends on the method chosen by the reviewer(s). It is recommended to find a good way to capture the findings of interest. It can be interpretation offered by the authors, typically in the form of analytical concepts, metaphors or themes (interpretive synthesis), but in a realist synthesis, the focus will be less on specific concepts and more on overarching theories or explanations which can be synthetized. They claim that the way data are extracted and stored, would vary among reviewers. Whichever method is chosen, it is worth creating a standard record of the data extracted as this can enable sharing of the material within teams of reviewers, and in the long term provides a transparent record of how this part of the review was undertaken (Pope, Mays and Popay, 2007). They also state that in practice, “it would be rather impossible to decide whether a study is within the scope of the review question or of sufficient quality without a good knowledge of the content and this is difficult to do consistently across a number of studies without extracting information from the text reporting each study in a consistent way” (p.41).

Therefore, data extraction is suggested to be the part of the previous two elements of a review. I applied their theory through the tabulation of all 426 articles that were carefully checked with the aim of selecting the most convincing findings.

Title and abstract screening

Data for the review were extracted by one person (myself).

I have decided to work through a multiple-stage study selection process.
In the first stage, I reviewed the titles to determine eligibility of the study based on the defined inclusion and exclusion criteria. For example, titles that indicated a target population with an existing medical condition other than depression or where application of other treatment options in addition to medication was detected, were not considered. At this primary stage of the review, any uncertainty with a title did not eliminate the citation for consideration in the second stage.

The second stage of the selection process included a further review of the titles and abstracts with the use of the above eligibility criteria. In studies where titles did not clearly indicate a target population or illness than depression, I read through the abstracts, and searched for information about participants, medical condition, and type of the study, if not formulated in the title. I accepted conditions such as unipolar depression accompanied by anxiety, but eliminated studies that analysed other major mental diseases such as e.g. schizophrenia, as this was beyond the scope of this study.

In the third stage, I used RefWorks, a bibliographic management program, to organize references and eliminate duplicates.

The fourth stage brought a major change to my initial method of searching for relevant papers. My original intention to collect and sort key pieces of information from the abstracts of the selected articles changed when I realized that numerous abstracts did not provide information sought for the synthesis. I found a large number of abstracts that did not provide sufficient data about research methods, or target population and also, a clear description of the mental condition subject to analysis was missing. I was instructed that, if additional data extraction categories were needed, or if missing data emerge, consultation with the librarian will guide my decisions and will be reported with the findings. This, indeed, occurred and brought me to a final reading of over 500 articles that were initially found and seemed suitable for the review.
In the fifth stage, the full texts of all articles that met the inclusion criteria during the title, abstract and content screening process (n=426) have been retrieved and saved as PDF files in a separate folder. The idea of sorting out and storing the papers proved to be very helpful in the process of continuous extraction of further data.

In the sixth stage, the charted data were entered onto a ‘data charting form’, using Excel. For the extraction process, as recommended by Arksey and O’Malley, I extracted general information about each study, such as: year of publication, author’s name, country of study or publication, study design/research method applied in the study, diagnosis, intervention/focus of the study, results/conclusions and implications for further research/actions. I did not assess the quality of evidence at this stage (as recommended by Arksey and O’Malley). The table of 426 selected studies is a presentation of extracted data with attention to relevant details. Extracting the data in this systematic manner was a very helpful process that assisted me in further detection of studies already analysed by other researchers (they have been exposed by color in the table) as well as in consecutive reviewing of information during the write-up process. Another relevant strategy was sorting the papers in chronological order by year. The purpose for doing so was to visualize and expose the historical dimension and intensity of research on this topic and the gradually increasing number of studies parallel with development of insightful ideas and implications for further research and actions.

**Framework Stage 5: Collating, summarizing and reporting the results**

Outcomes assessed in the review

The following collected/extracted data/information are introduced:

- Author(s), year of publication, study location, and title
- Methodology
• Depressive symptoms/Depression type/diagnosis
• Intervention (medication used/recommended) or alternative focus of the study
• Important results and conclusions
• Implications for further research/actions

The qualitative studies have been logically grouped and divided into thematic clusters by using qualitative analysis. The review will then present the findings in form of a narrative synthesis regardless of the outcome, thus studies presenting recovery from depression as well as relapses and attrition (as defined by the authors) will be subject to discussion.

The table below illustrates how my final interpretation of findings fits within the third order constructs (Noblit & Hare, 1988 and Britten et al., 2002). Patients’ accounts, either recorded verbatim, or transcribed by the authors, create the core content of each study. The first order constructs create the contextual base, and all other comments, interpretations and conclusions, are built upon them. The 11 previous reviews introduced here, as well as all authors’ comments and summaries from the articles reviewed in this study constitute the second order construct. By undertaking synthesis and analysis of the second order constructs, I present third order constructs that will be received as my own views and interpretation of the summary of findings based on original patients’ accounts.

3.8. Triangulation

Using triangulation as a methodological ‘metaphor’ can help the researcher facilitate the integration of qualitative and quantitative findings with the aim to expose results from both research areas in the process of data validation (Östlund et al., 2011). Denzin (1978) and Patton (1999) identify four types of triangulation of a qualitative data: a) Methods triangulation (using different data collection methods); b) Theory/perspective triangulation (using multiple
theoretical perspectives to examine and interpret the data; c) Triangulation of sources (examining the consistency of different data sources from within the same method); and d) Analyst triangulation (using a group of analysts and implementing their various perspectives). The first and second from the above approaches were used in this review and served the purpose of: presenting qualitative and quantitative data together, adding new aspects of the same phenomenon, providing insights, produce an understanding and ensure that “an account is rich, robust, comprehensive and well-developed” (Denzin, 1978; Patton, 1999). Mixed methods analysis can be viewed as an approach which draws upon the strengths and perspectives of each method, recognising the existence and importance of both, may this be randomized controlled trials and larger cohort studies as well as the undisputable value of individual experience. The latter, recorded for the purpose of exploration of phenomena of interest, serves as literary proof of real human interactions that took place in the physical, natural world. Mixed methods approaches are believed to support a better understanding of the links between empirical findings emerging from multiple sources (Östlund et al., 2011). The technique of triangulation is used for the purpose of this review in the process of examining the consistency of qualitative, quantitative and mixed-methods data on non-adherence to antidepressants. Results from qualitative interviews and narrative textual synthesis are validated with presentation of narrative synthesis of quantitative data on depression, which emphasizes the importance of patients’ personal beliefs and perceptions.
CHAPTER 4. SUMMARY OF FINDINGS

4.1. Narrative Summary of Previous Reviews

I retrieved 11 existing reviews which demonstrate a focus similar to this thesis. The papers are introduced in Table 2, page 60. The presentation of data extracted from these reviews takes a form of a chart and includes details such as: authors in alphabetical order, title, journal and publication date, type of the review, the way data was collected, focus of the study and finally, implications for further research or clinical practice. Non-adherence is said to be a major problem in depression treatment as about one in three patients on average do not follow physicians’ recommendations and discontinue medication intake. However, Pampallona et al. (2002) claimed that adherence to medication did not grasp much of the research attention in comparison with the vast amount of studies on antidepressants. This definitely has changed since. A growing number of scholars have attempted to discover why patients taking antidepressant drugs continue or discontinue their treatment. The model of taking antidepressant drugs is found to be similar to other treatments of chronic conditions; yet mood modifying drugs are said to produce not only concerns in relation to the adverse side effects, but also pertain to the perception that society has about them and involves the aspect of stigma. Trying to understand the patient's perspective and all other factors present in decision making about adherence or non-adherence to mood modifying drugs, may help professionals avoid excessively long treatment or early dropouts (Mahtani-Chugani & Sanz, 2011). The intake of medication is found to involve a dual aspect: consideration of benefits and risk. By making decisions, patients balance their views and own experiences. Adherence can be improved, and several measures of adherence are discussed by Pampallona et al. (2002): pill counts, blood drug levels, behavioral indicators, psychological symptoms, subjective evaluations or adherence to pre-defined schedule.
of appointments. Pampallona’s et al. 2002 review does not provide data on whether an increase in adherence relates to an increase in response rate. Similarly, no clear indications of specific interventions or combinations of different types of treatment that may be applied to improve adherence, could be found.

I found the primary research model reported by Pound et al. (2005) to be most examplary within this thematic context. Their study focused on the synthesis of qualitative papers of lay experiences of medicine taking. Pound et al. claim that research shows the tendency to expose experiences of people not adhering to their drug treatment with a smaller number of papers concerned with those who fully reject pharmacological treatment or accept it uncritically. Pound et al. found issues such as fear of dependence, addiction, and tolerance, the potential harm from taking medicines on a long-term basis and the possibility of medicines masking other symptoms to be relevant in treatment adherence. Additionally, in some cases, medicines are believed to have a significant impact on patients’ identity, presenting problems of disclosure and stigma.

Pound’s synthesis stresses the “widespread caution about taking medicines” and discusses the general practices of testing medicines in everyday use. By presenting the results of their review, Pound et al. (2005) claim that, generally, people tend to be approving of their medicines either passively or actively, or to fully reject them. Some are persuaded into taking medications by others. Active accepters might be found modifying their regimens by taking pills symptomatically or, strategically, also by minimizing doses to avoid adverse side effects, or to make the regimen more acceptable according to their preferences. It seems interesting that patients tend not to disclose those changes to their physicians. Pound’s conclusion evolves around treatment non-adherence. The authors claim that “the main reason why people do not take their medicines as prescribed is not because of failings in patients, doctors or systems, but
because of concerns about the medicines themselves”. Pound et al. (2005) point out the fact that patients’ resistance to medicine taking will continue and stress the importance of marketing safe drugs, as well as identifying and evaluating alternative treatments preferences.

Mitchell (2007) examines “the evidence for and against intentionality in psychotropic adherence behaviour”. In his narrative review, he takes into consideration studies on depression, schizophrenia and bipolar disorder and draws a common conclusion for concordance in all three mental diseases. He concludes that adherence behaviour with psychotropic medication is a form of self-medication. Results from the studies that Mitchell reviewed indicate that patients’ attitudes towards psychopharmacological treatment depend upon the individual, illness and the medical specialist however, a patient’s choice and final decision are usually the strongest indicators. The model of self-medication in affective disorders is said to usually be referring to the intake of drugs and alcohol; and in this paper, we learn about a second possible form of self-medication practiced by patients who supplement their prescription drugs with over-the-counter medications. A third way of self-medicating, introduced by Mitchell, is the control that individuals exercise over conventionally prescribed medicines. People tend to not inform their doctors about their decisions to reduce or stop the medication and most individuals finish their therapy as soon as they feel better, or due to adverse effects or perceived stigma. Mitchell concludes that most of the studies he reviewed indicate the tendency to fully refuse pharmacological treatment in affective disorders, or to reduce the intake to the absolute minimum. Patients have been found to enjoy their personal control over the direction of treatment.

In 2007, Mitchell published another review in collaboration with Selmes. In their study, adherence and compliance are used as synonyms (as opposed to Pound et al., 2005) and define
them as an extent to which individuals change their health behavior to follow medical advice. ‘Concordance’ on the other hand, is introduced as the degree to which health behaviour agrees with clinical advice. Furthermore, the terms of a) ‘therapeutic alliance’ and b) ‘therapeutic disagreement’ are being described as a) “an agreement between patients and health professionals to work together”, and b) “a divergence in the views of patients and doctors on the subject of treatment”. Mitchell and Selmes (2007) further claim that synthetising data on adherence behaviour could present a challenge because of the wide range of assessment methods. Their conclusions are as follows:

- Premature medication discontinuation is costly;
- Undisclosed non-adherence appears to be particularly hazardous;
- The outcome for patients who vary medication doses without consulting the physician is poorer.

Predictors of non-adherence may be divided into: patient, clinician, and illness factors, and a distinction should be made between intentional non-adherence (missing or altering doses to suit one’s needs) and unintentional non-adherence (forgetting to take medication).

- Predictors of intentional non-adherence: less severe disease symptoms, feeling well, self-efficacy (the desire to manage medication independently), disagreement or low trust in clinicians, receiving insufficient information,
- specific adverse effects causing non-adherence: weight gain (more distressing than any other side-effect), sexual dysfunction (associated with global lower ratings on quality of life (QoL), illness beliefs and knowledge of medication, doctor-patient relationship.

This review summarizes the following research findings:

- about 10 % of patients prescribed antidepressants fail to pick up their first prescription;
▪ 1/3 of depressed patients collect only the initial (typically 4 week) prescription;
▪ of those who start antidepressants (ADs), non-adherence rates increase with time;
▪ in those on long-term maintenance treatment, discontinuation rates for antidepressants are above 70%;
▪ of all those who discontinue ADs, 60% have not informed their doctor by 3 months and ¼ by 6 months (covert non-adherence);
▪ unintentional non-adherence was associated with greater cognitive impairment;
▪ providing more information is a way of improving adherence;
▪ many patients change regular medication dose in a flexible as-required manner, apparently without harmful effect

The authors suggest “simple strategies to improve concordance”:

▪ Basic communication: establish trust and a therapeutic relationship between the physician and patient, identify the patient’s concerns, take into account the patient’s preferences, explain the benefits and hazards of existing treatment options.
▪ Strategy-specific interventions: adjust medication timing and dosage in maximising efficacy and minimising adverse effects, offer support, encouragement and follow-ups.
▪ Reminders: consider adherence aids (such as medication boxes and alarms, reminders via mail, email or telephone, home visits, family support, and counselling).
▪ Evaluating adherence: ask about problems with medication, missed or changed doses, thoughts of discontinuation, and further suggest direct methods of adherence evaluation: pill counting, measuring serum or urine drug levels, collaboration with general practitioners and pharmacists regarding prescriptions
Patients’ perspectives and health beliefs have been further explored by Prins, M. A., Verhaak, P. F., Bensing, J. M., & Meer, K. V. (2008). The perceived need for mental health care in anxiety and depression as well as general views on recovery from both conditions had been summarised as follows:

- The majority of lay people are rather optimistic about recovery from depression;
- Depressed patients assign significantly higher importance to medical/biological causes than non-depressed individuals;
Similarly, perception of biological mechanisms of depression is more present in women than in men;

Non-melancholic depressed patients are more likely to rate non-biological causes of their depression than melancholic patients;

Younger, rather than older, patients believed in the biological model of depression

Older patients endorsed cognitive attributional styles as etiologically relevant;

Most people in both, depressed and non-depressed groups, provided multi-dimensional explanations for depression;

Depressed patients demonstrated more negative beliefs about the duration of illness than non-depressed;

Primary care patients believe that they will see treatment benefits within one month;

Depressed patients showed concerns about their antidepressant treatment;

Beliefs in danger of addiction in treatment with antidepressants were frequent;

Men believe more in addictiveness of antidepressants than women do;

Studies selected by Prins et al. (2008) were found to only indirectly indicate people’s awareness of depressive illness and effective treatment. Some more specific beliefs about the causes of depression as identified by the authors are:

- non-biological, psychological or environmental causes;

- physical and biological reasons;

- reactions to external problems;

- stressful life events;

- interpersonal difficulties;
African Americans were found to be less willing to use antidepressants than Caucasians. Many depressed primary health care patients hold ambivalent beliefs about medicines; perceived need versus perceived harmfulness are the important factors in treatment adherence. Lay people recommended consultation with a professional in the case of depression; their treatment recommendations were dominated by psychotherapy (53.7%). In lack of inefficiency, psychotropic drugs (36.8%) and relaxation (18.3%) were suggested.

The following barriers to treatment were identified in the review: high cost, lack of time, emotional reservations, belief that one can work it out by him/herself, lack of information and knowledge about helpful resources. People in the general population also prefer to manage depressive symptoms by themselves. Another relevant issue identified by this study is an existing gap between patients’ beliefs about different treatment options for depression and their perceived needs, and the current guidelines regulating actions of physicians. For example, the Dutch guidelines for depression and anxiety have been cited here as attributing a more prominent role to antidepressants than patients would prefer. Also, a stepped care framework is recommended in this review. The stepped care model, used successfully in UK, seems to fit better to patients’ needs as it provides more alternatives to antidepressant medication.

Zivin and Kales’ (2008) study focuses on adherence to depression treatment in older adults. Studies included in this systematic review reported on patients with a range of disease severity, from depressive symptoms to mild depression and MDD, which are said to also influence adherence. Factors affecting patient adherence to depression treatment in older adults were divided into three groups and identified as follows:
Modifiable: attitudes, perceptions, preferences, spiritual beliefs, beliefs about aetiology as well as effectiveness of depression treatment, patient/provider communication, social norms, family caregiver opinions, and finally also stigma.

Modifiable with difficulty/potentially modifiable: co-morbid anxiety, substance use, cognitive ability, polypharmacy and medical co-morbidity, cost of treatment, and social support.

Non-modifiable: gender and race

The authors stress the importance of more rigorous studies in the area of depression treatment adherence. There is a pressing need to further understand the characteristics of older depressed patients that lead to optimal benefits of recommended drug therapies. Zivin and Kales find similarly urgent need to understand the barriers to adherence in older patients. Also, while physicians may have objections in regards to prescribing antidepressants in the older population, due to concerns about polypharmacy, actions should be taken to make sure that patients actually take the drugs as prescribed. The reviewers believe that strategies to improve adherence need to be multidimensional.

Malpass A, Shaw A, Sharp D, et al (2009) present a philosophically inclined analysis of 16 selected papers on patients’ experiences of antidepressants. Giving their meta-ethnography a title “Medication career” or “Moral career”?, they suggest a priori controversy. Indeed, their research synthesis tries to conceptualise the conflict between psychological, ‘moral’, and perhaps more human views of antidepressant therapy and the medicalized perception of ill emotions. The authors focus on how patients approach the meaning of drug therapy, in which “new self-concepts emerge”, and the rationale of ‘decision-making process’, in which the treatment decisions are made and justified.

2 groups of selected papers were created:
- Studies in the first group primarily showed how patients are involved in a decision-making process in which they are evaluating (a) their experience of antidepressant medication (b) models of illness causation and (c) the consultation/relationship with the physician and how far it meets information needs;
- Papers in the second group focussed on self-concept and how it is affected by antidepressants. The authors discuss two different sides of managing antidepressants however, they conclude, the problem requires further exploration through empirical studies. Trying to understand and explain the processes of transformations in self-concept is a difficult task and more qualitative data is needed.

Britten, N., Riley, R., & Morgan, M. (2010) analyze patients’ resistance to treatment with antidepressants. Their synthesis of qualitative studies on psychotropic medicine-taking presents the results of 12 papers on patients’ perspectives with the aim to suggest implications for clinical practice in mental health. The emerging concept was that of ‘resistance’, which is referring to the pattern of treatment, i.e. attempts to minimise the intake of medicine.

The model of medicine-taking identified patients’ behavioral patterns and grouped them into four categories:

- passive accepters take the medicine without resistance (often because patients trust the prescriber and are willing to do what the prescriber asks them to do);
- active accepters take medicine as prescribed, but only after a period of lay evaluation;
- active modifiers conduct lay evaluation, which leads them to take their medicines in their own way, which may involve changes in dose, frequency of dose or stopping the medicine altogether;
▪ rejecters reject the medication completely and may refuse to accept the prescription or fill the first prescription

This is not a permanent behavior and patients’ approaches to medicine use may change over time. The authors’ focus was therefore on identifying the varying influences on patients’ decisions about their use of psychotropic medicines.

How can health specialists help patients achieve concordance?

▪ Create comfortable and develop trust
▪ Avoid judgemental feedback to what patients’ opinions of their medicines
▪ Develop curiosity about patients’ reasons for altering their medicines
▪ Acknowledge patients lived experience
▪ Detect patients’ preferences and priorities
▪ Offer a professional opinion supported by facts
▪ Discuss non-pharmacological treatments where appropriate
▪ Be respectful in the process of involving patients only to the degree that they want to be involved.

Alderson’s et al. (2012) study focus was the comorbidity of chronic physical diseases and depression. A range of clinically relevant beliefs was identified from 65 studies including the difficulty in labeling depression, complex psycho-social causalility in place of the biomedical model, the roles of different treatments and negative views about the consequences of depression. Participants feared the outcome of others knowing about their condition. Depression was seen as poorly understood by the public, and misrepresented in the media, so that sufferers were to blame or responsible for their suffering. Individuals were ashamed of being seen as unable to cope. Perceived stigma in itself had consequences, such as their professional judgment
would no longer be trusted, leading to employment problems and reduced social involvement. In addition, other important themes less related to ideas about illness were found to be present in patients’ accounts: the existence of a self-sustaining ‘depression spiral’, depression as an existential state, the ambiguous status of suicidal thinking, and the role of stigma and blame in depression. In this thesis, I implemented Alderson’s et al. (2012) methodological approach and their model of mixed research methods involving a thematic analysis of qualitative and quantitative studies.

In 2014, Gibson, Cartwright & Read published their patient-centered review of studies on prescription drugs use in depression. Analysed data show that depressive patients often have reservations about taking antidepressants and health care specialists are advised to take these concerns seriously. Gibson, Cartwright & Read suggest that physicians demonstrate the power to influence their patients’ decisions, particularly by suggesting a line of treatment in the initial prescribing period during which patients feel particularly vulnerable. To solve this problem, physicians should be more sensitive and initiate discussion of both the pros and cons of taking medication and, if necessary, delay a decision until patients are ready to start treatment. As antidepressants seem not to be the first choice of treatment for many patients, physicians should also explore a range of intervention options with their patients. This review also suggests that patients tend to develop concerns and doubts about antidepressants after leaving their physician’s office with a prescription. Patients who choose not to fill their prescription are often left without information about other sources of help; those who start treatment, may continue to take an antidepressant even when they are unhappy with this choice or experience side effects. This suggests the importance of a follow-up soon after the initial consultation as well as regular follow-ups to check for side effects and other concerns.
In terms of the sought-after model of self-care, the above reviews partially focus on independent decision making, however an advice on how to promote such behavior, is not presented. Of great relevance is Pound’s et al. (2005) exposure of Dowell and Hudson’s (1997) argument that medicine taking translates directly into admitting that one suffers from an illness.
## Table 2. Chart of eleven existing reviews on a similar topic

<table>
<thead>
<tr>
<th>Review</th>
<th>Type</th>
<th>Data acquisition</th>
<th>Focus of the study</th>
<th>Clinical or research implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alderson, S. L., Foy, R., Glidewell, L., Mclintock, K., &amp; House, A. (2012). How patients understand depression associated with chronic physical disease – a systematic review. BMC Fam Pract BMC Family Practice, 13(1).</td>
<td>Systematic review</td>
<td>Medline, Embase, PsychInfo, Cinahl, Biosis, Web of Science, The Cochrane Library, UKCRN portfolio, National Research Register Archive, Clinicaltrials.gov; searched from database inception to December 31st 2010</td>
<td>Clinically relevant beliefs identified from 65 studies including the difficulty in labeling depression, complex causal factors instead of the biological model, the roles of different treatments and negative views about the consequences of depression.</td>
<td>Approaches to detection of depression in physical illness that are sensitive to the range of beliefs held by patients. Further research is needed to understand fully how people comprehend depression associated with a physical illness and how this influences help-seeking and engagement with health care services.</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title</td>
<td>Methodology</td>
<td>Patient-centered perspective on antidepressant use, which examines research on patients’ attitudes to antidepressants and their treatment preferences; experiences of being prescribed antidepressants and taking antidepressants, as well as reasons for adherence or nonadherence</td>
<td>Studies investigating positive experiences of antidepressants in order to better understand the complex mixture of views and experiences of antidepressants that may result in patients remaining on antidepressants in spite of their misgivings.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Mahtani-Chugani, V., &amp; Sanz, E. J. (2011).</td>
<td>Users Perception of Risk and Benefits of Mood Modifying Drugs. Current Clinical Pharmacology CCP, 6(2), 108-114.</td>
<td>Narrative review</td>
<td>Medline, Healthtalkonline Website</td>
<td>Users’ views about the consumption of mood modifying drugs; personal beliefs, fears and motivations for taking or not taking antidepressants</td>
</tr>
<tr>
<td>Mitchell, A. J. (2007).</td>
<td>Adherence behaviour with psychotropic medication is a form of self-medication. Medical Hypotheses, 68(1), 12-21.</td>
<td>Narrative review</td>
<td>Not provided</td>
<td>The evidence for and against intentionality in psychotropic adherence behavior; Compliance and related predictors in depression, schizophrenia and bipolar disorder</td>
</tr>
<tr>
<td><strong>Mitchell, A. J., &amp; Selmes, T. (2007).</strong> Why don’t patients take their medicine? Reasons and solutions in psychiatry. Advances in Psychiatric Treatment, 13(5), 336-346.</td>
<td>Literature review</td>
<td>Not provided</td>
<td>• Nonadherence, whether intentional or not; • Patients’ reasons for failure to concord with medical advice • Predictors of, and solutions to the problem of nonadherence</td>
<td>▪ Advanced strategies ▪ Simple strategies to improve concordance: ▪ The emerging concept of partial adherence</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Pampallona et al. (2002).</strong> Patient adherence in the treatment of depression. British Journal of Psychiatry, 180, 104-109.</td>
<td>Systematic review</td>
<td>Studies published between Jan. 1973 and Dec. 1999; multiple systematic searches of Medline, Current Contents, PsychInfo, and the Cochrane Collaborative Register of Trials</td>
<td>Non-adherence with antidepressant treatment is very common. Increasing adherence to pharmacological treatment may affect response rate. Factors associated with adherence and of adherence-enhancing interventions.</td>
<td>A new drug will not likely dramatically reduce the high number of patients who do not adhere to treatment. Carefully designed clinical trials needed to clarify the effect of single and combined interventions on adherence, as well as to further investigate the factors affecting adherence.</td>
</tr>
<tr>
<td><strong>Author</strong></td>
<td><strong>Article Title</strong></td>
<td><strong>Type of Review</strong></td>
<td><strong>Methodology</strong></td>
<td><strong>Findings</strong></td>
</tr>
<tr>
<td>-----------</td>
<td>------------------</td>
<td>-------------------</td>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Prins, M. A., Verhaak, P. F., Bensing, J. M., &amp; Meer, K. V. (2008)</td>
<td>Health beliefs and perceived need for mental health care of anxiety and depression—The patients’ perspective explored.</td>
<td>Systematic review</td>
<td>Articles published in peer-reviewed journals; from Jan. 1995 to December 2006, in English, on adults, in: PubMed, PsychInfo, Embase, Cinahl and the Nivel catalogues; General population samples</td>
<td>▪ Perceived causes of depression and specific needs for treatment; ▪ Beliefs about the causes of depression; ▪ Barriers to treatment</td>
</tr>
<tr>
<td>Zivin, K., &amp; Kales, H. C. (2008)</td>
<td>Adherence to Depression Treatment in Older Adults.</td>
<td>Narrative review</td>
<td>Medline search for articles published btw. 1950 and Jan. 2007; hand search.</td>
<td>Factors affecting patient level adherence to depression treatment in older adults</td>
</tr>
</tbody>
</table>
## 4.2. Table 3. Qualitative Studies Selected for Synthesis (n=41)

<table>
<thead>
<tr>
<th>#</th>
<th>Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>Gibson, K., Cartwright, C., &amp; Read, J. (2016). ‘In my life antidepressants have been…’: a qualitative analysis of users’ diverse experiences with antidepressants. <em>BMC psychiatry</em>, 16(1), 135.</td>
</tr>
<tr>
<td>#</td>
<td>Author(s)</td>
</tr>
<tr>
<td>----</td>
<td>-----------</td>
</tr>
</tbody>
</table>


4.3. Themes Emerging from Qualitative Studies Selected for Analysis

Burnard et al., (2008) argue that strict formulas to determine the validity in qualitative analysis do not exist. However, to ensure that the process of analysis is systematic and rigorous, the whole body of collected data must be thoroughly examined. In this review, I used a strategy proposed by Noblit & Hare, (1988) and Britten et al., (2002), known as creation of the third order constructs (Table 2 below). It summarizes conclusions and theories drawn in the process of a) direct interpretation of patients’ narratives (first order constructs) and b) other researchers’ opinions and interpretations expressed as themes and concepts of patients’ views of antidepressant use (second order constructs).

Table 4. Definition of 1st, 2nd and 3rd order constructs

<table>
<thead>
<tr>
<th>First order constructs</th>
<th>Patients’ views, accounts and interpretations of their experiences of using antidepressants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second order constructs</td>
<td>The authors’ views and interpretations (expressed as themes and concepts) of patients’ views of antidepressant use</td>
</tr>
<tr>
<td>Third order constructs</td>
<td>The views and interpretations of the synthesis team (expressed as themes and key concepts)</td>
</tr>
</tbody>
</table>

Adapted from: Noblit & Hare, 1988 and Britten et al., 2002

The basic concept of this review is to achieve a more in-depth focus on emergent issues around the use of antidepressants, such as non-acceptance and non-adherence to treatment, and to tackle problems that remained unsolved or were only partly addressed before (Heaton, 2004). This analysis, called an ‘amplified analysis’, said to be the most common form of qualitative secondary analysis used in health and social studies, is “by its nature closely related to the remit of the initial data collection and aims to extend the original work” (Heaton, 2004). Such analysis combines data emerging from secondary analysis with the primary research, and, by expanding
the volume of comparison, it highlights those aspects that were not attended to in the previous studies.

Qualitative methodologists represent the opinion that “regardless of whether data are analysed by hand or using computer software, the process of thematic content analysis (…) involves identifying themes and categories that 'emerge from the data'” (Pope, Ziebland & Mays, 1999). Discovering themes occurs through the process of verifying, confirming and qualifying findings “by searching through the data and repeating the process to identify further themes and categories” (Pope, Ziebland & Mays, 1999). I thoroughly read and re-read each transcript, making notes within the text and on the margins in the form of words, ideas and short phrases corresponding to what was said in the text. This process is described as open coding. The purpose of doing so is to present brief summaries and statements for each relevant element that is presented in the transcript. With the aim to achieve maximum clarity of my own findings, I adapted Anderson and Roy’s (2013) model of ‘Summary of key findings’. A fragment of my chart, presented below, demonstrates how certain themes emerged from the selected qualitative studies. Some themes identified by Anderson and Roy (2013) were found to match themes that emerged from the collected data. Each theme found multiple references in the studies that were analysed, and also, certain themes are visibly more prevalent than others. The full account of ‘first order constructs’ is introduced in Appendix D.

AD = antidepressant
## Table 5. Themes Emerging from Selected Qualitative Studies (Excerpts)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Positive views on antidepressants</th>
<th>Experiences with health care</th>
<th>Concerns about medicines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment decision and initiation</strong></td>
<td>People went to see GP only after family and friends urged them to do so, others because their behaviour was obviously affecting others (Anderson et al., 2015)</td>
<td>Trust and rapport established between them and their health practitioner (Anderson et al., 2015)</td>
<td>The first mention of medication and antidepressants. And I don't think she'd even finished saying the word before I said 'not a chance.' I said 'do you know who you're talking to here? I'm a detective. I think—this is—you can't do that.' And there was no way. I'd entertain just the label of the drug. Just the term antidepressant to me was ah you just can't hack it, and I thought 'well that's what I think so everybody else must think that.' So I said 'nup, not a chance' (Anderson et al., 2015)</td>
</tr>
<tr>
<td></td>
<td>Husband urged patient to see her GP. Her behavior was hyperactive and out of character. Patient requested referral to a psychiatrist for assessment (Amey, 2010)</td>
<td>“If she hadn’t been able to turn my thinking around in that first appointment in the way that she did, you know, I’m not convinced I would have been motivated to take the medication. And certainly, you know, knowing now that it does take sort of four to six weeks to really start to have an effect I might have—even if I had started taking it—I may well have given up after two weeks, you know. But her influence was powerful enough that it changed everything about the way I was looking at the illness and subsequently at myself...So she then spent the time explaining about depression and different causes and then the medications” (Anderson et al., 2015)</td>
<td>Carers wish for more easily accessible, detailed and user-friendly information (Boyle &amp; Chambers, 2000)</td>
</tr>
<tr>
<td></td>
<td>The case underscores the important role the GP has in the early detection (Amey, 2010)</td>
<td>Patients often felt depressed for a long time, only seeing a doctor and being prescribed an AD after reaching a crisis point (Anderson et al., 2015)</td>
<td>Three pregnant women elected not to use ADs at anytime during the pre- and postpartum periods (Bennett et al., 2007)</td>
</tr>
<tr>
<td></td>
<td>Participants often felt depressed for a long time, only seeing a doctor and being prescribed an AD after reaching a crisis point (Anderson et al., 2015)</td>
<td>Overwhelming impact of depressive symptoms meant that not taking the treatment was not an option (Anderson et al., 2015)</td>
<td>Patient history and the speed of recovery, which was coincident with the discontinuation of AD treatment, is consistent with the hypothesis of mania as a side effect of AD treatment (Amey, 2010)</td>
</tr>
<tr>
<td></td>
<td>Patient started taking an SSRI which convinced him that there was a problem because he felt much better, and the change was fantastic (Anderson et al., 2015)</td>
<td>People can feel unsure about what to expect once they take the AD (Anderson et al., 2015)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Some women took AD medication during pregnancy, five commenced medication within two months of delivering, and one woman delayed commencing AD medication (Anderson et al., 2015)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
until she had stopped breast feeding her baby. Three women elected not to use antidepressants at any time during the pre- and postpartum periods (Bennett et al., 2007)

Receiving a diagnosis, being informed about depression, that it is a common illness and recovery is expected, were extremely important for recovery (Badger & Nolan, 2007)

Many patients acknowledged that they experienced poor memory and concentration and could remember very little verbal information, especially from the initial consultation (Badger & Nolan, 2007)

Receiving a diagnosis was a turning point for many, especially if they had been unwell for some time, had been initially diagnosed with a physical illness, or not offered any diagnosis (Anderson et al., 2015)

I left them on my top shelf for ages and I just didn't want to take them because I was a bit confused as why I was prescribed me that after like a really short chat, just me saying I was down and maybe at the time they were handing them out left right and centre, I don't know (Anderson et al., 2015)

First experience was pleasant and viewed antidepressants as essential (Anderson & Roy, 2013)

Ombudsman about the management of her case by her GP (Amey, 2010)

The extent to which patients accept their diagnosis and prescription of antidepressants at the early point of consultation with health professionals is critical in determining their ongoing adherence to medication in the future (Badger & Nolan, 2007)

Concerns about the way consultations unfolded, particularly where patients felt like there was a lack of discussion and negotiation (Anderson et al., 2015)

Practice nurses, community mental health nurses (CMHNs) and GPs were identified as information providers (Badger & Nolan, 2007)

Community mental health nurses’ roles as good listeners and confidantes were complementary to GPs’ roles, most vital elements in patient’s roles were the initial consultation with the GP and subsequently the practice-based visits (Badger & Nolan, 2007)

Hearing ‘You have a common condition’ and ‘You will get better’ from practitioners was sometimes totally unexpected, but usually welcome information. People’s shock at being told they were suffering from depression was generally more than compensated for by it can be difficult to make decisions and think things through when very ill with depression (Anderson et al., 2015)

For some, attributing recovery to medication diminished their own roles and personal strengths emerged as important to beliefs about recovery (Badger & Nolan, 2007)

ADs are regarded as more stigmatizing than depression (Badger & Nolan, 2007)

Other people assume that I’m on it [antidepressants] because I’m lazy because I don’t want to put in that effort to go see a psychologist and empty my emotional bucket all the time (Brijnath & Antoniades, 2016)

First prescribed an AD he said he felt it signified his depression as ‘official’, likening it to a defeat, as though he had ‘surrendered’ (Anderson et al., 2015)

had felt it was taking the ‘lazy’ option when he was first prescribed an AD, and said it felt like avoiding responsibility for his own well-being (Anderson et al., 2015)
taking ADs for the first time can be a particularly anxiety provoking time, and people may reject the medicines at this time, particularly if they feel unsupported (Anderson et al., 2015)

people do want to know what to expect before they started taking an antidepressant (Anderson et al., 2015)

They felt reassured when they were provided with information and told that they can try different types of antidepressants if side effects were intolerable (Anderson et al., 2015)

Readiness to take the medication linked to expectation regarding the medicine’s therapeutic effects and to a strong belief in the authority of the prescribing therapists and healthcare professionals (Buus, 2014)

Continued taking the medication in accordance with professional advice, mainly because they saw medicine as the primary means of recovery (Buus, 2014)

Most of participants sceptical towards taking ADs and experienced some relatively mild adverse effects, but they justified continuing taking the medicine by referring to their necessity and to the risk of relapse. They feared stopping taking the medicine: “I don't know what it would be like if I didn't take them.” (Buus, 2014)

the relief that they had a known and common illness and recovery was possible (Badger & Nolan, 2007)

Understanding and unshockable health professionals who offered unhurried consultations had the potential to contribute towards recovery; for people were often extremely anxious about practitioners’ reactions to what they suspected was a mental illness (Badger & Nolan, 2007)

Many feared that the stigma present among the public also existed among health professionals. One respondent's GP told him ‘I've been expecting you for some time’, making the consultation easier (Badger & Nolan, 2007)

I felt completely excluded from the decision-making. Well, yeah, on her notes I think she wrote depressed, and I think she said to me, “I think you're suffering with depression and need antidepressants” And she put me on antidepressants straight away, and on sleeping tablets as well I think. She didn't even ask me! (Anderson & Roy, 2013)

This GP insisted that I take her prescription. And I had said, ‘no,’ I had said ‘no’ about three times. In the end she said to me, ‘I don't know what’s wrong with depressed people, why they always refuse to take my prescriptions. I think
Patients, who were initially very sceptical towards taking ADs, ended up accepting them as equivalent to taking vitamins (Buus, 2014).

Some went to the general practitioner (GP) only after family and friends urged them to do so, others because their behaviour was obviously affecting other people (Anderson et al., 2015).

It can be difficult for people to recognise the signs and symptoms of depression (Anderson et al., 2015).

Difficult for patients was feeling that they were being coerced into taking ADs, or that they do not have a choice in the matter (Anderson et al., 2015).

Many people were relieved to be diagnosed with depression and be prescribed an AD (Badger & Nolan, 2007).

Ten women took antidepressant medication during pregnancy, five commenced antidepressant medication within two months of delivering, and one woman delayed commencing antidepressant medication until she stopped breast feeding her baby (Bennett et al., 2007).

Some people perceive ADs as being no different to other medicines (Anderson et al., 2015).

depressed people like being depressed.’ I felt like she’d shamed me into taking her prescription (Anderson & Roy, 2013).

being listened too and given sufficient time and information was universally recognised as positive and valuable, and key to the trust and rapport established between them and their health practitioner (Badger & Nolan, 2007).

‘shared decision-making’ not experienced older people in particular described one-way conversations which involved them simply acceding to their doctors wishes, saying they had always believed that the ‘doctor knows best’ (Anderson et al., 2015).

People typically linked their experiences with ADs to their interactions with doctors in their consultations (Badger & Nolan, 2007).

People need to feel supported by health professionals when they start taking antidepressants (Anderson et al. 2015).

Participants reported that for health providers, prescriptions appeared to be an easier option (Anderson et al., 2015).

Some felt they were not given sufficient time during their consultation information or support to take the medicines (Anderson et al., 2015).
| Continuous medication treatment-attitudes to and concerns about ADs | Being offered a prescription for an AD brought significant relief, as it helped people to feel that their symptoms were recognised as a legitimate illness (Anderson et al., 2015)  
Internet is routinely used by people to look up health information, including about different types of ADs and side effects (Anderson et al., 2015)  
Internet used to find out about others’ experiences with ADs (Anderson et al., 2015)  
Internet forums used where witnessing others’ experiences helped people appreciate their own experience better (Anderson et al., 2015)  
Some people recalled very positive initial experiences of concordant consultations involving shared decision making, including a good discussion about their views, fears and apprehensions and previous experiences of taking antidepressants (Anderson et al., 2015)  
Women sought care from providers who were experts in the field of reproductive mental health (Bennett et al., 2007)  
Some, particularly those with a pre-existing depression, considered that only a psychiatrist experienced in the care of pregnant and postpartum women was acceptable (Bennett et al., 2007)  
Clinical inertia: doctors' unwillingness to initiate medicine even though that viewed essential by the patients themselves (Anderson & Roy, 2013)  
Apparent dismissive reactions and preoccupation with note taking or prescription writing (Anderson et al., 2015)  
Part of balancing the effects of antidepressant use included self-medication (Brijnath & Antoniades, 2016)  
In some instances, participants even went so far as to either buy medicines online or bring in medicines from overseas (Brijnath & Antoniades, 2016)  
I have “enferma de los nervios.” And there is stigma attached to it (Carpenter-Song et al. 2010)  
| Continuous medication treatment-attitudes to and concerns about ADs | Once they label you, they never look at you the same. The psychiatric label “changes you forever.” (Carpenter-Song et al. 2010)  
I have “enferma de los nervios.” And there is stigma attached to it (Carpenter-Song et al. 2010) |
The presence of, and support from, family and friends was often cited as central to recovery and identified by many as the major factor (Badger & Nolan, 2007)

ADs did help improve mood: “Brain space springing up,” “even keel” and “reduces the pain” were common descriptions of the positive effects of ADs that had to be balanced against adverse effects (Brijnath & Antoniades, 2016)

I got labeled mentally retarded and a psycho by my friends and stuff when I got out [of the hospital], I lost like all of my friends. It was rough (Carpenter-Song et al. 2010)

I would “never” tell my co-workers about receiving treatment: Because they would pick on me. When you tell people you have a mental problem, they pick on you and blame everything on you because they know you have something wrong with you (Carpenter-Song et al. 2010)

I was hoping to get some distance from my family. It’s the blame and change syndrome. They think it’s my fault that I’m mentally ill. Fourteen years ago I was diagnosed as mentally ill and my father and my mother and my brother talked about me like a ladybug on a window. They talked in circles and then got angry at me (Carpenter-Song et al. 2010)

They don’t know what works and what don’t work. First, they put you on a medication and when you tell them you don’t need it anymore they just put you on another one. I get sick of taking pills, pills, pills. I don’t need all this medication. They keep telling me I need medication but I don’t. The medication is what makes me sick. I don’t feel right when I take it anyway (Carpenter-Song et al. 2010)

| Adverse effects | Those who did not experience any adverse reactions- highlighted the importance of medicines and ignored minor side effects (if encountered any) (Anderson & Roy, 2013) | Continuous adverse side effects or at some point of their drug treatment (Anderson & Roy, 2013) |
negative side-effects such as dry mouth, sexual dysfunction, lethargy, tiredness, feeling dizzy and jittery (Brijnath & Antoniades, 2016)

ADs were not ‘silver bullets’ or ‘magic,’ often caused severe side-effects, and required experimentation until an appropriate drug and dosage was found (Brijnath & Antoniades, 2016)

AD might make one feel ‘fluffy’ or ‘out of control’ (Anderson et al., 2015).

Dry mouth, dizziness, inability to concentrate to routine work, sleep disruption, loss of motivation, weight loss/gain, agitation, hair loss. as side effects (Anderson & Roy, 2013)

Difficulties to perform routine works/job due to medicines use (Anderson & Roy, 2013)

Sexual dysfunction (Anderson & Roy, 2013)

inferiority complex/loss of self-confidence (Anderson & Roy, 2013)

suspected AD-induced mania (Amey, 2010)

Weight gain and tiredness (Buus, 2014)

I think any depression you have you’re half way, you’ve got to do it yourself, you cannot rely on the medication, you’ve got to be willing to try, you don’t get a miracle cure out of a bottle, it can help you over the bad times but it’s not a cure, that’s up to you. I might be mad but that’s how I think (Badger & Nolan, 2007)

<p>| Medicine information | Validating ADs by gathering information on prescribed medicine, internet routinely used by people to look up health information (Anderson et al., 2015) | Most respondents expressed a strong wish to be more informed about their prescribed medicines so that they could develop a trustworthy relationship with their doctors to continue their medicines (Anderson &amp; Roy, 2013) | Part of balancing the effects of AD use included self-medication. Self-medication involved adjusting drug dosages, combining ADs with alcohol and other drugs, and concurrently using AD and complementary and alternative medicines (Brijnath &amp; Antoniades, 2016) |</p>
<table>
<thead>
<tr>
<th>Many preferring to trust their practitioners to make choice on behalf of them. Many patients reflected good relationships with their doctors and had great confidence in the doctor’s skills (Anderson &amp; Roy, 2013)</th>
<th>Being able to talk to the doctor enabled many respondents to reflect on their difficulties, and to clarify or reframe their experiences (Anderson &amp; Roy, 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other reflected adversarial or disconnected relationships with their psychiatrists/GPs/consultants (Anderson &amp; Roy, 2013)</td>
<td>The participants often blamed the medicine having adverse effects rather than considering other reasons for their distress, such as their depressive illness (Buus, 2014)</td>
</tr>
<tr>
<td>Patients’ disappointment regarding chronic depression often leads many respondents to challenge the authority or the working style of the service providers (GPs, consultants, counselors) (Anderson &amp; Roy, 2013)</td>
<td>frustrated patients desperately sought to change their situation, who did not believe that the medicine was important for solving their issues, in most cases they believed that adverse effects added significantly to their problems (Buus, 2014)</td>
</tr>
<tr>
<td>A lack of information about ADs was a major cause of dissatisfaction often shaping attitudes to ADs (Anderson &amp; Roy, 2013)</td>
<td>Patient successfully insisted on a gradual reduction and stop of the medicine simply because he had taken it for exactly six months, which, allegedly, was the period needed to have a low risk of relapse. This happened despite him having frequently experienced severe and disabling symptoms of relapse into depression (Buus, 2014)</td>
</tr>
<tr>
<td>Dissatisfaction with the doctor-patient interaction in terms of lack of attention or acknowledgement on the part of the doctor (for example, dismissive reactions or preoccupation with note taking) and superficial responses (Anderson &amp; Roy, 2013)</td>
<td>It is good that you can get medicine when you have pain and medicine when you are depressed. But I don't think it is a solution to just add more and more medicine because you go crazy because you’re doped all the time. I think I’m taking something like 29 pills a day (Buus, 2014)</td>
</tr>
</tbody>
</table>

One participant, who came out of a family with severe mental illness, found taking ADs stigmatising and she continued to put pressure on her general practitioner to authorise phasing out of the medicine even though she feared a relapse of depression (Buus, 2014)
| doctors did not spend enough time with them, did not communicate well with them, did not listen well to them, did not inform the up-to-date information about medicine and did not behave well  
**Anderson & Roy, 2013**
| Persistent tension between the patient and provider has a fatalistic dimension too (e.g. taking overdose)  
**Anderson & Roy, 2013**
| Disconnected relationship with health care professionals further precipitated if patients were less informed about their health conditions and prescribed medicines  
**Anderson & Roy, 2013**
| A persistent tension was observed between “what was promised” and “what was actually delivered” in practice  
**Anderson & Roy, 2013**
| Most reported receiving little or no information from their providers about depression and their medicines (e.g. side effect, length of treatment, outcomes). They also felt the information they received from mental health professionals was inadequate  
**Anderson & Roy, 2013**
| Many welcomed information provided by the facilities and physicians. Few respondents reported having received |
| --- | --- | --- |
| Some adverse effects were experienced as intolerable if they threatened a particular person's identity  
**Buus, 2014**
| Some patients found weight gain or sexual disturbances stigmatising and intolerable (while others did not care much about it)  
**Buus, 2014**
| Experiences of such identity-threatening adverse effects added significantly to the patients’ eagerness to get off the medicine  
**Buus, 2014**
| Most patients were impatient to get back to their old life  
**Buus, 2014**
| For other patients, it was very hard following a regular treatment regime for an illness they were desperately eager to get rid of  
**Buus, 2014**
| A lack of information on their medicines appeared to be a key issue of dissatisfaction for many respondents  
**Anderson & Roy, 2013**
| Subjects often seeking out information from sources, such as books, broadcast media, the library, friends, and the Internet  
**Anderson et al., 2015**
| Deliberate adjustments were observed (either omissions or taking extra doses)  
**Anderson & Roy, 2013** |
<table>
<thead>
<tr>
<th>Factors relevant for optimal treatment outcome and patients’ recommendation</th>
<th>written information e.g. information leaflets (Anderson &amp; Roy, 2013)</th>
<th>Around 40% of patients who start treatment with ADs fill only a single prescription at the pharmacy, apparently not accepting treatment and, as with other new medicines stop taking them after 2 weeks (Anderson et al., 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Once people have got their ADs from the pharmacy they often struggle with actually taking the first dose (Anderson et al., 2015)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participant had previously been treated with ADs, but this time she experienced severe adverse effects of the medicine, which included a substantial weight gain and tiredness. But she was scared of discontinuing taking the medicine despite the adverse effects (Buus, 2014)</td>
</tr>
<tr>
<td>Many women shared previous lack of awareness about the possibility of experiencing depression during pregnancy (Benett et al., 2007)</td>
<td>People need to feel supported by health professionals when they start taking ADs (Anderson et al., 2015)</td>
<td>ADs appear to occupy a central place in many people’s lives. Many people described how their medicines had helped them and how this served as a reinforcement to continue taking them in order to maintain a “normal life” (Anderson &amp; Roy, 2013)</td>
</tr>
<tr>
<td>Supportive safety offered by family, friends and health practitioners was identified by many participants and the importance attached to such support means that practitioners should aim to clarify patients’ ‘supportive others’, and offer additional resources where appropriate (Badger &amp; Nolan, 2007)</td>
<td>People need additional support when they make decisions about starting ADs (Anderson et al., 2015)</td>
<td>Case of suspected antidepressant-induced mania strengthens the need for further investigation of this phenomenon in unipolar depression (Amey, 2010)</td>
</tr>
<tr>
<td></td>
<td>If people trusted and respected their doctor and felt guided and informed, they also reported initiation of treatment as less problematic (Badger &amp; Nolan, 2007)</td>
<td>Case study cautionary against the use of multiple antidepressants (Amey, 2010)</td>
</tr>
</tbody>
</table>
Practitioners involved in prescribing and medication management for depression must aim to explore patients’ beliefs about appropriate treatments and recovery (Badger & Nolan, 2007)

Addressing these can potentially promote treatment concordance and enhance recovery from depression by establishing and sustaining therapeutic relationships (Badger & Nolan, 2007)

Need for prompt specialist treatment for patients with sub-threshold hypomanic symptoms (Amey, 2010)

Due to difficulties encountered at initiation of antidepressant therapy, healthcare professionals should consider to optimally structure their consultations to provide the best information (Anderson et al. 2015)

Conflicting information found online can be frightening and health professionals could help by directing people to credible websites (Anderson et al., 2015)
4.4. Beliefs, Views, and Behaviors that Bring Patients to Start, Continue and/or Discontinue Treatment with Antidepressants

The next step taken in the analytical process of searching for more in-depth information was the identification of sub-themes and additional concepts or clues in order to provide an even more detailed description of beliefs, rationale, and behavioral patterns that bring patients to refuse or discontinue the intake of antidepressants after the initial start of treatment. The following events and situations were found to be the breaking points in patients’ treatment decisions:

1. **Acceptance of antidepressant treatment option**
   - Perceived health threat at start of treatment / Crisis
   - Treatment decision making and initiation of treatment
   - Reasons for accepting diagnosis and medication
   - Attitude towards own illness and treatment
   - Health literacy / knowledge of depression and available treatment options

2. **Execution of treatment**
   - Benefits of antidepressant use
   - Negative consequences of antidepressant use
   - Self-efficacy in adherence and non-adherence to treatment
   - Communication and support of health care professionals during treatment
   - Social pressure and support to start and continue vs. luck of support and pressure to discontinue the drug use

*Table 6*, adapted from van Geffen’s study, indicates how those issues are externalized and which studies touch upon them.
<table>
<thead>
<tr>
<th>Topic list</th>
<th>Initiation of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health threat at start of treatment/Crisis</td>
<td>Type of symptoms (sadness, worry, anxiety, somatic complains)</td>
</tr>
<tr>
<td>Duration of symptoms</td>
<td>Perceived seriousness of the illness</td>
</tr>
<tr>
<td>Perceived seriousness of the illness</td>
<td>Labeling of symptoms</td>
</tr>
<tr>
<td>Labeling of symptoms</td>
<td>Social impact of illness</td>
</tr>
<tr>
<td>Social impact of illness</td>
<td>Family history</td>
</tr>
<tr>
<td>Family history</td>
<td>Feelings of loss of control and helplessness</td>
</tr>
<tr>
<td>Feelings of loss of control and helplessness</td>
<td>Prior experiences</td>
</tr>
<tr>
<td>Prior experiences</td>
<td>Previous experience with antidepressants</td>
</tr>
<tr>
<td>Previous experience with antidepressants</td>
<td>Role of GP in treatment decision</td>
</tr>
<tr>
<td>Role of GP in treatment decision</td>
<td>Role of patient in treatment decision</td>
</tr>
<tr>
<td>Role of patient in treatment decision</td>
<td>Influence of family and friends</td>
</tr>
<tr>
<td>Influence of family and friends</td>
<td>Lack of information about medication</td>
</tr>
<tr>
<td>Lack of information about medication</td>
<td>Extreme bothersome mental and physical symptoms</td>
</tr>
<tr>
<td>Extreme bothersome mental and physical symptoms</td>
<td>Family support and encouragement</td>
</tr>
</tbody>
</table>
### Reasons for starting treatment

<table>
<thead>
<tr>
<th>Reason</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical diagnosis of illness</td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td></td>
</tr>
<tr>
<td>Lasting sadness</td>
<td></td>
</tr>
<tr>
<td>Feelings of emotional emptiness</td>
<td></td>
</tr>
<tr>
<td>Feelings of loneliness</td>
<td></td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td></td>
</tr>
<tr>
<td>Body aches</td>
<td></td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td></td>
</tr>
<tr>
<td>Stressful experiences</td>
<td></td>
</tr>
<tr>
<td>Awareness of family history of depressive illness</td>
<td></td>
</tr>
<tr>
<td>Knowledge of consequences of untreated symptoms</td>
<td></td>
</tr>
<tr>
<td>Encouragement from others</td>
<td></td>
</tr>
<tr>
<td>Loss of control</td>
<td></td>
</tr>
<tr>
<td>Aid to surviving a crisis</td>
<td></td>
</tr>
<tr>
<td>Old age</td>
<td></td>
</tr>
</tbody>
</table>

### Attitude toward illness and treatment

<table>
<thead>
<tr>
<th>Attitude</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional vs physical problem</td>
<td>Anderson et al. 2015; Bennett et al. 2007; Boyle &amp; Chambers 2000; Brijnath &amp; Antoniades 2016; Buus 2014; Carpenter-Song 2010; Castonguay, Filer &amp; Pitts 2016; Chur-Hansen &amp; Zion 2006; Cohen &amp; Hughes 2011; Dickinson et al. 2010; Fosgerau &amp; Davidsen 2014; Frank et al. 2007; Fullagar 2009; Fullagar &amp; O’Brien 2013; Gammel &amp; Stoppard 1999; Gibson, Cartwright &amp; Read 2016 (a); Gibbons,</td>
</tr>
<tr>
<td>Fear of side effects</td>
<td></td>
</tr>
<tr>
<td>Fear of addiction</td>
<td></td>
</tr>
<tr>
<td>Aversion toward medication (chemical, unnatural)</td>
<td></td>
</tr>
<tr>
<td>Influence on self-esteem</td>
<td></td>
</tr>
<tr>
<td>Religious beliefs and practices</td>
<td></td>
</tr>
<tr>
<td>Social influences</td>
<td></td>
</tr>
<tr>
<td><strong>Stereotypes and stigma</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Relief from symptoms</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Recovery</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Knowledge of depression and its treatment</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Ambivalence, disappointment</strong></td>
<td></td>
</tr>
</tbody>
</table>

| **Knowledge of depression and its treatment** | Own and others’ experience; Delay in effect; Risk and time course of side effects; Duration of use according to guidelines; Serotonin imbalance theory; Addiction and dependence; Discontinuation of antidepressants; Discontinuation symptoms | Amey 2010; Bennett et al. 2007; Boyle & Chambers 2000; Carpenter-Song 2010; Chur-Hansen & Zion 2006; Cohen & Hughes 2011; Dickinson et al. 2010; Dickenson et al. 2010; Fullagar & O’Brien 2013; Gammel & Stoppard 1999; Gibson, Cartwright & Read 2016 (a); Gibson, Cartwright & Read 2016 (b); Patel et al. 2013; Simon et al. 2007; Smardon 2007; Stanton & Randal 2016; van Geffen et al. 2011; van Grieken et al. 2014; |

| **Benefits of antidepressant use** | Effectiveness, improvement of symptoms; Improved quality of life; Social functioning; Improved cognition; Relief of symptoms; Recovery | Badger & Nolan 2007 (b); Bennett et al. 2007; Buus 2014; Castonguay, Filer & Pitts 2016; Chur-Hansen & Zion 2006; Cohen & Hughes 2011; Dickinson et al. 2010; Fosgerau & Davidsen 2014; Frank et al. 2007; Jaffray et al. 2014; Malpass et al. 2011; Murawiec 2008; Stanton & Randal 2016; van Geffen et al 2011; |
| Negative consequences of antidepressant use | Experienced side effects | Amey 2010; Bayliss & Holttum 2015; Buus 2014; Chur-Hansen & Zion 2006; Cohen & Hughes 2011; Fullagar 2009; Fullagar & O’Brien 2013; Gammel & Stoppard 1999; Gibson, Cartwright & Read 2016 (a); Gibson, Cartwright & Read 2016 (b); Givens et al. 2006; Lafrance 2014; Vargas et al. 2015; |
| | Bothersomeness of side effects | |
| | Ineffectiveness of treatment | |
| | Stigmatization | |
| | Feeling of ‘drug loop’ | |
| Self-efficacy | Confidence in one’s ability to take action | Bennett et al. 2007; Bayliss & Holttum 2015; Brijnath & Antoniades 2016; Buus 2014; Chur-Hansen & Zion 2006; Cohen & Hughes 2011; Dickinson et al. 2010; Frank et al. 2007; Fullagar 2009; Fullagar & O’Brien 2013; Gammel & Stoppard 1999; Gibson, Cartwright & Read 2016 (a); Gibson, Cartwright & Read 2016 (b); Lafrance 2007; Ridge et al. 2015; Vargas et al. 2015; |
| | Adherence to treatment | |
| | Able to communicate with GP | |
| | Alternative treatment strategies | |
| | Social involvement | |
| | Taking control | |
| | Non-adherence to treatment | |
| Communication and support of health care professionals during treatment | GP/Psychiatrist/Nurse | Anderson & Roy 2013; Anderson et al. 2015; Boyle & Chambers 2000; Buus 2014; Chur-Hansen & Zion 2006; Cohen & Hughes 2011; Fosgerau & Davidsen 2014; Gammel & Stoppard 1999; Izquierdo et al. 2014; Malpass et al. 2011; Stanton & Randal 2016; |
| | Underlying cause not addressed | |
| | Feeling ignored | |
| Social pressure and support to start and continue vs. luck of support and pressure to discontinue the drug use | Partner, family and friends | Boyle & Chambers 2000; Castonguay, Filer & Pitts 2016; Chur-Hansen & Zion 2006; Fullagar 2009; Fullagar & O’Brien 2013; Gammel & Stoppard 1999; Gibson, Cartwright & Read 2016 (b); Lafrance 2014; Smardon 2007; Vargas et al. 2015; |
| | GP | |
| Discontinuation of treatment | Feeling better  
Dilemmas about dependency,  
Side effects  
Frustration  
Lack of efficacy  
Adverse effects  
Balancing the risk  
Difficult process of withdrawing  
Self-regulation of drug treatment  
Doubts about chemical imbalance,  
Beliefs that medication causes a chemical imbalance  
Fear and uncertainty | Amey 2010; Anderson & Roy 2013; Bayliss & Holttum 2015; Boyle & Chambers 2000; Brijnath & Antoniades 2016; Buus 2014; Fosgerau & Davidsen; Fullagar 2009; Fullagar & O’Brien 2013; Gammel & Stoppard 1999; Gibson, Cartwright & Read 2016 (a); Gibson, Cartwright & Read 2016 (b); Givens et al. 2006; Hansen & Cabassa 2012; Jaffray et al. 2014; Kadir & Bifulco 2010; Lafrance 2014; Lavender, Khondoker & Jones 2006; Lawrence et al. 2006; Malpass et al. 2011; Patel et al. 2013; Smardon 2007; Stanton & Randal 2016; van Geffen et al. 2011; |
| Considerations to continue treatment | Symptom relief  
Improved cognition  
Improved sleep  
Optimism and hope  
Prior experiences  
Barriers to discontinuation | Anderson et al. 2015; Buus 2014; Castonguay, Filer & Pitts 2016; Cohen & Hughes 2011; Dickinson et al. 2010; Fosgerau & Davidsen 2014; Frank et al. 2007; Izquierdo et al. 2014; Murawiec 2008; Patel et al. 2013; Stanton & Randal 2016; van Geffen et al. 2011; |
| Considerations to discontinue treatment | Attitudes to taking ADs  
Conflicts about taking ADs  
Mixed experiences of ADs  
Adverse effects  
Social barriers  
Misconceptions and prejudice  
Prior experiences | Amey 2010; Bennett et al. 2007; Bayliss & Holttum 2015; Brijnath & Antoniades 2016; Buus 2014; Fosgerau & Davidsen 2014; Fullagar 2009; Fullagar & O’Brien 2013; Gibson, Cartwright & Read 2016 (a); Gibson, Cartwright & Read 2016 (b); Givens et al. 2006; Malpass et al. 2011; Patel et al. 2013; |
4.5. Triangulation of Synthetized Qualitative Data

Various approaches to data collection can be employed to confirm or disconfirm previous research results. “The underlying assumption is that the validity of research results is enhanced if the different methodological approaches produce convergent findings about the same empirical domain” (Erzerberger & Prein, 1997). Health research supports the analysis of mixed-methods studies with the belief that all types of scholarly investigation, qualitative as much as quantitative, “share a common goal of improving human condition” (Everest, 2014).

Triangulation of data refers specifically to the application and combination of several research methods in the study of the same phenomenon.

This study is conducted in such a way that the analysis of findings emerging from selected qualitative studies has been strengthened by content analysis of quantitative data on the same topic: non-acceptance of and non-adherence to antidepressant treatment. The application of various sources of data and the use of multiple perspectives and theories serve the purpose of demonstrating the consistency of information. The end result is believed to be the assertion of the true value of all collected data, which indicates their credibility and trustworthiness.

In promoting increasing adherence to therapeutic recommendations in depression, it is crucial to identify factors that are known to contribute to discontinuation of treatment (Bennett et al., 2010). Summarizing, my findings fall into two major parts:

(i) the ways people evaluate their needs of being treated with antidepressants;

(ii) the difficulties patients encounter in adhering with drug therapy in depression.

The following 71 epidemiological and quantitative studies have been used in the process of cross-examination of data.
<table>
<thead>
<tr>
<th>#</th>
<th>Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aikens, Nease &amp; Klinkman (2008)</td>
</tr>
<tr>
<td></td>
<td>Explaining patients’ beliefs about the necessity and harmfulness of antidepressants</td>
</tr>
<tr>
<td>2</td>
<td>Aikens &amp; Klinkman (2012)</td>
</tr>
<tr>
<td></td>
<td>Changes in patients’ beliefs about their antidepressant during the acute phase of depression treatment</td>
</tr>
<tr>
<td>3</td>
<td>Ambresin et al. (2015)</td>
</tr>
<tr>
<td></td>
<td>What factors influence long-term antidepressant use in primary care? Findings from the Australian diamond cohort study</td>
</tr>
<tr>
<td>4</td>
<td>Bazargan et al. (2005)</td>
</tr>
<tr>
<td></td>
<td>Treatment of Self-Reported Depression Among Hispanics and African Americans</td>
</tr>
<tr>
<td>5</td>
<td>Bennett et al. (2010)</td>
</tr>
<tr>
<td></td>
<td>Pregnancy-Related Discontinuation of Antidepressants and Depression Care Visits Among Medicaid Recipients</td>
</tr>
<tr>
<td>6</td>
<td>Bitner et al. (2003)</td>
</tr>
<tr>
<td></td>
<td>Subjective Effects of Antidepressants. A Pilot Study of the Varieties of Antidepressant-Induced Experiences in Meditators</td>
</tr>
<tr>
<td>7</td>
<td>Brown et al. (2005)</td>
</tr>
<tr>
<td></td>
<td>Beliefs About Antidepressant Medications in Primary Care Patients Relationship to Self-Reported Adherence</td>
</tr>
<tr>
<td>8</td>
<td>Burra et al. (2007)</td>
</tr>
<tr>
<td></td>
<td>Predictors of Self-Reported Antidepressant Adherence</td>
</tr>
<tr>
<td>9</td>
<td>Cabassa et al. (2007)</td>
</tr>
<tr>
<td></td>
<td>“It’s like Being in a Labyrinth:” Hispanic Immigrants’ Perceptions of Depression and Attitudes Toward Treatment</td>
</tr>
<tr>
<td>10</td>
<td>Chakraborty et al. (2009)</td>
</tr>
<tr>
<td></td>
<td>Attitudes and beliefs of patients of first episode depression towards antidepressants and their adherence to treatment</td>
</tr>
<tr>
<td>11</td>
<td>Cooper et al. (2007)</td>
</tr>
<tr>
<td></td>
<td>Why people do not take their psychotropic drugs as prescribed: results of the 2000 National Psychiatric Morbidity Survey</td>
</tr>
<tr>
<td>12</td>
<td>De las Cuevas et al. (2014)</td>
</tr>
<tr>
<td></td>
<td>Risk factors for non-adherence to antidepressant treatment in patients with mood disorders</td>
</tr>
<tr>
<td>13</td>
<td>Demyttenaere et al. (2015)</td>
</tr>
<tr>
<td></td>
<td>What is important in being cured from depression? Does discordance between physicians and patients matter?</td>
</tr>
<tr>
<td>14</td>
<td>Demyttenaere et al. (2015)</td>
</tr>
<tr>
<td></td>
<td>What is important in being cured from depression? Discordance between physicians and patients</td>
</tr>
<tr>
<td>15</td>
<td>Dijkstra and Jaspers (2008)</td>
</tr>
<tr>
<td></td>
<td>Psychiatric and Psychological Factors in Patient Decision Making Concerning Antidepressant Use</td>
</tr>
<tr>
<td>16</td>
<td>Dobscha et al. (2007)</td>
</tr>
<tr>
<td></td>
<td>Depression Treatment Preferences of VA Primary Care Patients</td>
</tr>
<tr>
<td>17</td>
<td>Dunlop et al. (2012)</td>
</tr>
<tr>
<td></td>
<td>Depression beliefs, treatment preference, and outcomes</td>
</tr>
<tr>
<td></td>
<td>Reference</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>18</td>
<td><strong>Ekselius, Bengtsson &amp; von Knorring (2000)</strong></td>
</tr>
<tr>
<td>19</td>
<td><strong>Fawzi et al. (2012)</strong></td>
</tr>
<tr>
<td>20</td>
<td><strong>Frankenberger et al. (2004)</strong></td>
</tr>
<tr>
<td>21</td>
<td><strong>Gabriel &amp; Violato (2010)</strong></td>
</tr>
<tr>
<td>22</td>
<td><strong>Gardner et al. (2007)</strong></td>
</tr>
<tr>
<td>23</td>
<td><strong>Gaudiano et al. (2013)</strong></td>
</tr>
<tr>
<td>24</td>
<td><strong>Goodman (2009)</strong></td>
</tr>
<tr>
<td>25</td>
<td><strong>Hamilton et al. (1984)</strong></td>
</tr>
<tr>
<td>26</td>
<td><strong>Hansson et al. (2012)</strong></td>
</tr>
<tr>
<td>27</td>
<td><strong>Hanson and Scogin (2008)</strong></td>
</tr>
<tr>
<td>28</td>
<td><strong>Houle et al. (2013)</strong></td>
</tr>
<tr>
<td>29</td>
<td><strong>Hudson et al. (2015)</strong></td>
</tr>
<tr>
<td>30</td>
<td><strong>Kasteenpohja et al. (2015)</strong></td>
</tr>
<tr>
<td>31</td>
<td><strong>Keers et al. (2010)</strong></td>
</tr>
<tr>
<td>32</td>
<td><strong>Kessing et al. (2005)</strong></td>
</tr>
<tr>
<td>33</td>
<td><strong>Kikuchi et al. (2011)</strong></td>
</tr>
<tr>
<td>34</td>
<td><strong>Kwan et al. (2010)</strong></td>
</tr>
<tr>
<td>35</td>
<td><strong>Kwon et al. (2003)</strong></td>
</tr>
<tr>
<td>36</td>
<td><strong>Lewis-Fernández et al. (2013)</strong></td>
</tr>
<tr>
<td>37</td>
<td>Leykin et al. (2007)</td>
</tr>
<tr>
<td>38</td>
<td>Madsen et al. (2009)</td>
</tr>
<tr>
<td>39</td>
<td>Lynch et al. (2011)</td>
</tr>
<tr>
<td>40</td>
<td>Maidment et al. (2002)</td>
</tr>
<tr>
<td>41</td>
<td>Mergl et al. (2010)</td>
</tr>
<tr>
<td>42</td>
<td>Misri et al. (2013)</td>
</tr>
<tr>
<td>43</td>
<td>Molenaar et al. (2007)</td>
</tr>
<tr>
<td>44</td>
<td>Moradveisi et al. (2014)</td>
</tr>
<tr>
<td>45</td>
<td>Mundt et al. (2001)</td>
</tr>
<tr>
<td>46</td>
<td>Patten (2008)</td>
</tr>
<tr>
<td>47</td>
<td>Parker and Crawford (2007)</td>
</tr>
<tr>
<td>48</td>
<td>Partridge, Lucke and Hall (2012)</td>
</tr>
<tr>
<td>49</td>
<td>Pedrelli et al. (2008)</td>
</tr>
<tr>
<td>50</td>
<td>Pilkington et al. (2013)</td>
</tr>
<tr>
<td>51</td>
<td>Read et al. (2015)</td>
</tr>
<tr>
<td>52</td>
<td>Samples et al. (2015)</td>
</tr>
<tr>
<td>53</td>
<td>Serrano et al. (2014)</td>
</tr>
<tr>
<td>54</td>
<td>Sher et al. (2005)</td>
</tr>
<tr>
<td>55</td>
<td>Shigemura et al. (2008)</td>
</tr>
<tr>
<td>Reference</td>
<td>Authors</td>
</tr>
<tr>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>56</td>
<td>Shigemura et al. (2010)</td>
</tr>
<tr>
<td>57</td>
<td>Sigurdsson et al. (2008)</td>
</tr>
<tr>
<td>58</td>
<td>Sinokki et al. (2009)</td>
</tr>
<tr>
<td>59</td>
<td>Sirey et al. (2001)</td>
</tr>
<tr>
<td>60</td>
<td>Soudry et al. (2008)</td>
</tr>
<tr>
<td>61</td>
<td>Sun et al. (2011)</td>
</tr>
<tr>
<td>62</td>
<td>Sundell et al. (2011)</td>
</tr>
<tr>
<td>63</td>
<td>Tatano Beck and Indman (2005)</td>
</tr>
<tr>
<td>64</td>
<td>Vanelli and Coca-Perraillon (2008)</td>
</tr>
<tr>
<td>65</td>
<td>Vega et al. 2010</td>
</tr>
<tr>
<td>66</td>
<td>Weich et al. (2007)</td>
</tr>
<tr>
<td>67</td>
<td>Wilhelm et al. (2005)</td>
</tr>
<tr>
<td>68</td>
<td>Wouters et al. (2014)</td>
</tr>
<tr>
<td>69</td>
<td>Wouters et al. (2014)</td>
</tr>
<tr>
<td>70</td>
<td>Yau et al. (2014)</td>
</tr>
<tr>
<td>71</td>
<td>Yen et al. (2009)</td>
</tr>
</tbody>
</table>
CHAPTER 5. KNOWLEDGE SYNTHESIS

“Assessing medication depends upon appropriate knowledge and understanding”
(Dowell & Hudson, 1997)

The aim to detect the most significant and prevalent reasons for undertreatment in depressive illness should not be underestimated. The process of reviewing selected papers was a memorable and educational experience per se. By identifying the key points in interpretation of patients’ attitudes and views of pharmacological treatment, the researcher enters an area of real-life experiences and gets exposure to human pain and suffering. The analysis feels like a disclosure of private, discrete and almost intimate information, touching upon people’s identities and also upon their deepest feelings and fears. The findings summed up, creating a research space where individuals shared their accounts of emotional highs and lows, complained about being misunderstood or marginalized, shared their religious and cultural beliefs, disappointments, anxieties and also their hopes. Almost all participants of the analysed studies were found to hold preconceptions about antidepressant treatments based on their own beliefs and on general views. Hence, the coexistence of several conflicting issues around the use of medicines in depression deserves further attention and explanation. People’s views may be based on their past experiences of the use of mood stimulizing drugs, but they can also result directly from depression paradigm, social judgments and stigma. Innovative steps must be taken with the attempt to explain not only “how treatment beliefs may influence treatment but also how and why treatment experiences in turn shape subsequent beliefs” (Aikens & Klinkman, 2012). Here, an effort was made to expose the most serious motives in patients’ decision making in regards to antidepressant therapy by extracting specific themes from the more extensive content presented earlier (Chapter 4.3.), and resulted in the following synthesis of findings:
5.1. Perceived Reasons for Non-acceptance of Antidepressants

You want to put the baby first, but, at the same time, you're just balancing out what is the risk to the baby of having a mom who is on Prozac versus what is the risk to the baby of having a mom who really can't cope and is falling apart (Bennett et al., 2007).

Beliefs about the role and relevance of antidepressant treatment may affect whether or not patients wish to have depressive symptoms detected. Fear of social judgment and stigmatization plays a role in admitting to ill health. Misconceptions of depressive disorders, misinterpretation of symptoms and mismatches in patients’ and medical specialists’ beliefs and concepts about causes of depression negatively determined acceptance of treatment and subsequent adherence. Many patients raised concern about actual needfulness of their medicines. Resistance to viewing depression as an illness, the associated doubts about the need for antidepressants; and also, concerns about addiction and dependency, proved to play a significant role in the refusal of antidepressant treatment. A large number of people demonstrated strong resistance to being prescribed antidepressants, ascribing their attitude to the stigma attached to mood-regulating drugs. Patients were mostly concerned about side effects they might experience before they experience any therapeutic effects. Attitudes towards starting antidepressants use were shaped by stereotypes and stigmas related to perceived drug dependency and potentially extreme side effects. Views about cause of depressive symptoms were complex, and tended to evolve over time and through the experience of different medications. A large number of patients believed that underlying causes of illness cannot be not addressed by medication. The uncertainty was found particularly unsettling and had impact on patients’ ongoing views on and refusal of antidepressants as a potentially effective treatment option. People worried about the possibility of experiencing adverse effects and implications for their senses of self.
5.2. People’s Identities Feel Affected and Questioned

The reason I want to wean myself away from the medicine is simply because I will not conceive of myself as ill ... I think that is very important to my conception of myself that I don’t think I’m some kind of therapeutic case (Knudsen et al., 2002 a)

Religious and cultural beliefs may serve as protective measures against medical diagnosis; perceived need for autonomy may interpret drug treatment as ‘attack’ on the ‘self’. Knowledge and perception of depression, and viewing themselves as being given a label of mentally ill, may influence patients’ acceptance or refusal of medical diagnosis and treatment recommendations, thus patients may not engage in symptoms detection or chose denial as a form of self-protection. Taking antidepressants meant signifying either to themselves or others that they were a ‘failure’, someone who was ‘mentally ill’. In addition, there was not always awareness present that treatments for their ailments existed that might help. Some participants felt that medication was limiting their lifestyle and that antidepressants were not helping to address one’s real lifestyle’.

5.3. Stigma, Blame & Responsibility

There is a stigma definitely attached to them... of course there is you're doing something wrong if you're on antidepressants...

I felt quite bad about taking them. It felt like kind of surrendering a bit...
almost like having a criminal record...(Ridge et al., 2015).

Often patients heard other people saying they are crazy because they were taking ‘depression pills’. They experienced this as hurtful, and felt marginalised and excluded (Egede, 2002). Quite often, close family members, in a fear of being blamed themselves for a relative’s emotional indisposition, developed feelings of shame and embarrassment, and demonstrated
negative attitudes toward antidepressant treatment. Being in denial of a next of kin’s depression and rejecting medical treatment is a frequently observed attitude, especially where concerns based on cultural or religious beliefs play a role (Vargas et al., 2015).

5.4. Seeking and Accepting Help

Antidepressants, they aren’t a quick fix to make you better, but they help you to cope better with what you’re going through (Anderson & Roy, 2015).

Individuals often described trying to ‘manage’ on their own, long before seeking help. Also, difficulties caused by impaired cognitive ability to engage in decision making justified the reasons for denial of depressive conditions. However, the individuals who sought help from health services in order to gain and maintain control over their depression, accepted offered treatment options as suggested by their physicians. Others felt they benefited in time, if not immediately.

5.5. Receiving/Obtaining Information about Medications

...there is one person saying it’s a good idea to take them and somebody saying no, you should not take them; I was in the middle and I couldn’t make my mind up, I was really confused, I think, I’m worse at the minute; I just can’t make my own mind up’ (Malpass et al., 2011).

In the absence of information from their doctors, patients wanted to find out more information before taking their first tablet. Primary information sources were media, culture, anecdotes, and past experiences with nonpsychotropic medications (Aiken, Nease & Klinkman, 2008). Depressive patients often wished to know how the antidepressants work by seeking information from the health care system or public sources such as libraries, media and Internet. There were
patients who spent days and weeks before or after filling the first prescription, educating themselves and wondering whether or not to take the antidepressant. Some had second thoughts after reading articles or public forums online. Printed information was found important; sources of non-verbal information included leaflets generally obtained from doctors. People also felt that the information they had received from the health care professional was true when confirmed by another source. In these instances, people more happily accepted the treatment option as suggested by their doctors, which fitted with their view of what treatment was needed. Carers wished for ‘detailed knowledge about the diagnosis and progress of the dependent individual's condition and, as far as possible, the prognosis: what to expect.’

5.6. Initial Use of Antidepressants

*I did know a bit about antidepressants and I definitely didn't want any of that. The doctor suggested it to me three times, and all three times I pushed it off. Eventually, when the situation got quite desperate, I gave in* (van Geffen et al., 2011).

Interestingly, once people have actually made the decision to seek help, what happened at the initial consultation with their physician was critical for patients in their decisions to subsequently take their antidepressant or not. Anxieties were expressed about starting use, and about how long the antidepressant might begin to take effect, how much it might help, and about what to expect in the initial weeks. People who had not been prescribed an antidepressant straight away appreciated the time given to reflect about it. Some waited before deciding that medication was appropriate. First experiences with medicines were often not pleasant. The majority of patients preferred to be ‘in control’ of their own emotions and saw antidepressants only as a temporary rather than a permanent solution. Medication was often seen as an initial aid to surviving a crisis.
Once participants had survived a crisis, they often began to re-evaluate their treatment. For others, just the fact that they were taking the antidepressant and were doing something about their depression, helped. Some believed that antidepressants are not the only solution to improve one’s health and that alternative medicines are a better choice, or antidepressants combined with other therapy. Several respondents wanted to get rid of their depression and medicine was viewed as a necessity to overcome the depression. A number of patients started the prescribed drug treatment soon after diagnosis. Participants who received information about the ‘chemical imbalance’ in neurotransmitters found the ‘news’ helpful, as this enabled them to interpret their depression as a physical rather than a mental illness, and accepting antidepressants became easier. Medicines were then considered as an important aid through which one could gain a sense of having a “normal life.”

5.7. Views of Antidepressants

I started taking (an SSRI) which convinced me that there was a problem because I felt so much better, the change was fantastic (Badger & Nolan, 2007).

People’s experiences with antidepressants use were found to have a major impact on treatment continuation and treatment outcomes. Participants differed in how they experienced and evaluated the effects of medication. Outside of crises, participants often felt more ambivalent about medication. Skepticism about antidepressants was strongest among younger patients who have never taken antidepressants, viewed their symptoms as mild and transient, and felt unclear about the factors affecting their depression (Aikens, Nease & Klinkman, 2008). Beliefs in efficacy of mood stabilizing drugs also varied between cultures. For example, Chakraborty’s et al. (2009) study conducted in an Indian population found that most patients have erroneous
beliefs regarding antidepressants per se which in turn influence the drug compliance, particularly in male patients.

5.8. Side effects

[They were] greatly disappointing. I wish I had never tried them, because before I tried them at least there was hope that something could have helped. Each one has had a worse effect than the previous.... I can’t remember them all. It started with memory loss then progressed to me becoming borderline catatonic staring at the wall for hours unable to stand up. Within a few weeks and genuinely terrified. It was a relief to go back to the misery of depression after these experiences (Gibson, Cartwright & Read, 2016 b).

Unexpected side effects were discovered that were severe, long-term or psychological in nature (such as feeling ‘flat’ or ‘dulled’). Perceiving a medication as ineffective or having unwanted ‘side effects’ lead the patients and their prescriber to seek a different medication, maintaining the drug loop. In some cases, respondents believed their physicians withheld information about side effects of the medication.

Table 8. Reported adverse effects associated with antidepressant use

<table>
<thead>
<tr>
<th>Side effect</th>
<th>Total study population</th>
<th>Male patients</th>
<th>Female patients</th>
<th>χ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurological: tremors, headaches, dizziness, etc</td>
<td>26 (30)</td>
<td>11 (31)</td>
<td>15 (36)</td>
<td>0.23</td>
</tr>
<tr>
<td>Daytime sleepiness/sleep disturbance</td>
<td>19 (22)</td>
<td>8 (22)</td>
<td>11 (26)</td>
<td>0.17</td>
</tr>
<tr>
<td>Sexual: decreased libido, erectile dysfunction</td>
<td>17 (20)</td>
<td>11 (31)</td>
<td>6 (14)</td>
<td>3.01</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>17 (20)</td>
<td>9 (25)</td>
<td>8 (19)</td>
<td>0.40</td>
</tr>
<tr>
<td>Anxiety, restlessness or agitation</td>
<td>10 (11)</td>
<td>5 (14)</td>
<td>5 (12)</td>
<td>0.07</td>
</tr>
<tr>
<td>Gastrointestinal: nausea, vomiting, diarrhea, constipation</td>
<td>10 (11)</td>
<td>4 (11)</td>
<td>6 (14)</td>
<td>0.18</td>
</tr>
<tr>
<td>Weight gain</td>
<td>6 (8)</td>
<td>0 (0)</td>
<td>6 (14)</td>
<td>5.57*</td>
</tr>
<tr>
<td>No side effect reported/nonresponse</td>
<td>14 (18)</td>
<td>8 (22)</td>
<td>6 (14)</td>
<td>0.83</td>
</tr>
</tbody>
</table>

From: Burra et al., 2007
5.9. Personal Control and Perceived Effectiveness of Treatment

*Self discipline, I'd be disappointed to think it was just the medication. I would like to think that I don’t need to go back on them (medication) again* (Badger & Nolan, 2007).

In multiple cases, medicines were said to have given the patients control over their health. Carpenter-Song et al., (2010) talks about efficacy of treatment. One of the patients from her study positively reflected on taking antidepressants: *But I would never regret taking them because taking them has totally changed my life ... Taking them ... I don't feel that so much now ... But when I first took them, I felt like I had been given my life back. I feel like I can now be a normal person* (Carpenter-Song et al., 2010). Also, Anderson & Roy’s (2015) included patients’ positive feedback on antidepressants: *People call them happy pills [...]. But you don't walk around stoned or sort of “Oh isn't life wonderful.” You just feel normal, that's what they make you do, they just make you feel normal. You don't feel euphoric, you don't feel manic, you don't feel spaced out, drunk, stoned, whatever you want to call it. You just sort of feel yeah, this is the way life is supposed to be, everything just feels alright, balanced* (31-year-old male). *I had to try a lot of different antidepressants until they found one that worked and suited me* (Anderson & Roy, 2015).

However, medication was not always perceived as appropriate. In other situations, the act of taking medicines took away control over health as well as it was believed to have destroyed motivation and interest of life. Tensions/ambivalence around medicines was observed. A large number of people admitted they would prefer to manage their ill symptoms without antidepressants, wanting to come off them as soon as possible if continuing the therapy. One woman strongly felt that the root cause of her depression was living with an alcoholic partner and consequently, she perceived medication as irrelevant (Badger & Nolan, 2007). Participants
were more likely to experience a drug loop when they felt passive, which was often linked to a strong medical emphasis and lack of collaboration in consultations. Elements of the drug loop appeared to include medication effects, a limited ‘Prozac’ lifestyle, feelings of passivity, experiences of not being listened to, unaddressed underlying causes, perceived personal fragility, and dilemmas about dependency. At the same time, positive effects were noticed: respondents felt better as a result of their medicines.

5.10. Communication and Relationship Issues with Health Care Specialists

I felt neglected by my doctor that day and I was convinced that he had given up on me and my depression, because he did not care to listen: because he just wrote the prescriptions and then he was finished with me. He didn’t say that I should return; he didn’t say that I should come for some counselling; he didn’t say, “I'd like to keep track of you”. “You can come and get a renewed prescription and we'll talk”.

He didn’t say that he had any such an offer, and, out I go (Buus, 2014).

People’s views on effectiveness or harmfulss of antidepressant treatment was extremely often based on the quality of their relationships with healthcare providers. Having a good relationship with a doctor was an important indicator of whether people would discuss their need for information about adverse effects. Being able to talk to their doctor enabled them to reflect on their difficulties, and to better understand or reframe their experiences. In Chakraborty’s quantitative study, 92% agreed that doctor reserved sufficient time to listen to patient’s problem, explained the causes of depression sufficiently, and felt confident that antidepressants are suitable treatment of their depression etc. (Chakraborty et al., 2009). For some patients, the first experience was pleasant and antidepressants were viewed as essential in fighting illness. Unfortunately, many patients had unsatisfactory interactions with health care professionals and
patient-doctor interactions often implied treatment setbacks. Examples included thinking that the doctor did not communicate well or, did not listen to them, did not spend enough time with them. Doctors also tend to not provide sufficient up to date information. A common experience was feeling ill-informed about medication and about alternatives such as psychological therapies. Superficial or shallow responses from doctors to patients were commonly described and experienced as negative and disempowering.

A large number of patients experienced limited autonomy in their encounters with health professionals. Often the reasons for their antidepressant prescriptions, or the side effects were not explained at all. Doctors who prescribe medication should engage in open dialogues about treatment options as patients weigh up their experiences of the effects of antidepressants, their beliefs in illness causation, and their relationships with health care professionals, to make a series of decisions about their treatment. Some people believed they were completely excluded from the decision-making. Several participants described prescribers not listening to their concerns, and this could also be a factor influencing them to seek alternative therapies.

5.11. Timeline and Prediction of Recovery

I don’t really know. The doctors will keep an eye on things and if the time was appropriate then they would take me off it but… having kept me on it I assume they are happy for me to go on taking it so I take it but … with all this medication I would come off it if I could. If I can’t come off it then I accept it (Dickinson et al., 2010).

Patient beliefs about the course of their indisposition are said to affect detection of symptoms. Those who expect quick resolution may not think it to be appropriate to seek treatment. Those not believing in biological mechanism of depression, will be avoiding medical diagnosis and initiation of therapy. Others were surprised and even frightened by some of the things doctors
said about what antidepressant taking would mean for them in the future, for example, that the treatment would take a long time.

5.12. Continuation of Treatment

*But I would never regret taking them because taking them has totally changed my life ... Taking them ... I don't feel that so much now ... But when I first took them, I felt like I had been given my life back.*

*I feel like I can now be a normal person* (Anderson & Roy, 2015).

A Canadian quantitative study by Burra et al., (2007) reported high levels of adherence. A rapid return to ‘normal’ functioning, supportive relationships with professionals, and information about medication effects all tended to lead people to continue taking their prescribed antidepressants. People who stopped medication and experienced a recurrence of depression often came to feel more dependent on medication, and feared stopping it again in the future. Frequent consultations with physicians, involving shared decision making, including a good discussion about their views, fears and goals and previous experiences of taking antidepressants, were found to be helpful. There was a frequent perception that taking medicines is an act of balancing benefit versus risks.

5.13. Discontinuation of Treatment

*I had reached the point where I took very little of it. It was just once in a while. Really, there was no control. I just took it when I thought, “Well, it's been a while, so I'd better take a pill or two”. In the end, it was horrendous. And I just didn't feel that I needed it. And then I just stopped completely. I threw them out and haven't taken any since* (Buus, 2014).
The number of patients who discontinued the use of antidepressants due to adverse reactions was high. Forgetting or a change in the routine were the most frequently identified reasons for nonadherence. Staying on medication longer term resulted in some participants feeling caught in a ‘drug loop’. Feeling dependent on medication and viewing it as an artificial control of mind, created dilemmas. Frequent reasons leading individuals to stop the medication or to experiment with the dosage included a lack of regular follow-up routine from their doctors. Since consultations with practitioners were not always therapeutic and multiple patients’ questions about alternatives to prescribed medication were dismissed, people explained the intake of antidepressants as non-therapeutic and made the decision to withdraw from treatment after the initial start and short-term use. A number of people tend to stop using healthcare services and withdraw from treatment, trying to self-manage their depression through self-medication and alternative practices, but also with the use of controlled substances such as alcohol and drugs.

5.14. Self-Reported Reasons for Nonadherence with Antidepressants

Presented by Burra et al., 2007 model of ‘unintentional non-adherence’ (a term used by Gadkari & McHorney, 2012), describes a “passively inconsistent medication-taking behavior”, e.g. forgetfulness or carelessness, marking the most frequently identified grounds for not taking antidepressants as prescribed. For example, the most frequent reasons were simply forgetting, experiencing a change in daily routine, or running out of pills. Gadkari & McHorney (2012) studied the prevalence and predictors of unintentional non-adherence and explored the interrelationship between intentional and unintentional non-adherence in relation to patients’ medication beliefs. Yet if the non-adherence to antidepressant treatment is, indeed, caused by such simple factors, it should not be very problematic to improve it. The reasons for undertreatment of depression must be therefore much more serious than those indicated above.
Burra’s et al. (2007) quantitative data support the qualitative findings summarized in this review. However, it is important to remember that they are all based on self-reports; therefore, in consideration of possible bias, they should be seen as a possible variation of truth: “Reported levels of adherence, experience of side effects, and rating of depression severity may all have been subject to recall bias” (Burra et al., 2007). Beck stated that an astonishing contrast between the depressed person’s image of him-herself and the objective facts has been observed (Beck, 2009). Thus, recall bias may be present in patients’ accounts as the result of cognitive disturbance. These factors should be substantiated in the analysis of the results and be accounted for in the interpretation (Althubaiti, 2016).

**Table 9. Self-reported reasons for non-adherence**

<table>
<thead>
<tr>
<th>Reason for not taking antidepressant</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forgot</td>
<td>1.04</td>
<td>0.97</td>
</tr>
<tr>
<td>Change in daily routine</td>
<td>0.76</td>
<td>0.91</td>
</tr>
<tr>
<td>Ran out of pills</td>
<td>0.60</td>
<td>0.86</td>
</tr>
<tr>
<td>Busy</td>
<td>0.59</td>
<td>0.89</td>
</tr>
<tr>
<td>Away from home</td>
<td>0.56</td>
<td>0.85</td>
</tr>
<tr>
<td>Depressed/overwhelmed</td>
<td>0.55</td>
<td>0.91</td>
</tr>
<tr>
<td>Believed drug was not helpful</td>
<td>0.53</td>
<td>0.87</td>
</tr>
<tr>
<td>Felt better/did not need pills</td>
<td>0.53</td>
<td>0.86</td>
</tr>
<tr>
<td>Fell asleep/slept through dose time</td>
<td>0.49</td>
<td>0.83</td>
</tr>
<tr>
<td>Felt ill</td>
<td>0.49</td>
<td>0.77</td>
</tr>
<tr>
<td>Wanted to avoid side effects</td>
<td>0.46</td>
<td>0.89</td>
</tr>
<tr>
<td>Problem taking pills at specified times</td>
<td>0.44</td>
<td>0.86</td>
</tr>
<tr>
<td>Advised against taking pills by family or friends</td>
<td>0.29</td>
<td>0.74</td>
</tr>
<tr>
<td>Antidepressants too costly</td>
<td>0.26</td>
<td>0.70</td>
</tr>
<tr>
<td>Too many pills</td>
<td>0.25</td>
<td>0.59</td>
</tr>
<tr>
<td>Did not want others to notice me taking medication</td>
<td>0.22</td>
<td>0.55</td>
</tr>
<tr>
<td>Concern/fear about addiction</td>
<td>0.21</td>
<td>0.51</td>
</tr>
</tbody>
</table>

* 4-point Likert scale ranging from never (0) to often (3).

**From: Burra et al., 2007**
CHAPTER 6. DISCUSSION

*Treatment beliefs changed as patients gained experience with medication.*

*Moreover, these changes were in the proadherence direction.*

(Aikens & Klinkman, 2012)

Burra et al. (2007) propose a summary of factors which are believed to affect patients’ adherence to antidepressants. In support of their concepts (Table X), they also provide additional academic sources. These themes correspond with the concepts identified earlier in Chapter 5. Adherence to treatment resulting from satisfaction or refusal to use antidepressants is associated with patients’ ethical, cultural and religious choices, drug-tolerability, ease of administration and a preference for relatively inexpensive (covered by insurance) treatment in mental illness (Gussin and Raskin, 2000). Preferences can be discussed only in cases where individuals will receive the chance to try different treatments. Research findings suggest that people have predominantly negative views of antidepressants and most of patients as well as non-depressed persons prefer psychotherapy to medication, when given the choice (Gibson, Cartwright and Read, 2014). Negative views about the consequences of receiving diagnosis of depressive illness often lead to hopelessness and prolonged denial, or cause defensive attitudes. Pessimistic approach toward treatment with antidepressants may lead to refusal of medications or to discontinuation of initiated therapy. Consequences of untreated or undertreated depression can be serious, and lead to poor quality of life and in extreme cases, to suicidal ideation.

Treatment adherence results from personal beliefs and treatment satisfaction in cases when the treatment is initiated. Patients who experience symptom relief and improvement of their quality of life, are believed to take the medication correctly for the prescribed time and their collaboration in treatment predicts the desired therapeutic outcome (Simon et al., 2001).
Table 10. Summary of factors that affect adherence to antidepressants

<table>
<thead>
<tr>
<th>Factor</th>
<th>Supported by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The experience of adverse effects associated with the medication</td>
<td>Hotopf et al., 1997; Williams et al. 2000; MacGillivray 2003; Sleath 2003; Ayalon 2005;</td>
</tr>
<tr>
<td>Medication efficacy</td>
<td>Geddes et al., 2000; Furukawa 2002;</td>
</tr>
<tr>
<td>Physician-patient communication</td>
<td>Lin et al., 1995; Demyttenaere, 1997; Bull et al., 2002; Nierenberg, 1999; Bultman &amp; Svarstad, 2000; Keller et al., 2002; Demyttenaere, 2004; Kessing et al., 2005;</td>
</tr>
<tr>
<td>Cognitive behavioral constructs (eg. Patients’ general attitudes toward medication, specific attitudes toward mood disorders, perceived stigma associated with mental illness)</td>
<td>Lingam &amp; Scott, 2002; Ayalon, 2005; Demyttenaere, 1997; Demyttenaere et al., 2004; Kessing, 2005; Sirey et al., 2001; Becker &amp; Maiman, 1975; Fawcett, 1995; Hoencamp et al., 2002; Brown et al., 2005; Sher et al., 2005;</td>
</tr>
<tr>
<td>Fear of addiction or dependence and the desire to solve health problems without the use of medication</td>
<td>Lin et al., 1995; Demyttenaere et al., 2004; Hoencamp et al., 2002; Delgado, 2000; Demyttenaere et al., 2001;</td>
</tr>
<tr>
<td>Clinical features of depressive disorders, such as lack of insight, poor concentration, low motivation, excessive guilt, periods of remission</td>
<td>Adams &amp; Scott, 2000; Keller et al., 2002; Kessing et al., 2005; Sirey et al., 2001; Fawcett, 1995; Wrigth, 1993;</td>
</tr>
<tr>
<td>Depression severity</td>
<td>Adams &amp; Scott, 2000; Cohen et al., 2004; Sirey et al., 2001; Brown et al., 2005;</td>
</tr>
<tr>
<td>Comorbid anxiety or substance abuse disorders</td>
<td>Fawcett, 1995;</td>
</tr>
<tr>
<td>Sociodemographic characteristics such as age and gender</td>
<td>Cohen et al., 2004; Ayalon et al., 2005; Lin et al., 1995; Bull et al., 2002; Sirey et al., 2001; Demyttenaere et al., 2001;</td>
</tr>
</tbody>
</table>

By: Burra et al., 2007

Key issues, such as quality of the relationship with health care professionals, or patient’s feelings of control over treatment and own well-being, influence the interpretation and use of medications (Benson and Britten, 2002; Ridge et al., 2015). Here, patients are increasingly considered to be active agents in medication management (Ridge et al., 2015). People who had
sought doctors’ help for depression were less likely to believe in the helpfulness of alternative treatment and they more likely believed in medical interventions and quick solution. The general belief patterns emerged in those who had sought help, were more likely to choose antidepressants as helpful, and assigned less value to external support. Those with current depressive symptoms were less likely to rate telephone counselling, family and friends as helpful. Patients with a history of depression who refused pharmacological intervention preferred counselling as the most effective strategy. At the same time, genuine compassion and full collaboration of health care professionals, family members and friends were found to be crucial in depression management. Also, patient-doctor relationship based on trust was believed to provide a positive environment where wise and careful treatment decisions were made.

Generally speaking, having sought medical help reflected patients’ beliefs similar to those of health care providers and predicted improved adherence to drug treatment (Jorm et al., 2000).

Dilemmas and uncertainty around medicines often arise and continue as treatment progresses. Long-term antidepressant use is said to be relatively common in primary care. Yet it occurs within the context of complex mental, physical and social problems. The most frequent long-term use of medications is associated with recurrent depression (Ambresin et al., 2015). The beliefs in treatment resistant depression and prognosis of prolonged symptomatic cycle lead patients to view medications as harmful and useless when facing the challenge of long term interventions. Perspectives of a long-life-treatment and necessity of tolerating bothersome side effects of antidepressants frequently lead to non-adherence. Patients reported feeling dependent on medication, but at the same time, they experienced fears that discontinuation would cause a relapse and another crisis. Therefore, constant treatment re-evaluation, adjustments, as well as
timely discontinuation of drug intake where cessation is recommended, should become a routine practice (Ambresin et al., 2015).

The majority of studies presented descriptions of aspects that prevented individuals from taking their medications as prescribed. At the same time, a number of patients invested a great amount of trust into their drug therapies, hoping for a quick relief and prolonged control of depressive symptoms. Other hopes were for avoidance of relapse and hospitalisation, for disease progression to slow down or cease, for the prevention of a more serious and permanent illness, and mostly, for normality of everyday life. All studies reported people’s experiences of adverse effects of antidepressants. These reactions were unpleasant and caused individuals’ frustration, and also, because they were frequent, severe and unpredictable, they brought fear and distrust of the medicine. Some patients found drug treatment so overwhelming that they were no longer physically in control of their lives. The drug regimen had a long-term impact on social relationships, employment and studying, not just on daily routines.

The informants also claimed that aversion to psychotropic medications was much stronger in men than in women. Women were more concerned about the impact of the regimen on relationships while men were concerned about its impact on themselves. The intake of mood stimulating pills was also found to be problematic because it disrupted the individuals’ perception of ‘self’ and in their own beliefs, it marked them out as different (self-stigma). For these reasons, many patients decided not to pursue the treatment. Weighing and balancing the undesirable effects of pharmacological therapies against benefits occured almost in every single case. For some, the negative aspects of the medicine intake appeared to be so drastic that it was not negotiable to try them or continue with the treatment. Many patients felt that despite the possible benefits of treatment, side effects were too debilitating to make it worth the risk; others
believed that ‘alternative’ treatments were better for the quality of life they desired. In multiple
interviews the informants described the medicine as more threatening to their well-being than the
depressive disorder itself. Similarly, some individuals chose quality of life with untreated
depression over using antidepressants.

Patients tend to experiment with antidepressants by modifying their medication use
without professional input. People are involved in a constant ‘lay evaluation’ process (Pound
et al., 2005) which is characterised by uncertainty: Uncertainty is defined as an ongoing process
of evaluation of antidepressant use, in which “risks and benefits, hopes and fears, positive and
negative self-images are all balanced, and decisions reached” (Verbeek-Heida & Mathot, 2006,
p. 138). During this process, patients weigh up the evidence for starting, continuing and stopping
antidepressants. This involves two key aspects – their medication experience and their
consultation experience. Patients' experiential knowledge (based upon observations of their own
and others' behaviour and experiences) is compared to information given by health practitioners.
The latter was experienced as inadequate or even harmful by many patients (Bollini et al.,
2004, Garfield et al., 2004, Haslam et al., 2004 and Nolan and Badger, 2005). A study by Martin
et al. (2005) found that some practitioners tend to ignore their patients’ symptoms, what may be
resulting in late interventions (Martin et al., 2005). Multiple encounters with the health system
were found unrewarding because health providers reinforced that the responsibility for help-
seeking and self-managing rested entirely on the patients.

Health professionals should consult research findings to better understand and explore
with patients their concerns before prescribing antidepressants. These insights are key to
supporting patients, many of whom feel intimidated by the prospect of taking antidepressants,
especially during the uncertain first few weeks of treatment (Aikens & Klinkman, 2012).
Aikens & Klinkman (2012) also suggest that prescribers should be advised to carefully elicit patient beliefs at the time of treatment initiation. Health care professionals might expect patients' beliefs about their antidepressant to evolve in a more pro-adherence direction as treatment proceeds. They should actively encourage this movement by pointing out when actual experience suggests either desired medication response or a lack of side effects. Prescriptions for those patients who express concerns about side effects should be tailored towards a less aggressive, “built for comfort” regimen that tends to minimize side effects even if this is at the expense of rapid relief. Another proactive strategy clinicians should adopt is to predict adverse effects and inform the patient about them. Perceiving a medication as ineffective or experiencing bothersome ‘side effects’ should lead the patient and the physician to seek a different medication to maintain the drug loop (Brown & Bussel, 2011).

Clinicians could also encourage patients to observe and track their symptoms because this allows the clinician to evaluate the efficacy, which in turn may strengthen adherence. On the other hand, because perceived need increases regardless of actual symptomatic improvement, this approach must be balanced with active consideration of nonpharmacologic treatment strategies such as psychotherapy, physical exercise and supportive watchful waiting (Rottman et al., 2016). Moreover, because medication concerns can be expected to either strengthen or weaken based on treatment experience, suggesting brief counselling sessions in addition to drug therapy may help, and this actually is, what most patients wish for. Perhaps, depression treatment guidelines and policies should put less emphasis on attempting to modify people’s adherence behaviours and more on implementing efficient diagnostic tools.

The perceived dependency on medication or difficulty communicating with doctors has been linked to patients’ own perceived values and personal goals, but also to the cognitive–
behavioural presentations of that person's depression. In addition to featuring emotional
instability, depression is associated with considerable cognitive dysfunction, although cognitive
impairments may also be produced by chronic administration of some tricyclic antidepressants
(Judd et al., 1987). Marazziti et al. (2010) claims that major depression affects the ability to
think, focus, make decisions as well as formulate ideas and reasons. This becomes a concerning
issue. Patients are expected to make wise decisions about their treatment, but, due to their mental
confusion are unable to do so. When talking about depressive patients making firm treatment
choices in the context of their cognitive impairment, we must not forget that their decisions may
“deviate from a certain standard of rationality” (Patel, Kaufman and Arocha, 2001) and can be
primarily heuristic and biased (also in: Chapman and Sonnenberg, eds. 2000; 2003).

Depression is said to be a growing issue for the general population and a significant
public health concern across all regions of the world, with the prediction to become a major
contributor to the global disease burden by 2030 (WHO, 2001). While primary prevention in
depressive disorder remains an elusive goal, provision of pharmacological treatment has been
viewed as having the capacity to reduce its impact on population health. The newer
antidepressants are said to be relatively safe and their administration is becoming very common
(Hollon et al., 2002). Ironically, depression treatment quality and outcomes are thought to be
relatively poor and result mainly from low compliance (Hidalgo et al., 2015).

As the findings of this study confirmed, people’s beliefs, perceived personal values as well as the
opinions of others, influence adherence to treatment in depressive disorder. Patients’ accounts of
their experiences with depressive illness, medical consultations, acceptance versus refusal of
pharmacological treatment, and descriptions of adverse side effects of antidepressants, refer to
the perceived rationality of thinking and to common behaviours in depression. In the times of the
overwhelming presence of media and social networks, public opinions are shaped and spread, influencing individual perceptions, views and beliefs. Since barriers to medication adherence are complex and diverse as described above, the solutions to improve compliance should also be multifactorial (Brown & Bussel, 2011); however, this problem is beyond the scope of this review.

Nevertheless, my final remarks in the adherence discussion will repeat what was indicated previously and are based upon the important aspect of prescribing antidepressants. In lieu of focussing on the patients and the issue of their nonadherence to antidepressants, the research might focus on ways to improve diagnostic procedure in depression. A simple reflection of one of the patients in Lavender, Khondoker and Jones’ (2006) study speaks volumes: My own advice to doctors..if it is a woman, they should try to invite the husband…and tell him that look, the wife got a depression [...] and they should [...] try to advise them that he is the right person to help the woman, because that woman is only with the doctors for a few minutes (Lavender, Khondoker and Jones’, 2006).

The aspect of rushed and seemingly premature administration of antidepressants was largely discussed earlier, nonetheless including the next of kin into a patient’s therapy in depression, and especially when medication treatment is being considered, should become a routine in health care practices. It is because that patient “is only with the doctors for a few minutes” (Lavender, Khondoker and Jones’, 2006) and there is a big chance that the person suffering from affective disorder is simply unable to give a full account of their symptoms and behavioral patterns.
CHAPTER 7. CONCLUSION

“For population health management to work, the population must feel empowered to manage its health”
(Song & Lee, 2013)

Recent studies stress the need for continued research to assist patients and health care professionals in minimizing non-adherence to achieve maximum results in antidepressant treatment, in particular in chronic depression (Burra et al., 2007). There is a strong belief in the importance of contributions, which people with disabilities and illness make “to research and to their own care and the care of others” (Dupuis et al., 2012). Studies of anti-depressant medications also seem to possess a special value for research analysis because, as Karp (1993) stated, those pills “are linked with the meaning of emotional experience and they are designed to alter ‘abnormal’ moods and emotions”. Depression is a mental disorder that is pervasive in the world and affects us all. While efficacious therapies are said to be available, the resources remain unused. Cost-effective treatments are being offered to improve the health and lives of people suffering from this disorder. Ironically, all things a patient would need to do in order to recover from bothersome symptoms, are already made hard and unmanageable by depression alone: eat well, sleep well, be active, and develop realistic life approach; all greatly recommended as basic remedies. Typical symptoms of depression include anhedonia, insomnia, lethargy, negative thinking and cognitive impairment as well as feelings of emptiness and hopelessness in times when people should maintain optimism and hope. In addition, a large number of individuals suffering from depression resist taking their medicines. It is assumed that the most serious reasons for refusing or delaying treatment with antidepressants are of the social, cultural/religious, and/or financial nature (Lane, 2014). Changes in patients’ beliefs about their
antidepressant have been reported during both the acute phase of depression treatment and during continuous drug therapy (Aikens & Klinkman, 2012). The underlying mechanism of indecisiveness or wrong decision making may be rooted in memory and (sub)conscious awareness (Henke, Reber, and Duss, 2013). Research on undertreatment in depression provides data on undiagnosed and untreated individuals with self-awareness of depression (Cabassa et al., 2007). Findings emerging from the studies reviewed here are based on self-reports and as such, they represent patients’ subjective views. Thus, individual motives leading to undertreatment in depressive illness should continue to be explored; and hopefully, depression will be one day finally understood in terms of its paradoxes (Beck, 2009).

By assigning value to patients’ opinions and beliefs, summarised by qualitative and quantitative research, this thesis aims to provide an in-depth understanding of people’s perspectives on mood-stimulizing medicines. Let us start with a basic question: What makes the diagnosis and treatment of depression so difficult in comparison to other diseases? One respondent in Lafrance’s (2007) study voices the opinion: “[I]t is so personal. Nobody can understand how bad you’re feeling. And like you can go to a doctor, you got bad asthma, you can’t breathe? They can understand that. They can see it, they can feel bad for you and they can really try to help you without feeling sorry for you. When you’re feeling depressed, people don’t understand, they figure you’ve just got the blues and you’re not dealing with it (Lafrance, 2007).

A chronic disease management approach is becoming widespread practice for depressive disorder; qualitative studies of how patients behave when first seeking help in primary care and continuing treatment, is important. The ambiguity of understanding symptoms as either a disease or a normal emotional response to life events suggests significant differences between patients with recurrent depression and those with initial episodes. The findings presented here
demonstrate the individual nature of understandings of depression, and the variety of self-management strategies used in primary care. In Brown’s et al. (2005) quantitative study, depressive patients generally confirmed the view that their current or future health depended on antidepressant medication. More than a half reported that mood-stimulizing drugs prevented them from getting worse. Bitner et al. (2003) found reductions in negative emotions of anger and sadness and the enhancement of positive emotions of happiness, joy, and love are consistent with therapeutic expectations, as are the improvements in calm and self-esteem. All positive changes were attributed to antidepressants by the respondents in this study (Bitner et al., 2003). One patient in Anderson’s et al., (2013) study confessed: I was relieved to be diagnosed with depression and be prescribed an antidepressant. Once that was done it was like such a relief because I knew what was wrong and I could see there was now a way of fixing it. I have to say my father had depression a few years ago so I knew that there was a ‘fix’ because he recovered, he got treatment and he got better, which helped me a lot (Anderson et al., 2013).

Nevertheless, major concerns about antidepressants were also shared. Ambresin’ et al. (2015) study suggests that patients continue to experience symptoms and disability despite antidepressants and high primary care use. Many individuals admitted that they worried about the long-term effects of antidepressants, about becoming too dependent on tablets, or, that they could not comprehend how psychotropic medications work. Commonly reported beliefs were concerns about the overuse of medication. Some patients endorsed the belief that medication was harmful; 20% of participants believed in addictive properties of medications (Brown et al. 2005). A 39-year-old male patient’s hesitation is explained as follows: I've been prescribed antidepressants in the past but I've always felt reluctant and apprehensive about taking it, largely because a) I feel that the effects are probably short-term, they're not going to actually
resolve the depression, b) because they do have side-effects and, and c) I didn't feel comfortable, myself, with taking some tablets (Anderson & Roy, 2015). Being ‘drug-free’ after a short-term or prolonged antidepressant treatment is perceived as a sign of being cured from depression (Brijnath & Antoniades, 2016). The most common way of coming off the medication is by experimenting by lowering doses: In time, adverse effects of the medicine became unacceptable to me and occasional slips, which seemed less scary than making a deliberate stop, became more frequent and eventually confirmed me in having no need for the medicine (Buus, 2014).

My findings provide evidence that adherence to antidepressants is a complex health behavior that is mediated by multiple factors based on cultural, religious and ethical beliefs. The most serious reason for non-compliance are adverse side effects that people experience, similar to those presented in Chur-Hansen & Zion’s (2006) paper:

Vanessa: I reacted badly: I was shaking, trembling, unable to sit still, being jittery, felling worse, felling ‘not normal’, dry mouth, felling sick, and being drowsy as side effects.

Lily: I experienced adverse reactions to the SSRI, including apathy, emotional numbness and hallucinations (including seeing myself being hit by a car and falling on knifes). I simply believed that the SSRI actually induced a depressive state worse than the one for which it had been prescribed.

Cheryl: I did not have any physical side effects, but I found that the medication resulted in me having ‘no emotions’. You just feel like a zombie at times. And I don’t know if it’s worth it.

Julie: You name it: nausea, tremor, decreased appetite, headaches, thirst, feeling sick, agitation, anxiety, impulsivity and violence. I have become particularly worried about the increase in my impulsivity and violent behaviour, which is totally uncharacteristic for me, and which was becoming more frequent and pronounced over the last three weeks. I have never been violent to
anything ever in my life, I’ve always taken it out on me. And [...] for the first time [...] I just snapped, and I basically threw the cat five meters across the room. And that just scared me, I didn’t know what that was. And I was impulsive, there was no thought behind it (Chur-Hansen & Zion, 2006).

Questioning physician’s ability to provide a correct diagnosis of depressive illness is voiced in multiple papers (Amey, 2010; Anderson & Roy, 2013; Anderson et al., 2015; Buus, 2014; Bennett et al., 2007; Bayliss & Holttum, 2015; Carpenter-Song et al., 2010; Lavender, Khondoker & Jones, 20016). They don’t know what works and what don’t work. First, they put you on a medication and when you tell them you don’t need it anymore they just put you on another one. I get sick of taking pills, pills, pills. I don’t need all this medication. They keep telling me I need medication but I don’t. The medication is what makes me sick. I don’t feel right when I take it anyway (Carpenter-Song et al., 2010).

Another similar view is presented in Bayliss & Holttum’s, (2015) study: [Doctors are] all about the medicines...we'd all like to think that we're visiting Frasier Crane but we're not, you don't get to lay on the couch, you don't get to discuss your problems...you get to go in for 10 minutes if you're lucky once every 3 months – ‘How are you feeling? Still taking medication? Sleeping alright? Well we'll leave you on that then’...and I've had that for 10 years so I guarantee you...that's what happens” (Bayliss & Holttum, 2015).

The issue of being able to make a correct diagnosis after a brief conversation with the patient and relying on patient’s self-report has been stressed in multiple articles. Here an example of a participant’s reflection: “Even after deciding to start antidepressants, actually contemplating swallowing the tablet for the first time could feel like a momentous occasion: I left them on my top shelf for ages and I just didn’t want to take them because I was a bit confused as why I; he’s
prescribed me that after like a really short chat, just me saying I was down and maybe at the
time they were handing them out left right and centre, I don't know (Anderson & Roy, 2013).

Hence, possible erroneous diagnoses in depression should be suggested, as they might lead to
wrongfully recommended antidepressants, and consequently, to unsuccessful treatment with
adverse effects and and ‘invited’ non-compliance (Gadkari & McHorney, 2012). Deciding how a
false diagnosis may be made in depression is beyond the scope of this review, however, in my
opinion, the issue predicts the nonadherence. It has been suggested that general practitioners
need more training to perform diagnoses and treatment in depression more effectively.

Although a precise assessment of levels of self-reported antidepressant adherence and reasons for
nonadherence (Burra et al., 2007) presents a challenge, this review aims to provide knowledge
support in the area of depression. Pope, Mays and Popay (2007) propose “different objectives of
reviews” by making a clear distinction between ‘knowledge’ versus ‘decision support’ (p.13).

Here, patients’ beliefs and views that are emerging directly from their lived experiences of
depression and antidepressant use are believed to create a solid fundament for continuous
research. Hopefully the results presented here will broaden the general knowledge of how the
drug treatment in depression is perceived by those directly affected by the disorder. This, in turn,
may deepen the understanding of the multiple challenges in depression management. Public
health should assist people in their lay evaluations of medicines by providing the necessary
information, feedback and support and by raising general knowledge and awareness of dangers
of untreated depressive illness. When prescribing antidepressant therapy, clinicians should be
cognizant of this complexity and address not only issues related to medication efficacy and
tolerability, but also social mediators and health beliefs (Burra et al., 2007). Gibson, Cartwright
and Read (2014) formulated implications for further research indicating that more studies
investigating positive experiences of antidepressants are needed “in order to better understand the complex mixture of views and experiences of antidepressants that may result in patients remaining on antidepressants in spite of their misgivings”. Sensitivity and alertness in mental health care may increase patients’ acceptance of the fact that depression can be a concern of clinicians. This may lead to improved treatment adherence (Marcus et al., 2012). Also, it has been discovered that treatment beliefs frequently change from negative to more accepting as patients gain experience with antidepressants (Aikens & Klinkman, 2012). It is possible that the pro-medication views will receive a greater attention and exposure in future research to counterbalance the aversion to pharmacological treatment in depression. Aikens, Nease & Klinkman (2008) suggest that adherence to drug treatment in depressive disorder will improve when health care specialists take into consideration patients’ specific concerns (eg, adverse effects, addiction, personality change, financial cost, stigma) and then offer treatments that respect these sensitivities and choices. This could “translate to prescribing a conservative dosing and titration schedule that patients can self-pace and providing specific educational input where appropriate” (Aikens, Nease & Klinkman, 2008). This recommendation seems to confirm the special value of positive relationships between depressive patients and their doctors, or the lack thereof as the indication of non-adherence to recommended therapies. Also, it gives more control to the patient who feels empowered through continuous support and gets a chance to develop the sense of responsibility and self-control.

7.1. **Strengths and Weaknesses of this Review**

This is the only existing review on the topic of patients’ beliefs on antidepressants that used mixed-methods data to extract meaningful theories on patients’ non-adherence to drug treatment. The usefulness of conducting parallel data analysis on quantitative and qualitative data
in healthcare research has been identified before (Östlund et al., 2011). Validating the findings emerging from qualitative studies with quantitative data in the process of triangulation, is believed to counterbalance the presumed weakness such as the selection of articles that may be questioned as biased. My exclusion tactic served the purpose of avoiding repetition in analysis of articles that had been previously reviewed. Another strength is an extensive summary of findings that has been presented in a tabulated form of 426 identified qualitative, epidemiological, and quantitative studies. This way, a rich data base has been created for academic references and their potential multiple use in future studies.

Another shortcoming might be the exclusion of grey literature, which seemed unavoidable and was also recommended by the librarian as a necessary search strategy. I think that examining Master’s and doctoral theses on this topic could be beneficial and these studies should be recommended for future inclusion.

7.2. What This Study Adds

The relevance of this scoping review is believed to be found in creating an extensive data base that will serve as a large source of information about antidepressant use. Few themes that emerged from the findings about noncompliance were found to deserve special exposure. Some of them evolved around wrongful medical practices and patterns of unprofessional behavior in health care providers, perceived by their patients as being inappropriate, disappointing and discouraging: “Erroneous attitudes and beliefs were found regarding the effects of antidepressants. Many patients also had wrong ideas about how to comply with the treatment regimen” (Cabassa et al., 2007). In addition to patients’ personal beliefs grounded in their upbringing, culture or religion, the following aspects hindered positive treatment outcomes, and
they were all determined by external factors. This strongly suggests that their advancement, hence improvement of medication adherence, can be achieved:

- Improper/quick diagnostic procedure in depression: first encounter with health care professional and the initial prescribing of antidepressants based on brief self-reports that might be inaccurate and misleading. It was found to determine future non-adherence.
- Dismissive and careless behaviors during initial and/or continuous consultations with health-care professionals resulting in potentially wrongful prescription of inappropriate drugs predicts non-adherence to treatment.
- Missing or inadequate information about mechanisms of action in administered medications, thus missing warnings about possible adverse effects. This may also predict refusal of medicines or non-adherence to recommended therapy.
- Perceived lack of understanding and lack of interest in patients’ personal experiences, beliefs and treatment preferences, leads to patients’ withdrawal from therapy and health care services.
- Perceived lack of deep knowledge about both depression and antidepressants that clinicians recommend, leads to patients developing doubts about their professional competency and efficacy of treatment, thus predicts non-adherence. All practitioners should ensure they have up-to-date knowledge of antidepressant medication.

These are external reasons found by patients to be major determinants in medication and treatment adherence in depression. Their relevance in depression management cannot be ignored. When the quality of health care services improves, patients will feel empowered and supported. Attempts to improve adherence to treatment should therefore start with extensive work on
changing attitudes in health care providers, by raising their medical knowledge but also psychological awareness and understanding of depressive patients’ vulnerability and dependence. When facing symptoms of depressive disorders, patients’ confrontation with the reality can be painful: fellings of being alone, misunderstood and helpless in their mental and physical suffering, also fears of stigmatization, often create what they describe as darkness. The decision of seeking help is usually inspired by others: friends or next-of kin. This moment is crucial and determines future effectiveness of treatment, or lack of thereof. The importance of first encounters with empathetic physician as well as a correct, not rushed, diagnosis and consequently, carefully chosen treatment, determine successful and efficacious therapy with positive outcomes. Cabassa et al. (2007) believe that distrust of physicians and their skepticism toward the effectiveness of antidepressants acts as barriers for seeking professional care and adhering to treatment. Physicians and other mental health professionals (e.g., social workers, psychologists) need to explore and openly discuss negative attitudes early on in the treatment process in order to actively engage patients into treatment (Cabassa et al., 2007).

7.3. Implications for Further Studies:

Hopefully, future attempts of discovering the most effective ways of treating depression will bring us closer to achieving remission. Further studies should focus more explicitly on self-management, and how the response of the primary care practitioner encourages or inhibits it. There is evidence to suggest that GPs could be more actively involved in considering treatment discontinuation and that a sub-group of long-term users may be candidates for cessation of antidepressant treatment: this is an important focus for future research, which could provide a starting point for more targeted encouragement of behavioral activation in depression within the self-help model as part of a comprehensive approach in primary care. It is possible that different
belief patterns exist in groups not specifically exposed in this study, for instance, the black and minority ethnic population or those with chronic physical diseases, so new, separate studies of beliefs and views on drug treatment in these populations may bring interesting results. Only a limited number of studies with focus on lived experiences of depressive illness in men was found during the search conducted for this review. Masculinity is typically perceived as equivalent to strength, power and toughness therefore men admitting to symptoms of ill emotions, moreover, being treated with antidepressants, fear to appear as extremely weak. In addition, a focus on comparing the efficacy and side effects of brand antidepressants with those of their generic equivalents could lead to interesting and useful findings. Also, more empirical studies on placebo effects of antidepressant treatment could deepen our understanding of the power of human thought and belief in effectiveness of therapeutic means. In addition, some other issues were found important and deserving of greater exposure: pregnancy-related discontinuation of antidepressants (discussed by Bennett et al., 2010), increased probability of an atypical or nonspecific clinical presentation of depression (Bazargan et al., 2005) and emphasis on screening and expansion of treatment in depression (Bazargan et al., 2005). Presenting screening as a normal and routine part of health care routine may help reduce feelings of shame and “give permission” to discuss depression more openly, raising patients’ awareness of efficacious treatment options. On the basis of this study, care for depression as well as some preventive measures could become increasingly effective and cost-saving.
BIBLIOGRAPHY


*Psychiatry, 5*(11), 417-419.


Brown et al. (2005). Beliefs About Antidepressant Medications in Primary Care Patients Relationship to Self-Reported Adherence. *Medical Care, 43*(12), 1203-1207.


Cabassa et al. (2007). “It’s Like Being in a Labyrinth:” Hispanic Immigrants’ Perceptions of
Depression and Attitudes Toward Treatments. Journal of Immigrant and Minority Health,


Campbell, L. C., Clauw, D. J., & Keefe, F. J. (2003). Persistent pain and depression: A
biopsychosocial perspective. Biological Psychiatry, 54(3), 399-409.

Evaluating meta-ethnography: a synthesis of qualitative research on lay experiences of
diabetes and diabetes care. Social science & medicine, 56(4), 671-684.

Canadian Institute for Health Information. Health region interventions that address the social
determinants of health: equity and structural lenses in intervention research. Ottawa:
Canadian Institute for Health Information, 2013.

evaluating patient adherence to antidepressant therapy: a real-world comparison of
adherence and economic outcomes. Medical care, 44(4), 300-303.


Chakraborty et al. (2009). Attitudes and beliefs of patients of first episode depression towards antidepressants and their adherence to treatment. *Social Psychiatry and Psychiatric Epidemiology, 44*(6), 482-488.


Churchill et al. (2000). Treating depression in general practice: factors affecting patients’

Cipriani, A., & Geddes, J. R. (2014). Placebo for depression: We need to improve the quality of
scientific information but also reject too simplistic approaches or ideological nihilism. *BMC
Medicine, 12*(1)

Clark, A. F. (2004). Incidences of new prescribing by British child and adolescent psychiatrists:
A prospective study over 12 months. *Journal of Psychopharmacology, 18*(1), 115-120.


(2006). Relapse of major depression during pregnancy in women who maintain or
discontinue antidepressant treatment. *Journal of the American Medical Association, 295*(5),
499-507.


of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight
States. Preventing Chronic Disease: *Public Health Research, Practice and Policy, 3*(2), 1–
14.


Cowen, P. J. (2015). A "fact of the matter" may not exist in scientific narratives such as serotonin and depression. *BMJ (Clinical Research Ed.), 350*, h2501.


Dobscha et al. (2007). Depression Treatment Preferences of VA Primary Care Patients. *Psychosomatics, 48*(6), 482-488.


Farinde, A. (2013). Adherence to antidepressants. *Archives of Pharmacy Practice, 4*(1), 44.


Fawzi et al. (2012). Beliefs about medications predict adherence to antidepressants in older adults. International Psychogeriatrics, 24(1), 159-169.


Frank et al. (2007). The patient experience of depression and remission: focus group results. The Journal of Nervous and Mental Disease, 195(8), 647-654.


Gibson, Cartwright, and Read (2016). ‘In my life antidepressants have been…’: a qualitative analysis of users’ diverse experiences with antidepressants. *BMC Psychiatry, 16*(135), 1-7.


Goodman (2009). Women’s Attitudes, Preferences, and Perceived Barriers to Treatment for Perinatal Depression. *Birth Issues in Perinatal Care, 36*(1), 60-69.


Hickie, I. B. (2011). Antidepressants in elderly people: Careful monitoring is needed for adverse effects, particularly in the first month of treatment. *BMJ (Online), 343*(7819)


Houle et al. (2013). Treatment preferences in patients with first episode depression. *Journal of Affective Disorders, 147*(1-3), 94-100.


Izquierdo et al. (2014). Older depressed Latinos’ experiences with primary care visits for personal, emotional and/or mental health problems: a qualitative analysis.


Maidment et al. (2002). ‘Just keep taking the tablets’: adherence to antidepressant treatment in older people in primary care. Geriatric Psychiatry 17(8), 752-757.


Mergl et al. (2010). Are Treatment Preferences Relevant in Response to Serotonergic Antidepressants and Cognitive Behavioral Therapy in Depressed Primary Care Patients? Results from a Randomized Controlled Trial Including a Patients’ Choice Arm. *Psychotherapy and Psychosomatics 80*(1), 39-47.


Misri et al. (2013). Factors impacting decisions to decline or adhere to antidepressant medication in perinatal women with mood and anxiety disorders. *Depression and Anxiety 30*(11), 1129–1136.


Molenaar et al. (2007). Does Adding Psychotherapy to Pharmacotherapy Improve Social Functioning in the Treatment of Outpatient Depression? *Depression and Anxiety 24*(8), 553–562.


Moretti, M., Manosso, L. M., & Rodrigues, A. L. S. (2015). Vitamins and minerals as alternative or complementary therapies in depression. *Advances in psychology research* (pp. 67-103)


Mental health by the Numbers https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers


Murawiec, S. (2007). Comments and analysis on depressive patient's relation about his pharmacotherapy and its results from the point of view of subjective aspects of
pharmacotherapy - case report. [Analiza wypowiedzi pacjenta z depresja na temat farmakoterapii z punktu widzenia subiektywnych aspektów prowadzonego leczenia i jego wyników - Opis przypadku] *Wiadomosci Psychiatryczne, 10*(2), 123-130.


Patten, S. B. (2009). Accumulation of major depressive episodes over time in a prospective study indicates that retrospectively assessed lifetime prevalence estimates are too low. *BMC psychiatry, 9*(1), 19.


Sapolsky, R. Stanford's Sapolsky On Depression in U.S. (Full Lecture).  
https://www.youtube.com/watch?v=NOAgplgTxfc


Sharma, A., Guski, L. S., Freund, N., & Gøtzsche, P. C. (2016). Suicidality and aggression during antidepressant treatment: Systematic review and meta-analyses based on clinical study reports. *BMJ (Online), 352*


Thase, M. E. (2002). What role do atypical antipsychotic drugs have in treatment-resistant depression?. *The Journal of clinical psychiatry, 63*(2), 95-103.


van Geffen et al. (2011). The decision to continue or discontinue treatment: experiences and beliefs of users of selective serotonin-reuptake inhibitors in the initial months--a qualitative study. *Research in Social and Administrative Pharmacy* 7(2), 134-150.


Consumer Reports. Best Buy Drugs, 2013.


APPENDIX A

Search Strategy Formulated in PubMed and Adapted for Use in Other Databases

Keywords: experience, remission, depressive disorders, cognition, antidepressants, adult patients

Main Terms: patients, experience, antidepressant, depression

Search terms:

Results of database searches

Medline – N=1779

Initial attempts to search for qualitative studies were unsuccessful insofar that unrealistic numbers of studies were pulled, among which the majority were not qualitative. Here are presented all the search words for ‘qualitative research’ that were approved by the librarian but were not included in the final search:

APPENDIX B

Description of Selected Studies n = 426

Most studies were from the USA (138), followed by the UK (77) and Canada (30), Australia (26), Netherlands (21), Denmark (12), Germany (11), New Zealand (10), Spain (10), Sweden (8), Belgium, Italy, Japan and Finland (5 each), Switzerland, Turkey, Korea and Saudi Arabia (3 each), France, Ireland, India, Uganda, Taiwan, Greece, Hong Kong, Brazil, Malaysia and Iran (2 each). Other countries that were represented are: Austria, Poland, Pakistan, Hungary, China, Iceland, Kuwait, Czech Republic, Sri Lanka, Portugal, Egypt, Israel, and South Africa (1 each). The number of participants differed greatly but was not specifically assessed on account of different qualitative research methods.

Summary by year of publication:
1961 (2); 1965 (1); 1985 (1); 1992 (2); 1993 (1); 1994 (2); 1995 (5); 1996 (4); 1997 (4); 1998 (2); 1999 (2); 2000 (9); 2001 (8); 2002 (15); 2003 (22); 2004 (16); 2005 (25); 2006 (32); 2007 (47); 2008 (26); 2009 (22); 2010 (23); 2011 (21); 2012 (27); 2013 (29); 2014 (34); 2015 (30); 2016 (14)

Qualitative and mixed methods studies n = 128
Antoniades 2016; Castonguay, Filer & Pitts 2016; Gibson, Cartwright & Read 2016; Gibson, Cartwright & Read 2016; Janakiraman, Hamilton & Wan 2016; Stanton & Randal 2016.

**Reviews (incl. minireviews, overviews, commentaries, summaries of literature, etc.)**

n = 32
APPENDIX C

Summary of Content of Selected Qualitative Papers

1 Amey (2010).

This study describes a history of a patient suffering from mental illness and intensively treated with antidepressants (tricyclics, dosulepin, a 16-year history of sertraline and dosulepin for insomnia). The coincidence of later speedy recovery with the discontinuation of the drug therapy, seems consistent with the patient’s (and author’s in one person), hypothesis of mania occurring as a side effect of antidepressant treatment. Patient, a medical writer, familiar with professional terminology, appears quite knowledgeable about mental illness and psychopharmacology. She describes in detail her symptoms and suffering, claiming that treatment with antidepressants triggered intense symptoms of mania that required hospitalization.

2 Anderson and Roy (2013)

While some people argue that there is no difference between taking antidepressants and medicines for other health conditions, such as insulin for diabetes, others reflect on the way antidepressants are considered to represent a different class, compared to other medicines: cited is experienced horror with psychiatric drugs, with many individuals turning against them; and a widespread judgement that they do not have the same lifesaving power as insulin or other drugs. A large number of patients refuse to take antidepressants. They think they can recover from depression on their own. Others report not having any ideological or philosophical position about medication. Individuals’ views and accounts of their lived experiences offer a wide spectrum of perceived ‘truths’: One patient admitted to being aware of available drug treatment in depression but she was not willing to accept them because of a stigma and her own fear of getting addicted to drugs. Another woman resisted taking antidepressants because she saw it as a sign of weakness that proved something must be wrong with her and feared social rejection.
Lay beliefs are that male patients are particularly inclined to see using antidepressants in this way. Some think that stigma around taking antidepressants is unjustified. People fear that antidepressants might mask personal problems but not actually resolve it, and the rationale is that people should manage their issues without medicines, rather than ‘papering over the cracks’. In the past, it was rather difficult for people to find information about prescribed medicines, but currently, the internet is being routinely used by people who look up symptoms and side effects of medications, as well as familiarize themselves with public forums where others share their illness and treatment experiences. A lay belief is that patients used to be more accepting of diagnoses and medical recommendations before. But there are also patients who, after trials of different medicines, find to be fortunate as to their knowledge, the medications they had been given have no major adverse effects as compared to others.

Many individuals who have felt depressed for a long time and have tried to ‘manage’ the symptoms on their own, may see the doctor only after reaching a crisis point, and be prescribed antidepressants. Others go to see the general practitioner because their family and friends urge them to do so, as their behaviour obviously affects other people. A woman did not go to see her GP until her husband threatened to leave her. Another patient’s wife made him go to the doctor after he broke down at work. It is said to be difficult to recognise own signs and symptoms of depression, and certainly many are not aware of existing effective treatments.

The physician’s role cannot be stressed enough: according to one female patient, if the doctor hadn’t been able to turn her thinking around depression and its effective treatment during the first appointment the way that she did, patient believes she would lack motivation to take the medication. And certainly, knowing now that it does take four to six weeks to see an effect, the patient might, even if she had started taking it, have given up after two weeks. But the doctor’s
influence was powerful enough to drastically change the patient’s perception. The physician took time to explain depression, its different causes and then, the medications.

Patients might be resistant to accepting antidepressants due to the strong stigma attached to them. One male patient reflected on his experience admitting that he did not let the physician even finish, and his response was simply, ‘not a chance.’ Just the term ‘antidepressant’ to him was not acceptable and he was convinced that other people in his position would have similar approach. But there are also other patients who, believing that the ‘doctor knows best’, had taken antidepressants most of their adult life on the advice of their physicians. There are individuals for whom the overwhelming impact of their depressive symptoms translates into continuous treatment. These people admit that refusing the intake of medication is not even an option.

Some patients in this study felt completely excluded from the treatment decision-making. One man’s account of the doctor writing on her notes the word ‘depressed’ says that this gesture made a negative impact on how the patient viewed himself and the diagnosis. The doctor diagnosed the man in a brief message, ‘I think you're suffering with depression and need antidepressants’ which was experienced as a non-personal and formal feedback. In another case, the GP put the patient on antidepressants and on sleeping tablets without hesitation and without any explanation. Patients often feel that their doctors have no time to listen. Another GP was particularly insistent that patient take her prescription. After the patient repeatedly refused it, the doctor’s response was, ‘I don't know what's wrong with depressed people, why they always refuse to take my prescriptions. I think depressed people like being depressed.’ Patient felt like the physician shamed her into taking the prescription.

Another patient was surprised, even frightened, by some of the things his doctors said about what antidepressant taking would mean for him in the future, for example, that it would
take a long time to get better, or that he would be dependent on them for life. But at the same time, there are patients who are relieved to be diagnosed with depression and be prescribed antidepressants. Once that is done, they become more optimistic because their suffering finally gets acknowledged and there is hope for a possible cure. Some people demonstrated a raised awareness because of their depression treatment experience with their relatives. One participant’s father recovered in the past with the help of antidepressants, which significantly helped this patient to become very accepting of drug treatment for his own depressive symptoms. Another optimistic story of a woman who described the first doctor she ever saw as ‘absolutely fantastic’, adds to the serie of positive views. The physician is said to have noticed the depression signs and have asked proper questions. The woman felt being correctly diagnosed and prescribed effective treatment. When the treatment didn’t work very well, they adjusted it and got her back on track within a couple of months. Another patient was first prescribed an antidepressant, thus he felt it signified his depression as ‘official’. He said that seeing it written in his notes felt, ‘almost like having a criminal record’. It had affected the way he viewed himself and he felt designated to a marginalized category; in his opinion, he now became someone who was ‘mentally ill’ and it affected his identity. This patient’s preference was to manage his symptoms without antidepressants so his wish was, to come off them as soon as possible. It was important to him for there to be ‘an end in sight’.

A number of individuals prefer to be ‘in control’ of their own emotions and they see antidepressants as a temporary ‘crutch’ to lean on rather than a permanent solution. To some people, receiving their first prescription for an antidepressant feels like avoiding responsibility for their own emotions and actions; they experience it as taking the ‘lazy’ option to create an emotional well-being. Such patients see taking antidepressant as a sign of a personal failure.
One participant wasn’t prescribed an antidepressant right away and he appreciated the time granted him to consider pros and cons: he didn’t really want to go on medication but he was aware that he was at the point where he needed treatment. He was grateful for not being immediately given a prescription. The medical stuff offered several options: they described available medications and their efficacy. They also suggested monitoring the patient’s situation before starting the drug treatment which the man thought was a very responsible approach. He eventually did go onto antidepressants, because no improvement of his condition was noticed.

People admit that even deciding to start the antidepressant treatment, and actually contemplating swallowing the tablet for the first time could become emotional and feel like a ‘momentous occasion’: one patient described having left the medications ‘on his top shelf for ages’ and not wanting to take them due to his confusion as why this would be his fate; the doctor prescribed him that after like a really short chat, with the patient saying his mood was down, and it crossed his mind that maybe at that time, doctors were handing the ‘happy pills” out left and right.

In the absence of instruction expected to come from their medical providers, patients are interested in finding out more information before taking the first tablet. One individual reported of being told to go home and take the prescribed Prozac pills, but as a person with a scientific mind, he looked up Prozac online, and he decided not to take any, because of his concern about many side effects. He just threw the pills away. A woman got her prescription dispensed but it took time to read through the information leaflet before deciding whether or not to take the first dose. She worried that the antidepressant might make she feel ‘fluffy’ or ‘out of control’. She spent a full week wondering whether to take the antidepressant and she had second thoughts after reading an article online. She saw the GP for a second chat before deciding whether to take it.
People’s antidepressant treatment behaviors can be dictated by fears: there is a striking report of a patient who thought that if he can be seen to be compliant to treatment it would make him less likely to be sectioned; or a story of a woman who read the drug information and got scared, nevertheless she decided to take a tablet after—not right away, but after a few weeks. “She took a tablet and it made her so sick, she retched the whole night in the toilet, just retching, and it made her feel like she almost died”. Generally speaking, most people are uncertain about how long it would take for the antidepressant to take effect, the extent to which it might help, and what to expect in the first few weeks. They are concerned whether the pills could make them feel worse rather than better, and how long they would need to take an antidepressant for. Many patients who initially accept the therapy, do not experience a quick relief from their bothersome symptoms. They may even feel a lot worse, at least at first, so they take the medicine for ‘a little bit’ and then stop it in the absence of immediate improvement.

Another patient felt that he benefitted in time, if not immediately; one of the most striking things that he noticed the first time he took antidepressants was, all of a sudden he realised how much colour there is in the world. But when he was depressed, his perception of colour had diminished. The next female participant felt as spaced out, controlled, drunk, completely flattened and numb, although not depressed any more: the first week of taking medication she felt she’d been “hit over the head with a sledgehammer”. She found it really hard to have her bearings and cope. It was just the most bizarre feeling but she hung in there and after about ten days, it got better.

For the next informant, just the fact that she was taking the antidepressant and was doing something about her depression, helped. She reflected on her experience: “straight away when you start taking it you feel great because somebody understands, somebody had listened to
what's wrong with you because you're in this bubble (and the only way you can describe it is a bubble), the whole world is going on around you and nobody seems to understand, at least you assume that you have no support…and all of a sudden, it just takes a lot of weight lifted off your shoulders that you're starting medication and that you're on the road to get better…”

3 Anderson et al. (2015)

A patient had been prescribed antidepressants in the past but he always felt reluctant and apprehensive about taking it, largely because a) he felt that the effects are probably short-term, they're not going to actually resolve the problems, b) because they do have side-effects and, and c) he didn't feel comfortable, himself, with taking tablets.

Being prescribed an antidepressant was vital for another patient, and she gladly accepted the treatment option as suggested by her doctor and when she took the first tablets, they made her feel that the decision was justified. Another optimistic story was told by a male study participant who was prescribed Effexor (venlafaxine). He soon experienced side-effects: swelling in the face and headache, which he knew this medication can cause. He therefore contacted his physician who told him to stop the treatment. Similar bothersome adverse effects appeared on the Lustral (sertraline) and Cipramil (citalopram) in the same individual. Patient finally settled on Seroxat (paroxetine). It was his doctor, the GP, not the specialist, who recommended trying Seroxat. As patient accepted the treatment, he was recommended to try it in a liquid form first. After the trial, the treatment was continued with paroxetine tablets and the man has continued with about 30mg without cessation.

Treatment with Paroxetine was found quite unpleasant by another male patient. The man admitted that ‘it was pretty nasty, actually’. In addition, he said, it had absolutely no effect on the depression. Patient took it dutifully every morning out of the little foil packets for 5 or 6 months.
He admitted that a lot of the professional interventions were unable to help him, and antidepressants did not at all, either. He commented that in his opinion, “antidepressants should not be called that at all because they don't really do very much against depression”. They work more as anti-anxiety pills or sedatives. The next case was described by a female patient who was issued a prescription for antidepressants automatically, and she was also put on sleeping tablets without being asked. In the medical notes, the doctor wrote, patient was depressed and she said to her, ‘I think you're suffering with depression and need antidepressants.’ The patient found the physician’s behavior unacceptable.

Prozac (fluoxetine) was fully accepted by another patient, and no bothersome side-effects of treatment were noticed. The open question remains, whether patients are feeling well anyway or is it the medication that is helping. But for that woman, the antidepressant therapy seemed to be working so she remained on the medication. One of the things that another patient thought was very important to him in this process was the fact that the doctor told him, ‘I'm going to get you out of this depression but don't expect a miracle. Don't expect to be okay tomorrow. It's a long process but I'll sort you out.’ Those were his words. That to the patient was very important.

People admit that being treated with antidepressants is not like, ‘you might kind of crave a cigarette’, but experiencing side effects is unpleasant. And it seems unnatural that ‘you just have to do take a tablet to feel normal’. Some would call them ‘happy pills’. “But you don't walk around stoned or sort of ‘Oh isn't life wonderful.’ You just feel normal, that is what they make you do, they just make you feel normal. You don't feel euphoric, you don't feel manic, you don't feel spaced out, drunk, stoned, and whatever you want to call it. You just sort of feel yeah, this is the way life is supposed to be, everything just feels alright, balanced”. ‘Antidepressants, they aren't a quick fix to make you better, but they help you to cope better with what you're going
through’ (patients’ accounts). Another female informant will never regret taking the medication because the treatment has totally changed her life. She no longer feels the intensity of it, but when she first took the pills, she felt like she had been given her life back. She feels like she can now be a normal person.

An older man (73) felt that it was going to be a question of time that medicine got him right. This patient had continued on a small dose of Sertraline which he shall take for the rest of his life. For another male patient the antidepressant wasn't working. Luckily, there was no pressure to deliver at work which, he found, was a tremendous blessing. The medication kind of worked - he found, it made him more functional. But how he described it, he was ‘a functional zombie’. He was able to function, to work, he could read, he did have his motivations, his mental capacities came back but he was still depressed. And some days, he said, he would be really overwhelmingly depressed.

Lay beliefs are that doctors know, patients do not want to be on antidepressants for the rest of their lives. So they try, they experiment, take guesses and choose between medicines, increasing and decreasing the doses. It happened to one female patient, when she discontinued her treatment, everything just went backwards, so she went back and continued with citalopram (cipramil). She reported, she was on 40mgs, has been up and down on them, and she was on the medication but realised that it takes a while to discover the right dosage, and there is the right level dosage for every person, she said. So it's gone up and it's gone down. They've tried going down and it did not work, patient was not ready for it, so the dose was increased again.

One female informant showed anger and frustration. She complained about the psychiatrist’s attitude and the manner he prescribed her the antidepressant. That was what made her come back to confront him. She questioned why the patients are not being informed about possible dangers
of medication treatment. She claimed that the intake of citalopram over a longer period of years can cause a brain damage. It is unclear how she obtained such information.

A mature, 69-year-old male patient explained: the only way you can avoid pain is by just getting away from the incident that's causing the pain; and the only other way is just to cut down your awareness of it, which is what medication is mostly for, she thought; it's really to cut down your feeling of pain. “But the thing is the pain is nature's way of showing you what's wrong, and without it you're in the dark”. And the thing is we've been given the ability to know what's wrong with us ourselves. But if we keep taking pills, if we keep taking things that are going to stop us being aware, if we keep getting drunk, if we use anything as a drug to reduce our awareness, then our ability to be healthy is cut down. So the first necessity to be healed is to raise your awareness.

Another possible reason for non-adherence is simple forgetfulness. Patients report having stopped their antidepressant therapy, without telling their physicians, just because they kept forgetting to take the pills. The next informant had been prescribed the tablets which felt like sedatives to her but she soon found out that they were also given to people with psychosis as well as other mental disorders, and patient just threw them away. One patient did take an overdose on one occasion, when things were quite desperate. It was a high dose of antidepressants and paracetamol. Patient later admitted to a pretty horrendous experience. A male participant was not certain whether these were side effect of the prescriptive medication what he suffered from. He thought it might have been a combination of both medication and depression because he had it before, he experienced it a little bit before he started taking the drugs and then it kind of got a little bit worse. Initially, with things like Tryptizol (amitriptyline, a trycyclic antidepressant), and later with other antidepressants, there was constipation, dizziness, double vision and as he
reported, all kind of other unpleasant side effects. But sertraline was prescribed later at a low
dose and it was not a really significant experience.

A female patient was unable to conclude if the medication would do her any good or not,
but she added up one day that she would, over the years, had taken almost 20 different sorts of
pills. And experienced a dry mouth and many side effects that were unpleasant.
A patient treated with Effexor (venlafaxine) said that he was no longer himself. He reflected with
a deep sadness: ‘[I]t took me away from me’. He was no longer able to do some of the things
which he enjoyed doing before. He liked writing music and he was unable to do that. He could
no longer see the patterns in written music. He no longer had the ideas of things that he could
perform before he started treatment. Although it improved the patient’s mood, and he no longer
felt depressed, it took the motivation away from him and it kind of took the fun out of his life as
well.

The next female informant complained that her brain functions went down while she was
treated with antidepressant medication. Before, she used to enjoy her very good writing skills
that disappeared completely. As also her confidence was gone, and as she said, she ‘couldn't
string two sentences together which was quite frightening for her job’. A male patient was taking
quite a lot of antidepressant drugs and was off work for about 6 months. When he went back to
work he had no recollection of what had happened while he was away. And he knew the job well
enough to go on doing it, but his memory remained impaired. Described was also a case of a
patient who reported feeling drunk while on psychotropic medication. She described the
antidepressants as ‘kind of old’. Most of the time, she was unable to function but she continued
the therapy. She suffered from the adverse effects for six months. She described her experience
as ‘something ridiculous’.

217
Male patients’ experiences with their sex life being negatively affected by antidepressants have been summarised by two other study participants. Their suspicion was that physicians who issue prescriptions are not fully aware of all the side effects involved in the drugs. Besides the ‘easy things like a dry mouth, and dizziness’ there other, more serious adversities. Lack of information can led to frustration and anger toward the physician. One of these patients suffered from impotence, which can put a great strain on the relationship and family life. Taking ‘Seroxat (paroxetine), the first thing a male patient noticed, and as he admitted, was a bit embarrassing, he couldn't ejaculate. In his words, “it's extraordinary, absolutely extraordinary, so you have no erection problems as such and you can have sex you know, but you just don't come. And it's kind of a weird … there's a question, you feel like a sort of porn star, you can go for hours you know”.

The next female patient who eventually stopped the therapy with antidepressants, reported having experienced her body shaking while on the medication. She would wake up in the middle of the night with a bolt of fright, and shaking. She also realized that the medicine made her pupils dilate. So you look like you were on drugs, she said. One informant described some withdrawal symptoms that he experienced. He said, ‘those they're the strangest things ever’. When you make a gross movement, a gross muscle movement, you get this incredible buzz in your head. It’s different from a tingling and quite bizarre.

Many informants stressed the importance of human sensitivity and acknowledgement of patient’s symptoms that is desired in medical care relations. A doctor who never criticises, who never makes judgements is described as trustworthy and reliable. Some people actually believe that when there is a new drug coming from America, suddenly all the psychiatrists want to treat
all with the same drug. A woman reported being prescribed a medication and soon, when talking to other patients in the hospital, she found out that everybody was taking the same drug.

Another patient said, she came to the point where she was able to protest: ‘hang on this is my body here and this is me,’ she decided to speak up for herself, and she started to question the psychiatrist as well as her treatment. She suddenly realized the psychiatrist was becoming more respectful toward her. Her belief was that you have to fight for a proper treatment and attitude, even in medical settings. It is not a thing that is automatically given.

One male informant saw the same psychiatrist after 10 years. During the first visit he was prescribed lithium. After 10 years, the doctor said, ‘Oh, I remember you, you had an overdose of lithium!’ And the patient responded, ‘You told me it was stress.’ And the physician’s response was that he could have made a mistake. So all the patient’s ‘faith in psychiatrists went zooming out the window with one man’. People’s perception of treatment is, ‘You're ill, here take this pill.’ And like medicalisation, that's not even a word, but medicalising and the fact that they did put you onto it so quickly, could make people kind of go, ‘Oh no, that's just really bad’, admitted study participants.

Another patient always went to the clinic with a strange feeling that it was like a cattle-farm: you go in, you say what you feel, he gives you a prescription, and out the door you go, which isn't at all good, he complained. A new physician prescribed citalopram immediately, so within a week, the patient was on 40mg of Citalopram, and he found this being a high dose.

A bitterly pessimistic reflection comes from a mouth of a women who had remained in the drug therapy for years. She described it as “some anti-depressants”. They just gave her a repeat prescription with the plan to leave her on them for as long as only possible. She has been on them for 4 years now. No-one asked her if she is thinking about coming off them. No-one has
said anything. Patient says: ‘they just shove you on them, as long as you’re not trying to kill yourself, or coming in and crying to them, then they don’t care’. And the patient knows the doctors are very busy.

It was a tremendous, stressful period in another patient’s life. And when the 20-year-old female went to the clinic, a ‘lady doctor psychiatrist’ saw her in the day room and said something about ‘Is your illness imagined, or is it real?’ And she said this in front of several visitors and in a loud voice, so the patient felt ‘just about four inches off the ground’.

Another study participant shared her story and found it actually interesting. She continued Efexor (venlafaxine). It was the slow release capsule, and she was taking 75 mg a day. She was once feeling really bad, so she was told to increase the dose. The patient followed the doctor’s advice but then, she went back to the psychiatrist and his response was, ‘What! If you were surviving on 75mg, go back to it.’ Patient’s conclusion: ‘psychiatrists know about drugs, GPs don’t know as much obviously … You could end up on so much … but it is serious stuff’.

The next informant’s experience was very negative. She was bringing her memory loss to the doctors’ attention at the hospital, and after giving them an example, she heard that this was just normal and not an adverse effect of the medicine. As a consequence, the patient got disappointed and fully discouraged, and also doubtful about the effectiveness of treatment. She went into a suicidal mood feeling that she cannot be helped. She checked her life insurance policies believing that her husband and her son would be better off without her. Because what was the point in living like she was living, she hated it. She hated herself and she ended up taking an overdose. This is a drastic example, unfortunately, one of too many, where the medical personnel instead of showing understanding and offering support, left a depressed patient in a pessimistic mood that worsened her already poor mental state.
Depressed patients cannot be blamed for not believing everything their doctors say. Some decide to go and check the recommendations, because they either experienced themselves or heard from others that what the physician said, was ‘most of the time just wrong’. Rationale: ‘they can't be expected to know everything, especially GPs’. Patients generally want to know what options they have. They also want to learn about what methods others use to deal with their depression. They admit, a deeper knowledge of the illness and effective therapies would definitely be helpful. Most people go against taking medication, but if drug treatment is found necessary, ‘if that's the silver bullet’, people demonstrate willingness to recognise the needs and benefits. Individuals tend to question the antidepressant medicines and how much patients are being over sedated. Checking the websites has become trendy, looking at information that's available, reading about depression and really become informed customers because this is found to be an area where people aren't always telling you the right thing, and especially GPs are believed not always have that knowledge to hand.

Most patient admitted to conducting their research prior to taking medicine and starting treatment.

4 Badger and Nolan (2007)

There is a common belief, in depression you cannot rely on the medication, you don't get a miracle cure out of a bottle, it can help you over the bad times but it's not a cure. To be cured is up to you; you've got to be willing to try, half way, you've got to do it yourself. Self discipline has been stressed; patients would be disappointed to think it was just the medication. They like to think that they do not need to go back on the drugs again after they tried some other remedies and used different self-help strategies.
Stories of patients who started taking an SSRI vary. Some are account of positive experiences, and other are discouraging. One patient reported that after he started the antidepressants, the change was fantastic, which convinced him that there was a problem because he felt so much better.

In another case, the tablets were helping to a certain extent but they weren't by any means clearing things up. They were no good, patient didn't take them after the first course, he didn't collect the repeat prescription. Patient didn't think he really knew what the medication is supposed to do to you. Is it supposed to calm you down 24 hours a day or is it for an hour or two. Not knowing what it was makes it twice as bad. However, hearing ‘You have a common condition’ and ‘You will get better’ from the general practitioner was totally unexpected, but a very welcome information for the patient.

A GP told the patient: ‘I've been expecting you for some time’, making the consultation easier. It's the complete package, the doctor, voluntary work. The doctors have left the patient to make decisions, and he believed this was the thing that has done it for him, they haven't come up with a quick fix, like ‘here's a list’ but instead, they said ‘You're different to the next patient; let's put a package together for you’. Patient felt he had been involved in it; he haven't been on the outside.

Patient is crediting her recovery to her family, her GP and finally the medication. She took them for three or four weeks before feeling normal. It was gradual. But what was interesting, the woman believed that some of the healing process is also psychological because you know you are actually taking something which is designed to help and psychologically she believed that ‘Yeah, this is great’.
People say, it is almost a relief to find out that you are not the only one, and there are actually reasons behind it. It was one of those things that you kind of sense, but you don’t really admit it to anyone, even to yourself. Patients believe, family physicians and psychiatrists can be very open, especially when a patient comes with some informed knowledge. Reports exist that some doctors appear to be quite supportive, introducing facts based on research and may even bring relevant studies to patients’ attention. Unfortunately, other general practitioners seem not really equipped to deal with the questions of antidepressants use.

The physician’s encouraging attitude was found very comforting by one of the informants, and prepared the patient to say how far she was willing to go with the treatment, not only with medications, but with the whole therapy planned in advance. This patient was convinced, the doctor’s approach set her in motion to say, she is willing to take control over her moods and try to change to course of her disorder. One patient reported having taken a depression test. The score was checked each time. It was very high in the beginning, and then slowly went down, when the woman started taking the antidepressant medication.

Women’s experiences of depression during pregnancy are extremely important. You want to put the baby first, but, at the same time, you're just balancing out what is the risk to the baby of having a mom who is on Prozac versus what is the risk to the baby of having a mom who cannot cope with life situations and is falling apart. Often, a woman would admit, ‘I can only do the best I can as a mom’. Other women try to decrease the risk to the fetus by taking as low an antidepressant dose as possible to treat bothersome symptoms. Thanks to the counseling or to her medication, or perhaps the combination of both, the next study participant felt that she had arrived at a better place. Life still had moments of being ‘up and down’ but, there were ‘far less
bad days than there are good days’. Another patient reported to be in a much better place now than she was before even becoming pregnant. As the previous informant, she was still experiencing her ups and downs, but her ability to deal with some of the triggers had greatly improved. She had received counseling but remained medication-free during her obstetric and postpartum periods. She showed understanding of the slow pace in which the treatment was progressing. She still did get depressed sometimes. She still did get angry, exasperated. She still hasn't regained her full patience. It will take work, and that's what she believed and understood, it is a work in progress.

There's so much more to juggle, says another study participant. When you come home, you become a wife, you become a mother, and something, one time or another has got to give, you can't always be catching the ball. You need to take a break to recharge. Patient thought it was important, unfortunately, sometimes we just forget to recharge. The woman learned about herself. It was almost a gift in that, she doesn't know how to describe this; she learned about herself, she has learned to take time for herself. Another informant never thought that she would have worries. She didn't know that she should look out for these types of things. One of the reasons patient wanted to do this study was because she really thought it is important for women that are pregnant, either the first time, the second time, to share their experiences. That if they really think that they can't handle life any more, they really need to talk to somebody. It's important.

6 Bayliss and Holttum (2015)

A male patient believed that Mirtazapine probably did save his life. But another patient thought you can get stuck in a loop where they just prescribe you. A female patient reported to have been on antidepressants for 26 years (Iris). Initially, they were tricyclic antidepressants,
then the doctors tried MAOIs, which didn't work, and more recently the SSRIs…and then she was on lithium as well, and she also had ECT. Although another individual had survived her depression, as she confessed, she kept questioning herself, ‘what's the point in surviving if you can't feel?’ She realized that her medication was ineffective: She was going through a really bad period while still on medication.

Medication was significantly limiting another patient’s lifestyle. On Prozac he was functioning nicely, he admitted, but he was living the lifestyle of somebody in their late 70s, early 80s, rather than their mid-50s. He was not working. It wasn't helping him to address his lifestyle.

A quite pessimistic reflection came also from another informant: this patient believed he had every single pill on the market and every combination of pills. In addition, the drug therapy did not improve his condition, but he was hesitant to admit this to his doctor. His prediction was that they would say ‘okay, fine, we'll change the pills, we haven't tried this combination yet, you will have two of those, three of those and five of those…’

Lay beliefs are that doctors are all about the medicines. For somebody who is suffering from depressive symptoms, a listening ear could mean a world, but instead, ‘you get to go in for 10 minutes if you're lucky once every 3 months – ‘How are you feeling? Still taking medication? Sleeping alright? Well we'll leave you on that then’. This patient had that for 10 years. Regretfully, he says, ‘you don't get to lay on the couch, you don't get to discuss your problems…’

Many patients feel that they would prefer discussing the underlying causes of depression with their physicians and they would like to open up and sort that out to gain some clarity of thought and experience feelings of relief in place of pills they are prescribed. Feeling dependent
on medication creates dilemmas for patients. They don’t want to rely on drugs because they perceive it as an artificial control. One patient reported to have felt very dependent on his amitryptiline tablets and that made him want to stop taking the medicine. At the same time, it might be really difficult coming off an antidepressant. It is said to be really uncomfortable and like one patient admitted, ‘sort of feeling like you're losing your mind and getting really depressed, so you have to put a bit of faith in the tablets’.

7 Boyle and Chambers (2000)

Carers’ knowledge and understanding of antidepressant medication helps maintain care of people that suffer from depressive illness. Here, the care givers shared their experiences of managing drug treatment together with patients who remained in their care:

- Being cautious and checking the names of the medication in case other people share information about side effects;
- Receiving information about the tablets from health care personal;
- Receiving explanation from the physician and proper documentation included (leaflets);
- Consulting other professionals to check the appropriateness of the medication;
- Not being informed at all;
- Understanding patient’s fears of taking antidepressants due to their adverse effects;

Care givers’ attempts to ensure antidepressants treatment compliance and experienced obstacles:

- Patient believes the medication is not helping;
- Patient’s confusion about proper medicine and doses;
- Patient’s belief that tablets make her feel worse;
- Making sure the pills are taken;
Older persons’ perceptions of depression suggest that in the past depression was not seen as an illness; ‘you had to get up and get on with it. If you can't make yourself better they (medicines) are not going to help’.

8 Brijnath and Antoniades (2016)

Patients have been trying to balance the pros and cons of consuming antidepressants whereas for health providers, prescriptions appear to be an easier option. One informant was told by his psychiatrist: ‘You obviously function’ and also, ‘You know I see people that can barely sit down.’ He said the same thing as the GP and his recomendation was to look if the antidepressant works, and if the patient can tolerate its side effects. After five weeks of therapy and during follow-up, the psychiatrist said that he definitely recommended prescription over counselling. Taking pills was also found ‘easier’ by those adhering to treatment. You only have to consult two practitioners (the GP for a script and a pharmacist to fill the script), and could purchase medicines at reduced cost using benefits, and avoid the effort of finding a good mental health professional, care costs and the emotional work of psychotherapy.

For this patient, antidepressants did help improve mood: he felt like brain space springing up, even keel and it reduced the pain however, positive effects of antidepressants need to be balanced against possible adverse side-effects such as dry mouth, sexual dysfunction, lethargy, tiredness, and feeling dizzy and jittery. Lay beliefs are that medicines, specifically antidepressants are not ‘silver bullets’ or ‘magic’. They often caused severe side-effects, and experimentation might be unavoidable until an appropriate drug and dosage is found.

Some individuals would drink just to sleep. A man confessed, he wouldn't drink for the fun of it. It's just one of his depressive symptoms: if he doesn't drink, he will just lie awake and he will be awake for 72 hours. A female is questioning whether or not drinking wine would be
considered self-medicating. And she admits doing that a lot, knowing it is bad; but sometimes she goes home at night and all she wants to do is have a drink of wine because it helps her relax. And when the patient felt down, she added on five Lexapro® 10 mg tablets. Another informant run out of the Effexor® and instead of taking two she just took it down to one. She reduced her dosages with the intent of discontinuing medication.

Among people who were medicated, being ‘drug-free’ is understood as a sign of being cured from depression. A case of a patient who was trying to manage the antidepressant treatment by himself is not an exception: It was July when patient started reducing his dosage. September–October he stopped it completely. November–December depression hit him really hard. He couldn't concentrate on anything, felt really bad, couldn’t even explain, it was so bad. And then when he went back to the doctor in January he was made aware that this happened because he stopped the medication. The physician wanted him to get back on the tablets. And after he started the antidepressant treatment anew, he started feeling much better. He reported not to have that much of head pain, nor did he feel ‘so yucky’ any more. But still, he said, it was kind of ‘dying inside’.

One person argued that the consumption of pills, especially those that neuro-chemically alter the ‘self’, are less about pathologising deviance and more about modulating unruly or uncontrollable aspects of the self.

Many participants in this study perceived taking antidepressants as problematic and they called it ‘the easy way out’. Somebody concluded that people usually assume that one is on antidepressants because he/she is lazy and doesn’t want to make that effort to go see a psychologist and empty her emotional bucket all the time. Alternative medicine is recommended to substitute medicines. There is a belief that with herbal remedies, it's not just a simple matter of
consumption. Along with that you've to control or monitor a change of diet, the physical exercise, yoga and breathing and meditation. This is generally presumed to secure more control over the ‘self’ and person’s depressive symptoms. It could also be considered more of a money issue, to adhere to a long therapy; go to the doctor first and get referred to a psychologist and then possibly stay with the psychologist for another six times. So that strikes the patient, it is not really convenient. One person said, he could just go to some of his friends and family every weekend and talk.

A female patient thought it would be up to her, she should be working on her depression. She felt she needed to do further studies in childcare, yoga, exercising, walking, shopping, going out with friends and visiting a holistic doctor to obtain numerous pills (when she can afford it). Such transformative labour does help her and she noticed an improvement in mood. But such labour required constant effort and was often prompted by a sense of obligation and exchange, for example, the need to honour commitments (“not let down the team”), maintain relationships (“If my dad would tell me, ‘Do you want to go for a dirt bikeride?’ I say, ‘Yeah we'll go’”) and use services that were paid for (“We paid for these kick boxing classes, you have to go”).

Another woman confessed it was all her fault. She at times got ‘a little bit slack’ with her medication. She was a little bit overwhelmed when she came back to the house at the start of the year getting kids ready for school, schoolbooks, covering them, uniforms, just getting into that routine again. Patient was trying to get her depression and life under control with medication therapy. However, she refused to add eating healthy and exercising regularly to her drug treatment. She felt that adding additional responsibilities or activities would cause too much pressure and a break down. Another individual always kept a little hope alive, reminding himself
that if he follows everything properly, he will get out of this condition sooner or later. But unfortunately, he never made an effort to actually keep his own commitment.

9 Buus (2014)

Participant was depressed for the first time and he believed that it was caused by prolonged emotional stress. He had been discharged to psychotherapeutic follow-up at an outpatient clinic, but he did not think highly of the healthcare professionals or their psychotherapy. He thought that they did not provide him with anything useful beyond prescribing medicine, which he continued taking, and in time he choose to cancel his appointments with the therapists. Despite disliking the medical specialist, he would visit the psychiatric emergency room every time when he felt acutely depressed or desperately impatient about the time it took for him to recover. Participant’s visits to the emergency room: mostly, he would just talk to them and go home. Actually, it did help him a little, he admitted. He thought it was because he spoke with professionals who told him that it was not unusual that he was still so incredibly sad. You are told that it's normal even though you are discharged and take medicine. Things weren't happening fast enough, and it was when he couldn't understand that. The last time he went there seeking help, he got medication. He told the doctor they might as well admit him again, but the doctor refused and offered him another option: Lithium.

The patient had no prior personal experience of treatment for depression, and he felt that his need for a healthcare authority is to normalise his experiences of depressive symptoms by interpreting them in a less distressing way. But after starting to take Lithium to augment his antidepressant treatment, he gradually felt less impatient and distressed. He continued taking the medication in accordance with professional advice, mainly because he saw medicine as the primary means of recovery. He was sceptical towards taking antidepressants and experienced
some relatively mild adverse effects, but he believed that taking the medicine was necessary to avoid the risk of relapse. He feared stopping taking the medicine: he didn't know what it would be like if he didn't take them.

Another individual was initially very sceptical towards taking antidepressants, but ended up accepting them as equivalent to taking vitamins. In his family, he had relatives with severe mental illness. He found taking antidepressants stigmatising, so he was begging his general practitioner to authorise discontinuation of the medicine even though he feared a relapse and return of depressive symptoms. The next informant had previously been treated with antidepressants, but this time he experienced severe adverse effects of the medicine, which included a substantial weight gain and tiredness. But he was scared of stopping the medicine despite the adverse effects.

Another male participant realised he was a little afraid of what would happen if he didn't take the antidepressant. He did not ever again want to feel the way he felt when he was admitted. His fear was, it might happen again if he stops taking the medicine. He didn’t say that he'd like to take it for the rest of his life. He is sure that things will be good again, but right now the thought of having that feeling again was scary.

The next case is described, where in time, adverse effects of the medicine became unacceptable to the female patient. At the same time, occasional slips in the treatment routine became more frequent and seemed less scary than making a deliberate stop, and eventually confirmed her in having no need for the medicine. She had reached the point where she took very little of it. It was just once in a while. Really, there was no control. She just took it when she thought, “Well, it's been a while, so I'd better take a pill or two”. In the end, it was horrendous. And she just didn't feel that she needed it. And then she just stopped completely. She threw them
out and hasn't taken any since. She just felt better. She didn't feel, that the medicine changed anything for her, and her general practitioner and her psychiatrist kept on saying that it made her tired. So she thought, “Well, if that is what makes me tired, I have to … I don't feel up to this. I have to get off that rubbish”.

Another woman’s account: No, she hasn't asked her doctor if there might be an alternative to the medication. She tried some other ones and she didn’t take more than 3-4-5 tablets before she gave up. It felt like fire burning out into her arms and she couldn't take it. She hasn't had that with Noritren [Nortriptylin]. She has dry mouth and they give her the shakes. She would like to get rid of one of the medicine, but what if she gets worse? She saw someone during the admission, reducing their medicine and they ended up feeling awful.

A male patient was convinced that one of his two antidepressants was stressing him and gave him the restless evenings and nights. He eventually asked his general practitioner to reduce the prescribed dosage, but the doctor refused and told him that there was nothing to do but to continue. As a reaction to the GP's disheartening response the patient decided to solve the problems by halving the dosage on his own. Participant had continued taking Mirtazapin but had been allowed to halve it. He found out that when he went to bed something was stressing him. He would wake up and he couldn’t settle again. So, he was sure this medication was not working for him. The man admitted that after reducing the antidepressant to half dosage he was stressing about it until he found rest.

The next person was unable to confirm that he was having rewarding or trusting relationships with the therapists. He was only receiving prescriptions, and patient felt that the therapists were not ready or competent to meet his need for change. The prescribing therapists predominantly suggested maintaining the existing strategy by continuing, increasing or
supplementing the medical treatment. Such responses were extremely frustrating, as the patient desperately sought to change his situation, and did not believe that the medicine was important for solving all the issues, in most cases he felt that adverse effects added significantly to his problems. Patient found it difficult – and sometimes impossible – to challenge the therapist's authority during the consultations: When he sat in front of a doctor or someone with great knowledge, then he tended to believe all that was being said.

Another participant successfully insisted on a gradual reduction and ultimate cessation of his antidepressant simply because he had taken it for exactly six months, which, allegedly, was the period needed to have a low risk of relapse. This happened despite him having frequently experienced severe and disabling symptoms of relapse into depression. Another informant was shocked over having been admitted to hospital for depression and he continued struggling to reconstruct what had happened the day he broke down. He felt neglected by his doctor that day and he was convinced that the doctor had given up on him and his depression, because he did not care to listen: because he just wrote the prescriptions and then he was finished with the patient. He didn't say that the patient should return; he didn't say that the patient should come for some counselling; he didn't say, ‘I’d like to keep track of you’. ‘You can come and get a renewed prescription and we'll talk’. Participant decided to adhere to the hospital's original recommendation to take the antidepressants for six months, but because he felt abandoned by his general practitioner, he decided to get help to phase out safely from a kind employee at the local pharmacy.

This patient was treated by a consultant in an outreach team for several years, but he was increasingly unsatisfied with the treatment, because it made him feel very tired. By chance, due to overcrowding at the usual hospital, he was admitted to another hospital in a different town,
and he was pleased to get a second view on his illness and his medication. At the new hospital, the medication was altered because he asked for it. At the old place, which was the usual hospital he experienced what he believed was a dangerous lack of responsiveness: It could have been good if the medical personell at the usual hospital had been better at listening to the patient’s complaints regarding the medicine. He believed that the last admission could have been avoided if he'd stopped taking that Seroquel (Quetiapine) and started taking something else. Because the tiredness, he had, added to weaken the whole system. At first, he was pleased to have his medicine reorganised and he started using psychiatrists at the new hospital as his primary therapists. But then, he had started self-managing his medicine, moving to the frustrated search, because he felt bad and – paradoxically – by reducing the medicine, he could prove to hiself that things were good.

Patient then believed that his own reduction of medication added to his distress. He was readmitted to the new hospital where the psychiatrists wanted to augment the antidepressant treatment with Lithium, because they believed that he suffered from a bipolar disorder. And then Lithium made him feel tired and after discharge he decided to stop taking all the medicine augmenting his antidepressant treatment without consulting any professionals. He checked it on the the Internet, and learned that Lithium was fundamentally harmful to the body and had too many adverse effects and that he might as well test if he could do without it: He made this decision without talking to the doctor…It was probably because the doctor would be against it. Patient thinks he had an appointment in about a month from then. He thought that if he stopped them he could see if it reduced his tiredness, and if there are no problems, then there is no reason to take them. His perspective on taking medicine changed and his self-regulation increased gradually and was kept hidden from healthcare professionals and his wife because he was
convincing she would not approve his decisions. He also planned on informing his doctor, but then decided to cancel the appointments. He intended to eventually inform his therapists of his self-regulation but then realised that he would rather avoid all the comments.

Another individual self-regulated his medicine intake from the beginning. At first, he only regulated one of his medications. And whenever he felt bad and consulted a therapist, who was never the same because of institutional reorganisations, the only response was to prescribe more medicine. He felt more and more certain that this response added to the problem rather than to its solution. It is good that you can get medicine when you have pain and medicine when you are depressed. But he didn’t think it was a solution to just add more and more medicine because you go crazy because you’re doped all the time. He believed taking something like 29 pills a day.

A woman finally decided to reorganise her medication and she used her sister as a trusted person, who was the only one knowing about this complete and abrupt withdrawal. Her sister helped her by text-messaging frequently. And the decision just emerged: she had to say either or, and she felt so bad. Had it not been for her sister who texted her all the time, she would not have been here, she confessed. She didn’t think that she was going mad. She had to revise her life and find out ‘what is was that she wanted. It was so hard. She didn't sleep for four days after stopping taking Seroquel [Quetiapine]. She could not find rest. She had them, but she was stubborn and said no, it shouldn't be like that. Another person experienced adverse effects of the medicine, but in most situations, she was able to manage and tolerate them in her everyday life. Dry mouth, for instance, was managed by chewing gum and by always having a water bottle within reach.
A patient wanted to talk to the psychiatrist to see if he could be prescribed a new medication to make him less nervous. Medications don’t do nothin’, said this young Latino man. They are effective in treating nerves.

Another individual shared his belief that he would be sent back to the hospital for any reason, but his preference was to keep taking his meds and stay out of the hospital. He was under the impression that the specialists wanted to lower his medication dose, but that was exactly what happened last time and he did not want to go back to the inpatient clinic.

A young woman reported that her visits usually lasted about fifteen minutes and the doctor’s main concern was, whether she was taking her medication. This person got extremely frustrated.

She admitted that even her recent interaction with her vocational specialist was not helpful as his focus and only concern too was her taking the medication: ‘Take your medication and you will find work’, which she found absurd.

People complain about prescriptions being expensive. Another patient’s frustration was growing because she had already paid $40 for her prescriptions, which then got changed. She puts her hands to her forehead: she’s so sick of this mess. She doesn’t understand why they changed her medication. She didn’t sleep for a few nights and they just changed her medication just like that.

Patient got a feeling of being ‘experimented’ on, with all these changes to medications. But this all costs money, switching medication isn’t cheap. Some patients believe the doctors don’t know what works and what don’t work. First, they put you on a medication and when you tell them you don’t need it anymore they just put you on another one. Patient gets sick of taking pills. He is convinced, he doesn’t need all this medication. He feels that the medication is what makes him
sick. He doesn’t feel right when he takes it anyway. A female informant felt that the antidepressant she had been prescribed was unnecessary: she tried to explain that she was only depressed for about four or five days and she didn’t need medicine for depression because the symptoms didn’t last. She thinks that everyone gets depressed and they don’t take medication for it. But doctors give you a pill for everything, she concluded.

Many patients think, the psychiatrists just give you medications. Doctors’ idea is to get the patient stabilized on the meds first and then they hope he/she finds a job. Other depressed individuals may believe the doctors do not focus on patients’ needs. One man was convinced the doctor sees him anyway “so he can make the big bucks”. And, to support his diagnosis, he just gives him a little bit of medication ‘because he knows the patient is not crazy’ (says the patient about himself), so he takes it. Nothing changes for another patient, either– everything is the same and one just doesn’t have time for that game. She is trying to move on and do some positive things and they look like they are trying to keep people in the same old spot. The lay belief is, the doctors don’t really have any interest in helping people, they are trying to help themselves keep a job and that’s what that’s about. A patient asks: Why do I have to go talk to someone who doesn’t care about me or how I feel? I have spent seventeen years going to see doctors that didn’t really want to help. They get a paycheck and all they do is write prescriptions that don’t work.

Patient believes in his frustration, medical specialists just ask questions and listen, they don’t provide any solutions. They are mainly concerned about you taking your medication. They ask if you’re sleeping all right and if you have any problems you want to talk about and that’s it. They don’t solve any of your problems for you even when you tell them what they are. Patient’s wish was, if someone would just talk to her and help her figure out what’s wrong in her life, she would be fine. Unfortunately, no one could tell the patient what was wrong with her.
All these pills and more pills, another patient was tired of taking all these medicines. He wished somebody would find out what is really wrong with him and stop just giving him pills that ‘don’t do nothin’’. They don’t even try to find out what’s wrong with you, he said. They think it’s all in your head. This is his life, this is his head. Why does he have to do what everyone else wants him to do? He is not crazy and he will never live a normal life if everyone is telling him what to do. Patients may feel controlled by mental health providers. Once they label you, they never look at you the same way. The psychiatric label ‘changes you forever’, believe the Latino people. Patient has ‘enferma de los nervios.’ And there is stigma attached to it. Patient got labeled mentally retarded and a psycho by his friends and stuff when he got out of the hospital. He lost all his friends. It was rough. The next study participant was definitely against telling her co-workers about antidepressant treatment he was receiving. Her fear of being bullied and marginalized raised from her belief that ‘when you tell people you have a mental problem they pick on you and blame everything on you because they know you have something wrong with you’. Patient was hoping to get some distance from his family. He called it the blame and change syndrome. He was held responsible for being mentally ill. Fourteen years earlier, he was diagnosed as mentally ill and his father and his mother and his brother talked about him like a ladybug on a window. They talked in circles and then got angry at him.

Another story of a female participant who told her doctor she was depressed reflects the general perception of unnecessary medical treatment in depression. This woman was prescribed Prozac and she rejected the drug with the belief that being “simply” depressed does not require medication. The fact that doctor never took time to find out why she was depressed, made her very upset. All he said was, ‘Oh, you’re depressed; I’m gonna give you some medication for that.’ . . . He never asked the patient anything; he just wrote the prescription out and gave it to her.
Patient found, this was not helpful. Latino people were bitterly responding to the questions about antidepressants. Yeah, the doctor wants to get paid, but he doesn’t care because patients are poor and most of them are black and what does he care. It’s a paycheck for him; it keeps him employed. They don’t want to deal with the problem and try to help you solve it; they just want to give you medication and keep you coming back. If the problem doesn’t get discussed it will never get solved. Patient dislikes the doctor: he doesn’t answer his questions; and he doesn’t explain what’s wrong with him. Patient wants him to break things down so he can understand what’s going on with his body. He doesn’t tell the patient anything and he hates that.

Patients can be difficult to deal with. There is a story of Bernice who wished for a provider that would listen to her because she felt that she would benefit from ‘someone to talk to.’ Yet this was difficult because of the high turnover of clinicians. They assigned Bernice to a male doctor . . . But, the patient refused the treatment simply because she had no intentions of talking to a man about anything. She justified her decision explaining, ‘when you get comfortable with someone they change that person to another team or they leave’. Patient didn’t feel like starting all over again and was sure she is not going to talk to a man about her feelings. She can’t be building trust with someone new and then they get changed and then it’s someone else new. She can’t be pouring out her heart to everyone and they don’t stay long enough to help her. She needs someone to get to know her, she wants them to know her, so they can help her help herself.

11 Castonguay, Filer and Pitts (2016)

Interviewee was surprised that even celebrities suffer from depression: she felt that their life-style, at least on a materialistic level, would help them escape from going down with such things as depression. But it is obviously clear that materialistic plays no role, you can have a very
big house and 3 or 4 cars, whatever, at the end of the day it all depends how you feel within
yourself and within your mind, and nothing in terms of monetary wealth can ever make any
changes to that.

Interviewee’s mother has always experienced depression in a sort of similar way to her, she
thinks. The patient remembers saying to herself, ‘Oh no, not again.’ … she thought she was over
it and it’s back. Just the sheer onslaught of negative thoughts that you just can’t push out, this is
how it feels.

It’s almost as if you’re going in slow motion. If you’ve seen these films where you’re standing
still and everyone’s going around you, it was almost like that. It is a combination of panic,
increased heart rate, changes in sleep patterns, getting tired quickly, acting out, eating disorders,
inability to work, paranoia, and being uncommunicative. This experience means the deep
depression, patient feels physiologically different, he has this sort of pressure around his brain, it
feels that someone’s got their hands inside there.

And then comes the extreme: everything that you seemed to look at…you looked at it from a
suicide aspect, when you went over a bridge and you thought, that might be an idea, or a knife in
the kitchen, yes, that would be a good one. When she is really down it occurs to her when she
sees a train coming to jump in front of it. And again, she gets these compulsions, and she has to
physically take a step backwards so as not to do it. And these are strong urges. The suicidal
ideation is…”I just, just want to be out of it’, she confessed.

The participant told his friend about his suicidal thoughts, to which she replied, ‘you must
go and talk to your GP, you must do something about this.’ The friend called the doctor for him
and accompanied him to the waiting room. And the man’s friend said to him, ‘You’re
depressed.’ So, only because supported by his friend, he went to see the doctor.’
Another informant admitted that at some point, did not feel like himself and he felt something was off, and this spurred him to seek help. He felt that he wanted to jump out of a third-story window and he understood his action was not ‘the norm’. He thinks when you’re actually faced with, ‘Oh my God, I would have jumped if someone hadn’t come in.’ That just absolutely petrifies you because you know that you’re young, you shouldn’t be feeling like that, it’s not right, there’s got to be something wrong. No support from the family environment was offered. No one was picking up on how severe things had got for him.

There are people who think there is nothing ever to be ashamed about with mental health.

Patient’s recalled his conversation with the doctor. His concern was formulated around ‘the awful stigma on antidepressants’. In return, the physician asked: ‘Well if you are a diabetic and I said you are going to need insulin for the rest of your life, you wouldn’t argue, would you?’ So she seemed to give the patient permission to say, ‘Yeah I’ve got an illness. You know, this is not my fault.’

The next female interviewee giving account of her experience only sought counseling, but received both psychotherapy and medication. There was a great deal of fear expressed in relation to antidepressants due to her preconceptions. She was worried before she took them that she would become divorced from reality, and develop feelings of indifference.

Another patient knew very few people had used psychotherapy treatment. She was not familiar with the criteria for receiving it and who would be eligible. She only knew there were very long waiting lists. She knew of people who were waiting for 3 years, and 3 years is a big chunk out of somebody’s life. It’s just very sad. Interviewee was hesitatant at first, but all things considered, she would rather put on weight than be depressed so she took antidepressants and she felt like she had been given her life back.
A man reported that he suddenly was walking up the street with a smile on his face. Yes, the antidepressants did help this individual. The therapist listened and she responded to him in a caring, sympathetic manner, not as a distant professional. One participant admitted to having come to realize that ‘a miracle cure’ does not exist for depression. He shared his reflection about the medication that kept him stable; he was able to go to work, he was able to perform his job, able to enjoy quite a few things. But the medication did not remove his fears. He found his thinking processes had not improved, either. There is no miracle cure in depression, he concluded, adding that people have to do some work to achieve a fuller relief from depressive symptoms. Hope was also stressed as an important factor in recovery.

If people go to the doctors they know what they’re asking them, and they know what they’re expecting the patients to say, and they know what it’s all about. Patient knows the signs, and he knows what to do, and you get better. ‘This is my disease, it’s part of me, and I want to control it’, he admitted.

The next interviewee strongly urged other people who might be depressed and recommend that they seek help. Don’t suffer in silence. It may be difficult for you to reach out, and patient understands that because he didn’t for a long time. But he really urges you to reach out if you can muster anything, reach out because there is help out there.

One man recognized the need to seek help after struggling to read a children’s book to his daughter, and he needed his wife’s assistance to bring him closer to the source: he believed realistically in the stage that he was, he was not capable of doing anything. He needed somebody around him to do the initiating. It really needed somebody else to make that contact for him and ultimately, it was his wife saying, ‘You must go to the doctor, I will make the appointment. I will drive you there. I will take you there. I will sit in the waiting room with you,’ but, ‘you need the
help.’ It really had to come from somebody around him because he was incapable of doing it himself.

12 Chur-Hansen and Zion (2006)

Several patients do not receive any counselling or information from the pharmacists who fill the prescriptions.

And here follow accounts of people who were treated for depression:

- Patient was prescribed Cipramil and then Avanza, at the age of 18, after consulting a general practitioner because she was waking up at night, couldn’t sleep very well, feeling awful and sad all the time, following an end of a relationship.

- Patient was prescribed an SSRI at the age of 19, following a “breakdown” preceded by an eating disorder and trip overseas to work as a volunteer. She began on Aropax, which caused hallucinations, and was then prescribed Efexor.

- At 19 years of age, patient experienced anxiety for about three years, which was progressively worsening, and so she went to her general practitioner who prescribed Zoloft. Prior to taking the SSRI, for the previous four months, she had been managing her anxiety with the help of a psychologist and CBT.

- Patient was 14 when she was first prescribed Zoloft by a general practitioner after talking to a school counsellor, who referred her to the doctor. At that time she felt that there was no cause for her depression. She was again prescribed an SSRI at 18 years of age after the death of her both grandparents, whilst studying.

- Patient began taking SSRI medication at the age of 17, after a school counsellor noticed that she was cutting herself, and referred her to a psychiatrist. Over the last three years she has been prescribed three different SSRI medications – Luvox, Prozac, and Zoloft. She is non-
adherent to her medication and she self-monitors the dosage, often taking more than the prescribed amount.

- Patient reacted badly: she was shaking, trembling, unable to sit still, being jittery, feeling worse, feeling ‘not normal’, dry mouth, feeling sick, and being drowsy as side effects.
- Patient experienced adverse reactions to the SSRI, including apathy, emotional numbness and hallucinations (including seeing herself being hit by a car and falling on knifes). She simply believed that the SSRI actually induced a depressive state worse than the one for which it had been prescribed.
- Patient did not have any physical side effects, but she found that the medication resulted in her having ‘no emotions’. ‘You just feel like a zombie at times’. And she doubted it was worth the struggle.
- Another person reported: ‘You name it: nausea, tremor, decreased appetite, headaches, thirst, feeling sick, agitation, anxiety, impulsivity and violence’. This female patient became particularly worried about the increase in her impulsivity and violent behaviour, which before, was totally uncharacteristic for her, and which was becoming more frequent and pronounced over the weeks of medication intake. She admitted never being violent to anything ever in her life. And for the first time she just got, she just snapped, and she basically threw the cat five meters across the room. And that just scared her, she didn’t know what that was. And she was impulsive, there was no thought behind it, she said.
- Another account came from a patient whose general practitioner “freaked out” when the young woman reported feeling depressed. The doctor’s daughter had attempted suicide and the patient was told about it in some detail.
- The next person felt that her psychiatrist who used psychoanalytic psychotherapy in
conjunction with the medication to treat her depression, was uncaring: she thought his actions, to give her, to continue to prescribe medication without being concerned, at all, over the effects of it, was ignorant and unfair, and when she looked back, it became hurtful. Just unprofessional and completely inhumane, she admitted.

- A male informant felt that his general practitioner was ‘informative’ and helped him to think through the options, providing him with information, even videos to take home. This doctor also discussed possible side effects and contra-indications, and discussed withdrawal and the possibility that the SSRI may not be effective.

- Patient did not recall his general practitioner providing information about the medication he was prescribed. However, he found, just going and talking to the doctor was quite beneficial. He appreciated honesty of somebody outside of the family. He did not consider talking to any of his friends about it, because he thought, they couldn’t relate to how depression feels.

- Some other patient had seen many different general practitioners over the three years when she was taking SSRIs. She no longer remembered whether or not she was informed about how these worked. But she described a very common pharmacy practice: pharmacist: ‘do you know how these work?’ Patient: ‘yea…within reason’; Pharmacist: ‘have you taken this before?’ Patient: ‘yes, ‘yes,’ and this is it.

- Patient had suicidal ideation, which she had never experienced before.

- Patient had hallucinations about her own death, and eventually thought about ending her life.

- Another patient has repeatedly attempted suicide. She was positive that she wasn’t suicidal before she started the medication. She wasn’t sure whether it was just the SSRI not treating the depression, or a possible increase in suicidal ideation occurred.
• Patient’s general practitioner explained that she needs to, her body chemical are not balanced, and that she needed to fix that first, and then they could work on the problems second.

• To another informant, the doctor ‘explained something about a chemical imbalance’, and stated this needed to be fixed before other problems could be addressed.

• Another patient’s psychiatrist explained depression in psychoanalytic terms. He said: ‘Keep talking and you’ll figure it out. Well, it’s inside of you, you just need to concentrate on talking a bit more’.

• The next informant was given a neurobiological explanation.

• Patient was not provided with information about depression, as far as she could recall.

• Patient was provided with neurobiological explanations.

• Patient felt that her reaction to the breakdown of her relationship was ‘not normal’, but she thought that talking to people, not medication, was what she needed.

• Another patient wondered whether her mental health might have been affected by her eating disorder and the experience of observing poverty during her volunteer work. She was also curious as to whether her anti-malarian medication (Larium) might have had some influence. She believed that the SSRI actually caused her depression, and that she was probably suffering from anxiety prior to being treated.

• Another patient felt that while medication might make it easier to manage his anxiety, a positive outlook, exercise, fish oil, meditation, relaxation, and making an effort to change were more important.

• Depression is an illness, and it can be treated. However, patient sees a difference between
her first episode of depression, which had no “trigger”, and the second experience, resulting from the death of both her grandparents. She thinks that medication was needed in the first episode, but that counselling was more important in the second.

- Patient was overwhelmed by what was happening when she consulted the general practitioner: she was quite overwhelmed by the whole thing, what the doctor was saying to her because she didn’t really think that was what was going on…and the doctor didn’t actually prescribe it first, she gave the patient a trial pack to take home and then get the prescription filled. So it was kind of bombarded on the patient. ‘This is what’s wrong with you, you have to do this to fix it’, and patient was so overwhelmed by everything that the doctor was saying she just walked out of there and just took it.

- Patient felt helpless, to the point that although she was unhappy with her treatment, she was unable to seek help elsewhere.

- Although patient was satisfied with his general practitioner’s information, he felt that he needed to know more, particularly about adjunct therapies, so that he could make an informed decision.

- Patient was frustrated with her psychiatrist, and with the medication, and its side effects. She said to her doctor: ‘Look, I’ve had enough, it’s not working for me, I feel completely apathetic’.

- Patient was so frustrated because the doctor still kept saying to her: ‘Oh, just give it another week, you know, these things take time, your body is just adjusting’.

- It was frustrating because despite the treatment, patient’s mental health seemed to be deteriorating.

- It has, it’s fainted patient’s view a lot, because he went in there wanting help, and he said
what was going on, and it was just more the doctor trying to treat the symptoms, that actually what was happening.

- The experience has negatively influenced the patient’s opinion about doctors: It just scared him to think that, fourty minutes into speaking to this person, he was prescribed what was going to be 18 months of hell, on medication.
- Within fourty minutes physician felt he could make a decision.
- Patient got a feeling that his general practitioner needed to have more knowledge about the treatment of depression.
- Patient felt that these experiences have given her strength and wisdom, and that she knows now that she is the best judge of her own health. She now interviews health care providers before agreeing to treatment, and she seeks other opinions if she is not happy with what is offered. To regain control, she ceased seeing the psychiatrist.
- Patient strongly believed that hope was an important factor in keeping her alive: And there is all these little promises which you just, as much as she really resent the way that her psychiatrist, she feel that, he didn’t give her any care, the one thing he did give the patient was hope. And that’s not something that he of course, actively gave her, but just by going to see him and by having these drugs, it gave the patient hope that there at least, was something.
- Another patient perservered with SSRI medication: It’s the hope, it’s the hope that maybe this one will be the one. And so, a bit of nausea, physical pain is nothing until, you know, until you experience emotional pain. And, if it’s going to even reduce it by 1%, she is happy.
- Patient felt that not only had the medication not helped but it had made him worse: So
having all this hope that he was getting better and that this pill that he was taking was going to relieve his symptoms, yet physically spiralling down, still, so not even reaching a plateau, continuing to slide down.

- Another patient was doubtful about the efficacy of his medication.
- Another patient felt that the medication initially helped, but after a few weeks and increased dosage, she continued to feel depressed, or felt flat rather than depressed.
- Another female patient had never experienced a positive effect from a SSRI.
- Whilst unsure that the medication was helpful, patient did think it might have been helping little bit. But it is working a little bit. That is, when he get into a sort of negative emotions, he find he can come out of it a little bit easier. So, it perhaps doesn’t quite last as long. Patient felt relieved in having been prescribed the medication, even though it was not alleviating her depressive symptoms.
- The stigma of mental illness, and of taking an anti-depressant is there. For example, the reactions of his peers when he had to explain that he could not drink alcohol – ‘Oh, why do you need to be on that?’ Patient’s many close family and friends would be unaware of her experiences, and she finds it terrible even that she finds difficulty speaking about it.
- Another patient also felt the stigma. His anxiety and treatment is something he finds difficult to talk about, and that it’s like a lot of mental health things, there is no good reason to feel that stigma, and you’ve thought it through, but you still feel it.
- Another patient discussed his treatment with his parents who were very supportive. His close friends were also helpful.
- Another patient’s parents are unaware of her depression and her main support is another suicidal student with whom she discusses plans about how to end her life…
Another patient believes she is very good at keeping the façade.

The stigma the depressed individuals feel, it is visible in the way other people look down upon them. And mental health...there must be ‘something wrong’ with the person. Friends are important, as a component of treatment. There is a great need to stress the importance of everybody’s supports: Patients confessed, if they haven’t experienced family and friend support, they wouldn’t have been able to find enough things to live for, they wouldn’t have continued living. This is a very powerful message.

Cohen and Hughes (2011)

Lay beliefs in chemical imbalance because . . .

- Medication caused a change in the well being
- Medication wouldn’t do anything if there wasn’t an imbalance
- Medication made people feel different
- They’ve seen the change in their lives
- Medication obviously helps
- Trust in the physician’s diagnosis
- Individual told by experts who suggested he takes the drug
- The doctor explained it well
- The doctor showed the mechanism of depression using a plastic brain
- Patient knowledgeable about the field and chemical imbalances
- Patient has done his/her research
- Patient’s study showed how it works
- Patient’s understanding of depression is physiological
- Patient knows from own experience
• Knowledge from others’ experience

• Symptoms are physical as well as psychological

• Physical symptoms must have physical cause

• Medication helps maintain serotonin levels

Doubts about chemical imbalance because . . .

• No way of being tested

• No test can tell

Disbelief in the chemical imbalance because . . .

• Patient knows there is no biological cause for his problem

• Patient doesn’t believe in chemical imbalances

• Patient’s problem is due to environmental stress

• Patient’s therapists told him so

Beliefs that medication causes a chemical imbalance because . . .

• It triggers unwanted physical effects

• Drugs affect everyone the same

• My medication leaves body quickly so it doesn’t have long term effects

• I don’t know if drugs act chemically or psychologically

• No reason given

• Short half-life means no long term effect

How Medication Acts in My Body: Users’ Descriptions (In Alphabetical Order)

1. Causes a chemical imbalance

2. Changes the chemistry of my brain and makes it function better

3. Cleans the spark plugs so they fire properly
4. Completes the chemical dysfunction
5. Fills my brain
6. Fills the holes that depressed people have in the brain
7. Helps maintain serotonin levels in the brain
8. Increases dopamine release and produces more dopamine
9. Increases whatever it is in my body that makes me happy and calm
10. Levels out my brain
11. Makes serotonin go around better in the brain when it gets blocked
12. Manipulates chemicals like exercise releases endorphins
13. Stimulates the frontal lobes

Subject of chemical imbalance in 22 synthetised interviews with psychotropic medication users

The patients were approached with the following questions:

Do you think that the medications correct or help a chemical imbalance that people have in their body or brain? Why do you think it is a biochemical imbalance? Why do you think you had or you may have a chemical imbalance? Do you think that the medications you are currently on, may correct a biochemical imbalance? Do you think that the drug is correcting some imbalance, then, changing something in your brain? What makes you think that? How do you think the medication impacts your body or your mind? Do you think that the drugs are acting upon your body and mind, in what ways, in positive ways, in negative ways? How do you think and antidepressant acts in your body, your mind? Do you think that antidepressants correct some type of biochemical or hormonal imbalance? In your personal opinion, how do you think that these act upon your body, your mind? You said Celexa centers you. Do you feel it corrects a chemical imbalance? Are you able to explain to another person how this drug works for you?
The answers varied:

1. Woman, 59, taking sertraline and lorazepam for depression, believed that yes, for some reason the person has an imbalance. And the only thing you can do is to take the medications. She thought it is an imbalance—from the moment you take the better medication, if an imbalance didn’t exist you could take the pills and they wouldn’t do anything to you because you don’t have it.

2. Woman, age unknown, taking sertraline for depression. She believes that there is chemical imbalance. Because Zoloft made her feel different.

3. Woman, 27, doctoral student in clinical psychology, taking amphetamines, venlafaxine, lorazepam, and clonazepam for 7 years. She knew about chemical imbalances and she knew how she felt before and while taking antidepressants. She felt that her medication helped her to be who she really is. She thought it made her more complete, it helped the chemical dysfunction.

4. Man, 44, taking fluoxetine for 9 years. He was positive the medication was correcting his biochemical imbalance. His doctor showed him. He had a plastic brain with different colors, he demonstrated how it works. He showed the patient where the serotonin was going and how Prozac makes it go around better when it gets blocked, this is research. The patient had also done his own research and is now convinced about the mechanisms of drugs.

5. Woman, 62, taking paroxetine and alprazolam. Most definitely she believed in chemical imbalance. Her study showed her most probably what the reason for her anxiety and upset was and so by understanding and researching it allowed her to be more accepting of Paxil and Xanax.

6. Woman, 68, taking sertraline and alprazolam. She thinks in a very positive way. She believes the medication must be restoring the chemical imbalance in her brain so that she no longer has
her anxiety and panicky feelings. She definitely accepts the model of chemical imbalance
because her symptoms were physical as well as psychological attacks.

7. Woman, 53, taking escitalopram for anxiety and depression, just switched from paroxetine
and alprazolam. She believes that there is a biochemical imbalance in the brain. And not only from
her own experience; she claims other people have felt the same.

8. Woman, 56, taking fluoxetine for 8 years. Her doctor told her that Prozac changes the
chemistry of her brain and makes it function better, resolving the depression that way.

9. Woman, 30, just switched from fluoxetine to escitalopram, and also taking lamotrigine,
ziprasidone, and lorazepam for last 4 years, has simultaneous diagnoses of post-traumatic stress
disorder, borderline personality disorder, major depressive disorder, and generalized anxiety
disorder. Talking to her doctor, she was explained that there have been studies done and
breakthroughs that show the brain; that people who are depressed have holes in the brain and use
medication to fill the holes so they help. She feels the medication is helping her and it fills her
brain.

10. Man, 31, taking paroxetine for depression. Biochemical, as within his brain? Yes, he believes
that. This is what they told him the antidepressant was going to do, something biochemical.
Something to do with increasing serotonin, increasing whatever it is in the body that makes you
happy, makes you calm. It just kind of leveled out his brain. He believes that this was the
ultimate goal.

11. Man, 54, taking citalopram for depression. The analogy that he heard best describes it, is like,
if you have dirty spark plugs and you use a detergent gasoline, it cleans those spark plugs so
you’re getting a good, so they’re firing properly. Instead of getting sluggish performance, you
are getting peak performance. Being asked whether he tried any other solutions to aid his depression besides drug use, this man replyed that he does not see any reason to do so. His full understanding of depression is that it is physiological. So, if this drug allows him to cure that physiological problem then, there is really no need to seek any other help. Because, the problem is solved. He believes it because he had been told that by people who suggested he takes it.

12. Woman, 51, taking sertraline for social anxiety disorder. She admitted not being familiar with medical terminology but she did know that the medication helps maintain the serotonin levels in the brain and causes her to feel calm.

13. Woman, 23, taking lamotrigine for anxiety. She is convinced, antidepressants stimulate the chemistry of the brain. She would have panic attacks in her sleep. However, that never happens now since she is on the right medicine, so she knows that it had something to do with her brain.

14. Man, early 40s, taking quetiapine, lithium, venlafaxine, and lorazepam for 5 years for bipolar disorder. He has seen the change in his life in the last five or six years. There’s no doubt in his mind that there’s something wrong mentally. Today he can safely and honestly say, yes, there is a mental issue that goes on in his mind. What created it—what triggered it—he believes, it was the divorce.

15. Woman, 35, taking antidepressants on and off for 14 years, now taking sertraline for one year, since her marital breakup. She believes in chemical imbalance because the medication she is on, helps. And she took this medication almost vigorously just because she trusts her doctor. At the same time, having this long term experience with drugs she thinks that she can finally handle her problem without antidepressants, but this was a traumatic event. She got out of an abusive relationship so she understands anyone that goes through a trauma is going to react with sadness, grief and depression, this is normal. She was able to function for over a year without the
need of medications. Living a healthy lifestyle and exercising, which is something that she had done consistently before and she strongly believes, that was enough to create the chemicals in her brain that made her ‘normal’ or made her feel good. Her guess is, her brain chemicals are being manipulated with a drug instead of endorphins that you get through exercise.

16. Woman, 26, taking lorazepam, estazolam, and butalbital, does not think it is chemical. She thinks it is more of environmental stress, or some things that one can fix. But she is not certain because, she had not been tested for that. Also, she knows two professionals with degrees that outrank hers, and they too, work with anxiety and depression symptoms without medication, so she tends to believe that they’re correct.

17. Woman, 25, taking sertraline and venlafaxine for depression, diagnosed with post-traumatic stress disorder 7 years earlier, following a gang rape. Her aunt says she has lost a lot of weight since she has been taking the Effexor. As it makes her dizzy and she tends to lose her balance sometimes. So she assumes, the medications are not good for her health. And she does not think there is a biological cause for what she has. She rather believes it has something to do with the way she was brought up. She is doubtful that she can explain to anyone that her self-esteem is caused by a biochemical imbalance. She does not believe in biochemical imbalances. She concludes, it is a stupid reason that people use when they don’t know how to explain things.

18. Man, 32, taking methylphenidate, atomoxetine, venlafaxine, and alprazolam for attention-deficit/hyperactivity disorder and obsessive-compulsive disorder. He is not so sure, if it is an issue with the chemical imbalance. To his knowledge, Concerta stimulates the frontal lobe, makes him focus a little bit, and most of other drugs, he is not sure. He thinks the medicines get out of the system quickly, so you don’t necessarily have a long-term chemical difference. He is not really looking to change the chemistry and certainly not drastically.
19. Woman, 55, taking lithium and clonazepam for bipolar disorder. She thinks, it has something in common with the chemical imbalance. She has gained weight, up to 30 pounds, and she is dizzy, and she is feeling thirsty, so to her, the medication is definitely causing a chemical imbalance instead of correcting it.

20. Man, 29, graduate student in chemistry, taking amphetamines for 3 years for ADHD. He said, this is how it’s explained, with the chemical imbalance. But how can you tell? He has not been tested for an imbalance and it is unknown how would it be detected, how would they know, if one has an imbalance or none. Amphetamines affect dopamine. That’s right, but because they are all speed drugs they affect everyone the same, they increase dopamine release, you produce more dopamine, so this corrects a chemical imbalance. But he rather thinks, it probably causes a chemical imbalance.

21. Man, 37, taking sertraline for 1 year. He is not sure if the brain is affected chemically or psychologically, and he does not know what it is, or how it works.

22. Woman, 58, taking escitalopram, chlorazepate, and lorazepam for depression. She does not know how her medicines work.

14 Dickinson et al. (2010)

Three main themes were identified from the interviews: the benefits of antidepressants; ambiguities and dissonances in the understanding of depression and its treatment; and barriers to the discontinuation of antidepressants.

At the time of commencement of antidepressant treatment patient had a quite indifferent attitude. If the doctor had said take some rat poison the patient would have probably taken it, he was that down so he didn't bother; and then gradually, it got better. It seemed as if some fairy had waved a wand and got him this drug which brought him round. He swears by it. His worst point was when
he woke up in the morning. He just didn't see any point in going on and it certainly helped very much indeed.

If the cause is a social factor people can't get rid of that, but the medication might alleviate their symptoms a little bit. They admit, ‘if it makes them feel even a bit better it's worth it. Because at the end of the day most antidepressants are not that expensive’

Another patient started to get fatigue spells where he was abnormally tired, not sleepy, physically exhausted. It was an effort to walk and his GP said those were symptoms of depression, although the patient claimed he didn't feel depressed. But as far as he knows, not being very knowledgeable on medical matters, one could be what you call clinically depressed without being mentally depressed. That's how he understands it, so although he didn't feel depressed he accepted the fact that it could as well be the depressive illness.

The GPs also acknowledged a difficulty in providing a solid diagnosis of depression and understanding and treating its causes: We have to keep figures of who is depressed, but of course a number of people come in and it says “depressed”, but they are not actually clinically depressed. They experience deep sadness because someone has just died, and that's where the medical figures are high. The doctor thought, for all their patients who have coded as depression, maybe 10%, if that, actually had clinical depression. This ambiguity in understanding depression as an emotional or physical condition influences GPs’ views of antidepressants: In emotional medicine you are much more predisposed to the individual patient. In cardiology where essentially every patient comes in and gets an aspirin and a beta blocker and an ACE inhibitor and they all recover, you can't do the same with the emotional illness.

The problem with general practice is that the perception of psychiatric illness is such that it is still not necessarily viewed as a biological condition. GPs acknowledged the difficulties in
providing treatments other than pharmaceutical: In the area where this study was conducted, there is a 10 to 11 month waiting list for CBT [cognitive behavioural therapy], by which time the crisis has gone. People come to see the physician in extreme situations really, they are usually in a very distressed, disturbed state. The majority of patients have lived through the Second World War and they have an antipathy to counselling. The belief is, antidepressants do have a place, partly because it's not a lot of other things that help mild to moderately depressed elderly, the CBT has got a very limited place. Counselling works, admits the GP, but it is always very difficult to get elderly patients to engage, so the doctors are often stuck with just prescribing, so it is a bit “best of a bad bunch”. A patient didn’t want to go through counselling and he didn't because of his faith and his family, he said, he doesn't need anyone else. The doctor didn't offer anything else, what else could he offer? The older man felt that the young physician was rather embarrassed not being able to help him.

General perception is that nowadays, a medicalisation of life can be observed. But, while there are problems that we all have in our lives, some people may really need to have it turned into a medical problem to get validation of their suffering. But others abuse the circumstance; instead of admitting, they are struggling to cope with a bitter divorce, they come and say they suffer from depressive illness. The doctor who was interviewed in this study, didn’t think it is right to prescribe something that you don't necessarily need, and felt that writing prescriptions for social issues is, indeed, becoming trendy, but should we prescribe “lifestyle drugs”? Diagnosis presents a challenge when you can't measure the outcome. If someone has high blood pressure it can be measured that and it's a definite. Depression really becomes a part of your life and you just have to cope with it.
Patient never gets really well, where he could go longer without the meds. He has lived on them all his life. His prediction is, he will be on them for the rest of his life because he cannot be helped in any other way, so he believes he will be taking them for the rest of his life.

He already was able to cope very well with his depressive symptoms, but he then was diagnosed with cancer, which was a big shock to him; they coped with that very well, got over that. And he thinks he came off the first antidepressant and then, his eldest son was diagnosed with cancer so he was put back on the medication again and the son died but that was expected, patient coped with that quite well, and after a while came off the antidepressants; and then his youngest son collapsed and died, so patient was put back on antidepressants again.

Patient is normally tired and now his life gets difficult, his wife should have had her hip replacement but her blood pressure is far too high and she can't have it. So it can only get worse so for the last few years he had to take on more and more to help her like he had to do all the shopping; it doesn't bug him and physically nor emotionally they just accept it, it's just another thing that's come over that you have to cope with.

Patients acknowledged that often this was also a challenge for their doctor: they have done very well with this recent reduction to antidepressant regimen, in fact they have done better with these people than they have ever done. It can be very debilitating. GPs also acknowledged the intractability of some patient's situations: Doctor thinks some patients have horrible lives, a lot of them … doctor thinks it's a combination of all things, their health, their social circumstances.

Doctor thinks a lot of people are on antidepressants because of everything put together. And you can't change most of the factors that cause it.

They feel that unless they are on a tablet for it then they are not having any treatment. There are a lot of those kinds of people.
The doctors didn't say anything about why patient was depressed. They just seemed to think it was a general condition for her age.

With the old age, every year you sort of get something which as you get older is expected. If your eyes go they go. You see that doesn't bother me, my legs bother me, yes because I can't use them properly. I was a great walker at one time and I can't do that now.

Doctors are more bothered about blood tests, liver tests, breathing operations. No, the depression has gone into the bottom drawer according to the state of patients’ health and what the doctors think about older patients. Patient believes if he brought it up in conversation they would talk about depression, but if there is no need to talk … why not leave it alone!

Patient is summoned to the surgery once a year because of his age, where he has blood tests and urine tests, and a general talk about his health. But he doesn't think that either the antidepressant or the depression has been mentioned in those talks.

It's well known that depression is often overlooked in the elderly and people who have got physical disabilities and whose life has been significantly impaired by their illness …

The general belief is that there are some bigger battles out there, than persuading the patients to stop their antidepressant treatment.

Elderly people are generally more self effacing, and they don't make demands on the doctors for treatment. They say “oh I know it's old age”, you know, they expect that they are going to feel low because they are old. They have lower expectations of what can be achieved, and they are wary of antidepressants, but doctors thinks antidepressants do work in elderly people.

It's always difficult to assess because there are so many more layers with elderly people, they tell you what they think you want them to say … It takes a lot more detective work.
Patient is not coming off these because every time he comes off, something else happens; but these, these are more for a panic attack.

Patient takes half of the tablet for so long and then she thinks “oh blow this I'll get rid of it” but then, she is afraid to. She still doesn't know whether she would sleep if she came off them … She doesn't want to try!

When the GP was there she said “well, we could get you off them slowly”, and patient was in fear of her doing that because he supposed they're a crutch really. Would it make any different at your age? Why bother changing something now?

Patient thinks at his age he would just think “well carry on as he is with them”. Patient thinks it's too late to change now. It's scary to stop a medication that's been going for a long time, because you kind of think, are you opening a can of worms here, because you don't know what the reasons were for them starting that medication. To explore all that will take time.

They're frightened of coming off, because they don't want to feel like they did initially. And you can understand that.

Doctor doesn't agree with this treatment, it's not the best thing to do, but at the end of the day it depends whether harm outweighs benefit and is it worth having that major fall out with the patient and if I'm really stuck and I really want them off it I would send them to psychiatry to get someone else to try and do it for me. I've never had to do that.

There are some patients who need that little bit of a crutch, almost a placebo effect, the kind of people who sometimes feel they want to be on a low dose more permanently because they feel it keeps them on an even keel. The long-term patients generally are on probably sub-therapeutic doses really, how much actual effect it has on their mental health is probably minimal but it gives
them psychological support. If somebody did become more symptomatic then we would up the dose.

Patient just takes them … He just takes them thinking well if they do me good …

Oh, he thinks, you will continue with the medication, think now he got to this age anyway that you know I'll just go on.

Patient doesn't really know. The doctors will keep an eye on things and if the time was appropriate then they would take him off it but having kept me on it he assumes they are happy for me to go on taking it so he takes it but with all this medication he would come off it if he could. If he can't come off it then he accepts it.

As patient feels now like she'll be taking them for the rest of her life … after 4 years she can't see it improving, as she says it keeps it in check.

Well, older patient says he won't be here long so he thinks he'll keep on it ‘til he goes.

It would be a marvellous thing if you didn't have to take anything at all, but patient thinks that is asking a bit too much at my age. He thinks you have to have something to help you along.

Patient was called in to see the doctor because she thinks at that time they were a little concerned about what the long-term effects of taking it would be. And they chatted and the doctor said to her “I think you're taking these as a sophisticated sleeping pill, and if that is the case, I've no objection to that”. And the patient said “Well, they do help me to sleep, that's the reason why I keep taking them”.

Patient feels it's one that suits her and she'd be reluctant either to change or stop it.

Patient says he's reasonably happy with taking the medication; well very happy with taking the drug; it seems to be working and unless he suddenly get an attack of depression, he doesn't think he would mention it to the GP.
A female patient heard other people saying she’s crazy because she’s taking depression pills. She heard it. It was hurtful. She felt being marginalised and excluded.

The next participant thought diabetes is a sickness and depression is a state of the mind. Depression is something you can get rid of, diabetes you can’t.

Another informant was convinced, depression it is a lack of ideology. Having a positive ideology instead of a weak mind is what is helping people protect themselves from depression. Only those get it that have no knowledge or understanding of how to overcome obstacles in life. They take to heart everything what others say and it destroys their strength.

Somebody else concluded, people just sit back and worry about things. Things they want and can’t get. That is what some people do. This patient doesn’t care. She got that nonchalant attitude now. A lot of people tell her that. She doesn’t know if that is good or bad, she just doesn’t care. This is how she protects herself from depression. Another woman believed, with her it was a different story; she came from a poor family, they had nothing, there were 8 or 9 living in 3 rooms; so when she was a child she learned how to provide for herself and take care of herself. Her father made about $8 a week, mother made about $3 a week, so she grew up learning not to worry about things. She just keep on living, she just never let it bother her.

A male informant suffering from diabetes and depression feels to himself that depression can mean self-pity, it is like feeling sorry for what you have and then again thinking about the things you were able to do before you got sick. When they first put him on the pills, he used to think he doesn’t feel like taking these drugs, it just seemed like it started getting on his nerves at one point because he had to take those medications every day, and it was just like taking a pain
killer. It was what started him to get depressed, but then he had to shake it off. Because, he remembered, he had to shake it off…he just shook it off.

Another patient regrets the chronic use of antidepressants. She only took them because she had this fear of being ill…She doesn’t want to get sick. That’s all. She is trying to keep it down for now. Because she knows how it gets, she would need to go to the hospital. That’s some place she doesn’t like to be. She doesn’t like to go in there. So, that is why she does what she does, whatever is necessary to stop her from having depression. Diabetes can destroy you and depression can destroy you, both of them can do it to you.

There is a story of a young man who found himself extremely stressed. He was up for promotion, they put somebody else in his place, and he didn’t get the job. He got stressed out. And the doctor put him on stress pills, and then, he was all right. But he refused to take the antidepressant and she believed, he didn’t need the pills. And he took himself off of the medications, and every time he took himself off it he would have to get back on them. But it was all because he didn’t have a strong mind, reported his father.

The next participant just hopes he never gets depressed. He has a family history of depression, his both siblings have ‘a little nerve condition’ and he knows through dealing with them and seeing them, how it works. And he just hopes he will never have to get to that point.

Somebody who is strongly against antidepressants, made a reflection, that, if a woman feels like she needs to talk to somebody, she should not be saying, ‘I am depressed’. She might be depressed, but she is taking no medicine. Sometimes, she needs to go lean on somebody’s chest, so somebody can hear her, hear how she is feeling. And that is all. This is the therapy.

A medication advocate believed, antidepressants are only acceptable if prescribed for a short time.
A man who was about to receive prescription, told his physician, if just based on what’s on a piece of paper you are going to tell me that I’m depressed, and you’re just going to sell me some medication, it is not going to work like that. You give me medication when you know for sure, if you have enough evidence, over a period of time, but then it needs to be on a trial basis. For me, I need to know you for 6 months.

With depression, let’s call it a sickness, and as another female participant’s said, one just needs somebody to talk to. And you can get depression that makes you feel bad, make you feel really old, but you do not need the depression medicine.

A man protested: They’re no medications that can help depression. Not to him, it is all within yourself, your mind. Somebody else stated, ‘you may smoke cigarettes because you are depressed, but it actually relieves the stress, calms your mind. The medication for depression does the same thing. Depression is just relaxation backwards’. So, what is the difference? Would he tell anyone that he is depressed? Well, maybe his friends or people like that. He would probably let them know what he is going through but he would not allow people who don’t care for him or might want to do him harm to know.

A male was certain that most men will not discuss certain things in front of a woman (referring to emotional issues such as depression).

A woman on antidepressant medications talked about the shame and pain she felt because people around her made fun of depression. She began to cry, saying, well, they talk about you, laughing, and thinking, you’re crazy. She felt that something went bad for her. She raised 5 children and she thinks she did well. She didn’t recognize depression until she went and talked to her doctor; her doctor told her she has a little probem.
Another participant was positive that if he would really be depressed he knew, he was not going to take one doctor’s opinion as valid, because he might not be that depressed like this one doctor said he was. If the doctor said he is going to give him some medicine for depression, this patient was convinced, he would refuse to take it.

One person reserved the right to be sceptical. He meant that the doctor may tell an individual to take pills for depression, and all he might be doing is giving you aspirin to make you think in your mind that he is giving you something to help your depression. But he isn’t giving you nothing really, but a little confidence to build yourself up inside to get over the depression…so you can deal with it then.

Patient tries to do positive things, and she controls things, that she can control. If the physician says she is depressed, that’s just his opinion, but she’s not going to let him get her on medication or anything because that’s more depressing.

Fosgerau and Davidsen (2014)

A general practitioner’s and a psychiatrist’s interactions and little discussions with their patients about treatment with antidepressants have been recorded and are presented below. Both doctors challenged their patients to discover their views on treatment in depression.

The following were the physicians’ questions:

- Did you at all talk about what one could do about it or what is sort of treatment?
- What about medicine? Do you really feel uncomfortable taking medicine?
- So you have like integrated or accepted it?
- What do you think about the effect of the medication? now you have a little more experience with them
- It feels like the treatment puts a safety net underneath you?
The following statement are patients’ views, shared by different individuals. Interestingly, put together, they all created a convincing story, as if told by one person:

Well, they urged me to start medication as fast as possible, to use their expression. To me that request was both a little shocking and also kind of a relief. Because it is like a hope about something that could give me a little help. It took a ridiculous amount of time before I accepted it to begin with. But I think it is okay now because what I am getting now…I do not feel there are any side effects and I feel that it works so I am really not as angry about the medication any more as I have been..Yes, I have accepted them pretty well. I believe I have been lucky that I have not had any side effects. I think that it is that it in one way or the other, how I describe this that I go up and down and at least it cuts off the lowest part. So, the third time I got depressed and chose to stay in bed and started a vicious circle then. Now, I get out of bed every day, I get from my bed every day. The medication takes me up to a place from where I can push myself further ahead and then comes the snowball effect and that is what I would like to get started so that I never get to the opposite, lying three days in bed. It is just my friend who knows that I get depression tablets and my family. And no one else knows. It is not something that I am advertising.

17 Frank et al. (2007)

Study participants were asked about their remission symptoms in depression treated with medications. All individuals reported that irritability was the first symptom to improve.

As of depressive condition, one patient retrospectively shared her experience. It all started with a sleeping problem where the woman would only be sleeping maybe 4 hours a night, and in that 4 hours, she would wake up, and then it got to be where she didn't even want to get out of bed, she didn't want to put on makeup, she didn't want to do housework, she wanted to do absolutely
nothing. Low mood, low energy, lack of motivation, lack of focus/concentration, feelings of guilt, self-critical thoughts, feeling overwhelmed, lack of enjoyment, hypersomnia, restlessness, anger, and irritability. Those were very bothersome symptoms.

Another patient became more defensive. It felt to him that people were picking at him; and he was having a hard time enjoying things he used to enjoy; also, his inner anger was taking over. Fear and fear of the future; anxiety and fear that made the next patient want to completely draw in; the severity of the experience attacking through multiple symptoms; wanted to die … was afraid to die; wanted to withdraw … You just want to live in a cave … esteem is gone, self-conscious and self-aware, over-analyze everything …; Forgetful … and then he is agitated and he is mad at the world and he is frustrated. Then, all of a sudden, you're barking at your children and your wife. Functional impairment that is prominent among most bothersome symptoms; It got to the point to where … especially at work, his performance just kept going downhill.

Depressed mood, fatigue, and feelings of worthlessness…

A male informant: Irritability was probably the key thing; he was grumpy and cranky; hypersensitivity and reactivity to describe the symptom of ‘being overly sensitive to everything’, and easily set off; ‘anger’ along with irritability; irritability subsiding in social situations with close friends or family members: ‘Not being as cranky and angry with him over every little thing. He wasn't as easily set off. He used to snap at his mom, bite her head off.’

A male patient: medication helped me have ‘better impulse control at home—his first reaction wasn't ‘I am going to smack you’; the medication helped him stop ‘yelling’.

A father: the medication helped him stop ‘being short with his children.’

A female participant: Her internal experience of reduced irritability was strong: ‘She went from being overly sensitive to everything to finally being able to let some things go, roll off her back.’
The second most common symptom to remit early in treatment was a lack of energy or motivation. Female participant: She had noticed medication-related improvement when she actually got out of bed.

Another informant adherent to treatment related her interest level to functioning: She had more interest in her husband, more interest in taking care of her house, bathing and putting on makeup … Participant: Increased motivation leads to other improvements that follow: If you're motivated, then you allow yourself the ability to enjoy some things, but if you have no motivation, there is no way to enjoy it.

Woman: Her family noticed she was able to maintain more organization in our house.

The increased energy was linked to her experience of irritability: The first was she had more energy and she was less irritable. By ‘irritable’ she meant like in a home situation, she had better impulse control. What she noticed was energy, she was less irritable and less fidgety

Several participants: a sad mood was the first symptom they noticed improving.

Female participant: she was happy, her mood; she was happy for no reason, was just happy; she also felt very carefree and did not have the negative thought pattern, and then her energy started to come back.

Male participant: Happiness, that was his first thing; all of a sudden, he realized that he was walking around work whistling.

Others: ‘lifting of the cloud or feeling’ ‘lighter’. Anhedonia was relieved as mood improved.

Participants: other people frequently noticed improvements in their mood.

Mother: Her daughter told her she was less miserable than she used to be.
Several patients said their psychiatrists commented that they appeared ‘brighter.’ Patients: symptoms of anxiety were among the first to improve with antidepressant treatment. Words and phrases used by patients to describe this anxiety included “worry,” “fear,” and “nervousness.” Most of the patients appeared to perceive symptoms of anxiety and depression as being interrelated.

Patients: the first characteristics to improve with treatment was an ‘ability to cope.’

Patient: The ability to cope was a feeling of being ‘not quite so overwhelmed—he felt like he had more control of things that he was doing.’

Participant: The ‘ability to make decisions’ was the first characteristic to improve.

Two participants: said they quickly noticed improvements in the negative thought patterns that tend to accompany depressive episodes, such as hopelessness.

Patients also identified symptoms that were slower to improve: Sleep difficulties, problems concentrating, and feelings of social isolation were often cited as being more treatment-resistant.

Several of the patients reported: significant improvement in mood, irritability, and energy level said that their ability to concentrate or focus had still not improved.

Most subjects: indicated that sleep improvements took longer to establish.

18 Fullagar (2009)

Kaz (33 years, urban): he was having his medication dose increased again. Which is to the level that he is at now, which is fantastic. He is not changing it. He has actually come to the conclusion, after his doctor said this to him once: ‘If you’re a diabetic, would you stop taking your medication because you felt good?’ And the patient said ‘No.’ And she said, ‘Well, why would you, as a person who has a chemical imbalance in your brain, stop taking the medication, because you feel good?’ He went, ‘Because you’re not depressed any more.’ And she goes,
‘Yeah, but your chemical imbalance hasn’t gone though’ … if you’re on it because you’ve obviously got a shortage of serotonin or something, if you are on that, you could be on it for life as maintenance. Jasmin (37 years, urban): When she is not on medication and she is depressed, she feels like she is already in deficit because her mind is not working properly and her brain is not working properly, so at least on medication she feels like she is on a level playing field … so she is not at a disadvantage for working on life’s experiences.

Kaz (33 years, urban): Taking medication is a practice of ‘doing’ something to create the conditions for normality: You are not doing it to feel good, you are doing it to feel normal.

Sandy (53 years, rural): was relieved that it was her brain not her ‘self’ that was the problem: For the first time in her life she actually thought, ‘There is something wrong with my body.’ And that was a weight lifted off her shoulders. They explained it to her … in her case the serotonin was going across and going back quickly; not enough.

Roslyn (43 years, urban): Her depression arose in relation to this sense of failing to meet multiple gender expectations that culminated in a frightening panic attack: she felt a failure … she’d failed her kids … pursued her career at the expense of her family. And now she’d failed in her career and she’d failed them. As of her depression and anxiety, that was always something that happened to malingerers and people who weren’t strong.’

Jasmin (37 years, urban): that little pill is a reminder that there’s something not quite right, and that you’re a little bit dependent on something to keep you sane. So patient believes, there’s an aspect of your life then that you don’t have control over?

Irene (59 years, urban): You become two persons, two people in the one body, but there’s always the fear in the back of your mind that you are not standing hard enough on the other person (depressed self), and that other person is going to reappear, just when you don’t want them to.
Elisabeth (34 years, urban): Patient was quite shocked when she wanted to go off medication and that’s when she had terrible mood swings and she just kept crying and screaming. Roslyn (43 years, urban): her conflicting desires: because they made such a difference, the medication, she is just sort of a bit anxious about getting off them; it’s a bit of a safety net for her … She tried to get off them once and the side effects were just horrible; the doctor who first prescribed them for her painted a pretty rosy picture, which she thinks was misleading because she has suffered significant side effects trying to withdraw from them. She also thinks it is a psychological thing that one is dependent on these. Is she dependent on these drugs to be well, or not? It will be interesting to see.

Cathy (32 years, urban): You have to draw upon risk rationalities: she used medication to surveil her emotions as a prevention strategy: She thought as soon as she senses that something could be amiss, or that she’s at risk, like if there is a death in the family, she’ll start taking medication, even if she is not too grieved by it because maybe she might develop something, she always sort of keeps watching.

19 Fullagar, Simone and O'Brien (2013)

Tayla (31 years) was initially prescribed anti-depressants after she had suicidal thoughts. She decided to stop taking anti-depressants after a conversation with another person who had a similar experience. Tayla reflected on her own experience, she does not want to be on medication for five or six years. She believes she can beat this with the help of husband, kids, and friends.

Allie (69 years), who lived through the era when barbiturates were prescribed to treat depression, challenged this form of treatment by refusing to take medication because it sedated her too much: She thought no, this is no good, there must be something, something else. But she didn’t
know what that something else could be and it wasn’t until many, quite a few years later that she learned how to deal with depression. And then it was a matter of dealing with it, to learn how to live with it, but it was many more years after that before she came through it. Depression is complex and also the overcoming it is complex, so you try lots of things until you find what works for you. Renata (38 years) changed her relation to ‘self’, because she noticed that she hasn’t done exercise, or something for herself, or a massage, or something like that; that’s when she starts to go off the rails. And so what she does is, just say knowing her own triggers and signs, is, she kicks in the self-care. So, she mentioned the massage therapy or she cuts her workload down.

20 Gammel and Stoppard (1999)

The following questions were asked in the interview process of collecting data for this study:

_How did you come to be diagnosed as depressed? What forms of treatment have you received?_  
_What do you think caused your depression?; and, Do you think you are over or will get over this condition?_  

The patient was afraid that her physician was going to say that she didn’t need an anti-depressant drug … she thinks she would fight tooth and nail if anybody refused to prescribe it for me. (Ann)  

Taking medication…It made patient feel weak. Like to have to take a chemical … And then he got thinking about like the medication, he was just like, so what does this mean if he has to take this medication in order to be, in order to be normal? Like it just felt so weird … She hasn’t told her doctors but she has stopped taking her medication. (Susan)  

And she is not really, at this point she is still deciding; she thinks partly it is the fear of the drugs themselves. Like she is not really sure what, in terms of side effects and in terms of sort of like
and addiction. And just, she guesses the idea of needing, whatever drug to feel okay is a really, she doesn’t know, it’s kind of a nasty idea. (Tracy)

Patient felt she couldn’t talk to her psychiatrist. You’re in five minutes and okay we’ll try you on this pill. We’ll try you on that pill and there was no counselling. And she’d come home and there was no counselling, there was nowhere to go. The psychiatrist said ‘I’ll put you in touch with a clinical psychologist and he did’, and he put the patient in touch with a clinical psychologist and that was the best thing that ever happened. Patient thinks, counselling has helped probably the most. Taking time to look back and go over, you know, things that should have been dealt with. When patient started going through all the healing for her sexual abuse, the depression started lifting. (Debbie)

Patient doesn’t consider herself to be depressed just because she hates that classification … she doesn’t think about herself as depressed. Right now, like she doesn’t consider herself to be depressed. She doesn’t think she’s depressed right now. But she knows she is. If that makes sense. (Susan) Patient still did her daily activities of daily living. You know, had supper ready, had dinner ready, had their lunches ready. Did the wash. But none of that had ceased (Sarah)

But she just let go and went with the illness. She thought to hell with other people, she’s not going to. If she wants to lay on this couch, she’s going to lay on this couch. (Jane)

Patient want to go to law school and that’s another seven years and she just thought, if she can’t handle second year Arts, how in the hell she is supposed to be able to deal with this? (Susan)

Patient is hoping she won’t have any recurrence … she’ll never say that it’ll never happen again, but she’s hoping that with each time and with her experience, she’s hoping that she can minimize this feeling, and that it’s going to get better. (Sarah) Patient doesn’t think it’s something that can ever be permanently fixed. Patient thinks it’s something that you can deal with, she thinks it’s
something you can learn how to live with. But I don’t think it’s something you can ever cure. (Kelly)

There was always something wrong, a lot of physical you know, couldn’t sleep, always tired, didn’t want to eat and things like that. The big one was the insomnia. She just couldn’t sleep. (Kelly)

She’s got a small group of friends who are all suffering from various mental illnesses and they all, joke about it, how we’re all, we use the term crazy but we don’t use it in a derogatory sense. But there’s still that, when someone tells you your brain chemistry’s all messed up you’re sort of like ooh. (Kelly) Patient is not ashamed of depression, it was something that was natural, it was a natural occurrence. People aren’t ashamed to walk around with diabetes or a heart attack; people get cancer, it’s not something you’re going to hide. It’s the same thing. (Debbie)

It’s a chemical imbalance and, to me it just happened, it may have had something to do with my menopause (Gloria) you do need your medication or patient felt she needed her medication to alter that, the thought process (Sarah)

Patient thinks counselling probably was the best thing. More so than the Paxil. But she thinks she probably could have healed without the Paxil too, but the Paxil’s like an aid … giving you your ability to calm down. It takes awhile for it to work though, she thinks it helped, initially. (Debbie)

Well, just if she gets a medication that works for her. (Gloria)

And she knows she does need medication; they’ve tried three, well four different drugs now and this is the one that seems to be working the best. (Sarah)

you’re going to have to acknowledge that sometimes you know depression is going to invade in your life and you know, and at that time, times like that you have to ride it out you know. (Kelly)
If she had something that brought depression on or something to keep it here, but there’s nothing. Patient has a really good life with her family. And she has her car to drive and no problems. If she wants to go shopping and buy something she can go shopping and buy something so it’s it’s, there’s nothing, not a thing. (Gloria)

The psychologist knows so much more because patient sees him more often. He knows all about male acquaintances, and he knows all about situation with a relative and he knows all about you, the anxiety and stuff so I’d I’d say she talks more with him than she does with the psychiatrist. (Susan)

But it may have a bearing, the stress of that, work, on the genetic. But she was always one to strive like she’s always had many irons in the pot. And whether she just let herself get overwhelmed by too many things going on at the same time. (Sarah)

She still has to limit herself and that’s the hardest thing she does find is trying to limit. And, you know, take the ‘me time’, take that bubble bath. (Jane)

Like, patient went into hospital, her husband had to take over the budget. He’d never once looked at the budget. (Jane)

So therefore family members did not see a whole lot of change in me except that she couldn’t work outside the home. You know, because she worked around the home. (Sarah)

Several women felt more positive and made positive changes in their lives since their diagnosis and treatment. Patient has been off medication for a year or so, she has managed to straighten out a lot of, a lot of things in her life; she’s doing much better in school now and she is enjoying it a lot more and so for the most part she’s pretty, pretty happy she didn’t know like happiness, how cool it could be, how great it could be. (Kelly)
Another young women with a history of abuse and depression, admitted that her treatment had helped her become a stronger, more confident person. She feels totally healed and very positive about herself and, it’s just like, like on top of the world. Really she just feels like she has a total grip on, on life and, a lot stronger than she used to be. Having to go through that, you know, depression, just to just to get where she is now is worth it for sure.

Susan is concerned that depression will negatively influence her life in the future. For instance, the implications of her diagnosis for her future relationships.

21 Gibson, Cartwright and Read (2016 a)

Taking antidepressants makes you feel like a failure, like giving in (Participant 1).

Patient understands antidepressant use as a weakness: Maybe that’s also wrapped up in this idea about, you know, one should be able to cope with it without medication as well. It’s maybe it’s some sort of failing, maybe it’s some sort of sense of failure about having, you know, I’m not doing what I could do, I’m not achieving what I could achieve because I need medication, I should be able to manage these sorts of things.

Generally men tend to think that they can overpower any situation with just pure physical-ness.

We’ve always had people that used to talk about taking their happy pills and yeah one was never sure that they’d done enough themselves to try and fix things.

It’s not a sign of weakness, it helps your own mental stability sort of get back on even keel again. You’ve got to help yourself . . . there’s only so much that people from the outside can do. It’s got to come from within.

Patient has got pretty good at sitting back and analyzing what’s going on and looking back over a week he is able to chop and dice and go ‘ I’m going to stop those meds now, I’m going to
monitor myself for a couple of days and if I don’t improve after those two days I’ll go back on
the meds knowing that it’s something else. ‘

I didn’t want to be bothered going to the GP. I told the GP after I had done it . . . I made up my
mind I was going to do it, I didn’t want the doctor to say no, it’s bad. I don’t think he would
have. But I thought I can control this myself.

What I felt it was the loss of control over my own life. ‘my brain belongs to Mr. Pfizer’
The whole unpleasant thing, you know, your libido is absolutely stripped. I might as well live in
a monastery because I’ve got no libido and when it does come then I have erectile problems and
so it’s really, for something that’s supposed to stop depression, it causes me a lot of depression,
you know. There’s a stigma attached to, and particularly for a man, to be suffering from
depression. So I kept wanting to get off [antidepressants] and so from time to time I would wean
myself off. But I found that I couldn’t function under high pressure without them. And so here
they are, they give you functioning for day to day activities but possibly take away marriages for
certain people. . . . It makes you feel good but you can then coast into a separation that perhaps
might not have happened.

Well I think getting rid of the depression probably is the most important thing of all because it
affects everything whereas impotence only affects part of your life. . . . But then on the other
hand as you say it’s like do you sacrifice your sexuality or do you sacrifice your life and that’s
what it felt like.

Well it meant that I could never have another relationship. I mean how many people do you meet
who might be interested in you for taking things further through a relationship once they know
that you can’t perform a sex act. It would have to be a very special person. You can’t advertise
on the net “this and this and this wonderful—but no sex.”
Having said that when you get to your 60s your sex life is not as active as it used to be anyhow. (Participant 7).

I re-engaged. I became a loving and I think a better partner in the fact that it made me more facilitating, like I wasn’t sweating the small stuff. Now some people would say that’s disengagement again but for me it wasn’t. I actually re-engaged. (Participant 20)

So, I actually find the performance is actually great as well, because that means I can go for it quite a long time (Participant 9).

Pretty much all the classic things . . . highly emotionally unstable I guess in the sense of bursting into tears at a moment’s notice (Participant 14).

Well I’m quite a rational, stable sort of person but that would get me at times, in areas that were completely beyond my control. So, I was worried that I might be in the middle of a business presentation and suddenly crack up for no reason. (Participant 19)

When you crack you show the signs that you see in a woman, crying, not being able to cope, you know, just bursting into tears at the drop of a hat, and no one wants to go there. I guess that’s why we take the pills. (Participant 3)

You can’t think about how you feel if you are too clouded by emotion. You can’t step back from it. And even though I hate to admit it that was a really beneficial part of it. (Participant 1)

They’re terrible things because they take away, yeah they take away the lows, there’s no doubt about it, but they take away the highs and they put you in the ‘nothing zone.’ So you don’t feel things (Participant 3).

And then I found I wasn’t interested in movies. Oh I can’t be bothered. Couldn’t be bothered going to Art Galleries. No pleasure in it. Um sense of taste, just sort of flat. . . . I would eat in a completely functional way. (Participant 11)
Yeah I guess in one way [less emotion] is good. And in another way it’s not going to be good if you want to, you know, become more empathetic, more compassionate, or learn how to be more relational with people. (Participant 1)

I know in New Zealand especially, I mean you know you’ve got to sort of man up and be a man and do everything else and all the rest of it. But I think a lot of people nowadays are sort of realizing that people do have feelings, whether you’re male or female. But you can still have feelings without degrading yourself or belittling yourself. (Participant 5)

So I was trusting someone because I had lost all confidence, so I didn’t know what to do. It’s an all new experience for me, and you know. (Participant 15).

I can’t remember how many I cycled through with [my doctor] in that five months. There was always the question of we’ll give it a bit longer and see if it works. But I just got to the point where I said “Doc it’s not working. I’m not prepared to elongate the timeline because it makes no difference for me physiologically. It’s not going to help.” (Participant 10)

So you’ve just got to roll with it but I’m old enough and experienced enough now to know how to trust my own gut. This is telling me it’s not the thing for me then you know . . .

There are times when you go well I don’t need to take the pills because I feel good. But of course you feel good because you are taking the pills. I’m like well I don’t think I’m depressed, but that’s because I am depressed, so I’m not thinking properly in terms of knowing whether I am depressed or not. (Participant 8) You are left feeling insecure in your own ability to understand what you are going to become like, what you could be like, what is the real you anymore? (Participant 20).
Certainly a lot of the symptoms of depression that I exhibit, you know, I wonder whether they’re actually symptoms of depression or it just so happens to be that that’s the way that I am, if you know what I mean. (Participant 8)

No doubt there was an element of going along with it because I was in the relationship and I enjoyed that and she thought this would help and I thought well maybe it will.

I’m sure there would have been [my partner’s] expectations of what she wanted or expected me to be like, that would have been some kind of force.

My wife is very good obviously at now identifying where I am at and saying: ‘Hey come on, don’t you think you need to be taking your antidepressants again’ (Participant 14).

I wasn’t aware of the depression myself but my wife tells me my mood was much further down than I thought (Participant 16).

It’s because I can’t trust my judgement anymore and you’re my wife, you’re supposed to know that I’m not well (Participant 10).

( Participant 16) My wife would “divorce” me if I stopped.

My wife seemed to appreciate me more when I was taking antidepressants.

And I understand partners’ encouragement to take antidepressants as sign that they were uncomfortable with the emotional vulnerability of someone who is depressed…It’s just it seems to be, my wife expects you to be a male and be the strong one, and she’s a pretty strong person herself, but she expects me to be, I can’t really show too much vulnerability, which is hard work. (Participant 7)

For me it was a matter of my wife pointing out to me that I need to be responsible for my own behaviour and if you can’t control it you need to see somebody about it or do something about it,
like ‘You are a complete [a…e] and I am not prepared to tolerate it, now are you prepared to do something about it.’ (Participant 20)

My wife was saying: ‘you have to do something. You’re depressed, you’ve changed. You’re not the man I knew.’ And so I found that each time. I discontinued it three times before I found a way off it.

22 Gibson, Cartwright and Read (2016 b)

It’s just like diabetes – a chemical shortage… I need serotonin uptake inhibitors – simple!

I would hope that one day I could stop taking them but realize that for me it is the same as taking heart pill for someone else.

My GP said that if I had diabetes I would need to take insulin forever, so not to worry that I appear to need to continue to take anti-depressants forever.

I can still remember the desperation and pain and if it meant taking them forever I would not hesitate. It was a life-saver in a real sense of the word. That medication had prevented me from committing suicide. I truly feel that I would not be alive if I had not taken them. [Antidepressants are] the sole reason I can now function as normally as possible as a human being and a participating member of my family and community.

Antidepressants have been very helpful, they have allowed me to be a better parent than I would have otherwise been, I believe.

Antidepressants are helpful in enabling me to manage the stresses of job loss and unemployment. I feel that I can cope better with job interviews on them.

I have had such good therapy that I have been able to address the wider issues that had contributed to my mental state. … Without the medication though, I would never have had the ability to do this.
They were a waste of time and did not help me.

I get more benefit from mild to moderate exercise, or energy drinks, or spending quality time with friends.

They drug treatment was greatly disappointing. I wish I had never tried the pills, because before I tried them at least there was hope that something could have helped.

Each one has had a worse effect than the previous…. I can’t remember them all. It started with memory loss then progressed to me becoming borderline catatonic staring at the wall for hours unable to stand up. Within a few weeks and genuinely terrified. It was a relief to go back to the misery of depression after these experiences.

They don’t make the problems go away. They just make me numb enough to not give a shit.

By taking the medication I felt alienated from others almost as though I was walking around like a zombie in a kind of bubble.

In my life, antidepressants have been prescribed to me to cover up what was wrong, and to me were a fake fix. I believe that I stayed in a relationship that was unhealthy for me, because the antidepressants made me tolerate treatment that was unacceptable. [It’s] like smoking. When you smoke you know it’s bad for you, but you also feel momentary relief and therefore can’t (or don’t want to stop) because you miss that feeling of being slightly more capable to handle situations.

I felt bullied into keeping taking them and at times told I would not receive therapeutic treatment if I didn’t take them. There felt like no alternative and I felt very trapped into taking them. It is a necessary evil, with very unfortunate side effects in terms of weight gain and sexual dysfunction which lead to me stopping the treatment despite its benefits for my mood.
I know they do me good and I am better on them, but they do make me feel physically sick, and not like myself. I seem to be constantly trying life without them, but always go back to them in the end.

Antidepressants have been a two-edged sword. I felt less affected by things that would normally distress me while on anti-depressants... [but] when I came off them, my head felt clear, I felt like I was waking up and that I was in touch with myself again.

[Antidepressants were] helpful in making my depression less. However, the effects that they had on me as a person and how I treated others is the main reason I came off them. I am a considerate and selfless person and while on the antidepressants I was the complete opposite.

The thing is that I have been on them so long that I have no idea what it would be like not to be on them. I would love to come off them but they have become such a ‘normal’ part of my life since I was approximately 15 years old that I am not sure I would cope without them.

They helped me get back on my feet when I was facing a difficult time. However I was never told when to go off them and ...have not heard from the doctor who prescribed them to me in years.

The withdrawal effects if I forget to take my pill are severe shakes, suicidal thoughts, a feeling of too much caffeine in my brain, electric shocks, hallucinations, insane mood swings. [I’m] kinda stuck on them now coz I’m too scared to come off it. I have been on MANY different antidepressants. None of them were helpful at all to me until I tried Fluoxetine 4 years ago. My life now is greatly improved by taking this medication and a quality of life has returned.

I have tried almost all antidepressants available under prescription (including combinations), and most worked to varying amounts to start with, then stopped helping, then the dose was increased, then stopped working/made me worse, then dose increased to the maximum, then stopped
working, then I was put on something else. I’ve wondered if I would have been better off never starting taking them at all.

23 Givens et al. (2006)

I didn't want to start get myself hooked on a medication that I would have to be taking the rest of my life. I think sometimes medication is wonderful but I think you can't escape from your problems that way so I watch when I take it. I don't want to get dependent on it.

I stopped taking it on my own … I felt that I didn't want to stay on the medication. I didn't want to become addicted to an antidepressant.

I have a stressful time going, dealing with death in the family, losing my mother, losing my father a year ago. In fact, a year this February I lost six other family members in one year. And it just looked like it was just too much to cope with.

It's not—I don't know whether it's the depression or not but I think when it changed why I feel that the death of my husband has changed me. He was the first man that I loved and I—even feel yet that a part of me is missing, that something—just something I feel that a part of me is missing because he is not around. …If you can't see and you feel like you're going to lose your eyesight, you know, it kinda gets you down. Especially when you don't have nobody. I do think that there's a reason for my depression. I don't think it's just there like a cloud because nothing's wrong. I think there are things that are wrong and that's why I kind of don't like to take medication for it because the medication doesn't change the basics. He prescribed Zoloft for me. Well I never took it. I mean, my feeling at the time was that I wasn't interested in the pill. I didn't want to do this because I couldn't just bury my husband and then go on and go out and party.

I have to face reality and I think you have to feel some pain in life.
I didn't want to stay on the medication … why should I be different than everybody else? I didn't want to take them … 'cause I had taken tranquilizers when I was young … A doctor recommended that … I don't think they knew about antidepressants then … I never thought it was nerves but I couldn't take 'em, I slept.

I'm not interested in pills anymore. I get bad dreams. I mean, they gave me pills that left me waking up and not knowing where I was. I was still in a dream.

Hanssen and Cabassa (2012)

I was urged by my husband to talk to a female doctor in hopes this would help me feel comfortable discussing health concerns, which I struggled to do until that point.

Like the doctor tells me “You have to accept your diabetes. You have to accept your high blood pressure. You have to accept….bad moods….like you accept your problems, you have to accept your illness”. And I now, that is what I am trying to do, accept. (Focus group)

At times I take a half of the pill for depression…it’s what helps me, it’s what calms me…. I don’t take it every day, only when I get to the point of feeling a lot, a desire to cry, with anxiety… (Individual interview)

Look, in reality with the doctor here, I cannot communicate well, because he does not speak any Spanish. The doctor is informing me through an interpreter and so the interpreter does not tell us everything, because one very clearly sees… she is listening and in the whole time tells us two, three words. So realistically, you understand, that it is not everything that the doctor is saying. (Individual interview)

Well, I heard that it makes you sick, like that is the medicine for when one is loco [crazy] and all that…Well, also because of that I didn’t want to take them, because I was scared they would make me ill in the head… (Individual interview) Well, since they treat me every six months…
we hardly have talked, I only come and they look me over, and they say to me “where does it hurt, if it hurts”. They only prescribe me the medication and that is it.

Interviewer: You have never thought of talking to your doctor?

Respondent: No, because almost it never lends itself to do so, or moreover, since I know there are many patients, they try to get them out fast. (Individual interview)

---

**Izquierdo et al. (2014)**

A 61-year old woman said: I’m not happy that my body just doesn’t want to behave itself and that I have to use medications to correct this. I used to hate that I had to depend on a medication to make me feel normal, but then I realized that I had an imbalance and I had to take care of it. A
54-year old woman: You cannot control depression. Even if you discuss it with someone like a doc, by the time they finish medicating you and counseling you they didn’t cure it. It doesn’t stop. If you know that why put yourself through it?

Some believed depression was a condition that would take care of itself, or did not require medical treatment. “My depression will heal naturally,” said a 52-year old woman. A 54-year old woman described, “I just have to let the depression run its course.” Participants who believed they had to manage depression on their own described reticence or refusal to use therapeutic treatments. Though my doctor suggested counseling, it’s up to me myself to get better. I have to do it on my own. I don’t need any medication,” (a 71-year old woman).

A 58-year old woman: “I was prescribed my medication to be taken twice a day but I only take it that way sometimes because I don’t want to get hooked on pills.”

Participants also described antidepressant medications as unnatural or illicit substances; they referred to them as chemicals (“químicas”) and drugs (“drogas”).

A 61-year old woman said, “My mother was a prescription addict, so I didn’t even want to take aspirin. But I came to realize there’s a difference between tranquilizers and the medications I take for depression.”

A 54-year old woman Schizophrenia runs in the family and I don’t want to be in a looney-tooney bin. I can’t talk to nobody about it, no professionals, because they want to lock you up.

“I’ve been taking antidepressants a long time. I don’t like to take them but they help,” said a 55-year old woman.

A 57-year old woman stated, ‘I’ve tried to quit my anti-depressant medication twice by myself but my symptoms came back and I needed to go back on it. I know that if I stop taking it I will get sick and depressed and will be crying all the time.’ In contrast, participants who previously
experienced treatment side effects reported reluctance to re-start antidepressant medications. A 56-year old woman stated:

I used to take antidepressants years ago, but they made me have headaches and made me nervous. I generally felt worse throughout the day so I stopped taking them. I have no interest in getting antidepressants again.

26 Jaffray et al. 2014

…now that I’ve been to the doctor and the doctor said yeah you have a problem and everything…I can sort of go right, there is a bit of problems here I can do something about that.

(continuer)

I’ve a good friend who is a CPN [Community Psychiatric Nurse], she was supporting me and she said ‘I really think you should be going you know and speak to the doctor … I decided that yes I would go. (continuer)

I didn’t ask to go on them but I had that in my head you know if she offered me to go on these, on something then I would, so she did offer them. (continuer)

I felt quite embarrassed about it because I didn’t realise they were antidepressants she just said it was something to pick me up…like why do I need antidepressants? None of my family have ever needed antidepressants. (discontinuer)

I suspect my depression was more reactive. (discontinuer)

I just thought, well it’s a waste of time because they are not listening to me, they are not understanding what I’m saying. (discontinuer)

I was quite open with my husband but I haven’t told my parents because my mum has depression. (continuer)
Some of the employers,…one of them I spoke to was okay but the other one was probably thinking ‘get over it’. (continuer)

I think it’s just sort of got me over the worst of it, I think, that’s how I was starting to think perhaps I can come off of them. (discontinuer)

As long as I am feeling good, I know I shouldn’t question it but you start to wonder how will I feel if I come off them? (continuer)

I just felt perhaps now is the time to wean me off a bit, I have come to terms with a lot (continuer) Although things were explained quite clearly at the beginning I think at this point [now I feel better] I would have benefitted from a bit more support or just knowing a bit more about what I am doing (continuer)

My sister said I had put on weight, she said you probably should stop your antidepressants. I said no.

They just said that your moods will change, and you will have an upset tummy and your side effects. I thought, no, I am not going through that. (discontinuer)

I just felt that I shouldn’t really be, well, always depending on tablets. (continuer)

Latency period (perceived lack of efficacy of antidepressants)

Yeah, I was really, really surprised, although I did have my doubts, but no, I will persevere, and I’m glad I did actually. (continuer) No, I just, I actually felt more depressed, I just wanted to sleep, I just wanted to go to my bed and it [antidepressant] was encouraging me to do that…there was a spell that it wasn’t working. (discontinuer)

If there’s just a little niggle, you can talk about it, a little peace of mind, and then as I said they monitor you, they don’t give you automatic prescriptions. (continuer)
I’ve kind of been left to it, she said to make sure that I come back, I don’t know what would have happened if I had just stopped them, and not come back. (continuer)

I will know myself, if it’s not working then to increase it again. (continuer)

27 Kadir and Bifulco (2010)

I think I’ve got this illness because I’ve many worrisome thoughts… I went to see my GP at first, then I was referred to mental hospital. I believe I will be normal again with modern treatment but I can’t afford to pay for this treatment… so I decided to see bomoh too. It will help me get rid of this illness. (Anisa)

I never sought treatment, I was unaware of services offered. I though that mental hospitals offer treatment only for those people with serious mental illness who ‘run amok’. Depression is just a ‘thought problem’ and can be cured with ‘willpower’. This is why I never sought help. I cannot talk to other people, either… (Salina)

I did receive treatment for my depression and I was given an antidepressant medication and referred to a psychiatric unit at our community clinic. Then, I’ve decided to stop the medication due to the side effects: fatigue, being unable to sleep and nausea. I didn’t want to see the psychiatrist for continuous treatment because of was afraid to be labeled as mentally ill. (Norma)

I sought psychiatric treatment and was on medication for about a year, but stopped taking it because of the side effects: fatigue and memory loss. My parents decided I should seek alternative medicine. The bomoh advised me to stop the medication and not to think or worry too much.

The bomoh told me that evil spirits are happy if I feel depressed and do something stupid like attempting suicide.
I think the bomoh can cure my illness. I talked to her a lot about my illness … what I’ve felt … my sorrow… my sadness… my loss of interest… I’ve no job. The bomoh encouraged me to share my entire problem with her. I share lots of things with her. She gave holy water so I drink it everyday. I feel more confident. She asked me to chant every time after I perform my prayer. I did it… I feel relief. (Miriam)

I think my illness is normal. Not really severe compared to others. I can go to work. I can speak to people. I … sometimes feel unhappy and am not in a mood for doing things I like to do… but I still think I’m fine … I don’t go out and kill people as a few mad people do. Oh yeah … I was on medication … the GP gave me antidepressants … but I became worse day-by-day so I decided to stop. (Norma)

I’ve seen a psychiatrist and a bomoh. I knew it was not right to see bomoh but I do believe bomoh will help me strengthen my faith. To make me feel close to God and to make me feel I’m not alone in this world. I wanted to be a good follower … a good believer … I will see the psychiatrist again when my illness becomes severe but I do believe the power of will inside me will help me against my illness … you see … sorrow and sadness are not good for us … I should not grieve about my fate … I know that. (Rokiah)

28 Knudsen et al. (2002 a)

Informants’ accounts:

Because you see yourself in the situation which you know is completely crazy. You see yourself and you can’t do anything … That is what I think is really hard. Because you are thinking so clearly. Sometimes, I’m in such despair about myself … and you can’t keep that up in the long run.
You just felt so lonely. And that you were just killing time. Yeah … the emptiness … The feeling you don’t have anything to live for. That is what typically triggers the thinking about suicide. Life is hard. And you just sit and wallow in it, you know? And then you can fall apart. You’re caught in that kind of thinking.

I’m not really sociable. My work requires me to be quite extroverted and social. And that really drains my energy. When I get home, I can’t really stand being together with anyone … And perhaps that is partly why we’re getting a divorce. I don’t really think I can live up to it. I’m the one who wants a divorce. I can’t live up to what you’re supposed to live up to when you’re married. I spend such an incredible amount of energy getting my workday to function … and that’s how things are these days. In the society we live in, you have to work to survive … that’s how it is. It’s hard for me. And then when the doctor mentions the medicine, I just feel paralyzed. For me to take those pills. It was … but heavens I don’t feel that I have that kind of illness, you know? Well, it was really a shock. Really. I found it unpleasant in the extreme. It’s one thing to have a psychological illness, but if then you have to take medicine for it. Well, then, that’s twice as bad. To be down and have psychological problems. Lots of people can have them. So, okay, maybe we can accept that. You get over that by yourself. It’s just that you don’t quite mention that you didn’t in fact do that, but you had to take those pills. Double whammy. If you get those pills then people think “Well, so it was real”.

And I have always taken the stand that I wouldn’t take medicine. Because I have always believed that I could manage without it. So then I go see this psychiatrist and get a very positive impression of him. And he tells me that there is an imbalance in my brain that makes me get these depressions … and so after some major deliberations I start taking Seroxat [an SSRI]. It’s embarrassing, simply … Yes, why it is embarrassing. It just is. Because it’s not normal. You just
aren’t ordinary, a person who can function without having to take something chemical. With other diseases, that’s allowed. It’s allowed because it’s a physical problem, you know? But the other thing, that’s in your head. It’s because your head doesn’t work too good. But that’s the thing. When my doctor said that it was something chemical, then, then it was easier for me to handle it.

SSRIs users’ accounts:

I have much more energy for other people. Hmmm… I’m more open and … that means that I have started to believe more in myself. And be more. Not just say yes and well but really give something to people. Give something back to them. And not always be the … what should I say … the neutral person … I’ve blossomed. But when I’m taking the pills, then I have…Then I can function. I can. I can. I can go to work. Smile and be happy. And can enjoy things and I… can stay out of bed except when I have to sleep… hmmm, and I can be sociable. I can do things together with my friends… but that’s all they do.

The reason I want to wean myself away from the medicine is simply because I will not conceive of myself as ill … I think that is very important to my conception of myself that I don’t think I’m some kind of therapeutic case.

Cutting down wasn’t a problem I don’t think. So in that way you’re not dependent on them … not like with other types of medicine. You’re not that dependent on them. I’m not anyway. I think it’s more the anxiety that makes you dependent. It’s a psychological that dependence.

You’re afraid everything will go wrong if you don’t take your medicine.

I hope it’s not something I’ll have to take the rest of my life. I’m not counting on that. I would be sorry about that. But if that’s what it takes for me to have a good life. Then I would be willing to do it. But right now I still hope that at some point I can manage without it.
It was a validation that I had never had before and I had a name. It was like, you know, it’s a bad attitude, it’s not. I’m not … you know maladjusted, I’m not ill socially or whatever. It’s just I’m depressed. And that’s cool. Like it was really neat to have a name for it. (Kate)

I was reading this book [which listed the diagnostic criteria of depression] and it was describing what I was going through […] and all of a sudden I said Geeze that’s what’s wrong. I’m depressed. That’s what it is. Just to be able to put a name on it? Because there are times when I thought I was different from everybody. But what I found in that book, I found that when you have the symptoms I had, that the way I was feeling in my condition was normal. See? I wasn’t going crazy.

Something in me made me go to the doctor and I went into her office and she sat down and she said: ‘What’s the matter?’ And I said: ‘How do you know if you’re depressed?’ And she said, ‘OK, I have got ten questions to ask you’. And I was nine out of ten. […] So she said, you know, you’re depressed! There’s no way out of it’. So anyway, fine I said, what do I have to do? I was so relieved! I was so relieved I thought thank God! There’s something wrong with me! I’m not- there-it’s got a name! Like it’s not that I am just a terrible, awful person who is unattractive. It was kind of a relief to have somebody say, ‘Yes, you have something seriously wrong, you know, tis is what it is’. There’s something really wrong with me that they have even a name for it. It’s a sense of relief that there is something there that people know about that you know you’re not the only person in the world that’s had it and you really do have something. You’re not just making this up, you know. And that’s kind of good because people do have a tendency to sort of look at you and say, well, you just want attention. Well no, attention’s nice, but no, that was not the plan here. If I wanted attention I could dance on the table, I don’t have to try and kill myself.
I would like to see more women be honest about it and lose their shame because it doesn’t mean – And this is something that I’ve learned. I’m not a weak person because I have this, I’m not a bad person because I have this, I could just as easily have, you know diabetes or blond hair or red hair or long legs, I should be so lucky. You know it’s just, it’s one of those things and there’s no blame associated with it. So it’s right down the line, my mother, my brother, myself, my nice, my son. It certainly is hereditary. You know it’s … it is an illness the same as diabetes or a bad heart or anything like that, high blood pressure, it’s in the family. Well I think I did suffer depression. Because, and again I say, if I was on Prozac way back then, like I say to my boys, I’d say, ‘I know I would have been a much better mother. Because I would have put you in your snowsuits, we could have gone for walks, we could have gone out and made snowmen. I could have made cookies with you.’ You see? I could have enjoyed them. But they were just work. Laundry and laundry and bedding and it was just, it was just work work work work no enjoyment eh?

If you suffer from migraine headaches or say if you were diabetic you could say to a person ‘Oh, I’ve got a terrible migraine again’ or ‘My diabetes is acting up’. But with depression just to say ‘Oh, I’m depressed’, that doesn’t go with people. ‘Oh come on, come on you promised, you’re you’re well, ther’s nothing wrong with you, you promised, you can go, you can go’. See?

Interviewer: What do you think is the difference between people being able to say ‘I’ve got a migraine or my diabetes or’ and well, they accept that. But just to say, ‘Well I’m depressed, ah, they feel well … good kick in the butt. ‘You can do it, get up and you you can go. There’s nothing to prevent you from doing it. You haven’t got the flu, you haven’t got the cold. Whjt’s preventing you? So they don’t understand. It’s a hell of a thing to have. It’s a really bad thing. I’d far sooner deal with any of my physical ailments than I would depression. Depression is hard.
Interviewer: What makes it so much harder?

Well I find it’s so personal. Nobody can understand how bad you’re feeling. And like you can go to a doctor, you got bad asthma, you can’t breathe? They can understand that. They can see it, they can feel bad for you and they can really try to help you without feeling sorry for you. When you’re feeling depressed, people don’t understand they figure you’ve just got the blues and you’re not dealing with it.

Lafrance (2014)

Terrible. Wellbutrin makes it so you’re jumpy. I got palpitations from it, I could feel my heart going whoop, whoop, whoop, and it made me dizzy. I couldn’t sleep at night, so that’s why he gave me Ativan. Ativan? I don’t want to get addicted to this stuff. But I couldn’t relax, so I said, ‘No, this is not the way to go, I just don’t want to do this anymore.’

I was given Luvox and it made my heart flutter. And I would get very angry a lot and one day I forgot to eat. I did some really strange things like, just being angry and short tempered and my sleeping was way of whack. I was staying up all night, sleeping during the day. It was very difficult to do anything because I was tired all the time and then when it was time for me to go to sleep I couldn’t sleep. And it was just a bad experience and they said, ‘Oh well we’ll just put you on another kind’ and I was like ‘I don’t want to go through a whole, you know, test all these drugs’. I didn’t want to do that so I stopped thaking that eventually just cold.

Whenever I read about depression, it was always like ‘Go see your doctor, they will give you Prozac. And I especially found that with my doctor because the second it came up she’s like ‘Here is a prescription’. And that kind of makes me mad. When I read about it because and like a lot of pressures that women have to face, family and work and you know there’s a lot of different other things that affect it too that can make it worse.
When I went to the doctor and explained I was depressed, Prozac, right away. And I really had a
problem with that because I knew there was a lot of stuff wrong and I wanted to get to the
bottom of what was wrong and not just simply take the Prozac.

31 Lavender, Khondoker and Jones (2006)

And that evening a friend rang and I told her, and she said ‘have you had anything to eat?’ And I
realized I hadn’t had a thing to eat for about three days, not a thing. She said ‘you must have
something to eat, you must do’.

If it is this country’s only way to go to the doctor, but in Nigeria the people will tend to think of
so many ways of helping out, according to individuals’ beliefs.

My own advice to doctors … if it is a woman, they should try to invite the husband … and tell
him that look, the wife got a depression. So what’s going on? And they should, you know, try to
advise them that he is the right person to help the woman out, because that woman is only with
the doctor for a few minutes.

I think they are good, but not for a long period of time … because after a long time of it, your
body is immune to them. I’ve took them … I think it’s only me that can make myself get better.

In this situation medicine will not benefit. This is mind matter, unrest of mind. So doctors’
medicine can not work.

So I decided to take the antidepressant even though I don’t feel good in taking it. Actually, it
doesn’t help me much. I think going to my church for counselling has helped me a lot.

Taking medicine can change the mind … So medicine can make the brain normal and can make
the heart normal … medicine can make him better. If she is ill, there should be effect on her
body, maybe stomach ache, or headache or some other effect on her body. Because there is no
effect on her body, therefore with my little knowledge I think she is not ill. Perhaps she has a mental problem.

32 Lawrence et al. (2006)

I think the main helping with depression, any kind of depression, physical, mental, it is self-help. If you help yourself the way you want to do it, you will get over the depression 100%, I am that sure. But if you don’t want to do it, there’s nothing you can do. Treat yourself. (South Asian, not depressed)

It’s a mental attitude, mental attitude. If you change the mental attitude and all that and you become cheerful and start activities it will go. (South Asian/depressed & not treated)

It’s easier said than done, not to concentrate on one particular thing, especially bad things. Don’t concentrate on it a lot. Let it go away as quickly as you possibly can. (Black Caribbean/not depressed)

You think a bit differently you know with the way you think about things, it’s different but I don’t keep it in my mind. I like to read, I’m really interested in reading, papers, books, so then I forget everything. I kind of do it myself.

Getting out of the house helps me enormously. I have been paying someone to take me out usually once a week, at the weekend, but she’s moving to Norfolk and that’s been sort of my life-saver because I thought I would go mad if I didn’t get out the house…Yes, it’s the one thing that is guaranteed to help.

The first thing is communicating, that somebody is listening to what I am going through. You are pouring out your heart to that person and you feel a bit better that you have passed on your worries and problems to another person.

300
You’ve got to try and keep cheerful when you are with people, it’s difficult, you want them to know but no I put on a brave face and make out I’ve got no troubles. If they ask me how I am, ‘I’m all right, I’m fine, I don’t best to look on the bright side I find otherwise people get fed up, ‘Oh, she’s a misery’.

But of course, religion means that you are in talk with God and if God can’t help you what else will help you?

You see the GPs are so tied up with so much work they don’t have time to talk to their patients and they find a lot of people don’t get the necessary benefit that they would get from the GP if the GP talked to them. Even give them less medication and have a talk because it makes them feel good within themselves is like a self-healing power you know. That builds them up.

There’s so much to say and so little time. So you always feel like you haven’t got enough time with the doctor. Yes so then you think to yourself, ah well, the important thing, first, cure your pains and then think about the depression later on.

I mean you hear of people taking these drugs for years and years and they got so dependent on them.

I would feel that if someone was to say we are going to make an appointment for you to see a psychiatrist, straight away I would think oh I am going off me rocker kind of thing.

When you get a counsellor to talk to you, what the person says to you is encouraging, strengthen your body, strengthen your mind and whatever is there, it come right out.

Counsellors would be able to spend more time with them, to chat with them, to make them feel at home and things like that you know. Whereas a GP, they would be considered to be an official, authority, while these counsellors are normal people who gve their time in counsel. I suppose that’s what it is, so that would help them, the counsellors would be more helpful.
I was dreading going and saying I don’t feel better … that was getting me down … the pressure of having to tell someone ‘no I still feel terrible’; I want to say ‘this is really working’. I didn’t want her to panic and suddenly think ‘oh things have got so much worse’ …I felt I was in control of it, I didn’t want her to change my medication because of it’. (female patient)

I tend not to like to tell doctors what to do…I want someone to tell me what to do…I have always sort of thought, ‘right, a doctor just tells me what I have and I just say thanks and go’.

(female patient)

I have this panic that there’s not going to be anything else to help me so I’m trying to kid myself, ‘it’s alright, it’s quite contained, just tell her everything’s fine’, and I haven’t, I mean I’ve gone along and said ‘it’s been a difficult month’. (female patient)

As a doctor she really asks, she doesn’t just ask ‘Is the medication okay?’ she really asks how I am and how I am coping with things. (female patient). [sighs] she wasn’t very…sympathetic, and I just burst into tears as soon as I says [sic!] that I was sent over by the, health visitor [sighs]. I suppose some people you click with, some people you don’t and she just seemed a bit distant … I know she’s following procedures … it’s just I expected someone to be oh, you know, and she was ‘right, let’s start with … sleeping tablets first and then see how’… maybe she was in a hurry … I probably felt guilty for taking up the time, I was just crying, so she couldn’t get the information out of me because I was in a bit of a state’. (female patient)

I thought I’d come away with antidepressants and came away with sleeping tablets … perhaps she felt that I needed to have a decent sleep and see how I felt after that, so maybe she didn’t want to jump into things too quickly … In some ways that was good, but at the time I think I just wanted something to make me feel better’. (patient)
… he was just on your side because he’s sort of with you … He can empathise … I was quite determined tat I’ll go in and talk to him, tell him how I’m feeling … I did explain I don’t want anything too heavy but I’d like something to lift my spirits a bit … I felt like I’d got the goods. I felt like mission accomplished. (patient)

… there is one person saying it’s a good idea to take them and somebody saying no, you should not take them; I was in the middle and I couldn’t make my mind up, I was really confused, I think, I’m worse at the minute; I just can’t make my own mind up’. (patient)

What can they say to me if I go back and say ‘I haven’t taken the tablets but I still feel down’ … they’ll probably say ‘Take the tablets’ they might just think why am I back in the surgery … will I look a fool if I go back? I don’t know … the feeling I’ve got is that they happily give you tablets but they won’t recommend things like counselling. (patient)

She kept sort of going through the various options and kept avoiding going up dosage and I kept thinking ‘Well I think I need to’, but then I always have something my mother’s instilled in me “Don’t tell a doctor what to do”. (patient)

But I don’t know … if there’s an issue on dosage or not? … So shall I just carry on with this [dosage]?

GP: Well at the end of the day it’s up to you, but yes, I’d say carry on a bit longer and I think it will help answer your questions [about latency in the recovery process].

I want that guidance really which I don’t necessarily get … I want someone to say, ‘this is what you need, this will make you feel better.’ (patient)

Murawiec (2008)

Case study. Patient’s report. Treatment with citalopram and later fluoxetine for a year
Before starting the treatment I had experienced a continually increasing feeling of helplessness towards the course of life and a progressive loss, or at least a significant limitation of intellectual properties necessary for me to deal with my problems. I have noticed incread problems with concentration, memory, making association (deduction) and motivation for effort. I associated these symptoms with aging, although it seemed unusual, that at the age of 40 they were so intensive. These symptoms were accompanied by a decreasing self-esteem, poignant frustration and lack of success, and an increasing need of self-control unsuccessfully aiming to turn around this unfavourable situation. I realised that I needed medical help.

The medication started to be effective surprisingly quickly and in the right direction. In the first months of treatment its effect was even a little too strong. I could burst out laughing at my thoughts or speak to myself in the street. I started acting spontaneously, which was funny both for me and my surrounding: I would make frivolous remarks toward others, I paid complements to my female work colleagues; overstepping not so much the bounds of customs and morale, but my own psychologica boundaries. With a good effect, I have gone back to spending my free time enjoying myself, and all the time being able to return to my duties (controlling everything).

Having control over life is the key aspect for mental wellness here: it relates to i.e. drinking alcohol. I have successfully started to spend more time enjoying myself being sober than being drunk. As the mood functions as a background for emotional experiences, which are made gloomy by the alcohol, I decided that in this respect it has a negative influence and it is worth avoiding it.

At work I am able to impose discipline on myself, but at the same time I know when to stop an arduous activity, at least for a few minutes, to regenerate my strength.
Surprisingly, this self-centred attitude towards myself, allows me to develop altruism: this inclination, in turn, I define as a luxury of a person with a well-balanced self-esteem, who does not have to confirm his/her image perceived by other people, and in this way is able to step beyond his/her own needs. During the last 2 years, I have started many acquaintances, most of which go back to my school years, forgotten for the last 20 years and renewed with a great effort. Therefore I have a large circle of friends (my wife’s and mine) with whom I stay in touch. Some of them are my close friends, some I contact only occasionally. My present intensive social life reveals the loneliness I felt for the last few years and is a way of compensation for it. It is especially visible when one looks at my position in the professional circles.

If I were to name other areas in which I have become active recently, it is necessary to mention many sublimations (there are artistic and literary projects which I had abandoned in my adult years, and to which I have returned now, as well as social and scientific projects). The high number of engagements may suggest that I have fallen in a state of exaltation. Using an album of photographs of Camposanto, a necropolis in Genoa, published before the war, and being inspired by the whiteness of the walls in my living room, I have painted of both sides of the entrance natural size figures of Adam and Eve. By painting these figures I have dealt with getting used to the anonymous space, time giving it, at the same, intimate and universal dimensions. The figures live in various circumstances: I am socially praised by friends visiting our house, but in the lonely evenings I contemplate with pleasure these figures, laughing at the irritating insufficiency of my skills.

Considering that I am in the course of treatment and that I have wanted to get out of the magic circle of incapability, and do something useful (as opposed to professional activities undertaken
in recent years, which di not give me any satisfaction), I believe that this state reflects my needs and inclinations, and that it represents the emanation of my mental health.

35 Patel et al. (2013)

… that’s one more stress on top of every stress you’ve been put under and sort of, one of them must have been the straw that broke the camel’s back. But which one? There are just so many straws. I found it difficult to distinguish between what was just complete exhaustion and maybe what was the depression really and I still think that they are still linked.

I think it’s harder to grasp because it’s all to do with feelings and emotions and it’s hard to sort of try and understand that it’s a chemical that’s causing that.

I should just accept it and I just don’t know I am worried about what other people think about me…

…but I was adamant that I was fine and that it was just a lack of sleep and this, that and the other and I would not let her refer me to anybody because I was fine, I was just blocking it out.

I just can’t bring myself to say it. Fear of ridicule I suppose … and I don’t want people to feel that I can’t look after my children because I can …and I love them

People will think she needs to be on meds to be a normal mother

…if you are not taking the drugs you can kind of pretend you haven’t got it but when you are taking drugs, you can’t hide behind anything, you have a mental illness that you are taking drugs for and therefore, you’ve got that stigma.

I’d rather not, but it’s the lesser of two evils I guess.

I’m not the sort of person who easily gives into things. If I can possibly do it without the drugs, then I must be a stronger person.
I am quite happy to take it forever if it makes me feel like I can get up in the morning ... but ... I would like to think I could stop taking it and go back to my normal self but I don’t know whether I would want to for fear of going back to that crazed fool. You can’t really put a timescale on it; you just need to keep working towards it.

36 Ridge et al. (2015)

My general experience of antidepressants has been very positive in terms of all the horrible things that people talk about that can happen with them. (Tony)

... we have just a bit of a pill culture, take a pill for that, take a pill for a headache, that kind of thing, it's easy. (Michael)

... part of me feels like a failure for not being able to manage my life without chemicals. (Samantha)

It felt harder going back on antidepressants the second time because you sort of feel as if it should be sorted and you feel as if you're taking this antidepressant and it should be fine... (Paul)

... the doctor didn't think there was something wrong with me... I felt like I was just being a drain on my doctor. I was given antidepressants at one point, I think it was Prozac, and I was on those for about eighteen months or so. But I was never given a particular explanation of what they were to do with, other than they might help - have a side-effect of weight loss. I don't think that's a particularly good thing... (Rosey)

I left them on my top shelf for ages and I just didn't want to take them because I was a bit confused as why I; he's prescribed me that after like a really short chat, just me saying I was down and maybe at the time they were handing them out left right and center, I don't know. (George, UK)
Isn't that strange… I don't tell them [children] that I am taking antidepressants. I never have told them that I was diagnosed with depression. (Liza)

For me medication was a means to an end…but I wasn't going around shouting from the roof-tops…(Catherine). There is a stigma definitely attached to them... absolutely, I mean well of course there is you're doing something wrong if you're on antidepressants…(Steve)

I felt quite bad about taking them. It felt like kind of surrendering a bit… almost like having a criminal record…(Tony)

And I think I'm quite afraid of the thought of ever not having it, because I know how awful I feel if I stop taking it for a couple of days. I wish I didn't have to always go back and get those damn prescriptions. I wish I could just have the drugs - just hand them [over] - because each time I go back I think oh, maybe this time that doctor's going to fuss…(Charlotte)

They gave a bit of hope I didn't have any negative feelings about the drugs, I was very happy to take them because they were a straw to clutch at I guess. (Spencer)

I'm certainly not one of these people who thinks Oh God, some kind of poison in my body. It's like no, it makes me feel better… some people are diabetic, they take drugs, you know. And I know people say, “Oh, it's not the same”. But I'm afraid it bloody well is! (Matthew)

...the more people talk about antidepressants as a positive thing, the better it is that people don't end up, you know, people don't end up not taking something they need because of the stigma. (Layla)

I would like 100% take them [antidepressants] again… I'm not saying it's suitable for everyone but for me it is and so I'm not going to feel ashamed that I need them. Because like it's just an illness like anything else. (Lilly)

It was like being on really strong drugs… made your pupils dilate. (Peter)
I found it quite scary… I wasn't really ready for taking drugs of that strength. (Gary)

…it was amazing…within two hours I could feel different. (Christina)

I think between 24 and 48 hours I felt so different that I rang the doctor and I said, look do I have to go up to a full dose, because this is amazing. (George)

People call them like happy pills and stuff, you don't feel spaced out, drunk, stoned, whatever you want to call it. You just sort of feel yeah, this is the way life is supposed to be…(Matthew)

Actually I just don't see any bad in them other than potentially the stigma… you don't have to share it with the world, you can do it yourself, it's a tiny little pill that you take and nobody ever needs to know about it. (Sean)

I feared it was going to lead to drug addiction in a sense. (Gabriel) One of my friends was like “Oh well we've got to get you off them straight away,” and I sort of went “Well no because I've only just been on them and I need them for a bit,” …I think he was acting like I'd told him I'd got addicted or something…(Val)

[I did not take them] …she [doctor] said “they're not addictive anyway” but I was still scared. (Sasha)

I overdosed on everything I had, including Seroxat. I took all the rest of the tablets, [um] which, it turns out hasn't had any bad effect on me. (Nicola)

I think I might well be on this medication for life… They seem to suit me very well…. and for the next four and a half years from now I am quite safe. I can still continue taking that. But in five years time, do I have to go back [to the doctor] and sort of plead my case again? (Liza)

Zoloft, yeah, and I couldn't think and I took myself off it when [son] was about six months old and just went cold turkey. And I wouldn't recommend that. Never ever do that. [laughs] I had the
zapping - you get this zapping in your tongue… it was just awful. I had the shakes, I had dry mouth, it was just horrendous… (Catherine)

was full of anxiety around [um] becoming addicted to them… however they did help and they helped me to find what I would call the equilibrium… so my experience of kind of antidepressants have gone from kind of the very first ones that I got that were fantastic I lost weight but I would never want to take them again because I think they're now banned [um]…they messed with my mind. (Catherine)

Anyway, I can say, here we are, it is April, 29th 2010 and I am proudly still on one capsule of Lovan (fluoxetine). It gives me confidence, it is like a security blanket and I think it is fine… (Miho)

37 Simon et al. (2007)

For a long time I used every occasion as a reason and excuse for my problems and tried to live with it before I finally realized that I needed to look for some kind of treatment (male, age 33). I would have liked to know more about how to cope with a severe depression and how to continue with my life, but all my GP said was that I have to accept the fact that I am depressive. It took several weeks until I received more information in the hospital (female, age 48).

When I was told that in-patient treatment would be necessary all that came to my mind was that I would be completely isolated from the world outside. I could not think of anything positive a psychiatric hospital could have to offer (female, age 56)

I went to see my GP and said: I can’t go on anymore. I don’t know what to do. Please help me and do something (female, age 39).

I was not in a mood to feel anything or to be satisfied. Now I would say that the decision was alright but at that time I did not really care about what had happened (male, age 51).
And I like, I have to tell you that I like taking something that’s not Prozac or Zoloft; it’s just this thing that nobody knows about. I didn’t attach it to anything in particular… it’s just enigmatic enough that I wouldn’t… you know like if somebody looked in my medicine cabinet they wouldn’t know. Not like anybody would look in my medicine cabinet. (Celexa consumer)

author: What kind of antidepressant did they give you?

Helena: a serotonin reuptake inhibitor.

Helena: No, it was Celexa. Which is a European antidepressant and I had really good results.

And I wasn’t too keen on taking… I’d rather not take Prozac. Just because of all the stuff attached to that.

Helena: No, I wasn’t afraid of it, I just, you know if there were another one that could be effective that didn’t have this mystique about it.

Helena: He takes antidepressants.

Helena: It is very interesting how people … I was getting a prescription filled at the drug store and there were a lot of people there and there was this guy in front of me. And she said do you have any questions about taking Celexa and he said no. But I was like, hey he’s taking antidepressants, you know when you become aware of something it’s like …

You might not have known what Celexa was before you started taking it?

Helena: Right yeah right … and I like, I have to tell you that I like taking something that’s not Prozac or Zoloft; it’s just like this thing that nobody knows about. Helena: I didn’t attach it to anything in particular … it’s just enigmatic enough that I wouldn’t … you know like if somebody looked in my medicine cabinet they wouldn’t know. Not like anyone would look in my medicine cabinet.
Author: Did you discuss your decision about taking the antidepressants with anybody besides your doctor?

Mary: Um well, I think I talked about it with Annie, with my boyfriend, I think I just told my mom. I don’t think she really understood. I was just like, ‘well, this is what they’re doing’. I just sort of announced it. I was thinking tomorrow I’m supposed to be starting my Klonopin, that’s when I started Klonopin which is an anti-anxiety …

Mary: And it worked to help me fall asleep, temporarily …

Well I guess I questioned it first of all. And second of all I was seconded by my therapist. She said she believed the patient had a low grade depression for a while. And actually she had said that two years ago. Maybe a year prior to my going on the antidepressant. And I went to a psychiatrist and the psychiatrist said no you’re not depressed. So I knew that it wasn’t normal when I was questioning it and then through talking about it to her. And the resilience that I used to have wasn’t there. (Helena)

I didn’t like the word depression. I thought it was terrible. In my hyperliterary state I thought it was an awful word, you know, I preferred melancholy you know. Because that had more of a literary history too it, so I thought OK. But I was very resistant to the idea that what I had was clinical depression. So to me what I had was hypersensitivity to the side of life that … the dark side, the void, that life was just a painful experience. That’s what I had, I didn’t have depression. I didn’t really admit that I had depression for a few years. Even when I was in the hospital I wasn’t willing to admit that I was just one of many many people that suffered from this. (Thomas)

39 Stanners et al. (2014)
I started to get depressed because I couldn’t do the things that I was always doing. You know, looking after my family, cooking, things like that because I was told I had to get off my feet, I wasn’t allowed to walk… So my life sort of just, you know, from being a normal mother, wife and that, running around and doing my thing, to doing nothing at all. (Female aged 59, 10 chronic conditions)

Every day’s so hard, you know, to cope, well that’s with—the [morphine] pump’s good, but all it does is take the edge off, you still have severe, you still have severe pain. (Male aged 49, 7 chronic conditions)

I guess initially it sort of shocked me, because I thought that I wasn’t sort of in that category… (Male aged 65, 10 chronic conditions).

I’m very strong person, and I don’t allow myself, you know, to be how shall I say, overcome, you know, by emotions… Well, I was surprised. (Female aged 80, 8 chronic conditions)

See, on TV now there’s adverts about depression with young people, and that type of thing? So I haven’t felt like that, just maybe down for a little while”. (Female aged 61, 5 chronic conditions)

But because I know why I’m like that and I feel that it’s justified, I don’t think that I’m clinically depressed, do you know what I mean? Because I feel that my condition justifies my feelings”. (Female aged 75, 12 chronic conditions)

I had no reasons for being in this [state] (Male aged 62, 5 chronic conditions)

…here I go, I’m nutsville.’ And I didn’t agree with it. At first I fought the idea of being on antidepressants, but then realized I couldn’t cope the way I was going, and then went on antidepressants. . . . But at first I thought, oh no, here I go, I’m a nutcase, nobody’s going to take me seriously, and you know, it was embarrassing. (Female aged 48, 8 chronic conditions)
So there’s highs and lows, but I wouldn’t say, like, great depression. (Female aged 61, 5 chronic conditions).

The psychotherapy was helpful, unfortunately it doesn’t last forever. . . You get it off your chest. But as I said it doesn’t last forever. (Male aged 65, 10 chronic conditions)

I was pretty down on myself in all respects, and couldn’t understand how a tablet could take that away. (Male aged 62, 5 chronic conditions)

40 Stanton and Randal (2016)

And I suspect it was a thoroughly horrible situation for the psychiatrist as well. (DP 6)

I didn’t want to appear too assertive and too knowledgeable and too threatening. (DP 3)

The training keeps you away from a feeling state…allows you to stay even more in your head. You end up talking about brain biochemistry to your doctor which doesn’t fix the problem at all

I wasn’t listening to the cry of my heart, I wasn’t listening to my pain, I wasn’t listening to the truth I knew about what had happened and who I was.

The psychiatrist immediately made up his/her mind that it was clearly biological cause which I totally disagreed with and that was fine, let him/her talk and ramble on.

I’m actually not going back now, that’s me, I’ll just get your okay to increase my prescription and say, I’m just going to go now and I’ll go to my GP.

Doctors don’t want to know if their patients are angry with them. Doctors want to feel really good and helpful and wonderful.

I said I want another option. I have no bipolar disorder…I was very clear about it.

The psychiatrist just said ‘you’re depressed’ and started me on medication. It was just again that huge sense of relief that I just, I’m unwell and I’m doing something proper about it.
I went because I thought I was having a few problems. And [psychiatrist] told me I was depressed and that I needed antidepressants and I was devastated.

I just take it and I don’t give it much thought really. Except I know they keep me well and I don’t stop. I mean I realized very quickly that they worked. I didn’t want to be a doctor. I didn’t want to be a diagnosis. I didn’t want to be on medication. I wanted and needed to be me…as I learned to live with myself, then I kind of…this illness thing evaporated.

I’d never talked to anyone about it before in my life. I didn’t know you could, thinking back, I just didn’t know you could do that…

Not bound by ‘I’ve got to fill in my risk assessment documents and I’ve got to give you a diagnosis’. It just felt like, actually ‘I’m here and I’m listening to you and I’m going to do whatever I need to.’

I’m a doctor and I care about doctors, yeah, part of it’s about treating your own kind, like helping people in your own family.

Ranged from being extremely enjoyable, rewarding, interesting, worthwhile to being one of those things I had to do but wanted to get out of.

They’re either being good patients or being really difficult and foul and revolting.

It’s brilliant, I really love the fact that I’ve been depressed….It stinks as an illness but it’s a great extra dimension as a psychiatrist.

I feel really comfortable to talk about [taking time off work] because it’s part of my experience and I talk about how I push myself to work, even though I know probably that it would be better for me to take some time out…I find that easier really because there’s a bit of a connection yeah.
Van Geffen et al. (2011)

I felt very depressed and down. I was unable to settle down and do something. I started getting upset easily, even with my children. I felt fatigued and tense all the time; I didn’t have the energy. (patient 3, discontinuer)

For quite a while already I was suffering from anxiety and panic attacks. At some point it got out of control; I couldn’t suppress it any more. I was truly afraid of my fears and wasn’t looking forward to anything. Even opening the mailbox felt like it was too much to handle. (patient 13, continuer)

What I would usually get done in a day now took me three days. That, in turn, made me feel guilty, and even more depressed. It felt as if I had failed; I just couldn’t do it. (patient 15, continuer)

Until, at some point, you reach your limit, and then cross it. Just to avoid the constant thinking, the feeling of fear. That’s when I realised this is it, I have to stop this. (patient 13, continuer)

I didn’t believe it would work, as with the other antidepressant I hadn’t noticed any improvement either. I reluctantly went along; now it has become very clear to me that it actually works. I was truly surprised by its effect. (patient 10, continuer)

I started getting specific symptoms that I recognised from before. It didn’t seem like a good idea to let it get much worse, so I went back to our GP. Having used it before definitely helped; it makes it easier to explain certain side effects you might experience. You know it will all be just fine, if you give it some time. (patient 16, continuer)

I had used paroxetine before, several years ago. That had made me feel so much better. This time I again felt weird and awful, so I went to our GP. He said that since I had experience with using this medication, and it went well before, I got it again this time. (patient 17, continuer)
I’m not the kind of person that takes a lot of medication, but if I have to, I will. Our GP is knowledgeable, and he recommends this to me, so I will take it. (patient 11, continuer)

He told me “This is better for you,” so then I went ahead and started using it. Not really a conscious decision. You don’t really know why, or for how long; you don’t really know anything. (patient 3, discontinuer)

I did know a bit about antidepressants and I definitely didn’t want any of that. The doctor suggested it to me three times, and all three times I pushed it off. Eventually, when the situation got quite desperate, I gave in. (patient 7, discontinuer) My GP explained that your brain produces certain chemicals that have to be in balance. That balance may be what I’m missing. If this pill makes me get my balance back then I would sell myself short if I don’t take it, according to him. (patient 8, discontinuer)

The doctor had first prescribed a “Benzo,” but that made me feel quite groggy. There had to be a better alternative. That’s when I read about Prozac, and brought it up myself. I felt the doctor was taking me seriously. (patient 13, continuer) I don’t have a problem with it and don’t feel weird about this kind of medication. Obviously I’d rather be healthy without medication, but if you can’t live without then you have to take them. If the medication was bad then the GP wouldn’t have prescribed it to me. (patient 17, continuer)

To me it’s quite simple: a person with heart problems takes heart medication, so if there’s a short-circuit in your brain which causes you to have too little serotonin, then you take fluoxetine. (patient 13, continuer)

I actually wanted to fix it myself. If you can resolve it without medication then you’re part of the regular people, but now I no longer belong to that group. Taking medication means admitting failure. (patient 10, continuer) To me, cholesterol reducers are something different; that you can’t
really do anything about. In this you can’t really either, but still … it’s something that’s in your brain. That’s what makes it difficult for me to take medication. (patient 3, discontinuer)

I’m afraid to get labeled unstable. You generally get told to just get off you’re a[…] and do something about it, then it will be just fine. (patient 12, continuer)

You can get dependent on SSRIs. When you stop using it the depression can return even worse. I believe you should use an antidepressant only temporarily. (patient 7, discontinuer)

I always want to maintain control over my own life, but the medication dominates. The problem doesn’t get treated. You become depressed for various reasons, and you have to do something about it. (patient 7, discontinuer)

I was actually quite relieved when I got the medication. You are really sick and you’re not just pretending. Your behavior is no longer strange; it’s okay now. If you have a broken leg, then everyone accepts that you can’t move around. But if they can’t tell what your problem is, then you’re just weak, lazy, or egocentric, then you’re just not right. (patient 10, continuer)

I kept insisting it wasn’t a depression I was feeling, and I still don’t like it. (patient 12, continuer)

I was glad this guy on the radio explained it this way, that when you’re depressed your brain has too little of a certain chemical. I had heard that before and realise there are contradicting theories. But now it’s quite convenient for me to believe this particular one. (patient 10, continuer) For me it’s quite difficult to take medication for this. That’s because I don’t know what exactly I’m using it for. Perhaps if they had told me there’s a certain chemical that my body doesn’t produce by itself, then I’d be okay with it. (patient 3, discontinuer) The GP told me that the medication can take a little while to work, and what side effects might occur. He also said that I have to use it for at least six months, plus that I can’t quit all of a sudden, but rather reduce the dose over time. (patient 11, continuer) The doctor didn’t discuss any side effects. That’s what I had
indicated, because when they tell you, then you’ll probably get them. I don’t ask any questions, I
don’t need to know everything. (patient 18, continuer)

I don’t remember what the GP said. From the conversation I had with him I only remember how
it made me feel at the time. (patient 12, continuer)

I was told by the GP that in the beginning I might feel rushed. I’m glad I learned about that,
because I did suffer from that in the beginning. So when that happened I knew it was part of the
process and would soon pass. (patient 3, discontinuer)

When I started with this medication, I didn’t receive any information whatsoever, not even about
side effects. They did tell me in passing that it could take a while before I would notice the
intended effect. The doctors should be much keener about this. It would be so easy to just give
the main messages, and refer to the information leaflet for more information. When I asked my
doctor whether this medication has any side effects, he just grabbed a big book and said “If you
like I can read them for you.” (patient 6, discontinuer)

The first time the GP said it’s not addictive. I had reduced the dose over time, but yet from the
way I was walking it seemed like I was drunk. I had a headache all the time. I believe it actually
is addictive. The doctors better stop telling that story. (patient 16, continuer) My GP had
consulted the gynaecologist and said there appeared to be something wrong with my hormone
balance. I trusted him. I didn’t know then that it was an antidepressant until later when I read the
information leaflet. If a doctor can’t explain why you need it, then you won’t accept the
medication as easily either. (patient 3, discontinuer)

The first four weeks were really difficult. You don’t feel too great to start with, and on top of that
these side effects. The stomach aches were the worst part. I couldn’t keep any food down, just
tea I was able to manage. I was shaking a lot, felt nervous and restless. I had the feeling there
was so much I was supposed to be doing, but I didn’t have the energy to get to it. (patient 12, continuer)

I was rather apathetic. Temporarily, perhaps that’s a good thing, but not over a long period of time. I no longer had the energy to take any initiative; it seemed as if I lived in a bell jar. (patient 7, discontinuer)

I’m a lot less tense now, and more relaxed. I can take setbacks a lot better, and don’t let things get to me as much. I enjoy moving around and started picking up basic things like making coffee. The household is back in operation. (patient 10, continuer)

I no longer have panic attacks, and I’m not as scared. I’m noticing that the negative feelings are diminishing. I am more open now to positive aspects, which helps me focus on my inner self. (patient 16, continuer)

My emotions in general are more subdued. Some things I don’t care about any more; I’ve become more egocentric. (patient 10, continuer)

My head feels calmer now; it’s not churning thoughts as much any more. It doesn’t feel as heavy, though it’s not stable yet. I still have days of much doubt, of not being my true self. (patient 15, continuer)

I received a medication that didn’t do anything; the situation got worse. I kept sliding down further and further. (patient 6, discontinuer) My disease is a so-called “self-finishing process.” I feel better now, but I don’t know if it’s thanks to the medication or just because of time passing. If you don’t take anything, you’ll also get better. I started biking again; that may have actually helped me more than the Efexor. (patient 6, discontinuer)

My relationship with our GP is really good. He is always willing to listen to my side of the story. He understands my situation; I think that’s important. (patient 16, continuer)
My previous doctors never really counseled me. They just wrote out a prescription, opened a drawer, and before I knew it I was back outside. My current doctor is willing to admit he doesn’t know everything. He’s just trying to get things started again. He explains everything, and I feel comfortable discussing my doubts with him. (patient 6, discontinuer)

[SSRI]: The first four weeks I felt really lousy: heart palpitations, perspiring often, ear drums closing, and headaches. It was as if I was having a heart attack. I called the doctor at least six times because I thought it wasn’t normal. The doctor kept telling me that these were common side effects, that I had just had to bite the bullet. I thought that was quite limited. (patient 7, discontinuer)

I did tell my GP about the bruising, but he wasn’t too concerned. It’s not about craving for attention, or making up stories; it just worries me. (patient 10, continuer)

I’ve discussed the medication with my GP, a psychologist, and a psychiatrist. They each have a different opinion, that’s annoying. I was always told to avoid alcohol when taking an antidepressant. Then the psychiatrist told me: sure, that’s what we’re saying, but in principle there’s no such correlation. (patient 7, discontinuer)

Some people probably think it’s crazy that I’m taking this medication. Only my family knows, and my friend. I use it and it helps me, and I don’t care what anyone else says. (patient 17, continuer)

My family knows I use medication, but what for they don’t know. I believe they think it’s just some relaxation pills, nothing more. I’d rather not tell anyone. I’m afraid to get labeled mentally unsound, and not being able to get rid of it. When I get back to work I want to have all of my job’s responsibilities; no special treatments because of what happened to me. (patient 12, continuer)
When I talk about it with other people they’re often wondering if taking this kind of medication is a wise thing to do. You hear a lot of negative stories about these medicines. That’s a shame because I’m sure there are people who benefit from it. (patient 7, discontinuer)

My wife thinks this medication is scary since it’s affecting your brain. That doesn’t bother me. The list of side effects on the information leaflet was quite shocking to her. So we talked about it, and then asked our GP if I could stop using it. I am doing okay now, but the deepest fears haven’t gone away yet. (patient 1, discontinuer)

In my case the benefits outweigh the downsides, as far as I can tell. Obviously, I’m worried about the bruising and the muscle aches; what does that mean about what’s happening in your body? Perhaps if I knew more about that I would decide to quit. But I had thought long and hard on whether I should start with it, so you don’t quit just like that. After all, my quality of life did improve (patient 10, continuer)

The weather was fine, and I was doing okay. I was tired of being dependent on medication any longer, so I just quit. I thought I could do without; others also can. (patient 3, discontinuer)

I don’t believe I could do without my medication yet. I’m still feeling too unstable. Once I can quit I will do so, but I’m afraid I’ll slide back to my previous conditions. I update the GP on how I feel and leave the decision when to quit to him. After all, he’s the expert. (patient 11, continuer)

I don’t want to take any pills if it’s not absolutely necessary. I had called the doctor to start reducing the dose. I thought, if I don’t speak up, a year from now I would still be taking these pills. But he thought it was too soon, so I’ll continue for a little while longer, which is fine. (patient 15, continuer). I felt much better and was not sure whether this was due to the fact that I started dancing and sporting again, or due to the medicine. That’s what I wanted to find out, and that’s why I stopped taking the medicine. (patient 6, discontinuer)
I’d like to try quitting one more time. If I still get the symptoms back even after this third time, then I’ll accept that I just have to take this pill. Then it would no longer bother me. (patient 8, discontinuer) To me, quitting was a very positive experience. I did suffer from side effects, but with every day I felt I was becoming more “me.” I felt a boost in energy and started picking up activities. I do worry about the depression returning, knowing that I quit too soon. However, I would never take an antidepressant again. The cure is worse than the disease! (patient 7, discontinuer)

He just couldn’t go on any longer. So he started again; he has arranged it all himself. He just knows by now that it’s better for him to take this medicine. (patient 3, discontinuer)

I felt that I was more held back than that there was a connection to what I was experiencing. So the treatment method was leading more than I was. It was also really the method that didn't work for me. (ID26)

Everybody was in the same process and at the same courses… I think it was primarily the people who were taking a lot of antipsychotic medication, and were sometimes suddenly screaming loudly or demanding a lot of attention, and were physically very slow at the time that we were doing an activity, interfering more than that they were able to participate. I sometimes found that horrible, I really had trouble with that. (ID28)

The lack of a framework has a very negative impact: what are you working on, where are you headed, how long will it take? If I know what his or her perspective is, I can speak more easily. Then I know what's being measured, and in what direction someone wants to take me. It also has to be clear, I really missed that. You see, of course there is an end. At a certain moment you'll be
discharged. And that doesn't mean that you'll be 100% recovered and healthy, but it's nice to know that in advance.’ (ID23)

There must be a plan, a beginning and an end, and you have to have goals. I found that lacking very much. … What you were working towards and what you wanted. (ID4)

Because then if I went into therapy, very frequently I had to go through my whole childhood, family, and work, whereas that's not where the problem was. It lay primarily with the way I was thinking and incorrectly reacting to situations. You don't solve that directly by discussing your marriage, parents, or childhood, that in fact had nothing to do with it. (ID4)

Then I was referred to a psychologist for [therapy] sessions. And I thought, I'd also find medication perfectly fine. But I thought, they'll know… I would have preferred to think along and be involved in the decision-making. … So, we weren't making any progress, we were only talking about my past and meanwhile I was not recovering from my depression. … I experienced several times that in hindsight I thought: why are we doing it this way? (ID19)

If, for example, every psychiatrist would tell a client: we're going to work together for four sessions, and after those four sessions, you can say whether you think it's working or not. I've never experienced a psychiatrist who evaluates. (ID15)

The only reason why I am on medication now, is because friends and family have given me incredible support with this. Otherwise I wouldn't have taken pills. Thirty minutes with my psychiatrist was not enough to convince me. He didn't take enough time for that. I had a very serious fear that was not being recognised. And it was also not taken seriously. And that has a very large influence on adherence. (ID11)

I don't think that the confidence was really there to just talk about myself over there. It's just very important that there is a click in order to move forward together. (ID16)
Hope is incredibly important. That always has been a tremendously important basis for me. Therapists who have the balls to say that everything will be all right: that requires courage. Because there are also therapists who do not dare to say that, because they don't know whether that's true and they think it's not right to say it then. (ID20)

‘I had a very good psychiatrist, but then I couldn't go to him anymore and I had to go to someone else. And then you feel you need to start all over again. (ID2)

What doesn't work: someone who doesn't take you seriously. He wasn't warm, he didn't show any compassion…. Apparently I felt ‘you're not going to help me’. No, I didn't even start with him.’ (ID20)

There has to be a good mix between a professional attitude and not too much distance, And also not someone who sits across from or next to me and will continuously say ‘oh yeah, that's horrible’… yes, who will only commiserate. So also there will have to be a balance actually. That I have someone who confronts me with things, but where I also feel, whenever there is a confrontation, that he understands me.’ (ID9)

You also feel very dependent. I actually felt growing smaller and smaller during that conversation. I absolutely did not have a good feeling then. (ID16)

‘I would rather have someone who knows better than I do. That's what you need. There are certain phases where you really need to be told what to do. If that doesn't happen then, that works badly.’ (ID23)

‘A three month-waiting list! And one week afterwards I attempted suicide. Exactly because you're going there to ask for help because you can't deal with it anymore.’ (ID21)

What can be worse for someone with a depression than to be abandoned? I attempted suicide, amongst others because I could not get a hold of my therapist… who was just not available. Then
I thought now I'm done…. What I really find heart-warming, I now have an agreement with my psychiatrist: ‘I will never call you. And if I call you, all alarms are on red. Then I want you to directly intervene, to put me on medication, and to set me up with a specialist.’ That kind of agreements has a very high value for me. (ID20) At a certain point you're not sure who your primary contact person is. I also found that to be something very difficult. I never had the feeling that there was one person who I could always contact. (ID28)

You end therapy and after a while, you relapse again. Aftercare, that was not available. I think that it's better if you follow-up on people, that you let them return every month or every two months, and that you just go through those check-lists, like how is this going, how is that going, how is the other thing going? Because that's my experience, you yourself do not ring an alarm bell. Because you're already so fed up and you're ashamed that you failed again, and then you think, tomorrow things will be better again. (ID4)

To involve the significant other is important, not in the least for the significant other him/herself. Also that attention be paid to the possibilities of the partner to be supportive or to need support themselves. That should be part of treatment, as at least for me, one of the success factors has been my system. (ID20)

Vargas et al. 2015

Certain conclusions on the rationale and various misconceptions could be drawn upon accounts of participants’ of Vargas et al.’s study. Many individuals concluded, their depression can be treated by medication as such “helps to regularize the nerves (ayuda a regularizar los nervios).” Labeling occurred because of their depression: Close associates, such as relatives, friends, or acquaintances, viewed participants’ depression as a sign of personal weakness or lack of drive to
feel better, as if, ‘one wanted to feel depressed… but general opinions are that ‘with just a little extra effort, one can get out of it.’

Other people viewed depression as something which ‘does not exist, something that you cause yourself,’ through excessive investment in your own dilemmas (“believing in your own crap”), dwelling on problems, attending too strongly to negative circumstances, or apathy about negative emotive states (“you let yourself fall and let it happen”).

A female participant (María) explained that her family and friends believe, depressed people need to ‘put forth effort (poner de su parte), because depression is not an illness and the symptoms can be cured by oneself putting forth effort and going to church.’

Another woman (Silvia) described her depressive symptoms as chronic, but with her strong will (fuerza de voluntad) she had prevailed, however recently, she is no longer able to manage it herself. She used to have a quite healthy attitude and learned to disregard many issues by not paying attention until her mind started feeling changed.

Diego described his father’s negative attitude toward antidepressants. The man was not accepting of his son’s drug therapy and claimed he can get better on his own, but it was much harder for his son to manage depressive symptoms without the medication.

Gabriela described her preference for natural medicine, like tea, but explained how it did not address her mental health needs: she had always liked natural medicine, but finally came to realization that natural remedies are not strong enough to help her condition; indicating that her depression was too severe for alternate treatments.

One participant expressed her frustration at not being well informed about the diagnosis: (“so far they haven’t told me what class of depression I have”). “My psychiatrist would give me tests
similar to this one and I never knew what came of those tests.” He eventually dropped out of that treatment.

Many participants described delaying psychiatric treatment by trying first to “keep fighting with my problems and control myself.”

Pamela explained why she avoided treatment in the past: “I thought … I am going to take medicine and my nerves are going to become unwell (voy a estar mala de los nervios), I will have to start seeing a psychiatrist—the psychiatrist is for crazy people.”

Daniela stated that her family thought antidepressants could also precipitate the onset of madness. Seeing a psychiatrist could be construed as a pathway to madness.

Miguel explained how seeing a psychiatrist could yield further stigmatization: “[People say about a depressed person] that he is crazy … And if he sees a psychiatrist or something, they say, no, that one really becomes crazier every day. Because psychiatrists, they say … make people crazy.”

Ricardo explained this difficulty: “It took a lot from me to come [to the clinic] because of all the myths, the negative aspects … [attributed to] a person with depression … who sees a psychiatrist.”

Most sought help only when completely unable to cope: “If I were to find a solution … I would not look for help. But … this is overtaking me [me está rebasando]. And each time it’s … more so.”

Gabriela explained that she stopped going to a previous treatment because she at that point “thought I could … help myself without needing the medication.”

Other concerns with bodily effects included fluctuations in weight, sleeping habits, sexual function, dizziness, and “the way medications can alter one’s brain.”
Elena described, “if … they need to remove my liver because I have hepatitis as a result of the medications, my depression will get worse, it will get stronger.”

Margarita said she worried over feeling “abobada” (befuddled) as a result of taking the medication, and that “other people could do with me whatever they want, that I would not be aware of what was happening.”

If I stop taking it … you can feel more down, more depressed, a greater sense of guilt or a desire to kill yourself … if I don’t feel that way now, and by ceasing medication treatment I’d feel that way, well then I say things are just going to get worse.

Using medication for a long time would mean relying entirely on the pill to feel well. And in the public opinion, the pills should only be used for a limited time to help the person return to their normal state. A woman (Carolina) said, she heard that if you take antidepressants every day, they are addictive. But she put trust in her doctor’s professional judgement: “If the doctor says you must take it, you must take it. He will know when to stop it.” And Carmen explained, “If I go to the gym, I feel better as well, but right now I feel so impotent, so bad, that I can’t find the way to go exercise.” Elena explained that while others thought visiting a psychiatrist was “a thing crazy people do (cosa de loco),” she thought treatment was meant “to help everyone, crazy people and those who are not crazy.”

Vilhelmson, Svensson and Meeuwisse 2013

Woman (63) believed that her ‘so-called depression’ was a normal reaction to a distress that resulted from separation, homelessness, loss of two jobs within three years, and death in the family.

Woman, (41) sought help because she felt exhausted. Other symptoms she was experiencing were insomnia and cognitive impairment so she had to stop working. The doctor diagnosed her
with depression, but she refused to accept the diagnosis. She did not feel depressed, just tired and sad about her terrible life situation. But the physician insisted that all her symptoms of chronic fatigue were signs of depression. Woman (34) experienced a very severe, lonely, and anxious, but not a violent childhood and as an adult she suffered from frequent and deep periods of apathy and depression. Her memory was also impaired. Woman (50) felt ill after surviving her second breast cancer and was offered psychiatric help. She believed it would be useful to talk to someone, but after twenty minutes during the first consultation, she was offered ‘happy pills’ and she got very disappointed. Woman (36) refused taking pills and shared her reservations with the physician. In place of Seroxat (Paroxetine) she was willing to take Valium (Diazepam) however, her doctor wanted her to continue the antidepressant and recommended understanding the treatment as a ‘vitamin boost’. Woman (38) had doubts about the root cause of her depression being a chemical imbalance in the brain. Woman (38) was aware of her low levels of serotonin and she was suggested taking Cipramil (Citalopram) for the rest of her life. Woman (38) believed that the reason behind so many prescriptions for antidepressant medications might be the drugs being the only help doctors can offer, thus patients’ rejection of this help causes doctors’ frustration.

Woman (22): all she wanted was someone to talk to, some sort of conversational therapy.

Woman (42): The first doctor she visited, barely looked at her when she described her symptoms.

Woman (49) believes to be lucky of having an ongoing contact with psychiatrists with solid knowledge of the field who order laboratory tests to ensure that the right medicine is prescribed.

Woman (26): After a couple of months of being on sick leave due to severe burnout, the doctor
decided to issue an ultimatum: either the patient started treatment with an antidepressant (Fluoxetine) or he would not continue signing her sick-leave.

Woman (34) refused taking the antidepressant despite threats of ending her sick-leave. Doctor’s conclusion was that patient did not want to get better and was avoiding work.

Man (56): While the patient continued antidepressant treatment, no follow-up consultation took place. Woman (41): after she decided to end her antidepressant treatment, her physician had been ‘malicious and unpleasant and very unprofessional in his attitude’ towards her.
Experience of psychotic mania suspected to have been induced by the tricyclic antidepressant, dosulepin. I describe, as a first-person narrative, my own experience of psychotic mania, which was suspected to have been induced by the tricyclic antidepressant, dosulepin. I have had a 16-year history of depression and was receiving sertraline 50 mg when I was prescribed, off licence, dosulepin 25 mg for insomnia. Within days, I developed mild hypomanic symptoms and returned to my GP, who discontinued dosulepin but continued treatment with sertraline. I was also referred for psychiatric assessment. Two months later, I was detained under Section II of the Mental Health Act 1983 and admitted to hospital with psychotic manic symptoms. I was admitted, at the age of 36 years, to a mental health centre in February 2009 with psychotic manic symptoms, including thought disorder, persistent psychomotor agitation, pressure of speech and visual, auditory, and olfactory hallucinations. At the time, I was receiving sertraline 50 mg, which had been prescribed to me by my GP. I had no personal or family history of bipolar disorder, although my maternal grandmother had been diagnosed with postnatal affective disorder, and later, with schizophrenia. I had first been treated for depression with dosulepin 75 mg between March 1993 and April 1997. Since then, I had been treated with antidepressants intermittently, namely fluoxetine 20 mg and sertraline 50–100 mg. I had been treated mainly by my GP, although I had been assessed by a psychiatrist in June 2004, who, in view of the chronic nature of my recurrent depressive disorder, deemed it appropriate for me to receive long-term maintenance antidepressant medication.

On 19 November 2008, a locum GP prescribed me, off-label, dosulepin 25 mg 1–2 nocte, to help treat insomnia. The insomnia had been caused by work-related stress from a demanding job as a medical writer. I was already receiving sertraline 50 mg at the time. On 6 December 2008, I returned to my GP surgery with self-reported mild hypomanic symptoms. My insomnia had worsened and I had lost half a stone in weight through lack of appetite. In contrast, I had excelled at my work, exceeding my sales target by 200% and I had received an e-mail of commendation from the company’s Vice President. However, my husband had urged me to see my GP. He had described my behaviour as ‘hyperactive’ and ‘out of character’. I stopped taking dosulepin, but continued on sertraline 50 mg on my GP’s direction. My hypomanic symptoms subsided during the first few days following discontinuation of dosulepin. I reported my side effect on the Yellow Card Scheme and also requested referral to a psychiatrist for assessment as I feared I may have bipolar disorder. I hoped, however, that the experience was merely a disturbing, yet temporary drug side effect and I resumed my life as normal.

Prodromal phase

In early February 2009, I was under considerable stress. My husband was away and I was looking after my three-year-old son alone. I was also due to visit a particularly demanding client. I took Friday, 6 February 2009 off work as a holiday as I was feeling tired and knew that I needed rest. By midday, I phoned a friend sobbing in an inexplicable panic. A few hours later, my friend came with me to see my GP. I could not access my usual GP but the doctor I did see prescribed me a short course of zopiclone 7.5 mg and suggested that I see my usual GP the
following week. My friend called round other friends, who then worked as a tag team so that someone was with me the entire weekend until my husband returned home. My symptoms meanwhile worsened rapidly.
The next day I was thought disordered and delusional, believing myself to be a tortured genius. My delusion of grandiosity was that I had concealed my true intellect even from myself in an effort not to be considered a freak. Feeling alone, I tried to contact the cleverest people I knew but no one could understand what I was saying. I also regressed, reliving my difficult childhood, which had involved bullying and childhood abuse.

Acute psychosis
On Monday, 9 February 2009, my husband returned home and took me, in a terrified state, to see my usual GP for an emergency appointment. I told her that: “I'm not a risk to myself or others but I'm in so much pain I don't know whether I'm alive or dead.” I could not understand her reply. I had finally been overwhelmed by the psychosis. She prescribed diazepam 5 mg 1–2 nocte and trifluoperazine 1 mg 1–2 tds. I spent the night at home, awake and with vivid hallucinations. I thought I heard my husband kill my son. I heard my son crying and the imaginary sound of my husband hitting him but my body was paralysed. I believed my doctor must have told my husband that to save me he must re-enact what my father had done to me.
The following morning, I thought I was dead and that everyone around me was trying to bring me back to life. My metaphor at the time for death was ‘to leave the room’ – I raved continually about wanting ‘to leave the room’. I thought that people were challenging my decision to die by showing me that I had reason to live. My mother-in-law arrived at my home and I thought her challenge to me was her age – I was younger than her and therefore too young to die.
My husband again took me to see my GP who recommended that I be detained under Section II of the Mental Health Act 1983 due to acute psychotic presentation with thought disorder, anxiety, pacing, inability to settle, pressure of speech, flight of ideas and visual, auditory and olfactory hallucinations. I was taken from the GP surgery to the local Community Mental Health Team. As the healthcare professionals poured in the room to assess me, I tried to work out how each one of them was challenging me to live. One of the nurses was overweight and I thought his challenge to me was that I was too slim to die. To explain this, I lifted up my top to show that I was not in fact so very thin and could therefore die. The assessing psychiatrist quickly exclaimed “she's disinhibited” and noted on my acute care screening form that I had exposed myself and was exhibiting sexually inappropriate behaviour.
I was administered rapid tranquilization in the form of lorazepam 2 mg and olanzapine 10 mg, before being taken by ambulance to a mental health centre in a nearby town under Section II of the Mental Health Act 1983. I was assessed on admission and prescribed olanzapine 10 mg nocte. Sertraline 50 mg was discontinued. I was also prescribed 1–2 mg lorazepam prn (maximum 4 mg) for agitation. Admission laboratory tests were performed, the results of which were all normal.

Recovery
My recovery was rapid and the next day I was able to communicate my distress. I wrote: “This is how I can explain it to you at present. It hurt so much to be alive that I thought that I might as well be dead. When that happened, the boundaries between life and death became blurred. When that happened I got so scared that the only way I could feel comforted was to take refuge in madness. When I did it didn't hurt so much. But it appears that I might be ready to wake up now. It is not that I don't like being in here. I do feel safe but also very bored. Partly this
is because the people round here seem to have two topics of conversation: 1: their meds; 2: moaning about nurses – usually because they want them to give them more meds! I am not sure why that would possibly want more meds because if I ever saw another pill again I would want to stamp on it! Anyway, that's not the only reason. I want to feel alive again so I want to go back to my normal life. By normal, I mean before the breakdown. The breakdown was horrific for me. If I die and go to hell now I won't mind because I can't see any way that anyone could make a worse hell for me than the one I made for myself. So if I ever die and find myself in such a place as hell, I will track the devil down and laugh: "Is this really the best you can do?" So I am not even scared of the devil now. I therefore feel ready to join my friends and family. I don't want to hurt them so I put my complete trust in you to decide what is best for me. But like a child who is going on holiday but the journey there seems to be very long, I shall say to you continuously: “Am I ready to leave here now?"

A pivotal moment in my recovery came during a session in the hospital gym. While I was on the treadmill, my perception of time suddenly coincided with the time on the treadmill screen. Until that moment, time as I perceived it bore no resemblance to what it said on the clock and I could not tell the staff and the patients apart. Coming out of the psychosis, my initial feeling was of euphoria. I thought even the devil could not create a worse hell than the one that I had created for myself.

I was transferred to a mental health hospital nearer to where I live as a bed there had become available. I pleaded with my psychiatrist to allow me to leave the hospital and go home. On 17 February 2009, I returned home, for a week's leave, after which my section was rescinded. I received four doses of lorazepam 1 mg during my week's stay in hospital. I made several escape attempts during my stay when not under sedation with both olanzapine and lorazepam and was apparently difficult for the staff to manage.

I switched from olanzapine 10 mg to aripiprazole 15 mg due to poor tolerability to olanzapine. The aripiprazole dosage was later reduced to 10 mg then to 5 mg. Following discharge from hospital I also received citalopram 20 mg for depression. This was replaced by fluoxetine 20 mg due to my own preference and perceived lack of efficacy of citalopram. My consultant tapered me off the antidepressant, fluoxetine, and, two months later, I was able to discontinue the mood stabiliser as well. This was done in parallel with psychoeducation in the form of cognitive behavioural therapy-based group therapy. In addition, I am currently receiving psychotherapy and continue to receive monitoring by my consultant psychiatrist.

Since my illness and subsequent hospital admission, I have not felt able to resume my career as a medical writer. I have, however, been working part-time as first as a shop assistant and then as an editorial assistant for a medical publisher.

Conclusions
My patient history, in particular, the speed of my recovery, which was coincident with the discontinuation of antidepressant treatment, is consistent with the hypothesis of mania as a side effect of antidepressant treatment. Only a diagnosis of suspected antidepressant-induced switch to mania could be made in my case, however. The first reason for doubt was that the dose of dosulepin that prompted my initial, hypomanic episode was low. Even in combination with sertraline 50 mg od, raised serotonin levels seem an unlikely explanation for the switch considering that I had received sertraline at 100 mg od before and had experienced no hypomanic or manic symptoms. The second confounding factor was the time delay between me discontinuing dosulepin and the onset of psychotic manic symptoms.
However, TCAs are known to be associated with a higher risk of switch to mania than non-TCA antidepressants. (Peet, 1994, Boerlin et al., 1998, Gijsman et al., 2004, Haussmann et al., 2007, Truman et al., 2007, Mundo et al., 2006, Salvi et al., 2008, Goodwin, 2009, Koszewska & Rybakowski, 2009 and Sorvaniemi, 2009). It has been hypothesized that the higher frequency of TCA-induced mood conversions may, in part, be accounted for by anticholinergic activity (Koszewska and Rybakowski, 2009).

Since I had taken dosulepin before as monotherapy with no ill effects, the possibility of a drug–drug interaction with sertraline cannot be ruled out. One case study of antidepressant-associated mania reported possible switch due to complex drug interactions during a shift from fluoxetine to mirtazapine (Liu et al., 2009). However, in contrast to my own case, the patient’s pre-morbid characters and clinical presentations suggested an implicit bipolarity that pre-disposed her to a manic switch. These included ‘mixed’ features of depression, that is, irritable mood and psychomotor agitation.

Patients with bipolar disorder often spend more time experiencing depression than mania, which means that bipolar disorder may be incorrectly diagnosed as unipolar depression (Nierenberg, 2009). If depression in bipolar disorder is misdiagnosed as unipolar depression, the likelihood of treatment with antidepressants alone and the incumbent risk of treatment-associated switch to mania increases (Thase, 2006). In an European College of Neuropsychopharmacology (ECNP) consensus meeting in Nice, France, in March 2007, the risk that unipolar patients ultimately turn out as bipolar disorder in the longer run was estimated at >10% (Goodwin et al., 2008). However, in my case, due to the almost immediate onset of hypomanic symptoms associated with the prescription of dosulepin at the age of 36, antidepressant-induced mania seems more likely than a missed diagnosis of bipolar disorder.

Risk factors for antidepressant-induced switch to mania in unipolar depression are poorly characterized. Predictors of subsequent bipolarity in people with depression may include: history of psychosis, family history of bipolar disorder, psychotic features and reverse neurovegetative features (Goldberg et al., 2001, Thase, 2006 and Wada et al., 2006). None of these applied in my case; however, as more investigation needs to be done to identify risk factors for antidepressant-induced switch to mania, it may be that I had some unidentified risk factor. One possible risk factor may have been having a history of childhood abuse (Janssen et al., 2004). Increased exposure to antidepressant trials has been identified to increase the risk of manic switch (Goldberg and Truman, 2003). I had been exposed to different antidepressants for 16 years and this too could have pre-disposed me to antidepressant-induced mania.

My treatment with fluoxetine plus an antipsychotic, aripiprazole, and the decision to discontinue the antidepressant after successful treatment of my depressive episode is in accordance with current guidelines for the treatment of depression in bipolar disorder (National Institute for Health and Clinical Excellence, 2006 and Goodwin, 2009). The decision to discontinue the mood stabiliser in my case was more difficult given that one manic episode is a strong predictor for subsequent episodes in bipolar disorder. The rate of relapse of hypomania or mania in patients with antidepressant-induced switch to mania is unknown, which means there is little to guide the physician on long-term treatment for such patients. However, the idea that exposure to an antidepressant could cause permanent damage (the scar hypothesis) contradicts the increasing appreciation of the plasticity of the central nervous system and its ability to repair. It will be interesting to follow my patient journey now that I have discontinued medication. If I experience
no relapse of mania, this would be in keeping with the side-effect hypothesis of antidepressant-induced switch to mania rather than the ignition or alternative hypotheses.

I believe my case of suspected antidepressant-induced mania strengthens the need for further investigation of this phenomenon in unipolar depression. I hope that this article also offers some insight into the patient’s experience of psychosis. Clinicians need to realise that patients with psychosis may try to communicate through seemingly random actions or through metaphors, such as my repeatedly expressed desire ‘to leave the room’ and these need to be dealt with sensitively.

I believe my case study highlights the need for prompt specialist treatment for patients with sub-threshold hypomanic symptoms. In a study of clinical outcome in almost 600 patients with recurrent major depressive disorder and no family history of bipolar disorder, 9.6% had a lifetime history of sub-threshold manic symptoms similar to those that I experienced while on the dosulepin/sertraline combination treatment (Smith et al., 2009). Sub-threshold manic symptoms in this study were associated with a more morbid long-term clinical course, including a higher likelihood of psychosis and hospital admission. My case study is also cautionary against the use of multiple antidepressants. Finally, my case underscores the important role of the GP in the early detection of antidepressant-induced mania.

2 Anderson and Roy, 2013

Attitudes to taking antidepressants
I actually didn’t have an ideological or philosophical position about medication. For me medication was a means to an end. (Catherine, 39)

Although people frequently argued that it was no different to taking medicines for other health conditions, such as using insulin for diabetes, others reflected on the way antidepressants are considered to be in a different class to other medicines: I don't put my hands up in horror with psychiatric drugs...there's a lot of people turning against them...they wouldn't have the same attitude towards insulin or other drugs that were lifesaving. (Jean, 71)

I think taking medication is something I really struggled with because I didn't want to take it. I didn't want to—you know I thought I could just get better on my own. (Nicole, 27)

I obviously knew that there was antidepressants available but they've kind of got a stigma and I was worried that I didn't want anything I could get addicted to. (Maggie, 44)

I resisted taking antidepressants because I saw it as a sign of weakness that proved that something's wrong and a lot of people don't like to admit that something's wrong”. I feel that men are particularly inclined to see using antidepressants in this way. And I feel that the stigma around taking antidepressants is unjustified.

I feared that antidepressants might mask my problems but not actually resolve it, and I believe that people should manage it themselves, free of medicines, rather than ‘papering over the cracks’. (Ellie, 30)

Information
In the past, it was difficult for people to find information about the medicine they were prescribed, but these days the internet is routinely used by people to look up health information. I routinely use the internet to find information, including about different types of antidepressants and side effects, as well as to find out about others’ experiences with them. Years ago I kind of just accepted what I was given and didn't really ask any questions but now I know to kind of do research on the internet and to you know, which websites are good to look at and which ones are not too good. (Esther, 31)
I use internet forums where witnessing others’ experiences help me appreciate my own experience better. Ah I’ve also seen a lot of other people on the internet as well that have been through far worse than me. They’ve trialled different medications and I’ve been fortunate that the medication I’ve been given hasn’t had any, to my knowledge, any major effects. Because if something don't get ya something else will, something else will. (Joshua, 51)

The initial consultation: seeing the doctor
I had felt depressed for a long time, and saw the doctor and was prescribed an antidepressant after reaching a crisis point. I was trying to ‘manage’ on my own, long before seeking help. I went to the general practitioner only after my family and friends urged me to do so.
My behaviour was obviously affecting other people.
I went to see my GP when my husband was threatening to leave me (Charlotte, 51)
My wife made me go to the doctor after I broke down at work. (Scott, 46)
It was difficult for me to recognise the signs and symptoms of depression myself, and certainly I was not aware that treatments existed that might help me. (Spencer’s, 52)

The consultation
If she hadn’t been able to turn my thinking around in that first appointment in the way that she did, you know, I’m not convinced I would have been motivated to take the medication. And certainly, you know, knowing now that it does take sort of four to six weeks to really start to have an effect I might have—even if I had started taking it—I may well have given up after two weeks, you know. But her, her influence was powerful enough that, you know, it changed everything about the way I was looking at the illness and subsequently at myself…So she then spent the time explaining about depression and different causes and, and then the medications and all of that. (Scott, 46)

The first mention of medication and antidepressants.
I was resistant to being prescribed antidepressants due to the strong stigma attached to them. And um I don't think she’d even finished saying the word before I said ‘not a chance.’ I said ‘do you know who you’re talking to here? I’m a detective. I think—this is—you can’t do that.’ And there was no way I, I’d entertain um just the label of the drug. Just the term antidepressant to me was ah you just can’t hack it. Um and I thought ‘well that’s what I think so everybody else must think that.’ So I said ‘nup, not a chance.’ (Sean, 39)
I always believed that the ‘doctor knows best’. I had taken antidepressants most of my adult life on the advice of my doctors. For me, the overwhelming impact of my depressive symptoms meant that not taking the treatment was not an option. (Malcolm, 72)
I felt completely excluded from the decision-making. Well, yeah, on her notes I think she wrote depressed, and I think she said to me, “I think you’re suffering with depression and need antidepressants”…And she put me on antidepressants straight away, and on sleeping tablets as well I think. She didn’t even ask me! (Belinda, 33)
I wasn’t told the reason for my antidepressant prescription; I had never been given an explanation of what they would do, nor the side effects. (Rosey, 40)
I’m just thinking, ‘My God, you know, they [doctors] don’t believe me,’ but that’s what I felt, they just don’t have time to listen [about side effects]. (Anne, 39)
This GP was particularly um insistent that I take her prescription. And I had said, ‘no,’ I had said ‘no’ about three times. In the end she said to me, ‘um I don’t know what’s wrong with depressed people, why they always refuse to take um my prescriptions. I think depressed people like being depressed.’ I felt like she’d shamed me into taking her um prescription. (Vanessa, 35)
I was surprised, even frightened, by some of the things doctors said about what antidepressant taking would mean for me in the future, for example, that it would take a long time to get better, or that I would be dependent on them for life.

Being prescribed an antidepressant
I was relieved to be diagnosed with depression and be prescribed an antidepressant. Once that was done it was like such a relief because I knew what was wrong and I could see there was now a way of fixing it. I have to say my father had depression a few years ago so I knew that there was a ‘fix’ because he recovered, he got treatment and he got better, which helped me a lot. (Spencer, 52)

I think the first doctor I ever saw was absolutely fantastic. You know, he noticed the signs, he asked the questions. He diagnosed me, treated me, when the treatment didn’t work so well, you know, we adjusted it and got me back on track within a couple of months. (Nancy, 26)

When I was first prescribed an antidepressant, I felt it signified my depression as ‘official’. Seeing it written in my notes felt, ‘almost like having a criminal record’. It had affected the way I felt about myself and I felt designated to a denigrated category; now I was someone who was ‘mentally ill’. (Tony)

I would prefer to ‘manage’ without antidepressants. I want to come off them as soon as possible. It was important to me for there to be ‘an end in sight’. I prefer to be ‘in control’ of my own emotions and I see antidepressants as a temporary ‘crutch’ to lean on rather than a permanent solution.

When I was first prescribed an antidepressant, it felt like avoiding responsibility for my own I felt it was taking the ‘lazy’ option well-being. (Sam, 31)

I saw taking antidepressant as signifying to myself and to others that I was a ‘failure’. I wasn’t prescribed an antidepressant right away and I really appreciated the time to think about it: I didn’t really want to go on medication but I thought that I was at the point where I needed something to help me. They were very, very good in that they didn’t just immediately give me a prescription. Actually, we went through the options of what kind of medication...what they do, what they’re designed for. And they said that they would rather monitor my situation before letting me go onto them, which I think was very responsible of them. I did eventually, because I wasn’t getting any better, did go onto antidepressants. (Patrick, 30)

Taking an antidepressant for the first time
Even after deciding to start antidepressants, actually contemplating swallowing the tablet for the first time could feel like a momentous occasion: I left them on my top shelf for ages and I just didn’t want to take them because I was a bit confused as why I; he’s prescribed me that after like a really short chat, just me saying I was down and maybe at the time they were handing them out left right and centre, I don’t know. (George, 34)

In the absence of information from my doctor, I wanted to find out more information before taking the first tablet. He said go home and take these Prozac but as a person with a scientific mind as myself, I look up Prozac, I didn’t take any, because so many side effect, I was so worried. I just threw it away, threw them away... (Phuong, 59)

I got my prescription dispensed but it took time to read through the information leaflet before deciding whether or not to take the first dose. I worried that the antidepressant might make me feel ‘fluffy’ or ‘out of control’. (Maggie, 44)
I spent a full week wondering whether to take the antidepressant and I had second thoughts after reading an article online. I saw the GP for a second chat before deciding whether to take it. (Hilary, 28)

I thought if I can be seen to be compliant to treatment it would make me less likely to be sectioned. (Tony, 34)

Obviously the medication does what the medication does but if, if she, I went home and I was, I read the thing and I was very scared too, and I took a tablet after—not straight away, a few weeks. I took a tablet, I took a tablet and it sort of made me so sick I retched the whole night in the toilet, just retching, and it made me feel like I almost died... (Phuong, 59)

I was uncertain about how long it would take for the antidepressant to take effect, the extent to which it might help, and about what to expect in the first few weeks. I was also concerned that it could make me feel worse rather than better, and how long I would need to take an antidepressant for.

I did feel a lot worse, at least at first, so I took the antidepressants for ‘a little bit’ and then stopped.

And so I started taking the medicine, um and it was amazing. In, within two hours I could feel different. I felt, well, like there were side effects...there was my jaw would shake, and I would feel really sick, but within two hours I felt calm; that sort of anxiety wasn’t there so much. I felt calm and tired, too tired. I slept for, you know, like 12 hours straight and then I had to go work.

It was very difficult to go to work. (Laura, 55)

I felt that I benefitted in time, if not immediately: one of the most striking things that struck me the first time I took antidepressants...is all of a sudden you realise how much colour is, there is in the world. But I think when I was depressed my, my perception of colour had diminished. (Craig, 33)

I felt as spaced out, controlled, drunk, completely flattened and numb, although not depressed any more: the first week of it I felt I’d been hit over the head with a sledgehammer. I found it really hard to have my bearings and, and ah cope. It was just the most bizarre feeling but I hung in there and after about ten days it, that got better. (Edith, 55)

For me, just the fact that I was taking the antidepressant and doing something about my depression helped: straight away when you start taking it you feel great because somebody understands, somebody has listened to what’s wrong with you because you’re in this bubble the only way I can describe it is a bubble, the whole world is going on around you and nobody seems to understand you assume that nobody...it just takes a lot of weight lifted off your shoulders that you're starting medication and that you're starting on the road to get better... (Ellie, 30)

3 Anderson et al., 2015

Treatment initiation and initial experiences

I've been prescribed antidepressants in the past but I've always felt reluctant and apprehensive about taking it, largely because a) I feel that the effects are probably short-term, they're not going to actually resolve the depression, b) because they do have side-effects and, and c) I didn’t feel comfortable, myself, with taking some tablets. (39-year-old male)

Being prescribed an antidepressant was vital for me, and I gladly accepted the treatment option as suggested by my doctor.

You know like what I was saying about when I first took antidepressants that made me feel that, sort of vindicated ... (27-year-old female)
After about 2 months, having been signed off from work for 2 months, I found myself getting worse and worse and approached the subject with them about going onto medication which I sort of ... I didn't really ... before I thought, “I didn't really want to go on medication” but I thought that I was at the point where I needed something to help me. They were very, very good in that they didn’t just immediately give me a prescription. Actually, we went through the options of what kind of medication, what sort of ... what they do, what they're designed for. And they said that they would rather monitor my situation before letting me go onto them which I think was very responsible of them. I did eventually, because I wasn't getting any better, did go onto antidepressants. (30-year-old male)

I had to try a lot of different antidepressants until they found one that worked and suited me. Effexor [venlafaxine] and I had that, about two tablets, this was last year some—about May of last year I think. And as soon as I had it I came up with side-effects, sort of swelling in the face, and headache and so on and so on I know it can cause, cos I'd already read in the leaflet that can ... came with it. And that was no good at all, the Effexor, because I knew I couldn't go on with that. And I rang the doctor and he said, “Oh well you’ll have to stop it.” And it was the same I think with the Lustral [sertraline], before that as well, and another one called Cipramil [citalopram] I was on. That was no good either. (35-year-old male)

I finally settled on Seroxat [paroxetine]. So anyway so my doctor, the GP, not the specialist, said, “well try Seroxat. And so I said, “well alright” and I did, so I tried it in a liquid form first of all. And she said, “Well see if it suits you.” and I said, “well alright, I will do.” And fortunately it did. And then since then I've been on the tablets, probably about 30mg which I'm still on.” (35-year-old male)

That was paroxetine. It was pretty nasty, actually [laughing]. It had, again it had absolutely no effect on the depression. I took it dutifully every morning out of the little foil packets for, I think, 5 or 6 months ... a lot of the professional interventions didn't help me, antidepressants didn't. I'm always in two minds about whether to say ... give my opinion that I don't think antidepressants should be called that at all because they don't really do very much against depression. They're more anti-anxiety, or sedating or something, possibly ... (35-year-old male)

Well, yeah, on her notes I think she wrote depressed ... and I think she said to me, “I think you're suffering with depression and need antidepressants.” And she put me on antidepressants straight away, and oh sleeping tablets as well I think ... she didn't even ask me! (33-year-old female)

It (Prozac) [fluoxetine] was good because for me it had no side-effects or anything that, that bothered me. And it's hard to tell, you know, am I feeling like this anyway or is it the, the medication that's helping me? But for me, it seems to be good and I'm taking it again at the moment because I had a bad patch recently and, and I feel good so I don't know if it's the drugs or if it's me or whatever it is ... (33-year-old female)

Continuation of treatment, expectations and uncertainty around medicine use was a big concern. One of the things that I thought was very important to me in this process was the fact that the doctor said to me, “I'm going to get you out of this depression but don't expect a miracle. Don't expect to be okay tomorrow. It's a long process but I'll sort you out.” Those were his words. That to me was very important. (45-year-old male)

So it's not like, you might, I don't know, you might kind of crave a cigarette or whatever for itself. It's just that you just don't want to be experiencing this ... like side effects. It's not like you feel ... you just have to do it [take a tablet] to feel normal, you know. (27-year-old female)

Now I felt in myself that it was going to be a question of time that [medicine] got me right, I wasn't having to deliver at work which was a tremendous blessing. (66-year-old male)
People call them like happy pills and stuff [...]. But you don't walk around stoned or sort of “Oh isn't life wonderful.” You just feel normal, that's what they make you do, they just make you feel normal. You don't feel euphoric, you don't feel manic, you don't feel spaced out, drunk, stoned, whatever you want to call it. You just sort of feel yeah, this is the way life is supposed to be, everything just feels alright, balanced. (31-year-old male)

Antidepressants, they aren't a quick fix to make you better, but they help you to cope better with what you're going through. (19-year-old female)

But I would never regret taking them because taking them has totally changed my life ... Taking them ... I don't feel that so much now ... But when I first took them, I felt like I had been given my life back. I feel like I can now be a normal person. (27-year-old female)

And I now take one, one small dose of Sertraline which I shall take for the rest of my life. (73-year-old male)

It wasn't working. I still, it kind of worked in that it made me more functional. I was a functional zombie. I could function, I could work, I could read, I did have my motivations, my mental capacities back but I was still depressed. And some days would be, I would be really overwhelmingly depressed. (33-year-old male)

Because he knows I don't want to be on them for the rest of my life. And we tried between us and they have gone down. And last year I was, I was at the point where I was off them, and then everything just went backwards, so ... I take citalopram or some call it cipramil. I am on 40mgs, I have been up and down on them, and I was on ... it takes, I mean people find this a general thing, because they, it takes a while to take the right dosage, the right level dosage for every person. So it's gone up and it's gone down. They've tried ... we've tried going down and it's not worked, I'm not ready for it, so it's gone back up again in the last 2 months (43-year-old female)

And it blew my mind out basically, and that what made me come back and start confronting the psychiatrist about medication and the ins and outs and why aren't we being told about the dangers and this that, and the other. Well an example is being on a certain drug over a period of so many years, and it's not a lot of years either, that can actually cause mental health damage, it can actually cause brain damage. This one is actually a very popular one. It's called citalopram. (45-year-old female)

The only way you can avoid pain is by ... well part of just getting away from the incident that's causing the pain but the ... the only other way is just to cut down your awareness which is what, what medication is mostly for, it's really to cut down your ... your feeling of pain. But the thing is the pain is nature's way of showing you what's wrong, and without it you're in the dark. And the thing is we've been given the ability to know what's wrong with us ourselves. But if we keep taking pills, if we keep taking things that are going to stop us being aware, if we keep getting drunk, if we use anything as a drug to reduce our awareness, then our ability to be healthy is cut down. So the first necessity to be healed is to raise your awareness (69-year-old male)

I then kind of stopped taking them, without telling my GP, just 'cos I just kept forgetting to take them, and I thought I'll take them later, I'll take them later, I'll take them later. (20-year-old female)

He just prescribed me these tablets which were kind of sedatives but prescribed for people with psychosis as well as other things, and I just thought, what? And I threw them away. (27-year-old female)

I did take an overdose on one occasion, when things were quite desperate. Some of these well ... quite a lot of antidepressants and paracetamol ... That was a pretty horrendous experience. (45-year-old male)
Adverse effects and non-adherence

I'm not certain whether it's a side effect of the prescriptive medication. I think it's the combination of both medication and depression because I had it, I experienced it a little, little bit before I started taking the drugs, medication and then it kind of got a little bit worse. (21-year-old male)

I mean initially with things like Tryptizol (amitriptyline, a tricyclic antidepressant), and those sort of antidepressants, there was constipation, and oh, all manner of unpleasant things. Dizziness, double vision, and all those sort of things. But this [sertraline] is such a low dose as well that its insignificant really. But the other ones, when I first went on them, they were ghastly. (75-year-old male)

I didn't know if they would do any good or not, but I added up one day that I would, over the years, I had taken almost 20 different sorts of pills of one description or another. And had all the dry mouth and all the side effects that were unpleasant. (58-year-old female)

The problem that I did find ... with Effexor [venlafaxine] is it took, it took me away from me, if you wish. I was no longer myself. I was no longer able to do some of the things which I liked doing. I liked writing music and I was, I was unable to do that. I couldn't, I could no longer see the patterns in... in written music. I could no longer; I no longer had the ideas of things that I could do. (33-year-old male)

Although it improved my mood, I no longer felt depressed, it did, it took motivation away from me and it kind of took the fun out of my life as well. (49-year-old male)

My brain, and I was always very good at writing letters and reports and all sorts of things, I suppose I was a bit of a wordsmith really, but that had gone completely. As also my confidence had gone, and I couldn't string two sentences together which is quite frightening, quite frightening for my job. (55-year-old female)

So that period then I was taking quite a lot of antidepressants drugs as well and I was off work for about 6 weeks ... 6 months, I mean 6 months. When I went back to work I had no recollection of what had happened while I was away. And I knew the job well enough to go on doing it, but I my memory was bad so ... all gone! (64-year-old male)

The antidepressants were kind of old. I felt drunk really on them [laugh]. Most of the time, I couldn't work with them. I ... I was working, I was still working at the time and I went on with them actually. I suffered them for six months or something ridiculous. (33-year-old female).

They then fired me [laugh] which was like “what?” you know hanging around all this time I've been really depressed and doing nothing, now that I'm feeling good again and I, I can start doing things, you know they told me that I'm no longer needed. Essentially they were having difficulties themselves and as I'd known for a long time and yeah, I'd be, I'd be one of the first to go. (25-year-old male)

The other thing too, is I don't think that the physicians who treat you are totally aware of all the side effects involved in the drugs]. So many there—there are the easy things like a dry mouth, and dizziness, and things. What they don't tell you is, or didn't tell me, was one of the major side effects was impotence. Which can put a great strain on the relationship if you're married, or if you're living with someone (45-year-old male)

"Seroxat [paroxetine] the first thing I noticed was, [laughs] this is a bit embarrassing, but I couldn't ejaculate ... It's extraordinary, absolutely extraordinary, so you have no erection problems as such and you can have sex you know, but you just don’t come [laughs]. And it's kind
of a weird ... there's a question, you feel like a sort of porn star, you can go for hours you know [laughs]” (31-year-old male)
You looked like you were on pills. Because it made your pupils dilate. And I was shaking. And I would wake up in the middle of the night with a bolt of fright, and shaking and stuff. And I stopped taking them. (27-year-old female)
Yeah, I had a week of withdrawal. And when you experience those they're the strangest things ever. When you make a gross movement, a gross muscle movement, you get this incredible, uh ... it's not a tingling, you get this incredible buzz in your head. Which is quite bizarre. (43-year-old female)
Interactions with doctors
Yes, that's right. Acknowledgement of ... he never criticised, he never made judgements. And he was terribly sensitive, or he made me feel that he was. And I'm sure he was, and I had great confidence in his skill! (55-year-old female)
I think in a sense of medication wise, from what I can see from my experiences and others, is ... if there is a new drug coming from America, suddenly all the psychiatrists want everybody in that area on the same drug, because one minute you will be on one drug and the next minute you'll talk to other people in the hospital, and you'll find out that they're all on the same one. And that will happen in one week ... and it's to find out the side effects of this one and you're being used as a guinea-pig. That I, I ... when I came to the point where I was able to sort of “hang on this is my body here and this is me,” speak up for myself and I started to question the psychiatrist what they were doing for me, or what they ... and finding that suddenly I started getting respect from psychiatrists because I was starting to think for myself and questioning “is this right for me, is this not right for me” or “what do I think is right for me” and it was only though constant pressuring the psychiatrist and the NHS that I got psychotherapy. You have to fight for it, you have to fight for it. It's not a thing that is automatically given. (43-year-old female)
And I saw this same psychiatrist. This was about another 10 years after the first visit to him when he had prescribed lithium. And when I walked in he said, “Oh, I remember you, you had an overdose of lithium!” And I said, “You told me it was stress.” And he said that he could have made a mistake. So all my faith in psychiatrists went zooming out the window with one man. (75-year-old male)
‘You’re ill, here take this pill.’ [Um], and like medicalisation of, that's not even a word, but like [um], medicalising these low, these really low parts and it is kind of umming and erring, and the fact that they did put me onto it so quickly, [um], could make people kind of go, “Oh no, that's just really bad.” (20-year-old female)
I always went in there feeling that I was just being ... I was ... it was like a cattle-farm: I go in, I say what I feel, he gives me a prescription, and out the door I go, which wasn't at all good .... (30-year-old male)

This guy, the new guy prescribed citalopram immediately, so within, within, within a week I was on 40mg of Citalopram, so it's a high dose. (21-year-old female)
So they'll hand me some anti-depressants, give me a repeat prescription, especially in London I'm probably ... this is the impression I'm getting. Give me a repeat prescription and just leave me on them for as long as ... I've been on them for 4 years now. No-one has told me, said to me “Are you thinking about coming off them?” No-one has said anything, they just shove you on them, as long as you're not trying to kill yourself, or coming in and crying to them, then they don't care. And I know they're very busy (27-year-old female)
It was a tremendous, stressful period. And when I was in there a lady doctor psychiatrist saw me in the day room and said something about “Is your illness imagined, or is it real?” And she said this in front of several visitors and in a loud voice, so I was just about four inches off the ground. (20-year-old female)

I take Efexor [venlafaxine]. It is the slow release capsule, and I take 75 mg a day. So I’ve not changed the dose .... It is interesting actually, I was once feeling really bad, and they told me to up the dose, so I listened to them, and went back to the psychiatrist and he was like “What! If you were surviving on 75mg, go back to it.” Psychiatrists know about drugs, GPs don't know as much obviously ... You could end up on so much ... but it is serious stuff. (27-year-old female)

I, I felt my psychiatrist was a very .... oh ... like wet individual. Again, I ... I think because I'd been quite a numerate, factual, organised person, to have someone to talking about feelings and what about this and what about that? And it was ... nothing could ever be pin-pointed or .... I just found it annoying. And they, I found that they didn’t deliver on things that they'd promised. (39-year-old female)

I'm just thinking, ‘My God, you know, they don't believe me but that's what I felt ... they just don't have time to listen to.’ (22-year-old male)

I've tried to talk about my memory loss with the doctors at the hospital and they say, ‘Give me an example’ and I give them an example and they say, ‘Oh that's normal, that's just normal, that's not the medicine, that's normal’. I mean when they hear it, they don't want to hear, you know. (33-year-old female)

I started thinking that I couldn't carry on like that. That my life wasn't worth living, what's the point if the ... if these are the people that are supposed to be helping me, then I don't stand a chance. I checked out my life insurance policies ... I just thought my husband and my son would be better off without me .... because what was the point in living like I was living, I hated it. I hated myself and I ended up ... I took an overdose. (39-year-old female)

My feeling now is that I will not believe anything that a doctor says, and I'll go and check it, because most of the time it's just wrong. Which they can't be expected to know everything, especially GPs. (27-year-old female)

I wanna know what options I have. I wanna know the ways that other people deal with it. I want to know, I don't like taking medication, but if, if that's the silver bullet, I, I'm willing to recognise that. (18-year-old male)

I do question really the medicine and how much these patients are being over sedated .... I do worry let's put it that way, I worry for the people I know that I think about now back in those days that I knew and I worry for them and I think, ‘Has the system given up on them?’ (33-year-old female)

So I'd say look at websites, look at information that's available, read up about it and really become an informed customer because it is an area where people aren't always telling you the right thing, especially GPs don't always have that knowledge to hand. (21-year-old female)

But if ever I was going to take medicine or have any kind of treatment I'll do my research first—if you've got access to the Internet or a library research. It is so important to do your own research because the professionals will only give you their side of the story. I was never told this may cause you long term memory problems, which it has done. I have massive blanks, short-term and long-term. (33-year-old female)

4 Badger and Nolan, 2007
I think any depression you have you're half way, you've got to do it yourself; you cannot rely on the medication, you've got to be willing to try, you don't get a miracle cure out of a bottle, it can help you over the bad times but it's not a cure, that's up to you. I might be mad but that's how I think (Patient 44).

Self discipline, I'd be disappointed to think it was just the medication. I would like to think that I don't need to go back on them (medication) again (Patient 20).

I started taking (an SSRI) which convinced me that there was a problem because I felt so much better, the change was fantastic (Patient 26).

The tablets were helping to a certain extent but they weren't by any means clearing things up (Patient 60).

They were no good, I didn't take them after the first course, I didn't collect the repeat prescription (Patient 29).

I don't think I really know what (the medication) is supposed to do to you. Is it supposed to calm you down 24 hours a day or is it for an hour or two? (Patient 44)

Not knowing what it was making it twice as bad. Hearing 'You have a common condition' and 'You will get better' from my practitioner was totally unexpected, but very welcome information.

My GP told me: 'I've been expecting you for some time', making the consultation easier.

It's the complete package, the doctor, voluntary work. The doctors have left me to make decisions with them and I think this is the thing that has done it for me, they haven't come up with a quick fix, you know, here's a list, they've said 'You're different to the next patient let's put a package together for you'. I've felt I've been involved in it; I haven't been on the outside. I hope you won't recommend just one thing…… (Patient 27)

I am crediting my recovery to 'my family, my GP and finally the medication' (Patient 43).

I took them for three or four weeks before feeling normal. It was gradual, some of this is also psychological because you know you are actually taking something which is designed to help and psychologically I was probably thinking ‘Yeah, this is great' (Patient 53).

5 Bennett et al., 2007

Hearing the diagnosis

So, it's sort of almost a relief to find out that you are not the only one, and there are actually reasons behind it. (#20)

It was one of those things that you kind of know, but you don't really admit it to anyone, even to yourself. (#19)

Seeking information

But, he [family physician] was very open, probably because I came with some informed sort of knowledge already, but he was very willing, he did research on it as well, and he brought a couple of studies to my attention. (#7)

My family doctor wasn't really equipped to deal with the question of antidepressant use.

I received information about depression and its management from the psychiatrist which was really helpful, and which I found sufficient.

She told me everything, and she also told me I could call Motherisk and ask them. I didn't call them, because I thought about it, and her information was good. (#21)

I started off with Motherisk and then medical journals online and abstracts. I've definitely read stuff like on Safe Parent Web Site, or Baby Centre Web Site. I tend to not trust them as much..... I don't go into the whole journals, but usually just reading the abstracts is enough to get a summary. (#7)
Taking control and making a plan
It was comforting, and prepared me to say okay, how far I am willing to go, not only medication, but therapy wise. I think that set me in motion to say I am taking control over my moods, my disorder. (#16)

Re(Assessing) progress
I was doing that test, the EPDS. She would check the score each time. It was very high in the beginning, and then slowly when I started taking the medication, it became low. (#21)

(Re)Balancing the risks
You want to put the baby first, but, at the same time, you're just balancing out what is the risk to the baby of having a mom who is on Prozac versus what is the risk to the baby of having a mom who is, really can't cope and is falling apart. I kind of got to the point where I was like, well, I can only do the best I can as a mom. (#7)
I tried to decrease the risk to the fetus by taking as low an antidepressant dose as possible. I was kind of just teetering on, like I was trying to take the lowest dosage possible to treat my symptoms. (#18)

Being in a better place
Thanks to the counseling or to my medication, or perhaps the combination of both, I felt that had arrived at a better place. Life still had moments of being "up and down" but, there were "far less bad days than there are good days".
I'm in a much better place now than I was before even becoming pregnant. I still have ups and downs, but my ability to deal with some of the things that are triggers for me, is much better. (#18)

I had received counseling but remained medication-free during my obstetric and postpartum periods. For me I know it's slowly going. I do get depressed sometimes. I still do get angry, exasperated. I still haven't regained my full patience. It will take work, and that's what I believe – understand, it's a work in progress. It's like building a beautiful couture dress, it takes time. It's a work of art. It takes time. You are the art piece, and you are just slowly, you know, getting primped up. (#17)

Knowing self
There's so much more to juggle. When you come home, you be [come] a wife, you be [come] a mother, and ... something, one time or another has got to give, you can't always be catching the ball. You need to take a break to recharge. I think that's important, sometimes we just forget to recharge. (#3)

I learned about myself. It was almost a gift in that, I don't know how to describe this..... I learned about myself... I've learned to take time for myself. (#19)
I never thought that I would have worries. I didn't know that I should look out for, you know, these types of things. (#16)

One of the reasons I wanted to do this study was because I really think it's important for women that are pregnant, either the first time, the second time, that if they really think that they can't handle it any more, they really need to talk to somebody. It's important. (#3)

Bayliss and Holttum, 2015
Experiences of antidepressants
Mirtazapine probably did save my life. [Gerald]
I think you can get stuck in a loop where they just prescribe you.
The drug loop
Initially it was tricyclic antidepressants, then they tried MAOIs, which didn't work, and now more recently the SSRIs...and then I'm on lithium as well...I also have ECT. (Iris, on antidepressants for 26 years)

Medication effects
There came a point where, alright, I've survived, but what's the point in surviving if you can't feel?
I realized that my medication is ineffective: I was...going through a really bad period [although] I was still...on medication. [Frances]

The Prozac lifestyle
Medication was limiting my lifestyle in some way. [On Prozac] I was ticking along nicely, but I was living the lifestyle of somebody in their late 70s, early 80s, rather than their mid-50s. I was not working... It wasn't helping me to address my lifestyle. [David]
I didn't feel better...but if I said that they'd say 'okay, fine, we'll change the pills, we haven't tried this combination yet, have we, you'll have two of those, three of those and five of those'. I've had every single pill on the market and every combination of pills. [Brian]

Nobody listening
[Doctors are] all about the medicines...we'd all like to think that we're visiting Frasier Crane but we're not, you don't get to lay on the couch, you don't get to discuss your problems...you get to go in for 10 minutes if you're lucky once every 3 months – ‘How are you feeling? Still taking medication? Sleeping alright? Well we'll leave you on that then’...and I've had that for 10 years so I guarantee you...that's what happens'. [Charlie]

Underlying cause not addressed
And I told my GP: 'I'm on this medication and there's obviously some underlying cause and I'd like to try and sort that out'. [Leonard]

Dilemmas about dependency
It's always been really difficult coming off one...really uncomfortable and really feeling like you're losing your mind and getting really depressed...and so you have to put a bit of faith in the tablets. [Jerry]

Feeling dependent on medication creates dilemmas for me. I don't want to rely on drugs because I see it as an artificial control. [David]
I felt very dependent on [my amytriptiline tablets] and I didn't want to be dependent on them, and so that made me want to...stop taking them. [Jerry]

Boyle and Chambers, 2000
Carers' knowledge and understanding of antidepressant medication
- I brought the names of my mother's tablets in case I heard something bad about them.
- A primary nurse kindly informed me about the tablets.
- The doctor explained the situation and the documentation was in the tablets.
- I always phoned the chemist and asked was it suitable for her to be taking them.
- No one ever told me about the medication.
- When I ask I am told they are the anti-depressant ones.
- I could understand her not wanting to take it because it would frighten the life out of you.
- The leaflet . . . it tells you everything.

Ensuring compliance
- She believes that they are doing her no good.
- He says he will get mixed up so I have to give them to him.
- She felt the side-effects made her worse.
- I like to ensure he gets them.
- If I didn’t give them to him he wouldn’t take them.

Older persons’ perceptions of depression

My mother had felt about antidepressants: ‘If you can't make yourself better they are not going to.’

In the past ‘it’ [depression] was not seen as an illness; ‘you had to get up and get on with it.’

**Brijnath and Antoniades, 2016**

**Managing through self-medication**

My psychiatrist told me: “You obviously function” and he’s like, “You know I see people that can barely sit down.” He said the same thing [as the GP], he said, “Look if it [antidepressants] works, it works but you’ll have side effects. You just have to balance it up and you know it’s up to you” (Adam, 33yrs, Anglo-Australian).

I am trying to balance the pros and cons of consuming antidepressants.

For health providers, prescriptions appear to be an easier option.

After five weeks of therapy, my psychiatrist said that he recommended prescription over counselling. (Adam)

For me, antidepressants did help improve mood: I feel like brain space springing up, even keel and it reduces the pain.

The positive effects of antidepressants had to be balanced against negative side-effects such as dry mouth, sexual dysfunction, lethargy, tiredness, feeling dizzy and jittery.

Medicines, specifically antidepressants are not ‘silver bullets’ or ‘magic’.

They often caused severe side-effects, and required experimentation until an appropriate drug and dosage was found.

Taking antidepressants is ‘easier’. You only have to consult two practitioners (the GP for a script and a pharmacist to fill the script), and could purchase medicines at reduced cost on the government funded Pharmaceutical Benefits Scheme and avoid the effort of finding a mental health professional, care costs and the emotional work of therapy.

**Self-medication**

I would drink just to sleep. I wouldn't drink for the fun of it. It's just a case of if I don’t drink, I will just lie awake and I will be awake for 72 hours. It was a no brainer (Michael, 27yrs, Anglo-Australian).

Wine, is that self-medicating? Because if it is then I do that a lot, a lot and I know it's bad but sometimes ... I'll go home at night and all I want to do is have a drink of wine because I know it'll help me relax (Jennifer, 31yrs, Anglo-Australian).

When I felt ‘down, I'd add on like five [Lexapro® 10 mg tablets]. (Julie)

I run out of the Effexor® and instead of taking two I just took it down to one. I reduced my dosages with the intent of discontinuing medication. [Karen]

Being ‘drug-free’ is a sign of being cured from depression. It was July or something like that, I started reducing my dosage. September–October I stopped it completely. November–December it hit me really hard. Just couldn't concentrate on anything, felt really bad, I just can’t explain, it was so bad. And then when I went back to the doctor in Jan (sic) I was made aware that it's
because that I stopped the medication and they wanted to try getting me back on. And after me starting it, I started feeling much better ... and I don't have that much of head pain, I don't feel so yucky. But still, it's kind of dying inside. (Amir, 35yrs, Indian-Australian)

Rose (2003) argues that the consumption of pills, especially ones that alter the self neurochemically, are less about pathologising deviance and more about modulating unruly or uncontrollable aspects of the self. But many participants in this study perceived just taking antidepressants as problematic because it was 'the easy way out'.

Other people assume that I'm on it [antidepressants] because I'm lazy because I don't want to put in that effort to go see a psychologist and empty my emotional bucket all the time (Natalie, 31yrs, Anglo-Australian).

With some of the herbal or the Ayurvedic remedies, it's not just a matter of swallowing that. Along with that you've to control or monitor a change of diet, the physical exercise, yoga and breathing and meditation (Sumant, m, 31yrs, Indian-Australian).

Transformation and self-labour

It is more of a money issue, say for like long therapy ... go to the doctor first and get referred to a psychologist and then possibly stay with the psychologist for another six times. So that strikes me, it is not really convenient. You know, I could just go to some of my friends and family every weekend and talk. So yeah, cheaper therapy (Clifford, m, 29yrs, Indian-Australian).

I think it's me, I should be working on [my] depression. I need to do further studies in childcare, yoga, exercising, walking, shopping, going out with friends and visiting a holistic doctor to obtain numerous CAM pills (when I can afford it). Such transformative labour does help me and I notice an improvement in mood. But such labour required constant effort and was often prompted by a sense of obligation and exchange, for example, the need to honour commitments (“not let down the team”), maintain relationships (“If my dad would tell me, ‘Do you want to go for a dirt bike ride?’ I say, ‘Yeah we'll go’”) and use services that were paid for (“We paid for these kick boxing classes, you have to go”). (Dia, 59 years, Indian-Australian)

He [psychologist] left the practice and I dropped the ball from there (Nikhil, m, 25yrs, Indian-Australian).

My fault. Sometimes I get a little bit slack with my medication ... I was a little bit overwhelmed when I came back to the house at the start of the year getting kids ready for school, schoolbooks, covering them, uniforms, just getting into that routine again (Karen, f, 45yrs, Anglo-Australian). I'm trying to get my depression and everything under control with medication therapy. I can't add eating healthily and exercising regularly to that right now. If I add that it's too much pressure and I break (Olivia, f, 19yrs, Anglo-Australian).

I always have that kind of little hope, which always says that if I follow everything properly, I'll be out of this someday or a bit later. But, I never put an effort to actually follow that (Gauri, f, 25 years, Indian-Australian).

Buus, 2014

Participant 13: I was depressed for the first time and I believed that it was caused by prolonged emotional stress. I had been discharged to psychotherapeutic follow-up at an outpatient clinic, but I did not think highly of the healthcare professionals or their psychotherapy. I thought that they did not provide me with anything useful beyond prescribing medicine, which I continued taking, and in time I chose to cancel appointments with the therapists. Despite despising my professionals, I would visit the psychiatric emergency room when I felt acutely depressed or
desperately impatient about the time it took for me to recover. In the following data extract from
the 4th interview, she reflects back on the visits to the emergency room:
Participant 13 (4th interview): My visits to the emergency room: mostly, I would just talk to them
and go home. Actually, it did help a little. I think it was because I spoke with professionals who
told you that it was not unusual that you were still so incredibly sad. You are told that it's normal
even though you are discharged and take medicine. Things weren't happening fast enough, and it
was when I couldn't understand that, that I went out there. The last time I was out there, I got
Lithium. I told the doctor they might as well admit me again, but he said no and presented this
other option [Lithium].
Participant 13: I had no prior personal experience of treatment for depression, and I feel that my
need for a healthcare authority is to normalise my experiences of depressive symptoms by
interpreting them in a less distressing way. But after starting to take Lithium to augment my
antidepressant treatment, I gradually felt less impatient and distressed.
I continued taking the medication in accordance with professional advice, mainly because I saw
medicine as the primary means of recovery.
I was sceptical towards taking antidepressants and experienced some relatively mild adverse
effects, but I believe that taking the medicine was necessary to avoid the risk of relapse.
I fear stopping taking the medicine: I don't know what it would be like if I didn't take them.
(Participant 5): I was initially very sceptical towards taking antidepressants, but I ended up
accepting them as equivalent to taking vitamins.
Participant (3): In my family... I mean... we had family members with severe mental illness. I find
taking antidepressants stigmatising... so I was begging my general practitioner to authorise
phasing out of the medicine even though I feared a relapse of depression.
Participant 16: I had previously been treated with antidepressants, but this time I experienced
severe adverse effects of the medicine, which included a substantial weight gain and tiredness.
But I was scared of discontinuing taking the medicine despite the adverse effects.
Participant 16 (2nd interview): I think I am a little afraid of what would happen if I didn't take it
(...) I don't ever again want to feel the way I felt when I was admitted. I am afraid it would
happen again if I stop taking the medicine. I am not saying that I'd like to take it for the rest of
my life. I am sure that things will be good again, but right now it scares me if I was to have that
feeling again.
Respondent: In time, adverse effects of the medicine became unacceptable to me and occasional
slips, which seemed less scary than making a deliberate stop, became more frequent and
eventually confirmed me in having no need for the medicine.

Participant 16 (4th interview): I had reached the point where I took very little of it. It was just
once in a while. Really, there was no control. I just took it when I thought, “Well, it's been a
while, so I'd better take a pill or two”. In the end, it was horrendous. And I just didn't feel that I
needed it. And then I just stopped completely. I threw them out and haven't taken any since.
Respondent 16: I just felt better. I didn't feel, that the medicine changed anything for me, and
they [her general practitioner and her psychiatrist] kept on saying that it made me tired. So I
thought, “Well, if that is what makes me tired, I have to ... I don't feel up to this. I have to get off
that rubbish”.
Participant 2 (2nd interview): No, I haven't asked my doctor if there might be an alternative to
the medication. I tried some other ones and I didn't take more than 3-4-5 tablets before I gave
up. It felt like fire burning out into my arms and I couldn't take it. I haven't had that with
Noritren [Nortriptylin]. I have dry mouth and they give you the shakes and things like that. (…) I'd like to get rid of one of the medicine, but what if I get worse? I saw someone [during the admission] reducing their medicine and they ended up feeling awful.

Respondent: I was convinced that one of my two antidepressants was stressing me and gave me the restless evenings and nights. I eventually asked my general practitioner to reduce the prescribed dosage, but he refused and told me that there was nothing to do but to continue. As a reaction to the GP's disheartening response I decided to solve the problems by halving the dosage on my own.

Participant 2: I am still taking Mirtazapin but we've halved it, or rather, I've been allowed to halve it. I found out that when I go to bed something is stressing me. I wake up and I can't settle again. So, I am sure it's not good for me.

Participant 2: After reducing to half dosage I stress about until I find rest.

Interacting with healthcare professionals

I cannot say that I was having rewarding or trusting relationships with the therapists. They [therapists] only prescribed my medicine, and I felt that the therapists were not ready (or competent) to meet my need for change. The prescribing therapists predominantly suggested maintaining the existing strategy by continuing, increasing or supplementing the medical treatment. Such responses were extremely frustrating, as I desperately sought to change their situation, and did not believe that the medicine was important for solving all the issues, in most cases I felt that adverse effects added significantly to my problems.

I found it difficult – and sometimes impossible – to challenge the therapist's authority during the consultations: When I sit in front of a doctor or someone with great knowledge, well, then I believe all that's being said (Participant 8, 3rd interview).

Participant 14: I successfully insisted on a gradual reduction and stop of the medicine simply because I had taken it for exactly six months, which, allegedly, was the period needed to have a low risk of relapse. This happened despite me having frequently experienced severe and disabling symptoms of relapse into depression.

Participant 4: I was shocked over having been admitted to hospital for depression and I continued struggling to reconstruct what had happened the day I broke down. I felt neglected by my doctor that day and I was convinced that he had given up on me and my depression, because he did not care to listen: because he just wrote the prescriptions and then he was finished with me. He didn't say that I should return; he didn't say that should come for some counselling: he didn't say, “I'd like to keep track of you”. “You can come and get a renewed prescription and we'll talk”. He didn't say that he had any such an offer, and [whistles] out I go.

(Participant 4): I decided to adhere to the hospital's original recommendation to take the antidepressants for six months, but because I felt abandoned by my general practitioner, I decided to get help to phase out safely from a kind employee at the local pharmacy.

Participant 12: I was treated by a consultant in an outreach team for several years, but I was increasingly unsatisfied with the treatment, because it made me feel very tired. By chance, due to overcrowding at the usual hospital, I was admitted to another hospital in a different town, and I was pleased to get a second view on my illness and my medication. At the new hospital, the medication was altered because I asked for it. At the old place [usual hospital] I experienced what I believe was a dangerous lack of responsiveness: It could have been good if they [at the usual hospital] had been better at listening to my complaints regarding the medicine. I believe that the last admission could have been avoided if I'd stopped taking that Seroquel [Quetiapine]
and started taking something else. Because the tiredness, I had, added to weaken the whole system.
At first, I was pleased to have his medicine reorganised and I started using psychiatrists at the new hospital as my primary therapists. But then, I had started self-managing my medicine, moving to the frustrated search, because I felt bad and – paradoxically – by reducing the medicine, I could prove to myself that things were good.

**Self-regulation of drug treatment**
Honestly, I then believed that my own reduction added to my distress. I was readmitted to the new hospital where the psychiatrists wanted to augment the antidepressant treatment with Lithium, because they believed that I suffered from a bipolar disorder. And then Lithium made me feel tired and after discharge I decided to stop taking all the medicine augmenting my antidepressant treatment without consulting any professionals. I checked it on the Internet, and learned that Lithium was fundamentally harmful to the body and had too many adverse effects and that I might as well test if I could do without it: I made this decision without talking to the doctor...It was probably because the doctor would be against it. I think I have an appointment in about a month from now. I thought that if I stopped them I could see if it reduced my tiredness, and if there are no problems, then there is no reason to take them.
My perspective on taking medicine changed and my self-regulation increased gradually and was kept hidden from healthcare professionals and my wife because I was convinced she would not approve my decisions. I also planned on informing my doctor, but then decided to cancel the appointments. I intended to eventually inform my therapists of my self-regulation but then realised that I would rather avoid all the comments.

Participant 6: I self-regulated my medicines from the beginning. At first, I only regulated one of my medicines. And whenever I felt bad and consulted a therapist, who was never the same because of institutional reorganisations, the only response was to prescribe more medicine. I felt more and more certain that this response added to the problem rather than to its solution. It is good that you can get medicine when you have pain and medicine when you are depressed. But I don't think it is a solution to just add more and more medicine because you go crazy because you're doped all the time. I think I am taking something like 29 pills a day.

I finally decided to reorganise my medication and I used my sister as a trusted person, who was the only one knowing about this complete and abrupt withdrawal. My sister helped me by text-messaging frequently. And the decision just emerged: I had to say either or (...) I felt so bad. Had it not been for my sister who texted me all the time, I would not have been here. I don't think so (...) I was going mad. I had to revise my life and find out “what is it you want”. It was so hard. I didn't sleep for four days after stopping taking Seroquel [Quetiapine]. I didn't. I could not find rest. I had them, but I was stubborn and said ”no, Hell no, it shouldn't be like that.” I experienced adverse effects of the medicine, but in most situations, I was able to manage and tolerate them in my everyday life. Dry mouth, for instance, was managed by chewing gum and by always having a water bottle within reach.

10 Carpenter-Song et al., 2010

**Latinos and Euro-Americans taking medication**
Roberto: I gotta talk to the psychiatrist and see if he can give me a new medication to make me less nervous.. Medications don’t do nothin’. They are effective in treating “nerves”.
Mario: But you know they’d send me back for anything, and I’d just as soon keep taking my meds and stay out of there [the hospital.] I mean, they want to lower my meds, but that’s what happened last time and I don’t want to go back. They could have just raised my meds and kept me out of the hospital, but they just sent me back and I don’t want to go back.

Tamara: My visit usually last about fifteen minutes and his main topic is, ‘Am I taking my medication?’ and how I feel since I began taking the new medication.

Gladys: I am so frustrated!...even my recent interaction with my vocational specialist: He don’t try to help me. He won’t try to help me find a job, yes. He doesn’t want me to do his job. I beg him to help me. I beg him to help me, yes, and he didn’t. All he would say is, “Are you taking your medication?” I say, “Yes, yes I take my medication.” I tell him I need work, he would say, “Take your medication and you will find work.” I have to pay for a portion of my prescription. I’ve already paid $40 for my prescriptions and now they change them. [puts her hands to her forehead] I’m so sick of this mess . . . I don’t understand why they changed my medication. I didn’t sleep for a few nights and they just changed my medication just like that.

Gladys: I’ve got a feeling of being “experimented” on, with all these changes to medications. But this all costs money, switching medication isn’t cheap!

Jerome: They don’t know what works and what don’t work. First, they put you on a medication and when you tell them you don’t need it anymore they just put you on another one. I get sick of taking pills, pills, pills. I don’t need all this medication. They keep telling me I need medication but I don’t. The medication is what makes me sick. I don’t feel right when I take it anyway.

Bernice: I felt that the antidepressant I had been prescribed was unnecessary: I told [my case manager] I was only depressed for about four or five days and I don’t need medicine for depression because it didn’t last. Everyone gets depressed and they don’t take medication for it. Just because I have a mental illness doesn’t mean I’m never going to get depressed. But doctors give you a pill for everything.

Randy: They want me to get stabilized on the meds first and then get a job. They don’t think I’m ready [to get a job].

Roberto: The psychiatrist...? He just gives me medications. I just go there for my medications. I don’t go there for psychiatric care.

Mario: Yeah, they’ve got a lot of services, that’s why I go. They give me medications, and they have counseling though I haven’t used that. And they have groups that you can go to. I haven’t used that either because I don’t think I need it, but I could go if I wanted. I’m not crazy. I just go to the club so I can get a check . . . I just started acting crazy, but I fooled them. My doctor knows that I “ain’t crazy”: The doctor sees me anyway so he can make the big bucks . . . He just gives me a little bit [of medication] ’cause he knows I ain’t crazy, so I take it.

Bernice: Nothin’ changes – everything is the same and I just don’t have time for that . . . I’m trying to move on and do some positive things and they look like they are trying to keep people in the same ol’ spot . . . They really don’t have an interest in helping people, they are trying to help themselves keep a job and that’s what that’s about. Do you really think they don’t care about the people who are at [the clubhouse]? I was there so I know that they don’t care. Remember I was one of those people.

Jerome: Why do I have to go talk to someone who don’t care about me or how I feel? I have spent seventeen years going to see doctors that don’t really want to help. They get a paycheck and all they do is write prescriptions that don’t work. All they say [...] is if you don’t take your medicine I’ll lose my benefits. It’s like they tryin’ to blackmail me.
Gladys: No one wants to help me find work.
Tamara: They just ask questions and listen, they don’t provide any solutions. They are mainly concerned about you taking your medication. They ask if you’re sleeping all right and if you have any problems you want to talk about and that’s it. They don’t solve any of your problems for you even when you tell them what they are.
Bernice: If someone would just talk to me and help me figure out what’s wrong I’d be fine.
Tamara: No one could tell me what was wrong with me.
Jerome: All these pills, I’m tired of taking all this medication. I wish somebody would find out what is really wrong with me and stop just giving me pills that don’t do nothin’. They don’t even try to find out what’s wrong with you. They think it’s all in your head. This is my life, this is my head. Why do I have to do what everyone else wants me to do? I’m not crazy and I’ll never live a normal life if everyone is telling me what to do. I honestly feel controlled by these mental health providers.

Conceptions of Problems

Fred: I have a pathology, ADT . . . it’s not being able to concentrate. It’s a personality disorder, get highs and lows and irritability and it’s an anxiety disorder, it leaves me sexually dysfunctional . . . I watched a video tape about it and knew I had it. Then a doctor showed me what I had.
Horacio: Once they label you, they never look at you the same. The psychiatric label “changes you forever.”

Alicia: I have “enferma de los nervios.” And there is stigma attached to it.
Horacio: I got labeled mentally retarded and a psycho by my friends and stuff when I got out of the hospital. I lost like all of my friends. It was rough.
Bernice: I would “never” tell my co-workers about receiving treatment: Because they would pick on me. When you tell people you have a mental problem, they pick on you and blame everything on you because they know you have something wrong with you.

Social Contexts of Distress

Fred: I was hoping to get some distance from my family. It’s the blame and change syndrome. They think it’s my fault that I’m mentally ill. Fourteen years ago I was diagnosed as mentally ill and my father and my mother and my brother talked about me like a ladybug on a window. They talked in circles and then got angry at me.
Bernice: I told the doctor I was depressed and he put me on Prozac. He put me on more medication when I don’t need it . . . I’m not taking that medication because I was [simply] depressed and that was it . . . The doctor never took time to find out why I was depressed. All he said was, ‘Oh, you’re depressed; I’m gonna give you some medication for that.’ . . . He never asked me anything; he just wrote the prescription out and gave it to me.
Yeah, [the doctor] wants to get paid, but he doesn’t care because we are poor and most of us are black and what does he care. It’s a paycheck for him; it keeps him employed. They don’t want to deal with the problem and try to help you solve it; they just want to give you medication and keep you coming back. If the problem doesn’t get discussed it will never get solved. I dislike him: he doesn’t answer my questions; and he doesn’t explain what’s wrong with me. I want him to break things down so I can understand what’s going on with my body. He doesn’t tell me anything and I hate that.
I wished for a provider who would listen because I felt that I would benefit from “someone to talk to.” Yet this was difficult because of the high turnover of clinicians. Sometimes I talk to [my
But now I find out that [she] won’t be my clinician anymore. They assigned me to a man . . . I have no intentions of talking to him about anything. I told you before: when you get comfortable with someone they change that person to another team or they leave. I don’t feel like starting all over again and I sure as hell ain’t talking to a man. I can’t be building trust with someone new and then they get changed and then it’s someone else new. I can’t be pouring out my heart to everyone and they don’t stay long enough to help me. I need someone to get to know me, I want them to know me, Bernice, so they can help me help myself.

11 Castonguay, Filer and Pitts, 2016

Susceptibility
Interviewee 33: I am surprised that even celebrities are experiencing depression: I felt that the kind of life-style, at least on a materialistic level, that that would have helped them to escape from going down with such things as depression. But it is obviously clear that, you know, materialistic, you can have a very big house and 3 or 4 cars, whatever, at the end of the day it all depends how you feel within yourself and within your mind, and nothing in terms of monetary wealth can ever make any changes to that.

Family history of depression
Interviewee 2: [M]y Mum has always experienced depression in a sort of similar way to me, I think.
Interviewee 4: I remember saying to myself, ‘Oh no, not again.’ … I thought I was over it and it’s back. Just the sheer onslaught of negative thoughts that you just can’t push out.

Severity
Interviewee 11: ‘t’s almost as if you’re going in slow motion. If you’ve seen these films where you’re standing still and everyone’s going around you, it was almost like that.
It is a combination of panic, increased heart rate, changes in sleep patterns, getting tired quickly, acting out, eating disorders, inability to work, paranoia, and being uncommunicative.
Interviewee 23: this experience means [t]he deep depression, I feel physiologically different, I have this sort of pressure around my brain, you know I feel that someone’s got their hands inside there.
Interviewee 36: everything that you seemed to look at…you looked at it from a suicide aspect, when you went over a bridge and you thought, that might be an idea, or a knife in the kitchen, yes, that would be a good one.
Interviewee 12: [W]hen I’m really down it occurs to me when I see a train coming to jump in front of it. And again, I get these compulsions, and I have to physically take a step backwards so as not to do it. And these are strong urges.
Interviewee 34: The suicidal ideation is …I just, just want to be out of it.
Interviewee 6: I told my friend about my suicidal thoughts, to which she replied, “you must go and talk to your GP [general practitioner], you must do something about this.” The friend called the doctor for me and accompanied me to the waiting room.
Interviewee 32: My mate says to me, ‘You’re depressed.’ And I said, ‘I’m not.’ She said, ‘You are’ so, as I say, I went to the doctor.”
Interviewee: I did not feel like myself and I felt something was off, and this spurred me to seek help.
Interviewee 15: I felt that I wanted to jump out of a third-story window and this led me to seek help, as I understood my action was not “the norm”. I think when you’re actually faced with,
“Oh my God I would have jumped if someone hadn’t come in.” That just absolutely petrifies you because you know that you’re young, you shouldn’t be feeling like that, it’s not right, there’s got to be something wrong. No support from the family environment. No one was picking up on how severe things had got for me.

**Barriers**

Interviewee 8: There is nothing ever to be ashamed about with mental health. You know, there really isn’t.

Interviewee 19: I recall my conversation with the doctor: I said, “But, oh but there is an awful stigma to bring on antidepressants and stuff.” And she said, “Well if you are a diabetic and I said you are going to need insulin for the rest of your life, you wouldn’t argue would you?” ... So she gave me permission really to say, “Yeah I’ve got an illness. You know, this is not my fault.”

**Interviewee 15:** I recall comments made during the first therapy session that addressed my initial fears: So she explained to me that you know they’re not going to patronize me, they’re not gonna make me feel bad, they’re not gonna force me to talk about anything ...All of these fears and concerns and worries that I had, she brought down a level I suppose.

Interviewee 2: I only sought counseling, but received both psychotherapy and medication. There was a great deal of fear expressed in relation to antidepressants. It was my preconceptions. I was worried before I took them that I would become divorced from reality...like you don’t care about anything.

**Interviewee:** I mean I know very few people in all these years who have had psychotherapy. I don’t know what the criteria [are] for choosing who has it, who doesn’t. I know there are very long waiting lists. I know people wait for 3 years, and 3 years is a big chunk out of somebody’s life. It’s just very sad.

**Benefits**

Interviewee 2: I was hesitant at first, but all things considered, I would rather put on weight than be depressed [so I took antidepressants and] I felt like I had been given my life back.

**Positive experiences:**

Interviewee 32: I could walk up the street with a smile on my face. Yeah, they [antidepressants] did help.

Interviewee 8: The therapist listens and she responds to me as a human being, not as a professional. She gives me time...She cares.

Interviewee 14: I had come to realize that ‘a miracle cure’ does not exist for depression.

**Interviewee:** And the medication keeps you stable... you’re able to go to work, you’re able to do your job, able to enjoy quite a few things. But it doesn’t get rid of the fears and whatnot because that’s a sort of a different, different area, your thinking processes... They’re yours and that’s where it’s got to come from you, you’ve got to get there yourself, I don’t think there’s a miracle cure.

You need to hope that it’s not the end of the line for you (Interviewee 3)

You need hope to believe that there is a light at the end of the tunnel (Interviewee 19)

**Self-efficacy**

Interviewee 2: If I go to the doctor’s I know what they’re asking me, and I know what they’re expecting me to say, and I know what it’s all about.

Interviewee 4: I know the signs, and I know what to do, and you get better.

Interviewee 5: This is my disease, it’s part of me, and I want to control it.
Interviewee 33: I would strongly urge other people who might be depressed and recommend that they seek help. Don’t suffer in silence.
Interviewee 8: It may be difficult for you to reach out, and I understand that because I didn’t for a long time. But I would really urge you to reach out if you can muster anything, reach out because there is help out there.

Interviewee 5: I recognized that I needed to seek help after struggling to read a children’s book to my daughter, and I needed My wife’s assistance to do so: I think realistically in the stage that I was, I was not capable of doing anything. I needed somebody around me to do the initiating... It really needed somebody else to make that contact for me and ultimately yeah, it was my wife saying, “You must go to the doctor, I will make the appointment. I will drive you there. I will take you there. I will sit in the waiting room with you,” but, “you need the help.” It really had to come from somebody around me because I was incapable of doing it myself.

Vanessa: I was prescribed Cipramil and then Avanza, at the age of 18, after consulting a general practitioner because I was waking up at night, couldn’t sleep very well and feeling awful and sad all the time, following an end of a relationship.
Lily: I was prescribed an SSRI at the age of 19, following a “breakdown” preceeded by an eating disorder and trip overseas to work as a volunteer. I began on Aropax, which caused hallucinations, and was then prescribed Efexor.
Hamish: At 19 years of age, I experienced anxiety for about three years, which was progressively worsening, and so I went to my general practitioner who prescribed Zoloft. Prior to taking the SSRI, for the previous four months, I had been managing my anxiety with the help of a psychologist and CBT.
Cheryl: I was 14 when I was first prescribed Zoloft by a general practitioner after talking to a school counsellor, who referred me to the doctor. At that time I felt that there was no cause for my depression. I was again prescribed an SSRI at 18 years of age after the deat of my both grandparents, whilst studying.
Julie: I began taking SSRI medication at the age of 17, after a school counsellor noticed that I was cutting myself, and referred me to a psychiatrist. Over the last three years I have been prescribed three different SSRI medications – Luvox, Prozac, and Zoloft. I am non-adherent to my medication and I self-monitor the dosage, often taking more than the prescribed amount.

Side effects
Vanessa: I reacted badly: I was shaking, trembling, unable to sit still, being jittery, felling worse, felling ‘not normal’, dry mouth, felling sick, and being drowsy as side effects.
Lily: I experienced adverse reactions to the SSRI, including apathy, emotional numbness and hallucinations (including seeing myself being hit by a car and falling on knives). I simply believed that the SSRI actually induced a depressive state worse than the one for which it had been prescribed.
Cheryl: I did not have any physical side effects, but I found that the medication resulted in me having ‘no emotions’. You just feel like a zombie at times. And I don’t know if it’s worth it.
Julie: You name it: nausea, tremor, decreased appetite, headaches, thirst, feeling sick, agitation, anxiety, impulsivity and violence. I have become particularly worried about the increase in my impulsivity and violent behaviour, which is totally uncharacteristic for me, and which was becoming more frequent and pronounced over the last three weeks. I have never been violent to
anything ever in my life, I’ve always taken it out on me. And ummm, for the first time I just got, I just snapped, and I basically threw the cat five meters across the room. And that just scared me, I didn’t know what that was. And I was impulsive, there was no thought behind it.

Role of the pharmacists
Vanessa, Lily, Cheryl, Julie: No, we haven’t received any counselling or information from the pharmacist who filled the prescriptions.

Doctor-patient communication
Vanessa: my general practitioner “freaked out” when I said that I was feeling depressed. The doctor’s daughter had attempted suicide and I was told about it in some detail.
Lily: I felt that my psychiatrist who used psychoanalytic psychotherapy in conjunction with the medication to treat my depression, was uncaring: I think his actions, to give me, to continue to prescribe medication without being concerned, at all, over the effects of it, was, ummm, ignorant and unfair, and ummm, whe I look back, it’s hurtful now. Ummm and ummm, just unprofessional and completely inhumane, really.
Hamish: I felt that my general practitioner was ‘informative’ and helped me to think through the options, providing him with information, videos to take home. This doctor also discussed possible side effects and contra-indications, and discussed withdrawal and the possibility that the SSRI may not be effective.
Cheryl: I do not remember whether my general practitioner had given me information about the medication I was prescribed. However, I found, just going and talking to him [was] quite beneficial. You know, somebody outside of the family, ‘cause I didn’t reslly talk to any of my friends about it, cause they couldn’t relate to how it felt, feels...
Julie: I have seen many different general practitioners over the three years that I had taken SSRIs. I no longer remember what I had been told, but thought that when I had first been prescribed the medication I had probably been given information. They say: ‘do you know how these work? And I say, yea…within reason, and so they just sort of said, ‘have you taken this before?’ and I say, ‘yes,’ and they don’t ask or tell you anything else.

Suicide
Vanessa: I had suicidal ideation, which I had never experienced before.
Lily: I had hallucinations about my own death, and eventually thought about ending my life.
Julie has repeatedly attempted suicide. She stated: “I know, I wasn’t suicidal before I was put on them…I don’t know whether it’s just the SSRI not treating the depression, or whatever it’s an increase in suicide”.

Medical explanation for depression and its treatment
Vanessa: my general practitioner explained that I need to, my body chemicals are not balanced, and that I need to fix that first, and then we could work on the problems second...yea...she explained something about a chemical imbalance, and we have to fix that before we fix the problem.
Lily: my psychiatrist explained depression in psychoanalytic terms. He said: ‘Keep talking and you’ll figure it out. Well, it’s inside of you, you just need to concentrate on talking a bit more’.
Hamish: I was given a neurobiological explanation.
Cheryl: I was not provided with info about depression, as far as I can recall.
Julie: I was provided with neurobiological explanations.

Patient’s explanation for depression and its treatment
Vanessa: I felt that my reaction to the breakdown of my relationship was ‘not normal’, but I thought that talking to people, not medication, was what I needed.
Lily: I wondered whether my mental health might have been affected by my eating disorder and the experience of observing poverty during my volunteer work. I was also curious as to whether my anti-malarian medication (Larium) might have had some influence. I believed that the SSRI actually caused my depression, and that I was probably suffering from anxiety prior to being treated.

Hamish: I felt that while medication might make it easier to manage my anxiety, a positive outlook, exercise, fish oil, meditation, relaxation, and making an effort to change were more important.

Cheryl: depression is an illness, and it can be treated. However, I see a difference between my first episode of depression, which had no “trigger”, and the second experience, resulting from the death of both my grandparents. I think that medication was needed in the first episode, but that counselling was more important in the second.

Feelings of loss of control and helplessness
Vanessa: I was overwhelmed by what was happening when I consulted the general practitioner: I was quite overwhelmed by the whole thing, what she was saying to me ’cause I didn’t really think that was what was going on...and she didn’t actually prescribe it first, she gave me a trial pack to take home and then get the prescription filled. So, it was kind of bombarded on me. “This is what’s wrong with you, you have to do this to fix it”, and I was so overwhelmed by everything that she was saying I just walked out of there and just took it.

Lily: I felt helpless, to the point that although I was unhappy with my treatment, I was unable to seek help elsewhere.

Hamish: although I was satisfied with my general practitioner’s information, I felt that I needed to know more, particularly about adjunct therapies, so that I could make an informed decision.

Frustration
Lily: I was frustrated with my psychiatrist, and with the medication, and its side effects. I said to my doctor: Look, I’ve had enough, it’s not working for me, I feel completely apathetic. I was so frustrated because he still kept saying to me: “Oh, just give it another week, you know, these things take time, your body is just adjusting.

Julie: It was frustrating because despite the treatment, my mental health seemed to be deteriorating.

Negative views about medical practitioners from the experience
Vanessa: It has, it’s fainted my view a lot, ’cause I went in there wanting help, and I said what was going on, and I guess, it was just more her trying to treat the symptoms that actually what was happening.

Lily: I found that the experience has negatively influenced my opinion about doctors: It just scares me to think that, ummm, fourty minutes into speaking to this person, I was prescribed what was going to be 18 months of hell, on medication. Within fourty minutes he felt he could make a decision.

Hamish: I’ve got a feeling that my general practitioner needed to have more knowledge about the treatment of depression.

Gaining control
Lily: I feel that my experiences have given me strength and wisdom, and that I know now that I am the best judge of my own health. I now interview health care providers before agreeing to treatment, and I seek other opinions if I am not happy with what is offered. To regain control, I ceased seeing the psychiatrist.
Hope
Lily: I strongly believe that hope was an important factor in keeping me alive: And there is all these little promises which you just, as much as I really resent the way that my psychiatrist, I feel that, he didn’t give me any care, the one thing he did give me was hope. And that’s not something that he of course, I think, actively gave me, but just by going to see him and by having these drugs, it gave me hope that there at least, was something.
Julie: I perservered with SSRI medication: It’s the hope, it’s the hope that maybe this one will be the one. And so, you know, a bit of nausea, if I could, you know, I mean, physical pain is nothing until, you know, until you experience emotional pain. And, if it’s going to even reduce it by 1%, I’m happy.

Lack of SSRI efficacy
Lily: I felt that not only had the medication not helped but it had made me worse: “So having all this hope that I was getting better and that this pill that I was taking was going to relieve my symptoms, yet physically, ummm, spiralling down, still, so not even reaching a plateau, continuing to slide down..
Hamish: I was doubtful about the efficacy of my medication.
Cheryl: I felt that the medication initially helped, but after a few weeks and increased dosage, I continued to feel depressed, or felt flat rather than depressed.
Julie: I had never experienced a positive effect from a SSRI.

Efficacy of the SSRI
Hamish: Whilst unsure that the medication was helpful, I did think it might have been helping a little bit. But yea, I mean, I think, it is working a little bit. That is, when I get into a sort of negative emotions or whatever, umm, I find I can come out of it a little bit easier. So, it perhaps doesn’t quite last as long.
Cheryl: I felt relieved in having been prescribed the medication, even though it was not alleviating my depression.

Stigma
Vanessa: The stigma of mental illness, and of taking an anti-depressant is there. For example, the reactions of my peers when I had to explain that I could not drink alcohol – Oh, why do you need to be on that?
Lily: many of my close family and friends would be unaware of my experiences, and I find it terrible even that I find difficulty speaking about it.
Hamish: I feel the stigma. My anxiety and treatment is something I find difficult to talk about, and that it’s like a lot of mental health things, you know, there is no good reason to feel that stigma, and you’ve thought it through, but you still feel it.
Cheryl: The stigma I feel, it gets to me how other people look down upon it, you know, mental health, you know, you must have something wrong with you.
Julie: I am very good at keeping the façade..

Social support
Vanessa: Friends are important, as a component of treatment.
Lily: I need to stress the importance of my supports: If I didn’t have that family and friend support, if I wouldn’t have been able to find enough things to live for, I wouldn’t have...continued living..
Hamish: I discussed my treatment with my parents, and they were very supportive. My close friends were also helpful.
Julie: My parents are unaware of my depression and my main support is another suicidal student with whom I discuss plans about how to end my life...

13 Cohen and Hughes, 2011
I have a chemical imbalance because . . .
• Medication did something to me
• Medication wouldn’t do anything if I didn’t have an imbalance
• Medication made me feel different
• I’ve seen the change in my life
• Medication obviously helps
• My doctor told me
• I’ve been told by experts who suggested I take the drug
• My doctor explained it to me
• My doctor showed me using a plastic brain
• I know about the field and chemical imbalances
• I’ve done my research
• My study showed me
• My understanding of depression is physiological
• I know by experience
• Others’ experience is like mine
• My symptoms are physical as well as psychological
• Physical symptoms must have physical cause
• Medication helps maintain serotonin levels
I don’t know if I have a chemical imbalance because . . .
• I haven’t been tested for one
• No test can tell
I don’t have a chemical imbalance because . . .
• I know of no biological cause for my problem
• I don’t believe in chemical imbalances
• My problem is due to environmental stress
• My therapists told me so
My medication causes a chemical imbalance because . . .
• It triggers unwanted physical effects
• Drugs affect everyone the same
• My medication leaves body quickly so it doesn’t have long term effects
• I don’t know if drugs act chemically or psychologically
• No reason given
• Short half-life means no long term effect

How Medication Acts in My Body: Users’ Descriptions (In Alphabetical Order)
1. Causes a chemical imbalance
2. Changes the chemistry of my brain and makes it function better
3. Cleans the spark plugs so they fire properly
4. Completes the chemical dysfunction
5. Fills my brain
6. Fills the holes that depressed people have in the brain
7. Helps maintain serotonin levels in the brain
8. Increases dopamine release and produces more dopamine
9. Increases whatever it is in my body that makes me happy and calm
10. Levels out my brain
11. Makes serotonin go around better in the brain when it gets blocked
12. Manipulates chemicals like exercise releases endorphins
13. Stimulates the frontal lobes

Bearing on the Subject of Chemical Imbalance in 22 Transcribed Interviews with Psychotropic Medication Users. Excerpts
1. Woman, 59, taking sertraline and lorazepam for depression.
Q: Do you think that the medications correct or help a chemical imbalance that people have in their body or brain?
A: Definitely yes, for some reason the person has an imbalance. And the only thing you can do is to take the medications.
Q: Why do you think it’s a biochemical imbalance? What makes you think so?
A: I think it’s an imbalance—from the moment you take the better medication, if an imbalance didn’t exist you could take the pills and they wouldn’t do anything to you because you don’t have it.
2. Woman, age unknown, taking sertraline for depression.
Q: OK, umm, why do you think you had a, why do you think you may have had a chemical imbalance?
A: Because Zoloft made me feel different.
3. Woman, 27, doctoral student in clinical psychology, taking amphetamines, venlafaxine, lorazepam, and clonazepam for 7 years.
Q: So do you think that the medications you’re currently on, may correct a biochemical imbalance, or—
A: Absolutely, yeah.
Q: And why do you think this?
A: Umm, because, well, what I know about the field I guess, what I know about chemical imbalances and I know how I felt before and how I feel now [. . .] I feel that my medication helps me to be who I really am, umm, I think it makes me more complete, it completes the chemical dysfunction, it helps the chemical dysfunction.
4. Man, 44, taking fluoxetine for 9 years.
Q: Do you think that the drug is correcting some imbalance, then, changing something in your brain?
A: Definitely. It’s correcting a biochemical imbalance. It’s—
Q: What, what makes you think that?
A: My doctor showed me. He had a plastic brain with different colors, he showed me. He showed me where the serotonin was going and how Prozac makes it go around better when it gets blocked, this is research. I’ve also done my own research and that’s how it works.
5. Woman, 62, taking paroxetine and alprazolam.
Q: How do you [think] the medication impacts your body or your mind? Do you think it has corrected a biochemical imbalance?
A: Most definitely, yes. I do. My study showed me most probably what the reason for my anxiety and upset was and so by understanding and researching it allowed me to be more accepting of Paxil and Xanax.

6. Woman, 68, taking sertraline and alprazolam.
Q: And so how do you think that the drugs are acting upon your body and mind, in what ways, in positive ways, in negative ways?
A: I think in a very positive way. I think it must be restoring the chemical imbalance in my brain so that I don’t have any of these anxiety and panicky feelings.
Q: That was actually my next question. Do you think these drugs are correcting a biochemical imbalance?
A: I definitely think they are because my symptoms were physical as well as psychological attacks.

7. Woman, 53, taking escitalopram for anxiety and depression, just switched from paroxetine and alprazolam.
Q: Do you think that the drugs correct a biochemical imbalance?
A: Yes, I do believe that. That there is a biochemical imbalance in the brain. And not only by experience—other people have felt the same.

8. Woman, 56, taking fluoxetine for 8 years.
Q: How do you think Prozac acts in your body, your mind? Do you think that Prozac corrects some type of biochemical or hormonal imbalance?
A: Well, that’s what the doctor tells me, that Prozac changes the chemistry of my brain and makes it function better, resolving the depression that way.

9. Woman, 30, just switched from fluoxetine to escitalopram, and also taking lamotrigine, ziprasidone, and lorazepam for last 4 years, has simultaneous diagnoses of post-traumatic stress disorder, borderline personality disorder, major depressive disorder, and generalized anxiety disorder.
Q: What would you think, in your personal opinion, how do you think that these act upon your body, your mind? [. . .]
A: Well, I know that, talking to my doctor, he explained that there have been studies done and breakthroughs that show the brain, people [who] are depressed have holes in the brain and use medication to fill the holes so they, they help.
Q: So you are referring to biochemical imbalance.
A: I don’t know what the term is, I’m just, I’m sure he put it in simple terms for me but that’s how he explained it, so I feel the medication’s helping me and it fills my brain.

10. Man, 31, taking paroxetine for depression.
Q: Do you think that the drugs corrected a biochemical imbalance?
A: Biochemical, as in within my brain?
Q: Yes.
A: Yes, I believe that’s what they told me it was gonna do, it was gonna, something Biochemical, as in within my brain?
Q: Yes.
A: Yes, I believe that’s what they told me it was gonna do, it was gonna, something to do with increasing serotonin, increasing you know whatever it is in my body that makes you happy, makes you calm. It just kind of leveled out my brain. I think that was the, umm, overall goal.

11. Man, 54, taking citalopram for depression.
Q: How do you feel the drug acts upon your body and your mind?
A: Well, the analogy that I’ve heard best describes it, is like, if you have dirty spark plugs and you use a detergent gasoline, it cleans those spark plugs so you’re getting a good, so they’re firing properly. Instead of getting sluggish performance, you’re getting peak performance. [. . .]

Q: Have you tried any other solutions to aid your depression besides drug use?
A: I don’t see any reason to. I mean, again, my understanding of depression is that it is physiological. So, if this drug allows me to cure that physiological problem then, you know there is really no need to seek any other help. Because, the problem is solved. [. . .]

Q: You said Celexa centers you. Do you feel it corrects a chemical imbalance?
A: Yes.

Q: Why do you believe that?
A: I believe it because I’ve been told that by people who suggested I take it.


Q: Are you able to explain to another person how this drug works for you?
A: In a way, I am not good at the medical term but I do know that the medication helps maintain serotonin levels in the brain and cause me to feel calm.


Q: Do you think that, umm, do you think that the drug in a way is correcting a chemical imbalance?
A: Yes.

Q: Why do you think that?
A: Umm, because I know it’s not in my head.

Q: What do you mean by that?
A: Because it would happen in my sleep. I would have panic attacks in my sleep. And that never happens now that I am on the right medicine, so I know that it had something to do with my brain.

14. Man, early 40s, taking quetiapine, lithium, venlafaxine, and lorazepam for 5 years for bipolar disorder.

Q: Do you, let me just [ask] for a second about, do you believe that you, because you tell me that you have been diagnosed with manic depressive, you tell me that you’ve experienced obsessive-compulsive disorder symptoms, do you believe that you have a biochemical imbalance, or something?
A: Yeah, I would have to say yes. I would have to say yes because I’ve seen the change in my life in the last five or six years. There’s no doubt in my mind that there’s something wrong mentally. [. . .] Uh, today I can, you know, safely and honestly say, yes, there is a mental issue that goes on in my mind. What created it—what triggered it—I would say would have been the divorce.

15. Woman, 35, taking antidepressants on and off for 14 years, now taking sertraline for one year, since marital breakup.

Q: Do you think it corrects any biochemical imbalance?
A: Yeah, I would say so because obviously, it does help, uh—

Q: Why would you say that? Do you have any facts?
A: No, no, no, actually it’s just, I am, let’s put it this way, I took this medication almost vigorously just because I trust my doctor but, I don’t know, seeing that I have experience with drugs for enough time I don’t know, I think that I can handle my problem without it, but this was a traumatic event. I got out of an abusive relationship so I understand anyone that goes through a trauma is going to react with sadness, grief and depression, this is normal, but, I mean I was able to function like I said for over a year without the need of medications—

364
Q: Okay.
A: —living a healthy lifestyle and exercising which is something that I have done consistently before and that was enough to create the chemicals in my brain that made me normal or made me feel good. So I don’t know, I guess so, I guess the answer to your question is yes, it’s manipulating my chemicals [with] a drug instead of endorphins that you get through exercise.

16. Woman, 26, taking lorazepam, estazolam, and butalbital.
Q: Do you think that you have a chemical imbalance or that these, the medications, are correcting a chemical imbalance that is giving you [. . .] the anxiety, the depression, and [lack of] sleep? What is your view on that?
A: Well, seeing is that I have two professionals with degrees that outrank mine, whatever, experience, umm, say that I can, umm, work with these anxiety, umm, symptoms and these depression symptoms without medication, I tend to believe that they’re correct.[. . .] I mean, I don’t think it’s chemical. I think it’s more, you know, environmental stress, or some things that I can fix. Umm, but I don’t know because I, I haven’t been tested for any thing like that so I have no idea.

17. Woman, 25, taking sertraline and venlafaxine for depression, diagnosed with post-traumatic stress disorder 7 years earlier, following a gang rape.
Q: How do you think the drugs act upon your body or mind? Do you think the drugs correct a biochemical imbalance? Why or why not?
A: Well, my aunt says I have lost a lot of weight since I’ve been taking the Effexor. As I told you before it makes me dizzy and I tend to lose my balance sometimes. So I think this is not good for my health. Can you repeat the other part? I forgot what else you asked—
Q: Do you think the drugs correct a biochemical imbalance? Why or why not?
A: I don’t think there is a biological cause for what I have. . . I do think that it is the way I was brought up. How can I explain to anyone that my self-esteem is caused by a biochemical imbalance? I don’t believe in biochemical imbalances. That’s a stupid reason that people use when they don’t know how to explain things..

18. Man, 32, taking methylphenidate, atomoxetine, venlafaxine, and alprazolam for attention-deficit/hyperactivity disorder and obsessive-compulsive disorder.
Q: So, do you think that the drugs corrected [a] chemical imbalance?
A: You know, I’m not so sure, if it’s an issue with the chemical imbalance. I think, I mean I know what some of these drugs do, I’m going to go with Concerta, which stimulates the frontal lobe, makes me focus a little bit, and most of them I’m not sure. I mean a lot of these drugs get out of the system quickly so you don’t necessarily have a long-term chemical difference. You know, I’m not really looking to change the chemistry and certainly not drastically.

19. Woman, 55, taking lithium and clonazepam for bipolar disorder.
Q: So is it causing a chemical imbalance or—
A: Well, for sure. I’m gaining weight, up to 30 pounds, and I’m dizzy, and I’m feeling thirsty, so it’s definitely causing a chemical imbalance.
Q: Causing or correcting an imbalance?
A: Well it’s supposed to correct one.

20. Man, 29, graduate student in chemistry, taking amphetamines for 3 years for ADHD.
Q: My next question is, do you think that the drug helps to correct a biochemical imbalance, that you have a biochemical imbalance?
A: Like a neurotransmitter imbalance.
Q: Yes.
A: That’s how it’s explained. But how can you tell? I haven’t been tested for an imbalance and how would they look for it, how would they know, if you have an imbalance or if you don’t?
Q: Amphetamines affect dopamine. So, could—
A: That’s right, but because they’re speed drugs they affect everyone the same, they increase dopamine release, you produce more dopamine—
Q: So, this corrects a chemical imbalance.
A: *This corrects your problem!* But it probably causes a chemical imbalance.

21. Man, 37, taking sertraline for 1 year.
Q: So, do you think it corrects a quote unquote biochemical imbalance?
A: Yeah, *I mean,* yeah, it definitely does something, umm, I wouldn’t know if it’s chemically or psychologically, I don’t know what it is, or how it works . . .

22. Woman, 58, taking escitalopram, chlorazepate, and lorazepam for depression.
Q: I wanted to ask you about your psychological wellbeing. Do you think you have any chemical imbalance?
A: *Maybe to balance out my mind.*
Q: Do you think you had an imbalance?
A: *I cannot respond if I do not know if that is the case.*

14 Dickinson et al., 2010

Three main themes were identified from the interviews: the benefits of antidepressants; ambiguities and dissonances in the understanding of depression and its treatment; and barriers to the discontinuation of antidepressants.

The benefits of antidepressants

*At that time [commencement of treatment] I didn't really care! If he'd have said take some rat poison I would have probably taken it, you know, I was that down so I didn't bother; and then gradually ... it got better.* (Patient 33)

*It seemed as if some fairy had waved a wand and got me this [drug] which brought me round. I swear by it.* (Patient 4)

*My worst point was when I woke in the morning. I just didn't see any point in going on and it certainly helped very much indeed.* (Patient 18)

*If the cause is a social factor I can't get rid of that ... but I might alleviate their symptoms a little bit.* (GP 5)

*‘If it makes them feel even a bit better it's worth it. Because at the end of the day a lot of them don't cost a huge amount, they are quite cheap.’* (GP 8)

Ambiguities and dissonances in the understanding of depression and its treatment

*After that I started to get tired spells where I was abnormally tired, not sleepy, physically tired ... it's an effort to walk about and that was when [the GP] said that this was depression, although I'll say I didn't feel depressed. But as far as I know not being very knowledgeable on medical matters you could be what you call clinically depressed without being mentally depressed. That's how I understand it, so although I didn't feel depressed I accepted the fact that it could well be.* (Patient 4)

The GPs also acknowledged a difficulty in providing a solid diagnosis of depression and understanding and treating its causes:

*We have to keep figures of who is depressed, but of course loads of people come in and it says “depressed”, but they are not actually clinically depressed. They are depressed because*
someone has just died ... and that's where our figures have been mucked up ... I think for all our patients who have coded as depression, maybe 10%, if that, actually have depression. (GP 6)

This ambiguity in understanding depression as an emotional or physical condition influences GPs' views of antidepressants:
In emotional medicine you are much more predisposed to the individual patient. In cardiology where essentially every patient comes into the sausage factory and gets an aspirin and a beta blocker and an ACE inhibitor and they all come out at the other end, you can't do that with the emotional illness. (GP 7)
Statins, yes I have my concerns about statins. But I suppose the gain from that is more tangible and more ... easy to sell. The problem with general practice is that the perception of psychiatric illness is one where it's still not seen necessarily as a biological condition. I happen to believe it is. (GP 10)
GPs acknowledged the difficulties in providing treatments other than pharmaceuticals:
We have ... a 10 to 11 month waiting list here for CBT [cognitive behavioural therapy], by which time the crisis has gone. People come to us in extremis really, they are usually in a very, very distressed, disturbed state. (GP 5)
The majority of [patients] have lived through the Second World War and they have an antipathy to counselling. (GP 1)
I think [antidepressants] do have a place, partly because it's not a lot of other things that help mild to moderately depressed elderly, the CBT has got a very limited place. Counselling; its always very difficult to get them to engage, so we are often stuck with just prescribing, so it's a bit “best of a bad bunch” really. (GP 4)
The GP said “Well, do you want to go for bereavement counselling?” Well I didn't and I don't because with my faith and my family, I don't need anyone else. He didn’t offer anything else, poor lad, what else could he offer? You feel that they're embarrassed about it sometimes. He's only a youngish man ... no, I haven't ever spoken to anybody about it really. (Patient 11)
I've been offered one or two [alternatives] ... and I said, “Well I'll see” and let them know. In the meantime I've been missing my little walks. I was offered walks from home but they had to close because no funds. I was offered people to come and have conversation with me ... no funds; no volunteers and that's the problem whatever I've been offered. (Patient 21)
Nowadays there is medicalisation of life, really. There are problems that we all have in our life. Some people need to have it turned into a medical problem to make it more valid or something. Rather than say I'm struggling to cope with my divorce or whatever, they come and say I'm depressed. (GP 2)
I don’t think it's right to prescribe something that they don't necessarily need, so we prescribe for social issues, but should we prescribe ... lifestyle drugs? I don't think we should ... But it's difficult when you can't measure an outcome. If someone has high blood pressure I can measure that and it's a definite. (GP 6)
Barriers to discontinuation of antidepressants
It's a part of my life really and I've just got to cope with it. (Patient 20)
I never get really well ... where I can do without these things. I've lived on them all my life. (Patient 19)
I don't think now at my age ... I think I'll be on them for the rest of my life because they can't do nothing for me so I think I will be taking them for the rest of my life. (Patient 1)
He coped with that very well and then was diagnosed with cancer ... so that was a big shock to me ... we coped with that very well, got over that. And I think I came off the first antidepressant, or whatever they call them ... and then 2000 my eldest son was diagnosed with cancer so they put me back on them again ... and he died in June 2001 but that was expected, I coped with that quite well, and after a while came off the antidepressants; and then 2003 my youngest son collapsed and died ... so my GP put me back on them again (Patient 5)
I'm normally tired and now you see my situation, my wife should have had her hip replacement but her blood pressure is far too high and she can't have it. So it can only get worse so for the last few years I've had to take on more and more to help her like I've had to do all the shopping and ... it doesn't bug me and ... physically nor emotionally I just do and ... we just accept it, it's just another thing that's come over that we have to cope with ... (Patient 21)
Patients acknowledged that often this was also a challenge for their doctor:
Oh I have done very well with this [recent reduction to antidepressant regimen], in fact I have done better with these people than I have ever done. With the other people, well I think they were just ... I don't think they knew what to give me ... I mean more than once I've been told “just get on with you” you know. I do get on with it but it can be very debilitating. (Patient 19)
GPs also acknowledged the intractability of some patient's situations:
I think they have horrible lives, a lot of them ... I think it's a combination of all things, their health, their social circumstances ... I think a lot of people are on antidepressants because of everything put together. And you can't ... change most of the factors that cause it. (GP 8)
They feel that unless they are on a tablet for it then they are not having any treatment. There are a lot of those kinds of people. (GP 2)
Negative perceptions of ageing
They didn't say anything about why I was depressed or anything ... they just seemed to think it was a general condition for my age. (Patient 20)
With old age every year you sort of get something which as you get older is expected. I mean if my eyes go they go. You see that doesn’t bother me, my legs bother me, yes because I can’t use them properly. I was a great walker at one time and I can’t do that now. (Patient 19)
[Doctors] are more bothered about blood tests, liver tests, breathing operations. No, the depression has gone into the bottom drawer ... I think according to the state of my health and what the doctors think about me ... I suppose if I brought it up in conversation they would talk about depression, but if there is no need to talk ... why not leave it alone! (Patient 4)
I'm summoned to the surgery once a year because of my age, where I have blood tests and urine tests, and a general talk about my health. But I don’t think that either the [antidepressant] or the depression has been mentioned in those talks. (Patient 17)
I think it's well known that depression is often overlooked in the elderly and people who have got physical disabilities and whose life has been significantly impaired by their illness ... (GP 2)

There are some bigger battles I think out there, than persuading them to stop their [antidepressant treatment].(GP 8)
Elderly people are generally more self effacing, and they don't make demands on us for treatment. They say “oh I know it's old age”, you know, they expect that they are going to feel low because they are old. They have lower expectations of what can be achieved. I think, and they are wary of antidepressants, but I think antidepressants do work in elderly people. (GP 9)
It's always difficult to assess because there are so many more layers with elderly people, they tell you what they think you want them to say ... I think it takes a lot more detective work. (GP 4)
I'm not coming off these because every time I come off, something else happens; but these, these are more for a panic attack. (Patient 5)
I sort of take half of one for so long and then I think “oh blow this I'll get rid of it” and then of course I get the collywobbles then. (Patient 19)
I still don't know whether I would sleep if I came off them … I don't want to try! (Patient 32)
When [the GP] was there she said, “well, we could get you off them slowly”, and I was in fear of her doing that because I suppose they're a crutch really. (Patient 34)
I'm not being funny but … would it make any different at my age? I mean why bother changing something now? (Patient 6)
I think at my age I would just think “well carry on as I am with them”. I think it's too late to change now. (Patient 20)
It's scary to stop a medication that's been going for a long time, because you kind of think am I opening a can of worms here, because I don't know what the reasons were for them starting that medication. To explore all that will take, you know, I can't do all that now, I will have to do that at another time. (GP 9)
They're frightened of coming off, because they don't want to feel like they did initially. And you can understand that. (GP 8)
I don't agree with this treatment, it's not the best thing to do, but at the end of the day it depends whether harm outweighs benefit and is it worth having that major fall out with the patient and if I'm really stuck and I really want them off it I would send them to psychiatry to get someone else to try and do it for me. I've never had to do that. (GP 5)
There are some patients who need that little bit of a crutch, almost a placebo effect, the kind of people who sometimes feel they want to be on a low dose more permanently because they feel it keeps them on an even keel. (GP 2)
The long-term patients generally are on probably sub-therapeutic doses really, how much actual effect it has on their mental health is probably minimal but it gives them psychological support. If somebody did become more symptomatic then we would up the dose. (GP 2)
But I just do. I take them ... I just take them thinking well if they do me good … (Patient 23)
Patient (P): Oh, I think, I you will continue with the medication think now I've got to this age anyway that you know I'll just go on. (Patient 26)

I don't really know. The doctors will keep an eye on things and if the time was appropriate then they would take me off it but... having kept me on it I assume they are happy for me to go on taking it so I take it but ... with all this medication I would come off it if I could. If I can't come off it then I accept it. (Patient 21)
As I feel now I feel like I'll be taking them for the rest of my life ... after 4 years I can't see it improving, as I say it keeps it in check. (Patient 1)
Well, I won't be here long so I think I'll keep on it ’til I go. (Patient 27)
It would be a marvellous thing if you didn't have to take anything at all, but I think that is asking a bit too much at my age. I think you have to have something to help you along. (Patient 29)
Patient: I was called in to see the doctor because I think at that time they were a little concerned about what the long-term effects of taking it would be. And we chatted and the doctor said to me “I think you’re taking these as a sophisticated sleeping pill, and if that is the case, I’ve no objection to that”. And I said “Well, they do help me to sleep, that's the reason why I keep taking them”.
Patient: I feel it's one that suits me and I'd be reluctant either to change or stop it.
Patient: As I say I'm reasonably happy with taking the ... well very happy with taking the drug; it seems to be working and unless I suddenly get an attack of depression, I don't think I would mention it to the GP. (Patient 17)

Egede 2002

I don’t know what other people are thinking but I have heard other people saying she’s crazy because she’s taking depression pills. I heard it. So, that is what comes to mind; so, I just let them know that I ain’t crazy...because I don’t want nobody saying: “Yea, she is crazy, she is taking those depression pills”. And I feel badly because they say that. They don’t have to laugh like that. (A woman).

I think diabetes is a sickness and depression is a state of the mind. Depression is something you can get rid of; diabetes you can’t, okay. (a participant)

I think it is a lack of ideology, a positive ideology instead of a weak mind. They don’t have knowledge or understanding of how to overcome it. They take what people say in the street and it destroys their strength. (a participant)

People just sit back and worry about things, you know. Things they want and can’t get, or whatever, you know. That is what some people do. And see, I just don’t care. I got that nonchalant attitude now. And you know, a lot of people tell me that. I don’t know if that is good or bad, I just don’t care. (a woman)

I guess with me it is different from everybody, I came from a poor family, we had nothing, there were 8 or 9 of us living in 3 rooms; so, when I was a child I learned how to provide for myself and take care of myself just about...I guess my daddy made about $8 a week, mother made about $3 a week, so I grew up learning not to worry about things...I just keep on living, I just never let it bother me. I do what I am supposed to do. (a man).

I feel to myself that depression can mean self-pity, it is like feeling sorry for what you have and then again thinking about the things you were able to do before you had diabetes. (a participant)

When they first put me on the pills [for diabetes], I used to think I don’t feel like taking these pills, you know, just seem like it started getting on my nerves at one point because I had to take those pills every day, ... and it was just like taking a pain killer ... Yeah, it was what started me to get depressed, but then I had to shake it off. Because, I remember, I had to shake it off...I just shook it off. (a woman).

I regret the chronic use of antidepressants. I only took them because I had this fear of being ill...I don’t want to get sick. That’s all. I am trying to keep it down for now. Because I know how it gets, I know it will put me in the hospital. That’s some place I don’t like to be. I don’t like to go in there. So, that is why I do what I do...to stop me from having depression. (a woman).

Diabetes can destroy you and depression can destroy you, both of them can do it to you. (a participant).

My son was stressed out,...it was not warranted. He was up for promotion, they put somebody else in his place, and he didn’t get it. He got stressed out. And the doctor put him on stress pills, and he was all right. He had the same mind you got, he said: ‘I don’t need this.’ And he took himself off of them [the medications], and every time he took himself off it he would have to get back on them. But it was all because he didn’t have a strong mind. (a man).

I just hope I never get depressed. I’ve got two people with depression, I’ve got a sister and a brother, and they both have a little nerve condition and I know through dealing with them and
seeing them, how it works. And you know, I just hope I never have to get to that point. (a participant).

If I feel like I need to talk to somebody, I am not going to go to them saying I am depressed, you know. I may be depressed, but I ain’t taking no medicine. Yeah, you know, I...sometimes...I need to go lean on somebody’s chest... Yes, I do, so somebody can hear me, you know, hear how I am feeling. (a woman).

Medications are only acceptable if prescribed for a short time. (a medication advocate).

If just based on what’s on a piece of paper you are going to tell me that I’m depressed, and you’re just going to sell me some medication, no. It’s not going to work like that. You know, you have enough evidence, you know, over a period of time, and then it’s going to be on a trial basis. For me, I need to know you for 6 months. (a man).

With depression, I just call it a sickness, and as she said [referring to another participant’s comment], I just need somebody to talk to...And you can get depression that makes you feel bad...make you feel real old, but I won’d take them, I won’d take the depression medicine. (a woman).

[T]his is what I say. They’re no medication that can help depression. Not to me, it is all within yourself, your mind. (a man).

Excuse me, I am not saying you smoke cigarettes because you are depressed, but it actually relieves the stress, calms your mind. The medication for depression does the same thing. What I am saying is if you smoke a cigarette, you do it to calm yourself. Depression is just relaxation backwards. So, what is the difference? (participant).

Would I tell anyone that I am depressed? Well, maybe my friends or people like that. I would probably let them know what I am going through but I would not allow people who don’t care for me or might want to do me harm to know. (participant).

This is the best confidence right here because it is only fellows. I am not saying that I am knocking the women out, but I mean most men will not discuss certain things in front of a woman [referring to emotional issues such as depression]. (a male participant).

A woman on antidepressant medications talked about the shame and pain she felt because people made fun of depression. She began to cry, saying, [w]ell, they talk about you, laughing, and thinking, you’re crazy. Something went bad for me. I raised 5 children and I think I did good. I didn’t recognize it [depression] until I went and talked to my doctor; my doctor told me I have a little probem.

If I am really depressed I know I’m not going to take one doctor’s opinion on that because I might not be that depressed like he said I am. If the doctor said he is going to give me some medicine for depression, I will tell him no. (participant).

I think, he might tell you to take this for depression, and all he might be doing is giving you aspirin to make you think in your mind that he is giving you something to help your depression. But he ain’t giving you nothing really, but a little confidence to build yourself up inside to get over the depression...so you can deal with it then. (participant).

I try to, you know, do positive things, and I control things, that, you know, that I can control. If he [the physician] says I am depressed, that’s just his opinion, but I’m not going to let him get me on medication or anything because that’s more depressing. (male participant).

16 Fosgerau and Davidsen 2014

The following extracts are discussing antidepressant use:
Extract 1:
GP: did you at all talk about what one could do about it or what is sort of treatment?
Patient: well they urged me to start medication as fast as possible to use their expression. To me that request was both a little shocking and also kind of a relief. Because it is like a hope about something that could give me a little help

Extract 7:
GP: But what about your friends? Are they there for you?
PA: They are, they are..
PA: It is just my friend Petra who knows that I get depression tablets [right] and then my family and no one else knows. It is not something that I am advertising. Because it is not something that I like...
PA: You do not need to..
GP: You are the one deciding who you want to share your problems with

Extract 8:
GP: What do you think about the effect of the medication Peter? Now you have a little more experience with them
Patient: well.: I believe I have been lucky that I have not had any side effects.
GP: exactly… but four months..you have been taking them for four to five months
PA: yes, but actually I think that it is like..that it in one way or the other hmm..how I describe this that I go up and down and at least it cuts off the lowest part
PA: so...when I ..the third time I got depressed and chose to stay in bed and started a vicious circle then I get out of bed every day, I get from my bed every day..
GP: so, it puts such a safety net underneath you
PA: Well...it..takes me up to a place from where I can push myself further ahead and then comes the snowball effect right and that is what I would like to get started so that I never get to the opposite lying three days in bed

Extract 9:
Psychiatrist: what about medicine? Do you really have like – do you feel uncomfortable taking medicine or has it just become such a:..
Patient: It took a ridiculous amount of time before I accepted it to begin with. But I – I think it is okay now because what I am getting now...I do not feel there are any side effects and I feel that it works so I am really not as angry about the medication any more as I have been..
PS: So, you have like integrated or accepted it?
Patient: Yes, I have accepted them pretty well.

17 Frank et al., 2007
Symptom descriptions
... it started out with a sleeping problem where I would only be sleeping maybe 4 hours a night, and in that 4 hours, I would wake up even, and then it got to be where I didn’t even want to get out of bed, I didn’t want to put on makeup, I didn’t want to do housework, I wanted to do absolutely nothing. (Female S)
Low mood, low energy, lack of motivation, lack of focus/concentration, feelings of guilt, self-critical thoughts, feeling overwhelmed, lack of enjoyment, hypersomnia, restlessness, anger, and irritability.
I became more defensive ... feel like people are picking at me; having a hard time enjoying things you used to enjoy; Anger was a big one.
Most bothersome symptoms
Fear and fear of the future; anxiety fear that makes me want to completely draw in; the severity of the experience attacking through multiple symptoms; want to die ... afraid to die; want to withdraw ... You just want to live in a cave ... esteem is gone, self-conscious and self-aware, over-analyze everything ...; Forgetful ... and then I am agitated and I’m mad at the world and I’m frustrated. Then, all of a sudden, you’re barking at your children and your wife. Functional impairment that is prominent among most bothersome symptoms; It got to the point to where ... especially at work, my performance just kept going downhill. Depressed mood, fatigue, and feelings of worthlessness...

Improvement with drug treatment and first symptoms to remit
- Irritability
A male patient: Irritability is probably the key thing; grumpy, cranky; hypersensitivity and reactivity to describe this symptom: ‘being overly sensitive to everything’, and easily set off; ‘anger’ along with irritability; irritability subsiding in social situations with close friends or family members: ‘Not being as cranky and angry with him over every little thing. I wasn't as easily set off. I used to snap at my mom, bite her head off.’
A male patient: medication helped me have ‘better impulse control at home—my first reaction wasn't I am going to smack you’; the medication helped me stop ‘yelling’.
A father: the medication helped me stop ‘being short with my children.’
A female participant: My internal experience of reduced irritability was strong: ‘I went from being overly sensitive to everything, to finally I can let some of the things go, roll off my back.’
All Participants: irritability was the first symptom to improve.
- Energy/Motivation
The second most common symptom to remit early in treatment was a lack of energy or motivation. Female participant: I’ve noticed medication-related improvement when I actually got out of bed.
Participant related interest level to functioning: I have more interest in my husband, more interest in taking care of my house, bathing and putting on makeup ...
Participant: Increased motivation leads to other improvements that follow: If you’re motivated, then you allow yourself the ability to enjoy some things, but if you have no motivation, there is no way to enjoy it.
Woman: My family noticed I was able to maintain more organization in our house.
The increased energy was linked to my experience of irritability: The first was I had more energy and I was less irritable. By ‘irritable’ I mean like in a home situation, I had better impulse control. What I noticed was energy, I was less irritable and less fidgety.
- Sad Mood
Several participants: a sad mood was the first symptom they noticed improving.
Female participant: I was happy, my mood; I was happy for no reason, was just happy; I also felt very carefree and did not have the negative thought pattern, and then my energy started to come back.
Male participant: Happiness, that was my first thing; all of a sudden, I realized that I am walking around work whistling.
Others: ‘lifting of the cloud or feeling’ ‘lighter’. Anhedonia was relieved as mood improved.
Participants: other people frequently noticed improvements in their mood.
Mother: My daughter told me ‘I was less miserable than I used to be.’
Several patients said their psychiatrists commented that they appeared “brighter.”

- Anxiety
Patients: symptoms of anxiety were among the first to improve with antidepressant treatment. Words and phrases used by patients to describe this anxiety included “worry,” “fear,” and “nervousness.” Most of the patients appeared to perceive symptoms of anxiety and depression as being interrelated.

Other Symptoms: Coping, Decisiveness, Negative Thoughts
Patients: the first characteristics to improve with treatment was an ‘ability to cope.’
Patient: The ability to cope was a feeling of being ‘not quite so overwhelmed—I felt like I had more control of things that I was doing.’
Participant: The ‘ability to make decisions’ was the first characteristic to improve.
Two participants: said they quickly noticed improvements in the negative thought patterns that tend to accompany depressive episodes, such as hopelessness.
Patients also identified symptoms that were slower to improve: Sleep difficulties, problems concentrating, and feelings of social isolation were often cited as being more treatment-resistant.
Several of the patients reported: significant improvement in mood, irritability, and energy level said that their ability to concentrate or focus had still not improved.
Most subjects: indicated that sleep improvements took longer to establish.

18 Fullagar, 2009
Kaz (33 years, urban): I’m having my medication upped again. Which is to the level that I’m at now, which is fantastic. I’m not changing it. I’ve actually come to the conclusion, and one doctor ... said this to me once, ‘If you’re a diabetic, would you stop taking your medication because you felt good?’ And I said ‘No.’ And she said, ‘Well, why would you, as a person who has a chemical imbalance in your brain, stop taking the medication, because you feel good?’ I went, ‘Because you’re not depressed any more.’ And she goes, ‘Yeah, but your chemical imbalance hasn’t gone though’ ... if you’re on it because you’ve obviously got a shortage of serotonin or something, if you are on that, you could be on it for life as maintenance.
Jasmin (37 years, urban): When I’m not on medication and I’m depressed, I feel like I’m already in deficit because my mind’s not working properly and my brain is not working properly, so at least on medication I feel like I’m on a level playing field ... so I’m not at a disadvantage for working on life’s xperiences.
Kaz (33 years, urban): Taking medication is a practice of ‘doing’ something to create the conditions for normality: ‘I’m not doing it to feel good, I’m doing it to feel normal.

Sandy (53 years, rural): I am relieved that it was my brain not my ‘self’ that was the problem: For the first time in my life I actually thought, ‘There is something wrong with me.’ And that was a weight lifted off my shoulders. They explained it to me ... in my case the serotonin was going across and going back quickly; not enough.
Roslyn (43 years, urban): My depression arose in relation to this sense of failing to meet multiple gender expectations that culminated in a frightening panic attack: ‘I felt a failure ... I’d failed my kids ... pursued my career at the expense of my family. And now I’d failed in my career and I’d failed them. For me depression and anxiety ... was always something that happened to malingerers and people ... who weren’t strong.’
Jasmin (37 years, urban): … that little pill is a reminder that there’s something not quite right, and that you’re a little bit dependent on something to keep you sane. So, I guess there’s an aspect of your life then that you don’t have control over?

Irene (59 years, urban): You become two persons, two people in the one body, but there’s always the fear in the back of your mind that you are not standing hard enough on the other person (depressed self), and that other person is going to reappear, just when you don’t want them to.

**Difficult process of withdrawing**

Elisabeth (34 years, urban): It was quite a shock when I wanted to go off medication and that’s when I had terrible mood swings and I just kept crying and screaming.

Roslyn (43 years, urban): my conflicting desires: … because they made such a difference, the medication, I’m just sort of a bit anxious about getting off them … [it’s] a bit of a safety net for me … I tried to get off them once and the side effects are just horrible … the doctor who first prescribed them for me … painted a pretty rosy picture, which I think was misleading because I have suffered signifi can’t side effects trying to withdraw from them … [also] I think it’s a psychological thing that I’m dependent on these …Am I dependent on these drugs to be well, or not? It will be interesting to see.

Cathy (32 years, urban): You have to draw upon risk rationalities: I used medication to surveil my emotions as a prevention strategy: I thought as soon as I sense that something could be amiss, or that I’m at risk, like if there is a death in the family, I’ll start taking medication, even if I’m not too grieved by it because maybe I might develop something, I always sort of keep watch.

---

**19 Fullagar, Simone and O’Brien 2013**

Tayla (31 years) was initially prescribed anti-depressants after she had suicidal thoughts. She decided to stop taking anti-depressants after a conversation with another person who had a similar experience. Tayla reflected on her own experience,

Nop, I’m not going to be on medication for five or six years. I just went cold turkey …I can beat this with (the help of) husband, kids, friends.

Allie (69 years), who lived through the era when barbiturates were prescribed to treat depression, challenged this form of treatment by refusing to take medication because it sedated her too much:

I thought no, this is no good, there must be something, something else. But I didn’t know what the something else could be and it wasn’t until many, quite a few years later that I learnt, yeah how to deal with depression … And then it was a matter of dealing with it, I mean I learnt how to … live with it if you like, but it was many more years after that before I came through it. I mean I think you can’t go past exercise, but it’s not the only answer, it’s very complex, depression is complex and also the overcoming it is complex, so you try lots of things until you find what works for you.

Renata (38 years): I changed my relation to ‘self’, because I notice that I haven’t done exercise, or something for myself, or a massage, or something like that; that’s when I start to go off the rails. And so what I do is, just say knowing my signs, is I kick in the self-care. So … I mentioned the massage … or I cut my workload down.

---

**20 Gammel and Stoppard, 1999**

How did you come to be diagnosed as depressed? What forms of treatment have you received? What do you think caused your depression?; and, Do you think you are over or will get over this depression?
I was afraid that she [her physician] was going to say that I didn’t need an anti-depressant drug … I think I would fight tooth and nail if anybody refused to prescribe it for me. (Ann)
Taking medication…It made me feel weak, like, yeah. Like to have to take a chemical … And then I got thinking about like the medication, I was just like, so what does this mean if I have to take this medication in order to be, in order to be normal? Like it just felt so weird … I haven’t told my doctors but I’m, I have stopped taking my medication. (Susan)
And I’m not really, at this point I’m still deciding … I think partly it’s fear of the drugs themselves. Like I’m not really sure what, in terms of side effects and in terms of sort of like and addiction. And just, I guess the idea of needing, whatever drug to feel okay is a really, I don’t know, it’s kind of a nasty idea. (Tracy)
I felt I couldn’t talk to my psychiatrist. You’re in five minutes and okay we’ll try you on this pill. We’ll try you on that pill and there was no counselling. And I’d come home and there was no counselling, like there was no, there was nowhere to go. And um, so I, Dr. [name of psychiatrist] said I’ll put you in touch with a clinical psychologist and he did, and he put me in touch with a clinical psychologist and that was the best thing that ever happened. (Sarah)
I think, um, counselling has helped probably the, the most though. Yeah, yeah, taking time to to look back and go over, you know, things that should have been dealt with … When I started going through all the healing for, my sexual abuse, the depression started lifting. (Debbie)
It was good to be there [the psychiatric unit]. It was a safe place, a good time to get away and think … you get to know people, I got to know some really good people in there. (Debbie)

Life After Diagnosis with Depression
I mean even after all this, I really I don’t consider myself to be depressed just because I hate that classification … I don’t think about myself as depressed because I don’t want to be, kind of … Right now, like I don’t consider myself to be depressed. I don’t think I’m depressed right now. But I know I am. If that makes sense. They tell me I am. (Susan)
I still did my daily activities of daily living. You know, had supper ready, had dinner ready, had their lunches ready. Did the wash. But none of that had ceased, you know … (Sarah)
But I just let go and went with the illness. I thought to hell with other people, I’m not going to. If I want to lay on this couch, I’m going to lay on this couch. (Jane)
I want to go to law school like and that’s another seven years and I just think, if I can’t handle second year Arts, how in the hell am I supposed to be able to deal with this? (Susan)
I’m hoping I won’t have any recurrence … I’ll never say that it’ll never happen again, but I’m hoping that with each time and with my experience, I’m hoping that I can minimize you know … I hate this feeling, you know, it’s but you know that you can overcome it and you know that it’s going to get better. (Sarah)
I don’t think it’s something that can ever be permanently fixed. Um, I think it’s something that you can um, deal with better, I think it’s something you can learn how to live with. But I don’t think it’s something you can ever um, you know, cure. (Kelly)

Medicalization and Women’s Experiences of Depression
There was always something wrong, a lot of physical you know, couldn’t sleep, always tired, didn’t want to eat and things like that. Um, the big one was the insomnia. I just couldn’t sleep. (Kelly)
I’ve got a small group of friends who are all suffering from various mental illnesses and we all, you know, joke about it, you know how we’re all, we use the term crazy but we don’t use it in a derogatory sense you know. But I mean there’s still that you know, when someone tells you your brain chemistry’s all messed up you’re sort of like ooh. (Kelly)
I’m not ashamed of it [depression], I mean it was something that’s, it was natural, it was a natural occurrence ... People aren’t ashamed to walk around with diabetes or a heart attack ... people get cancer, it’s not something you’re going to hide. It’s the same thing. (Debbie)
It’s a chemical imbalance and, to me it just happened, it may have had something to do with my menopause ... (Gloria)
... you do need your medication or I felt I needed my medication to alter that, the thought process ... (Sarah)
I think counselling probably was the best thing. You know, more so than the Paxil [an anti-depressant drug] ... I don’t know, I shouldn’t say that. But I think I probably could have healed without the Paxil too, but the Paxil’s like an aid ... giving you your you know, your ability to you know, calm down or to. It takes awhile for it to work though, I I think it helped, initially.
(Debbie)
Well, just if I get a medication that works for me. (Gloria)
And I know I do need medication ... we’ve tried three, well four different drugs now and this is the one that seems to be working, you know, the best. (Sarah)
... you’re going to have to acknowledge that sometimes you know it [depression] is going to invade in your life and you know, and at that time, times like that you have to ride it out you know. (Kelly)
... if I had something that brought it [depression] on or something to keep it here, ah with me, ah but like I said there’s nothing, I have a really good life with my family. And I have my car to drive and no problems. If I want to go shopping and buy something I can go shopping and buy something so it’s it’s, there’s nothing, not a thing. (Gloria)
Dr. [name of psychologist] knows so much more because I see him more often. He knows all about [male acquaintances], and he knows all about [situation with a relative] and he knows all about you, the anxiety and stuff so I’d I’d say I talk more with him than I do with the psychiatrist. (Susan)
But it may have a bearing, the stress of that, work, on the genetic ... But I was always one to strive like I’ve always had many irons in the pot. And whether I just let myself get overwhelmed by too many things going on at the same time. (Sarah)
I still have to limit myself um and that’s the hardest thing I do find is trying to limit. And, you know, take time for [Jane], take that bubble bath. (Jane)
Like, I went into hospital, he [husband] had to take over the budget. He’d never once looked at the budget. (Jane)
So therefore, they [family members] did not see a whole lot of change in me except that I couldn’t work [outside the home]. You know, because I worked around here [in the home]. (Sarah)
... when I go to work I feel very comfortable there, very safe. I’d rather just work there forever. Um, I just work part-time as a sales person and as far as school, surprisingly it hasn’t affected as much as I thought it would. Um, I figured I’d just fall behind really bad. I dropped a course immediately and just said forget this. (Amy)
Several women felt more positive and made positive changes in their lives since their diagnosis and treatment.
I’ve been off medication for a year or so, um, I have managed to straighten out a lot of, a lot of things in my life ... mean I’m doing much better in school now and ah, I’m enjoying it a lot more and so I mean for the most part I’m pretty, pretty happy you know ... I didn’t know like happiness, how cool it could be, how great it could be. (Kelly)
Another young woman with a history of abuse and depression, admitted that her treatment had helped her become a stronger, more confident person.
I feel so totally healed and so positive about myself and, oh gosh, it’s just like, like on top of the world. Really I just feel like I have a total grip on, on life and, a lot stronger than I used to be ... Having to go through that, you know, depression, just to just to get where I am is worth it for sure. (Debbie) 

Susan: I am concerned that depression will negatively influence my life in the future. For instance, the implications of my diagnosis for my future relationships.

21 Gibson, Cartwright and Read 2016 (a) 
Taking Charge or Giving up Control 
Taking antidepressants makes you feel like a failure . . . like giving in (Participant 1). 
I understand antidepressant use as a weakness: Maybe that’s also wrapped up in this idea about, you know, I should be able to cope with it without medication as well. It’s maybe it’s some sort of failing, maybe it’s some sort of sense of failure about having, you know, I’m not doing what I could do, I’m not achieving what I could achieve because I need medication, I should be able to manage these sorts of things. (Participant 13) 
Generally, men tend to think that they can overpower any situation with just pure physical-ness (Participant 20). 
We’ve always had people that used to talk about taking their happy pills and yeah I was never sure that they’d done enough themselves to try and fix things (Participant 4). It’s not a sign of weakness, it helps your own mental stability sort of get back on even keel again (Participant 5). You’ve got to help yourself . . . there’s only so much that people from the outside can do. It’s got to come from within (Participant 6). 
I’ve got pretty good at sitting back and analyzing what’s going on and looking back over a week I’m able to chop and dice and go “mm I’m going to stop those meds now, I’m going to monitor myself for a couple of days and if I don’t improve after those two days I’ll go back on the meds knowing that it’s something else. (Participant 10) 

I didn’t want to be bothered going to the GP. I told the GP after I had done it . . . I made up my mind I was going to do it, I didn’t want the doctor to say no, it’s bad. I don’t think he would have. But I thought I can control this myself. (Participant 16) 
What I felt it was the loss of control over my own life. ‘my brain belongs to Mr. Pfizer’ (Participant 12). 
Functioning in Life or in Sex 
The whole unpleasant thing, you know, your libido is absolutely stripped. I might as well live in a monastery because I’ve got no libido and when it does come then I have erectile problems and so it’s really, for something that’s supposed to stop depression, it causes me a lot of depression, you know. (Participant 12) 
There’s a stigma attached to, and particularly for a man, to be suffering from depression. So I kept wanting to get off [antidepressants] and so from time to time I would wean myself off. But I found that I couldn’t function under high pressure without them. (Participant 7) 
And so here they are, they give you functioning for day to day activities but possibly take away marriages for certain people. . . . It makes you feel good but you can then coast into a separation that perhaps might not have happened. (Participant 20)
Well I think getting rid of the depression probably is the most important thing of all because it affects everything whereas impotence only affects part of your life. . . . But then on the other hand as you say it’s like do you sacrifice your sexuality or do you sacrifice your life and that’s what it felt like. (Participant 19)

Well it meant that I could never have another relationship. I mean how many people do you meet who might be interested in you for taking things further through a relationship once they know that you can’t perform a sex act. It would have to be a very special person. You can’t advertise on the net “this and this and this wonderful—but no sex.

Having said that when you get to your 60s your sex life is not as active as it used to be anyhow. (Participant 7).

I re-engaged. I became a loving and I think a better partner in the fact that it made me more facilitating, like I wasn’t sweating the small stuff. Now some people would say that’s disengagement again but for me it wasn’t. I actually re-engaged. (Participant 20)

So I actually find the performance is actually great as well, because that means I can go for it quite a long time (Participant 9).

Relieving Distress or Reducing Emotional Vitality

Pretty much all the classic things . . . highly emotionally unstable I guess in the sense of bursting into tears at a moment’s notice (Participant 14).

Well I’m quite a rational, stable sort of person but that would get me at times, in areas that were completely beyond my control. So, I was worried that I might be in the middle of a business presentation and suddenly crack up for no reason. (Participant 19)

When you crack, you show the signs that you see in a woman, crying, not being able to cope, you know, just bursting into tears at the drop of a hat, and no one wants to go there. I guess that’s why we take the pills. (Participant 3)

[They] kind of take the edge off if you like (Participant 8).

You can’t think about how you feel if you are too clouded by emotion. You can’t step back from it. And even though I hate to admit it that was a really beneficial part of it. (Participant 1)

They’re terrible things because they take away, yeah they take away the lows, there’s no doubt about it, but they take away the highs and they put you in the ‘nothing zone.’ So, you don’t feel things (Participant 3).

And then I found I wasn’t interested in movies. Oh, I can’t be bothered. Couldn’t be bothered going to Art Galleries. No pleasure in it. Um sense of taste, just sort of flat. . . . I would eat in a completely functional way. (Participant 11)

Yeah I guess in one way [less emotion] is good. And in another way, it’s not going to be good if you want to, you know, become more empathetic, more compassionate, or learn how to be more relational with people. (Participant 1)

I know in New Zealand, especially, I mean you know you’ve got to sort of man up and be a man and do everything else and all the rest of it. But I think a lot of people nowadays are sort of realizing that people do have feelings, whether you’re male or female. But you can still have feelings without degrading yourself or belittling yourself. (Participant 5)

So, I was trusting someone because I had lost all confidence, so I didn’t know what to do. It’s an all new experience for me, and you know. (Participant 15).

I can’t remember how many I cycled through with [my doctor] in that five months. There was always the question of we’ll give it a bit longer and see if it works. But I just got to the point where I said “Doc it’s not working. I’m not prepared to elongate the timeline because it makes no difference for me physiologically. It’s not going to help.” (Participant 10)
So you’ve just got to roll with it but I’m old enough and experienced enough now to know how to trust my own gut. This is telling me it’s not the thing for me then you know . . . There are times when you go well I don’t need to take the pills because I feel good. But of course you feel good because you are taking the pills. I’m like well I don’t think I’m depressed, but that’s because I am depressed, so I’m not thinking properly in terms of knowing whether I am depressed or not. (Participant 8)

You are left feeling insecure in your own ability to understand what you are going to become like, what you could be like, what is the real you anymore? (Participant 20). Certainly, a lot of the symptoms of depression that I exhibit, you know, I wonder whether they’re actually symptoms of depression or it just so happens to be that that’s the way that I am, if you know what I mean. (Participant 8)

No doubt there was an element of going along with it because I was in the relationship and I enjoyed that and she thought this would help and I thought well maybe it will. I’m sure there would have been [my partner’s] expectations of what she wanted or expected me to be like, that would have been some kind of force. My wife is very good obviously at now identifying where I am at and saying: ‘Hey come on, don’t you think you need to be taking your antidepressants again’ (Participant 14).

I wasn’t aware of the depression myself but [my wife] tells me my mood was much further down [than I thought] (Participant 16).

It’s because I can’t trust my judgement anymore and you’re my wife, you’re supposed to know that I’m not well (Participant 10). (Participant 16) My wife would “divorce” me if I stopped.

My wife seemed to appreciate me more when I was taking antidepressants.

And I understand partners’ encouragement to take antidepressants as sign that they were uncomfortable with the emotional vulnerability of someone who is depressed…

It’s just it seems to be, [my wife] expects you to be a male and be the strong one, and she’s a pretty strong person herself, but she expects me to be, I can’t really show too much vulnerability, which is hard work. (Participant 7)

For me it was a matter of my wife pointing out to me that I need to be responsible for my own behaviour and if you can’t control it you need to see somebody about it or do something about it, like “You are a complete asshole and I am not prepared to tolerate it, now are you prepared to do something about it.” (Participant 20)

My wife was saying: “[Participant’s name] you have to do something. You’re depressed, you’ve changed. You’re not the man I knew.” And so, I found that each time. I discontinued it three times before I found a way off it.

22 Gibson, Cartwright and Read, 2016 (b)

Positive experiences of antidepressants

[Its] just like diabetes – a chemical shortage…I need serotonin uptake inhibitors – simple! I would hope that one day I could stop taking them but realize that for me it is the same as taking heart pill for someone else.

My GP said that if I had diabetes I would need to take insulin forever, so not to worry that I appear to need to continue to take anti-depressants forever. I can still remember the desperation and pain and if it meant taking them forever I would not hesitate.
It was a life-saver in a real sense of the word. That medication had prevented me from committing suicide. I truly feel that I would not be alive if I had not taken them. [Antidepressants are] the sole reason I can now function as normally as possible as a human being and a participating member of my family and community. [They have been] very helpful, they have allowed me to be a better parent than I would have otherwise been, I believe. [Antidepressants are] helpful in enabling me to manage the stresses of job loss and unemployment. I feel that I can cope better with job interviews on them. I have had such good therapy that I have been able to address the wider issues that had contributed to my mental state. ...Without the medication though, I would never have had the ability to do this.

Negative experiences of antidepressants
They were a waste of time and did not help me. I get more benefit from mild to moderate exercise, or energy drinks, or spending quality time with friends. [They were] greatly disappointing. I wish I had never tried them, because before I tried them at least there was hope that something could have helped. Each one has had a worse effect than the previous.... I can’t remember them all. It started with memory loss then progressed to me becoming borderline catatonic staring at the wall for hours unable to stand up. Within a few weeks and genuinely terrified. It was a relief to go back to the misery of depression after these experiences. They don’t make the problems go away. They just make me numb enough to not give a shit. By taking the medication I felt alienated from others almost as though I was walking around like a zombie in a kind of bubble. In my life, antidepressants have been prescribed to me to cover up what was wrong, and to me were a fake fix. I believe that I stayed in a relationship that was unhealthy for me, because the antidepressants made me tolerate treatment that was unacceptable. [It’s] like smoking. When you smoke, you know it’s bad for you, but you also feel momentary relief and therefore can’t (or don’t want to stop) because you miss that feeling of being slightly more capable to handle situations. I felt bullied into keeping taking them and at times told I would not receive therapeutic treatment if I didn’t take them. There felt like no alternative and I felt very trapped into taking them.

Mixed experiences of antidepressants
It is a necessary evil, with very unfortunate side effects in terms of weight gain and sexual dysfunction which lead to me stopping the treatment despite its benefits for my mood. I know they do me good and I am better on them, but they do make me feel physically sick, and not like myself. I seem to be constantly trying life without them, but always go back to them in the end. Antidepressants have been a two-edged sword. I felt less affected by things that would normally distress me while on anti-depressants... [but] when I came off them, my head felt clear, I felt like I was waking up and that I was in touch with myself again. [Antidepressants were] helpful in making my depression less. However, the effects that they had on me as a person and how I treated others is the main reason I came off them. I am a considerate and selfless person and while on the antidepressants I was the complete opposite.
The thing is that I have been on them so long that I have no idea what it would be like not to be on them. I would love to come off them but they have become such a ‘normal’ part of my life since I was approximately 15 years old that I am not sure I would cope without them. They helped me get back on my feet when I was facing a difficult time. However I was never told when to go off them and ...have not heard from the doctor who prescribed them to me in years. The withdrawal effects if I forget to take my pill are severe shakes, suicidal thoughts, a feeling of too much caffeine in my brain, electric shocks, hallucinations, insane mood swings. [I’m] kinda stuck on them now coz I’m too scared to come off it.

I have been on MANY different antidepressants. None of them were helpful at all to me until I tried Fluoxetine 4 years ago. My life now is greatly improved by taking this medication and a quality of life has returned.

I have tried almost all antidepressants available under prescription (including combinations), and most worked to varying amounts to start with, then stopped helping, then the dose was increased, then stopped working/made me worse, then dose increased to the maximum, then stopped working, then I was put on something else. I’ve wondered if I would have been better off never starting taking them at all.

23 Givens et al., 2006

I didn’t want to start get myself hooked on a medication that I would have to be taking the rest of my life.

I think sometimes medication is wonderful but I think you can’t escape from your problems that way so I watch when I take it. I don’t want to get dependent on it.

I stopped taking it on my own ... I felt that I didn't want to stay on the medication. I didn't want to become addicted to it, an antidepressant.

I have (a) stressful time going, dealing with death in the family, losing my mother, losing my father a year ago. In fact, a year this February I lost six other family members in one year. And it just looked like it was just too much to cope with.

It’s not—I don’t know whether it’s the depression or not but I think when it changed why I feel that the death of my husband has changed me. He was the first man that I loved and I—even feel yet that a part of me is missing, that something—just something I feel that a part of me is missing because he is not around. ...

If you can’t see and you feel like you’re going to lose your eyesight, you know, it kinda gets you down. Especially when you don’t have nobody.

I do think that there’s a reason for my depression. I don’t think it’s just there like a cloud because nothing’s wrong. I think there are things that are wrong and that’s why I kind of don’t like to take medication for it because the medication doesn't change the basics.

He prescribed Zoloft for me. Well I never took it. I mean, my feeling at the time was that I wasn’t interested in the pill. I didn’t want to do this because I couldn’t just bury my husband and then go on and go out and party.

I have to face reality and I think you have to feel some pain in life.

I didn't want to stay on the medication ... why should I be different than everybody else?

I didn't want to take them ... ’cause I had taken tranquilizers when I was young ... A doctor recommended that ... I don't think they knew about antidepressants then ... I never thought it was nerves but I couldn't take 'em, I slept.
I'm not interested in pills anymore. I get bad dreams. I mean, they gave me pills that left me waking up and not knowing where I was. I was still in a dream.

**24 Hanssen and Cabassa, 2012**

**Treatment Initiation**

I was urged by my husband to talk to a female doctor in hopes this would help me feel comfortable discussing health concerns, which I struggled to do until that point.

Like the doctor tells me “You have to accept your diabetes. You have to accept your high blood pressure. You have to accept….bad moods….like you accept your problems, you have to accept your illness”. And I now, that is what I am trying to do, accept. (Focus group)

**Adherence**

At times I take a half of the pill for depression…it’s what helps me, it’s what calms me…. I don’t take it every day, only when I get to the point of feeling a lot, a desire to cry, with anxiety...

(Individual interview)

**Barriers to Care**

Look, in reality with the doctor here, I cannot communicate well, because he does not speak any Spanish. The doctor is informing me through an interpreter and so the interpreter does not tell us everything, because one very clearly sees... she is listening and in the whole time tells us two, three words. So realistically, you understand, that it is not everything that the doctor is saying.

(Individual interview)

**Stigma**

Well, I heard that it makes you sick, like that is the medicine for when one is loco [crazy] and all that...Well, also because of that I didn’t want to take them, because I was scared they would make me ill in the head... (Individual interview)

**Barriers in accessing services**

Well, since they treat me every six months... we hardly have talked, I only come and they look me over, and they say to me “where does it hurt, if it hurts”. They only prescribe me the medication and that is it.

Interviewer: You have never thought of talking to your doctor?

Respondent: No, because almost it never lends itself to do so, or moreover, since I know there are many patients, they try to get them out fast. (Individual interview)

**25 Izquierdo et al., 2014**

**Beliefs about the nature of depression and its treatments**

A 61-year old woman said: I’m not happy that my body just doesn’t want to behave itself and that I have to use medications to correct this. I used to hate that I had to depend on a medication to make me feel normal, but then I realized that I had an imbalance and I had to take care of it.

IA 54-year old woman: You cannot control depression. Even if you discuss it with someone like a doc, by the time they finish medicating you and counseling you they didn’t cure it. It doesn’t stop. If you know that why put yourself through it?
Some believed depression was a condition that would take care of itself, or did not require medical treatment. “My depression will heal naturally,” said a 52-year old woman. A 54-year old woman described, “I just have to let the depression run its course.” Participants who believed they had to manage depression on their own described reticence or refusal to use therapeutic treatments. “Though my doctor suggested counseling, it’s up to me myself to get better. I have to do it on my own. I don’t need any medication,” (a 71-year old woman).

A 58-year old woman: “I was prescribed my medication to be taken twice a day but I only take it that way sometimes because I don’t want to get hooked on pills.”

Participants also described antidepressant medications as unnatural or illicit substances; they referred to them as chemicals (“químicas”) and drugs (“drogas”).

Prior experiences with mental illness and its treatments

A 61-year old woman said, “My mother was a prescription addict, so I didn’t even want to take aspirin. But I came to realize there’s a difference between tranquilizers and the medications I take for depression.”

A 54-year old woman” “Schizophrenia runs in the family and I don’t want to be in a looney-tooney bin. I can’t talk to nobody about it, no professionals, because they want to lock you up.”

“I’ve been taking them a long time. I don’t like to take them but they help,” said a 55-year old woman.

A 57-year old woman stated, “I’ve tried to quit [my anti-depressant medication] twice by myself but my symptoms came back and I needed to go back on it. I know that if I stop taking it I will get sick and depressed and will be crying all the time.” In contrast, participants who previously experienced treatment side effects reported reluctance to re-start antidepressant medications. A 56-year old woman stated:

I used to take antidepressants years ago, but they made me have headaches and made me nervous. I generally felt worse throughout the day so I stopped taking them. I have no interest in getting antidepressants again.

26 Jaffray et al. 2014

Initiation of treatment
...now that I’ve been to the doctor and the doctor said yeah you have a problem and everything... I can sort of go right, there is a bit of problems here I can do something about that. (continuer)

I’ve a good friend who is a CPN [Community Psychiatric Nurse], she was supporting me and she said ‘I really think you should be going you know and speak to the doctor ... I decided that yes I would go. (continuer)

I didn’t ask to go on them but I had that in my head you know if she offered me to go on these, on something then I would, so she did offer them. (continuer)

I felt quite embarrassed about it because I didn’t realise they were antidepressants she just said it was something to pick me up... like why do I need antidepressants? None of my family have ever needed antidepressants. (discontinuer)

I suspect my depression was more reactive. (discontinuer)

I just thought, well it’s a waste of time because they are not listening to me, they are not understanding what I’m saying. (discontinuer)

I was quite open with my husband but I haven’t told my parents because my mum has depression. (continuer)

Some of the employers,...one of them I spoke to was okay but the other one was probably thinking ‘get over it’. (continuer)

When patients began to feel better
I think it’s just sort of got me over the worst of it, I think, that’s how I was starting to think perhaps I can come off of them. (discontinuer)

As long as I am feeling good, I know I shouldn’t question it but you start to wonder how will I feel if I come off them? (continuer)

I just felt perhaps now is the time to wean me off a bit, I have come to terms with a lot (continuer)

Although things were explained quite clearly at the beginning I think at this point [now I feel better] I would have benefitted from a bit more support or just knowing a bit more about what I am doing (continuer)

Experiences of side effects
My sister said I had put on weight, she said you probably should stop your antidepressants. I said no.

They just said that your moods will change, and you will have an upset tummy and your side effects. I thought, no, I am not going through that. (discontinuer)

I just felt that I shouldn’t really be, well, always depending on tablets. (continuer)

Latency period (perceived lack of efficacy of antidepressants)

Yeah, I was really, really surprised, although I did have my doubts, but no, I will persevere, and I’m glad I did actually. (continuer)

No, I just, I actually felt more depressed, I just wanted to sleep, I just wanted to go to my bed and it [anticipant] was encouraging me to do that…there was a spell that it wasn’t working. (discontinuer)

If there’s just a little niggle, you can talk about it, a little peace of mind, and then as I said they monitor you, they don’t give you automatic prescriptions. (continuer)

I’ve kind of been left to it, she said to make sure that I come back, I don’t know what would have happened if I had just stopped them, and not come back. (continuer)

I will know myself, if it’s not working then to increase it again. (continuer)

27 Kadir and Bifulco 2010

I think I’ve got this illness because I’ve many worrisome thoughts… I went to see my GP at first, then I was referred to mental hospital. I believe I will be normal again with modern treatment but I can’t afford to pay for this treatment… so I decided to see bomoh too. It will help me get rid of this illness. (Anisa)

I never sought treatment, I was unaware of services offered. I though that mental hospitals offer treatment only for those people with serious mental illness who ‘run amok’. Depression is just a ‘thought problem’ and can be cured with ‘willpower’. This is why I never sought help. I cannot talk to other people, either… (Salina)

I did receive treatment for my depression and I was given an antidepressant medication and referred to a psychiatric unit at our community clinic. Then, I’ve decided to stop the medication due to the side effects: fatigue, being unable to sleep and nausea. I didn’t want to see the
psychiatrist for continuous treatment because of was afraid to be labeled as mentally ill.  
(Norma)

I sought psychiatric treatment and was on medication for about a year, but stopped taking it  
because of the side effects: fatigue and memory loss. My parents decided I should seek  
alternative medicine. The bomoh advised me to stop the medication and not to think or worry  
too much.  
The bomoh told me that evil spirits are happy if I feel depressed and do something stupid like  
attempting suicide.  

I think the bomoh can cure my illness. I talked to her a lot about my illness ... what I’ve felt ...  
my sorrow... my sadness... my loss of interest... I’ve no job. The bomoh encouraged me to share  
my entire problem with her. I share lots of things with her. She gave holy water so I drink it  
everyday. I feel more confident. She asked me to chant every time after I perform my prayer. I  
did it... I feel relief. (Miriam)

I think my illness is normal. Not really severe compared to others. I can go to work. I can speak  
to people. I ... sometimes feel unhappy and am not in a mood for doing things I like to do... but I  
still think I’m fine ... I don’t go out and kill people as a few mad people do. Oh yeah ... I was on  
medication ... the GP gave me antidepressants ... but I became worse day-by-day so I decided to  
stop. (Norma)

I’ve seen a psychiatrist and a bomoh. I knew it was not right to see bomoh but I do believe  
bomoh will help me strengthen my faith. To make me feel close to God and to make me feel I’m  
not alone in this world. I wanted to be a good follower ... a good believer ... I will see the  
psychiatrist again when my illness becomes severe but I do believe the power of will inside me  
will help me against my illness ... you see ... sorrow and sadness are not good for us ... I should  
not grieve about my fate ... I know that. (Rokiah)

28 Knudsen et al. 2002 (a)

Informant: Because you see yourself in the situation which you know is completely crazy. You see  
yourself and you can’t do anything ... That, that is what I think is really hard. Because you are  
thinking so clearly. Sometimes, I’m in such despair about myself ... and you can’t keep that up in  
the long run.

Informant: You just felt so lonely. And that you were just killing time. Yeah ... the emptiness ...  
The feeling you don’t have anything to live for. That is what typically triggers the thinking about  
suicide. Life is a piece of s[...] and all that. And you just sit and wallow in it, you know? And  
then you can fall apart. You’re caught in that kind of thinking.
Informant: I’m not really sociable. My work requires me to be quite extroverted and social. And that really drains my energy. When I get home, well … I can’t really stand being together with anyone … And perhaps that is partly why we’re getting a divorce. I don’t really think I can live up to it. I’m the one who wants a divorce. I can’t live up to what you’re supposed to live up to when you’re married. I spend such an incredible amount of energy getting my workday to function … and that’s how things are these days. In the society we live in, you have to work to survive … that’s how it is. It’s hard for me.

Conflicts about taking antidepressants
And then when she [the doctor] mentions the medicine, I just feel paralyzed. For me to take those pills. It was ... but haevens I don’t feel that I have that kind of illness, you know? Well, it was really a shock. Really. I found it unpleasant in the extreme.

It’s one thing to have a psychological illness, but if then you have to take medicine for it. Well, then, that’s twice as bad. To be down and have psychological problems. Lots of people can have them. So, okay, maybe we can accept that. You get over that by yourself. It’s just that you don’t quite mention that you didn’t in fact do that, but you had to take those pills. Double whammy. If you get those pills then people think “Well, so it was real”.

And I have always ... taken the stand that I wouldn’t take medicine. Because I ... I have always believed that I could manage without it. So then I go see this psychiatrist and get a very positive impression of him. And he tells me that there is an imbalance in my brain that makes me get these depressions ... and so after some major deliberations I start taking Seroxat [an SSRI].

It’s embarrassing, simply ... Yes, why it is embarrassing [laughs]. It just is. Because it’s not normal. You just aren’t ordinary, a person who can function without having to take something chemical [laughs]. [But what about your goiter, isn’t that also chemical?] Yes, okay, it is. But that’s allowed. It’s allowed because it’s a physical problem, you know? But the other thing, that’s in your head. It’s because [laughs] it doesn’t work too good. But that’s the thing. When he [her doctor] said that it was something chemical, then, then it was easier for me to handle it.

SSRIs users’ accounts:
I have much more energy for other people. Hmmm… I’m more open and ... that means that I have started to believe more in myself. And be more. Not just say yes and well but really give something to people. Give something back to them. And not always be the ... what should I say ... the neutral person ... I’ve blossomed.

But when I’m taking the pills, then I have...Then I can function. I can. I can. I can go to work. Smile and be happy. And can enjoy things and I... can stay out of bed except when I have to
sleep... hmmm, and I can be sociable. I can do things together with my friends... but that's all they do.

**Discontinuing the medication**

The reason I want to wean myself away from the medicine is simply because I will not conceive of myself as ill ... I think that is very important to my conception of myself that I don’t think I’m some kind of therapeutic case.

Cutting down wasn’t a problem I don’t think. So in that way you’re not dependent on them... not like with other types of medicine. You’re not that dependent on them. I’m not anyway [laughter]. I think it’s more the anxiety that makes you dependent. It’s a psychological that dependence. You’re afraid everything will go wrong if you don’t take your medicine.

I hope it’s not something I’ll have to take the rest of my life. I’m not counting on that. I would be sorry about that. But if that’s what it takes for me to have a good life. Then I would be willing to do it. But right now I still hope that at some point I can manage without it.

29 Lafrance 2007

**Receiving diagnosis**

It was a validation that I had never had before and I had a name. It was like, you know, it’s a bad attitude, it’s not. I’m not ... you know maladjusted, I’m not ill socially or whatever. It’s just I’m depressed. And that’s cool. Like it was really neat to have a name for it. (Kate)

I was reading this book [which listed the diagnostic criteria of depression] and it was describing what I was going through [...] and all of a sudden I said Geeze that’s what’s wrong. I’m depressed. That’s what it is. Just to be able to put a name on it? Because there are times when I thought I was different from everybody [...] But what I found in that book, I found that when you have the symptoms I had, that the way I was feeling in my condition was normal. See? I wasn’t going crazy. (Dianne)

Something in me made me go to the doctor and I went into her office and she sat down and she said: ‘What’s the matter?’ And I said: “How do you know if you’re depressed?” And she said, ‘OK, I have got ten questions to ask you’. And I was nine out of ten. [...] So she said, you know, you’re depressed! There’s no way out of it’. [...] So anyway, fine I said OK what do I have to do?

I was so relieved! I was so relieved I thought thank God! There’s something wrong with me! I’m not- there-it’s got a name! Like it’s not that I am just a terrible, awful person who is unattractive [...] (Cynthia)
It was kind of a relief to have somebody say, ‘Yes, you have something seriously wrong, you know, tis is what it is’ [...] There’s something really wrong with me that they have even a name for it [...] It’s a sense of relief that there is something there that people know about that you know you’re not the only person in the world that’s had it and you really do have something. You’re not just making this up, you know. And that’s kind of good because people do have a tendency to sort of look at you and say, well, you just want attention. Well no, attention’s nice, but no, that was not the plan here. If I wanted attention I could dance on the table, I don’t have to try and kill myself. (Joanne)

I would like to see more women be honest about it and lose their shame because it doesn’t mean – And this is something that I’ve learned. I’m not a weak person because I have this, I’m not a bad person because I have this, I could just as easily have, you know diabetes or blond hair or red hair or long legs, I should be so lucky. You know it’s just, it’s one of those things and there’s no blame associated with it. (Kate)

So it’s right down the line, my mother, my brother, myself, my nice, my son [...] It certainly is hereditary. You know it’s ... it is an illness the same as diabetes or a bad heart or anything like that, high blood pressure, it’s in the family. (Bea)

Well I think I did suffer depression. Because, and again I say, if I was on Prozac way back then, like I say to my boys, I’d say, ‘I know I would have been a much better mother. Because I would have put you in your snowsuits, we could have gone for walks, we could have gone out and made snowmen (crying) I could have made cookies with you.’ You see? ... I could have enjoyed them. But they were just work. Laundry and laundry and bedding and it was just, it was just work work work work work no enjoyment eh? (Bea)

[If you suffer from migraine headaches or say if you were diabetic you could say to a person ‘Oh, I’ve got a terrible migraine again’ or ‘My diabetes is acting up’. But with depression just to say ‘Oh, I’m depressed’, that doesn’t go with people. ‘Oh come on, come on you promised, you’re you’re well, ther’s nothing wrong with you, you promised, you can go, you can go’. See?

Interviewer: What do you think is the difference between people being able to say ‘I’ve got a migraine or my diabetes or’ and

Well, they accept that. But just to say, ‘Well I’m depressed, ah, they feel well ... good kick in the butt. ‘You can do it, get up and you you can go. There’s nothing to prevent you from doing it. [...] You haven’t got the flu, you haven’t got the cold. Whjat’s preventing you? So they don’t understand. (Bea)
It’s a hell of a thing to have. It’s a really bad thing. I’d far sooner deal with any of my physical ailments than I would depression. Depression is hard.

**Interviewer:** What makes it so much harder?

**Well** I find it’s so personal. Nobody can understand how bad you’re feeling. And like you can go to a doctor, you got bad asthma, you can’t breathe? They can understand that. They can see it, they can feel bad for you and they can really try to help you without feeling sorry for you. When you’re feeling depressed, people don’t understand they figure you’ve just got the blues and you’re not dealing with it. (Joanne)

---

**30 Lafrance 2014**

Terrible. Wellbutrin makes it so you’re jumpy. I got palpitations from it, I could feel my heart going whoop, whoop, whoop, and it made me dizzy. I couldn’t sleep at night, so that’s why he gave me Ativan. Ativan? I don’t want to get addicted to this stuff. But I couldn’t relax, so I said, ‘No, this is not the way to go, I just don’t want to do this anymore.’ (Barb)

I was given Luvox and it made my heart flutter. And I would get very angry a lot and one day I forgot to eat […] I did some really strange things like, just being angry and short tempered and my sleeping was way of whack. I was staying up all night, sleeping during the day. It was very difficult to do anything because I was tired all the time and then when it was time for me to go to sleep I couldn’t sleep. And it was just a bad experience and they said, ‘Oh well we’ll just put you on another kind’ and I was like ‘I don’t want to go through a whole, you know, test all these drugs’. I didn’t want to do that so I stopped taking that eventually just cold. (Shelly)

Whenever I read about it [depression], it was always like ‘Go see your doctor, they will give you Prozac […] And I especially found that with my doctor because the second it came up she’s like ‘Here is a prescription’. And that kind of makes me mad. When I read about it because and like a lot of pressures that women have to face, family and work and you know there’s a lot of different other things that affect it too that can make it worse. (Shelly)

When I went to the doctor and explained I was depressed, Prozac, right away. And I really had a problem with that because I knew there was a lot of stuff wrong and I wanted to get to the bottom of what was wrong and not just simply take the Prozac. (Joan)

---

**31 Lavender, Khondoker and Jones 2006**

**Coping with depression:**

**Friends**

And that evening a friend rang and I told her, and she said ‘have you had anything to eat?’ And I realized I hadn’t had a thing to eat for about three days, not a thing. She said ‘you must have something to eat, you must do’. (White British)

If it is this country the only way [is] … to go to the doctor, but in Nigeria the people will tend to think of so many ways of helping out, according to individuals’ beliefs. (Yoruba)

**Doctors involving the family**

My own advice to doctors … if it is a woman, they should try to invite the husband … and tell him that look, the wife got a depression. So what’s going on? And they should, you know, try to
advise them that he is the right person to help the woman out, because that woman is only with
the doctor for a few minutes. (Yoruba)

Antidepressants
I think they are good, but not for a long period of time ... because after a long time of it, your
body is immune to them. I’ve took them ... I think it’s only me that can make myself get better.
(White British)

In this situation medicine will not benefit. This is mind matter, unrest of mind. So doctors’
medicine can not work. (Bangladeshi)

So I decided to take [the antidepressant] even though I don’t feel good in taking it. Actually, it
doesn’t help me much. I think going to my church for counselling has helped me a lot. (Yoruba)

Taking medicine can change the mind ... So medicine can make the brain normal and can make
the heart normal ...medicine can make him better. (Bangladeshi)

Depression as an illness
If she is ill, there should be effect on her body, maybe stomach ache, or headache or some other
effect on her body. Because there is no effect on her body, therefore with my little knowledge I
think she is not ill. Perhaps she has a mental problem. (Bangladeshi)

32 Lawrence et al. 2006

Self-help
I think the main helping with depression, any kind of depression, physical, mental, it’s self-help.
If you help yourself the way you want to do it, you will get over the depression 100%, I am that
sure. But if you don’t want to do it, there’s nothing you can do. Treat yourself. (South Asian, not
depressed)

Cognitive techniques
It’s a mental attitude, mental attitude. If you change the mental attitude and all that and you
become cheerful and start activities it will go. (South Asian/depressed & not treated)

Avoidance/not to dwell on things
It’s easier said than done, not to concentrate on one particular thing, especially bad things.
Don’t concentrate on it a lot. Let it go away as quickly as you possibly can. (Black
Caribbean/not depressed)

Taking your mind off
You think a bit differently you know with the way you think about things, it’s different but I don’t
keep it in my mind. I like to read, I’m really interested in reading, papers, books, so then I forget
everything. I kind of do it myself. (South Asian/not depressed)

Getting out of the house helps me enormously. I have been paying someone to take me out
usually once a week, at the weekend, but she’s moving to Norfolk and that’s been sort of my life-
saver because I thought I would go mad if I didn’t get out the house...Yes, it’s the one thing that
is guaranteed to help. (White British/depressed & treated)

The first thing is communicating, that somebody is listening to what I am going through. You are
pouring out your heart to that person and you feel a bit better that you have passed on your
worries and problems to another person. (Black Caribbean/depressed & not treated)

You’ve got to try and keep cheerful when you are with people, it’s difficult, you want them to
know but no I put on a brave face and make out I’ve got no troubles. If they ask me how I am,
‘I’m all right, I’m fine, I don’t best to look on the bright side I find otherwise people get fed up,
‘Oh, she’s a misery’. (White British/depressed & not treated)
Religion
But of course, religion means that you are in talk with God and if God can’t help you what else will help you? (Black Caribbean/not depressed)

General practitioners
You see the GPs are so tied up with so much work they don’t have time to talk to their patients and they find a lot of people don’t get the necessary benefit that they would get from the GP if the GP talked to them. Even give them less medication and have a talk because it makes them feel good within themselves is like a self-healing power you know. That builds them up. (Black Caribbean/depressed & not treated)

There’s so much to say and so little time. So you always feel like you haven’t got enough time with the doctor. Yes so then you think to yourself, ah well, the important thing, first, cure your pains and then think about the depression later on. (Black Caribbean/depressed & treated)

Medication
I mean you hear of people taking these drugs for years and years and they got so dependent on them. (White British/depressed & not treated)

Psychiatrist
I would feel that if someone was to say we are ging to make an appointment for you to see a psychiatrist, straight away I would think oh I am going off me rocker kind of thing. (White British/depressed & not treated)

Counselling
When you get a counsellor to talk to you, what the persn says to you is encouraging, strengthen your body, strengthen your mind and whatever is there, it come right out. (Black Caribbean/depressed & treated)

Counsellors would be able to spend more time with them, to chat with them, to make them feel at home and things like that you know. Whereas a GP, tey would be considered to be an official, authority, while these counsellors are normal people who gve their time in counsel. I suppose that’s what it is, so that would help them, the counsellors would be more helpful. (South Asian/not depressed)

Malpas et al. 2011
I was dreading going and saying I don’t feel better ... that was getting me down ... the pressure of having to tell someone ‘no I still feel terrible’; I want to say ‘this is really working’. I didn’t want her to panic and suddenly think ‘oh things have got so much worse’ ...I felt I was in control of it, I didn’t want her to change my medication because of it’. (female patient)
I tend not to like to tell doctors what to do...I want someone to tell me what to do...I have always sort of thought, ‘right, a doctor just tells me what I have and I just say thanks and go’. (female patient)
I have this panic that there’s not going to be anything else to help me so I’m trying to kid myself, ‘it’s alright, it’s quite contained, just tell her everything’s fine’, and I haven’t, I mean I’ve gone along and said ‘it’s been a difficult month’. (female patient)
As a doctor she really asks, she doesn’t just ask ‘Is the medication okay?’ she really asks how I am and how I am coping with things. (female patient)
[sighs] she wasn’t very...sympathetic, and I just burst into tears as soon as I says [sic!] that I was sent over by the, health visitor [sighs]. I suppose some people you click with, some people you don’t and she just seemed a bit distant ... I know she’s following procedures ... it’s just I expected someone to be oh, you know, and she was ‘right, let’s start with ... sleeping tablets first
and then see how’... maybe she was in a hurry ... I probably felt guilty for taking up the time, I was just crying, so she couldn’t get the information out of me because I was in a bit of a state’. (female patient)

I thought I’d come away with antidepressants and came away with sleeping tablets ... perhaps she felt that I needed to have a decent sleep and see how I felt after that, so maybe she didn’t want to jump into things too quickly ... In some ways that was good, but at the time I think I just wanted something to make me feel better’. (patient)

... he was just on your side because he’s sort of with you ... He can empathise ...I was quite determined tat I’ll go in and talk to him, tell him how I’m feeling ... I did explain I don’t want anything too heavy but I’d like something to lift my spirits a bit ...I felt like I’d got the goods [laughter]. I felt like mission accomplished. (patient)

...there is one person saying it’s a good idea to take them and somebody saying no, you should not take them; I was in the middle and I couldn’t make my mind up, I was really confused, I think, I’m worse at the minute; I just can’t make my own mind up’. (patient)

What can they say to me if I go back and say ‘I haven’t taken the tablets but I still feel down’...they’ll probably say ‘Take the tablets’ [laughter] ...they might just think why am I back in the surgery...will I look a fool if I go back? I don’t know ... the feeling I’ve got is that they happily give you tablets but they won’t recommend things like counselling. (patient)

She kept sort of going through the various options and kept avoiding going up dosage and I kept thinking ‘Well I think I need to’, but then I always have something my mother’s instilled in me “Don’t tell a doctor what to do”. (patient)

But I don’t know...if there’s an issue on dosage or not? ...So shall I just carry on with this [dosage]? 

GP: Well at the end of the day it’s up to you, but yes, I’d say carry on a bit longer and I think it will help answer your questions [about latency in the recovery process].

I want that guidance really which I don’t necessarily get ... I want someone to say, ‘this is what you need, this will make you feel better.’ (patient)

34 Murawiec 2008

Case study. Patient’s report. Treatment with citalopram and later fluoxetine for a year

Before starting the treatment I had experienced a continually increasing feeling of helplessness towards the course of life and a progressive loss, or at least a significant limitation of intellectual properties necessary for me to deal with my problems. I have noticed incread problems with concentration, memory, making association (deduction) and motivation for effort. I associated these symptoms with aging, although it seemed unusual, that at the age of 40 they were so intensive. These symptoms were accompanied by a decreasing self-esteem, poignant frustration and lack of success, and an increasing need of self-control unsuccessfully aiming to turn around this unfavourable situation. I realised that I needed medical help.

The medication started to be effective surprisingly quickly and in the right direction. In the first months of treatment its effect was even a little too strong. I could burst out laughing at my thoughts or speak to myself in the street. I started acting spontaneously, which was funny both for me and my surrounding: I would make frivolous remarks toward others, I paid complements to my female work colleagues; overstepping not so much the bounds of customs and morale, but my own psychologica boundaries.
With a good effect, I have gone back to spending my free time enjoying myself, and all the time being able to return to my duties (controlling everything). Having control over life is the key aspect for mental wellness here: it relates to i.e. drinking alcohol. I have successfully started to spend more time enjoying myself being sober than being drunk. As the mood functions as a background for emotional experiences, which are made gloomy by the alcohol, I decided that in this respect it has a negative influence and it is worth avoiding it.

At work I am able to impose discipline on myself, but at the same time I know when to stop an arduous activity, at least for a few minutes, to regenerate my strength.

Surprisingly, this self-centred attitude towards myself, allows me to develop altruism: this inclination, in turn, I define as a luxury of a person with a well-balanced self-esteem, who does not have to confirm his/her image perceived by other people, and in this way is able to step beyond his/her own needs. During the last 2 years, I have started many acquaintances, most of which go back to my school years, forgotten for the last 20 years and renewed with a great effort. Therefore I have a large circle of friends (my wife’s and mine) with whom I stay in touch. Some of them are my close friends, some I contact only occasionally. My present intensive social life reveals the loneliness I felt for the last few years and is a way of compensation for it. It is especially visible when one looks at my position in the professional circles.

If I were to name other areas in which I have become active recently, it is necessary to mention many sublimations (there are artistic and literary projects which I had abandoned in my adult years, and to which I have returned now, as well as social and scientific projects). The high number of engagements may suggest that I have fallen in a state of exaltation. Using an album of photographs of Camposanto, a necropolis in Genoa, publishe before the war, and being inspired by the whiteness of the walls in my living room, I have painted of both sides of the entrance natural size figures of Adam and Eve. By painting these figures I have dealt with getting used to the anonymous space, time giving it, at the same, intimate and universal dimensions. The figures live in various circumstances: I am socially praised by friends visiting our house, but in the lonely evenings I contemplate with pleasure these figures, laughing at the irritating insufficiency of my skills.

Considering that I am in the course of treatment and that I have wanted to get out of the magic circle of incapability, and do something useful (as opposed to professional activities undertaken in recent years, which did not give me any satisfaction), I believe that this state reflects my needs and inclinations, and that it represents the emanation of my mental health.

---

35 Patel et al. 2013

... that’s one more stress on top of every stress you’ve been put under and sort of, one of them must have been the straw that broke the camel’s back. But which one? There are just so many straws... (P7)

I found it difficult to distinguish between what was just complete exhaustion and maybe what was the depression really and I still think that they are still linked. (P3)

I think it’s harder to grasp because it’s all to do with feelings and emotions and it’s hard to sort of try and understand that it’s a chemical that’s causing that. (P11)

I should just accept it and I just don’t know I am worried about what other people think about me... (P1)
...but I was adamant that I was fine and that it was just a lack of sleep and this, that and the other and I would not let her refer me to anybody because I was fine, I was just blocking it out ...(P3)
I just can’t bring myself to say it. Fear of ridicule I suppose … and I don’t want people to feel that I can’t look after my children because I can ...and I love them ...(P2)
Antidepressants: ‘the lesser of two evils’
People will think she needs to be on meds to be a normal mother ...(P2)
...if you are not taking the drugs you can kind of pretend you haven’t got it but when you are taking drugs, you can’t hide behind anything, you have a mental illness that you are taking drugs for and therefore, you’ve got that stigma. (P7)
I’d rather not, but it’s the lesser of two evils I guess. (P4)
I’m not the sort of person who easily gives into things. If I can possibly do it without the drugs, then I must be a stronger person. (P3)
I am quite happy to take it forever if it maks me feel like I can get up in the morning ...but ...I would like to think I could stop taking it and go back to my normal self but I don’t know whether I would want to for fear of going back to that crazed fool. (P2)
You can’t really put a timescale on it; you just need to keep working towards it. (P6)

36 Ridge et al. 2015
My general experience of antidepressants has been very positive in terms of all the horrible things that people talk about that can happen with them. (Tony)
...we have just a bit of a pill culture, take a pill for that, take a pill for a headache, that kind of thing, it's easy. (Michael)
...part of me feels like a failure for not being able to manage my life without chemicals. (Samantha)
[It] felt harder going back [on antidepressants] the second time because you sort of feel as if it should be sorted and you feel as if you're taking this antidepressant and it should be fine...(Paul)
... the doctor didn't think there was something wrong with me... I felt like I was just being a drain on my doctor. I was given antidepressants at one point, I think it was Prozac, and I was on those for about eighteen months or so. But I was never given a particular explanation of what they were to do with, other than they might help - have a side-effect of weight loss. Well that's [laughs] I don't think that’s a particularly good thing...(Rosey)

I left them on my top shelf for ages and I just didn’t want to take them because I was a bit confused as why I; he’s prescribed me that after like a really short chat, just me saying I was down and maybe at the time they were handing them out left right and center, I don’t know. (George, UK)
Isn’t that strange... I don’t tell them [children] that I am taking antidepressants. I never have told them that I was diagnosed with depression. (Liza)
For me medication was a means to an end…but I wasn’t going around shouting from the rooftops ...(Catherine)
There is a stigma definitely attached to them... absolutely, I mean well of course there is you’re doing something wrong if you’re on antidepressants...(Steve)
I felt quite bad about taking them. It felt like kind of surrendering a bit... almost like having a criminal record...(Tony)
And I think I'm quite afraid of the thought of ever not having it, because I know how awful I feel if I stop taking it for a couple of days. I wish I didn't have to always go back and get those damn prescriptions. I wish I could just have the drugs - just hand them over - because each time I go back I think oh, maybe this time that doctor's going to fuss… (Charlotte)
They gave a bit of hope… I didn't have any negative feelings about the drugs, I was very happy to take them because they were a straw to clutch at I guess. (Spencer)
[I'm] certainly not one of these people who thinks Oh God, some kind of poison in my body. It's like no, it makes me feel better... some people are diabetic, they take drugs, you know. And I know people say, “Oh, it's not the same”. But I'm afraid it bloody well is! (Matthew)
...the more people talk about antidepressants as a positive thing, the better it is that people don't end up, you know, people don't end up not taking something they need because of the stigma. (Layla)
I would like 100% take them [antidepressants] again... I'm not saying it's suitable for everyone but for me it is and so I'm not going to feel ashamed that I need them. Because like it's just an illness like anything else. (Lilly)
It was like being on really strong drugs... made your pupils dilate. (Peter)
I found it quite scary... I wasn't really ready for taking drugs of that strength. (Gary)
… it was amazing...within two hours I could feel different. (Christina)
I think between 24 and 48 hours I felt so different that I rang the doctor and I said, look do I have to go up to a full dose, because this is amazing. (George)
People call them like happy pills and stuff, that's f[...]g crap.... you don't feel spaced out, drunk, stoned, whatever you want to call it. You just sort of feel yeah, this is the way life is supposed to be... (Matthew)

Actually I just don't see any bad in them other than potentially the stigma... you don't have to share it with the world, you can do it yourself, it's a tiny little pill that you take and nobody ever needs to know about [it]. (Sean)
[I feared it was] going to lead to drug addiction in a sense. (Gabriel)
One of my friends was like “Oh well we've got to get you off them straight away,” and I sort of went “Well no because I've only just been on them and I need them for a bit,” ...I think he was acting like I'd told him I'd got addicted or something... (Val)
[I did not take them] ...she [doctor] said “they're not addictive anyway” but I was still scared. (Sasha)
I overdosed on everything I had, including Seroxat. I took all the rest of the tablets, [um] which, it turns out hasn't had any bad effect on me. (Nicola)
I think I might well be on this medication for life... They seem to suit me very well.... and for the next four and a half years from now I am quite safe. I can still continue taking that. But in five years time, do I have to go back [to the doctor] and sort of plead my case again? (Liza)
Zoloft, yeah, and I couldn't think and I took myself off it when [son] was about six months old and just went cold turkey. And I wouldn't recommend that. Never ever do that. [laughs] I had the zapping - you get this zapping in your tongue... it was just awful. I had the shakes, I had dry mouth, it was just horrendous... (Catherine)
was full of anxiety around [um] becoming addicted to them.... however they did help and they helped me to find what I would call the equilibrium... so my experience of kind of antidepressants have gone from kind of the very first ones that I got that were fantastic I lost
weight but I would never want to take them again because I think they're now banned [um]...they messed with my mind. (Catherine)
Anyway, I can say, here we are, it is April, 29th 2010 and I am proudly still on one capsule of Lovan (fluoxetine). It gives me confidence, it is like a security blanket and I think it is fine...(Miho)

37 Simon et al. 2007
For a long time I used every occasion as a reason and excuse for my problems and tried to live with it before I finally realized that I needed to look for some kind of treatment (male, age 33).
I would have liked to know more about how to cope with a severe depression and how to continue with my life, but all my GP said was that I have to accept the fact that I am depressive. It took several weeks until I received more information in the hospital (female, age 48).
When I was told that in-patient treatment would be necessary all that came to my mind was that I would be completely isolated from the world outside. I could not think of anything positive a psychiatric hospital could have to offer (female, age 56)
I went to see my GP and said: I can’t go on anymore. I don’t know what to do. Please help me and do something (female, age 39).
I was not in a mood to feel anything or to be satisfied. Now I would say that the decision was alright but at that time I did not really care about what had happened (male, age 51).

38 Smardon 2007
[And I like, I have to tell you that I like taking something that’s not Prozac or Zoloft; it’s just this thing that nobody knows about. Umm so...I didn’t attach it to anything in particular... it’s just enigmatic enough that I wouldn’t... you know like if somebody looked in my medicine cabinet they wouldn’t know. Not like anybody would look in my medicine cabinet. (Celexa consumer)

author: What kind of antidepressant did they give you?
Helena: Um a serotonin reuptake inhibitor.
author: Prozac?
Helena: No, it was Celexa. Which is a European antidepressant and I had really good results. And I wasn’t too keen on taking... I’d rather not take Prozac. Just because of all the stuff attached to that. So...
author: Did you think that anything bad would happen if you took Prozac?Were you afraid of it?
Helena: No, I wasn’t afraid of it, I just, you know if there were another one that could be effective that didn’t have this mystique about it.
Helena: He takes antidepressants.
author: Really?
Helena: It is very interesting how people ... I was getting a prescription filled at the drug store and there were a lot of people there and there was this guy in front of me. And she said do you
have any questions about taking Celexa and he said no. But I was like, hey he’s taking antidepressants, you know when you become aware of something it’s like ...
author: And you might not have known what Celexa was before you started taking it?
Helena: Right yeah right ... and I like, I have to tell you that I like taking something that’s not Prozac or Zoloft: it’s just like this thing that nobody knows about. Um so ...
author: What does the word make you think of?
Helena: I didn’t attach it to anything in particular ... it’s just enigmatic enough that I wouldn’t ... you know like if somebody looked in my medicine cabinet (author: Right.) they wouldn’t know.
(author: mmm) Not like anyone would look in my medicine cabinet. (Helena laughs)
Author: Did you discuss your decision about taking the antidepressants with anybody besides your doctor?
Mary: Um well, I think I talked about it with Annie, with um my boyfriend, um I think I just told my mom. I don’t think she really understood. I was just like, ‘well, this is what they’re doing’. I just sort of announced it. Um, ... well there was an Ally McBeal show and she was prescribed Prozac and the character that played the psychiatrist said happiness does not come in church, a man, love, church any of these things, she listed off a lot of different things, it comes in a pill. It was really sort of depressing. And in the end Ally flushed away the Prozac. And I was thinking oh boy tomorrow I’m supposed to be starting my Klonopin, that’s when I started Klonopin which is an anti-anxiety ...
Author: Mmhmm.
Mary: And it worked to help me fall asleep, temporarily ...
Author: What did you think about the Ally McBeal show at the time?
Mary: I thought Ally needs it more than me (laughs); the character Ally needs it more than me. I think she should try it, I think also that the show generally addressed everything and like you know she’s not gonna take Prozac, sounds like a great thing, but I think if they were to do it a more believable thing I think she should have tried it.
Well I guess I questioned it first of all. And second of all I was seconded by my therapist. She said yeah I think you’ve had a low grade depression for a while. And um and actually now that I remember, she had said that two years ago. Maybe a year prior to my going on the antidepressant. And I went to a psychiatrist and the psychiatrist said no you’re not depressed.
And I was like ha ha ha I’m not depressed, you’re wrong and I’m just you know ... So I knew that it wasn’t normal when I was questioning it and then through talking about it to her. And the resilience that I used to have wasn’t there. (Helena)

I didn’t like the word depression. I thought it was terrible. In my hyperliterary state I thought it was an awful word, you know, I preferred melancholy you know. Because that had more of a literary history too it, so I thought OK. But I was very resistant to the idea that what I had was clinical depression. So to me what I had was hypersensitivity to the side of life that ... the dark side, the void, that life was just a painful experience. That’s what I had, I didn’t have depression. I didn’t really admit that I had depression for a few years. Even when I was in the hospital I wasn’t willing to admit that I was just one of many many people that suffered from this.
(Thomas)

39 Stanners et al. 2014
I started to get depressed because I couldn’t do the things that I was always doing. You know, looking after my family, cooking, things like that because I was told I had to get off my feet, I wasn’t allowed to walk... So my life sort of just, you know, from being a normal mother, wife and that, running around and doing my thing, to doing nothing at all. (Female aged 59, 10 chronic conditions)

Every day’s so hard, you know, to cope, well that’s with-- the [morphine] pump’s good, but all it does is take the edge off, you still have severe, you still have severe pain. (Male aged 49, 7 chronic conditions)

I guess initially it sort of shocked me, because I thought that I wasn’t sort of in that category... (Male aged 65, 10 chronic conditions).

…I’m very strong person, and I don’t allow myself, you know, to be how shall I say, overcome, you know, by emotions... Well, I was surprised. (Female aged 80, 8 chronic conditions)

See, on TV now there’s adverts about depression with young people, and that type of thing? So I haven’t felt like that, just maybe down for a little while”. (Female aged 61, 5 chronic conditions)

But because I know why I’m like that and I feel that it’s justified, I don’t think that I’m clinically depressed, do you know what I mean? Because I feel that my condition justifies my feelings”. (Female aged 75, 12 chronic conditions)

I had no reasons for being in this [state] (Male aged 62, 5 chronic conditions)

…here I go, I’m nutsville.’ And I didn’t agree with it. At first I fought the idea of being on antidepressants, but then realized I couldn’t cope the way I was going, and then went on antidepressants. . . . But at first I thought, oh no, here I go, I’m a nutcase, nobody’s going to take me seriously, and you know, it was embarrassing. (Female aged 48, 8 chronic conditions)

So there’s highs and lows, but I wouldn’t say, like, great depression. (Female aged 61, 5 chronic conditions).

Yeah yeah, it [psychotherapy] was helpful, unfortunately it doesn’t last forever. . . . You get it off your chest. But as I said it doesn’t last forever. (Male aged 65, 10 chronic conditions)

I was pretty down on myself in all respects, and couldn’t understand how I f[...]d up my life, excuse me and I just didn’t think a tablet could take that away”. (Male aged 62, 5 chronic conditions)

40 Stanton and Randal 2016

And I suspect it was a thoroughly horrible situation for [psychiatrist] as well. (DP 6)

I didn’t want to appear too assertive and too knowledgeable and too threatening. (DP 3)

It [training] keeps you away from a feeling state...allows you to stay even more in your head. (DP 4)

You end up talking about brain biochemistry to your doctor which doesn’t fix the problem at all (DP 7)

I wasn’t listening to the cry of my heart, I wasn’t listening to my pain, I wasn’t listening to the truth I knew about what had happened and who I was. (DP 3)

[Psychiatrist] immediately made up his/her mind that it was clearly biological cause which I totally disagreed with and that was fine, let him/her talk and ramble on. (DP 7)

I’m actually not going back now, that’s me, I’ll just get your okay to increase my prescription and say, I’m just going to go now and I’ll go to my GP. (DP 6)

Doctors don’t want to know if their patients are angry with them. Doctors want to feel really good and helpful and wonderful. (DP 3)

I said I want another option. I have no bipolar disorder...I was very clear about it. (DP 8)
[Psychiatrist] just said ‘you’re depressed’ and started me on [medication] ... it was just again that huge sense of relief that I just, I’m unwell and I’m doing something proper about it. (DP 5)

I went because I thought I was having a few problems. And [psychiatrist] told me I was depressed and that I needed antidepressants and I was devastated (DP 4)

I just take it and I don't give it much thought really. Except I know they keep me well and I don’t stop. I mean I realized very quickly that they worked. (DP 9)

I didn’t want to be a doctor. I didn’t want to be a diagnosis. I didn’t want to be on medication. I wanted and needed to be me... as I learned to live with myself, then I kind of... this illness thing evaporated. (DP 4)

I’d never talked to anyone about it before in my life. I didn’t know you could, thinking back, I just didn’t know you could do that... (DP 10)

Not bound by ‘I’ve got to fill in my risk assessment documents and I’ve got to give you a diagnosis’. It just felt like, actually ‘I’m here and I’m listening to you and I’m going to do whatever I need to.’ (DP 6)

I’m a doctor and I care about doctors, yeah, part of it’s about treating your own kind, like helping people in your own family. (TP 2)

Ranged from being extremely enjoyable, rewarding, interesting, worthwhile to being one of those things I had to do but wanted to get out of. (TP 2)

They’re either being good patients or being really difficult and foul and revolting. (TP 6)

It’s brilliant, I really love the fact that I’ve been depressed.... It stinks as an illness but it’s a great extra dimension as a psychiatrist. (TP 5)

I feel really comfortable to talk about [taking time off work] because it’s part of my experience and I talk about how I push myself to work, even though I know probably that it would be better for me to take some time out...I find that easier really because there’s a bit of a connection yeah. (TP 5)

van Geffen et al. 2011

I felt very depressed and down. I was unable to settle down and do something. I started getting upset easily, even with my children. I felt fatigued and tense all the time; I didn’t have the energy. (patient 3, discontinuer)

For quite a while already I was suffering from anxiety and panic attacks. At some point it got out of control; I couldn’t suppress it any more. I was truly afraid of my fears and wasn’t looking forward to anything. Even opening the mailbox felt like it was too much to handle. (patient 13, discontinuer)

What I would usually get done in a day now took me three days. That, in turn, made me feel guilty, and even more depressed. It felt as if I had failed; I just couldn’t do it. (patient 15, discontinuer)

Until, at some point, you reach your limit, and then cross it. Just to avoid the constant thinking, the feeling of fear. That’s when I realised this is it, I have to stop this. (patient 13, discontinuer)

I didn’t believe it would work, as with the other antidepressant I hadn’t noticed any improvement either. I reluctantly went along; now it has become very clear to me that it actually works. I was truly surprised by its effect. (patient 10, discontinuer)

I started getting specific symptoms that I recognised from before. It didn’t seem like a good idea to let it get much worse, so I went back to our GP. Having used it before definitely helped; it makes it easier to explain certain side effects you might experience. You know it will all be just fine, if you give it some time. (patient 16, discontinuer)
I had used paroxetine before, several years ago. That had made me feel so much better. This time I again felt weird and awful, so I went to our GP. He said that since I had experience with using this medication, and it went well before, I got it again this time. (patient 17, continuer)

I'm not the kind of person that takes a lot of medication, but if I have to, I will. Our GP is knowledgeable, and he recommends this to me, so I will take it. (patient 11, continuer)

He told me “This is better for you,” so then I went ahead and started using it. Not really a conscious decision. You don't really know why, or for how long; you don’t really know anything. (patient 3, discontinuer)

I did know a bit about antidepressants and I definitely didn't want any of that. The doctor suggested it to me three times, and all three times I pushed it off. Eventually, when the situation got quite desperate, I gave in. (patient 11, continuer)

My GP explained that your brain produces certain chemicals that have to be in balance. That balance may be what I’m missing. If this pill makes me get my balance back then I would sell myself short if I don’t take it, according to him. (patient 8, discontinuer)

The doctor had first prescribed a “Benzo,” but that made me feel quite groggy. There had to be a better alternative. That's when I read about Prozac, and brought it up myself. I felt the doctor was taking me seriously. (patient 13, continuer)

I don't have a problem with it and don't feel weird about this kind of medication. Obviously I'd rather be healthy without medication, but if you can't live without then you have to take them. If the medication was bad then the GP wouldn't have prescribed if to me. (patient 17, continuer)

To me it's quite simple: a person with heart problems takes heart medication, so if there's a short-circuit in your brain which causes you to have too little serotonin, then you take fluoxetine. (patient 13, continuer)

I actually wanted to fix it myself. If you can resolve it without medication then you're part of the regular people, but now I no longer belong to that group. Taking medication means admitting failure. (patient 10, continuer)

To me, cholesterol reducers are something different; that you can't really do anything about. In this you can't really either, but still ... it's something that's in your brain. That's what makes it difficult for me to take medication. (patient 3, discontinuer)

I'm afraid to get labeled unstable. You generally get told to just get off you’re a[...] and do something about it, then it will be just fine. (patient 12, continuer)

You can get dependent on SSRIs. When you stop using it the depression can return even worse. I believe you should use an antidepressant only temporarily. (patient 7, discontinuer)

I always want to maintain control over my own life, but the medication dominates. The problem doesn't get treated. You become depressed for various reasons, and you have to do something about it. (patient 7, discontinuer)

I was actually quite relieved when I got the medication. You are really sick and you're not just pretending. Your behavior is no longer strange; it's okay now. If you have a broken leg, then everyone accepts that you can't move around. But if they can't tell what your problem is, then you're just weak, lazy, or egocentric, then you're just not right. (patient 10, continuer)

I kept insisting it wasn't a depression I was feeling, and I still don't like it. (patient 12, continuer)

I was glad this guy on the radio explained it this way, that when you're depressed your brain has too little of a certain chemical. I had heard that before and realise there are contradicting theories. But now it's quite convenient for me to believe this particular one. (patient 10, continuer)
For me it's quite difficult to take medication for this. That's because I don't know what exactly I'm using it for. Perhaps if they had told me there's a certain chemical that my body doesn't produce by itself, then I'd be okay with it. (patient 3, discontinuer)
The GP told me that the medication can take a little while to work, and what side effects might occur. He also said that I have to use it for at least six months, plus that I can't quit all of a sudden, but rather reduce the dose over time. (patient 11, continuer)
The doctor didn't discuss any side effects. That's what I had indicated, because when they tell you, then you'll probably get them. I don't ask any questions, I don't need to know everything. (patient 18, continuer)
I don't remember what the GP said. From the conversation I had with him I only remember how it made me feel at the time. (patient 12, continuer)

I was told by the GP that in the beginning I might feel rushed. I'm glad I learned about that, because I did suffer from that in the beginning. So when that happened I knew it was part of the process and would soon pass. (patient 3, discontinuer)
When I started with this medication, I didn't receive any information whatsoever, not even about side effects. They did tell me in passing that it could take a while before I would notice the intended effect. The doctors should be much keener about this. It would be so easy to just give the main messages, and refer to the information leaflet for more information. When I asked my doctor whether this medication has any side effects, he just grabbed a big book and said “If you like I can read them for you.” (patient 6, discontinuer)
The first time the GP said it's not addictive. I had reduced the dose over time, but yet from the way I was walking it seemed like I was drunk. I had a headache all the time. I believe it actually is addictive. The doctors better stop telling that story. (patient 16, continuer)
My GP had consulted the gynaecologist and said there appeared to be something wrong with my hormone balance. I trusted him. I didn't know then that it was an antidepressant until later when I read the information leaflet. If a doctor can't explain why you need it, then you won't accept the medication as easily either. (patient 3, discontinuer)
The first four weeks were really difficult. You don't feel too great to start with, and on top of that these side effects. The stomach aches were the worst part. I couldn't keep any food down, just tea I was able to manage. I was shaking a lot, felt nervous and restless. I had the feeling there was so much I was supposed to be doing, but I didn't have the energy to get to it. (patient 12, continuer)
I was rather apathetic. Temporarily, perhaps that's a good thing, but not over a long period of time. I no longer had the energy to take any initiative; it seemed as if I lived in a bell jar. (patient 7, discontinuer)
I'm a lot less tense now, and more relaxed. I can take setbacks a lot better, and don't let things get to me as much. I enjoy moving around and started picking up basic things like making coffee. The household is back in operation. (patient 10, continuer)
I no longer have panic attacks, and I'm not as scared. I'm noticing that the negative feelings are diminishing. I am more open now to positive aspects, which helps me focus on my inner self. (patient 16, continuer)
My emotions in general are more subdued. Some things I don't care about any more; I've become more egocentric. (patient 10, continuer)
My head feels calmer now; it’s not churning thoughts as much any more. It doesn’t feel as heavy, though it’s not stable yet. I still have days of much doubt, of not being my true self. (patient 15, continuer)

I received a medication that didn’t do anything; the situation got worse. I kept sliding down further and further. (patient 6, discontinuer)

My disease is a so-called “self-finishing process.” I feel better now, but I don’t know if it’s thanks to the medication or just because of time passing. If you don’t take anything, you’ll also get better. I started biking again; that may have actually helped me more than the Efexor. (patient 6, discontinuer)

My relationship with our GP is really good. He is always willing to listen to my side of the story. He understands my situation; I think that’s important. (patient 16, continuer)

My previous doctors never really counseled me. They just wrote out a prescription, opened a drawer, and before I knew it I was back outside. My current doctor is willing to admit he doesn’t know everything. He’s just trying to get things started again. He explains everything, and I feel comfortable discussing my doubts with him. (patient 6, discontinuer)

My family knows I use medication, but what for they don’t know. I believe they think it’s just some relaxation pills, nothing more. I’d rather not tell anyone. I’m afraid to get labeled mentally unsound, and not being able to get rid of it. When I get back to work I want to have all of my job’s responsibilities; no special treatments because of what happened to me. (patient 12, continuer)

When I talk about it with other people they’re often wondering if taking this kind of medication is a wise thing to do. You hear a lot of negative stories about these medicines. That’s a shame because I’m sure there are people who benefit from it. (patient 7, discontinuer)

My wife thinks this medication is scary since it’s affecting your brain. That doesn’t bother me. The list of side effects on the information leaflet was quite shocking to her. So we talked about it, and then asked our GP if I could stop using it. I am doing okay now, but the deepest fears haven’t gone away yet. (patient 1, discontinuer)

Moment of discontinuation
In my case the benefits outweigh the downsides, as far as I can tell. Obviously, I’m worried about the bruising and the muscle aches; what does that mean about what’s happening in your body? Perhaps if I knew more about that I would decide to quit. But I had thought long and hard on
whether I should start with it, so you don't quit just like that. After all, my quality of life did improve (patient 10, continuer)
The weather was fine, and I was doing okay. I was tired of being dependent on medication any longer, so I just quit. I thought I could do without; others also can. (patient 3, discontinuer)
I don't believe I could do without my medication yet. I'm still feeling too unstable. Once I can quit I will do so, but I'm afraid I'll slide back to my previous conditions. I update the GP on how I feel and leave the decision when to quit to him. After all, he's the expert. (patient 11, continuer)
I don't want to take any pills if it's not absolutely necessary. I had called the doctor to start reducing the dose. I thought, if I don't speak up, a year from now I would still be taking these pills. But he thought it was too soon, so I'll continue for a little while longer, which is fine. (patient 15, continuer)
I don't want to take any pills if it's not absolutely necessary. I had called the doctor to start reducing the dose. I thought, if I don't speak up, a year from now I would still be taking these pills. But he thought it was too soon, so I'll continue for a little while longer, which is fine. (patient 15, continuer)
I felt much better and was not sure whether this was due to the fact that I started dancing and sporting again, or due to the medicine. That's what I wanted to find out, and that's why I stopped taking the medicine. (patient 6, discontinuer)

Considerations for continuation
I'd like to try quitting one more time. If I still get the symptoms back even after this third time, then I'll accept that I just have to take this pill. Then it would no longer bother me. (patient 8, discontinuer)

Reasons for discontinuation and consequences of it
To me, quitting was a very positive experience. I did suffer from side effects, but with every day I felt I was becoming more "me." I felt a boost in energy and started picking up activities. I do worry about the depression returning, knowing that I quit too soon. However, I would never take an antidepressant again. The cure is worse than the disease! (patient 7, discontinuer)
I just couldn't go on any longer. So I started again; I have arranged it all myself. I just know by now that it's better for me to take this medicine. (patient 3, discontinuer)

van Grieken et al. 2014
I felt that I was more held back than that there was a connection to what I was experiencing. So the [treatment] method was leading more than I was. It was also really the method that didn't work for me. (ID26)
Everybody was in the same process and at the same courses... I think it was primarily the people who were taking a lot of antipsychotic medication, and were sometimes suddenly screaming loudly or demanding a lot of attention, and were physically very slow at the time that we were doing an activity, interfering more than that they were able to participate. I sometimes found that horrible, I really had trouble with that. (ID28)

The lack of a framework has a very negative impact: what are you working on, where are you headed, how long will it take? If I know what his or her perspective is, I can speak more easily. Then I know what's being measured, and in what direction someone wants to take me. It also has to be clear, I really missed that. You see, of course there is an end. At a certain moment you'll be discharged. And that doesn't mean that you'll be 100% recovered and healthy, but it's nice to know that in advance.' (ID23)
There must be a plan, a beginning and an end, and you have to have goals. I found that lacking very much. ... What you were working towards and what you wanted. (ID4)
Because then if I went into therapy, very frequently I had to go through my whole childhood, family, and work, whereas that's not where the problem was. It lay primarily with the way I was
thinking and incorrectly reacting to situations. You don't solve that directly by discussing your marriage, parents, or childhood, that in fact had nothing to do with it. (ID4)

Then I was referred to a psychologist for [therapy] sessions. And I thought, I'd also find medication perfectly fine. But I thought, they'll know... I would have preferred to think along and be involved in the decision-making. ... So, we weren't making any progress, we were only talking about my past and meanwhile I was not recovering from my depression. ... I experienced several times that in hindsight I thought: why are we doing it this way? (ID19)

If, for example, every psychiatrist would tell a client: we're going to work together for four sessions, and after those four sessions, you can say whether you think it's working or not. I've never experienced a psychiatrist who evaluates. (ID15)

The only reason why I am on medication now, is because friends and family have given me incredible support with this. Otherwise I wouldn't have taken pills. Thirty minutes with my psychiatrist was not enough to convince me. He didn't take enough time for that. I had a very serious fear that was not being recognised. And it was also not taken seriously. And that has a very large influence on adherence. (ID11)

I don't think that the confidence was really there to just talk about myself over there. It's just very important that there is a click in order to move forward together. (ID16)

Hope is incredibly important. That always has been a tremendously important basis for me. Therapists who have the balls to say that everything will be all right: that requires courage. Because there are also therapists who do not dare to say that, because they don't know whether that's true and they think it's not right to say it then. (ID20)

'I had a very good psychiatrist, but then I couldn't go to him anymore and I had to go to someone else. And then you feel you need to start all over again. (ID2)

What doesn't work: someone who doesn't take you seriously. He wasn't warm, he didn't show any compassion.... Apparently I felt 'you're not going to help me'. No, I didn't even start with him.' (ID20)

There has to be a good mix between a professional attitude and not too much distance, And also not someone who sits across from or next to me and will continuously say 'oh yeah, that's horrible'... yes, who will only commiserate. So also there will have to be a balance actually. That I have someone who confronts me with things, but where I also feel, whenever there is a confrontation, that he understands me.' (ID9)

You also feel very dependent. I actually felt growing smaller and smaller during that conversation. I absolutely did not have a good feeling then. (ID16)

'I would rather have someone who knows better than I do. That's what you need. There are certain phases where you really need to be told what to do. If that doesn't happen then, that works badly.' (ID23)

'A three month-waiting list! And one week afterwards I attempted suicide. Exactly because you're going there to ask for help because you can't deal with it anymore.' (ID21)

What can be worse for someone with a depression than to be abandoned? I attempted suicide, amongst others because I could not get a hold of my therapist... who was just not available. Then I thought now I'm done.... What I really find heart-warming, I now have an agreement with my psychiatrist: 'I will never call you. And if I call you, all alarms are on red. Then I want you to directly intervene, to put me on medication, and to set me up with a specialist.' That kind of agreements has a very high value for me. (ID20)
At a certain point you're not sure who your primary contact person is. I also found that to be something very difficult. I never had the feeling that there was one person who I could always contact. (ID28)

You end therapy and after a while, you relapse again. Aftercare, that was not available. I think that it's better if you follow-up on people, that you let them return every month or every two months, and that you just go through those check-lists, like how is this going, how is that going, how is the other thing going? Because that's my experience, you yourself do not ring an alarm bell. Because you're already so fed up and you're ashamed that you failed again, and then you think, tomorrow things will be better again. (ID4)

To involve the significant other is important, not in the least for the significant other him/herself. Also that attention be paid to the possibilities of the partner to be supportive or to need support themselves. That should be part of treatment, as at least for me, one of the success factors has been my system. (ID20)

Vargas et al. 2015

Many participants said their depression could be treated by medication that “helps to regularize the nerves (ayuda a regularizar los nervios).”

Labels because of their depression: Close associates, such as relatives, friends, or acquaintances, viewed participants’ depression as a sign of personal weakness or lack of drive to feel better, as if, “you want to feel [depressed]… [and] that with just a little extra effort, you can get out of it.”

Other people viewed depression as something which “does not exist, something that you cause yourself,” through excessive investment in your own dilemmas (“believing in your own crap”), dwelling on problems, attending too strongly to negative circumstances, or apathy about negative emotive states (“you let yourself fall and let it happen”).

María explained that her family and friends said depressed people need to “put forth effort (poner de su parte), that it is not an illness … that depression is cured … by oneself putting forth effort … and going to church.”

Silvia described, “I have always been depressive … but with strong will (fuerza de voluntad) I have prevailed, but not now. The other [times I’ve used] the remedy of ‘I won’t pay attention,’ of patching up the problem … and now … my mind says no.”

Diego described his father’s attitude toward antidepressants as follows: “My father … doesn’t agree with this … he says I can get better on my own, but it’s not as easy as he thinks.”

Gabriela described her preference for natural medicine, like tea, but explained how it did not address her mental health needs: “I have always liked natural medicine, but you know … it is very delayed and … too mild (suave) for what I have,” indicating her depression was too severe for alternate treatments.

One participant expressed her frustration at not being located on this gradient: “so far … they haven’t told me what class of depression I have.”

“[My psychiatrist] would give me tests similar to this one and I never knew what came of those tests.” He eventually dropped out of that treatment.

Many participants described delaying psychiatric treatment by trying first to “keep fighting with my problems and control myself.”

Pamela explained why she avoided treatment in the past: “I thought … I am going to take medicine and my nerves are going to become unwell (voy a estar mala de los nervios), I will have to start seeing a psychiatrist—the psychiatrist is for crazy people.”
Daniela stated that her family thought antidepressants could also precipitate the onset of madness. Seeing a psychiatrist could be construed as a pathway to madness.

Miguel explained how seeing a psychiatrist could yield further stigmatization: “[People say about a depressed person] that he is crazy ... And if he sees a psychiatrist or something, they say, no, that one really becomes crazier every day. Because psychiatrists, they say ... make people crazy.”

Ricardo explained this difficulty: “It took a lot from me to come [to the clinic] because of all the myths, the negative aspects ... [attributed to] a person with depression ... who sees a psychiatrist.”

Most sought help only when completely unable to cope: “If I were to find a solution ... I would not look for help. But ... this is overtaking me [me está rebasando]. And each time it’s ... more so.”

Gabriela explained that she stopped going to a previous treatment because she at that point “thought I could ... help myself without needing the medication.”

Other concerns with bodily effects included fluctuations in weight, sleeping habits, sexual function, dizziness, and “the way they [medications] can alter my brain.”

Elena described, “if ... they need to remove my liver because I have hepatitis as a result of the medications, my depression will get worse, it will get stronger.”

Margarita said she worried over feeling “abobada” (befuddled) as a result of taking the medication, and that “other people could do with me whatever they want ... that I would not be aware of what was happening.”

“I stop taking it ... you can feel more down, more depressed, a greater sense of guilt or a desire to kill yourself ... if I don’t feel that way now, and by ceasing medication treatment I’d feel that way, well then I say things are just going to get worse.

[Using medication for a long time] would be ... relying entirely on the pill to feel well. And the pills only, in my opinion, [should be used for] a limited time to help the person return to their normal state.

Carolina said, “I have heard that if you take it every day, they are addictive every day. But I think that ... if the doctor says you must take it, you must take it. He will know when to stop it.”

Carmen explained, “If I go to the gym, I feel better as well, but right now I feel so impotent, so bad, that I can’t find the way to go exercise.”

Elena explained that while others thought visiting a psychiatrist was “a thing crazy people do (cosa de loco),” she thought treatment was meant “to help everyone, crazy people and those who are not crazy.”

Vilhelmsen, Svensson and Meeuwisse 2013

In fact, my so-called ‘depression’ was a normal reaction to crisis following separation, homelessness, loss of two jobs within three years, and death in the family. (Woman, 63 years old).

Went to see a doctor because I was exhausted. Could not sleep, could not think, had stopped working. The doctor said it was depression, but I was hesitant. I did not feel depressed, just tired and sad about the terrible situation I was in...He stated all symptoms of fatigue to be the same as depression. (Woman, 41 years old).

I have had a very severe, lonely, and anxious childhood (not because of incest or physical violence) and as an adult have had more and more frequent and deeper periods of apathy and
depression. My memory works poorly, and I have had big blackouts in the past and have needed therapy to make out what is missing. (Woman, 34 years old).

I was not feeling well after my second breast cancer and was offered psychiatric help and thought that it would be useful to talk to someone, but after twenty minutes, first consultation, I was offered ‘happy pills’. (Woman, 50 years old).

I do not like taking pills and told this to the doctor. Then she proposed Valium [Swedish benzodiazepine brand name (substance: Diazepam) – author’s note] so I would feel more relaxed in taking Seroxat [Swedish antidepressant brand name, substance: Paroxetine – author’s note]. (Woman, 50 years old).

The doctor has told me to continue in order to feel better and that I shall understand it as a ‘vitamin boost’. (Woman, 36 years old).

Maybe the root cause is not a chemical imbalance in the brain! (Woman, 38 years old).

I along with my doctors know that I have low levels of serotonin and one doctor told me that I probably will have to take Cipramil [Swedish antidepressant brand name (substance: Citalopram – author’s note) for the rest of my life (Woman, 38 years old).

I have felt that the reason for doctors to prescribe antidepressant medication is that it is the only help they can offer, and that this is why the doctor can be frustrated if you reject this help. (Woman, 38 years old).

All I wanted was someone to talk to, some sort of therapy. (Woman, 22 years old).

The first doctor I visited barely looked at me when I told her about my symptoms. (Woman, 42 years old).

I have the ‘luck’ nowadays of having ongoing contact with psychiatrists with solid knowledge of the field and who also order laboratory tests to ensure that the right medicine is prescribed. (Woman, 49 years old).

After a couple of months of being sick-listed because of severe burnout, the doctor decided to issue an ultimatum: either I started with Fluoxetine [Generic antidepressant, substance: Fluoxetine – author’s note], or he would not continue my sick-listing. (Woman, 26 years old).

…I refused despite threats of ending my sick-listing, since I ‘apparently did not want to get better as I was avoiding work’, as he [the doctor] concluded. (Woman, 34 years old).

While I have been medicating, my doctor and I have not spoken. (Man, 56 years old).

This one [the doctor] after I ended drug treatment has have been malicious and unpleasant and very unprofessional in his attitude towards me. (Woman, 41 years old).
## APPENDIX E

### Summary of Qualitative Studies Analysed in Previous Reviews

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Karp 1993</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Karp 1994</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lewis 1995</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North et al. 1995</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barter &amp; Cormack, 1996</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Priest et al. 1996</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooper-Patrick et al. 1997</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bultman &amp; Svarstad 2000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Churchill et al. 2000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooper et al. 2000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Dwight-Johnson et al. 2000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jorm et al. 2000</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kadam et al. 2001</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sirey et al. 2001 (b)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bull et al. 2002 (a)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bull et al. 2000 (b)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knudsen et al. 2002 (a)</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knudsen et al. 2002 (b)</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maidment et al. 2002</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prabhakaran &amp; Butler 2002</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Garfield et al. 2003</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gask et al. 2003</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knudsen et al. 2003</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masand 2003</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roeloffs et al. 2003</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleath et al. 2003</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Bann et al.</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bollini et al.</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Garfield et al. 2004</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grime &amp; Pollock 2004</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haslam et al. 2004 (a)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Van Schaik et al. 2004</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aikens et al. 2005</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashton et al. 2005</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Badger &amp; Nolan 2005</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brown et al. 2005</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonzales et al. 2005</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jorm et al. 2005</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kessing et al. 2005</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lin et al. 2005</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maxwell 2005</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>2005</td>
<td>2006</td>
<td>2007</td>
<td>2008</td>
<td>2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ozmen et al. 2005</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pound et al. 2005</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rieder-Heller et al. 2005</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Van Vorhees et al. 2005</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Backenstrass 2006</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burroughs et al. 2006</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Givens et al. 2006</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gum et al. 2006</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Karasz &amp; Watkins 2006</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitchell 2006 (b)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olfson et al. 2006</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Van Vorhees et al. 2006</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbeek-Heida&amp; Mathot 2006</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Badger &amp; Nolan 2007 (b)</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burra et al. 2007</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooper et al. 2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Cornford et al.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dobscha et al. 2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Givens et al. 2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Hansen &amp; Kessing 2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Holt 2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Hunot et al. 2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Interian et al. 2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Leydon et al. 2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leykin et al. 2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitchell 2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitchell &amp; Selmes 2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aikens et al. 2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Cabassa et al. 2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Dijkstra et al. 2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

414
<table>
<thead>
<tr>
<th>Study</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shigemura et al.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turner et al. 2008</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wittkampf et al. 2008</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chakraborty et al. 2009</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Goodman 2009</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Malpass et al. 2009</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pohjanoksa et al. 2009</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Price et al. 2009</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Van Geffen et al. 2009</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Britten et al. 2010</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Holma et al. 2010</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Schofield et al. 2011</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

The studies are listed above in a chronological order by the publication date and then, alphabetic order of authors. The purpose of putting the studies in this particular order was to compare the development of timely research and frequency and randomness (or lack of it) of selection by all authors.
### Appendix F. Step 3 of study selection. Summary of screened qualitative, quantitative, and mixed method studies (n=426)

<table>
<thead>
<tr>
<th>Year</th>
<th>Author/s</th>
<th>Title</th>
<th>Country</th>
<th>Study design &amp; method</th>
<th>Diagnosis &amp; Diagnostic instruments</th>
<th>Focus of the study</th>
<th>Results/Conclusion</th>
<th>Recommendation for future studies/actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>Beck &amp; Ward</td>
<td>Dreams of depressed patients</td>
<td>USA</td>
<td>Interviews; statistical analysis</td>
<td>APA Diagnostic Manual; Depression Inventory</td>
<td>Masochistic dreams in persons diagnosed with depression</td>
<td>The moderately to severely depressed group reported significantly more masochistic dreams than the non-depressed group.</td>
<td>Psychoanalytic interview with focus on the verbal and nonverbal behavior of the patient can be tested in rigorously controlled experiments</td>
</tr>
<tr>
<td>1961</td>
<td>Neylan, Prowse, M.</td>
<td>The depressed patient</td>
<td>Canada</td>
<td>Commentary</td>
<td>Depression</td>
<td>Depressed patients demand attention and sympathy. They can drain nurses emotionally.</td>
<td>In patients who are prevented from externalizing their feelings, it is more than likely, their anger will be internalized with consequent prolongation of the depression.</td>
<td>The nurse can be guided by the knowledge that it takes time for anyone to work through a depression.</td>
</tr>
<tr>
<td>1965</td>
<td>Ayd, Frank J.</td>
<td>The chemical assault on mental illness: The antidepressants</td>
<td>USA</td>
<td>Commentary</td>
<td>Depression</td>
<td>Antidepressants and their adverse effects</td>
<td>Although the progress made from 1953 to 1963 can rightfully be called unprecedented, the fact remains that much needs to be accomplished.</td>
<td>To discover more effective, safer drugs for the mind. Equally necessary are more nurses prepared to care for psychiatric patient</td>
</tr>
<tr>
<td>1985</td>
<td>Reda et al.</td>
<td>Thinking, depression and antidepressants: modified and unmodified depressive beliefs during treatment with amitriptyline</td>
<td>Italy</td>
<td>Cohort, prospective study: questionnaires</td>
<td>MDE with melancholia; DSM III, DAS, HRS-D</td>
<td>Amitriptyline 75-120 mg + benzodiazepine</td>
<td>Positive effects of the tricyclic antidepressants on depressive symptomatology are accompanied by changes in cognitive patterns</td>
<td>Role of persistent irrational beliefs in people prone to depression and the optimal coordination of pharmacotherapy and psychotherapy</td>
</tr>
<tr>
<td>1992</td>
<td>Brugha &amp; Bebbington</td>
<td>The under-treatment of depression</td>
<td>UK</td>
<td>Cohort, prospective CACO study: 4 interviews</td>
<td>Clinical depression; DSM III R&amp;ICD 10-DCR</td>
<td>Tricyclic AD or similar; MOI; benzodiazepine &amp; 'other'; 100 mg of Amitriptyline</td>
<td>Treatment is not effectively deployed</td>
<td>Systematic research on the effectiveness of services for depressed patients</td>
</tr>
<tr>
<td>1992</td>
<td>Karp, D.</td>
<td>Illness ambiguity and the search for meaning</td>
<td>USA</td>
<td>Case study of a self-help-group</td>
<td>Depression or manic depression</td>
<td>Diagnosis, personal responsibility for the illness, reliance on medical experts, efficacy of ADs</td>
<td>Group discussions provided plausible explanations for shared difficulties. Group talk implied an antipsychiatry ideology that questioned medical dominance</td>
<td>Examine a variety of personal troubles and learn the timing and let the circumstances respond to them.</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Topic</td>
<td>Summary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>-------</td>
<td>---------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td>Karp, D.</td>
<td>Taking anti-depressant medications: Resistance, trial commitment, conversion, disenchantment</td>
<td>USA</td>
<td>Qualitative: in-depth interviews, case studies</td>
<td>Depression</td>
<td>To explore the symbolic meanings attached to taking antidepressant medications. However long it took the respondents to recognize and label their difficulty as depression, their eventual treatment by physicians involved use of prescribed medication. An individual’s response to medication can be described as process of unfolding consciousness and identity change consisting of: resistance, trial commitment, conversion, and disenchantment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1994</td>
<td>Flare</td>
<td>Personality by prescription</td>
<td>Canada</td>
<td>GREY LIT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1994</td>
<td>Karp, David A.</td>
<td>Living with depression: Illness and identity turning points</td>
<td>USA</td>
<td>Qualitative; Grounded Theory; interviews, observation; discussion</td>
<td>Unipolar depression</td>
<td>Person's lived experience with clinical depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>Bech, Per</td>
<td>Quality-of-life measurements for patients taking which drugs? The clinical PCASEE perspective</td>
<td>Denmark</td>
<td>Overview</td>
<td>Depressive illness; DSM III</td>
<td>PCASEE P=physical indicators, C=cognitive ind., A=affective ind., S=social ind., E=economic-social stressors or negative life events, E=ego function or personality problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>Garcia-Campayo et al.</td>
<td>Orgasmic sexual experiences as a side effect of fluoxetine</td>
<td>Spain</td>
<td>Qualitative, case study; patient’s accounts</td>
<td>MDE without psychotic features; DSM-III-R</td>
<td>Fluoxetine 20mg/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Suggested increases in central serotogenic neuronal activity as a probable cause of orgasmic sexual experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Experience with fluoxetine to understand the pathophysiology of this side effect</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Not found.
<table>
<thead>
<tr>
<th>Year</th>
<th>Author(s)</th>
<th>Title</th>
<th>Country</th>
<th>Design, Methodology</th>
<th>Findings</th>
<th>Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>Lewis, S. E.</td>
<td>A search for meaning: Making sense of depression.</td>
<td>UK</td>
<td>Qualitative, grounded theory and discourse analytic techniques, symbolic interactionism: in-depths interviews</td>
<td>Patients diagnosed as depressed + non-patients who described themselves as depressed. Identification of depression through diagnosis, explanation of depression, the search for meaning and patients' explanations for their depression experience</td>
<td>Depression is a different experience for everybody. Looking at how clinicians understand the concept of depression and how far this is consistent with their patients' understanding of depression</td>
</tr>
<tr>
<td>1995</td>
<td>North et al.</td>
<td>Patient responses to benzodiazepine medication: a typology of adaptive repertoires developed by long-term users</td>
<td>New Zealand</td>
<td>Long-term benzodiazepine users</td>
<td>In all cases, benzodiazepines were initially prescribed during a high-stress period in the participant's life. Once prescribed benzodiazepines, participants were given a high degree of autonomy to manage their own use.</td>
<td>Type and dosage of the regime was established by the user's doctor, but the community-based participants in the study were granted considerable autonomy in the management of their regime and had generally developed an understanding of mutual trust with their doctor. Emergent concepts of this kind can serve to sustain patterns of patient self-regulation and active management, rather than merely to extend the reach of medical dominance and control.</td>
</tr>
<tr>
<td>1995</td>
<td>Rosholm et al.</td>
<td>Antidepressant treatment in general practice-An interview study</td>
<td>Denmark</td>
<td>Cross-sectional, descriptive interview study: interviews</td>
<td>tricyclic Ads (incl. maprotiline), SSRIs, moclobemide &amp; mianserin</td>
<td>The use of low doses, long duration of treatment and uncertainty are important features. Also, discrepancy btw. The use of ADs in GP and the scientifically-based recommendation not found</td>
</tr>
<tr>
<td>1996</td>
<td>Ahnlund, K. &amp; Frodi, A.</td>
<td>Gender differences in the development of depression</td>
<td>Sweden</td>
<td>Non-experimental design: analysis of hospitalized patients records</td>
<td>Examined the relations btw. gender and eliciting factors of depression, marital status, age, season of hospital admission, type of medication</td>
<td>Significant gender differences re. eliciting factors, marital status and age. Results concerning type of medication and season of hospitalization need to be replicated in Scandinavian and non-Scandinavian samples</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Methods</td>
<td>Findings</td>
<td>Conclusions</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>---------</td>
<td>---------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>1996</td>
<td>Barter &amp; Cormack</td>
<td>The long-term use of benzodiazepines: patients' views, accounts and experiences</td>
<td>UK</td>
<td>Qualitative interviews and analysis; non-parametric statistics</td>
<td>This study found that the participants had no knowledge of what their doctors thought of their use of benzodiazepines</td>
<td>Participants perceived 'giving up' their drugs as problematic, indicating that research is needed to examine the conceptions long-term users hold about discontinuing their drugs</td>
</tr>
<tr>
<td>1996</td>
<td>Lewis, S. E.</td>
<td>The Social Construction of Depression: Experience, Discourse and Subjectivity</td>
<td>UK</td>
<td>Dissertation</td>
<td>Depression; lay beliefs &amp; public opinions</td>
<td>Counselling favoured; antidepressants and tranquillisers believed to be addictive; tranquillisers found affective in depression</td>
</tr>
<tr>
<td>1996</td>
<td>Priest et al.</td>
<td>Lay people's attitudes to treatment of depression: results of opinion poll for Defeat Depression Campaign just before its launch</td>
<td>UK</td>
<td>Opinion poll; Research Quorum; qualitative survey-group discussions; quantitative survey</td>
<td>Counselling favoured; antidepressants and tranquillizers believed to be addictive; tranquillizers found affective in depression</td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>Bosc, Dubini, &amp; Polin</td>
<td>Development and validation of a social functioning scale, the social adaptation self-evaluation scale.</td>
<td>France &amp; Italy</td>
<td>Population survey and two controlled studies; multivariate analyses</td>
<td>The SASS scale represents a useful additional tool for the evaluation of social functioning in depression</td>
<td>The SASS scale will facilitate the development of new antidepressants with differential effects in this domain in depressed patients</td>
</tr>
<tr>
<td>1997</td>
<td>Cooper-Patrick et al.</td>
<td>Identification of patient attitudes and preferences regarding treatment of depression</td>
<td>USA</td>
<td>Focus groups</td>
<td>Identified a wide range of patient attitudes and preferences</td>
<td>Incorporate the range of factors identified by patients</td>
</tr>
<tr>
<td>1997</td>
<td>Ferreres et al.</td>
<td>Antidepressant treatment before hospitalization for major depression: often prescribed, often undertreated</td>
<td>Switzerland</td>
<td>Small scale retrospective study: in-depth focus-group discussions; semi-structured interview</td>
<td>A large number of patients did not receive adequate treatment prior to hospitalization</td>
<td>Pay more attention to the training of physicians in regards to prescribing antidepressants</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Key Findings</td>
<td>Implications</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>1997</td>
<td>Hagerty, Williams &amp; Liken</td>
<td>Prodromal symptoms of recurrent major depressive episodes: A qualitative analysis</td>
<td>USA</td>
<td>Qualitative: focus groups and grounded theory methods</td>
<td>People entering a major depressive episode often have difficulty identifying prodromal symptoms, although they experience early warning phases</td>
<td>Identifying specific characteristics of the prodromal phase of recurrent depression and patient responses, and toward a more comprehensive phenomenological description of the experience and characteristics of this phase</td>
</tr>
<tr>
<td>1998</td>
<td>Bultman, Dara Catherine</td>
<td>Consumer Perspectives of Provider Communication Styles and Antidepressants: a Study of Beliefs and Outcomes.</td>
<td>USA</td>
<td>Dissertation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>Lewis &amp; Nicolson</td>
<td>Talking about early motherhood: Recognizing loss and reconstructing depression</td>
<td>UK</td>
<td>Qualitative; 2 studies combined: In-depth verbal accounts transcribed verbatim</td>
<td>Depression Women's experiences with depression and transition to motherhood</td>
<td>Deconstructed experience of depression as part of women's life and motherhood experience</td>
</tr>
<tr>
<td>1999</td>
<td>Domino Edward F.</td>
<td>History of modern psychopharmacology: a personal view with an emphasis on antidepressants</td>
<td>USA</td>
<td>Opinion &amp; personal experiences: commentary</td>
<td>Depression Provided the chemical basis for the molecular modification of H1 antihistamines in the development of some antidepressant and antipsychotic drugs</td>
<td>Molecular manipulation can produce new therapeutic leads</td>
</tr>
<tr>
<td>1999</td>
<td>Gammel &amp; Stoppard</td>
<td>Women's experiences of treatment of depression: Medicalization or empowerment?</td>
<td>Canada</td>
<td>Qualitative; feminist approach: interviews</td>
<td>Depression A medicalized understanding and treatment of women's depressive experiences cannot readily co-exist with personal empowerment</td>
<td>Medicalization of depression has disempowering consequences</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methods</td>
<td>Diagnosis</td>
<td>Research Focus</td>
</tr>
<tr>
<td>------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2000</td>
<td>Boyle &amp; Chambers</td>
<td>Medication compliance in older individuals with depression: gaining the views of family carers</td>
<td>N. Ireland</td>
<td>Qualitative - focus groups and qualitative analysis: interviews</td>
<td>Depression</td>
<td>Carers' attitudes and experiences with older patients' medication compliance</td>
</tr>
<tr>
<td>2000</td>
<td>Bultman &amp; Svarstad</td>
<td>Effects of physician communication style on client medication beliefs and adherence with antidepressant treatment</td>
<td>USA</td>
<td>Mixed - Communication framework, prospective design and statistical analysis: Initial and follow up telephone interviews</td>
<td>Depression</td>
<td>Client beliefs about and satisfaction with pharmacological treatment</td>
</tr>
<tr>
<td>2000</td>
<td>Churchill et al.</td>
<td>Treating depression in general practice</td>
<td>UK</td>
<td>Cross-sectional survey: self-completion questionnaire. Data analysis: SPSS. Chi-square tests and logistic regression</td>
<td>Depression</td>
<td>Patients' preferences re. treatment for depression and characteristics associated with those preferences</td>
</tr>
<tr>
<td>2000</td>
<td>Cooper et al.</td>
<td>Primary care patients' opinions regarding the importance of various aspects of care for depression</td>
<td>USA</td>
<td>Cross-sectional survey: focus groups; statistical analyses</td>
<td>Depression</td>
<td>The most important attributes of treatment (with medications and counseling) were their effectiveness, ability to restore patients to their usual level of functioning, ability to cure</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Study Design</td>
<td>Methods</td>
<td>Outcomes</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>--------------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>2000</td>
<td>Dwight-Johnson et al.</td>
<td>Treatment preferences among depressed primary care patients</td>
<td>USA</td>
<td>Mixed - qualitative inquiry with statistical analysis: self-administered questionnaires and telephone interviews</td>
<td>Current depressive symptoms; Composite International Diagnostic Interview (CIDI) &amp; Center for Epidemiologic Studies Depression Scale (CES-D)</td>
<td>Preferences for depression treatment</td>
</tr>
<tr>
<td>2000</td>
<td>Ekselius, Bengtsson, &amp; von Knorring</td>
<td>Non-compliance with pharmacotherapy of depression is associated with sensation seeking personality</td>
<td>Sweden</td>
<td>Randomized, double-blind study</td>
<td>Depression; DSM-III-R &amp; MADRS score of at least 21; Karolinska Scale of Personality</td>
<td>Sertraline (50-150 mg/day) or citalopram (20-60 mg/day)</td>
</tr>
<tr>
<td>2000</td>
<td>Jorm et al.</td>
<td>Public belief system about the helpfulness of interventions for depression: associations with history of depression and professional help-seeking</td>
<td>Australia</td>
<td>Mixed-method: A postal survey, questionnaire; statistical analysis; structural equation modelling</td>
<td>Depression; Goldberg Depression Scale; ICD-10; MIMIC for stat. analysis</td>
<td>Public belief systems; experience of depression and seeking professional help</td>
</tr>
<tr>
<td>2000</td>
<td>Lin et al.</td>
<td>Low-Intensity treatment of depression in primary care: is it problematic?</td>
<td>USA</td>
<td>Cohort study: Structured Clinical Interview for Depression</td>
<td>Depression &amp; dysthymia, MDEs + statistical analyses (chi-square tests); DSM-IV</td>
<td>Adherence to antidepressant medications</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Location</td>
<td>Study Type</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>----------</td>
<td>------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>Williams et al.</td>
<td>New drugs for old folks: the evidence based argument for newer antidepressants</td>
<td>USA</td>
<td>Review</td>
<td>Depression</td>
<td>Comparative benefits and drawbacks of the newer medicinal and botanical therapies for depression (SSRIs, SNRIs and St. John's wort)</td>
</tr>
<tr>
<td>2001</td>
<td>Demyttenaere Koen</td>
<td>Compliance and acceptance in antidepressant treatment</td>
<td>Belgium</td>
<td>Commentary</td>
<td>Depression</td>
<td>Antidepressants</td>
</tr>
<tr>
<td>2001</td>
<td>Greden, J.F.</td>
<td>The burden of recurrent depression: Causes, consequences, and future prospects.</td>
<td>USA</td>
<td>Review</td>
<td>Depression</td>
<td>Recurrent depression</td>
</tr>
<tr>
<td>2001</td>
<td>Kadam et al.</td>
<td>A qualitative study of patients' views on anxiety and depression</td>
<td>UK</td>
<td>Qualitative: Semi-structured individual interviews and focus groups + grounded theory analysis</td>
<td>Anxiety &amp; depression; HAD questionnaire</td>
<td>Benzodiazepines, antidepressants, counselling</td>
</tr>
<tr>
<td>2001</td>
<td>Lauer-Williams, Jeanne</td>
<td>Postpartum depression: A phenomenological exploration of the woman's experience</td>
<td>USA</td>
<td>Dissertation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Application of newer agents for the treatment of mood disorders beyond MD and among more representative clinical populations; data on the options not responding to initial treatment; benefits of botanicals over the newer agents.
<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Title</th>
<th>Country</th>
<th>Study Design</th>
<th>Data Collection Method</th>
<th>Diagnosis</th>
<th>Methodology</th>
<th>Findings</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>Mundt et al.</td>
<td>Effectiveness of antidepressant pharmacotherapy: the impact of medication, compliance and patient education</td>
<td>USA</td>
<td>Longitudinal study; IVR data collection system (by mail)</td>
<td>MDD: DSM-IV, HDRS, SCID-P, WSAS, PGI of Improvement Rating, Satisfaction with Treatment questionnaire</td>
<td>Antidepressant pharmacotherapy (excl. Trazodone)</td>
<td>Effective treatment with pharmacotherapy; medication compliance is critical to effectiveness</td>
<td>Additional efforts at program improvement</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>Schaub et al.</td>
<td>What do patients in a lithium outpatient clinic know about lithium therapy?</td>
<td>Germany</td>
<td>Quantitative assessment of lithium-related knowledge; questionnaire adapted from the Lithium Knowledge Test</td>
<td>n=123; DSM-III; bipolar disorder, recurrent unipolar depression and schizoaffective disorder</td>
<td>Lithium</td>
<td>Negative correlation with age; no correlation with duration of treatment, sex, education and diagnosis</td>
<td>Patient education about lithium should be intensified to adverse effects, especially in older patients</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>Sirey et al. (a)</td>
<td>Perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence</td>
<td>USA</td>
<td>Two-stage sampling procedure, SCID-IV, MMSE, HAMD, GAF, Chronic Disease Score, Inventory of Interpersonal Problems, Cornell Services Index (CSI), bivariate analyses with Student's t-test or chi-square</td>
<td>MDD, Structured Clinical Interview for Diagnosis, mixed age,</td>
<td>Antidepressant medication</td>
<td>1) Treatment adherence correlates with lower perceived stigma, higher self-rated severity of illness, age over 60 years, and absence of personality pathology 2) Patients' views are important in explaining treatment behaviors</td>
<td>Deepen understanding of the individualized impact of perceived stigma to develop successful treatment strategies</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methods</td>
<td>Diagnoses</td>
<td>Findings</td>
<td>Implications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>---------</td>
<td>-----------</td>
<td>----------</td>
<td>--------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>Sirey et al. (b)</td>
<td>Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression</td>
<td>USA</td>
<td>Two-stage sampling design; Center for Epidem. Studies Depression Scale, Global Assessment of Functioning, Chronic Disease Score, 47-item Inventory of Interpersonal Problems, Stigma Coping Scale</td>
<td>MDD</td>
<td>Perception of stigma was greater in younger patients. Stigma negatively influenced treatment only in older adults.</td>
<td>Patient stigma is a useful target for intervention to improve treatment adherence outcomes in depression. Stigma is an appropriate target for intervention aimed at improving treatment adherence and outcomes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Andersson, Lindberg, &amp; Troein</td>
<td>What shapes GP's work with depressed patients? A qualitative interview study</td>
<td>Sweden</td>
<td>Qualitative semi-structured interview study</td>
<td>Depression</td>
<td>GPs discussing doctor-patient relationship</td>
<td>GPs preference for individual 'tacit knowledge'</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Bechdolf, Schultze-Lutter, &amp; Klosterkötter</td>
<td>Self-experienced vulnerability, prodromal symptoms and coping strategies preceding schizophrenic and depressive relapses</td>
<td>Germany</td>
<td>Retrospective pilot study: interviews with BSABS, DSM IV, ESQ, ESS + cluster analysis, chi-quadrat of Fisher's exact test</td>
<td>Schizophrenia &amp; depression</td>
<td>Pre-episodic disturbances, i.e. self-experienced vulnerability and prodromal symptoms + related coping strategies</td>
<td>Schizophrenic patients showed a more increased emotional reactivity whereas depressive patients reported an increased emotional reactivity, certain perception and thought disturbances. Confirm these findings in first episode or initial prodromal state to use them for early diagnosis and intervention.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Bull et al. (a)</td>
<td>Discontinuation of use and switching of antidepressants Influence of patient-physician communication</td>
<td>USA</td>
<td>Mixed method: Tel. interviews; ICD-9; 7-item BDI-FS; survey + statistical analysis: 2 logistic regression models</td>
<td>Major depression or depressive disorder</td>
<td>SSRIs: Fluoxetine hydrochloride or paroxetine</td>
<td>Frequent patient-physician contact may increase treatment adherence. The study captures information from the perspectives of both patient and physician. Precise instructions about pharmacological treatment and possible adverse effects may improve adherence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Outcome</td>
<td>Findings</td>
<td>Recommendations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>-------------</td>
<td>---------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Bull et al. (b)</td>
<td>Discontinuing or switching Selective Serotonin-Reuptake Inhibitors</td>
<td>USA</td>
<td>Mixed method: Telephone surveys at 3 and 6 mos after treatment start + statistical analysis: logistic regression model</td>
<td>Major depression or depressive disorder; ICD 9</td>
<td>SSRIs Adverse effects are the main reason for treatment discontinuation. Suggestion of possible adverse effects appears to induce such effects</td>
<td>Physicians and pharmacists should inform patients about possible adverse effects. Future research should address development of strategies to manage adverse effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Castle, Morgan, &amp; Jablensky</td>
<td>Antipsychotic use in Australia: the patients’ perspective</td>
<td>Australia</td>
<td>Qualitative: interviews</td>
<td>‘atypical’, antipsychotics (risperidone, olanzapine, and quetiapine)</td>
<td>The vast majority were receiving antipsychotic medication; a substantial proportion were also on antidepressant and mood stabilizing agents. Atypical antipsychotics tended to be associated with lower levels of psychotic and affective symptomatology, and a generally lower side-effect burden.</td>
<td>Determine the optimal medication regime for each individual patient, and in exploring psychosocial treatments which can augment medications in the holistic care of people living with psychosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Egede Leonard E.</td>
<td>Beliefs and Attitudes of African Americans with type 2 diabetes toward depression</td>
<td>USA</td>
<td>Qualitative study: focus group interviews. Health Belief Model used as a theoretical framework for design and analysis</td>
<td>Depression</td>
<td>The beliefs &amp; patient attitudes and preferences re. depression treatment: general misconceptions low perception of vulnerability, denial as a barrier to effective treatment</td>
<td>Despite knowledge of depression and of effective treatment, multiple barriers and false beliefs may negatively influence adherence</td>
<td>Need to compare the beliefs of African Americans diabetics with such patients from other ethnic groups. Need for studies on the relationship btw beliefs &amp; attitudes in depressed diabetics and treatment outcomes in ethnic minorities</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Hensley &amp; Nurnberg</td>
<td>SSRI sexual dysfunction: a female perspective</td>
<td>USA</td>
<td>Commentary; 2 Case reports</td>
<td>Depression: DSM IV</td>
<td>Female sexual dysfunction associated with SSRIs and treatment with sildenafil</td>
<td>Sexual dysfunction is a common side effect of many ADs from different classes</td>
<td>Double-blind placebo-controlled trials of SSRIs-induced sexual dysfunctions in women are proceeding</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Mental Health</td>
<td>Lay Beliefs and General Attitudes</td>
<td>Depression was perceived to have the greatest impact on quality of life (QoL). Attitudes toward ADs were less negative than in the past.</td>
<td>The goal is to change critical attitudes and health behaviors. Future mental health campaigns need to be of significant intensity and duration</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>---------------</td>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Highet, Hickie, &amp; Davenport</td>
<td>Monitoring awareness of attitudes to depression in Australia</td>
<td>Australia</td>
<td>Cross-sectional telephone survey; stratified; reports of Australian community awareness, knowledge and attitudes</td>
<td>Mental health; depression</td>
<td>Lay beliefs and general attitudes in an Australian community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Katona &amp; Livingston</td>
<td>How well do antidepressant work in older people? A systematic review of Number Needed to Treat</td>
<td>UK</td>
<td>Review: Medline (1966-1999) &amp; Embase (1994-1999) search. Analysis of data with Internet Interactive Statistical Calculation Pages; NNT</td>
<td>Depression, HAMD &amp; MADRS scores</td>
<td>Analysis of research findings on antidepressants evaluated by placebo-controlled trials in older patients</td>
<td>The analysis supports the preferential use of SSRIs(exc. Fluoxetine) and of venlafaxine in depression treatment in older ppl</td>
<td>The authors urge that regulatory authorities consider requiring NNT &amp; NNH data in future trials as one clinically relevant and understandable measure</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Knudsen et al. (a)</td>
<td>Changes in self-concept while using SSRI antidepressants</td>
<td>Denmark</td>
<td>Qualitative; Interviews taped and transcribed verbatim; Empirical analysis</td>
<td>SSRIs</td>
<td>Emotional problems vs. emotional illness</td>
<td>Findings in this study showed, the women’s self-concept was closely related to their social lives</td>
<td>Further studies be made with other age groups and for men, and in other contexts and cultures, to analyze experiences with regard to the use of SSRIs in a broader perspective</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Knudsen, Hansen, &amp; Traulsen (b)</td>
<td>Perceptions of young women using SSRI antidepressants – a reclassification of stigma</td>
<td>Denmark</td>
<td>Qualitative: Interviews</td>
<td>SSRIs</td>
<td>When suffering from emotional problems, the women saw themselves as dysfunctional in their daily lives</td>
<td>The young women using SSRIs felt stigmatized</td>
<td>Further studies should be conducted with other population groups of users of SSRIs to analyse perceptions in a broader perspective</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Region</td>
<td>Methods</td>
<td>Findings</td>
<td>Conclusion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>--------</td>
<td>---------</td>
<td>----------</td>
<td>------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Maidment, Livingston, &amp; Katona</td>
<td>Just keep taking the tablets': adherence to antidepressant treatment in older people in primary care.</td>
<td>UK</td>
<td>Assessment of patients using ADs; measured adherence and its multiple factors; statistical analysis</td>
<td>Depression, adherence to ADs measured with multiple scales &amp; questionnaires; interviews</td>
<td>Prevalence or the associates of adherence to ADs in older ppl</td>
<td>1/3 of primary care patients who are thought to be adherent to ADs are not; a 'concordance therapy' &amp; using medications that minimize side effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Pampallona et al.</td>
<td>Patient adherence in the treatment of depression</td>
<td>USA, UK, Canada &amp; Europe</td>
<td>Systematic review of computerized databases; studies published from 1973 to 1999. An ad hoc developed data extraction form</td>
<td>Unipolar depression</td>
<td>Extracting meaningful indications on non-adherence factors</td>
<td>1) confirmation that adherence is a major problem in the treatment of depression; 2) adherence has rarely been the specific research subject; 3) quantitative studies on adherence are neither reliable nor consistent</td>
<td>Carefully designed clinical trials are needed to clarify effects of single and combined interventions on adherence</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Posternak &amp; Zimmerman</td>
<td>The effectiveness of switching antidepressants during remission: a case series of depressed patients who experienced intolerable side effects</td>
<td>USA</td>
<td>Prospective cohort study</td>
<td>MD: Structured Clinical Interview for DSM-IV; SCORs, CGI-I</td>
<td>Switching ADs due to medications' troublesome side effects</td>
<td>Patients were followed for 8 to 110 weeks. Preliminary evidence: switching ADs while in remission eliminated intolerable adverse effects in all patients (n=9)</td>
<td>The results of this study need to be confirmed with larger, controlled trials</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Prabhakaran &amp; Butler</td>
<td>What are older peoples' experiences of taking antidepressants</td>
<td>UK</td>
<td>Patients interviewed by doctors: face-to-face, or by telephone, brief questionnaire</td>
<td>Hospital diagnosis of depression: ICD-10, F30- F39</td>
<td>ADs: SSRIs &amp; TCAs; older patients' self-reported experiences of treatment</td>
<td>2/3 of the patients felt that ADs were helpful, 1/3 felt that they were not effective. Almost 2/3 of participants experienced moderate or severe adverse effects of ADs</td>
<td>Maximize efforts to reduce adverse effects of ADs in older people</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Barbui, Tognoni, &amp; Garattini</td>
<td>Clinical databases of patients receiving antidepressants. The missing link between research and practice?</td>
<td>Italy</td>
<td>Brief report</td>
<td>Clinical pharmacology</td>
<td>Clinical databases for patients treated with ADs</td>
<td>Clinical databases should be developed, organized and utilized in avoidance of the gap between research and practice</td>
<td>Developing and maintaining clinical databases could ultimately constitute a permanent link btw. routine clinical practice and research</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Study Design</td>
<td>Method</td>
<td>Dependent Variable(s)</td>
<td>Findings</td>
<td>Implications</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>--------------</td>
<td>--------</td>
<td>----------------------</td>
<td>----------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Bitner et al.</td>
<td>Subjective effects of antidepressants. A pilot study of the varieties of antidepressant-induced experiences in meditators</td>
<td>USA</td>
<td>Qualitative: 2-part questionnaire mailed, Likert scales + statistical analysis</td>
<td>Combined bipolar and unipolar subjects</td>
<td>A pilot study of subjective effects of ADs on meditators; combined SSRIs and ‘other medication groups’</td>
<td>Meditation might be a helpful strategy in depression treatment, combined with ADs</td>
<td>Investigate the effects of meditation in prevention of relapse</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Bolling Madelon Y.</td>
<td>Subtle psychological side effects: documentation, description, and treatment implications of Selective Serotonin Reuptake Inhibitors taken for depression</td>
<td>USA</td>
<td>Dissertation</td>
<td>MDD and persistent pain</td>
<td>No studies have tested the effectiveness of early pain management in patients who are at risk for depression or who have recently become depressed.</td>
<td>Early pain management might be especially useful for patients who are at risk for depression who are not yet exhibiting significant depressive symptoms.</td>
<td>To elucidate cultural contributions to the experience of pain and depression, much more research is needed across a variety of racial and ethnic groups.</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Campbell, Clauw, &amp; Keefe</td>
<td>Persistent pain and depression: a biopsychosocial perspective</td>
<td>USA</td>
<td>Review</td>
<td>MDD and persistent pain</td>
<td>No studies have tested the effectiveness of early pain management in patients who are at risk for depression or who have recently become depressed.</td>
<td>Early pain management might be especially useful for patients who are at risk for depression who are not yet exhibiting significant depressive symptoms.</td>
<td>To elucidate cultural contributions to the experience of pain and depression, much more research is needed across a variety of racial and ethnic groups.</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Garfield, Smith &amp; Francis</td>
<td>The paradoxical role of antidepressant medication - returning to normal functioning while losing the sense of being normal.</td>
<td>UK</td>
<td>Qualitative: interviews taped and coded</td>
<td>Depression and depression stigma</td>
<td>To identify factors of importance to patients beginning courses of antidepressant medication</td>
<td>Adverse drug reactions were of importance to respondents because of their direct effects and because they increased the stigma attached to taking antidepressant medication</td>
<td>Patients may find it beneficial if doctors talk about the number of similar people that they treat for depression each day, thereby normalising the condition.</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Gask et al.</td>
<td>Qualitative study of patients' perceptions of the quality of care for depression in general practice</td>
<td>UK</td>
<td>Qualitative: purposive sampling &amp; semi-structured interviews, n=27</td>
<td>Depression</td>
<td>To explore patients' actual experiences with the primary mental health care and quality of their services</td>
<td>Quality of care in depression depends on good communication btw doctors and patients. People tend to accept non-professional help because of low expectations toward the health care and low self-worth</td>
<td>A model of health care is advocated, in which patients with depression are followed up systematically</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Location</td>
<td>Methodology</td>
<td>Conditions</td>
<td>Findings</td>
<td>Implications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>----------</td>
<td>-------------</td>
<td>------------</td>
<td>----------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Geddes et al.</td>
<td>Relapse prevention with antidepressant drug treatment in depressive disorder: a systematic review</td>
<td>UK</td>
<td>Systematic review of evidence from all RCTs published &amp; unpublished</td>
<td>Depression, depressive disorder, dysthymia</td>
<td>All randomized trials until 2000 in which continued AD therapy was compared with placebo in patients who responded to acute treatment with ADs</td>
<td>Prolonged treatment with ADs is recommended in patients who responded well to ADs in the acute phase. Further trials are needed to establish the optimum duration of therapy. These studies need to also include patients with low risk of relapse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Knudsen et al.</td>
<td>Leading ordinary lives: a qualitative study of younger women's perceived functions of antidepressants</td>
<td>Denmark</td>
<td>Qualitative: interviews, re-interviews; community-based sample recruitment through pharmacies</td>
<td>Depression, OCD, Anxiety, Eating disorder/Depression</td>
<td>SSRIs</td>
<td>Patients experienced relief from depressive symptoms while on SSRIs. The AD gave them resources to lead active lives and function on psychological and social level. It is imperative for health professionals to explore users' views on pharmacological treatment and to gain insight beyond the knowledge derived from RTCs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Kwon et al.</td>
<td>Antidepressant use: Concordance between self-report and claims records</td>
<td>USA</td>
<td>Longitudinal depression study, Cross-sectional analysis</td>
<td>Depression</td>
<td>Adherence to antidepressant medications</td>
<td>Self-report and claims showed good concordance, but they revealed different aspects and discrepant responses. Percentage adherence with medications, especially among depressed patients, may be best assessed through multiple sources.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Lin et al.</td>
<td>Enhancing adherence to prevent depression relapse in primary care</td>
<td>USA</td>
<td>RCT, n= 386 primary care patients at high risk for recurrent depression, interviews at baseline</td>
<td>Depression</td>
<td>Pragmatic &amp; biopsychosocial program to prevent relapse: patients randomized to receive a 12 months intervention. 12 months assessed attitudes about drugs, side effects, and symptom self-management</td>
<td>This depression relapse prevention program showed significant increase in: positive attitudes towards ADs, self-confidence in managing adverse effects, depressive symptoms monitoring, checking for early warning signs, and coping. Addressing patients' attitudes and concerns about the use and side-effects of ADs is useful in improving adherence to long-term treatment in primary care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Manning &amp; Marr</td>
<td>'Real-life burden of depression' surveys - GP and patient perspectives on treatment and management of recurrent depression</td>
<td>UK</td>
<td>Qualitative: survey, narrative synthesis; standard deviation</td>
<td>Recurrent depression</td>
<td>A large proportion of depression sufferers experience repeated episodes of depression. A majority of patients had made a lifestyle change to manage their depression or avoid relapse.</td>
<td>GPs may benefit from educational programmes that promote awareness of current guidelines for treating depression.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Study Type</td>
<td>Area of Research</td>
<td>Findings/Implications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Masand, Prakash</td>
<td>Tolerability and adherence issues in antidepressant therapy</td>
<td>USA</td>
<td>Lit. review, Commentary</td>
<td>Depression</td>
<td>Factors contributing to nonadherence, efficacy and adverse effects of pharmacologic treatment, limitations of current strategies to improve adherence. Patient-physician and medication-specific issues represent obstacles to successful treatment in depression. Combination of: adequate treatment duration, realistic patient expectations, and the right dose of medication improves adherence and reduces relapses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Moore Darlene</td>
<td>The impact of antidepressant use on self-efficacy and athletic performance in female student athletes</td>
<td>USA</td>
<td>Dissertation</td>
<td>Depression</td>
<td>An assessment of trial adequacy being an important element in any evaluation of treatment history. Patients were able to recall about 80% of their treatment history. They were unable to recall situations where two ADs were administered together (augmentation trials).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Posternak &amp; Zimmerman</td>
<td>How accurate are patients in reporting their antidepressant treatment history?</td>
<td>USA</td>
<td>Diagnoses of MD at baseline, treated with antidepressants; TRAQ, Structured Clinical Interview for DSM-IV</td>
<td>depressive symptomatology</td>
<td>An assessment of trial adequacy being an important element in any evaluation of treatment history. Patients were able to recall about 80% of their treatment history. They were unable to recall situations where two ADs were administered together (augmentation trials).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Roeloffs et al.</td>
<td>Stigma and depression among primary care patients</td>
<td>USA</td>
<td>Systematic literature review &amp; research report, retrospective</td>
<td>Current depressive disorder</td>
<td>Stigma is a major problem in primary care patients. The relationship btw. stigma and perceived unmet needs of depressed patients indicate there may be some unmeasured illness burden. Further research should document effects of stigma in different communities and treatment settings and determine strategies to decrease its negative impact.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Scheibe et al.</td>
<td>Are there gender differences in major depression and its response to antidepressants?</td>
<td>Germany/Canada</td>
<td>Systematic literature review &amp; research report</td>
<td>Major depression, unipolar depression</td>
<td>Antidepressants (SSRIs, TCAs, SNRIs, MAOIs, &amp; RIMAs) Women experience more vegetative and atypical symptoms, anxiety, and anger than men, and reported higher severity of depressive symptoms. No differences were found in the course of illness and treatment response.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Methods</td>
<td>Setting</td>
<td>Research Focus</td>
<td>Findings</td>
<td>Implications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>---------</td>
<td>---------</td>
<td>----------------</td>
<td>---------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Sleath, Wurst, &amp; Lowery</td>
<td>Drug Information Sources and Antidepressant Adherence</td>
<td>Mixed method: qualitative interviews + statistical analysis; SPSS version 10.1</td>
<td>USA</td>
<td>Depression</td>
<td>Available and popular sources of antidepressant information. Influence of self-obtained information about AD on treatment adherence</td>
<td>Patients listed pharmacists, primary care physicians, and mental health specialists as sources of information. Health care providers should give all patients chance to inquire about their AD medication and educate them about their treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Sleath, Rubin, &amp; Huston</td>
<td>Hispanic Ethnicity, Physician-Patient Communication, and Antidepressant Adherence</td>
<td>Mixed method: qualitative audio-taped interviews + statistical analysis; linear regression</td>
<td>USA (New Mexico)</td>
<td>Depression</td>
<td>Hispanic patients respond and adhere to AD treatment differently than non-Hispanic people</td>
<td>Primary care doctors asked only one of five patients on continued therapy how well the AD was working and only one in 10 patients if they were experiencing side effects. Future research needs to be conducted in other parts of the US to examine if Hispanic patients are treated differently and how Hispanic ethnicity impacts antidepressant adherence in larger samples.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Solberg et al.</td>
<td>When Depression is the Diagnosis, What Happens to Patients and Are They Satisfied?</td>
<td>Questionnaires, administrative record search, comparisons, chart audits, statistical analysis</td>
<td>USA</td>
<td>Depression</td>
<td>Effectiveness of available treatment options, which includes organized multifaceted and collaborative care approaches</td>
<td>A much larger share of depression is chronic than usually assumed and depressed patients have a significantly lower quality of life. Primary care physicians need to improve depression care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Sullivan et al.</td>
<td>Patient Beliefs Predict Response to Paroxetine among Primary Care Patients with Dysthymia and Minor Depression</td>
<td>RCT; DSM IV, Prime-MD major depression mode, 17-item HAM-D; PAB scale, Hopkins Symptom Checklist; statistical analyses: t-Test and chi-square</td>
<td>USA</td>
<td>Mild depression or Dysthymia</td>
<td>Patients' beliefs about their health and depression add to depression type and age predicting responsiveness to ADs. No need to believe in own depression as a biological illness to adhere to treatment was demonstrated as well.</td>
<td>Patients with milder types of depression should be scheduled for a return appointment after 1 or 2 months of watchful waiting in place of immediate medication.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Wiens Juliana</td>
<td>Depression and Decision Making: A Material-Discursive Analysis of Antidepressant Use in Women</td>
<td>MA THESIS</td>
<td>Canada</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

432
<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Title</th>
<th>Region</th>
<th>Methods</th>
<th>Diagnosis</th>
<th>Findings</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>Bann et al.</td>
<td>Assessing patient beliefs in a clinical trial of Hypericum perforatum in major depression</td>
<td>USA</td>
<td>RCT, double-blind, HAM-D scale, GAF, EMD; confirmatory factor analysis with LISREL psychometric analyses; descriptive statistics: SAS; PROC MIXED for the longitudinal data models</td>
<td>MDD</td>
<td>Patients' beliefs about the causes of their depression and the helpfulness of certain treatment options can have impact on their adherence; trial of hypericum, sertraline, or placebo treatment</td>
<td>The results support the role of patients' beliefs in their recovery: people who believe in causes of their depression being outside of their control will less likely improve over time; Future studies should explore if patients' beliefs have an even greater impact if supported by patients' knowledge about the treatment and accept it as in accordance with their beliefs</td>
</tr>
<tr>
<td>2004</td>
<td>Bhugra &amp; Hsiao-Rei Hicks</td>
<td>Effect of an educational pamphlet on help-seeking attitudes for depression among British South Asian women</td>
<td>UK</td>
<td>Qualitative fieldwork and focus groups, test of feasibility and acceptance by patients and doctors to be applied in real-world situations</td>
<td>Depression and suicidality</td>
<td>South Asian women suffer disproportionately high rates of suicide and attempted suicide. An educational pamphlet about depression and suicidality was introduced</td>
<td>Pattern of significant improvement: large proportion of women reading the pamphlet remonstrated a help-seeking attitude; 51% agreed at baseline that AD were efficient in depression treatment; Verification of findings would require a large, prospective study</td>
</tr>
<tr>
<td>2004</td>
<td>E Boath, E Bradley &amp; C Henshaw</td>
<td>Women's views of antidepressants in the treatment of postnatal depression</td>
<td>UK</td>
<td>Qualitative: interviews, case notes, questionnaires; qualitative analysis + p-value assessed</td>
<td>Postnatal depression</td>
<td>Women are likely to choose options of self-medication in postnatal depression, which may be clinically ineffective</td>
<td>The majority of women in this study did not take their AD as prescribed, and were self-regulating or discontinuing treatment; Women need ongoing support and monitoring from their GPs. Communication and information about treatment is necessary. Fears of dependence and stigma may dictate the women's decisions</td>
</tr>
<tr>
<td>2004</td>
<td>Bollini et al.</td>
<td>Understanding treatment adherence in affective disorders: a qualitative study</td>
<td>Italy</td>
<td>Qualitative: 8 separate focus groups</td>
<td>Depression</td>
<td>Patients' models of depression, perceptions of the disease, treatment options, main causes of non-adherence; helpful interventions</td>
<td>The study highlighted several themes which should be considered when designing specific interventions to improve adherence with treatment; Need to address stigma and discrimination which were brought up in this study but are beyond the scope of the focus groups</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Findings</td>
<td>Implications</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>-------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>Dinos et al.</td>
<td>Stigma; the feelings and experiences of 46 people with mental illness</td>
<td>UK</td>
<td>Qualitative: narrative interviews</td>
<td>Authors relied on patients’ own reports of their diagnoses as the most relevant description of their illnesses</td>
<td>Perceptions of depressive illness and stigma were not always negative. Some participants denied feelings of stigma and discrimination and showed positive attitude towards their treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Experiencing stigma, forms of stigma and forms of mental illness, types of stigma, perceived consequences of stigma, positive outcomes and/or lack of stigma</td>
<td>Data collected through this study is being used to develop a quantitative measure of felt and enacted stigma that is hoped to be applied in evaluations of mental health services and treatments</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>Frankenberg er et al.</td>
<td>Effects of information on college students' perceptions of antidepressant medication</td>
<td>USA</td>
<td>Mixed: 2 summaries of information, 4-part response packet, BDE-II + statistical analysis</td>
<td>DSM-IV-TR Commercial advertising vs scientific information about depression and its treatment accessible to college students; influence of general perceptions</td>
<td>Several conclusions. One of them is that college students should be presented with effective methods to reduce or cope with stress before they are diagnosed with depression and placed on AD. Further research, using an appropriate sample of men, should be conducted on the effects of mass advertising by pharmaceutical companies</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>Garfield, Francis &amp; Smith</td>
<td>Building concordant relationships with patients starting antidepressant medication</td>
<td>UK</td>
<td>Prospective, naturalistic study, audiotaped interviews, data transcribed verbatim and coded to allow qualitative analysis</td>
<td>Depression Work on a concordant approach responsive to the patients' needs</td>
<td>Large amount of information was needed to support individuals beginning courses of AD medications. Current health services did not provide patients with sufficient information about their AD treatment Developing and evaluating intervention that would provide verbal and written information by healthcare professionals to patients who start treatment with ADs.</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>Grime &amp; Pollock</td>
<td>Information versus experience: a comparison of an information leaflet on antidepressants with lay experience of treatment</td>
<td>UK</td>
<td>Qualitative; semi-structured interviews typed and fully transcribed with qualitative data analysis software program</td>
<td>Depression 6 commonly asked questions about AD in the Depression Alliance leaflet were used as a framework for analysis</td>
<td>There is a gap btw. the professional representation of depression as a physical illness and patients' own experience of depression Improving the leaflet to accommodate patient’s knowledge would encourage the public to consult the professionals, making them aware of views and attitudes</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Study Type</td>
<td>Design Details</td>
<td>Findings/Implications</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>---------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>Halter M J</td>
<td>The stigma of seeking care and depression</td>
<td>USA</td>
<td></td>
<td>Depression</td>
<td>The belief that depression was under personal control associated with not seeking care, and greater anger toward persons with depression. Pity involved. There is still the perception that depression is a sign of weakness of evidence of a flaw. Providing information and careful patient monitoring may improve compliance.</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>Haslam et al.</td>
<td>Patients’ experiences of medication for anxiety and depression: effects on working life</td>
<td>UK</td>
<td>Qualitative; focus groups,</td>
<td>Depression</td>
<td>Non-compliance was widespread due to adverse effects, lack of improvement in symptoms and fear of dependence. Patients were not well informed by their physicians about the medication. Providing information and careful patient monitoring may improve compliance. Development and evaluation of accessible patient information leaflets a high priority for primary care research and care.</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>Higgins, Livingston &amp; Katona</td>
<td>Concordance therapy: an intervention to help older people take antidepressants</td>
<td>UK</td>
<td>RTC</td>
<td>Depression in older people</td>
<td>The therapy was acceptable to patients. The cases had less depressive symptoms; beliefs about ADs were more positive in this group. Concordance Therapy for older patients taking ADs is acceptable and feasible. It is suggested that Concordance Therapy be tested with a larger, statistically robust trial and also test economic feasibility of the tool.</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>Rabheru Kiran</td>
<td>Special Issues in the management of depression in older patients</td>
<td>Canada</td>
<td>Narrative review</td>
<td>SSRIs, venlafaxine, mirtazapine</td>
<td>Depression in older patients can impact comorbid medical conditions. Rates of strokes and cardio-vascular events are higher in depressed older patients than in others. More trials should examine the long-term efficacy and safety of AD treatment in older patients. More data are needed on the effects of ADs on comorbid medical conditions.</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>Schwenk et al.</td>
<td>Treatment outcome and physician-patient communication in primary care patients with chronic, recurrent depression</td>
<td>USA</td>
<td>Research report from a national probability sample; retrospective and self-report telesurveys; interviews</td>
<td>Chronic, recurrent depression</td>
<td>The patients were not treated to full remission, complete wellness and full life function. Almost half of participants complained about adverse effects of ADs. Patient-physician communication needs improvement. An important area of such improvement is the way in which treatment decisions are made.</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title/Description</td>
<td>Country</td>
<td>Methodology</td>
<td>Outcomes/Analysis</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>--------------------</td>
<td>---------</td>
<td>-------------</td>
<td>------------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>Swan et al.</td>
<td>&quot;Coping with depression&quot;: an open study of the efficacy of a group psychoeducational intervention in chronic, treatment-refractory depression</td>
<td>UK</td>
<td>Brief report from uncontrolled group case series. EQ5D - + statistical analysis</td>
<td>Chronic or recurrent depressive disorder, BDI-II, BSI, global severity index, EQ</td>
<td>The CWD course for adults is a structured, psychoeducational program. Chronicity, recurrence and treatment-resistance were confirmed. Psychoeducational courses recommended for the chronically depressed patients. Baseline assessments confirmed chronicity and treatment resistance, high symptom burden and poor QOL in the study cohort.</td>
<td>There is a need to evaluate the efficacy of CWD in a formal RCT and to determine if the course should be modified to improve patients' adherence.</td>
</tr>
<tr>
<td>2004</td>
<td>van Schaik et al.</td>
<td>Patients' preferences in the treatment of depressive disorder in primary care</td>
<td>The Netherlands</td>
<td>Systematic literature review</td>
<td>Depressive disorders</td>
<td>Patients' choice and autonomy should be respected. These preferences can be supported by primary health care. Providing information and discussing concerns and assumptions underlying preferences is necessary before starting therapy. Involvement of family and friends is recommended.</td>
<td>Attention should be paid to the validation of preference measures, making comparability btw. Studies feasible.</td>
</tr>
<tr>
<td>2005</td>
<td>Aikens et al.</td>
<td>Adherence to maintenance-phase antidepressant medication as a function of patient beliefs about medication</td>
<td>USA</td>
<td>Survey + multivariate statistical analysis</td>
<td>Depression</td>
<td>Maintenance phase of treatment with antidepressants: factors influencing adherence</td>
<td>During the maintenance phase, patients' demonstrate various adherence. It is caused by their perception of need and harmfulness of AD. 4 attitudes toward ADs: skepticism, indifference, ambivalence, and acceptance.</td>
</tr>
<tr>
<td>2005</td>
<td>Ashton et al.</td>
<td>Antidepressant-related adverse effects impacting treatment compliance: results of a patient survey</td>
<td>USA</td>
<td>Survey</td>
<td>Depression</td>
<td>The impact of adverse effects on compliance and quality of life</td>
<td>This survey of patients with mild to severe depression suggest that compliance /efficacy can be promoted.</td>
</tr>
<tr>
<td>2005</td>
<td>Badger &amp; Nolan</td>
<td>Attributing recovery from depression. Perceptions of people cared for in primary care</td>
<td>UK</td>
<td>Purposeful sample, semi-structured interview</td>
<td>Unipolar depression, depressive symptoms</td>
<td>Personal accounts of attribution of recovery are largely absent from the literature</td>
<td>Ppl with depression consider their recovery multifactorial. Preferences for a 'portfolio' of care.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Design</td>
<td>Measures</td>
<td>Findings</td>
<td>Discussion</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>--------</td>
<td>----------</td>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>2005</td>
<td>Bazargan, Bazargan-Hejazi, &amp; Baker</td>
<td>Treatment of self-reported depression among Hispanics and African Americans</td>
<td>USA</td>
<td>Mixed: Survey of random samples of 287 adults where over 48% reported to suffer from depression; statistical analysis</td>
<td>Mental disorders; untreated depression</td>
<td>There is an urgent need for aggressive intervention toward identifying and treating underserved minority individuals with mental disorders</td>
<td>The perception of discrimination and racism is significantly correlated with depression status in Hispanics and African Americans</td>
</tr>
<tr>
<td>2005</td>
<td>Beck Cynthia et al.</td>
<td>Psychotropic medication use in Canada</td>
<td>Canada</td>
<td>Mixed: Cross-sectional survey; Statistical analysis; SAS</td>
<td>CIDI-diagnosed disorders</td>
<td>Sedative-hypnotic, mood stabilizer, psychostimulant, &amp; antipsychotic use; Prozac, Paxil, Effexor</td>
<td>Antidepressant use may be higher and antipsychotic use may be lower in Canada than in recent European and American reports. SSRIs and venlafaxine are mostly used.</td>
</tr>
<tr>
<td>2005</td>
<td>Brown et al.</td>
<td>Beliefs about antidepressant medications in primary care patients: relationship to self-reported adherence</td>
<td>USA</td>
<td>Observational study of medication adherence. Report, Statistical analyses</td>
<td>Depression</td>
<td>Beliefs about medicines in 192 primary care patients</td>
<td>Patients believe that their current or future health depends on ADs. Still, concerns about ADs were expressed: long term use and dependency and overuse of medication</td>
</tr>
<tr>
<td>2005</td>
<td>Chao et al.</td>
<td>The mediating role of health beliefs in the relationship between depressive symptoms and medication adherence in persons with diabetes</td>
<td>USA</td>
<td>Cross-sectional design; Survey + multivariate statistical analysis SAS</td>
<td>MD; depressive symptoms and diabetes. PHQ-8 derived from PHQ-9. Morisky's and Horne's scales</td>
<td>How depression effects medication adherence and other self-care behaviors in diabetes</td>
<td>Subjects with greater depressive symptoms had lower adherence to their diabetes medication regimens</td>
</tr>
<tr>
<td>2005</td>
<td>Gonzales et al.</td>
<td>Adherence to mental health treatment in a primary care clinic</td>
<td>USA</td>
<td>Prospective Cohort Observational study; questionnaire; statistical analysis; logistic regression</td>
<td>Depression</td>
<td>This is said to be one of few studies to prospectively identify predictors of nonadherence</td>
<td>Nonadherence to mental health treatments in primary care is of significant concern. Early identification of patients likely to be non-adherent to mental health treatment is one of the most urgent issues to be addressed</td>
</tr>
<tr>
<td>2005</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Explore how race/ethnicity, culture, beliefs, and patient preferences influence the expression of depressive symptoms vs the interpretation of these symptoms by health care providers. Strategies needed to make the therapies more acceptable to minorities</td>
</tr>
</tbody>
</table>

Note: CIDI = Composite International Diagnostic Interview; MD = Multidimensional Depression Scale; PHQ-9 = Patient Health Questionnaire-9; AD = Antidepressant; SSRIs = Selective Serotonin Reuptake Inhibitors.
<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Title</th>
<th>Country</th>
<th>Methodology</th>
<th>Measure</th>
<th>Findings</th>
<th>Future Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>Haslam et al.</td>
<td>Perceptions of the impact of depression and anxiety and the medication for these conditions on safety in the workplace</td>
<td>UK</td>
<td>Qualitative, descriptive approach; focus groups; transcribed data analyzed by sorting and coding</td>
<td>Anxiety &amp; depression; HAD questionnaire</td>
<td>Occupational health strategy. Early detection of mental health problems in workplaces is fundamental.</td>
<td>Future quantitative studies in this area might focus on reported accidents at workplaces and link them with depression</td>
</tr>
<tr>
<td>2005</td>
<td>Jorm, Christensen &amp; Griffiths</td>
<td>Belief in the harmfulness of antidepressants: Results from a national survey of Australian public</td>
<td>Australia</td>
<td>Survey; interview, vignette; statistical analysis</td>
<td>Depression</td>
<td>Sociodemographic characteristics, exposure to depression, ability to recognize depression, beliefs about: causes and alternative treatment and long-term outcomes with and without treatment; stigma</td>
<td>About a quarter of Australians believe in harmfulness of ADs if the persons suffers from depression and is suicidal. A common belief is that depression is a sign of weakness and is under the person's control. It is recommended to increase public awareness of depression and reduce stigma through media exposure</td>
</tr>
<tr>
<td>2005</td>
<td>Karasz Alison</td>
<td>Cultural differences in conceptual models of depression</td>
<td>USA</td>
<td>Purposive (snowball) sampling vignette, interview; Statistical hypothesis testing and descriptive analysis</td>
<td>Depression</td>
<td>Why do SA and individuals from other traditional societies rarely seek treatment for depression?</td>
<td>Depressive emotional symptoms do not constitute depression-as-disease in the SA context but rather reflect painful and threatening real-life problems. “Treatment” involves: solving the problem or avoiding thinking about it. Future analyses of data collected in a larger study will address questions such as: what constitutes depression-as-disease in South Asian population</td>
</tr>
<tr>
<td>2005</td>
<td>Kessing et al.</td>
<td>Depressive and bipolar disorders: patients' attitudes and beliefs towards depression and antidepressants</td>
<td>Denmark</td>
<td>Antidepressant Compliance Questionnaire; statistical analysis</td>
<td>Depressive and bipolar disorders, ICD-10</td>
<td>Among patients discharged from hospital with depressive or bipolar disorders, older patients (aged above 40 years) had more negative views</td>
<td>Lack of knowledge about affective disorder and its effective treatment is a critical attitude, especially among older patients, and may add to poor prognosis of depressive and bipolar disorders. Suggested is a need to carry out further investigations to confirm findings of this study</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Results/Implications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>---------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>Lauber, Nordt, &amp; Rössler (a)</td>
<td>Lay beliefs about treatments for people with mental illness and their implications for anti-stigma strategies</td>
<td>Switzerland</td>
<td>Representative sample, computer assisted telephone interviews, vignette; DSM-III-R; statistical analysis</td>
<td>Treatment suggestions included: psychologist, GP, getting outside and becoming active, psychiatrist, psychopharmacology, psychiatric hospitalization and ECT, were less favoured. Respondents especially warned of hypnotics and, to a lower extent, antidepressants and antipsychotics. More research is needed to clarify the relation btw. social distance and knowledge about treatment methods and generally, mental disorders.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>Lauber, Nordt, &amp; Rössler (b)</td>
<td>Recommendations of mental health professionals and the general population on how to treat mental disorders</td>
<td>Switzerland</td>
<td>Mixed method: vignette and interview + statistical analysis</td>
<td>Mental health professionals must be aware of their shortcomings, i.e. poor knowledge or ignorance. Improvement of public awareness and basic understanding of mental disorders and therapeutic options To improve treatment of mental disorders, various strategies must be considered: continuous education of all mental health professionals, especially nurses and other therapists. A special focus must be given to the treatment of affective disorders and to potential (over-) treatment of normal behavior without appropriate symptomatology.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>Lin et al.</td>
<td>The influence of patient preference on depression treatment in primary care</td>
<td>USA</td>
<td>Screening interview, assessment interview, final assessment in a statistical analysis</td>
<td>72% of participants were matched with their treatment preference; matched participants demonstrated more rapid improvement in depression symptomatology. An ongoing study of stakeholders values in collaborative care for depression would provide more information on the ways in which decision makers view the issue.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>Maxwell, M.</td>
<td>Women's and doctors' accounts of their experiences of depression in primary care: the influence of social and moral reasoning on patients' and doctors' decisions</td>
<td>UK</td>
<td>Qualitative interviews; constant comparison method of analysis (Glaser &amp; Strauss)</td>
<td>The women's perceptions of their ability to function within their social roles played a large part in their accounts of help-seeking, thus help-seeking was portrayed as a sense of duty. A broader understanding of the range of emotional problems that GPs encounter, and the development of a broader range of options for GPs in caring for their patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Topic</td>
<td>Implications</td>
<td>Implications</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>-------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2005</td>
<td>Ozmen et al.</td>
<td>Public opinions and beliefs about the treatment of depression in urban Turkey</td>
<td>Turkey</td>
<td>Public survey</td>
<td>Depression</td>
<td>Opinions and beliefs about the treatment of depression; influence of demographic features, perception and causality of depression on people’s perception</td>
<td>The beliefs that &quot;psychological and social interventions are more effective than pharmacotherapy&quot; and &quot;antidepressants are harmful and addictive&quot; must be taken into account in clinical practice and in anti-stigma campaigns</td>
</tr>
<tr>
<td>2005</td>
<td>Pound et al.</td>
<td>Resisting medicines: a synthesis of qualitative studies of medicine taking</td>
<td>UK</td>
<td>Synthesis of qualitative studies on medicine taking</td>
<td>6 studies on psychotropic medications</td>
<td>The significance of the lay evaluation of medicines lies not simply in the fact that it occurs, but in the reasons why it occurs</td>
<td>A person’s experience of medicines is likely to differ according to the medicine in question and the nature of the illness for which it is taken.</td>
</tr>
<tr>
<td>2005</td>
<td>Rapaport et al.</td>
<td>Quality-of-life impairment in depressive and anxiety disorders</td>
<td>USA</td>
<td>Baseline Quality of Life Enjoyment and Satisfaction Questionnaire, demographic, and clinical data from 11 trials; regression analyses</td>
<td>Depressive and anxiety disorders</td>
<td>The degree of QoL-impairment across depressive and anxiety disorders is examined and the relative contribution of symptom severity, the presence of psychiatric comorbidity, the duration of illness, and demographic features</td>
<td>Patients with affective or anxiety disorders who enter clinical trials demonstrate significant quality-of-life impairment, although the degree of dysfunction varies</td>
</tr>
<tr>
<td>2005</td>
<td>Rieder-Heller, Matchinger, &amp; Angermeyer</td>
<td>Mental disorders - who and what might help? Help seeking and treatment preferences of the lay public</td>
<td>Germany</td>
<td>A fully structured face-to-face interview</td>
<td>Depression &amp; schizophrenia</td>
<td>A ranking approach permits for the preferences of the lay public to be introduced with the aim to reflect the real-life decision making process</td>
<td>Public expectations differ from evidence-based psychiatric treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>More effort should be put into psychoeducation; public knowledge about mental disorders and their treatment strategies needs to be enhanced</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Domain</td>
<td>Study Details</td>
<td>Findings</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>--------</td>
<td>---------------</td>
<td>----------</td>
</tr>
<tr>
<td>2005</td>
<td>Sher et al.</td>
<td>Effects of caregivers' perceived stigma and causal beliefs on patients' adherence to antidepressants</td>
<td>USA</td>
<td>Prospective, longitudinal analysis</td>
<td>Depression</td>
<td>Caregivers' attribution of depression to cognitive and attitudinal problems significantly predicted patients' decreased adherence</td>
<td>The findings stress the importance of patients' social environment in determining treatment adherence and the necessity of education caregivers about the impact that their causal attribution have on patients</td>
</tr>
<tr>
<td>2005</td>
<td>Singh, Reshmi</td>
<td>College students' depression treatment decision-making: A narrative of the trajectory of their antidepressant use.</td>
<td>USA</td>
<td>Dissertation Qualitative-Phenomenology</td>
<td>Depression</td>
<td></td>
<td>Scores on all seven dimensions of PD: sleeping/eating disturbances, anxiety/insecurity, emotional lability, mental confusion, loss of self, guilt/shame, and suicidal thoughts, were elevated. Emotional lability was the highest reported dimension</td>
</tr>
<tr>
<td>2005</td>
<td>Tatano Beck &amp; Indman</td>
<td>The many faces of postpartum depression</td>
<td>USA</td>
<td>Secondary analysis conducted on data collected from an earlier psychometric testing of PDSS</td>
<td>PDSS followed by DSM-IV diagnostic interview. convenience sample</td>
<td>Mother's responses in this sample support anxiety and irritability as major symptoms in PD</td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>Van Vorhees et al.</td>
<td>Beliefs and attitudes associated with the intention to not accept the diagnosis of depression among young adults</td>
<td>USA</td>
<td>Cross-sectional study</td>
<td>CES-D; an internet-based public health depression screening program; statistical analysis</td>
<td>Beliefs and attitudes, views on social norms; past behavior; rejection of medication, disbelief in depression's biological causes, embarrassment</td>
<td>Negative beliefs and attitudes, subjective social norms and lack of successful treatment history are linked with non-acceptance of diagnosis and refusal of treatment in young people</td>
</tr>
<tr>
<td>2005</td>
<td>Willhelm et al.</td>
<td>Great expectations: Factors influencing patient expectations and doctors recommendations et the Mood Disorders Unit</td>
<td>Australia</td>
<td>Self-report questionnaires, CIDI, MDU, 2 principal component analyses,+ statistical analysis</td>
<td>DSM-III-R or DSM-IV major depression, current depressive symptoms and lifetime diagnoses for anxiety disorders</td>
<td>Help seeking behavior is complicated by the stigma of depression and the non-recognition of its symptoms</td>
<td>Patients' illness characteristics were found to be the strongest predictor of patients' expectations and doctor's recommendations</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Findings</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>--------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>-----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Backenstrass</td>
<td>Preferences for treatment in primary care: a comparison of nondepressive, subsyndromal and major depressive patients</td>
<td>Germany</td>
<td>the German form of the PHQ-9, univariate analysis</td>
<td>Subsyndromal or major depression, DSM-IV-Research Appendix criteria; Asking patients about treatment preferences. The subsyndromal depression includes minor depression and subsyndromal symptomatic depression; Psychotherapy is clearly preferred over pharmacological treatment &lt;20% of primary care patients accepted both therapy options and ca 12% refused both treatment options</td>
<td>The group of depressive patients could be differentiated from patients without the disorder regarding their preferences</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Bulloch, Adair, &amp; Patten</td>
<td>Forgetfulness: A role in noncompliance with antidepressant treatment</td>
<td>Canada</td>
<td>Survey using data from the Alberta Mental Health Survey + statistical analysis with Stata Software</td>
<td>Noncompliance: failure to fill a prescription, to take the medication, dropout, and failure to regularly take prescribed dosages; The study replicates prior reports indicating that noncompliance is common with AD treatment</td>
<td>To confirm generalizability, a Canada-wide study would need to be conducted</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Burroughs et al.</td>
<td>Justifiable depression': how primary care professionals and patients view late-life depression? A qualitative study</td>
<td>UK</td>
<td>qualitative: semi-structured interviews; Depression as most common mental health problem in elderly people and continues to be underdiagnosed and undertreated</td>
<td>The study highlights the complicated nature of the diagnosis and management of late-life depression</td>
<td>There is a need for the development of evidence-based provision for older patients with depression, and for motivating older patients to report depressive symptoms to their doctors</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Chur-Hansen &amp; Zion</td>
<td>Let's fix the chemical imbalance first, and then we can work on the problems second': an exploration of ethical implications of prescribing an SSRI for 'depression'</td>
<td>Australia</td>
<td>Qualitative: in-depth, open-ended, semi-structured interviews</td>
<td>Depression; SSRIs; none of the participants had received any counselling or information from the pharmacist; The increasing use of SSRIs meaning that depression is viewed as biological illness challenges the evidence that its etiology is still unknown</td>
<td>A quantitative study could address the question of the relative incidence of both positive and negative experiences with SSRIs.</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Cohen et al.</td>
<td>Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment</td>
<td>USA</td>
<td>Prospective nonrandomized cohort study; longitudinal psychiatric assessment; statistical analysis</td>
<td>Main outcome measure: Relapse of major depression defined as Structured Clinical Interview for DSM-IV criteria; 43% of women experienced relapse of MD during pregnancy. While some women may experience affective well-being during pregnancy, the pregnancy is not protective against the risk of relapse in MD.</td>
<td>Several limitations of this study give directions to improved research strategies, i.e. it is possible that participants' depressive illness was of highly recurrent nature</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Study Design/DATA Collection</td>
<td>Key Findings</td>
<td>Additional Information</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>--------------------</td>
<td>-----------------------------------------------------------------------</td>
<td>---------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>de Groot et al.</td>
<td>Depression treatment and satisfaction in a multicultural sample of type 1 and type 2 diabetes</td>
<td>USA</td>
<td>Convenience sampling, cross-sectional survey design; self-report questionnaires; statistical analysis</td>
<td>Depression is two times greater in patients with diabetes than in regular population. Cost of comorbid depression and diabetes is high. The majority of people reporting high levels of depressive symptoms reported some form of depression treatment in their lifetime.</td>
<td>Longitudinal studies are needed to evaluate effectiveness of depression treatment in community samples.</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Givens et al.</td>
<td>Older patients’ aversion to antidepressants: A qualitative study</td>
<td>USA</td>
<td>Cross-sectional, qualitative study; semi-structured interviews</td>
<td>Fear of dependence; resistance to view depression as illness; concerns that ADs will prevent natural sadness; prior negative experiences with AD medications</td>
<td>Many older patients resisted the use of ADs. Concerns reflected their concepts of depression and ADs.</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Granger et al.</td>
<td>An assessment of patient preference and adherence to treatment with Wellbutrin SR</td>
<td>USA</td>
<td>A Web-based online survey; analysis with descriptive statistics</td>
<td>Wellbutrin SR twice a day. The most common reason reported for missing a dose of Wellbutrin SR was simply forgetting to take it. Users were interested in a once-daily formula. Reduction in dosing frequency is favored by Wellbutrin users. Such adjustment is likely to improve adherence to treatment.</td>
<td>Associations btw. nonadherence and other variables, such as age, gender, and concomitant AD use.</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Gum et al.</td>
<td>Depression treatment preferences in older primary care patients</td>
<td>USA</td>
<td>Multisite RCT comparing usual care to collaborative care</td>
<td>Baseline assessment on demographics, depression, health information, prior depression treatment, potential barriers, and treatment preferences (medication, counselling). Outcomes assessed after 12 months.</td>
<td>More patients preferred counselling to medication. Discussion about treatment preferences should include an assessment of prior treatment experiences. A collaborative care model is recommended as it increases collaboration btw. primary care and mental health professionals and can increase access to patient preferred treatment.</td>
<td></td>
</tr>
</tbody>
</table>
Hanley & Long 2006
A study of Welsh mothers' experience of postnatal depression
UK Qualitative interviews: semi-structured questionnaire Postnatal depression Mothers had little knowledge of the effects of postnatal depression before becoming pregnant
The findings suggest that, to some extent, postnatal depression is a consequence of social deterioration rather than a purely physiological reaction to motherhood.
A greater understanding of the emotional and social effects of childbirth could help mothers overcome the feelings of isolation

Karasz & Watkins 2006
Conceptual models of treatment in depressed Hispanic patients USA Semi-structured interviews coding scheme used standard iterative procedures Depression Tricyclic AD, SSRIs More than half of the participants viewed medical consultation and treatment as helpful. Almost all considered psychotherapy helpful and found anxiolytic and sedative effects of medications helpful
More research is needed on actual experiences of patients currently in treatment for depression.

Kessing, Hansen, & Bech 2006
Attitudes and beliefs among patients treated with mood stabilizers Denmark The Mood Stabilizer Compliance Questionnaire was mailed to a large group of patients; statistical analysis Depressive and bipolar disorders Pharmacological treatment raises a doubt whether the medication is really necessary, or believed in addictive properties of drugs and that medication can alter personality.
The majority of participants had incorrect views on the effects of mood stabilizers; older patients had negative views on doctor-patient relations
There is a need of improving knowledge and attitudes toward diagnosis and treatment especially among elder patients

Lafrance & Stoppard 2006
Constructing a Non-depressed Self: Women’s Accounts of Recovery from Depression Canada Qualitative: semi-structured interviews; discourse analysis Depression Women’s recovery from depression: struggling with subjective experiences of distress with the social meaning of identity
Participants’ accounts of their depressive and recovery experiences point to their lives as women as central to their distress
A further direction for research involves the analysis of naturally occurring talk and texts

Lavender, Khondoker, & Jones 2006
Understandings of depression: an interview study of Yoruba, Bangladeshi, and White British people UK Qualitative, semi-structured interviews, vignettes; Atlas ti software used to organize the data Depression Cultural models of depression, incl. its causes and treatment, are diverse, and experienced differently; various cultural groups.
Diverse views on causes and cures for depression. Magic & religion played a role. Coping methods and help-seeking behaviors included religion, family, friends and neighbors, and becoming more active
Implications for strategies that are successful and beneficial for the patient: provision of culturally specific information, cultural beliefs to minimize distress in ethnic patients
<table>
<thead>
<tr>
<th>Year</th>
<th>Author(s)</th>
<th>Title</th>
<th>Country</th>
<th>Qualitative Methodology</th>
<th>Research Area</th>
<th>Findings</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>Lawrence et al. (a)</td>
<td>Coping with depression in later life: A qualitative study of help-seeking in three ethnic groups</td>
<td>UK</td>
<td>Qualitative; in depth-interviews</td>
<td>Depression</td>
<td>There was wide variation in how older adults construed the role of the general practitioner. Participants felt that the responsibility for combating depression was an internal and individual task with support considered secondary.</td>
<td>Efforts to socialize and remain active may provide a useful and acceptable adjunct to clinical interventions.</td>
</tr>
<tr>
<td>2006</td>
<td>Lawrence et al. (b)</td>
<td>Concepts and causation of depression: a cross-cultural study of the beliefs of older adults</td>
<td>UK</td>
<td>Qualitative: In depth separate interviews</td>
<td>Depression</td>
<td>A multicultural approach used to demonstrate perspectives of Black Caribbean, South Asian, and White British older adults. Depression was often viewed as an illness arising from adverse personal and social circumstances in old age.</td>
<td>Health and social care professionals need to be sensitive to language in depression in various ethnic groups.</td>
</tr>
<tr>
<td>2006</td>
<td>Lynch et al.</td>
<td>Patients' beliefs about depression and how they relate to duration of antidepressant treatment. Use of a US measure in a UK primary care population</td>
<td>UK</td>
<td>Cross-sectional questionnaire survey, PDIQ, HADS, MARS; multiple regression</td>
<td>Depression</td>
<td>ADs taken longer by older patients and those who believed in efficacy and viewed depression and biological illness; ADs taken for a shorter time by people who were in stable relationships or believed in alternative treatment. Beliefs seem to be related to duration of treatment.</td>
<td>Longitudinal research is needed to establish cause and effect.</td>
</tr>
<tr>
<td>2006</td>
<td>Martin-Lopez et al.</td>
<td>The strategy of combining antidepressants in the treatment of Major Depression: clinical experience in Spanish outpatients</td>
<td>Spain</td>
<td>Review of 3 databases, surveys</td>
<td>MDE DSM-IV; HAMD 17; statistical analysis, chi-square</td>
<td>The strategy of combining AD medication seems to be dictated by trends and tendencies in prescription patterns.</td>
<td>Further efforts to evaluate this strategy are required.</td>
</tr>
<tr>
<td>2006</td>
<td>McKay, Bill</td>
<td>The use of antidepressants and counselling for depression: the lived experience of post-secondary students and counsellors</td>
<td>Canada</td>
<td>MSc THESIS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Type of Study</td>
<td>Patients/Observations</td>
<td>Findings/Recommendations</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>--------------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Mitchell, A.J. (a)</td>
<td>Adherence behaviour with psychotropic medication is a form of self-medicati</td>
<td>UK</td>
<td>Narrative review</td>
<td>Depression, schizophrenia and bipolar disorder</td>
<td>The self-medication hypothesis states that patients decide to start, adjust or stop prescribed medication according to perceived health needs. Significant influences upon self-medicating habits are prior health beliefs, medication attitudes, adverse effects and adequacy of communication from the health care professional. The self-medication hypothesis with prescribed psychotropic medication should assist clinicians in improving adherence by taking a patient centred approach and where possible promoting patient autonomy.</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Mitchell, A.J. (b)</td>
<td>Depressed patients and treatment adherence</td>
<td>UK</td>
<td>Commentary</td>
<td>Depression</td>
<td>The reason why most people discontinue treatment with ADs remains unclear. Collaborative communication by the clinician enhances the patient's knowledge of the medication and treatment options, improves patients satisfaction and increases adherence. Recommendations about the long-term benefit of ADs are not explained by doctors in a way that is convincing to patients. This phenomenon requires more attention. The term “antidepressant” should be abandoned.</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Moncrieff &amp; Cohen</td>
<td>Do antidepressants cure or create abnormal brain states?</td>
<td>UK</td>
<td>Review and summary of findings</td>
<td>Depression</td>
<td>The term AD refers to a drug that helps to rectify specific biological abnormalities that give rise to the symptoms of depression. There are no specific antidepressant drugs that most of the short-term effects of antidepressants are shared by many other drugs, and that long-term drug treatment with antidepressants or any other drugs has not been shown to lead to long-term elevation of mood.</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Morgan et al.</td>
<td>Difficulty taking medications, depression, and health status in heart failure patients</td>
<td>USA</td>
<td>Clinical evaluation, Questionnaires, 5-level Likert-scale question; statistical analyses; multivariable regression</td>
<td>Heart failure, depression</td>
<td>Patients reporting difficulty with medication adherence had worse heart-failure related health conditions, more social limitations, less self-efficacy and poor quality of life. Among outpatients with heart failure, nonadherence to AD medication relates to worse health status. This association can be explained in part by comorbid depression. Future studies should evaluate interventions such as depression treatment to improve medication adherence and health condition.</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Mental Health</td>
<td>Significance</td>
<td>Conclusion</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>---------------</td>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>2006</td>
<td>Naeem et al.</td>
<td>Stigma and psychiatric illness. A survey of attitude of medical students and doctors in Lahore, Pakistan</td>
<td>Pakistan</td>
<td>Survey + statistical analyses (SPSS)</td>
<td>mental illness</td>
<td>Exploring stigma a) well spoken English and familiarity with English psychiatric terminology, b) medical professionals can influence the reduction of mental health stigma</td>
<td>Attitudes of doctors and medical students were not very different. Doctors were less likely to have negative attitudes toward mental illness compared with medical students</td>
</tr>
<tr>
<td>2006</td>
<td>Olsson et al.</td>
<td>Continuity of antidepressant treatment for adults with depression in the United States</td>
<td>USA</td>
<td>Data were drawn from the household component of the Medical Expenditure Panel Survey for 1996-2001</td>
<td>Antidepressant medication SSRI, SNRI</td>
<td>Recipients of psychotherapy more likely to continue with AD treatment beyond 30 days; self-perceived physical and mental health status and limitations in cognitive and social function were not significantly related to continue drug treatment beyond 30 days</td>
<td>Patients treated with SSRIs and SNRIs are significantly more likely to continue the therapy than are patients treated with tricyclic ADs or other older ADs</td>
</tr>
<tr>
<td>2006</td>
<td>Ros, Leszek Tomasz</td>
<td>Treatment of postpsychotic depression with sertraline in patients with schizophrenia - own experience</td>
<td>Hungary</td>
<td>Case report and commentary</td>
<td>Post-psychotic depression, drug-refractory depression</td>
<td>AD neuroleptic, Sertraline, imipramine, DSM-IV, HAMD</td>
<td>The authors found that both drugs sertraline and imipramine were effective but sertraline proved better than imipramine</td>
</tr>
<tr>
<td>2006</td>
<td>Tully et al.</td>
<td>Why Am I Depressed? An Investigation of Whether Patients’ Beliefs About Depression Concur With Their Diagnostic Subtype</td>
<td>Australia</td>
<td>BDI, questionnaire, interview; statistical analysis</td>
<td>Primary depressive disorder</td>
<td>The study suggests a need for greater focus on etiological factors and subtyping.</td>
<td>Patients can distinguish btw. differing causes for depression and patients’ beliefs about their non-melancholic depression concur with the clinical subtyping diagnosis.</td>
</tr>
<tr>
<td>2006</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The authors plan to further this work, by exploring attitudes of the lay public.</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>In efforts to improve adherence of AD medications, priority should be given to the socioeconomically disadvantaged populations</td>
<td></td>
</tr>
</tbody>
</table>

447
### 2006 Van Vorhees et al.

**Attitudes and illness factors associated with low perceived need for depression treatment among young adults**

**USA**

**A cross-sectional study; n= 10,962; statistical analysis**

**Depression**

**Low perceived need for treatment leads many young adults not to seek care for their depression**

**Low perceived need for therapy can be viewed as an "intention" not to seek treatment. Negative beliefs and attitudes, social norms and past treatment experiences, rather than low levels of depressive symptoms, accounted for the majority of model variance**

**Policy makers should consider funding what is currently considered non-traditional treatment. Substantial psychological education of the public required to deepen knowledge of treatment options to increase the rate of depression treatment in young adults**

### 2006 Verbeek-Heida & Mathot

**Better safe than sorry - why patients prefer to stop using SSRI antidepressants but are afraid to do so: results of a qualitative study.**

**The Netherlands**

**Qualitative; interviews tape-recorded and transcribed verbatim**

**Reported physical symptoms: headaches, heart problems and back pain**

**SSRIs, benzodiazepines, Continuing SSRs, has a tendency to give experienced users the idea that this is a chronic condition, which cannot be cured but can be managed by medication**

**Research is needed about people who were successful after stopping the medications. Also, addiction and withdrawal effects of AD, if any, should be explored**

### 2006 Wang, JianLi

**Perceived barriers to mental health service use among individuals with mental disorders in the Canadian general population**

**Canada**

**Cross-sectional analysis; Canadian Community Health Survey-Mental Health and Well-being, DSM-IV, CIDI, statistical analysis**

**Depressive-, anxiety-, and substance-use related disorders**

**Because mental health services in Canada are publicly funded, barriers due to accessibility and availability were not significant**

**The percentage of perceived barriers due to acceptability was higher than barriers due to accessibility and availability. Clinical characteristics play a role in perceiving barriers to mental health care**

**Future effort should pay focused attention to the needs of individuals with chronic and severe mental health problems and focus on improving the effectiveness of mental health services**

### 2006 Wittwer, Sherri D.

**The patient experience with the mental health system: A focus on integrated care solutions**

**USA**

**Commentary**

**Depression**

**From the perspective of patients, there are multiple barriers to treatment in depression**

**According to patients and their families, stigma is the primary barrier hindering treatment of depression. Working with a recovery model-"You are not alone, treatment works, recovery is possible, and there is hope", NAMI brings treatment closer to the patients**

**With future innovations and programs in place, hope might be realized for all patients with mental illness and their family members**
<table>
<thead>
<tr>
<th>Year</th>
<th>Author(s)</th>
<th>Title</th>
<th>Country</th>
<th>Design/Methods</th>
<th>Depression</th>
<th>Findings</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>Zimmerman <em>et al.</em></td>
<td>How should remission from depression be defined? The depressed patient's perspective</td>
<td>USA</td>
<td>Qualitative: interview, questionnaire</td>
<td>Major depressive episode, DSM I-V</td>
<td>Constructs that are determining whether a patient’s depressive episode is in remission include the ability to cope with stress, a sense of well-being, quality of life, and feeling like one’s normal self.</td>
<td>Depressed patients consider symptom resolution as only one factor in determining the state of remission. Presence of positive features of mental health such as optimism, vigor, and self-confidence was a better indicator of remission than the absence of the symptoms of depression. Recommended that studies comparing the respective validity of alternative conceptualizations of remission focus on prognosis.</td>
</tr>
<tr>
<td>2007</td>
<td>Akincigil <em>et al.</em></td>
<td>Adherence to antidepressant treatment among privately insured patients diagnosed with depression</td>
<td>USA</td>
<td>Retrospective, observational study; HEIDIS quality measures</td>
<td>Depression</td>
<td>Factors associated with poor adherence in a privately insured population using medical and pharmacy claims.</td>
<td>Alcohol and other substance abuse increase risk of poor depression treatment outcomes. More research needed to clarify responsible mechanisms for adherence.</td>
</tr>
<tr>
<td>2007</td>
<td>Badger F. &amp; Nolan P. (a)</td>
<td>Use of self-chosen therapies by depressed people in primary care</td>
<td>UK</td>
<td>Qualitative: interviews and documented self-reported treatment stories</td>
<td>Depression</td>
<td>Use of complementary and alternative treatments are common among people with depression and doctors' familiarity with such treatments might be beneficial.</td>
<td>Health practitioners need to be aware that people with mental problems are using a range of self-chosen therapies and might consider initiation of discussions on self-chosen treatments with patients. The findings of this study require a larger debate and identification of appropriate knowledge elements.</td>
</tr>
<tr>
<td>2007</td>
<td>Badger &amp; Nolan (b)</td>
<td>Attributing recovery from depression. Perceptions of people cared for in primary care</td>
<td>UK</td>
<td>A purposeful sampling; semi-structured interviews; Framework approach to data analysis;</td>
<td>Depression</td>
<td>Identifying and understanding people's accounts of their recovery is important for practitioners in medication prescribing and management. Depressive patients regard their recovery as multifactorial and are keen to have their own roles in recovery acknowledged.</td>
<td>Doctors must aim to explore patients' beliefs about treatments and recovery. Addressing these can promote adherence and enhance recovery.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Location</td>
<td>Methods</td>
<td>Findings</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>----------</td>
<td>---------</td>
<td>----------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>Baldwin et al.</td>
<td>Discontinuation symptoms in depression and anxiety disorders</td>
<td>Europe, Canada, and South Africa</td>
<td>Used data from all completed RCTs; evaluated with DESS checklist, statistical analysis</td>
<td>MDD, SAD, GAD</td>
<td>SSRI (escitalopram), venlafaxin XR, SNRI, paroxetine, placebo</td>
<td>Escitalopram showed a lower number of discontinuation symptoms than paroxetine or venlafaxine XR, confirming that discontinuation symptom profiles differ btw. antidepressants and btw. SSRIs.</td>
</tr>
<tr>
<td>2007</td>
<td>Bennett et al.</td>
<td>Becoming the best mom that I can: women's experiences of managing depression during pregnancy</td>
<td>Canada</td>
<td>Constructivist grounded theory</td>
<td>Depression</td>
<td>When confronted with depression, the women employed strategies of overcoming barriers, gaining knowledge, and taking control.</td>
<td>For many women, the idea of becoming depressed during pregnancy was unethical to the concept of the pregnant self. The challenge for a pregnant woman diagnosed with depression is that medical treatment can be harmful to the baby.</td>
</tr>
<tr>
<td>2007</td>
<td>Burra et al.</td>
<td>Predictors of self-reported antidepressant adherence</td>
<td>Canada</td>
<td>Self-report questionnaires</td>
<td>Depressive disorders</td>
<td>A group of mood-disorder outpatients (n=80) were assessed for beliefs about ADs, self-efficacy, and reasons for nonadherence</td>
<td>High levels of adherence were reported. Forgetting or a change in the routine were the most frequently identified reasons for nonadherence. Patient did not adhere to treatment if they were: female, had not completed post-secondary education, and experienced sexual side-effects of ADs.</td>
</tr>
<tr>
<td>2007</td>
<td>Buultjens &amp; Liamputtong</td>
<td>When giving life starts to take the life out of you: women's experiences of depression after childbirth</td>
<td>Australia</td>
<td>Qualitative: in-depth interviews</td>
<td>Postnatal depression is a complex illness with varying degrees, reasons for onset and medical treatments.</td>
<td>Emotions and feelings of women were captured and it is hoped that health-care practitioners will gain a deeper understanding of this debilitating condition.</td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>Cabassa, Lester, &amp; Zayas</td>
<td>&quot;It's like being in a labyrinth&quot;: Hispanic Immigrants' perceptions of depression and attitudes toward treatments</td>
<td>USA</td>
<td>vignette, interviews; open-ended questions, IPQ-R, PARC-D, BAS, CES-D, NVIVO 2.0, Chi-square, t-test</td>
<td>Depression</td>
<td>The study examined how demographics, acculturation, clinical factors, and past treatment influenced their perceptions and attitudes</td>
<td>Hispanic immigrants perceived depression as a serious condition caused by interpersonal and social factors. Most patients demonstrated positive attitudes toward treatments but were apprehensive toward antidepressants.</td>
</tr>
</tbody>
</table>

This study did not examine whether tapering might demonstrate advantages compared to abrupt discontinuation. Further studies may focus on the effect of tapering. Improved awareness of depression during pregnancy is needed in health care professionals. Further qualitative research is needed to determine the specific aspects to be addressed. Doctors should be aware of this complexity and address issues not only related to efficacy and tolerability, but also social mediators and health beliefs when prescribing Ads. It is hoped, in making the wider community aware of depression after childbirth, fewer women will suffer in silence. The study emphasizes the need to incorporate Hispanic immigrants' perceptions and attitudes into depression treatment.
<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Title</th>
<th>Country</th>
<th>Methods</th>
<th>Key Findings</th>
<th>Further Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Cooper et al.</td>
<td>Why people do not take their psychotropic drugs as prescribed: results of the 2000 National Psychiatric Morbidity Survey</td>
<td>UK</td>
<td>Data used from 2000 British Survey of National Psychiatric Morbidity; interviews,</td>
<td>Psychosis, early psychosis and depression</td>
<td>34.2% of participants reported incomplete adherence to their psychotropic medication. Reasons given: forgetting, losing, running out, reluctance to taking drugs and side effects</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>People reported that nonadherence was their decision because they did not want it or did not think the treatment was necessary</td>
<td>About 1 in 10 people reported over-medicating themselves, people with diagnosed depression. The reason given: to control the symptoms and perceived need for sedation an important factor. This is common and should be asked about routinely in clinical practice</td>
</tr>
<tr>
<td>2007</td>
<td>Cornford, Hill &amp; Reilly</td>
<td>How patients with depressive symptoms view their condition: a qualitative study</td>
<td>UK</td>
<td>Semi-structured interviews</td>
<td>Depression</td>
<td>HADS in a primary care settings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patients' views about depressive symptoms differ from conventional medical views.</td>
<td>Differentiating depression from understandable reactions to life adversity was difficult for patients. Negative images of depression, i.e. depression is a 20-century phenomenon, were pervasive. Views about medication varied</td>
</tr>
<tr>
<td>2007</td>
<td>Dobscha, Corson, &amp; Gerrity</td>
<td>Depression treatment preferences of VA primary care patients</td>
<td>USA</td>
<td>RCT, DEP-PC, PHQ, Hopkins Symptom Check List, CIDI, AUDIT-C; statistical analysis</td>
<td>Depression, PTSD</td>
<td>Half of the veterans preferred ADs or ADs plus counselling, and one-quarter preferred watchful waiting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>Eisenberg, Golberstein, &amp; Gollust</td>
<td>Help-seeking and access to mental health care in a university student population</td>
<td>USA</td>
<td>random sample, a Web-based survey, statistical analysis</td>
<td>MD, other depression, panic disorder, GAD</td>
<td>Greater investments in student mental health services may be necessary</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>Ellen, Steven</td>
<td>Depression and anxiety. Pharmacological treatment in general practice</td>
<td>Australia</td>
<td>GREY LIT.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Depression</td>
<td>Results</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>------------</td>
<td>---------</td>
</tr>
<tr>
<td>2007</td>
<td>Frank et al.</td>
<td>The patient experience of depression and remission: Focus group results.</td>
<td>USA</td>
<td>Qualitative: focus groups; audiotaped and transcribed; interpretive summary with qualitative methods</td>
<td>Depression, DSM-IV</td>
<td>Content analysis involved organization of statements into thematic categories based both on the semi-structured interview and on the review of the group discussion. The most bothersome symptoms were depressed mood, fatigue, and feelings of worthlessness. More women than men included diminished interest and hypersomnia on the list of most bothersome symptoms. Suicidal ideation and insomnia were among the least bothersome symptoms for this sample.</td>
</tr>
<tr>
<td>2007</td>
<td>Gardner et al.</td>
<td>A comparison of factors used by physicians and patients in the selection of antidepressant agents</td>
<td>Canada</td>
<td>Matching surveys, focus groups; statistical analysis</td>
<td>Depression</td>
<td>Patients and doctors, using a shared decision process, should consider how antidepressants compare in terms of risks. Patient participation in AD decision will lead to improved acceptance of the AD in the long term, which should offer better treatment outcomes, such as improved symptoms response and better QOL.</td>
</tr>
<tr>
<td>2007</td>
<td>Gilchrist &amp; Gunn</td>
<td>Observational studies of depression in primary care: what do we know?</td>
<td>Australia</td>
<td>Systematic review of observational studies</td>
<td>Depression</td>
<td>To determine: the nature and scope of the published studies; the methodological quality of the studies; identified recovery and risk factors for persistent depression; treatment and health service use patterns among patients. Risk factors for persistence of depression identified in this review were: severity and chronicity of the depressive episode, the presence of suicidal thoughts, AD use, poorer self-reported QOL, lower self-reported social support, experiencing key life events, lower education level and unemployment.</td>
</tr>
<tr>
<td>2007</td>
<td>Givens et al.</td>
<td>Ethnicity and preferences for depression treatment</td>
<td>USA</td>
<td>Cross-sectional Internet survey, CES-D, statistical analysis: multivariable regression</td>
<td>Depression</td>
<td>The study utilized a novel method of depression screening by inviting Internet users to access an online assessment. Racial and ethnic minorities prefer counseling for depression more than whites. Beliefs about the effects of antidepressants, prayer, and counseling partially mediate preferences for expression treatment.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Method</td>
<td>Depression</td>
<td>Summary</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>--------</td>
<td>------------</td>
<td>---------</td>
</tr>
<tr>
<td>2007</td>
<td>Hansen &amp; Kessing</td>
<td>Adherence to antidepressant treatment</td>
<td>Denmark</td>
<td>Review</td>
<td>Depression</td>
<td>Misperceptions regarding depression and medication; there is a connection btw. patients' beliefs about depression and medication adherence. Adherence is essential for obtaining full efficacy of the treatment, and awareness of the importance of adherence is mandatory for improving treatment results. Results from qualitative and other studies should in the future be tested in RCTs investigating the effect on adherence to treatment and acute and long-term outcomes.</td>
</tr>
<tr>
<td>2007</td>
<td>Hickie et al.</td>
<td>Perspectives of young people on depression: Awareness, experiences, attitudes and treatment preferences</td>
<td>Australia</td>
<td>Mixed methods: survey and statistical analysis</td>
<td>Depression</td>
<td>Ascertaining current knowledge and attitudes towards depression among young people is vital for developing campaigns promoting community awareness and early intervention. Small but continuous improvements in knowledge and beliefs were occurring over time in younger persons. Further education on the risks and benefits of using antidepressant medication appears warranted given the substantial proportion of young people who consider them harmful.</td>
</tr>
<tr>
<td>2007</td>
<td>Holt, Martin</td>
<td>Agency and dependency within treatment: Drug treatment clients negotiating methadone and antidepressants</td>
<td>Australia</td>
<td>Qualitative: interviews</td>
<td>Depression, opioids abuse</td>
<td>Experiences of methadone maintenance treatment and that of commonly prescribed ADs. (SSRIs) for depression. Those receiving MMT or ADs appreciated the beneficial effects of these treatments, aligning themselves with treatment goals. If clients cannot be convinced of the need for medication or its efficacy, they will continue to modify or refuse treatment regiments. Instead of positioning clients as 'non-compliant', treatment providers could do much better by recognizing clients' investment in their own &quot;well-being&quot;.</td>
</tr>
<tr>
<td>2007</td>
<td>Hunot et al.</td>
<td>A cohort study of adherence to antidepressants in primary care: The influence of antidepressant concerns and treatment preferences</td>
<td>UK</td>
<td>A cohort study: self-report, MARS, statistical analysis</td>
<td>Depression</td>
<td>This article provides the first longitudinal evidence for the strength of independent association for ADs concerns, treatment preferences and illness perceptions on adherence to ADs in primary care. Findings highlight the central role of the patient-physician partnership in exploring and addressing treatment concerns and in providing support in treatment. Possible overconsumption or misuse of ADs is of clinical importance and, being an under investigated area of nonadherence, would be worthy of further study.</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Methodology</td>
<td>Country</td>
<td>Design</td>
<td>Findings</td>
<td>Implications</td>
</tr>
<tr>
<td>------</td>
<td>-----------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------</td>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2007</td>
<td>Iacoviello et al.</td>
<td>Treatment preferences affect the therapeutic alliance: Implications for RCTs</td>
<td>USA</td>
<td>RCT comparing supportive-expressive psychotherapy with sertraline or pill placebo</td>
<td>Patients who randomized to their preferred mode of treatment would develop a stronger alliance over the early phase of therapy than patients who did not receive their preferred treatment</td>
<td>Because treatment preference was assessed with a forced-choice format, the strength of patient preference cannot be determined. Future studies that use a format that measures the absolute strength of a preference (a Likert scale for each treatment option) may better illustrate preferences and their effect on alliance development.</td>
</tr>
<tr>
<td>2007</td>
<td>Interian et al.</td>
<td>A qualitative analysis of the perception of stigma among Latinos receiving antidepressants</td>
<td>USA</td>
<td>Qualitative-grounded theory approach and qualitative analysis</td>
<td>Perceptions of stigma related to both the diagnosis of depression and use of ADs. ADs use seen as implying more severe illness, weakness or failure to cope with problems, and being under the effect of drugs.</td>
<td>Stigma was a prominent concern among Latinos treated with AD medications. Stigma often affected adherence. The perceived negative attributes of AD use were at odds with self-perceived cultural values. Employ hypothesis-driven, quantitative or mixed-methods studies to confirm these findings. Interventions for treatment adherence may benefit from considering issues explored in this study.</td>
</tr>
<tr>
<td>2007</td>
<td>Johnston et al.</td>
<td>Qualitative study of depression management in primary care</td>
<td>UK</td>
<td>Qualitative-grounded theory</td>
<td>Constructing and resisting boundaries btw. depression, the self, and the normal sadness; goals in the management of depression, GPs frustration with chronic depression, and the failure of GPs.</td>
<td>The majority of participants who considered management strategies in depression, wanted to 'get out' of their condition. The importance of GPs listening to their patients was identified, but patients felt that this did not happen very often. These findings highlight the potential relevance of narrative medicine which emphasizes listening to patients' individual stories. Approaches that emphasize drug or psychological treatments may fail to engage many patients.</td>
</tr>
<tr>
<td>2007</td>
<td>Kates &amp; Mach</td>
<td>Chronic disease management for depression in primary care: A summary of the current literature and implications for practice</td>
<td>Canada</td>
<td>Review of RCTs</td>
<td>Primary care practices need to be able to regularly monitor patients during and after treatment of a depressive episode.</td>
<td>There is conclusive evidence for the benefits of changing systems of care delivery to support a more effective management of depression in primary care. Primary care practices need to examine how they can incorporate different concepts and models for managing depression.</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Study Type</td>
<td>Area</td>
<td>Abstract</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>-------</td>
<td>---------</td>
<td>------------</td>
<td>------</td>
<td>----------</td>
</tr>
<tr>
<td>2007</td>
<td>Lader, M.</td>
<td>Pharmacotherapy of mood disorders and treatment discontinuation</td>
<td>UK</td>
<td>Review and commentary</td>
<td>Depression</td>
<td>In many countries, the public regards AD drugs as 'addictive'. Discontinuation (withdrawal) symptoms can occur in almost all classes of ADs, including SSRIs. More resources should be devoted to establishing how various forms of therapy in depression can be combined and include a discontinuation phase for all these treatments. Physicians should educate themselves and the public about discontinuation and withdrawal, so that these clinical features can be put in a realistic context.</td>
</tr>
<tr>
<td>2007</td>
<td>Lafrance, Michelle N.</td>
<td>A bitter pill: A discursive analysis of women's medicalized accounts of depression</td>
<td>Canada</td>
<td>Discourse analytic approach; semi-structured interviews</td>
<td>Depression</td>
<td>Through talk of diagnosis, and by drawing comparisons btw depression and physical illnesses, participants constructed depression as medical condition. By examining medicalized accounts of depression, this analysis simultaneously explored how stigma and de-legitimation are worked up and resisted in sufferers' talk. This analysis reinforces the importance of community-based research and activism aimed at disrupting the dominance of the medical model.</td>
</tr>
<tr>
<td>2007</td>
<td>Leahy-Warren &amp; McCarthy</td>
<td>Postnatal depression: prevalence, mothers' perspectives, and treatments</td>
<td>UK</td>
<td>Review</td>
<td>Postnatal depression</td>
<td>Mothers' experiences of living with postnatal depression: loneliness, anxiety, hopelessness, and loss of control. Treatment options for mothers with postnatal depression require consideration of the severity of depression and mothers' preferences for treatment. An up-to-date systematic review is recommended to establish current prevalence rates. Further research on psychosocial and support systems and their relation to postnatal depression is required.</td>
</tr>
<tr>
<td>2007</td>
<td>Leydon, Rodgers, &amp; Kendrick</td>
<td>A qualitative study of patient views on discontinuing long-term SSRIs</td>
<td>UK</td>
<td>Qualitative</td>
<td>Depression</td>
<td>SSRIs. There is concern that patients may be remaining on SSRIs longer than it is clinically indicated. Patients need to be reassured that, thinking about or, actually stopping medication is a task that will be managed with the professional help. Research highlights the importance of GPs contact when deciding to start treatment and it is likely that the same holds true when deciding to stop.</td>
</tr>
<tr>
<td>2007</td>
<td>Leykin et al.</td>
<td>The relation of patients' treatment preferences to outcome in a RCT</td>
<td>USA</td>
<td>RCT, longitudinal analysis with Hierarchical Linear Modeling</td>
<td>MDD; DSM-IV; HRSD; Treatment preference; ADs, cognitive therapy and placebo</td>
<td>The study examined whether matching patients to treatments according to their preferences produces positive results. No significance was detected. Much larger studies with many more dropouts would need to be conducted in order to make a confident conclusion.</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Study Design</td>
<td>Setting</td>
<td>Sample</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>---------</td>
<td>--------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>2007</td>
<td>Mitchell, A. J.</td>
<td>Adherence behavior with psychotropic medication is a form of self-medication</td>
<td>UK</td>
<td>Narrative review</td>
<td>Depression, bipolar disorder, schizophrenia</td>
<td>Adherence with psychotropic medication at least as poor as with medication for physical health problems. Patients often have strong pre-existing beliefs about different therapeutic options</td>
</tr>
<tr>
<td>2007</td>
<td>Mitchell &amp; Selmes</td>
<td>Why don't patients take their medicine? Reasons and solutions in psychiatry</td>
<td>UK</td>
<td>Literature review</td>
<td>Schizophrenia &amp; depression</td>
<td>Over the course of a year, three-quarters of patients on psychotropic medication discontinue without informing the doctor</td>
</tr>
<tr>
<td>2007</td>
<td>Molenaar et al.</td>
<td>Does adding psychotherapy to pharmacotherapy improve social functioning in the treatment of outpatient depression?</td>
<td>The Netherlands</td>
<td>Diagnosis with a semi structured interview, RCT</td>
<td>MDD, recurrent or chronic depression, dysthymia, DSM-III-R; 17-HDRS</td>
<td>SSRI: fluoxetine, TCA, amitryptyline, moclobemide (RIMA), COT (combined therapy), SPSP, statistical analysis ANCOVA</td>
</tr>
<tr>
<td>2007</td>
<td>Okuyama et al.</td>
<td>Mental health literacy in Japanese cancer patients: ability to recognize depression and preferences of treatment-comparison with Japanese lay public</td>
<td>Japan</td>
<td>Random sampling, structured interviews; vignette; statistical analysis</td>
<td>Depression in cancer patients</td>
<td>To examine Japanese cancer patients’ (CP) ability to recognize depression and their preferences of its treatments</td>
</tr>
<tr>
<td>2007</td>
<td>Parker &amp; Crawford</td>
<td>Judged effectiveness of differing antidepressant strategies by those with clinical depression</td>
<td>Australia</td>
<td>Survey on the Black Dog Institute Website; n=2692; quantitative analyses, SPSS</td>
<td>clinical depression; DSM IIIIR &amp; ICD 10-DCR</td>
<td>venlafaxine rated higher than SSRIs with fluvoxamine rated lowest in the SSRI class; TCA dothiepin superior to other TCAs</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Study Method</td>
<td>Topic</td>
<td>Findings</td>
</tr>
<tr>
<td>------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2007</td>
<td>Prins et al.</td>
<td>Health beliefs and perceived need for mental health care of anxiety and depression</td>
<td>The Netherlands</td>
<td>Systematic review</td>
<td>Depression</td>
<td>A majority of people view Ad as addictive and many perceive stigma and see practical and economic barriers to care</td>
</tr>
<tr>
<td>2007</td>
<td>Sherwood, Salkovskis, &amp; Rimes</td>
<td>Help-seeking for depression: The role of beliefs, attitudes and mood</td>
<td>UK</td>
<td>CACO Cohort study; self-report questionnaires,</td>
<td>Depression</td>
<td>Threshold was measured for: help-seeking, beliefs about depression, current depression and self-management skills</td>
</tr>
<tr>
<td>2007</td>
<td>Simon et al.</td>
<td>Depressed patients' perceptions of depression treatment decision-making</td>
<td>Germany</td>
<td>Convenience sample; semi-structured interview</td>
<td>Depression</td>
<td>Patients' prior experiences with depression and treatment perceptions of the treatment decision-making process, needs and expectations about treatment. Assessed depression severity</td>
</tr>
<tr>
<td>2007</td>
<td>Slingsby et al.</td>
<td>Physician strategies for addressing patient adherence to prescribed psychotropic medications in Japan: a qualitative study</td>
<td>Japan</td>
<td>Qualitative: semi-structured interviews; purposive sample; analysis; data collection; reflexive journal</td>
<td>Depression</td>
<td>Physicians across the world seek to overcome patients' misperceptions re. mental health diagnoses and psychotropic medications.</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Topic</td>
<td>Abstract</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2007</td>
<td>Smardon, R.</td>
<td>‘I’d rather not take Prozac’: stigma and commodification in antidepressant consumer narratives</td>
<td>USA</td>
<td>Qualitative: narrative interviews</td>
<td>Depression</td>
<td>Combining the study of illness narratives, the meaning of medicine and the concept of stigma management, provides the foundation for interactions with macro-socio-cultural patterns of consumption.</td>
</tr>
<tr>
<td>2007</td>
<td>Tentler et al.</td>
<td>Factors affecting physicians’ responses to patients’ requests for antidepressants: focus group study</td>
<td>USA</td>
<td>Focus groups interviews and brief demographic questionnaires</td>
<td>not found</td>
<td>Patients’ requests have a profound impact on prescribing, especially when prompted by direct-to-consumer-advertising (DTCA)</td>
</tr>
<tr>
<td>2007</td>
<td>Jürgen Unützer</td>
<td>Late-life depression</td>
<td>USA</td>
<td>Vignette, review, commentary; PHQ;</td>
<td>Depression</td>
<td>More than 20 ADs have been approved by the FDA for the treatment of depression in older adults</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Findings</td>
<td>Implications</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td>2007</td>
<td>van Geffen et al.</td>
<td>Evaluation of patients' experiences with antidepressants reported by means of a medicine reporting system</td>
<td>The Netherlands</td>
<td>Reports submitted to an internet-based medicine reporting system related to the use of ADs were analysed, statistical analysis</td>
<td>Relevance of side effects was assessed by comparing the proportion of adverse effects that cause discontinuation of the initial AD use, incl. categories &quot;discontinuation&quot; and &quot;switching to other treatment&quot;</td>
<td>Patients report the ineffectiveness and side effects of AD therapy as negative and leading to treatment discontinuation. Patients and HCPs differ in the nature of the reported side effects. Patient experiences should be included in the evaluation of AD treatment in clinical practice</td>
</tr>
<tr>
<td>2007</td>
<td>Wang et al.</td>
<td>Gender specific correlates of stigma toward depression in a Canadian general population sample</td>
<td>Canada</td>
<td>Probability sampled population-based survey; depression stigma scale, statistical analysis</td>
<td>Depression</td>
<td>In multivariate linear regression models, correct identification of depression in a case description and agreement with health professionals about treatments were associated with low stigma scores, regardless of gender</td>
</tr>
<tr>
<td>2007</td>
<td>Weich et al.</td>
<td>Attitudes to depression and its treatment in primary care</td>
<td>UK</td>
<td>Cross-sectional survey</td>
<td>Experience of moderate and severe depressive episodes</td>
<td>1) depression is a disabling, permanent state; 2) it is a medical condition responsive to support; 3) ADs are addictive and ineffective</td>
</tr>
<tr>
<td>2007</td>
<td>Winkler et al.</td>
<td>Escitalopram in a working population: results from an observational study of 2378 outpatients in Austria</td>
<td>Austria</td>
<td>Treatment with escitalopram were compared (mirror study design). Further clinical examination using SGI-S and CGI-I</td>
<td>Mood and anxiety disorders</td>
<td>Most of the patients in this study were treated with 10 mg/day of escitalopram</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methods</td>
<td>Outcomes</td>
<td>Additional Information</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>---------</td>
<td>----------</td>
<td>------------------------</td>
</tr>
<tr>
<td>2008</td>
<td>Aikens, Nease, &amp; Klinkman</td>
<td>Explaining patients' beliefs about the necessity and harmfulness of antidepressants</td>
<td>USA</td>
<td>Interview and self-report measures; cross-sectional trial; multi-staged trial of medication and psychotherapy; statistical analysis</td>
<td>Unipolar nonpsychotic major depression</td>
<td>Young people view their depressive symptoms as mild and transient and feel unclear about the factors affecting their depression</td>
</tr>
<tr>
<td>2008</td>
<td>An, S.</td>
<td>Antidepressant direct-to-consumer advertising and social perception of the prevalence of depression: Application of the availability heuristic</td>
<td>USA</td>
<td>Telephone surveys + statistical analysis</td>
<td>Depression</td>
<td>DTCA - Zoloft, Paxil, Prozac and Wellbutrin</td>
</tr>
<tr>
<td>2008</td>
<td>Cabassa et al.</td>
<td>Azucar y nervios: Explanatory models and treatment experiences of Hispanics with diabetes and depression</td>
<td>USA</td>
<td>Purposive sample from RCT; focus groups, in depth semi-structured interviews; Data analysis: grounded theory</td>
<td>Depression</td>
<td>Depression was perceived as a serious condition linked to the accumulation of social stressors</td>
</tr>
<tr>
<td>2008</td>
<td>Dijkstra, Jaspers &amp; van Zwieten</td>
<td>Psychiatric and psychological factors in patient decision making concerning antidepressant use</td>
<td>The Netherlands</td>
<td>Cohort study, questionnaire, statistical analysis</td>
<td>Anxiety &amp; depression</td>
<td>It is important to increase insight into patients' decision making regarding the use of ADs</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Study Type</td>
<td>Topic</td>
<td>Summary</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>---------</td>
<td>------------</td>
<td>-------</td>
<td>---------</td>
</tr>
<tr>
<td>2008</td>
<td>Katja van Geffen</td>
<td>Initiation, execution and discontinuation of antidepressant therapy.</td>
<td>The Netherlands</td>
<td>Dissertation</td>
<td></td>
<td>Participants rated a combination of treatment consisting of CT and AM as more acceptable for treating depression than either treatment alone. Further studies examining depression treatment preferences in older adults would be useful, as acceptability attitudes may affect treatment adherence.</td>
</tr>
<tr>
<td>2008</td>
<td>Hanson &amp; Scogin</td>
<td>Older adults' acceptance of psychological, pharmacological, and combination treatments for geriatric depression</td>
<td>USA</td>
<td>Community-dwelling non-depressed participants; vignette, statistical analysis</td>
<td>Depression</td>
<td>To provide a framework for linking psychological and biological processes in emotional disorders and their treatment. Antidepressant drug administration affects aspects of emotional processing thought to be important in depression and anxiety. Such effects can be seen very early on following drug administration and independently from mood change. The challenge remains to fully assess the relevance of these early shifts to antidepressant drug action in depression and anxiety and the contribution of different neurochemical systems and neural circuitry to these changes.</td>
</tr>
<tr>
<td>2008</td>
<td>Harmer, C.J.</td>
<td>Serotonin and emotional processing: Does it help explain antidepressant drug action?</td>
<td>UK</td>
<td>Review</td>
<td>Treatments for depression and their effects on emotional processing.</td>
<td>To provide a framework for linking psychological and biological processes in emotional disorders and their treatment. Antidepressant drug administration affects aspects of emotional processing thought to be important in depression and anxiety. Such effects can be seen very early on following drug administration and independently from mood change. The challenge remains to fully assess the relevance of these early shifts to antidepressant drug action in depression and anxiety and the contribution of different neurochemical systems and neural circuitry to these changes.</td>
</tr>
<tr>
<td>2008</td>
<td>Hwang et al.</td>
<td>A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model</td>
<td>USA</td>
<td>Review and commentary</td>
<td>Depression</td>
<td>This review offers a basic framework for understanding systematic and interrelated cultural issues and their impact on mental health. Mental health researchers, practitioners, and teachers can contribute to greater cultural awareness and competence. Mental health providers need to develop a more sophisticated understanding of how culture affects several interrelated mental domains.</td>
</tr>
<tr>
<td>2008</td>
<td>Lakey, Gerald F.</td>
<td>&quot;Feeling blue&quot; in Spanish: A qualitative inquiry of depression among Mexican immigrants</td>
<td>USA</td>
<td>A qualitative inquiry; vignette, discussions</td>
<td>Depression</td>
<td>5 aspects of the cultural concepts about depression: identification of depression, symptoms presentation, perceived causes, suggested remedies, and colloquial terminology. Depression appears as familiar and valid. Reporting of somatic symptoms did occur, but interpersonal problems and depressed affect symptoms are among the most salient in identifying someone as depressed. Future qualitative studies examining illness perceptions and healing behaviors are recommended, but these must be approached with care and sensitivity about generalizing findings about Latinos.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Methodology</td>
<td>Country</td>
<td>Additional Information</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>-------------</td>
<td>---------</td>
<td>-------------------------</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>Levin et al.</td>
<td>Life-threatening serotonin toxicity due to a citalopram-fluconazole drug interaction: case report and discussion</td>
<td>Case report and lit. review: Medline search without date limitation</td>
<td>USA</td>
<td>Although case report methodology has intrinsic limitations on generalizability, the citalopram-fluconazole drug interaction is predictable. Because the use of fluconazole is common in oncology treatment, it is recommended that precautions be taken in the setting of concurrent citalopram treatment.</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>Löwe et al.</td>
<td>Depression, anxiety and somatization in primary care: syndrome overlap and functional impairment</td>
<td>Self-report questionnaire, measurement scales; statistical analysis</td>
<td>USA</td>
<td>While somatization and depression contributed to a similar extent to disability days, somatization was the only disorder without mental health impairment. In over 50% of cases, comorbidities existed btw. depression, anxiety and somatic symptoms. The contribution of the commonalities of depression, anxiety and somatization to functional impairment substantially exceeded the contribution of their independent parts.</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>Martinez Pincay, Igda</td>
<td>Latino perspectives on the treatment of depression: an exploratory study</td>
<td>Dissertation</td>
<td>USA</td>
<td>Describe basic diagnostic criteria for a single overreaching disorder and optionally code additional diagnostic features that allow a more detailed classification into specific depressive, anxiety, and somatoform subtypes.</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>Murawiec S.</td>
<td>Symbolic function of medication – a case report</td>
<td>Qualitative: a case study, vignette</td>
<td>Poland</td>
<td>Pharmacotherapy is usually seen in the context of the biological action of the medication use. The action of the medication can be also discussed on many other levels, i.e. on the level of the transformation of this action into universal symbols experienced individually in the patient’s mind.</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>Nabeel et al.</td>
<td>Depressed patients’ preferences for education about medications by pharmacists in Kuwait</td>
<td>Cohort study; statistical analysis</td>
<td>Kuwait</td>
<td>Patients with depression appear very eager to receive additional drug information. These results provided further evidence that leaflets and counselling should be widely used. Specialized educational interventions by pharmacists may improve patients' compliance and probably treatment outcome.</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Location</td>
<td>Study Design</td>
<td>Diagnosis</td>
<td>Interventions</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>----------</td>
<td>--------------</td>
<td>-----------</td>
<td>---------------</td>
</tr>
<tr>
<td>2008</td>
<td>Patten, Scott B.</td>
<td>Confounding by severity and indication in observational studies of antidepressant effectiveness</td>
<td>Canada</td>
<td>Random, community residents, interviews, PHQ-9, statistical analysis</td>
<td>Depression, DSM-IV</td>
<td>This study found evidence for confounding by severity</td>
</tr>
<tr>
<td>2008</td>
<td>Pedrelli et al.</td>
<td>Dysfunctional attitudes and perceived stress predict depressive symptoms severity following antidepressant treatment in patients with chronic depression</td>
<td>USA</td>
<td>Subsample of patients from RCT with fluoxetine; statistical analysis</td>
<td>MDD, dysthymia; DSM-III-R</td>
<td>Fluoxetine, HAM-D 17;</td>
</tr>
<tr>
<td>2008</td>
<td>Politis et al.</td>
<td>Combination therapy with amisulpride and antidepressants: clinical observations in case series of elderly patients with psychotic depression</td>
<td>Greece</td>
<td>RCT</td>
<td>Psychotic depression, DSM-IV-TR</td>
<td>Combination of AD with antipsychotic agent; amisulpride, citalopram, mirtazapine</td>
</tr>
<tr>
<td>2008</td>
<td>Prins et al.</td>
<td>Health beliefs and perceived need for mental health care of anxiety and depression- the patients' perspective explored</td>
<td>The Netherlands</td>
<td>Systematic review</td>
<td>Depression and anxiety</td>
<td>Patients give multidimensional explanations for depression and see both psychological and medication treatment as helpful</td>
</tr>
<tr>
<td>2008</td>
<td>Seedat, Haskis &amp; Stein</td>
<td>Benefits of consumer psychoeducation: A pilot program in South Africa</td>
<td>South-Africa</td>
<td>drop-out rates during paroxetine-treatment were surveyed</td>
<td>Depression</td>
<td>paroxetine and other SSRIs</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Diagnosis</td>
<td>Findings</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>2008</td>
<td>Shigemura et al.</td>
<td>Patient satisfaction with antidepressants: An internet based study</td>
<td>Japan</td>
<td>Online survey, statistical analysis: SPSS</td>
<td>MDD</td>
<td>ADs: fluvoxamine, milnacipran, paroxetine, TCA</td>
</tr>
<tr>
<td>2008</td>
<td>Sigurtsson, Olafsdottir, &amp; Gottfredsson</td>
<td>Public views on antidepressant treatment: Lessons from a national survey</td>
<td>Iceland</td>
<td>Self-report questionnaire, statistical analysis</td>
<td>Depression</td>
<td>It appears that ADs are so widely used in Iceland because of their perceived effectiveness by users and owing to limited access to talking therapies in primary care settings</td>
</tr>
<tr>
<td>2008</td>
<td>Soudry et al.</td>
<td>Factors associated with antidepressant use in depressed and non-depressed community-dwelling elderly: the three city study</td>
<td>France</td>
<td>Face-to-face interviews, statistical analysis</td>
<td>Depression</td>
<td>3 groups were defined: non-depressed, high depressive symptoms and current MDD</td>
</tr>
<tr>
<td>2008</td>
<td>Turner et al.</td>
<td>Women's views and experiences of antidepressants as a treatment for postnatal depression: a qualitative study</td>
<td>UK</td>
<td>RTC, In-depth interviews, data analysed thematically</td>
<td>Postnatal depression</td>
<td>Most participants had negative views on ADs at the time of randomization</td>
</tr>
<tr>
<td>2008</td>
<td>Vanelli &amp; Coca-Perraillon</td>
<td>Role of patient experience in antidepressant adherence: A retrospective data analysis</td>
<td>USA</td>
<td>Deidentified computerized pharmacy records; adherence was measured using Kaplan-Meier analysis</td>
<td>Mood and anxiety disorders</td>
<td>extended-release venlafaxine, controlled-release paroxetine, sertraline, fluoxetine, escitalopram, and/or citalopram</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Design</td>
<td>Outcome</td>
<td>Findings</td>
</tr>
<tr>
<td>------</td>
<td>-----------------</td>
<td>----------------------------------------------------------------------</td>
<td>--------------</td>
<td>-------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2008</td>
<td>Wang &amp; Lai</td>
<td>The relationship between mental health literacy, personal contacts and personal stigma against depression</td>
<td>Canada</td>
<td>Cross-sectional study; self-report; data collected in a probability sampled population-based survey; statistical analysis</td>
<td>Depression</td>
<td>The findings may be affected by recall and reporting biases; lack of evidence that improving mental health literacy and personal contact with depression will reduce stigma</td>
</tr>
<tr>
<td>2008</td>
<td>Wittkamp et al.</td>
<td>Patients' view on screening for depression in general practice</td>
<td>The Netherlands</td>
<td>Qualitative; semi-structured in-depth interviews; double analysis with MAXqda2</td>
<td>MDD</td>
<td>All patients appreciated being approached for screening, but some did not accept the diagnosis</td>
</tr>
<tr>
<td>2008</td>
<td>Zivin &amp; Kales</td>
<td>Adherence to depression treatment in older adults</td>
<td>USA</td>
<td>A narrative review</td>
<td>Depression</td>
<td>Adherence to depression treatment in older adults is associated with multiple factors</td>
</tr>
<tr>
<td>2009</td>
<td>Chakraborty et al.</td>
<td>Attitudes and beliefs of patients of first episode depression towards antidepressants and their adherence to treatment</td>
<td>India</td>
<td>Assessment , questionnaire, statistical analysis SPSS</td>
<td>First episode unipolar depression</td>
<td>DSM-IV, ICD-10, MINI, BDI, ADCQ</td>
</tr>
<tr>
<td>2009</td>
<td>Cipriani et al.</td>
<td>Depression in adults: drug and physical treatment</td>
<td>UK</td>
<td>Systematic review</td>
<td>Depression</td>
<td>Information relating to the effectiveness and safety of the following: AD drugs (TCAs), SSRIs, MOI, or venlafaxine; continuing prescription AD drugs, electroconvulsive therapy, exercise, lithium augmentation, pindolol augmentation, and St. John's wort</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Research Method</td>
<td>Main Findings</td>
<td>Notes</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>---------</td>
<td>----------------</td>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>2009</td>
<td>Demyttenaere, Koen</td>
<td>Compliance and acceptance in antidepressant treatment</td>
<td>Belgium</td>
<td>Review, discussion and commentary</td>
<td>Depression Non-compliance with AD medications is common, and it is the greatest barrier to effective treatment of MDD</td>
<td>Non-compliance, either through treatment discontinuation or variation in the frequency and intensity of dosing, is associated with incomplete symptom resolution or relapse, adverse effects and treatment discontinuation syndromes</td>
</tr>
<tr>
<td>2009</td>
<td>ten Doesschatte, Bockting, &amp; Schene</td>
<td>Adherence to continuation and maintenance antidepressant use in recurrent depression</td>
<td>The Netherlands</td>
<td>Prospective cohort study; self-reported non-adherence</td>
<td>MDD Non-adherence to continuation and maintenance AD treatment in recurrent depression is frequent and a potential risk of recurrence</td>
<td>Non-adherence ranged from 39.7% to 52.7%. 20.9% were always non-adherent, 48.4% were intermittently non-adherent and 30.8% were always adherent.</td>
</tr>
<tr>
<td>2009</td>
<td>Fullagar, Simone</td>
<td>Negotiating the neurochemical self: anti-depressant consumption in women's recovery from depression</td>
<td>Australia</td>
<td>Qualitative study, Nvivo used to code and analyse comments</td>
<td>Depression The biomedical consumer is motivated not by a simple belief in biomedicine but by affective investment of self in the power of medication to change the embodied relation to self</td>
<td>Despite the dominance of biomedical accounts, very few women attributed their recovery solely to medication or understood depression as caused by chemical imbalance only</td>
</tr>
<tr>
<td>2009</td>
<td>Goodman, Janice H.</td>
<td>Women's attitudes, preferences, and perceived barriers to treatment for perinatal depression</td>
<td>USA</td>
<td>Questionnaire</td>
<td>Perinatal depression Perinatal depression can lead to a chronic or recurrent depressive course throughout the woman's life</td>
<td>Understanding what prevents women from seeking or obtaining help for depression and determining their preferences for treatment may lead to better outcomes</td>
</tr>
<tr>
<td>2009</td>
<td>Hodges et al.</td>
<td>Patient and general practitioner preferences for the treatment of depression in patients with cancer: How, who, and where?</td>
<td>UK</td>
<td>Questionnaire</td>
<td>depression &amp; cancer Options for how depression should be treated, who should deliver the treatment and where treatment should occur</td>
<td>Patients preferred talking treatment alone, whereas GPs preferred combination of drug and talking therapy. Both patient and GP preferred treatment to be given by GPs,</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Themes</td>
<td>Findings</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>-----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2009</td>
<td>R. Liebert &amp; N. Gavey</td>
<td>&quot;There are always two sides to these things&quot;: Managing the dilemma of serious adverse effects from SSRIs</td>
<td>New Zealand</td>
<td>in-depth semi-structured interviews</td>
<td>Depression</td>
<td>SSRIs</td>
</tr>
<tr>
<td>2009</td>
<td>Madsen, McQuaid, &amp; Craighead</td>
<td>Working with reactant patients: Are we prescribing nonadherence?</td>
<td>USA</td>
<td>Questionnaires following medication evaluation to measure predictor variables, statistical analysis</td>
<td>MDD, BDI-II, HPRS, PAQ, follow-up assessment, descriptive statistics analysis</td>
<td>Patients that rate their doctor as more collaborative will report greater AD adherence than those who view their provider as less collaborative</td>
</tr>
<tr>
<td>2009</td>
<td>Malpass et al.</td>
<td>&quot;Medication career&quot; or &quot;Moral career&quot;? The two sides of managing antidepressants</td>
<td>UK</td>
<td>3 stages: a) Systematic search; b) critical appraisal; c) synthesis using techniques of meta-ethnography (Noblit &amp; Hare, 1988)</td>
<td>Depression &amp; anxiety</td>
<td>One obstacle to qualitative synthesis is the challenge of bringing together data grounded in different theoretical or methodological perspectives</td>
</tr>
<tr>
<td>2009</td>
<td>McPherson &amp; Armstrong</td>
<td>Negotiating 'depression' in primary care: A qualitative study</td>
<td>UK</td>
<td>Qualitative: purposive sampling, semi-structured interviews, audio-recorded and transcribed verbatim</td>
<td>Mild, moderate, &amp; severe depression</td>
<td>GPs in this study often responded in non-medical ways incl. feeling unsympathetic, breaking confidentiality, and prescribing social interventions</td>
</tr>
<tr>
<td>2009</td>
<td>Ööpik &amp; Maaroos</td>
<td>The preferences and rationale of family doctors in pharmacological treatment for depression</td>
<td>Estonia</td>
<td>Questionnaire-based survey</td>
<td>anxiety; anxiety with depression; mixed mood disorders</td>
<td>SSRIs, SNRIs,</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Location/Country</td>
<td>Methodology/Design</td>
<td>Depression</td>
<td>Reasons for obtaining drug information online: seeking second opinion and verify information provided by leaflets to learn about somebody's experiences, preparing for a doctor's visit</td>
</tr>
<tr>
<td>------</td>
<td>-----------------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------</td>
<td>--------------------</td>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2009</td>
<td>Pohjanoksa et al.</td>
<td>How and why do people with depression access and utilize online drug information: A qualitative study</td>
<td>Finland</td>
<td>Qualitative: focus groups</td>
<td>Depression</td>
<td>Reasons for obtaining drug information online: seeking second opinion and verify information provided by leaflets to learn about somebody's experiences, preparing for a doctor's visit</td>
</tr>
<tr>
<td>2009</td>
<td>Price, Cole, &amp; Goodwin</td>
<td>Emotional side-effects of SSRIs: qualitative study</td>
<td>UK</td>
<td>Qualitative: individual, and group interviews, searching patients' websites for relevant posts</td>
<td>Depression: BDI-II</td>
<td>Some people taking SSRIs, report that their experience of emotions is 'blunted'.</td>
</tr>
<tr>
<td>2009</td>
<td>Prins et al.</td>
<td>Primary care patients with anxiety and depression: Need for care from the patient's perspective</td>
<td>The Netherlands</td>
<td>Cross-sectional data derived from NESDA, multiple logistic regression analysis</td>
<td>Anxiety and depression, PNCQ,</td>
<td>Patients' confidence in professional help and their evaluation of received care positively influenced their perception of medication and counselling</td>
</tr>
<tr>
<td>2009</td>
<td>Sawada et al.</td>
<td>Persistence and compliance to antidepressant treatment in patients with depression</td>
<td>Japan</td>
<td>Retrospective chart-review, 6-mos adherence to ADs was examined, statistical analysis</td>
<td>MDD: ICD-10, MPR, sulpride, paroxetine, fluvoxamine, sertraline, milnacipran, amoxapine, trazodone</td>
<td>Behaviors towards treatment might be subject to patients' social and cultural background</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Study Title</td>
<td>Country</td>
<td>Study Design</td>
<td>Dep. Measures</td>
<td>ADs</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------------</td>
<td>---------</td>
<td>--------------</td>
<td>---------------</td>
<td>-----</td>
</tr>
<tr>
<td>2009</td>
<td>Sinokki et al.</td>
<td>The association of social support at work and in private life with mental health and antidepressant use: The health 2000 study</td>
<td>Finland</td>
<td>Cohort study; Self-assessment scales; population-based health survey; statistical analysis</td>
<td>Depression: DSM-IV, major mental disorders</td>
<td>Antidepressants</td>
</tr>
<tr>
<td>2009</td>
<td>de Toledo Piza Peluso &amp; Blay</td>
<td>Public stigma in relation to individuals with depression</td>
<td>Brazil</td>
<td>Cross-sectional study; structured questionnaire, vignette</td>
<td>Depression: DSM-IV and ICD-10</td>
<td>Assessment of perceived negative reactions and discrimination, perceived dangerousness and emotional reactions in relation to the case introduced in vignette</td>
</tr>
<tr>
<td>2009</td>
<td>van Geffen et al.</td>
<td>Initiation of antidepressant therapy: do patient follow the GP's prescription?</td>
<td>The Netherlands</td>
<td>Retrospective study linking a general practice to a pharmacy dispensing database</td>
<td>Decision to initiate /or not/ drug taking is influenced by the way in which patients evaluate their need for medication based on their concerns about negative effects</td>
<td>Patients who received a first-time AD prescription from a GP. 3 patient groups were identified: non-fillers, single Rx-fillers and patients who filled at least 2 consecutive prescriptions</td>
</tr>
<tr>
<td>2009</td>
<td>Vergouven et al.</td>
<td>Improving patients' beliefs about antidepressants in primary care: A cluster-RCT of the effect of a Depression Care Program</td>
<td>The Netherlands</td>
<td>A cluster-RCT, comparison of 2 interventions to improve management of MDD in primary care;</td>
<td>Depression: DSM-IV</td>
<td>SSRI</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Findings</td>
<td>Implications</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td>2009</td>
<td>Yen et al.</td>
<td>Predictive value of self-stigma, insight, and perceived adverse effects of medication for the clinical outcomes in patients with depressive disorders</td>
<td>Taiwan</td>
<td>Project on self-stigma; cross-sectional and prospective research studying the self-stigma; statistical analysis</td>
<td>Depression disorders: DSM-IV, CES-D, MABS, QAMD, statistical analysis</td>
<td>Self-stigma, Insight, Adverse effects of medication</td>
</tr>
<tr>
<td>2010</td>
<td>Amey, C.</td>
<td>Suspected antidepressant-induced switch to mania in unipolar depression: a first-person narrative</td>
<td>UK</td>
<td>A first-person narrative</td>
<td>Depression, mania; Tricyclic AD dosulepin</td>
<td>Author’s own experience of psychotic mania</td>
</tr>
<tr>
<td>2010</td>
<td>Aselton, P.</td>
<td>The lived experience of college students who have been medicated with antidepressants.</td>
<td>USA</td>
<td>Dissertation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>Bennett et al.</td>
<td>Pregnancy-related discontinuation of antidepressants and depression care visits among Medicaid Recipients</td>
<td>USA</td>
<td>Matched cohort study design; Medicaid claims data from all 50 US states were used; statistical analysis</td>
<td>Depression; ICD-9</td>
<td>Women who become pregnant, significantly reduce their ongoing depression care compared to non-pregnant controls</td>
</tr>
<tr>
<td>2010</td>
<td>Birnbaum et al.</td>
<td>Employer burden of mild, moderate, and severe major depressive disorder: Mental health services utilization and costs, and work performance</td>
<td>USA</td>
<td>Survey; interview, assessment of risk factors; statistical analyses</td>
<td>MDD</td>
<td>Cost effectiveness of MDD treatment: prevalence of mild depression and its potential to become more severe suggests focus on treatment effectiveness</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Location</td>
<td>Methodology</td>
<td>Cysteopathological Findings</td>
<td>Additional Notes</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>----------</td>
<td>-------------</td>
<td>-----------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>2010</td>
<td>Bob et al.</td>
<td>Traumatic stress, dissociation, and limbic irritability in patients with unipolar depression being treated with SSRIs</td>
<td>Czech Republic</td>
<td>CACO study</td>
<td>Unipolar depression: DSM-IV</td>
<td>Establishing psychometric criteria to identify unipolar depressive patients with high seizure-like symptoms which may respond to anticonvulsant treatment</td>
</tr>
<tr>
<td>2010</td>
<td>Britten, Riley, &amp; Morgan</td>
<td>Resisting psychotropic medicines: a synthesis of qualitative studies of medicine-taking</td>
<td>UK</td>
<td>Synthesis of qualitative research</td>
<td>Psychotic and depressive conditions</td>
<td>Patients’ perspectives of psychotropic medications (continuation and update of work by 2005 Pound et al)</td>
</tr>
<tr>
<td>2010</td>
<td>Bulloch &amp; Patten</td>
<td>Non-adherence with psychotropic medications in the general population</td>
<td>Canada</td>
<td>Data from Canadian Community Health Survey: Mental Health &amp; Well-Being; statistical analysis</td>
<td>Antipsychotics, Sedative-hypnotics, Anxiolytics, Mood stabilizers, Antidepressant</td>
<td>A high frequency of non-adherence was found with all five classes of psychotropic medication</td>
</tr>
<tr>
<td>2010</td>
<td>Carpenter et al.</td>
<td>Ethno-cultural variations in the experience and meaning of mental illness and treatment: Implications for access and utilization</td>
<td>USA</td>
<td>Qualitative: ethnographic study</td>
<td>Psychotropic medications</td>
<td>How individuals diagnosed with severe mental illness understand mental health problems and respond to engagement with mental health services</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Topic</td>
<td>Findings/Implications</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>-----------------------------------------------------------------------</td>
<td>---------</td>
<td>-------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2010</td>
<td>Dickinson et al.</td>
<td>Long-term prescribing of antidepressants in the older population</td>
<td>UK</td>
<td>A qualitative study; interviews, recorded and transcribed; field notes were collected</td>
<td>Antidepressant medications; the benefits of ADs; understanding of depression and its treatment; barriers; discontinuation of ADs</td>
<td>GPs feel limited when considering alternative treatments for older patients with depression.</td>
</tr>
<tr>
<td>2010</td>
<td>Ezeobele et al.</td>
<td>Depression and Nigerian-born immigrant women in the United States: a phenomenological study</td>
<td>USA</td>
<td>Qualitative: phenomenologic study: face-to-face, semi-structured, audio-taped interviews; open-ended questions</td>
<td>Depression</td>
<td>Women described depression as affecting others and not them. Women’s perception: the clergy was preferred for treatment of depression rather than health care professionals</td>
</tr>
<tr>
<td>2010</td>
<td>Gabriel &amp; Violato</td>
<td>Knowledge of and attitudes towards depression and adherence to treatment: The Antidepressant Adherence Scale</td>
<td>Canada</td>
<td>Antidepressant Adherence Scale (AAS), patients on ADs, statistical analysis</td>
<td>Depression</td>
<td>Non-adherence to treatment can result from forgetting, carelessness, adverse effects, or stopping the drug when feeling better.</td>
</tr>
<tr>
<td>2010</td>
<td>Holma et al.</td>
<td>Treatment attitudes and adherence of psychiatric patients with MDD: A five year prospective study</td>
<td>Finland</td>
<td>Prospective study</td>
<td>DSM-IV MDD</td>
<td>Throughout the follow-up, most patients reported positive attitudes and good adherence</td>
</tr>
<tr>
<td>2010</td>
<td>Interian et al.</td>
<td>Adaptation of a motivational interviewing intervention to improve antidepressant adherence among Latinos</td>
<td>USA</td>
<td>Focus groups, preliminary, pilot, and adapt interventions, observation, participants’ feedback, RCT in process</td>
<td>Depression</td>
<td>Poor AD adherence is a significant issue in depression treatment, and it tends to be more common among Latinos.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Country/Region</td>
<td>Methodology</td>
<td>Setting</td>
<td>Description</td>
<td>Findings/Implications</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------</td>
<td>----------------</td>
<td>----------------------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2010</td>
<td>Kadir &amp; Bifulco</td>
<td>Malaysia</td>
<td>Qualitative: structured clinical interviews, qualitative analysis</td>
<td>Depression</td>
<td>The women gave full and open descriptions of their emotional symptoms, easily recognizable by standard symptom categories; somatic symptoms were included, and the spiritual context to understanding depression was prevalent.</td>
<td>Attention to such views of depression can help develop services in Malaysia.</td>
</tr>
<tr>
<td>2010</td>
<td>Keers et al.</td>
<td>8 European countries</td>
<td>GENDEP collected longitudinal data on the symptoms; statistical analysis</td>
<td>Major depression, MADRS; HRSD-17; BDI; LTE-Q</td>
<td>SLEs occurring prior to treatment may predict response to ADs, but the effects are both symptoms and drug specific. The association btw SLEs and the cognitive symptoms of depression may have important implications for treatment.</td>
<td>Those reporting stress and therefore higher cognitive symptoms may benefit more from treatment with SSRIs than with TCAs</td>
</tr>
<tr>
<td>2010</td>
<td>Kwan, Dimidjian, &amp; Rizvi</td>
<td>USA</td>
<td>Participants randomly assigned to therapies and conditions; statistical analysis</td>
<td>MDD</td>
<td>A mismatch btw. preferred and actual treatment was associated with greater attrition, fewer expected visits attended, and a less positive working alliance. Significant indirect effect of preference match on depression outcomes.</td>
<td>These findings highlight the importance of addressing patient preferences in the treatment of MDD.</td>
</tr>
<tr>
<td>2010</td>
<td>Lee et al.</td>
<td>Korea</td>
<td>Quantitative</td>
<td>DSM-IV depression</td>
<td>The incidence of sexual dysfunction was substantially high during AD treatment. Of the ADs, the mirtazapine group’s total ASEX score was significantly lower than the scores of citalopram, fluoxetine, and paroxetine groups.</td>
<td>The study suggests the need for clinicians to consider the impact of pharmacotherapy on patients’ sexual functioning.</td>
</tr>
<tr>
<td>2010</td>
<td>Malpass et al.</td>
<td>UK</td>
<td>Mixed methods: PHQ-9, in-depth interviews; follow up, 4-stage-analysis with software package ATLAS</td>
<td>Depression</td>
<td>Evidence of patients ‘gaming’ when completing severity questionnaires, either to avoid unwanted treatment outcomes (stigma) or to achieve their desired outcome, is relevant to these findings.</td>
<td>The potential therapeutic value of PHQ-9 may be dependent upon the GP’s willingness to openly discuss the results and what they mean for the patient.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Conditions</td>
<td>Objectives</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2010</td>
<td>Mendel et al.</td>
<td>'What would you do if you were me, doctor?': Randomised trial of psychiatrists' personal v. professional perspectives on treatment recommendations</td>
<td>Germany</td>
<td>Randomised experimental design; depression case and schizophrenia case vignettes; statistical analysis</td>
<td>Depression, schizophrenia</td>
<td>To study whether this question really leads psychiatrists to reveal their personal preferences.</td>
</tr>
<tr>
<td>2010</td>
<td>Ragan &amp; Kane</td>
<td>Meaningful Lives: Elders in Treatment for Depression</td>
<td>USA</td>
<td>Descriptive qualitative approach; open-ended interviews</td>
<td>Depressive disorder</td>
<td>Elders in treatment for depression with interpersonal psychotherapy and medication were interviewed to better understand their day-to-day lives</td>
</tr>
<tr>
<td>2010</td>
<td>Serna et al.</td>
<td>Duration and adherence of antidepressant treatment (2003 to 2007) based on prescription database</td>
<td>Spain</td>
<td>Retrospective cohort followed-up for 5 years</td>
<td>Depression</td>
<td>To estimate the duration of AD treatment and to analyse the factors: age, sex, polypharmacy and the type of drug</td>
</tr>
<tr>
<td>2010</td>
<td>Shigemura et al.</td>
<td>Predictors of antidepressant adherence</td>
<td>Japan</td>
<td>Internet-based survey; statistical analysis</td>
<td>Depressive disorder</td>
<td>To identify the psychosocial/pharmacological predictors of AD adherence</td>
</tr>
<tr>
<td>2010</td>
<td>Vega et al.</td>
<td>Addressing stigma of depression in Latino primary care patients</td>
<td>USA</td>
<td>Depression screening: PHQ-2 and PHQ-9; medical records were reviewed; statistical analysis</td>
<td>Depression</td>
<td>To develop a validated stigma checklist to assist physicians in addressing depression in Latino patients</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country/Countries</td>
<td>Methodology</td>
<td>Main Findings</td>
<td>Implications</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2010</td>
<td>Wade, Johnson, &amp; McConnachie</td>
<td>Antidepressant treatment and cultural differences - a survey of the attitudes of physicians and patients in Sweden and Turkey</td>
<td>Sweden/Turkey</td>
<td>Questionnaires; HADS, CGI, SDS scales; statistical analysis; Fisher’s exact test and 2-sample t-tests</td>
<td>Depressive or anxiety disorders symptoms and response to AD medications in Swedish and Turkish patients. Presenting symptoms of depression can be influenced by cultural differences. Presenting symptoms differed btw. Sweden and Turkey, with Turkish patients presenting more physical symptoms. After 8 weeks of AD treatment, the improvement from baseline was greater in Turkish patients.</td>
<td>In countries populated by diverse ethnic groups, it is important that physicians are aware of cultural differences in patients’ presentations and expectations.</td>
</tr>
<tr>
<td>2011</td>
<td>Abdullah &amp; Brown</td>
<td>Mental illness stigma and ethno-cultural beliefs, values and norms: an integrative review</td>
<td>USA</td>
<td>An integrative review</td>
<td>Mental illness To examine the relationship btw. mental illness stigma and culture for Americans of American Indian, Asian, African, Latino, Middle Eastern, and European descent.</td>
<td>Researchers may be disinclined to study culture as it is difficult to measure however, when culture is ignored, over-generalizations occur. Better organize and more explore of the role of cultural history and values as they relate to mental illness stigma. A detailed, systematic approach to future research in the area is proposed.</td>
</tr>
<tr>
<td>2011</td>
<td>Ballon, Diana</td>
<td>Fear of falling, fear of failing. Antidepressant users - and prescribers - need more guidance around withdrawal</td>
<td>Canada</td>
<td>GREY LIT.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>Cohen &amp; Hughes</td>
<td>How do people taking psychiatric drugs explain their &quot;chemical imbalance?&quot;</td>
<td>USA</td>
<td>Qualitative: interviews transcribed verbatim; recorded medication histories</td>
<td>Self-reported: depression, anxiety, bipolar, ADHD, borderline personality disorder, PTSD, and others SSRI+ benzodiazepine</td>
<td>The most frequent explanation for believing that one had an imbalance was that medication changed or relieved distressful symptoms.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Findings</td>
<td>Conclusions</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>2011</td>
<td>Cook &amp; Wang</td>
<td>Causation beliefs and stigma against depression: Results from a population-based study</td>
<td>Canada</td>
<td>Random selection survey; case vignette; causation questionnaire; stigma scores analysed statistically</td>
<td>Depression focused on 3 depression etiologies: a biological model, a psychosocial model, and a medical model.</td>
<td>Endorsing un-related cause of depression (allergy, virus, “being a nervous person”, weakness of character) was associated with increased stigma.</td>
</tr>
<tr>
<td>2011</td>
<td>Griffiths et al.</td>
<td>Does stigma predict a belief in dealing with depression alone?</td>
<td>Australia</td>
<td>Data collected from national survey. Vignettes; logistic regression analyses</td>
<td>Depression</td>
<td>Higher levels of personal stigma predicted belief in the helpfulness of dealing alone with depression and suicidal ideation.</td>
</tr>
<tr>
<td>2011</td>
<td>Hansson, Chotai, &amp; Bodlund</td>
<td>Patients' beliefs about the cause of their depression</td>
<td>Sweden</td>
<td>Open-ended questions and statistical analysis of the results</td>
<td>Depression</td>
<td>Patients’ beliefs about causes of their depression affect coping strategies, their help-seeking behaviour, treatment preferences and adherence.</td>
</tr>
<tr>
<td>2011</td>
<td>Kikuchi et al.</td>
<td>Subjective recognition of adverse events with antidepressant in people with depression: A prospective study</td>
<td>Japan</td>
<td>Self-administered questionnaires; statistical analyses</td>
<td>Depressive illness</td>
<td>A prospective study to specifically investigate subjective recognition of antidepressant adverse effects</td>
</tr>
<tr>
<td>2011</td>
<td>Lynch et al.</td>
<td>Are patient beliefs important in determining adherence to treatment and outcome for depression? Development of the beliefs about depression questionnaire</td>
<td>UK</td>
<td>Cross-sectional study; Questionnaires, Leventhal’s CSM model; statistical analysis</td>
<td>Depression</td>
<td>Leventhal’s theory postulates that there are six underlying dimensions on which health beliefs are based.</td>
</tr>
<tr>
<td>2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Study Design</td>
<td>Methodology</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>---------</td>
<td>--------------</td>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>2011</td>
<td>Mahtani-Chugani &amp; Sanz</td>
<td>Users Perception of Risk and Benefits of Mood Modifying Drugs</td>
<td>Spain</td>
<td>Narrative review of qualitative research</td>
<td>Major and minor depressions</td>
<td>There are still many concerns related to the continuity of treatment and efficacy of ADs: major questions about the problem of continuing the treatment longer than recommended and, the issue of premature dropouts.</td>
</tr>
<tr>
<td>2011</td>
<td>Malpass et al.</td>
<td>I didn't want her to panic': unvoiced patient agendas in primary care consultations when consulting about antidepressants</td>
<td>UK</td>
<td>Qualitative: interviews; case studies; thematic analysis</td>
<td>Depression</td>
<td>The study aimed to recruit patients with a range of experiences and preferences regarding treatment for depression, and to include patients with varying prior experiences of depression.</td>
</tr>
<tr>
<td>2011</td>
<td>Mergl et al.</td>
<td>Are treatment preferences relevant in response to serotogenic antidepressants and CBT in depressed primary care patients? Results from a RCT including a patients' choice arm</td>
<td>Germany</td>
<td>Randomized, placebo-controlled trial</td>
<td>Depression</td>
<td>Depressed patients receiving their preferred treatment responded significantly better than those who did not receive their preferred therapy.</td>
</tr>
<tr>
<td>2011</td>
<td>Mounce, S.</td>
<td>The lived experiences of women with postpartum depression and medicine.</td>
<td>USA</td>
<td>Dissertation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Study Design</td>
<td>Topic</td>
<td>Findings</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>--------------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td>2011</td>
<td>Rizo et al.</td>
<td>A rapid, Web-based method for obtaining patient views on effects and side-effects of antidepressants</td>
<td>Canada</td>
<td>Report of systematic search of many URLs</td>
<td>Depression</td>
<td>There are several reasons for developing a rapid Internet-based method for obtaining and interpreting patients views and self-reports on the efficacies and side-effects of antidepressants.</td>
</tr>
<tr>
<td>2011</td>
<td>Sanyal et al.</td>
<td>The utilization of antidepressants and benzodiazepines among people with MD in Canada</td>
<td>Canada</td>
<td>Data drawn from 2002 Canadian Community Health Survey; statistical analysis</td>
<td>Major depressive episode</td>
<td>Clinical guidelines recommend monotherapy with ADs; polypharmacy with benzodiazepines remains an issue.</td>
</tr>
<tr>
<td>2011</td>
<td>Schofield et al.</td>
<td>Patients’ views of antidepressants: from first experiences to becoming expert</td>
<td>UK</td>
<td>Qualitative interview study; qualitative analysis</td>
<td>Depression; mixed depression &amp; anxiety</td>
<td>A wide range of factors that helped shape patients’ decisions about whether or not to take, and continue with AD medication</td>
</tr>
<tr>
<td>2011</td>
<td>Sennfeld et al.</td>
<td>Bupropion in the treatment of MDD in real-life practice</td>
<td>Portugal</td>
<td>Qualitative: case reports; discussion</td>
<td>MDD</td>
<td>Bupropion is a second generation AD drug that inhibits reuptake of dopamine and norepinephrine and has no direct serotogenic effects.</td>
</tr>
<tr>
<td>2011</td>
<td>Sun et al.</td>
<td>Mediating roles of adherence attitude and patient education on antidepressant use in patients with depression</td>
<td>Taiwan</td>
<td>Cross-sectional study design</td>
<td>Depression</td>
<td>To examine the role of adherence attitude to ADs and patients’ education as mediators.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Study Design</td>
<td>Data Source</td>
<td>Diagnosis/Issue</td>
</tr>
<tr>
<td>-------</td>
<td>------------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2011</td>
<td>Sundell et al.</td>
<td>Antidepressant utilization patterns and mortality in Swedish men and women aged 24-30 years</td>
<td>Sweden</td>
<td>Data on purchased medicines from the Swedish Prescribed Drug Register; statistical analysis</td>
<td>Depression</td>
<td>To compare AD utilization patterns and mortality in relation to AD use in patients aged 20-34 years</td>
</tr>
<tr>
<td>2011</td>
<td>Tallon et al.</td>
<td>Involving patients with depression in research: survey of patients' attitudes to participation</td>
<td>UK</td>
<td>Data from trial database; qualitative analysis; coding themes and subthemes + statistical analysis</td>
<td>Depression</td>
<td>Recruitment to RCTs is often difficult in primary care, and particularly in mental health research.</td>
</tr>
<tr>
<td>2011</td>
<td>van Geffen et al.</td>
<td>The decision to continue or discontinue treatment: experiences and beliefs of users of SSRIs in the initial months-A qualitative study</td>
<td>The Netherlands</td>
<td>Semi-structured qualitative interview study; audiotaped and transcribed verbatim</td>
<td>To explore the experiences and beliefs of SSRI users in relation to initiation and execution of treatment</td>
<td>Feelings of psychological dependency on the AD and denial of the disease, rather than side effects, were seen as the underlying reasons for nonadherence</td>
</tr>
<tr>
<td>2011</td>
<td>Vlahiotis et al.</td>
<td>Discontinuation rates and health care costs in adult patients starting generic versus brand SSRI or SNRI antidepressants in commercial health plans.</td>
<td>USA</td>
<td>Cohort study, observational design; statistical analysis</td>
<td>Depression and anxiety disorders</td>
<td>There are suggestions that some generic antidepressants are not as safe or effective as the brand alternatives</td>
</tr>
<tr>
<td>2012</td>
<td>Aikens &amp; Klinkman</td>
<td>Changes in patients’ beliefs about their antidepressant during the acute phase of depression treatment</td>
<td>USA</td>
<td>Multi-stage trial; statistical analysis</td>
<td>Unipolar major depression</td>
<td>Citalopram; tested medication beliefs in relation to adherence, side effects, and response during the acute phase of treatment</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Study Design</td>
<td>Domain</td>
<td>Methods</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>--------------</td>
<td>--------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2012</td>
<td>Al-Jumah &amp; Qureshi</td>
<td>Impact of pharmacist interventions on patients' adherence to antidepressants and patient-reported outcomes: a systematic review</td>
<td>Saudi Arabia</td>
<td>Systematic review</td>
<td>Depressive illness</td>
<td>To explore different types of pharmacists interventions used in order to enhance patients’ adherence to ADs</td>
</tr>
<tr>
<td>2012</td>
<td>Alderson et al.</td>
<td>How patients understand depression associated with chronic physical disease - a systematic review</td>
<td>UK</td>
<td>Mixed-method systematic review; thematic analysis</td>
<td>Depression</td>
<td>A narrative synthesis of qualitative and quantitative data</td>
</tr>
<tr>
<td>2012</td>
<td>Baumeister, H.</td>
<td>Inappropriate prescriptions of antidepressant drugs in patients with subthreshold to mild depression: Time for the evidence to become practice</td>
<td>USA</td>
<td>Narrative review</td>
<td>Subthreshold and mild depression</td>
<td>Researchers continue to judge the prescription of ADs for subthreshold and mild depression as adequate treatment</td>
</tr>
<tr>
<td>2012</td>
<td>Berkowitz et al.</td>
<td>Vicarious experience affects patients’ treatment preferences for depression</td>
<td>USA</td>
<td>RCT</td>
<td>Depression</td>
<td>Both, personal past experiences and the experiences of others can significantly affect attitudes toward treatment</td>
</tr>
<tr>
<td>2012</td>
<td>Buus, Johannessen, &amp; Stage</td>
<td>Explanatory models of depression and treatment adherence to antidepressant medication: A qualitative interview study</td>
<td>Denmark</td>
<td>In-depth, qualitative interviews; illness narratives; thematic and statistical analysis</td>
<td>Depression</td>
<td>To gain detailed insight into patients’ personal accounts of depression</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Study Type</td>
<td>Groups</td>
<td>Data Collection</td>
</tr>
<tr>
<td>------</td>
<td>-----------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>---------</td>
<td>------------</td>
<td>--------</td>
<td>-----------------</td>
</tr>
<tr>
<td>2012</td>
<td>Cru et al.</td>
<td>Duration and compliance with antidepressant treatment in immigrant and native-born populations in Spain: a four year follow-up descriptive study</td>
<td>Spain</td>
<td>Retrospective cohort study; statistical analysis</td>
<td>Mental illness</td>
<td>Cultural identities of immigrant patients and their previous experiences of mental illness affect their ability to understand, accept and believe in the benefits of treatment</td>
</tr>
<tr>
<td>2012</td>
<td>Dunlop et al.</td>
<td>Depression beliefs, treatment preference, and outcomes in a randomized trial for MDD</td>
<td>USA</td>
<td>RCT; statistical analysis</td>
<td>MDD</td>
<td>CBT; escitalopram; tested associations btw. beliefs and preferences, beliefs and outcomes, and preferences and outcomes</td>
</tr>
<tr>
<td>2012</td>
<td>Fawzi et al.</td>
<td>Beliefs about medications predict adherence in older adults</td>
<td>Egypt</td>
<td>Multiple study measures: GAM, MARS; statistical analysis</td>
<td>ICD-10 depressive disorder</td>
<td>To investigate the variables associated with adherence to ADs in older Egyptians</td>
</tr>
<tr>
<td>2012</td>
<td>Hansen &amp; Cabassa</td>
<td>Pathways to depression care: Help-seeking experiences of low-income Latinos with diabetes and depression</td>
<td>USA</td>
<td>Qualitative</td>
<td>Depression</td>
<td>Adherence to depression care focused on interpersonal aspects of care, evaluated symptom relief, and improved functioning.</td>
</tr>
<tr>
<td>2012</td>
<td>Hansson, Chotai, &amp; Bodlund</td>
<td>What made me feel better? Patients’ own explanations for the improvement of their depression</td>
<td>Sweden</td>
<td>Questionnaire; HADS, GAF, Contactus programme; statistical analysis</td>
<td>Depression</td>
<td>To investigate previously depressed patients’ beliefs about the cause of their improvement</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Location</td>
<td>Study Type</td>
<td>Study Population</td>
<td>Outcomes/Findings</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>----------</td>
<td>------------</td>
<td>------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>2012</td>
<td>Himmerich &amp; Wranik</td>
<td>Choice of treatment with antidepressants: Influencing factors</td>
<td>Germany</td>
<td>Systematic review</td>
<td>Unipolar depressive disorders</td>
<td>The choice of treatment is based on the variety of factors: illness and treatment characteristics, patient, physician and settings characteristics, decision supports and pharmaco-economic aspects. Hypothesis that clinical, individual and contextual factors are the three major groups of factors influencing AD treatment decision has to be evaluated in future studies.</td>
</tr>
<tr>
<td>2012</td>
<td>Houle et al.</td>
<td>Treatment preferences in patients with first episode depression</td>
<td>Canada</td>
<td>Treatment acceptability and preferences measures; statistical analysis</td>
<td>Depression</td>
<td>The first study examining treatment preferences of persons with newly diagnosed first episode Study revealed an association btw. level of education and treatment preference. Physicians should make every effort to discuss treatment options with patients presenting mild to moderate symptoms.</td>
</tr>
<tr>
<td>2012</td>
<td>Jylhä et al.</td>
<td>Do antidepressants change personality? - A five year observational study</td>
<td>Finland</td>
<td>Observational and naturalistic study; interviews; statistical analysis</td>
<td>MDD; a variety of ADs were used</td>
<td>No evidence found for a clinically significant covariation of AD pharmacotherapy with neuroticism or extraversion scores Scores of neuroticism decreased and those of extraversion increased as scores of depression decreased. Investigate the possibility of a single drug having a drug-specific pattern of covariation (suggested by U.P). Authors’ indications not found here</td>
</tr>
<tr>
<td>2012</td>
<td>Kikuchi et al.</td>
<td>Coping strategies for antidepressant side effects: An Internet survey</td>
<td>Japan</td>
<td>Web-survey; statistical analysis, SPSS</td>
<td>Depression</td>
<td>milnacipran, fluvoxamine, paroxetine, sertraline, amitriptyline, amoxapine, clomipramine, dosulepin, imipramine, nortriptyline, trimipramine, lithium carbonate, maprotiline, mianserin, setiptiline, sulpiride, trazodone Patients use various ways in alleviating ADs side effects. Some effects such as sexual dysfunction and fatigue may not be amenable to subjective coping efforts. Future studies are advised to disentangle various elements involved in subjective perception of side effects and coping strategies</td>
</tr>
<tr>
<td>2012</td>
<td>Knudsen et al.</td>
<td>Changes in self-concept while using SSRI antidepressants</td>
<td>Denmark</td>
<td>Qualitative, interviews, narrative analysis</td>
<td>Depression</td>
<td>SSRIs The extent to which the findings can be generalized cannot be concluded. The women’s self-concept during the use of SSRI was closely related to their social lives Further studies be made with other age groups and for men, in other contexts and cultures</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Type</td>
<td>Summary</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
<td>---------------------------------</td>
<td>---------</td>
<td>------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>LeClair, A. M.</td>
<td>Medicated life in the pharmaceutical era: mental health, antidepressants &amp; young adult identity</td>
<td>USA</td>
<td>Dissertation</td>
<td>Systemic inflammation does contribute to depression. Over the long run, antidepressants contribute to inflammation. The recognition that depression is an inflammatory disease ushers in a wealth of new possibilities for treating and preventing mood disorders.</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>Littrell, J.L.</td>
<td>Taking the perspective that a depressive state reflects inflammation: Implications for the use of antidepressants</td>
<td>USA</td>
<td>Review</td>
<td>Overall belief in the harmfulness of ADs for depression decreased between 1995 and 2011. Greater knowledge of the characteristics of those who believe in the harmfulness of ADs may assist clinicians in their efforts to engage and counsel patients with depression. Education about the role of ADs in the treatment of depression should focus on males and those from non-English speaking background.</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>Murata et al.</td>
<td>Risk factors for drug nonadherence in antidepressant-treated patients and implications of pharmacist adherence instructions for adherence improvement</td>
<td>Japan</td>
<td>DAI-10 scale to measure patient’s subjective responses to treatment; statistical analysis</td>
<td>Systemic inflammation does contribute to depression. Over the long run, antidepressants contribute to inflammation. The recognition that depression is an inflammatory disease ushers in a wealth of new possibilities for treating and preventing mood disorders. Patients with melancholic depression were significantly more non-adherent with AD medication than patients with other types of depression. Pharmacist adherence instruction can ameliorate AD non-adherence.</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>Partridge, Lucke, &amp; Hall</td>
<td>Public attitudes towards the acceptability of using drugs to treat depression and ADHD</td>
<td>Australia</td>
<td>Survey; statistical analysis</td>
<td>Systemic inflammation does contribute to depression. Over the long run, antidepressants contribute to inflammation. The recognition that depression is an inflammatory disease ushers in a wealth of new possibilities for treating and preventing mood disorders. Patients with melancholic depression were significantly more non-adherent with AD medication than patients with other types of depression. Pharmacist adherence instruction can ameliorate AD non-adherence.</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>Reavley &amp; Jorm</td>
<td>Belief in the harmfulness of antidepressants: Associated factors and change over 16 years</td>
<td>Australia</td>
<td>Surveys; statistical analysis</td>
<td>Systemic inflammation does contribute to depression. Over the long run, antidepressants contribute to inflammation. The recognition that depression is an inflammatory disease ushers in a wealth of new possibilities for treating and preventing mood disorders. Patients with melancholic depression were significantly more non-adherent with AD medication than patients with other types of depression. Pharmacist adherence instruction can ameliorate AD non-adherence.</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Key Topics</td>
<td>Findings</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>-------------</td>
<td>-------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2012</td>
<td>Seekles et al.</td>
<td>Personality and perceived need for mental health care among primary care patients</td>
<td>The Netherlands</td>
<td>Cross-sectional data from NESDA; statistical analysis</td>
<td>DSM-IV diagnoses of anxiety and/or depression</td>
<td>Patients with higher level of openness to experience were more likely to seek help. Personality traits are important in help-seeking behavior. These new findings suggest that people with different traits need different types of treatment.</td>
</tr>
<tr>
<td>2012</td>
<td>Singh et al.</td>
<td>Antidepressant use amongst college students: Findings of a phenomenological study</td>
<td>USA</td>
<td>Qualitative: longitudinal, phenomenological research methodology</td>
<td>Depression</td>
<td>Students wanted to be the ‘player’ in their treatment decisions and needed to be acknowledged as such by their care providers. Overall, the underlying essential theme of ‘autonomy’ was portrayed by the students in their accounts of depression treatment and treatment decision making.</td>
</tr>
<tr>
<td>2012</td>
<td>Vega et al.</td>
<td>Differences in depressed oncologic patients' narratives after receiving two different therapeutic interventions for depression: a qualitative study</td>
<td>Spain</td>
<td>Qualitative: grounded theory; videotaped focus groups; ATLAS software</td>
<td>Depression; cancer</td>
<td>Self-medication appeared to be frequent, with little understanding of how the drugs work; patients took ADs when they feeling down. Qualitative analysis is an efficient method of examining the meaning of quantitative results in depth, particularly patients’ perspectives on quality of life.</td>
</tr>
<tr>
<td>2012</td>
<td>Zimmerman et al.</td>
<td>Symptoms differences between depressed outpatients who are in remission according to the HAMD who do not consider themselves to be in remission</td>
<td>USA</td>
<td>Interviews; statistical analysis</td>
<td>DSM-IV MDD, HAMD, CUDOS</td>
<td>Depressed patients’ perception of their remission status impacts their desire for a modification in their treatment. High rates of residual symptoms were found in patients who were considered to be in remission. Generalizability to samples with different demographic characteristics needs to be demonstrated.</td>
</tr>
<tr>
<td>2012</td>
<td>Acosta, Rodriguez, &amp; Cabrera</td>
<td>Beliefs about depression and its treatments: Associated variables and the influence of beliefs on adherence to treatment</td>
<td>Spain</td>
<td>BMQ, DAI,</td>
<td>Depression</td>
<td>Beliefs and attitudes towards medication potentially influence adherence and should be evaluated in all patients. Given that beliefs and attitudes are changeable, influenced by various factors, they should be assessed throughout the progress of the illness. The search for the best possible adherence strategy should take place in the context of a good therapeutic relationship and psychoeducation.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors/Title</td>
<td>Country</td>
<td>Study Method/Design</td>
<td>Description</td>
<td>Contribution</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
<td>---------</td>
<td>---------------------</td>
<td>-------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>Aggarval et al.</td>
<td>USA</td>
<td>Interviews, open-ended questionnaires, qualitative data analysis</td>
<td>This is the first study to report implementation barriers to the cultural formulation of psychiatric diagnoses excluding acute suicidal ideation, intoxication, dementia, mental retardation or florid psychosis.</td>
<td>This paper points to new research directions based on clinically applied medical anthropology and cultural psychiatry.</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>Agyapong V.I.O.</td>
<td>Ireland</td>
<td>Review</td>
<td>Depression and AUD co-occur at levels greater than expected by chance in clinical and epidemiological samples.</td>
<td>Treatment must involve multiple interventions, including the use of antidepressants and other pharmacological and psychological therapies.</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>Anderson &amp; Roy</td>
<td>UK</td>
<td>Qualitative: qualitative analysis of 80 in-depth interviews</td>
<td>ADs appear to occupy a central place in many people’s lives.</td>
<td>People’s experiences with ADs use have a major impact on treatment continuation and treatment outcome.</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>Balan, Moyers, &amp; Lewis-Fernandez</td>
<td>USA</td>
<td>Review /commentary</td>
<td>Motivational pharmacotherapy integrates motivational interviewing into psychopharmacology sessions in order to increase treatment adherence.</td>
<td>Motivational pharmacotherapy results in a patient-clinician interaction that is more patient-centered, collaborative, and personalized than standard psycho-pharmacology.</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Findings</td>
<td>Implications</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td>2013</td>
<td>Bet et al.</td>
<td>Side effects of antidepressants during long-term use in a naturalistic setting</td>
<td>The Netherlands</td>
<td>Naturalistic (NESDA) cohort study; statistical analysis</td>
<td>Depression and co-morbid depression</td>
<td>Side effects are usually underreported in clinical trials and large scale naturalistic studies are restricted to 6 months of use</td>
</tr>
<tr>
<td>2013</td>
<td>Coppens et al.</td>
<td>Public attitudes toward depression and help-seeking in four European countries baseline survey prior to the OSPI-Europe intervention</td>
<td>Multi-cultural: 4 European countries</td>
<td>Survey, statistical analysis</td>
<td>Depression</td>
<td>Findings indicate a moderate degree of personal stigma toward depression and help-seeking.</td>
</tr>
<tr>
<td>2013</td>
<td>Corruble et al.</td>
<td>Efficacy of agomelatine and escitalopram on depression, subjective sleep and emotional experiences in patients with MDD: a 24-wk double-blind RCT</td>
<td>Multi-country</td>
<td>Double-blind, international, randomised study; statistical analysis</td>
<td>Moderate to severe MDE in a context of MDD</td>
<td>Agomelatine; escitalopram; placebo; emotional blunting</td>
</tr>
<tr>
<td>2013</td>
<td>DeJean et al.</td>
<td>Patient experiences of depression and anxiety with chronic disease: A systematic review and qualitative meta-synthesis</td>
<td>Canada</td>
<td>Systematic review and qualitative meta-synthesis</td>
<td>Depression, anxiety; chronic conditions</td>
<td>Patients may be reluctant to acknowledge depression or anxiety as separate condition</td>
</tr>
<tr>
<td>2013</td>
<td>Fullagar &amp; O’Brien</td>
<td>Problematizing the neurochemical subject of anti-depressant treatment: The limits of biomedical responses to women’s emotional distress</td>
<td>Australia</td>
<td>Qualitative: empirical; feminist approach; discourse analysis</td>
<td>Depression</td>
<td>Critique of scientific and market oriented rationalities underpinning neurochemical recovery that ignore the social conditions that enable the self to change</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Study Title</td>
<td>USA</td>
<td>Methods</td>
<td>Findings</td>
<td>Implications</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------------</td>
<td>-----</td>
<td>---------</td>
<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td>2013</td>
<td>Garrido &amp; Boockvar</td>
<td>Perceived symptom targets of antidepressants, anxiolytics, and sedatives: The search for modifiable factors that improve adherence</td>
<td>USA</td>
<td>Survey, statistical analysis</td>
<td>Mood-disorders; MDD, anxiety, comorbid physical conditions</td>
<td>Identifying modifiable factors, such as beliefs, may improve adherence to mood disorder medications</td>
</tr>
<tr>
<td>2013</td>
<td>Gaudiano, Hughes, &amp; Miller</td>
<td>Patients' treatment expectancies in clinical trials of antidepressants versus psychotherapy for depression: a study using hypothetical vignettes</td>
<td>USA</td>
<td>Vignettes, questionnaires; statistical analysis ANOVA</td>
<td>BDI II depression</td>
<td>Depressed patients read vignettes describing hypothetical clinical trials of ADs vs. placebo, ADs vs ADs, and psychotherapy vs. psychotherapy</td>
</tr>
<tr>
<td>2013</td>
<td>Glattaker, Heyduck, &amp; Meffert</td>
<td>Illness beliefs and treatment beliefs as predictors of short and middle term outcome in depression</td>
<td>Germany</td>
<td>Prospective cohort study; statistical analysis</td>
<td>ICD 10 MDE, recurrent depressive disorder</td>
<td>Investigating illness beliefs in people with depression might be less relevant because mood may influence illness and treatment beliefs</td>
</tr>
<tr>
<td>2013</td>
<td>Kales et al.</td>
<td>Racial differences in adherence to antidepressant treatment in later life</td>
<td>USA</td>
<td>Prospective, observational study; interviews at baseline; statistical analysis</td>
<td>Clinically significant depression</td>
<td>No differences found in baseline function with the exception of the executive function. White subjects had less impairment</td>
</tr>
<tr>
<td>2013</td>
<td>Lewis-Fernandez et al.</td>
<td>Impact of motivational pharmacotherapy on treatment retention among depressed Latinos</td>
<td>USA</td>
<td>Intervention/Treatment/sessions; Motivational Interviewing Training; statistical analysis</td>
<td>DSM-IV MDD</td>
<td>U.S. racial/ethnic minority groups show higher non-adherence with outpatient AD therapy</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Location</td>
<td>Methodology</td>
<td>Condition</td>
<td>Conclusion</td>
</tr>
<tr>
<td>------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2013</td>
<td>Liekens et al.</td>
<td>Instructional design and assessment. A depression training session with consumer educators to reduce stigmatizing views and improve pharmacists' depression care attitudes and practices</td>
<td>Belgium</td>
<td>Randomized, clustered, comparative design; statistical analysis, ANOVA</td>
<td>Depression</td>
<td>To measure the impact of a depression training day</td>
</tr>
<tr>
<td>2013</td>
<td>Misri et al.</td>
<td>Factors impacting decisions to decline or adhere to antidepressant medication in perinatal women with mood and anxiety disorders</td>
<td>Canada</td>
<td>Questionnaires, short-structured diagnostic interview; statistical analysis</td>
<td>Moderate to severe mood disorders and anxiety</td>
<td>Specific quantitative and qualitative factors in decisions to adhere or decline ADs in antenatal women with moderate to severe mood disorders and anxiety</td>
</tr>
<tr>
<td>2013</td>
<td>Moncrieff, Cohen &amp; Porter</td>
<td>The psychoactive effects of psychiatric medication: The elephant in the room</td>
<td>UK</td>
<td>Review, commentary</td>
<td>Psychiatric disorders</td>
<td>Dependence, and the need of support for people wishing to withdraw from AD medications</td>
</tr>
<tr>
<td>2013</td>
<td>Munizza et al.</td>
<td>Public beliefs and attitudes towards depression in Italy: A national survey</td>
<td>Italy</td>
<td>Tel. survey; questionnaire; statistical analysis</td>
<td>Depression</td>
<td>Barriers to the disclosure of depressive symptoms linked to concerns about ADs that are seen as potentially harmful and addictive.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methods</td>
<td>Investigation</td>
<td>Findings</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>---------</td>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td>2013</td>
<td>Ngo et al.</td>
<td>A qualitative analysis of the effects of depression and antidepressants on physical and work functioning among antiretroviral therapy clients in Uganda</td>
<td>Uganda</td>
<td>Mixed methods: Qualitative: interview, thematic analyses of narratives</td>
<td>Depression, HIV, AIDS</td>
<td>Qualitative data from the interview transcripts used to illustrate the lived experience of the participants</td>
</tr>
<tr>
<td>2013</td>
<td>Nitzan et al.</td>
<td>Consenting not to be informed. A survey on the acceptability of placebo use in the treatment of depression</td>
<td>Israel</td>
<td>Survey, questionnaire; statistical analyses with SPSS</td>
<td>Depression</td>
<td>Investigation of opinions of healthy students regarding acceptability of placebo treatment if they were to experience depression</td>
</tr>
<tr>
<td>2013</td>
<td>Park &amp; Ahn</td>
<td>Direct-to-consumer (DTC) antidepressant advertising and consumer misperceptions about the chemical imbalance theory of depression: The moderating role of scepticism</td>
<td>USA</td>
<td>Survey online; statistical analysis</td>
<td>Depression</td>
<td>Exposure to direct-to-consumer advertising of ADs may shape common misperceptions about the chemical imbalance theory</td>
</tr>
<tr>
<td>2013</td>
<td>Patel et al.</td>
<td>An exploration of illness beliefs in mothers with postnatal depression</td>
<td>UK</td>
<td>Qualitative: face-to-face, semi-structured interviews</td>
<td>Postnatal depression PND</td>
<td>Illness beliefs: unmet expectations, identifying stressors in their life context, antidepressants, uncertain futures, etc.</td>
</tr>
<tr>
<td>2013</td>
<td>Pilkington, Reavley, &amp; Jorm</td>
<td>The Australian public's beliefs about the causes of depression: Associated factors and changes over 16 years</td>
<td>Australia</td>
<td>2011 national survey; statistical analysis</td>
<td>Depression</td>
<td>Biological conceptualizations of depression are increasingly prevalent</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methods</td>
<td>Diagnosis</td>
<td>Findings</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>---------</td>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>2013</td>
<td>Simon, Peterson, &amp; Hubbard</td>
<td>Is treatment adherence consistent across time, across different treatments and across diagnoses?</td>
<td>USA</td>
<td>Data extracted from electronic medical records; statistical analysis</td>
<td>Depression</td>
<td>Data analyses examined individual patients’ consistency of adherence behavior for the same and to a different depression treatment</td>
</tr>
<tr>
<td>2013</td>
<td>Torres-Lopez et al.</td>
<td>Follow up of patients who start treatment with antidepressants: treatment satisfaction, treatment compliance, efficacy and safety</td>
<td>Spain</td>
<td>Proposal for observational longitudinal cohort study; statistical analysis</td>
<td>Depression</td>
<td>AD prescription in the primary care setting by evaluating compliance, clinical effectiveness, safety, and treatment satisfaction</td>
</tr>
<tr>
<td>2013</td>
<td>Treuer et al.</td>
<td>Use of antidepressants in the treatment of depression in Asia: Guidelines, clinical evidence, and experience revisited</td>
<td>6 Asian countries</td>
<td>Evaluation of the current use of AD treatment based on review of treatment guidelines, publications, and local clinical experience</td>
<td>MDD</td>
<td>Appropriate use of SSRIs in the personalized treatment of MDD</td>
</tr>
<tr>
<td>2013</td>
<td>Vilhelmson, Svensson, &amp; Meeuwisse</td>
<td>A pill for the ill? Patients' reports of their experience of the medical encounter in the treatment of depression</td>
<td>Sweden</td>
<td>Internet-based reports; narrative experience, qualitative content analysis</td>
<td>Depression</td>
<td>A biochemical understanding of mental ill health may win as it relieves people of responsibility for their circumstances; can result in a sense of powerlessness</td>
</tr>
<tr>
<td>2013</td>
<td>Wittink et al.</td>
<td>Towards personalizing treatment for depression</td>
<td>USA</td>
<td>Internet based questionnaire; statistical analysis</td>
<td>Depression</td>
<td>To describe and demonstrate a method to develop</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Study Type &amp; Analysis</td>
<td>Diagnosis</td>
<td>Key Findings</td>
</tr>
<tr>
<td>------</td>
<td>-------------------</td>
<td>-----------------------------------------------------------------------</td>
<td>---------</td>
<td>-----------------------</td>
<td>-----------</td>
<td>-----------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2013</td>
<td>Yang et al.</td>
<td>Response to antidepressants in MDD with melancholic features</td>
<td>South Korea</td>
<td>Observational, statistical analysis</td>
<td>DSM-IV MDD with and without melancholic features</td>
<td>SSRI The findings suggest a faster and more evident response to pharmacotherapy in melancholia compared to other depressive syndromes, particularly with SSRI</td>
</tr>
<tr>
<td>2014</td>
<td>Aljuma, Hassali, &amp; AlQhatani</td>
<td>Examining the relationship between adherence and satisfaction with antidepressant treatment</td>
<td>Saudi Arabia</td>
<td>Observational, non-experimental survey; statistical analysis</td>
<td>DSM-IV MDD</td>
<td>General patient overuse and harm beliefs showed a direct positive correlation with the side effects domain</td>
</tr>
<tr>
<td>2014</td>
<td>Bosman et al.</td>
<td>Adherence of antidepressants during pregnancy: MEMS compared with three other methods</td>
<td>The Netherlands</td>
<td>Observational study; statistical analysis (logistic regression); MEMS</td>
<td>MDD during pregnancy</td>
<td>Searching for an inexpensive and easy method to implement daily for assessing medication adherence during pregnancy</td>
</tr>
<tr>
<td>2014</td>
<td>Burnett-Zeigler et al.</td>
<td>The association between race and gender, treatment attitudes, and antidepressant treatment adherence</td>
<td>USA</td>
<td>Assessment with depression and adherence scales HADS-A, ASI-R; statistical analysis</td>
<td>Clinically significant depression</td>
<td>Examined the associations btw. treatment attitudes and beliefs with race/gender differences in AD adherence</td>
</tr>
<tr>
<td>2014</td>
<td>Buus, N.</td>
<td>Adherence to antidepressant medication: A medicine-taking career</td>
<td>Denmark</td>
<td>Qualitative: Prospective semi-structured interview study based on an interactionist conception and data were analysed thematically</td>
<td>Study of medicine taking is controversial as it often reveals a discrepancy btw. health care professionals’ advice and patients’ actual behavior.</td>
<td>Healthcare professionals played a very peripheral role in most participants’ lives, and that unsatisfactory interactions often isolated participants and left them to solve their own problem. Healthcare professionals are challenged to expand their traditional role as therapists and accept and accompany patients who would otherwise be alone in their search for solutions</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Mental Health Condition</td>
<td>Research Focus</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>-------------</td>
<td>------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2014</td>
<td>Cabassa et al.</td>
<td>Primary health care experiences of Hispanics with serious mental illness: a mixed-method study</td>
<td>USA</td>
<td>Mixed-methods: focus groups, structured patient interviews; statistical analysis, triangulation</td>
<td>Serious mental illness SMI</td>
<td>The patient’s Hispanic identity can also activate other clinicians’ biases, i.e. the unexamined assumption that the patient’s physical complains are somatization of psychological problems</td>
</tr>
<tr>
<td>2014</td>
<td>De las Cuevas, Penate, &amp; Sanz</td>
<td>Risk factors for non-adherence to antidepressant treatment in patients with mood disorders</td>
<td>Spain</td>
<td>Scales and subscales, questionnaires; statistical analysis ANOVA</td>
<td>Depressive disorders</td>
<td>Adherence to prescribed psychotropic medications is relevant given that diagnosis of mental disorder is well established</td>
</tr>
<tr>
<td>2014</td>
<td>Dickson, Matthew E.</td>
<td>Expectations and beliefs associated with different treatment modalities for depression.</td>
<td>USA</td>
<td>Dissertation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>Elnazer &amp; Baldwin</td>
<td>Treatment with citalopram, but not with agomelatine, adversely affects sperm parameters: a case report and translational review</td>
<td>UK</td>
<td>Case report and translational review</td>
<td>Mixed depressive &amp; anxiety disorder; citalopram, agomelatine</td>
<td>Investigations of the effects of antidepressant drug administration on sperm production; possible underlying mechanisms.</td>
</tr>
<tr>
<td>2014</td>
<td>Fosgerau &amp; Davidsen</td>
<td>Patients' perspectives on antidepressant treatment in consultation with physicians</td>
<td>Denmark</td>
<td>Qualitative: video recording, conversation analysis</td>
<td>Depression</td>
<td>Patients were more likely to express their perspectives on medications in consultations with GPs than with psychiatrists.</td>
</tr>
<tr>
<td>2014</td>
<td>Gibson, Cartwright, &amp; Read</td>
<td>Patient-centered perspectives on antidepressant use</td>
<td>New Zealand</td>
<td>A narrative review</td>
<td>Depression</td>
<td>High rates of ADs prescribing in Western countries have coincided with increasing doubts about their effectiveness</td>
</tr>
<tr>
<td>2014</td>
<td>Hartley et al.</td>
<td>Narratives reflecting the lived experiences of people with brain disorders: Common psychosocial difficulties and determinants</td>
<td>UK</td>
<td>First person narratives from 6 focus groups and 77 qualitative studies</td>
<td>7 brain disorders: AD, depression, epilepsy, MS, Parkinson’s disease, schizophrenia, stroke</td>
<td>The strength of the methodology and the narratives provide the opportunity for the reader to empathise with people with brain disorders</td>
</tr>
<tr>
<td>2014</td>
<td>Izquierdo et al.</td>
<td>Older depressed Latinos' experiences with primary care visits for personal, emotional and/or mental health problems: a qualitative analysis</td>
<td>USA</td>
<td>Qualitative, grounded theory analysis</td>
<td>Depression</td>
<td>To describe the salient themes that emerged when older depressed Latinos discussed their experiences of their primary care visit for emotional, personal or mental health problems</td>
</tr>
<tr>
<td>2014</td>
<td>Jaffray et al.</td>
<td>Why do patients discontinue antidepressant therapy early? A qualitative study</td>
<td>UK</td>
<td>Qualitative : interviews audio-recorded and transcribed verbatim</td>
<td>Depression</td>
<td>Patients’ views on ADs are influenced by their perceptions of ownership, knowledge and support</td>
</tr>
<tr>
<td>2014</td>
<td>Jumah et al.</td>
<td>Factors associated with adherence to medication among depressed patients from Saudi Arabia: a cross-sectional study</td>
<td>Saudi Arabia</td>
<td>Non-experimental cross-sectional design; statistical analysis</td>
<td>MDD</td>
<td>Low adherence to AD medication and severity of depression had a negative correlation</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Location</td>
<td>Type of Study</td>
<td>Topic</td>
<td>Depressant Effectiveness</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>----------</td>
<td>---------------</td>
<td>-------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>2014</td>
<td>Katona, Bindman, &amp; Katona</td>
<td>Antidepressants for older people: What can we learn from the current evidence base?</td>
<td>UK</td>
<td>Review</td>
<td>Depression</td>
<td>How effective are antidepressants in older people?</td>
</tr>
<tr>
<td>2014</td>
<td>Kirino, Eiji</td>
<td>Escitalopram for the management of MDD: a review of its efficacy, safety, and patient acceptability</td>
<td>Japan</td>
<td>Review</td>
<td>MDD</td>
<td>SSRI, escitalopram</td>
</tr>
<tr>
<td>2014</td>
<td>Lafrance, M.N.</td>
<td>Depression as oppression: Disrupting the biomedical discourse in women's stories of sadness.</td>
<td>Canada</td>
<td>Re-analysis of interviews previously collected for studies from 2006 and 2007, 2009</td>
<td>Depression</td>
<td>The superficiality of medication as solution, and the readiness with which ADs are prescribed, was described by several participants</td>
</tr>
<tr>
<td>2014</td>
<td>Lam &amp; Sun</td>
<td>Stigmatizing opinions of Chinese toward different types of mental illnesses: A qualitative study in Hong Kong</td>
<td>Hong Kong</td>
<td>Qualitative: Focus group interview, audio-taped, transcribed verbatim</td>
<td>Mental illness: depression, mania, bipolar disorders, schizophrenia</td>
<td>For depression, it was usually regarded as a minor psychological problem which many people suffered from in life</td>
</tr>
<tr>
<td>2014</td>
<td>Mikocka-Walus &amp; Andrews</td>
<td>Attitudes toward antidepressants among people living with inflammatory bowel disease: An online Australia-wide survey</td>
<td>Australia</td>
<td>Cross-sectional online survey; descriptive statistics; simple content analysis</td>
<td>Mental health problems comorbid with IBD</td>
<td>ADs; inflammatory bowel disease due to the widespread evidence that ADs may improve immuno-regulatory activity</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Topic</td>
<td>Findings</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td>2014</td>
<td>Moradveisi et al.</td>
<td>The influence of patients’ preference/attitude towards psychotherapy and antidepressant medication on the treatment of MDD</td>
<td>Iran</td>
<td>Study conducted in Iran</td>
<td>MDD</td>
<td>High scores on psychotherapy preference vs ADs attitude predicted dropout from ADs. Patients’ preferences and attitudes toward depression treatment influence dropout from ADs.</td>
</tr>
<tr>
<td>2014</td>
<td>Powell, Overton, &amp; Simpson</td>
<td>The revolting self: An interpretative phenomenological analysis of the experience of self-disgust in females with depressive symptoms</td>
<td>UK</td>
<td>Qualitative: interviews and Interpretative Phenomenological Analysis</td>
<td>Depression</td>
<td>Self-disgust is a consuming negative psychological phenomenon, associated with depression, problems with eating, physical appearance, interpersonal relationships, and self-persecution.</td>
</tr>
<tr>
<td>2014</td>
<td>Ramirez &amp; Badger</td>
<td>Men navigating inward and outward through depression</td>
<td>USA</td>
<td>Grounded theory study</td>
<td>Depression in men</td>
<td>Understanding depression in men remains poor. Depression in men is underdiagnosed.</td>
</tr>
<tr>
<td>2014</td>
<td>Read, Carthwright, &amp; Gibson</td>
<td>Adverse emotional and interpersonal effects reported by 1829 New Zealanders while taking antidepressants</td>
<td>New Zealand</td>
<td>Questionnaire; the study fully relied on self-report; statistical analysis</td>
<td>Depression</td>
<td>The adverse effects of ADs are many and varied and are experienced by very high percentages of ADs recipients. The overrepresentation of women (76.6%) is not of great concern as women are prescribed ADs at approx. twice the rate as men internationally.</td>
</tr>
<tr>
<td>2014</td>
<td>Read et al.</td>
<td>Beliefs of people taking antidepressants about causes of depression and reasons for increased prescribing rates</td>
<td>New Zealand</td>
<td>Online survey; statistical analysis</td>
<td>Depression</td>
<td>17 causal beliefs were most frequently endorsed. Factor analysis produced 3 factors: bio-genetic, adulthood stress, childhood adversity. Clinicians should consider exploring patients’ causal beliefs. The public, even when taking ADs, continues to hold a multi-factorial causal model of depression with a primary emphasis on psycho-social causes.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Study Design/Methodology</td>
<td>Findings</td>
<td>Implications</td>
</tr>
<tr>
<td>------</td>
<td>-----------------</td>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>-----------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2014</td>
<td>Serrano et al.</td>
<td>Therapeutic adherence in primary care depressed patients: a longitudinal study</td>
<td>Spain</td>
<td>Observational and longitudinal study; statistical analysis with SPSS 19.0</td>
<td>Patients with a higher level of therapeutic adherence are those who have a better perception of the effects of the medication, showing earlier remission</td>
<td>The analysis of factors associated with greater adherence to AD treatment shows that personality factors and beliefs surrounding medication do not influence therapeutic compliance.</td>
</tr>
<tr>
<td>2014</td>
<td>Speerfork et al.</td>
<td>Different biogenetic causal explanations and attitudes toward persons with major depression, schizophrenia and alcohol dependence: is the concept of a chemical imbalance beneficial?</td>
<td>Germany</td>
<td>Cross-sectional study, population survey, case vignettes; statistical analysis</td>
<td>Depression, schizophrenia, alcohol dependence</td>
<td>‘Chemical imbalance of the brain’ and ‘brain disease’ were both associated with a stronger desire for social distance in schizophrenia and depression, and with more social acceptance in alcohol dependence.</td>
</tr>
<tr>
<td>2014</td>
<td>Stanners et al.</td>
<td>Depression diagnosis and treatment amongst multimorbid patients: a thematic analysis</td>
<td>Australia</td>
<td>Qualitative study: Semi-structured interviews, digitally recorded and transcribed; qualitative analysis</td>
<td>Depression and 2 or more chronic conditions</td>
<td>All participants described depression as developing subsequent to a life event that resulted in the loss of their identity.</td>
</tr>
<tr>
<td>2014</td>
<td>Tahirkheli et al.</td>
<td>Postpartum depression on the neonatal intensive care unit: current perspectives</td>
<td>USA</td>
<td>Review</td>
<td>Post-partum depression</td>
<td>The diagnosis of PPD is complicated by not only a lack of understanding but also varying definitions of the diagnosis itself.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>With larger and more diverse sample sizes, improved PPD assessment measures, and observations of mother–infant interactions, we will achieve more powerful results than those found in the current research.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Diagnostic</td>
<td>Abstract</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>2014</td>
<td>Van Grieken et al.</td>
<td>Patients' perspectives on how treatment can impede their recovery from depression</td>
<td>The Netherlands</td>
<td>Qualitative: interviews, transcripts, coding procedures and constant comparative method of analysis</td>
<td>MDD</td>
<td>This study highlights the importance of clinicians taking a more exploring role in uncovering the patients' perspective to MDD treatment. More awareness of the patients' perspective may increase treatment adherence, motivation and finally success.</td>
</tr>
<tr>
<td>2014</td>
<td>Ward, Mengesha, &amp; Issa</td>
<td>Older African American women's lived experiences with depression and coping behaviors</td>
<td>USA</td>
<td>Qualitative: phenomenology</td>
<td>Depression</td>
<td>Findings suggested all of the women endorsed use of culturally sanctioned coping behaviors such as religious coping and resilience. Research focusing on older African American women’s mental health is in an infancy stage; there is a need for more research in this area.</td>
</tr>
<tr>
<td>2014</td>
<td>Wouters et al.</td>
<td>Antidepressants in primary care: patients' experiences, perceptions, self-efficacy beliefs, and nonadherence</td>
<td>The Netherlands</td>
<td>Self-report; statistical analysis</td>
<td>Depression</td>
<td>Assessing a wide array of patients’ experiences and perceptions regarding the efficacy, side effects, and practical problems of ADs contributes to better understanding of nonadherence to ADs. Guiding physician–patient conversations about patient experiences and perceptions may reduce both intentional and unintentional nonadherence.</td>
</tr>
<tr>
<td>2014</td>
<td>Wouters et al.</td>
<td>Primary-care patients' trade-off preferences with regards to antidepressants</td>
<td>The Netherlands</td>
<td>Questionnaire; statistical analysis</td>
<td>Depression</td>
<td>Relapse prevention and symptom relief were on average equally important. Side effects were as important. For approx. one in five patients, the benefits of ADs do not outweigh their drawbacks. Longitudinal studies in which patients are enrolled at the start of the regimen are recommended.</td>
</tr>
<tr>
<td>2014</td>
<td>Wu et al.</td>
<td>Individual counseling is the preferred treatment for depression in breast cancer survivors</td>
<td>USA</td>
<td>Survey; statistical analyses</td>
<td>Breast cancer survivors; depression</td>
<td>Survivors preferred counseling for treatment of depression. Cancer centres should be prepared to provide preferred treatment methods, particularly as screening, and therefore management of psychosocial distress is to be required.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Location</td>
<td>Study Design</td>
<td>Depression</td>
<td>Major reasons for non-continuous ADs use: defaulting follow-ups, side effects, feeling improved in condition, concerns about stigma</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>-----------</td>
<td>--------------</td>
<td>------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2014</td>
<td>Yau et al.</td>
<td>Non-continuous use of antidepressant in adults with MDDs-a retrospective cohort study</td>
<td>Hong Kong</td>
<td>Retrospective cohort study; electronic patient records</td>
<td>Depression</td>
<td>Non-continuous use is an important predictor of relapse and recurrence with significant implications for long-term prognosis. The results from this study highlighted high early recurrence rate.</td>
</tr>
<tr>
<td>2015</td>
<td>Amarasuriya, Jorm, &amp; Reavley</td>
<td>Depression literacy of undergraduates in non-western developing contest: the case of Sri Lanka</td>
<td>Sri Lanka</td>
<td>Survey, vignette, questionnaire, coding open-ended questions; statistical analysis</td>
<td>DSM-IV MDD</td>
<td>A majority of undergraduates recognized the problem as a mental health problem, only 17.4% recognized it as depression</td>
</tr>
<tr>
<td>2015</td>
<td>Ambresin et al.</td>
<td>What factors influence long-term antidepressant use in primary care? Findings from the Australian diamond cohort study</td>
<td>Australia</td>
<td>Cross-sectional analysis, survey about ADs use; statistical analysis</td>
<td>Depression, PHQ-9</td>
<td>The study presents a comprehensive examination of the characteristics of long-term ADs users in primary care.</td>
</tr>
<tr>
<td>2015</td>
<td>Anderson et al.</td>
<td>Starting antidepressant use: a qualitative synthesis of UK and Australian data</td>
<td>UK/Australia</td>
<td>Qualitative interpretive approach, thematic analysis with constant comparison, NVivo</td>
<td>Depression</td>
<td>Exploring people’s experiences of starting ADs treatment. Only people willing to talk about their depression or taking ADs were interviewed and many regarded themselves as being ‘in recovery’</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Outcome(s)</td>
<td>Comments</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>2015</td>
<td>Arco, L.</td>
<td>A case study in treating chronic comorbid OCD and depression with behavioral activation and pharmacotherapy</td>
<td>Australia</td>
<td>Single case study</td>
<td>OCD, MDD, measures: OCI-R, DASS-D, DASS-A, DASS-S, BDI</td>
<td>The study shows a successful application of behavioral activation and pharmacotherapy for chronic and comorbid OCD and depression. Behavioral activation shows promise as a primary psychological treatment for comorbid disorders that include severe depression.</td>
</tr>
<tr>
<td>2015</td>
<td>Atkins et al.</td>
<td>Elderly care recipients’ perceptions of treatment helpfulness for depression and the relationship with help-seeking</td>
<td>Australia</td>
<td>Cross-sectional study, survey; statistical analysis</td>
<td>Depression</td>
<td>Use of treatment and lifetime experience of symptoms of depression were assessed through self-report. It would be recommended to access objective measures about diagnosis and treatment of depression. Campaigns or educational programs aimed at changing beliefs about treatments may be useful in older adults. More research is needed into ways to overcome barriers to help-seeking and treatment in elderly patients.</td>
</tr>
<tr>
<td>2015</td>
<td>Bayliss &amp; Holttum</td>
<td>Experiences of antidepressant medication and CBT for depression: A grounded theory study</td>
<td>UK</td>
<td>Qualitative: Grounded theory, semi-structured interviews</td>
<td>Depression</td>
<td>Participants differed in how they experienced and evaluated the effects of medication. Medication was frequently perceived as an aid to surviving in crisis: “Mirtazapine probably saved my life”. It might be appropriate to conduct quantitative studies on this topic. Also, consider application of the current model to combined treatment of other difficulties (i.e. psychotic disorders, CBT and drugs)</td>
</tr>
<tr>
<td>2015</td>
<td>Blandin et al.</td>
<td>No evidence in favor of a more deleterious impact of a major depressive episode on verbal memory in older patients with antidepressant response</td>
<td>France</td>
<td>GPs’ assessment +statistical analysis</td>
<td>Hippocampal toxicity may be independent of age in depressed patients with AD treatment response</td>
<td>Any kind of antidepressant</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Type</td>
<td>Depressive Disorders in Women (Type and Time)</td>
<td>Contribution to Midwifery Model</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>2015</td>
<td>Brown-Bowers et al.</td>
<td>Postpartum depression in refugee and asylum-seeking women in Canada: A critical health psychology perspective</td>
<td>Canada</td>
<td>Theoretical article</td>
<td>Postpartum depression (PPD)</td>
<td>The authors emphasise the contribution that midwives can make to integrated partnerships with other care providers in the care of refugee and asylum-seeking women with perinatal distress.</td>
</tr>
<tr>
<td>2015</td>
<td>Chambers et al.</td>
<td>The self-management of longer-term depression: learning from the patient, a qualitative study</td>
<td>UK</td>
<td>Qualitative: semi-structured, in-depth interviews, Interpretative Phenomenological Analysis</td>
<td>Long-term or chronic depression</td>
<td>Reported an array of symptoms: cognitive, emotional and physical. Each person’s experience of longer-term depression was unique. Mental health services may have failed to develop a systematic approach to supporting and facilitating self-management</td>
</tr>
<tr>
<td>2015</td>
<td>Demyttenaere et al.</td>
<td>What is important in being cured from depression? Discordance between physicians and patients (1)</td>
<td>Belgium</td>
<td>Prospective, non-interventional study; statistical analysis</td>
<td>Depression</td>
<td>Physicians differ significantly from patients in what they consider important for ‘being cured’ from depression: physicians mainly focus on alleviation of depressive symptoms while patients mainly focus on the restoration of positive affect.</td>
</tr>
</tbody>
</table>

2015

Postpartum depression in refugee and asylum-seeking women in Canada: A critical health psychology perspective

A critical psychological approach involves questioning the belief that diseases and symptoms are objective entities that exist outside of subjective interpretation or cultural context.

Physicians had been asked to include patients with a diagnosis of clinical depression ‘where treatment with AD was indicated and initiated’. Somatic symptoms consistently get lowest ranking, in physicians and in patients.

Physicians differ significantly from patients in what they consider important for ‘being cured’ from depression: physicians mainly focus on alleviation of depressive symptoms while patients mainly focus on the restoration of positive affect.
<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Title</th>
<th>Country</th>
<th>Methods</th>
<th>Outcomes</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Demyttenaere et al.</td>
<td>What is important in being cured from depression? Does discordance between physicians and patients matter? (2)</td>
<td>Belgium</td>
<td>Meta-regression analysis</td>
<td>Depression</td>
<td>Previous study (1) showed that what physicians and patients consider to be important in being cured from depression is different</td>
</tr>
<tr>
<td>2015</td>
<td>Hudson et al.</td>
<td>Reduction of patient-reported antidepressant side effects, by type of Collaborative Care</td>
<td>USA</td>
<td>Prospective study, pragmatic, multisite, comparative-effectiveness trial; statistical analysis</td>
<td>Mostly treatment resistant depression</td>
<td>This secondary data analysis tested the hypothesis that patient-reported AD side effects were lower for depressed patients receiving high-intensity, telemedicine-based collaborative care (TBCC) than for patients receiving low-intensity, practice-based collaborative care (PBCC)</td>
</tr>
<tr>
<td>2015</td>
<td>Jacob, Rahman, &amp; Hassali</td>
<td>Attitudes and beliefs of patients with chronic depression toward antidepressants and depression</td>
<td>Malaysia</td>
<td>MADRS, ADCQ, ACQ; statistical analysis</td>
<td>Depression</td>
<td>Primary aim: to determine the attitudes and beliefs of depressed patients toward depression and ADs; secondary aim: to assess the influence of ethnicity on patients’ attitudes and beliefs</td>
</tr>
</tbody>
</table>

501
<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Title</th>
<th>Country</th>
<th>Methods</th>
<th>Results</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Kasteenpohja et al.</td>
<td>Treatment received and treatment adequacy of depressive disorders among young adults in Finland</td>
<td>Finland</td>
<td>Questionnaire, SCID interview, final diagnostic assessment, DSM-IV Structured Clinical Interview; statistical analysis</td>
<td>Depressive disorders checked on severity (MDD or not)</td>
<td>Delays in help-seeking and discontinuation of treatment seem to create a barrier to proper care.</td>
</tr>
<tr>
<td>2015</td>
<td>Kim &amp; E-O Im</td>
<td>Korean-Americans' knowledge about depression and attitudes about treatment options</td>
<td>USA</td>
<td>Cross-sectional, correlational design: Self-report survey; statistical analysis: SPSS 20; descriptive and inferential statistics, t-test</td>
<td>Depression</td>
<td>Pilot study to explore first generation’s Korean-Americans (KA) knowledge about depression and attitudes towards various treatments</td>
</tr>
<tr>
<td>2015</td>
<td>King et al.</td>
<td>Role of patient treatment beliefs and provider characteristics in establishing patient-provider relationships</td>
<td>USA</td>
<td>Deductive parallel convergent mixed method design with cross-sectional data; statistical + qualitative text analysis</td>
<td>Depression</td>
<td>The relationship btw. patient treatment beliefs and patient-provider-relationships by gender, race, and current depression</td>
</tr>
<tr>
<td>2015</td>
<td>Lesen et al.</td>
<td>Beliefs about antidepressants among persons aged 70 years and older in treatment after a suicide attempt</td>
<td>Sweden</td>
<td>Interviews, BMQ specific for ADs were analysed 1 year later; statistical analysis</td>
<td>Depression in older age</td>
<td>To assess beliefs about ADs in older persons in treatment one year after a suicide attempt. (Up to ¾ of those who commit suicide in later life suffer from a current depression)</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Study Title</td>
<td>Country</td>
<td>Methods</td>
<td>Findings</td>
<td>Implications</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------------</td>
<td>---------</td>
<td>---------</td>
<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td>2015</td>
<td>Lossnitzer et al.</td>
<td>A patient-centered perspective of treating depressive symptoms in chronic heart failure: What do patients prefer?</td>
<td>Germany</td>
<td>Standardized interview statistical analysis</td>
<td>Depressive disorder (PHQ-9; comorbid and chronic heart failure, anxiety (GAD 7))</td>
<td>SSRI; SNRI</td>
</tr>
<tr>
<td>2015</td>
<td>McCarrier et al.</td>
<td>Patient-centered research to support the development of the symptoms of MDD Scale (SMDDS): Initial qualitative research</td>
<td>USA</td>
<td>Qualitative: interviews, cognitive semi-structured interviews, preliminary version of SMDDS (Symptoms of MDD Scale); qualitative analysis, ATLAS ti</td>
<td>DSM-IV-TR and DSM 5 MDD, recent MDE, HAMD &gt; 18 at screening</td>
<td>The current preliminary version of SMDDS has 35 items covering 11 hypothesized domains that comprehensively address clinically relevant symptoms of MDD that are important and meaningful to patients</td>
</tr>
<tr>
<td>2015</td>
<td>Mert et al.</td>
<td>Perspectives on reasons of medication nonadherence in psychiatric patients</td>
<td>Turkey</td>
<td>Self-report, statements of relatives, information on patients' files; statistical analysis</td>
<td>Psychiatric diseases: DSM 5 bipolar, schizophrenia and depression</td>
<td>To evaluate factors resulting in medication nonadherence: “not willing to use medication”, “not accepting the disease”, “being disturbed by side effects”, “feeling well”</td>
</tr>
<tr>
<td>2015</td>
<td>Moradveisi, Huibers, &amp; Arntz</td>
<td>The influence of patients' attributions of the immediate effects of treatment of depression on long-term effectiveness of behavioral activation and antidepressant medication</td>
<td>Study conducted in Iran</td>
<td>Randomized study: behavioral activation, AD medication (sertraline); statistical analysis; additional analyses</td>
<td>Depression</td>
<td>ADs are the first-choice treatment for severe MDD with or without psychiatric features. Little is known about the long-term effectiveness of ADs and how it compares to psychotherapy. Long-term effects are predicted by attributional factors. Attribution to increased coping capacities and giving credit to oneself appeared essential. One attribution waiting for further study is that offering BA (behavioral activation) helps them learn new skills and strategies in coping with problematic life events. Future studies should investigate the effects of attributions for BA and ADs in other clinical settings and in other cultures.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Study Design</td>
<td>Key Findings</td>
<td>Notes</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>-----------------------------------------------------------------------</td>
<td>------------------------</td>
<td>---------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>2015</td>
<td>Novick et al.</td>
<td>Antidepressant medication treatment patterns in Asian patients with MDD</td>
<td>6 Asian countries</td>
<td>Prospective, observational, statistical analysis</td>
<td>Median time to discontinuation was 70 days; patient-reported nonadherence was 57.5%, and clinician-reported nonadherence was 14.6%</td>
<td>Early discontinuation of ADs among Asian MDD patients was high. 25.6% of those who discontinued prematurely were experiencing an adequate response to ADs. Nonadherent patients had significantly higher disease severity, lower QoL ratings, lower response and lower remission rates.</td>
</tr>
<tr>
<td>2015</td>
<td>Read et al.</td>
<td>Beliefs of people taking antidepressants about the causes of their own depression</td>
<td>New Zealand</td>
<td>Online survey; statistical analysis</td>
<td>Depression beliefs about the causes of their own depression: chemical imbalance, family stress, work stress, heredity, relationship problems and distressing events in childhood</td>
<td>Self-reported effectiveness of the ADs positively associated with bio-genetic causal beliefs. The quality of the relationship with the prescribing doctor was positively related to a belief in chemical imbalance. 83% reported that the medication reduced their depression.</td>
</tr>
<tr>
<td>2015</td>
<td>Read et al.</td>
<td>Understanding the non-pharmacological correlates of self-reported efficacy of antidepressants</td>
<td>New Zealand</td>
<td>Online survey questionnaire; statistical analysis</td>
<td>2 outcomes were measured: i) perceived reduction in depression, ii) perceived improvement in quality of life</td>
<td>Listening carefully to someone’s story, rather than being too concerned about adherence to a single treatment modality, can, it seems, be curative all by itself.</td>
</tr>
<tr>
<td>2015</td>
<td>Ridge et al.</td>
<td>&quot;My dirty little habit&quot;: Patient constructions of antidepressant use and the 'crisis' of legitimacy</td>
<td>UK/ Australia</td>
<td>Qualitative secondary analysis; qualitative interpretive approach: thematic analysis and constant comparison (NVivo)</td>
<td>Experiences of ADs users to unpack key moral underpinnings of everyday practice, illustrating how ADs and interpretations of them influence lives of people with depression</td>
<td>Many participants described ADs as powerful medications that could make them high, numb, or sedated, and/or suggested such opinions were widely held. In terms of discontinuing the medication, people talked about this being difficult but different from addiction. People with depression who could benefit from ADs may well be put off by the moral concerns.</td>
</tr>
</tbody>
</table>

Prospective studies are essential as it is difficult to draw firm conclusions about the meanings of some findings, incl. causality. Professionals might help patients make better choices by illuminating the moral issues as severely ill patients may over-look the life-saving nature of the medications when distracted by moral concerns.
<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Title</th>
<th>Methods</th>
<th>Findings</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Samples &amp; Mojtabai</td>
<td>Antidepressant self-discontinuation: Results from the collaborative psychiatric epidemiology surveys USA</td>
<td>Survey data, self-reported ADs use; statistical analysis</td>
<td>To examine the extent and correlates of self-discontinuation of AD medications without physician advice or approval.</td>
<td>Physicians prescribing ADs need to clearly communicate the expected benefits of treatment, the minimum duration of use required to experience benefits, and the potential side effects. Need for improved quality of diagnosis and treatment of mental disorders, incl. improved adherence with medications.</td>
</tr>
<tr>
<td>2015</td>
<td>Sari &amp; Gencöz</td>
<td>Shame experiences underlying depression of adult Turkish women Turkey</td>
<td>Qualitative: purposive sampling; semi-structured interviews; Interpretative Phenomenological Analysis DSM-IV Depression</td>
<td>In depth-analysis of shame experiences of women diagnosed with depression</td>
<td>4 themes were identified: substitution of rage for the feeling of shame and unworthiness, perfection struggle to overcompensate belief of being inadequate, feeling of shame for their own body and sexual acts, and need for individuation. Not found</td>
</tr>
<tr>
<td>2015</td>
<td>Tundo, de Filippis, &amp; Proietti</td>
<td>Pharmacologic approaches to treatment resistant depression: Evidences and personal experience Italy</td>
<td>Systematic review MDD, TRD (treatment resistant depression)</td>
<td>Given the controversial findings of the trials, clinicians find difficult to decide how to proceed if the patient does not improve or shows only a partial response to the initial AD treatment. Switching from TCA to another TCA provides only a modest advantage (response rate 9%-27%), while switching from one SSRI to another SSRI is more advantageous (response rate up to 75%). The study identifies alternative effective treatment strategies for TRD. Further large observational multicenter studies are needed to compare the efficacy of different strategies in more homogeneous subpopulations. Double-blind control study, directly comparing the efficacy of different pharmacological strategies, should be conducted, too.</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>Vargas et al.</td>
<td>Toward a cultural adaptation of pharmacotherapy: Latino views of depression and antidepressant therapy USA</td>
<td>Qualitative: interviews, open coding, iterative analytical approach; NVivo DSM-IV MDD, HAMD-17</td>
<td>Participants’ narratives focused on modifiable barriers to treatment; examined were views about depression and AD treatment</td>
<td>The study emphasizes the importance of understanding and addressing cultural views of depression and treatment with ADs. Latino patients attribute complex meanings to ADs. Integrating cultural views into psycho-pharmacotherapy can help patients negotiate and address their views in order to improve treatment engagement.</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Depreciation</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>2015</td>
<td>Whiters et al.</td>
<td>Perspectives of Vulnerable US Hispanics With Rheumatoid Arthritis on Depression: Awareness, Barriers to Disclosure, and Treatment Options</td>
<td>USA</td>
<td>Semi-structured interviews; statistical analysis</td>
<td>Hispanics with rheumatoid arthritis and depression</td>
</tr>
<tr>
<td>2016</td>
<td>Akioyamen et al.</td>
<td>Effects of depression pharmacotherapy in fertility treatment on conception, birth, and neonatal health: a systematic review</td>
<td>Canada</td>
<td>Systematic review</td>
<td>Depression</td>
</tr>
<tr>
<td>2016</td>
<td>Barr et al.</td>
<td>Competing priorities in treatment decision-making: A US national survey of individuals with depression and clinicians who treat depression</td>
<td>USA</td>
<td>Online cross-sectional surveys; convenience sampling approach; collaborate; statistical analysis</td>
<td>Depression</td>
</tr>
<tr>
<td>2016</td>
<td>Bortolato et al.</td>
<td>Cognitive remission: a novel objective for the treatment of major depression?</td>
<td>Brazil</td>
<td>2 multicenter RCTs</td>
<td>Cognition; major depression, Antidepressants, Cognition, Cognitive enhancers, Erythropoietin, Lisdexamfetamine dimesylate, Novel targets, Vortioxetine</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Study Design</td>
<td>Method</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>--------------</td>
<td>--------</td>
</tr>
<tr>
<td>2016</td>
<td>Brinijah &amp; Antoniades</td>
<td>&quot;I'm running my depression&quot;: self-management of depression in neoliberal Australia</td>
<td>Australia</td>
<td>Qualitative: interviews,</td>
<td>Depression</td>
</tr>
<tr>
<td>2016</td>
<td>Castonguay, Filer, &amp; Pitts</td>
<td>Seeking Help for Depression: Applying the Health Belief Model to Illness Narratives</td>
<td>Study conducted primarily in UK</td>
<td>Collected illness narratives among people living with depression</td>
<td>Major depressive disorder</td>
</tr>
<tr>
<td>2016</td>
<td>Chaitanaya et al.</td>
<td>Reasons for poor medication adherence in patients with depression</td>
<td>India</td>
<td>Prospective, observational study, MMAS-8</td>
<td>Depression</td>
</tr>
<tr>
<td>2016</td>
<td>Economou et al.</td>
<td>Attitudes towards depression, psychiatric medication and help-seeking intentions amid financial crisis</td>
<td>Greece</td>
<td>Telephone interviews, Personal Stigma Scale; statistical analysis</td>
<td>Major depression</td>
</tr>
<tr>
<td>2016</td>
<td>Gibson, Cartwright, &amp; Read</td>
<td>Conflict in men's experiences with antidepressants</td>
<td>New Zealand</td>
<td>Qualitative: In-depth, qualitative interviews; thematic analysis</td>
<td>Depression</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Study Title</td>
<td>Location</td>
<td>Methodology</td>
<td>Research Focus</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td>-------------</td>
<td>---------------</td>
</tr>
<tr>
<td>2016</td>
<td>Gibson, Cartwright, &amp; Read</td>
<td>In my life antidepressants have been…: a qualitative analysis of users’ diverse experiences with antidepressants</td>
<td>New Zealand</td>
<td>Qualitative: online survey, thematic analysis</td>
<td>Depression</td>
</tr>
<tr>
<td>2016</td>
<td>Hanson et al.</td>
<td>Attitudes and preferences towards self-help treatments for depression in comparison to psychotherapy and antidepressant medication</td>
<td>UK</td>
<td>Quantitative: questionnaire about treatment options; statistical analysis</td>
<td>Depression</td>
</tr>
<tr>
<td>2016</td>
<td>Huijbers et al.</td>
<td>Discontinuation of antidepressant medication after mindfulness-based cognitive therapy for recurrent depression: non-inferiority RCT</td>
<td>The Netherlands</td>
<td>Non-inferiority RCT; statistical analysis</td>
<td>Depression</td>
</tr>
<tr>
<td>2016</td>
<td>Janakiraman, Hamilton, &amp; Wan</td>
<td>Unravelling the efficacy of antidepressants as analgesics</td>
<td>Australia</td>
<td>Case study and commentary</td>
<td>Depression</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Title</td>
<td>Country</td>
<td>Methodology</td>
<td>Clinical focus</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>---------------</td>
</tr>
<tr>
<td>2016</td>
<td>Lu et al.</td>
<td>Beliefs about antidepressant medication and associated adherence among older Chinese patients with MD: A cross-sectional survey</td>
<td>China</td>
<td>Quantitative: BMQ (beliefs about medication questionnaire); statistical analysis</td>
<td>Depression</td>
</tr>
<tr>
<td>2016</td>
<td>Stanton &amp; Randal</td>
<td>Developing a psychiatrist-patient relationship when both people are doctors: A qualitative study</td>
<td>New Zealand</td>
<td>In-depth, semi-structured interviews; thematic analysis</td>
<td>The sample includes doctors with experience of severe illness diagnoses who are barely mentioned in the research</td>
</tr>
</tbody>
</table>