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

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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 antidepresant 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.

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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 particularily 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 hoplessness. 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 presense 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 hyposomnia; 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 presense 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). (http://www.who.int/healthinfo/global_burden_disease/GlobalDALYmethods_2000_2015.pdf?ua=1). 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' 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 expences 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 phenomen: 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 offerring 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.

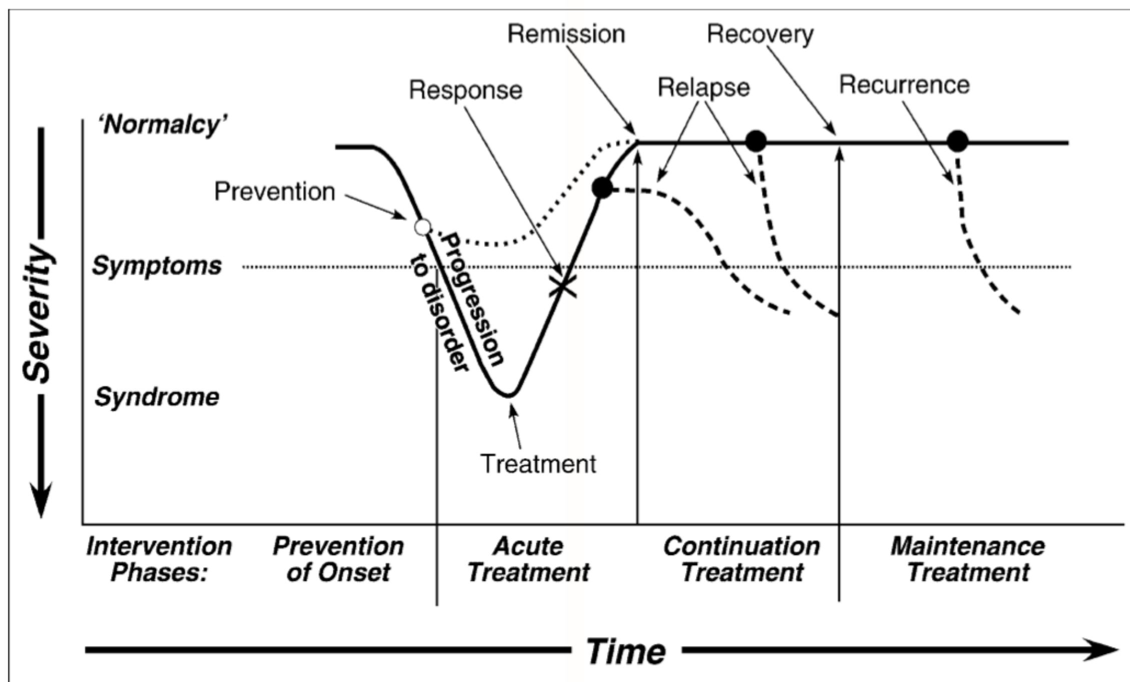


Fig. 1. Phases of treatment and the five "Rs" of depression: response, remission, relapse, recovery, and recurrence. The solid line represents the course of a prototypical episode of depression, the dotted line represents normalization that occurs if the oncoming episode is prevented, and the dashed 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/).

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 unsused 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: **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 excusively 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:

Papers initially included in synthesis	46
Papers excluded during synthesis	5
Total papers finally synthesised	41

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 intruments, 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,

2007, p. 43). 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 emergining 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, an d 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-readung 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

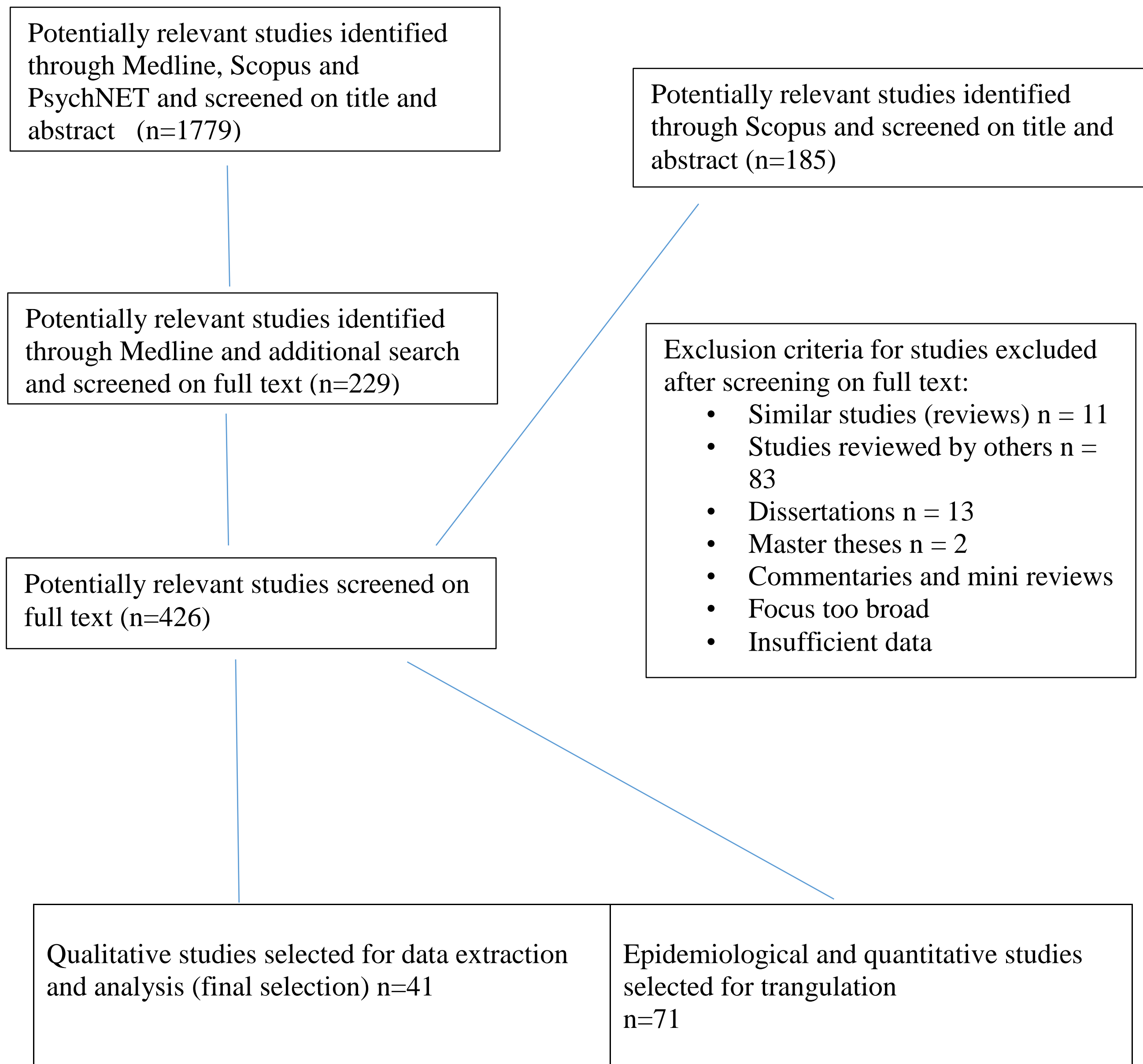
subject to modification during the reading and further review process as recommended by Arksey and O'Malley, 2005:

- 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.



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.

<u>Explicit exclusion criteria have been identified as:</u>

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 conduced 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 assesment. 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 we 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, methaphors 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 diseasses 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 autors, 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' recommenations 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. Similarily, 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 desision 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:

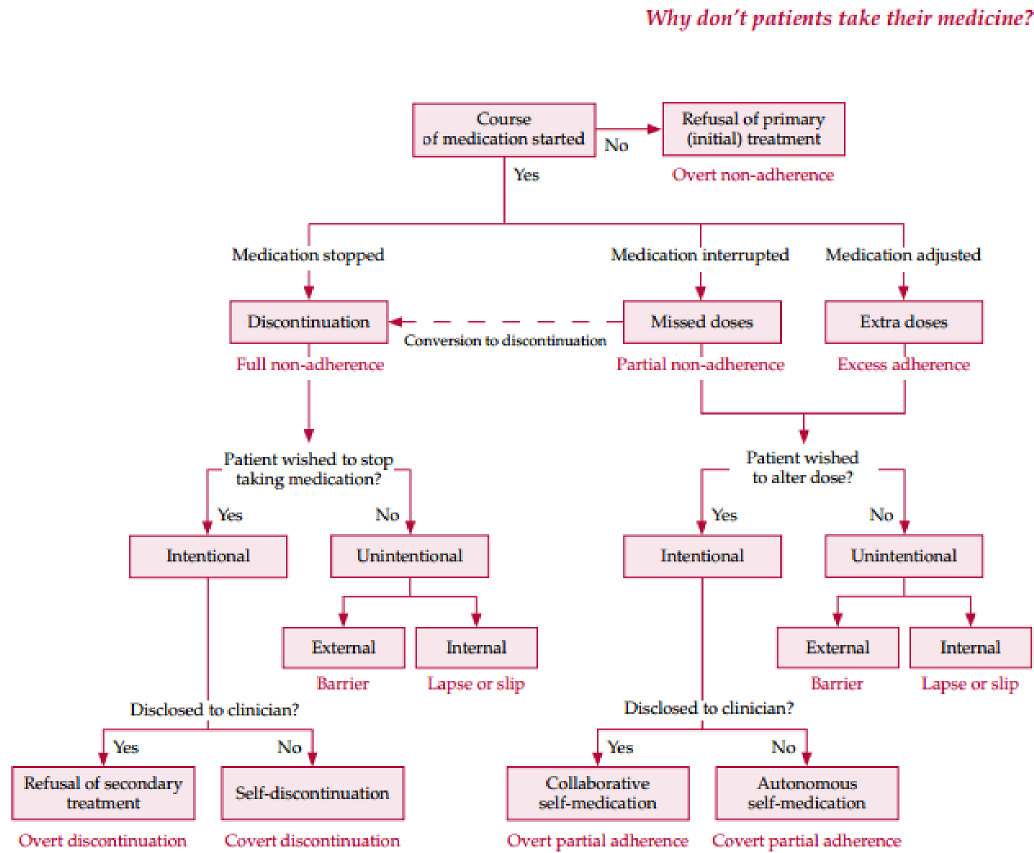
- about 10 % of patients prescribed antidepressants fail to pick up their first prescription;

- 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, colaboration with general practitioners and pharmacists regarding prescriptions

Fig. 3. Why don't patients take their medicine



From: Mitchel and Selmes, 2007

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 philsophically 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 causalilty 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

Review	Type	Data acquisition	Focus of the study	Clinical or research implications
Alderson, S. L., Foy, R., Glidewell, L., Mclintock, K., & House, A. (2012). How patients understand depression associated with chronic physical disease – a systematic review. BMC Fam Pract BMC Family Practice, 13(1).	Systematic review	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	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.	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.
Britten, N., Riley, R., & Morgan, M. (2010). Resisting psychotropic medicines: A synthesis of qualitative studies of medicine-taking. Advances in Psychiatric Treatment, 16(3), 207-218.	Synthesis of qualitative research articles	Systematic search Medline, PubMed, Cinahl Plus, PsycInfo, Embase, Assia and Web of Science, 2002 to 2008; Search was completed before the paper by Malpass et al (Malpass 2008) was published	Lay perspectives on prescribed psychotropic medicines. Updates on a model of medicine-taking developed by Pound et al.	Achieving concordance

Gibson, K., Cartwright, C., & Read, J. (2014). Patient-Centered Perspectives on Antidepressant Use. International Journal of Mental Health, 43(1), 81-99.	Narrative review	PsychInfo (using "client attitudes" and "antidepressants"); Web of Science (using "patient attitudes" and "antidepressant medication" Google Scholar and manual search	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	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.
Mahtani-Chugani, V., & Sanz, E. J. (2011). Users Perception of Risk and Benefits of Mood Modifying Drugs. Current Clinical Pharmacology CCP, 6(2), 108-114.	Narrative review	Medline, Healthtalkonline Website	Users' views about the consumption of mood modifying drugs; personal beliefs, fears and motivations for taking or not taking antidepressants	How health care providers should provide support to patients who need treatment with antidepressants
Malpass A, Shaw A, Sharp D, et al (2009). "Medication career" or "Moral career"? The two sides of managing antidepressants: a meta-ethnography of patients' experiences of antidepressants. Social Science and Medicine 68: 154168.	Meta-ethnogra-Phy	Systematic search of Medline, Embase, Cinahl, Web of Science (WoS) and PsycInfo. 1990–June 2007, Hand search	Patients involved in a decision-making process in treatment with antidepressants	Transformations in self-concept result in more involvement in decision-making Research needed on how more involvement helps to foster new types of self-concept
Mitchell, A. J. (2007). Adherence behaviour with psychotropic medication is a form of self-medication. Medical Hypotheses, 68(1), 12-21.	Narrative review	Not provided	The evidence for and against intentionality in psychotropic adherence behavior; Compliance and related predictors in depression, schizophrenia and bipolar disorder	Further studies required to clarify if these predictors of missed medication hold true for partial non-adherence in depression

Mitchell, A. J., & Selmes, T. (2007). Why don't patients take their medicine? Reasons and solutions in psychiatry. Advances in Psychiatric Treatment,13(5), 336-346.	Literature review	Not provided	• Nonadherence, whether intentional or not; • Patients' reasons for failure to concord with medical advice • Predictors of, and solutions to the problem of nonadherence	▪ Advanced strategies ▪ Simple strategies to improve concordance: ▪ The emerging concept of partial adherence
Pampallona et al. (2002). Patient adherence in the treatment of depression. British Journal of Psychiatry, 180, 104-109.	Systematic review	Studies published between Jan. 1973 and Dec. 1999; multiple systematic searches of Medline, Current Contents, PsychInfo, and the Cochrane Collaborative Register of Trials	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.	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.
Pound, P., Britten, N., Morgan, M., Yardley, L., Pope, C., Daker-White, G., & Campbell, R. (2005). Resisting medicines: A synthesis of qualitative studies of medicine taking. Social Science & Medicine, 61(1).	Systematic review	Qualitative studies Jan. 1, 1992 to Dec. 31, 2001 in English: Medline, Embase, Cinahl, Web of Science, PsychInfo, Zetoc; handsearches; individual suggestions	6 studies of psychotropic medicine and mental illness were chosen: 1. Kalijee and Beardsley (1992) 2. North et al. (1995) 3. Barter and Cormack (1996) 4. Rogers et al. (1998) 5. Angermeyer et al. (2001) 6. Usher (2001)	▪ Importance of monitoring drugs' effectiveness and acceptability to individual patients; ▪ Determining patients' treatment preferences and evaluate the safety and effectiveness of those preferred treatments

Prins, M. A., Verhaak, P. F., Bensing, J. M., & Meer, K. V. (2008). Health beliefs and perceived need for mental health care of anxiety and depression—The patients' perspective explored. Clinical Psychology Review, 28(6), 1038-1058.	Systematic review	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	▪ Perceived causes of depression and specific needs for treatment; ▪ Beliefs about the causes of depression: ▪ Barriers to treatment	Stepped care framework
Zivin, K., & Kales, H. C. (2008). Adherence to Depression Treatment in Older Adults. Drugs & Aging, 25(7), 559-571.	Narrative review	Medline search for articles published btw. 1950 and Jan. 2007; hand search.	Factors affecting patient level adherence to depression treatment in older adults	Need for more rigorous studies in the area of depression treatment adherence

4.2. **Table 3. Qualitative Studies Selected for Synthesis** (n=41)

#	**Study**
1	**Amey, C. (2010)**. Suspected antidepressant-induced switch to mania in unipolar depression: A first-person narrative. *Journal of affective disorders*, *125*(1), 111-115.
2	**Anderson, C., Kirkpatrick, S., Ridge, D., Kokanovic, R., & Tanner, C. (2015)**. Starting antidepressant use: a qualitative synthesis of UK and Australian data. *BMJ open*, *5*(12), e008636.
3	**Anderson, C., & Roy, T. (2013).** Patient experiences of taking antidepressants for depression: A secondary qualitative analysis. *Research in Social and Administrative Pharmacy*, *9*(6), 884-902.
4	**Badger, F., & Nolan, P. (2007)**. Attributing recovery from depression. Perceptions of people cared for in primary care. *Journal of clinical nursing*, *16*(3a), 25-34.
5	**Bennett, H. A., Boon, H. S., Romans, S. E., & Grootendorst, P. (2007)**. Becoming the best mom that I can: women's experiences of managing depression during pregnancy–a qualitative study. *BMC women's health*, *7*(1), 13.
6	**Bayliss, P., & Holttum, S. (2015)**. Experiences of antidepressant medication and cognitive–behavioural therapy for depression: A grounded theory study. *Psychology and Psychotherapy: Theory, Research and Practice*, *88*(3), 317-334.
7	**Boyle, E., & Chambers, M. (2000)**. Medication compliance in older individuals with depression: gaining the views of family carers. *Journal of psychiatric and mental health nursing*, *7*(6), 515-522.
8	**Brijnath, B., & Antoniades, J. (2016).** “I'm running my depression:” Self-management of depression in neoliberal Australia. *Social Science & Medicine*, *152*, 1-8.
9	**Buus, N. (2014)**. Adherence to anti-depressant medication: A medicine-taking career. *Social Science & Medicine*, *123*, 105-113.
10	**Carpenter-Song, E., Chu, E., Drake, R. E., Ritsema, M., Smith, B., & Alverson, H. (2010)**. Ethno-cultural variations in the experience and meaning of mental illness and treatment: Implications for access and utilization. *Transcultural Psychiatry*, *47*(2), 224-251.
11	**Castonguay, J., Filer, C. R., & Pitts, M. J. (2016)**. Seeking help for depression: Applying the health belief model to illness narratives. *Southern Communication Journal*, *81*(5), 289-303.

12	**Chur-Hansen, A., & Zion, D. (2006)**. 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. *Monash bioethics review*, *25*(1), 15-30.
13	**Cohen, D., & Hughes, S. (2011)**. How do people taking psychiatric drugs explain their "chemical imbalance?". *Ethical Human Psychology and Psychiatry*, *13*(3), 176-189.
14	**Dickinson, Rebecca, et al. (2010).** "Long-term prescribing of antidepressants in the older population: a qualitative study." *Br J Gen Pract.* 60.573: e144-e155.
15	**Fosgerau, C. F., & Davidsen, A. S. (2014).** Patients' perspectives on antidepressant treatment in consultations with physicians. *Qualitative health research*, *24*(5), 641-653.
16	**Frank, L., Matza, L. S., Hanlon, J., Mannix, S., Revicki, D. A., Feltner, D., & Morlock, R. J. (2007).** The patient experience of depression and remission: focus group results. *The Journal of nervous and mental disease*, *195*(8), 647-654.
17	**Fullagar, S. (2009).** Negotiating the neurochemical self: anti-depressant consumption in women's recovery from depression. *Health*, *13*(4), 389-406.
18	**Fullagar, S., & O'Brien, W. (2013).** Problematizing the neurochemical subject of anti-depressant treatment: The limits of biomedical responses to women's emotional distress. *Health:*, *17*(1), 57-74.
19	**Gammell, D. J., & Stoppard, J. M. (1999)**. Women's experiences of treatment of depression: Medicalization or empowerment? *Canadian Psychology/Psychologie canadienne*, *40*(2), 112.
20	**Gibson, K., Cartwright, C., & Read, J. (2016).** Conflict in Men's Experiences with Antidepressants. *American journal of men's health*, 1557988316637645.
21	**Gibson, K., Cartwright, C., & Read, J. (2016).** 'In my life antidepressants have been…': a qualitative analysis of users' diverse experiences with antidepressants. *BMC psychiatry*, *16*(1), 135.
22	**Givens, J. L., Datto, C. J., Ruckdeschel, K., Knott, K., Zubritsky, C., Oslin, D. W., ... & Barg, F. K. (2006).** Older patients' aversion to antidepressants. *Journal of General Internal Medicine*, *21*(2), 146-151.
23	**Izquierdo, A., Sarkisian, C., Ryan, G., Wells, K. B., & Miranda, J. (2014).** Older depressed Latinos' experiences with primary care visits for personal, emotional and/or mental health problems: a qualitative analysis. *Ethnicity & disease*, *24*(1), 84.

24	**Jaffray, M., Cardy, A. H., Reid, I. C., & Cameron, I. M. (2014).** Why do patients discontinue antidepressant therapy early? A qualitative study. *The European journal of general practice*, *20*(3), 167-173.
25	**Kadir, N. B. Y. A., & Bifulco, A. (2010).** Malaysian Moslem mothers' experience of depression and service use. *Culture, Medicine, and Psychiatry*, *34*(3), 443-467.
26	**Knudsen, P., Hansen, E. H., Traulsen, J. M., & Eskildsen, K. (2002).** Changes in self-concept while using SSRI antidepressants. *Qualitative Health Research*, *12*(7), 932-944.
27	**LaFrance, M. N. (2007).** A bitter pill: A discursive analysis of women's medicalized accounts of depression. *Journal of Health Psychology*, *12*(1), 127-140.
28	**Suzanne McKenzie-Mohr, Michelle N., Lafrance, ed. January 2014**, Depression as oppression: Disrupting the biomedical discourse in women's stories of sadness. Chapter in book: Women voicing resistance: Discursive and narrative explorations, Publisher: Routledge, pp.141-158.
29	**Lavender, H., Khondoker, A. H., & Jones, R. (2006)**. Understandings of depression: an interview study of Yoruba, Bangladeshi and White British people. *Family practice*, *23*(6), 651-658.
30	**Lawrence, V., Banerjee, S., Bhugra, D., Sangha, K., Turner, S., & Murray, J. (2006).** Coping with depression in later life: a qualitative study of help-seeking in three ethnic groups. *Psychological medicine*, *36*(10), 1375-1383.
31	**Malpass, A., Kessler, D., Sharp, D., & Shaw, A. (2011).** 'I didn't want her to panic': unvoiced patient agendas in primary care consultations when consulting about antidepressants. *Br J Gen Pract*, *61*(583), e63-e71.
32	**Murawiec S. (2008)**. Archives of Psychiatry and Psychotherapy, 3, 65–69.
33	**Patel, S., Wittkowski, A., Fox, J. R., & Wieck, A. (2013).** An exploration of illness beliefs in mothers with postnatal depression. *Midwifery*, *29*(6), 682-689.
34	**Ridge, D., Kokanovic, R., Broom, A., Kirkpatrick, S., Anderson, C., & Tanner, C. (2015).** "My dirty little habit": Patient constructions of antidepressant use and the 'crisis' of legitimacy. *Social Science & Medicine*, *146*, 53-61.
35	**Simon, D., Loh, A., Wills, C. E., & Härter, M. (2007).** Depressed patients' perceptions of depression treatment decision-making. *Health Expectations*, *10*(1), 62-74.
36	**Smardon, R. (2008).** I'd rather not take Prozac': stigma and commodification in antidepressant consumer narratives. *Health, 12*(1), 67-86.

37	**Stanners, M. N., Barton, C. A., Shakib, S., & Winefield, H. R. (2014).** Depression diagnosis and treatment amongst multimorbid patients: a thematic analysis. *BMC family practice*, *15*(1), 124.
38	**van Geffen, E. C., Hermsen, J. H., Heerdink, E. R., Egberts, A. C., Verbeek-Heida, P. M., & van Hulten, R. (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.
39	**van Grieken, R. A., Beune, E. J., Kirkenier, A. C., Koeter, M. W., van Zwieten, M. C., & Schene, A. H. (2014).** Patients′ perspectives on how treatment can impede their recovery from depression. *Journal of affective disorders*, *167*, 153-159.
40	**Vargas, S. M., Cabassa, L. J., Nicasio, A., De La Cruz, A. A., Jackson, E., Rosario, M., ... & Lewis-Fernández, R. (2015).** Toward a cultural adaptation of pharmacotherapy: Latino views of depression and antidepressant therapy. *Transcultural psychiatry*, *52*(2), 244-273.
41	**Vilhelmsson, A., Svensson, T., & Meeuwisse, A. (2013).** A pill for the ill? Patients' reports of their experience of the medical encounter in the treatment of depression. *PloS one*, *8*(6), e66338.

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

First order constructs	Patients' views, accounts and interpretations of their experiences of using antidepressants
Second order constructs	The authors' views and interpretations (expressed as themes and concepts) of patients' views of antidepressant use
Third order constructs	The views and interpretations of the synthesis team (expressed as themes and key concepts)

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)			
Theme	**Positive views on antidepressants**	**Experiences with health care**	**Concerns about medicines**
Treatment decision and initiation	People went to see GP only after family and friends urged them to do so, others because their behaviour was obviously affecting others (**Anderson at al., 2015**) 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)** The case underscores the important role the GP has in the early detection **(Amey, 2010)** 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)** overwhelming impact of depressive symptoms meant that not taking the treatment was not an option **(Anderson et al., 2015)** 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)** Some women took AD medication during pregnancy, five commenced medication within two months of delivering, and one woman delayed commencing AD medication	Trust and rapport established between them and their health practitioner **(Anderson et al., 2015)** *"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)** During times of crisis, when they required immediate help, participants described being referred to under-resourced helplines and being given pamphlets and brochures, none of which were found to be helpful. Patient filed a complaint to the Parliamentary and Health Service	*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)** Carers wish for more easily accessible, detailed and user-friendly information (**Boyle & Chambers, 2000**) Three pregnant women elected not to use ADs at anytime during the pre- and postpartum periods **(Bennett et al., 2007)** 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)** people can feel unsure about what to expect once they take the AD **(Anderson et al., 2015)**

	until she had stopped breat feeding her baby. Three women elected not to use antidepressants at anytime 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 Ieft 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 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 recovery 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)** Frst 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)**	

	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)**	
Continuous medication treatment- attitudes to and concerns about ADs	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**)		*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)**
Medicine information	Validating ADs by gathering information on prescribed medicine, internet routinely used by people to look up health information **(Anderson et al., 2015)** Internet forums consulted to witness others' experiences **(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 & 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 & Antoniades, 2016**)

		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 & Roy, 2013)** Being able to talk to the doctor enabled many respondents to reflect on their difficulties, and to clarify or reframe their experiences **(Anderson & Roy, 2013)** Other reflected adversarial or disconnected relationships with their psychiatrists/GPs/consultants **(Anderson & Roy, 2013)** 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 & Roy, 2013)** A lack of information about ADs was a major cause of dissatisfaction often shaping attitudes to ADs **(Anderson & Roy, 2013)** 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 & Roy, 2013)**	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)** The participants often blamed the medicine having adverse effects rather than considering other reasons for their distress, such as their depressive illness **(Buus, 2014)** 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)** 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)** *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)**

		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 tention 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 tention was observed between "what was promised" and "what was actually delievered" 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)**

		written information e.g. information leaflets **(Anderson & Roy, 2013)**	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)** Once people have got their ADs from the pharmacy they often struggle with actually taking the first dose **(Anderson et al., 2015)** 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)**
Factors relevant for optimal treatment outcome and patients' recommendation	Many women shared previous lack of awareness about the possibility of experiencing depression during pregnancy **(Benett et al., 2007)** 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 & Nolan, 2007)**	People need to feel supported by health professionals when they start taking ADs **(Anderson et al., 2015)** People need additional support when they make decisions about starting ADs **(Anderson et al., 2015)** If people trusted and respected their doctor and felt guided and informed, they also reported initiation of treatment as less problematic **(Badger & Nolan, 2007)**	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 & Roy, 2013)** Case of suspected antidepressant-induced mania strengthens the need for further investigation of this phenomenon in unipolar depression **(Amey, 2010)** case study cautionary against the use of multiple antidepressants **(Amey, 2010)**

		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 6. Descriptions of beliefs, rationale, and behavioral patterns that bring patients to start, continue and/or discontinue treatment with antidepressants		
Topic list		
Initiation of treatment		
Health threat at start of treatment/Crisis	Type of symptoms (sadness, worry, anxiety, somatic complains) Duration of symptoms Perceived seriousness of the illness Labeling of symptoms Social impact of illness Family history Feelings of loss of control and helplessness Prior experiences	Anderson et al. 2015; Bennett et al. 2007; Boyle & Chambers 2000; Buus 2014; Carpenter-Song 2010; Carpenter-Song 2010; Castonguay, Filer & Pitts 2016; Chur-Hansen & Zion 2006; Cohen & Hughes 2011; Frank et al. 2007; Gibson, Cartwright & Read 2016 (b); Fullagar & O'Brien 2013; Gammel & Stoppard 1999; Gibson, Cartwright & Read 2016 (a); Hansen & Cabassa 2012; Jaffray et al. 2014; Kadir & Bifulco 2010; Murawiec 2008; Patel et al. 2013; Stanners et al. 2014; Vilhelmson et al. 2013;
Treatment decision making	Previous experience with antidepressants Role of GP in treatment decision Role of patient in treatment decision Influence of family and friends Lack of information about medication Extreme bothersome mental and physical symptoms Family support and encouragement	Anderson & Roy 2013; Anderson et al 2015; Badger & Nolan 2007 (b); Bennett et al. 2007; Boyle & Chambers 2000; Brijnath & Antoniades 2016; Buus 2014; Carpenter-Song 2010; Castonguay, Filer & Pitts 2016; Chur-Hansen & Zion 2006; Cohen & Hughes 2011; Dickinson et al. 2010; Fosgerau & Davidsen 2014; Frank et al. 2007; 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; Malpass et al. 2011; Murawiec 2008; Patel et al. 2013; Simon et al. 2007;

		Stanners et al. 2014; Stanton & Randal 2016;van Grieken et al. 2014;Vilhelmson et al. 2013;
Reasons for starting treatment	Fatigue and loss of energy Medical diagnosis of illness Insomnia Lasting sadness Feelings of emotional emptiness Feelings of loneliness Suicidal ideation Body aches Cognitive impairment Stressful experiences Awareness of family history of depressive illness Knowledge of consequences of untreated symptoms Encouragement from others Loss of control Aid to surviving a crisis Old age	Bennett et al. 2007; Bayliss & Holttum 2015; Buus 2014; Castonguay, Filer & Pitts 2016; Chur-Hansen & Zion 2006; Cohen & Hughes 2011; Fosgerau & Davidsen 2014; Frank et al. 2007; 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; Izquierdo et al. 2012; Jaffray et al. 2014; Kadir & Bifulco 2010; Lafrance 2007; Lavender, Khondoker & Jones 2006; Lawrence et al. 2006; Malpass et al. 2011; Murawiec 2008; Patel et al. 2013; Ridge et al. 2015; Simon et al. 2007; Smardon 2007; Stanners et al. 2014; Stanton & Randal 2016; van Geffen et al. 2011; Vargas et al. 2015; Vilhelmson et al. 2013;
Attitude toward illness and treatment	Emotional vs physical problem Fear of side effects Fear of addiction Aversion toward medication (chemical, unnatural) Influence on self-esteem Religious beliefs and practices Social influences	Anderson et al. 2015; Bennett et al. 2007; Boyle & Chambers 2000; Brijnath & Antoniades 2016; Buus 2014; Carpenter-Song 2010; Castonguay, Filer & Pitts 2016; Chur-Hansen & Zion 2006; Cohen & Hughes 2011; Dickinson et al. 2010; Fosgerau & Davidsen 2014; Frank et al. 2007; Fullagar 2009; Fullagar & O'Brien 2013; Gammel & Stoppard 1999; Gibson, Cartwright & Read 2016 (a); Gibson,

	Self-medication Stereotypes and stigma Relief from symptoms Recovery Knowledge of depression and its treatment Ambivalence, disappointment	Cartwright & Read 2016 (b); Givens et al. 2006; Hansen & Cabassa 2012; Izquierdo et al. 2014; Jaffray et al. 2014; Kadir & Bifulco 2010; Knudsen et al. 2002 (a); Lafrance 2007; Lavender, Khondoker & Jones 2006; Lawrence et al. 2006; Malpass et a l. 2011; Murawiec 2008; Patel et al. 2013; Ridge et al. 2015; Simon et al. 2007; Smardon 2007; Stanners et al. 2014; van Geffen et al. 2011; van Grieken et al. 2014; Vargas et al. 2015; Vilhelmson et al. 2013;
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; Dickinson 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;
	Execution of treatment	
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 Bothersomeness of side effects Ineffectiveness of treatment Stigmatization Feeling of ‘drug loop’	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;
Self-efficacy	Confidence in one’s ability to take action Adherence to treatment Able to communicate with GP Alternative treatment strategies Social involvement Taking control Non-adherence to treatment	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;
Communication and support of health care professionals during treatment	GP/Psychiatrist/Nurse Underlying cause not addressed Feeling ignored	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;
Social pressure and support to start and continue vs. luck of support and pressure to discontinue the drug use	Partner, family and friends GP	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;

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;

Adapted from van Geffen, 2011

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 strenghtened 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 7. Epidemiological and quantitative studies selected for triangulation	
#	Study
1	**Aikens, Nease & Klinkman (2008)** *Explaining patients' beliefs about the necessity and harmfulness of antidepressants*
2	**Aikens & Klinkman (2012)** *Changes in patients' beliefs about their antidepressant during the acute phase of depression treatment*
3	**Ambresin et al. (2015)** *What factors influence long-term antidepressant use in primary care? Findings from the Australian diamond cohort study*
4	**Bazargan et al. (2005)** *Treatment of Self-Reported Depression Among Hispanics and African Americans*
5	**Bennett et al. (2010)** *Pregnancy-Related Discontinuation of Antidepressants and Depression Care Visits Among Medicaid Recipients*
6	**Bitner et al. (2003)** *Subjective Effects of Antidepressants. A Pilot Study of the Varieties of Antidepressant-Induced Experiences in Meditators*
7	**Brown et al. (2005)** *Beliefs About Antidepressant Medications in Primary Care Patients Relationship to Self-Reported Adherence*
8	**Burra et al. (2007)** *Predictors of Self-Reported Antidepressant Adherence*
9	**Cabassa et al. (2007)** *"It's like Being in a Labyrinth:" Hispanic Immigrants' Perceptions of Depression and Attitudes Toward Treatment*
10	**Chakraborty et al. (2009)** *Attitudes and beliefs of patients of first episode depression towards antidepressants and their adherence to treatment*
11	**Cooper et al. (2007)** *Why people do not take their psychotropic drugs as prescribed: results of the 2000 National Psychiatric Morbidity Survey*
12	**De las Cuevas et al. (2014)** *Risk factors for non-adherence to antidepressant treatment in patients with mood disorders*
13	**Demyttenaere et al. (2015)** *What is important in being cured from depression? Does discordance between physicians and patients matter?*
14	**Demyttenaere et al. (2015)** *What is important in being cured from depression? Discordance between physicians and patients*
15	**Dijkstra and Jaspers (2008)** *Psychiatric and Psychological Factors in Patient Decision Making Concerning Antidepressant Use*
16	**Dobscha et al. (2007)** *Depression Treatment Preferences of VA Primary Care Patients*
17	**Dunlop et al. (2012)** *Depression beliefs, treatment preference, and outcomes*

18	**Ekselius, Bengtsson & von Knorring (2000)** *Non-compliance with pharmacotherapy of depression is associated with a sensation seeking personality*
19	**Fawzi et al. (2012)** *Beliefs about medications predict adherence to antidepressants in older adults*
20	**Frankenberger et al. (2004)** *Effects of Information on College Students' Perceptions of Antidepressant Medication*
21	**Gabriel & Violato (2010)** *Knowledge of and attitudes towards depression and adherence to treatment*
22	**Gardner et al. (2007)** *A Comparison of Factors Used by Physicians and Patients in the Selection of Antidepressant Agents*
23	**Gaudiano et al. (2013)** *Patients' treatment expectancies in clinical trials of antidepressants versus psychotherapy for depression*
24	**Goodman (2009)** *Women's Attitudes, Preferences, and Perceived Barriers to Treatment for Perinatal Depression*
25	**Hamilton et al. (1984)** *Gender Differences in Antidepressant and Activating Drug Effects on Self-Perceptions*
26	**Hansson et al. (2012)** *What made me feel better? Patients' own explanations for the improvement of their depression.*
27	**Hanson and Scogin (2008)** *Older Adults' Acceptance of Psychological, Pharmacological, and Combination Treatments for Geriatric Depression*
28	**Houle et al. (2013)** *Treatment preferences in patients with first episode depression*
29	**Hudson et al. (2015)** *Reduction of Patient-Reported Antidepressant Side Effects, by Type of Collaborative Care.*
30	**Kasteenpohja et al. (2015)** *Treatment received and treatment adequacy of depressive disorders among young adults in Finland*
31	**Keers et al. (2010)** *Stressful life events cognitive symptoms of depression and response to antidepressants in GENDEP*
32	**Kessing et al. (2005)** *Depressive and bipolar disorders: patients' attitudes and beliefs towards depression and antidepressants*
33	**Kikuchi et al. (2011)** *Subjective recognition of adverse events with antidepressant in people with depression: A prospective study*
34	**Kwan et al. (2010)** *Treatment preference, engagement, and clinical improvement in pharmacotherapy versus psychotherapy for depression*
35	**Kwon et al. (2003)** *Antidepressant Use Concordance Between Self-Report and Claims Records*
36	**Lewis-Fernández et al. (2013)** *Impact of Motivational Pharmacotherapy on Treatment Retention Among Depressed Latinos*

37	**Leykin et al. (2007)** *The relation of patients' treatment preferences to outcome in a Randomized Clinical Trial*
38	**Madsen et al. (2009)** *Working with Reactant Patients: Are We Prescribing Nonadherence?*
39	**Lynch et al. (2011)** *Are patient beliefs important in determining adherence to treatment and outcome for depression? Development of the beliefs about depression questionnaire.*
40	**Maidment et al. (2002)** *'Just keep taking the tablets': adherence to antidepressant treatment in older people in primary care*
41	**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*
42	**Misri et al. (2013)** *Factors impacting decisions to decline or adhere to antidepressant medication in perinatal women with mood and anxiety disorders*
43	**Molenaar et al. (2007)** *Does Adding Psychotherapy to Pharmacotherapy Improve Social Functioning in the Treatment of Outpatient Depression?*
44	**Moradveisi et al. (2014)** *The influence of patients' preference/attitude towards psychotherapy and antidepressant medication on the treatment of major depressive disorder*
45	**Mundt et al. (2001)** *Effectiveness of Antidepressant Pharmacotherapy: The Impact of Medication Compliance and Patient Education*
46	**Patten (2008)** *Confounding by severity and indication in observational studies of antidepressant effectiveness*
47	**Parker and Crawford (2007)** *Judged effectiveness of differing antidepressant strategies by those with clinical depression*
48	**Partridge, Lucke and Hall (2012)** *Public attitudes towards the acceptability of using drugs to treat depression and ADHD*
49	**Pedrelli et al. (2008)** *Dysfunctional attitudes and perceived stress predict depressive symptoms severity following antidepressant treatment in patients with chronic depression*
50	**Pilkington et al. (2013)** *The Australian public's beliefs about the causes of depression*
51	**Read et al. (2015)** *Beliefs of people taking antidepressants about the causes of their own depression*
52	**Samples et al. (2015)** *Antidepressant Self-Discontinuation: Results from the Collaborative Psychiatric Epidemiology Surveys*
53	**Serrano et al. (2014)** *Therapeutic adherence in primary care depressed patients: a longitudinal study*
54	**Sher et al. (2005)** *Effects of Caregivers' Perceived Stigma and Causal Beliefs on Patients' Adherence to Antidepressant Treatment*
55	**Shigemura et al. (2008)** *Patient satisfaction with antidepressants. An internet based study*

56	**Shigemura et al. (2010)** *Predictors of antidepressant adherence: Results of a Japanese Internet-based survey*
57	**Sigurdsson et al. (2008)** *Public views on antidepressant treatment: Lessons from a national survey*
58	**Sinokki et al. (2009)** *The association of social support at work and in private life with mental health and antidepressant use: The Health 2000 Study*
59	**Sirey et al. (2001)** *Perceived Stigma and Patient-Rated Severity of Illness as Predictors of Antidepressant Drug Adherence*
60	**Soudry et al. (2008)** *Factors associated with antidepressant use in depressed and non-depressed community-dwelling elderly: the three-city study*
61	**Sun et al. (2011)** *Mediating Roles of Adherence Attitude and Patient Education on Antidepressant Use in Patients with Depression*
62	**Sundell et al. (2011)** *Antidepressant utilization patterns and mortality in Swedish men and women aged 20–34 years*
63	**Tatano Beck and Indman (2005)** *The Many Faces of Postpartum Depression*
64	**Vanelli and Coca-Perraillon (2008)** *Role of Patient Experience in Antidepressant Adherence: A Retrospective Data Analysis*
65	**Vega et al. 2010** *Addressing stigma of depression in Latino primary care patients*
66	**Weich et al. (2007)** *Attitudes to depression and its treatment in primary care*
67	**Wilhelm et al. (2005)** *Great expectations: Factors influencing patient expectations and doctor recommendations at a Mood Disorder Unit*
68	**Wouters et al. (2014)** *Primary-care patients' trade-off preferences with regard to antidepressants*
69	**Wouters et al. (2014)** *Antidepressants in primary care: patients' experiences, perceptions, self-efficacy beliefs, and nonadherence*
70	**Yau1et al. (2014)** *Noncontinuous use of antidepressant in adults with major depressive disorders – a retrospective cohort study*
71	**Yen et al. (2009)** *Predictive Value of Self-Stigma, Insight, and Perceived Adverse Effects of Medication for the Clinical Outcomes in Patients with Depressive Disorders*

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 efficiacy 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

Side effect	Total study population†		Male patients‡		Female patients§		χ^2
	n	%	*n*	%	*n*	%	
Neurological: tremors, headaches, dizziness, etc	26	30	11	31	15	36	0.23
Daytime sleepiness/sleep disturbance	19	22	8	22	11	26	0.17
Sexual: decreased libido, erectile dysfunction	17	20	11	31	6	14	3.01
Dry mouth	17	20	9	25	8	19	0.40
Anxiety, restlessness or agitation	10	11	5	14	5	12	0.07
Gastrointestinal: nausea, vomiting, diarrhea, constipation	10	11	4	11	6	14	0.18
Weight gain	6	8	0	0	6	14	5.57*
No side effect reported/nonresponse	14	18	8	22	6	14	0.83

† $N = 78$.
‡ $n = 36$.
§ $n = 42$.
* $p < .05$ (Fisher's Exact Test).

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 harmfulnesss 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

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

† 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 antidpressants 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

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

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 doctos 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 doctos 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 ot 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 indeciseveness 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 illnss 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 comparisson 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).

Nevetheless, 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 thay 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 abiliy 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 Ieft 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 continous 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 preceived 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.

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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:
accounts[tiab] OR perspective[tiab] OR perspectives[tiab] OR view[tiab] OR views[tiab] OR opinion[tiab] OR opinions[tiab] OR reflection[tiab] OR reflections[tiab] OR thoughts[tiab] OR insights[tiab] OR attitudes[tiab] OR perception*[tiab] OR beliefs[tiab] OR believe[tiab] OR belief*[tiab] OR think[tiab] OR thoughts[tiab] OR feel[tiab] OR feeling*[tiab] OR story[tiab] OR stories[tiab] OR "attitude to health"[mesh] OR comments[tiab] OR viewpoints[tiab] OR "Interview, Psychological"[mesh] OR interview*[tiab] OR "attitude to health"[mesh] OR "truth disclosure"[mesh] OR narrative*[tiab] OR narration[mesh] OR understanding[tiab] OR perception*[tiab] OR preferences[tiab] OR information[tiab] OR expression[tiab] OR define[tiab] OR definition*[tiab] OR complain*[tiab] OR interpretation*[tiab] OR evidence[tiab] OR feel*[tiab] OR regard[tiab] OR think*[tiab] OR reflect*[tiab]
patient[tiab] OR patients[tiab] OR patients'[tiab] OR layperson*[tiab] OR adult*[tiab] OR women*[tiab] OR individual*[tiab] OR people*[tiab] OR patients[mesh:NoExp] OR outpatients[mesh] OR inpatients[mesh] OR informant*[tiab] OR female[mesh] OR male[tiab] OR men[tiab] OR user*[tiab] OR "treatment recipient*"[tiab]
experienc*[tiab] OR experiences[tiab] OR life[tiab] OR lives[tiab] OR live[tiab] OR observation*[tiab] OR awareness[tiab] OR knowledge[tiab] OR record*[tiab] OR encounter*[tiab] OR "personal narratives as topic"[mesh] OR "patient medication knowledge"[mesh] OR "health education"[mesh] OR "health literacy"[mesh] OR knowledge[tiab] OR practices[tiab] OR "Health Knowledge, Attitudes, Practice"[mesh] OR "quality of life*"[mesh] OR "Patient satisfaction"[mesh] OR "men's health"[tiab] OR "women's health"[tiab] OR "patient preference"[mesh] OR "patient education as topic*"[mesh] OR coping[tiab] OR choice*[tiab] OR need*[tiab] OR tolerance[tiab] OR barrier*[tiab] OR obstacle*[tiab] OR denial[tiab] OR behavior[tiab] OR approach[tiab] OR difficulty[tiab] OR difficulties[tiab]
antidepressant[tiab] OR antidepressants[tiab] OR pharmacotherapy[tiab] OR drug[tiab] OR drugs[tiab] OR pill[tiab] OR pills[tiab] OR medication[tiab] OR medications[tiab] OR "mood stabilizer*"[tiab] OR prescription*[tiab] OR "Antidepressive Agents"[tiab] OR "Drug Therapy"[subheading] OR "pharmacological treatment*"[tiab] OR "medication adherence*"[mesh] OR drug[tiab] OR drugs[tiab] OR "Mood stabilizer*"[tiab] OR Antidepressive Agents[mesh] OR "medication adherence"[tiab] OR therapy(ies)[tiab] OR therapy[subheading] OR adherent[tiab] OR non-adherent[tiab] OR compliance[tiab] OR non-compliance[tiab] OR refusal[tiab] OR pharmacotherapy[tiab] OR response[tiab] OR

effective[tiab] OR ineffective[tiab] OR “side effect*”[tiab] OR “adverse effect*”[tiab] OR efficacy[tiab] OR “antidepressive agent*”[tiab] OR withdrawal[tiab] OR continue[tiab] OR discontinue[tiab] OR treatment regimen[mesh] OR take[tiab] OR intake[tiab] OR “drug effects”[subheading] OR “patient compliance”[mesh] OR “drug effects”[subheading] OR “treatment refusal”[mesh]
depression[tiab] OR depressive[tiab] OR depressed[tiab] OR dysthymia[tiab] OR “psychological distress”[tiab] OR “emotional distress”[tiab] OR “affective disorders”[tiab] OR “Depressive Disorder”[mesh] OR “depressive illness”[tiab] OR “Mood Disorders”[mesh] OR melancholia[tiab] OR unipolar[tiab] OR mood[tiab] OR dysthymia[tiab] OR Major Depressive Disorder[tiab] OR MDD[tiab] OR episode*[tiab] OR symptom*[tiab] OR psychological[tiab] OR distress[tiab] OR struggle[tiab] OR “mental health”[tiab] OR suicide[tiab] OR “depressive syndrome*”[tiab] OR “affective disorder*”[tiab] OR “emotional condition”[tiab] OR “mental condition”[tiab]

Results of database searches

Medline – N=1779

Initial attempts to search for qualitative studies were unsuccessful in sofar 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:

qualitative[tiab] OR (interview[tiab] OR interview'[tiab] OR interview's[tiab] OR interviewability[tiab] OR interviewable[tiab] OR interviewable'[tiab] OR interviewadministered[tiab] OR interviewbased[tiab] OR interviewd[tiab] OR interviewdata[tiab] OR intervieweе[tiab] OR interviewed[tiab] OR interviewed'[tiab] OR interviewedfor[tiab] OR interviewedited[tiab] OR intervieweds[tiab] OR interviewee[tiab] OR interviewee's[tiab] OR interviewee'speeches[tiab] OR interviewees[tiab] OR interviewees'[tiab] OR interviewer[tiab] OR interviewer'[tiab] OR interviewer's[tiab] OR interviewer3[tiab] OR intervieweradministered[tiab] OR interviewerd[tiab] OR interviewers[tiab] OR interviewers'[tiab] OR interviewes[tiab] OR interviewguide[tiab] OR interviewin[tiab] OR interviewing[tiab] OR interviewing'[tiab] OR interviewing's[tiab] OR interviewingfor[tiab] OR interviews[tiab] OR interviews'[tiab] OR interviews1[tiab] OR interviews3d[tiab] OR interviewsfrom[tiab] OR interviewshowed[tiab] OR interviewsurvey[tiab] OR interviewtext[tiab] OR interviewwas[tiab] OR interviewwd[tiab]) OR stories[tiab] OR narrative[tiab] OR (discussion[tiab] OR discussion'[tiab] OR discussion's[tiab] OR discussional[tiab] OR discussionconversations[tiab] OR discussiondetailing[tiab] OR discussionfigure[tiab] OR discussionfindings[tiab] OR discussionhostility[tiab] OR discussionin[tiab] OR discussioninteraction[tiab] OR discussionit[tiab] OR discussionnegative[tiab] OR discussionnotwithstanding[tiab] OR discussionof[tiab] OR discussionrelation[tiab] OR discussions[tiab] OR discussions'[tiab] OR discussionself[tiab] OR discussionskewed[tiab] OR

discussionthe[tiab] OR discussionthis[tiab] OR discussionwe[tiab]) OR "grounded theory"[tiab] OR "focus group*"[tiab] OR "semi-structured"[tiab] OR "open-ended"[tiab] OR phenomenology[tiab] OR diary[tiab] OR diaries[tiab] OR (questionnaire[tiab] OR questionnaire'[tiab] OR questionnaire'07[tiab] OR questionnaire's[tiab] OR questionnaire1[tiab] OR questionnaire11[tiab] OR questionnaire12[tiab] OR questionnaire2[tiab] OR questionnaire25[tiab] OR questionnaire30[tiab] OR questionnaireand[tiab] OR questionnairebased[tiab] OR questionnairebefore[tiab] OR questionnaireconsisted[tiab] OR questionnairecopyright[tiab] OR questionnaired[tiab] OR questionnairedeveloped[tiab] OR questionnaireforpediatric[tiab] OR questionnairehas[tiab] OR questionnairel02[tiab] OR questionnairenurse[tiab] OR questionnaireonline[tiab] OR questionnairepf[tiab] OR questionnairephq[tiab] OR questionnairers[tiab] OR questionnaires[tiab] OR questionnaires'[tiab] OR questionnaires"[tiab] OR questionnairescan[tiab] OR questionnairess[tiab] OR questionnairev[tiab] OR questionnairewere[tiab] OR questionnairex[tiab] OR questionnairey[tiab]) OR (observation[tiab] OR observation'[tiab] OR observation"[tiab] OR observation's[tiab] OR observation1[tiab] OR observationa[tiab] OR observationable[tiab] OR observational[tiab] OR observational'[tiab] OR observationalfield[tiab] OR observationallv[tiab] OR observationally[tiab] OR observationalprospectivecontrolled[tiab] OR observationals[tiab] OR observationary[tiab] OR observationd[tiab] OR observationes[tiab] OR observationf[tiab] OR observationn[tiab] OR observationnal[tiab] OR observationnel[tiab] OR observationnelle[tiab] OR observationnelles[tiab] OR observationof[tiab] OR observationprocedure[tiab] OR observations[tiab] OR observations'[tiab] OR observationsdemonstration[tiab] OR observationson[tiab] OR observationsreported[tiab] OR observationss[tiab] OR observationum[tiab] OR observationwere[tiab] OR observationzs[tiab]) OR "qualitative analysis"[All Fields] OR "qualitative research"[mesh] AND ("humans"[MeSH Terms] AND English[lang] AND "adult"[MeSH Terms])

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); 193 (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

Karp 1992; Karp 1993; Karp 1994; Garcia-Campayo et al. 1995; Lewis 1995; North et al. 1995; Rosholm et al. 1995; Ahnlund & Frodi 1996; Barter & Cormack 1996; Cooper-Patrick et al. 1997; Ferreres 1997; Hagerty, Williams & Liken 1997; Lewis & Nicolson 1998; Gammel & Stoppard 1999; Boyle & Chambers 2000; Kadam et al. 2001; Andersson, Lindberg, & Troein 2002; Castle, Morgan, & Jablensky 2002; Egede 2002; Hensley & Nurnberg 2002; Knudsen et al. 2002; Knudsen, Hansen & Traulsen 2002; Garfield, Smith & Francis 2003; Gask et al. 2003; Givens et al. 2003; Knudsen et al. 2003; Manning & Marr 2003; Bhugra & Hsiao-Rei Hicks

2004; Boath, Bradley & Henshaw 2004; Bollini et al. 2004; Dinos et al. 2004; Grime & Pollock 2004; Halter 2004; Haslam et al. 2004; Anderson et al. 2005; Ashton 2005; Badger & Nolan 2005; Maxwell 2005; Rieder-Heller, Matchinger & Angermeyer 2005; Burroughs et al. 2006; Chur-Hansen & Zion 2006; Givens et al. 2006; Hanley & Long 2006; Karasz & Watkins 2006; Lafrance & Stoppard 2006; Lavender, Khondoker & Jones 2006; Lawrence et al. 2006; Lawrence et al. 2006; Ros 2006; Verbeek-Heida & Mathot 2006; Zimmerman et al. 2006; Badger & Nolan 2007; Badger & Nolan 2007; Bennet et al. 2007; Buultjens & Liamputtong 2007; Cornford, Hill & Reilly 2007; Frank et al. 2007; Holt 2007; Interian et al. 2007; Johnston et al. 2007; Lafrance 2007; Leydon, Rodgers & Kendrick 2007; Morawiec 2007; Slingsby et al. 2007; Smardon 2007; Tentler et al. 2007; Unützer 2007; Cabassa et al. 2008; Lakey 2008; Turner et al. 2008; Wittkampf et al. 2008; Fullagar 2009; Liebert & Gavey 2009; Malpass 2009; McPherson & Armstrong 2009; Pohjanoksa et al. 2009; Price, Cole & Goodwin 2009; Amey 2010; Carpenter et al. 2010; Ezeobele et al. 2010; Kadir & Bifulco 2010; Ragan & Kane 2010; Cohen & Hughes 2010; Malpass et al. 2011; Schofield et al. 2011; Sennfeld et al. 2011; van Geffen et al. 2011; Buus, Johannessen & Stage 2012; Hansen & Cabassa 2012; Knudsen et al. 2012; Singh et al. 2012; Vega et al. 2012; Acosta, Rodriguez & Cabrera 2013; Aggarval et al. 2013; Anderson & Roy 2013; DeJean et al. 2013; Fullagar & O'Brien 2013; Ngo et al. 2013; Patel et al. 2013; Treuer et al. 2013; Vilhelmson, Svensson & Meeuwisse 2013; Buus 2014; Fogtman-Fosgerau & Davidsen 2014; Hartley et al. 2014; Isquierdo et al. 2014; Jaffray et al. 2014; Lafrance 2014; Lam & Sun 2014; Powell, Overton & Simpson 2014; Ramirez & Badger 2014; Stanners et al. 2014; van Grieken et al. 2014; Ward, Mengesha & Issa 2014; Anderson et al. 2015; Arco 2015; Bayliss & Holttum 2015; Brown-Bowers et al. 2015; Chambers et al 2015; Ridge et al. 2015; Sari & Gencöz 2015; Vargas et al. 2015; Whiters et al. 2015; Brinijah &

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

Williams et al. 2000; Katona & Livingston 2002; Pampallona et al. 2002; Campbell, Clauw & Keefe 2003; Geddes et al. 2003; Masand 2003; Scheibe et al. 2003; Rabheru 2004; van Schaik et al. 2004; Pound et al. 2005; Martin-Lopez et al. 2006; Mitchell 2006; Moncrieff & Cohen 2006; Gilchrist & Gunn 2007; Hansen & Kessing 2007; Kates & Mach 2007; Lader 2007; Warren & McCarthy 2007; Mitchell 2007; Mitchell & Selmes 2007; Unützer 2007; Harmer 2008; Hwang et al. 2008; Levin et al. 2008; Prins et al. 2008; Zivin & Kales 2008; Cipriani et al. 2009; Demyttenaere 2009; Ööpik & Maaroos 2009; Britten, Riley & Morgan 2010; Glue et al. 2010; Abdullah & Brown 2011; Mahtani-Chugani & Sanz 2011; Al-Jumah & Qureshi 2012; Alderson et al. 2012; Baumeister 2012; Himmerich & Wranik 2012; Jenkins & Goldner 2012; Littrell 2012; Agyapong 2013; Balan, Moyers & Lewis-Fernandez 2013; DeJean et al. 2013; Moncrieff, Cohen & Porter 2013; Gibson, Cartwright & Read 2014; Katona, Bindman & Katona 2014; Kirino 2014; Tundo, de Filippis & Proietti 2015; Akioyamen et al. 2016

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 antidpressants 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', ads 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 do 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 patiens 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 ceasation.

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 (fluoexetine) 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. Luckilly, 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'.

Male patients' experiences with their sex life being negatively affected by antidepressants have been summarised by two other study participants. Their suspition 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 personel 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 discpouraging. One patient reported that after he started the antidperssants, 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’.

[5] Bennett et al. (2007)

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 stil 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 come 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 hesitatant to admit this to his doctor. His prediction was that they woud 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 thos

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 amytriptiline 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 personel;
- Receiving explaination 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 ceseation 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

convinced 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.

[10] Carpenter-Song et al. (2010)

A patient wanted to talk to the psychiatrist to see if he could by 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, switiching 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 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 unnecassary 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 vey 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 helpe 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" preceeded 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 deat 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, felling worse, felling ‘not normal’, dry mouth, felling 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 occured.

- 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 powerty 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.

[13] **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 knowledgeabl about the field and chemical imbalances

• Patient has done his/her research

• Pateint'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

<u>Subject of chemical imbalance in 22 synthetised interviews with psychotropic medication users</u>

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.

[15] Egede (2002)

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 wpuld 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 thst 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.

[16] 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 xperiences.

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 Ishe doesn'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)

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.

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.

[24] 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)

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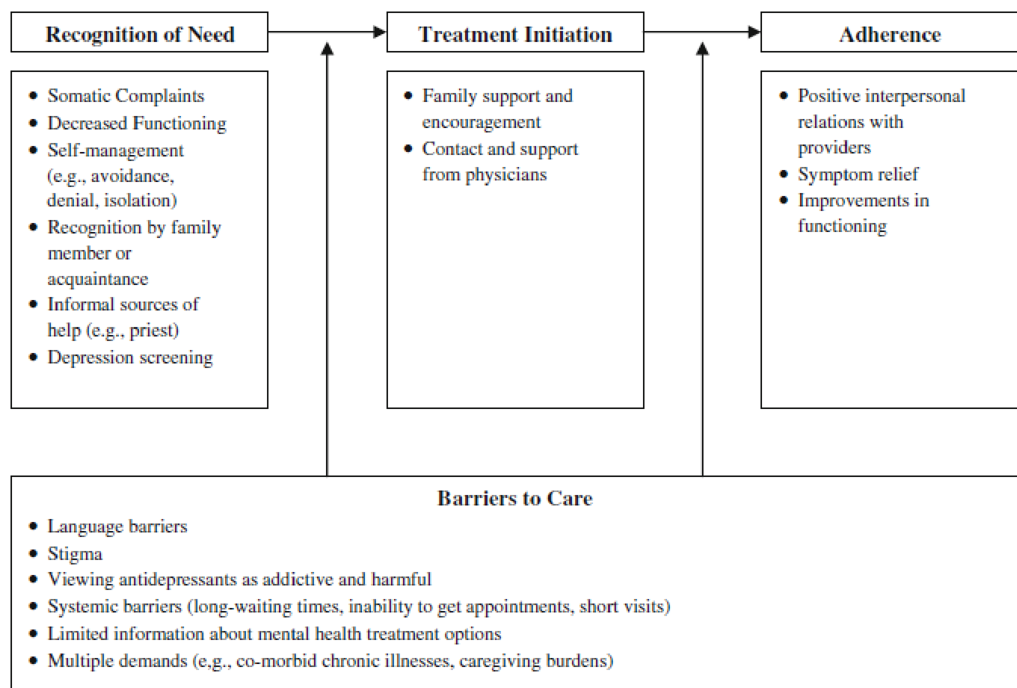

Fig. 1 Help-seeking pathway model

[25] 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 (perceieved 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 affort 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 mentiones 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 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.

<u>SSRIs users’ accounts:</u>

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.

[29] Lafrance (2007)

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 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. Whjat'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.

[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.'

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, yiu 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.

You've got to try aand 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 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.

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.

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.

[33] **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. 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)

[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 dealth 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 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. 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 Ieft 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).

[38] Smardon (2007)

[A]nd 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.

[41] 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 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)

[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)

[42] 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)

[43] 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 occured 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 antidepressanst 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."

[44] 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.

APPENDIX D

Qualitative Narratives with the Application of the Verbatim style

[1] Amey, 2010

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.

<u>Prodromal phase</u>

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 olzanapine. The apriprazole 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, Hausmann 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)

<u>The initial consultation: seeing the doctor</u>

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)

<u>The consultation</u>

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)

<u>The first mention of medication and antidepressants</u>.

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.

<u>Being prescribed an antidepressant</u>

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)

<u>Taking an antidepressant for the first time</u>

Even after deciding to start antidepressants, actually contemplating swallowing the tablet for the first time could feel like a momentous occasion: I Ieft 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 which 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 so, that was 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) [fluoexetine] 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)

<u>Adverse effects and non-adherence</u>

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 trycyclic 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)

[6] 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]

[7] 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.

[8] 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 neuro-chemically, 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,).

[9] 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.*
<u>Interacting with healthcare professionals</u>
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 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 [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 belive 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.
<u>Self-regulation of drug treatment</u>
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 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**
<u>Latinos and Euro-Americans taking medication</u>
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, switiching 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 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.
<u>Conceptions of Problems</u>
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.*
<u>Social Contexts of Distress</u>
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

case manager.] 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: *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.

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 hesitatant 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: *[I]f 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.*

[12] Chur-Hansen and Zion, 2006
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.*
<u>Side effects</u>
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 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 powerty 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.*

<u>Hope</u>
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.*
<u>Lack of SSRI efficacy</u>
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.*
<u>Efficacy of the SSRI</u>
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.*
<u>Stigma</u>
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..*
<u>Social support</u>
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.*
12. Woman, 51, taking sertraline for social anxiety disorder.
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 the serotonin levels in the brain and cause me to feel calm.*
13. Woman, 23, taking lamotrigine for anxiety.
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—*

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)
<u>Negative perceptions of ageing</u>
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)

[15] 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 anothr 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 sometjing 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).

<u>Relieving Distress or Reducing Emotional Vitality</u>

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.

<u>Negative experiences of antidepressants</u>

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.

<u>Mixed experiences of antidepressants</u>

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 quite [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 (perceieved 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 affort 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.*

<u>Conflicts about taking antidepressants</u>

And then when she [the doctor] mentiones 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.*

<u>SSRIs users' accounts:</u>

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 sociallyor 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 <u>much better mother</u>. 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)

[I]f 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?

<u>Interviewer</u>: 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 <u>can</u> do it, get up and you you <u>can</u> 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 thaking 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 aand 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)

[33] 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 dealth 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…(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 Ieft 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, 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
[A]nd 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)

[41] 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)
F*or 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 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)
[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)
<u>Moment of discontinuation</u>
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)
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)

[42] 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)

[43] **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]f 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."

[44] Vilhelmson, 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 not] 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

Review / Study	Pound et al. 2005	Mitchell 2007	Mitchell & Selmes 2007	Prins et al. 2008	Zivin 2008	Malpass et al. 2009	Britten, Riley & Morgan 2010	Mahtani-Chugani 2011	Alderson et al. 2012	Gibson, Cartwright & Read 2014
Karp 1993						✓		✓		✓
Karp 1994								✓	✓	
Lewis 1995									✓	
North et al.1995	✓									
Barter & Cormack, 1996	✓									
Priest et al. 1996				✓				✓		
Cooper-Patrick et al. 1997				✓					✓	
Bultman & Svarstad 2000										✓
Churchil et al. 2000				✓						
Cooper et al. 2000				✓					✓	
Dwight-Johnson et al. 2000				✓						

Jorm et al. 2000				✓						
Kadam et al. 2001								✓		
Sirey et al. 2001 (b)		✓	✓		✓					
Bull et al. 2002 (a)		✓	✓							
Bull et al. 2000 (b)		✓	✓							
Knudsen et al. 2002 (a)						✓	✓			
Knudsen et al. 2002 (b)						✓				
Maidment et al. 2002		✓	✓		✓					
Prabhakaran & Butler 2002					✓					
Garfield et al. 2003						✓			✓	✓
Gask et al. 2003				✓					✓	
Knudsen et al. 2003						✓		✓		
Masand 2003										✓
Roeloffs et al. 2003				✓						
Sleath et al. 2003		✓	✓							

Bann et al. 2004				✓					✓	
Bollini et al. 2004						✓				
Garfield et al. 2004		✓	✓			✓	✓	✓		
Grime & Pollock 2004						✓	✓	✓		
Haslam et al. 2004 (a)						✓	✓	✓		✓
Van Schaik et al. 2004		✓		✓						✓
Aikens et al. 2005		✓	✓	✓						✓
Ashton et al. 2005		✓								
Badger & Nolan 2005				✓		✓				
Brown et al. 2005				✓					✓	✓
Gonzales et al. 2005			✓							
Jorm et al. 2005		✓								
Kessing et al. 2005				✓	✓					✓
Lin et al. 2005				✓						
Maxwell 2005						✓			✓	

Ozmen et al. 2005		✓								
Pound et al. 2005		✓						✓		✓
Rieder-Heller et al. 2005				✓						
Van Vorhees et al. 2005				✓	✓				✓	
Backenstrass 2006										✓
Burroughs et al. 2006									✓	
Givens et al. 2006				✓	✓	✓		✓	✓	✓
Gum et al. 2006				✓		✓				
Karasz & Watkins 2006									✓	
Mitchell 2006 (b)			✓							
Olfson et al. 2006								✓		
Van Vorhees et al. 2006									✓	
Verbeek-Heida& Mathot 2006						✓	✓			
Badger & Nolan 2007 (b)									✓	✓
Burra et al. 2007										✓
Cooper et al. 2007										✓

Cornford et al. 2007									✓	
Dobscha et al. 2007										✓
Givens et al. 2007									✓	
Hansen & Kessing 2007										✓
Holt 2007						✓				
Hunot et al. 2007										✓
Interian et al. 2007										✓
Leydon et al. 2007								✓		✓
Leykin et al. 2007									✓	✓
Mitchell 2007			✓							
Mitchell & Selmes 2007			✓							
Aikens et al. 2008										✓
Cabassa et al. 2008									✓	
Dijkstra et al. 2008										✓

Shigemura et al. 2008										✓
Turner et al. 2008										✓
Wittkampf et al. 2008									✓	
Chakraborty et al. 2009									✓	✓
Goodman 2009										✓
Malpass et al. 2009								✓		✓
Pohjanoksa et al. 2009								✓		
Price et al. 2009										✓
Van Geffen et al. 2009										✓
Britten et al. 2010								✓		
Holma et al. 2010										✓
Schofield et al. 2011										✓

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)

Year	Author/s	Title	Country	Study design & method	Diagnosis & Diagnostic instruments	Focus of the study	Results/Conclusion	Recommendation for future studies/actions
1961	**Beck & Ward**	Dreams of depressed patients	USA	Interviews; statistical analysis	APA Diagnostic Manual; Depression Inventory	Masochistic dreams in persons diagnosed with depression	The moderately to severely depressed group reported significantly more masochistic dreams than the non-depressed group.	Psychoanalytic interview with focus on the verbal and nonverbal behavior of the patient can be tested in rigorously controlled experiments
1961	**Neylan, Prowse, M.**	The depressed patient	Canada	Commentary	Depression	Depressed patients demand attention and sympathy. They can drain nurses emotionally.	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.	The nurse can be guided by the knowledge that it takes time for anyone to work through a depression.
1965	**Ayd, Frank J.**	The chemical assault on mental illness: The antidepressants	USA	Commentary	Depression	Antidepressants and their adverse effects	Although the progress made from 1953 to 1963 can rightfully be called unprecedented, the fact remains that much needs to be accomplished.	To discover more effective, safer drugs for the mind. Equally necessary are more nurses prepared to care for psychiatric patient
1985	**Reda et al.**	Thinking, depression and antidepressants: modified and unmodified depressive beliefs during treatment with amitriptyline	Italy	Cohort, prospective study: questionnaires	MDE with melancholia; DSM III, DAS, HRS-D	amitryptyline 75-120 mg + benzodiazepine	Positive effects of the tricyclic antidepressants on depressive symptomatology are accompanied by changes in cognitive patterns	Role of persistent irrational beliefs in people prone to depression and the optimal coordination of pharmacotherapy and psychotherapy
1992	**Brugha & Bebbington**	The under-treatment of depression	UK	Cohort, prospective CACO study: 4 interviews	Clinical depression; DSM III R& ICD 10-DCR	tricyclic AD or similar; MOI; benzodiazepine & 'other'; 100 mg of Amitriptyline	Treatment is not effectively deployed	Systematic research on the effectiveness of services for depressed patients
1992	**Karp, D.**	Illness ambiguity and the search for meaning	USA	Case study of a self-help-group	Depression or manic depression	Diagnosis, personal responsibility for the illness, reliance on medical experts, efficacy of ADs	Group discussions provided plausible explanations for shared difficulties. Group talk implied an antipsychiatry ideology that questioned medical dominance	Examine a variety of personal troubles and learn the timing and let the circumstances respond to them.

1993	**Karp, D.**	Taking anti-depressant medications: Resistance, trail commitment, conversion, disenchantment	USA	Qualitative: in-depth interviews, case studies	Depression	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.	Not found
1994	**Flare**	Personality by prescription	Canada	GREY LIT				
1994	**Karp, David A.**	Living with depression: Illness and identity turning points	USA	Qualitative; Grounded Theory; interviews, observation; discussion	Unipolar depression	Person's lived experience with clinical depression	Shared features of the depression experience found; living with depression varies	How gender, marital status, occupation, race and ethnicity influence the meaning of being depressed
1995	**Bech, Per**	Quality-of-life measurements for patients taking which drugs? The clinical PCASEE perspective	Denmark	Overview	Depressive illness; DSM III	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	Patients with primary depression are less reliable than doctors or their relatives in giving reliable assessments of their cognitive and affective symptoms when they are ill.	Health-related QOL measurements are recommended as they have an impact on doctor-patient relationship and involve a holistic approach to drug treatment by checking all PCASEE components
1995	**Garcia-Campayo et al.**	Orgasmic sexual experiences as a side effect of fluoxetine	Spain	Qualitative, case study; patient's accounts	MDE without psychotic features; DSM-III-R	Fluoxetine 20mg/day	Suggested increases in central serotogenic neuronal activity as a probable cause of orgasmic sexual experiences	Experience with fluoxetine to understand the pathophysiology of this side effect

1995	**Lewis, S. E.**	A search for meaning: Making sense of depression.	UK	Qualitative, grounded theory and discourse analytic techniques, symbolic interactionism: in-depths interviews	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	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
1995	**North et al.**	Patient responses to benzodiazepine medication: a typology of adaptive repertoires developed by long-term users	New Zealand	Qualitative: in-depth interviews	Long-term benzodiazepine s users	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	Type and dosage of the regime was established by the users'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.
1995	**Rosholm et al.**	Antidepressant treatment in general practice-An interview study	Denmark	Cross-sectional, descriptive interview study: interviews	no formal diagnostic classification; HDS symptoms rating scale; WONCA rating & the GP general assessment	tricyclic Ads (incl. maprotiline), SSRIs, moclobemide & mianserin	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
1996	**Ahnlund, K. & Frodi, A.**	Gender differences in the development of depression	Sweden	Non-experimental design: analysis of hospitalized patients records	Depression, DSM III R; statistical analysis	Examined the relations btw. gender and eliciting factors of depression, marital status, age, season of hospital admission, type of medication	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

1996	**Barter & Cormack**	The long-term use of benzodiazepines: patients' views, accounts and experiences	UK	Qualitative interviews and analysis; non-parametric statistics	Depressive symptoms	This study found that the participants had no knowledge of what their doctors thought of their use of benzodiazepines	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	Doctors need to be informed on how to introduce the idea of discontinuation to their patients without evoking distress, disappointment, fear and failure.
1996	Lewis, S. E.	The Social Construction of Depression: Experience, Discourse and Subjectivity	UK	Dissertation				
1996	**Priest et al.**	Lay people's attitudes to treatment of depression: results of opinion poll for Defeat Depression Campaign just before its launch	UK	opinion poll Research Quorum; qualitative survey-group discussions; quantitative survey	depression; MORI	lay beliefs &public opinions	Counselling favoured; antidepressants and tranquillisers believed to be addictive; tranquillisers found affective in depression	This survey was carried out in December 1991, before the launch of the Defeat Depression Campaign in January 1992. Findings of a further survey at the end of this campaign are expected
1997	**Bosc, Dubini, & Polin**	Development and validation of a social functioning scale, the social adaptation self-evaluation scale.	France & Italy	Population survey and two controlled studies; multivariate analyses	Depression; SASS (Social Adaptation Self-evaluation Scale)	The new selective noradrenaline reuptake inhibitor (NARI), reboxetine, with placebo and/or fluoxetine	The SASS scale represents a useful additional tool for the evaluation of social functioning in depression	The SASS scale will facilitate the development of new antidepressants with differential effects in this domain in depressed patients
1997	**Cooper-Patrick et al.**	Identification of patient attitudes and preferences regarding treatment of depression	USA	focus groups	Depression	Patient experiences and concerns re. treatment in depression	Identified a wide range of patient attitudes and preferences	Incorporate the range of factors identified by patients
1997	**Ferreres et al.**	Antidepressant treatment before hospitalization for major depression: often prescribed, often undertreated	Switzerland	small scale retrospective study: in-depth focus-group discussions; semi-structured interview	4 BPD; 12 UPD with a first depressive episode; 37 UPD with recurrent depressive episodes; DSM-III-R	Under-treatment prior to hospitalization	A large number of patients did not receive adequate treatment before hospitalization	Pay more attention to the training of physicians in regards to prescribing antidepressants

1997	**Hagerty, Williams & Liken**	Prodromal symptoms of recurrent major depressive episodes: A qualitative analysis	USA	Qualitative: focus groups and grounded theory methods	Early warning phases of depressive episodes; implications for clinical intervention	People entering a major depressive episode often have difficulty identifying prodromal symptoms, although they experience early warning phases	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	Specific clinical interventions should be developed to identify early warning signs and initiate actions that can help minimize or prevent a major depressive episode. This study can inform further investigations of the course of recurrent depression
1998	Bultman, Dara Catherine	Consumer Perspectives of Provider Communication Styles and Antidepressants: a Study of Beliefs and Outcomes.	USA	Dissertation				
1998	**Lewis & Nicolson**	Talking about early motherhood: Recognizing loss and reconstructing depression	UK	Qualitative; 2 studies combined: In-depth verbal accounts transcribed verbatim	Depression	Women's experiences with depression and transition to motherhood	Deconstructed experience of depression as part of women's life and motherhood experience	not found
1999	**Domino Edward F.**	History of modern psychopharmacology: a personal view with an emphasis on antidepressants	USA	Opinion & personal experiences: commentary	Depression	Provided the chemical basis for the molecular modification of H1 antihistamines in the development of some antidepressant and antipsychotic drugs	Molecular manipulation can produce new therapeutic leads	Increase research efforts in all branches of psychosomatic medicine
1999	**Gammel & Stoppard**	Women's experiences of treatment of depression: Medicalization or empowerment?	Canada	Qualitative; feminist approach: interviews	Depression	A medicalized understanding and treatment of women's depressive experiences cannot readily co-exist with personal empowerment	Medicalization of depression has disempowering consequences	Develop strategies for treatment of women's depression without precluding personal empowerment

2000	**Boyle & Chambers**	Medication compliance in older individuals with depression: gaining the views of family carers	N. Ireland	Qualitative - focus groups and qualitative analysis: interviews	Depression	Carers' attitudes and experiences with older patients' medication compliance	Number of key issues identified with carers acting as advisors	Explore methods to develop enhanced relationships btw caregivers and older patients
2000	**Bultman & Svarstad**	Effects of physician communication style on client medication beliefs and adherence with antidepressant treatment	USA	Mixed - Communication framework, prospective design and statistical analysis: Initial and follow up telephone interviews	Depression	Client beliefs about and satisfaction with pharmacological treatment	Mapping the ways the providers' communication influences patients' treatment adherence	Determine if physicians' collaborative style directly or indirectly effects treatment outcomes
2000	**Churchil et al.**	Treating depression in general practice	UK	Cross-sectional survey: self-completion questionnaire. Data analysis: SPSS. Chi-square tests and logistic regression	Depression	Patients' preferences re. treatment for depression and characteristics associated with those preferences	Counselling preferred over drug treatment (3 times); negative association of depression caused by problems in ppl's lives; no association btw a preference for counselling and age	Results of studies evaluating effectiveness of counselling for depression in primary care
2000	**Cooper et al.**	Primary care patients' opinions regarding the importance of various aspects of care for depression	USA	Cross-sectional survey; focus groups; statistical analyses	Depression	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	Patient-provider relationship is particularly important and should be considered in decisions affecting health policy for patients with depression.	Explore how patient attitudes and ratings of care differ across demographic groups and determine how patient attitudes influence their preferences for treatment, receipt of guideline-concordant care, and depression outcomes.

2000	**Dwight-Johnson et al.**	Treatment preferences among depressed primary care patients	USA	Mixed - qualitative inquiry with statistical analysis: self-administered questionnaires and telephone interviews	Current depressive symptoms; Composite International Diagnostic Interview (CIDI) & Center for Epidemiologic al Studies Depression Scale (CES-D)	Preferences for depression treatment	Most depressed primary care patients desire treatment, preferably counselling. Treatment preferences vary by ethnicity, gender, income, and knowledge about treatment	Examine the extent to which patient treatment preferences are honored; whether educational interventions shift patient preferences, and whether providing preferred treatments leads to improved treatment adherence and patient satisfaction
2000	**Ekselius, Bengtsson, & von Knorring**	Non-compliance with pharmacotherapy of depression is associated with sensation seeking personality	Sweden	Randomized, double-blind study	Depression; DSM-III-R & MADRS score of at least 21; Karolinska Scale of Personality	Sertraline (50-150 mg/day) or citalopram (20-60 mg/day)	Study provided new insights into possible mechanisms for non-compliance	The need for other more objective methods other than pill counting and patient questioning in controlled clinical studies
2000	**Jorm et al.**	Public belief system about the helpfulness of interventions for depression: associations with history of depression and professional help-seeking	Australia	Mixed-method: A postal survey, questionnaire; statistical analysis: structural equation modelling	Depression; Goldberg Depression Scale; ICD-10; MIMIC for stat. analysis	Public belief systems; experience of depression and seeking professional help	Analysis of reasonable and less reasonable public beliefs detected limited knowledge. The study forms part around the concept of mental health literacy.	Awareness of such belief systems is helpful in individual treatment programs and in health promotion campaigns that improve mental health literacy
2000	**Lin et al.**	Low-Intensity treatment of depression in primary care: is it problematic?	USA	Cohort study: Structured Clinical Interview for Depression	Depression & dysthymia, MDEs + statistical analyses (chi-square tests); DSM-IV	Adherence to antidepressant medications	Patients demonstrated poor adherence to pharmacotherapy and inconsistent follow-up visits	Systematic and pro-active monitoring of patient response after starting antidepressant treatment

2000	**Williams et al.**	New drugs for old folks: the evidence based argument for newer antidepressants	USA	Review of data of 8451 clinical trials, meta-analyses and expert opinion: Descriptive synthesis	Depression	Comparative benefits and drawbacks of the newer medicinal and botanical therapies for depression (SSRIs, SNRIs and St. John's wort)	The newer agents are superior to placebo for MD and dysthymia but their absolute superiority over the second generation tricyclic nortriptyline is not supported.	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
2001	**Demyttenaere Koen**	Compliance and acceptance in antidepressant treatment	Belgium	Commentary	Depression	Antidepressants	Poor acceptance of, and non-adherence to antidepressants continues to hinder effective treatment in MDD	Explore patients' beliefs and attitudes and their origin
2001	**Greden, J.F.**	The burden of recurrent depression: Causes, consequences, and future prospects.	USA	Review	Depression	Recurrent depression	Understanding the chronic nature of this illness is key to the development of a more informed, longitudinal perspective on the diagnosis and treatment of depression.	Re-conceptualizing major depression from this longitudinal and multidimensional perspective is crucial to providing an effective response to this critical public health challenge
2001	**Kadam et al.**	A qualitative study of patients' views on anxiety and depression	UK	Qualitative: Semi-structured individual interviews and focus groups + grounded theory analysis	Anxiety & depression; HAD questionnaire	Benzodiazepines, antidepressants, counselling	Patients' views are central to informing the debate on the management of affective disorders	1) Explore the degree to which patients perceive the GP as the main source of help; 2) Check how counselling services are delivered; 3) Explore patients' perceptions and experiences of drug treatment.
2001	Lauer-Williams, Jeanne	Postpartum depression: A phenomenological exploration of the woman's experience	USA	Dissertation				

2001	**Mundt et al.**	Effectiveness of antidepressant pharmacotherapy: the impact of medication, compliance and patient education	USA	Longitudinal study; IVR data collection system (by mail)	MDD; DSM-IV, HDRS, SCID-P, WSAS, PGI of Improvement Rating, Satisfaction with Treatment questionnaire	Antidepressant pharmacotherapy (excl. Trazodone)	Effective treatment with pharmacotherapy; medication compliance is critical to effectiveness	Additional efforts at program improvement
2001	**Schaub et al.**	What do patients in a lithium outpatient clinic know about lithium therapy?	Germany	Quantitative assessment of lithium-related knowledge; questionnaire adapted from the Lithium Knowledge Test	n=123; DSM-III; bipolar disorder, recurrent unipolar depression and schizoaffective disorder	Lithium	Negative correlation with age; no correlation with duration of treatment, sex, education and diagnosis	Patient education about lithium should be intensified to adverse effects, especially in older patients
2001	**Sirey et al. (a)**	Perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence	USA	Two-stage sampling procedure, SCID-IV, MMSE, HAM-D, GAF, Chronic Disease Score, Inventory of Interpersonal Problems, Cornell Services Index (CSI), bivariate analyses with Student's t-test or chi-square	MDD, Structured Clinical Interview for Diagnosis, mixed age,	Antidepressant medication	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	Deepen understanding of the individualized impact of perceived stigma to develop successful treatment strategies

2001	**Sirey et al. (b)**	Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression	USA	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	MDD	Perception of stigma was greater in younger patients. Stigma negatively influenced treatment only in older adults.	Patient stigma is a useful target for intervention to improve treatment adherence out outcomes in depression	Stigma is an appropriate target for intervention aimed at improving treatment adherence and outcomes
2002	**Andersson, Lindberg, & Troein**	What shapes GP's work with depressed patients? A qualitative interview study	Sweden	Qualitative semi-structured interview study	Depression	GPs discussing doctor-patient relationship	GPs preference for individual 'tacit knowledge'	GPs should make optimal use of available treatment options and be more critical of commercial marketing
2002	**Bechdolf, Schultze-Lutter, & Klosterkötter**	Self-experienced vulnerability, prodromal symptoms and coping strategies preceding schizophrenic and depressive relapses	Germany	Retrospective pilot study: interviews with BSABS, DSM IV, ESQ, ESS + cluster analysis, chi-quadrat of Fisher's exact test	Schizophrenia & depression	Pre-episodic disturbances, i.e. self-experienced vulnerability and prodromal symptoms + related coping strategies	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
2002	**Bull et al. (a)**	Discontinuation of use and switching of antidepressants Influence of patient-physician communication	USA	Mixed method: Tel. interviews; ICD -9; 7-item BDI-FS; survey + statistical analysis: 2 logistic regression models	Major depression or depressive disorder	SSRIs: Fluoxetine hydrochloride or paroxetine	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

2002	**Bull et al. (b)**	Discontinuing or switching Selective Serotonin-Reuptake Inhibitors	USA	Mixed method: Telephone surveys at 3 and 6 mos after treatment start + statistical analysis: logistic regression model	Major depression or depressive disorder; ICD 9	SSRIs	Adverse effects are the main reason for treatment discontinuation. Suggestion of possible adverse effects appears to induce such effects	Physicians and pharmacists should inform patients about possible adverse effects. Future research should address development of strategies to manage adverse effects
2002	**Castle, Morgan, & Jablensky**	Antipsychotic use in Australia: the patients' perspective	Australia	Qualitative: interviews	Self –reported use of antipsychotics in depression & schizophrenia	'atypical', antipsychotics (risperidone, olanzapine, and quetiapine)	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.	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
2002	**Egede Leonard E.**	Beliefs and Attitudes of African Americans with type 2 diabetes toward depression	USA	Qualitative study: focus group interviews. Health Belief Model used as a theoretical framework for design and analysis	Depression	The beliefs & patient attitudes and preferences re. depression treatment: general misconceptions low perception of vulnerability, denial as a barrier to effective treatment	Despite knowledge of depression and of effective treatment, multiple barriers and false beliefs may negatively influence adherence	Need to compare the beliefs of African Americans diabetics with such patients from other ethnic groups. Need for studies on the relationship btw beliefs & attitudes in depressed diabetics and treatment outcomes in ethnic minorities
2002	**Hensley & Nurnberg**	SSRI sexual dysfunction: a female perspective	USA	Commentary; 2 Case reports	Depression: DSM IV	Female sexual dysfunction associated with SSRIs and treatment with sildenafil	Sexual dysfunction is a common side effect of many ADs from different classes	Double-blind placebo-controlled trials of SSRIs-induced sexual dysfunctions in women are proceeding

2002	**Highet, Hickie, & Davenport**	Monitoring awareness of attitudes to depression in Australia	Australia	Cross-sectional telephone survey; stratified; reports of Australian community awareness, knowledge and attitudes	Mental health; depression	Lay beliefs and general attitudes in an Australian community	Depression was perceived to have the greatest impact on quality of life (QoL). Attitudes toward ADs were less negative than in the past.	The goal is to change critical attitudes and health behaviors. Future mental health campaigns need to be of significant intensity and duration
2002	**Katona & Livingston**	How well do antidepressant work in older people? A systematic review of Number Needed to Treat	UK	Review: Medline (1966-1999) & Embase (1994-1999) search. Analysis of data with Internet Interactive Statistical Calculation Pages; NNT	Depression, HAMD & MADRS scores	Analysis of research findings on antidepressants evaluated by placebo-controlled trials in older patients	The analysis supports the preferential use of SSRIs(exc. Fluoxetine) and of venlafaxine in depression treatment in older ppl	The authors urge that regulatory authorities consider requiring NNT & NNH data in future trials as one clinically relevant and understandable measure
2002	**Knudsen et al. (a)**	Changes in self-concept while using SSRI antidepressants	Denmark	Qualitative; Interviews taped and transcribed verbatim; Empirical analysis	SSRIs	Emotional problems vs. emotional illness	Findings in this study showed, the women's self-concept was closely related to their social lives	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.
2002	**Knudsen, Hansen, & Traulsen (b)**	Perceptions of young women using SSRI antidepressants – a reclassification of stigma	Denmark	Qualitative: Interviews	SSRIs	When suffering from emotional problems, the women saw themselves as dysfunctional in their daily lives	The young women using SSRIs felt stigmatized	Further studies should be conducted with other population groups of users of SSRIs to analyse perceptions in a broader perspective

2002	**Maidment, Livingston, & Katona**	Just keep taking the tablets': adherence to antidepressant treatment in older people in primary care.	UK	Assessment of patients using ADs; measured adherence and its multiple factors; statistical analysis	Depression, adherence to ADs measured with multiple scales & questionnaires; interviews	Prevalence or the associates of adherence to ADs in older ppl	1/3 of primary care patients who are thought to be adherent to ADs are not; a 'concordance therapy' & using medications that minimize side effects	Test the effectiveness of an intervention based on findings from this study
2002	**Pampallona et al.**	Patient adherence in the treatment of depression	USA, UK, Canada & Europe	Systematic review of computerized databases; studies published from 1973 to 1999. An *ad hoc* developed data extraction form	Unipolar depression	Extracting meaningful indications on non-adherence factors	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	Carefully designed clinical trials are needed to clarify effects of single and combined interventions on adherence
2002	**Posternak & Zimmerman**	The effectiveness of switching antidepressants during remission: a case series of depressed patients who experienced intolerable side effects	USA	Prospective cohort study	MD: Structured Clinical Interview for DSM-IV; SCORs, CGI-I	Switching ADs due to medications' troublesome side effects	Patients were followed for 8 to 110 weeks. Preliminary evidence: switching ADs while in remission eliminated intolerable adverse effects in all patients (n=9)	The results of this study need to be confirmed with larger, controlled trials
2002	**Prabhakaran & Butler**	What are older peoples' experiences of taking antidepressants	UK	Patients interviewed by doctors: face-to-face, or by telephone, brief questionnaire	Hospital diagnosis of depression: ICD-10, F30-F39	ADs: SSRIs & TCAs; older patients' self-reported experiences of treatment	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	Maximize efforts to reduce adverse effects of ADs in older people
2003	**Barbui, Tognoni, & Garattini**	Clinical databases of patients receiving antidepressants. The missing link between research and practice?	Italy	Brief report	Clinical pharmacology	Clinical databases for patients treated with ADs	Clinical databases should be developed, organized and utilized in avoidance of the gap between research and practice	Developing and maintaining clinical databases could ultimately constitute a permanent link btw. routine clinical practice and research

2003	**Bitner et al.**	Subjective effects of antidepressants. A pilot study of the varieties of antidepressant-induced experiences in meditators	USA	2-part questionnaire mailed, Likert scales + statistical analysis	Combined bipolar and unipolar subjects	A pilot study of subjective effects of ADs on meditators; combined SSRIs and 'other medication groups'	Meditation might be a helpful strategy in depression treatment, combined with ADs	Investigate the effects of meditation in prevention of relapse
2003	Bolling Madelon Y.	Subtle psychological side effects: documentation, description, and treatment implications of Selective Serotonin Reuptake Inhibitors taken for depression	USA	Dissertation				
2003	**Campbell, Clauw, & Keefe**	Persistent pain and depression: a biopsychosocial perspective	USA	Review	MDD and persistent pain	No studies have tested the effectiveness of early pain management in patients who are at risk for depression or who have recently become depressed.	Early pain management might be especially useful for patients who are at risk for depression who are not yet exhibiting significant depressive symptoms.	To elucidate cultural contributions to the experience of pain and depression, much more research is needed across a variety of racial and ethnic groups.
2003	**Garfield, Smith & Francis**	The paradoxical role of antidepressant medication - returning to normal functioning while losing the sense of being normal.	UK	Qualitative: interviews taped and coded	Depression and depression stigma	To identify factors of importance to patients beginning courses of antidepressant medication	Adverse drug reactions were of importance to respondents because of their direct effects and because they increased the stigma attached to taking antidepressant medication	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.
2003	**Gask et al.**	Qualitative study of patients' perceptions of the quality of care for depression in general practice	UK	Qualitative: purposive sampling & semi-structured interviews, n=27	Depression	To explore patients' actual experiences with the primary mental health care and quality of their services	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	A model of health care is advocated, in which patients with depression are followed up systematically

2003	**Geddes et al.**	Relapse prevention with antidepressant drug treatment in depressive disorder: a systematic review	UK	Systematic review of evidence from all RCTs published & unpublished	Depression, depressive disorder, dysthymia	All randomized trials until 2000 in which continued AD therapy was compared with placebo in patients who responded to acute treatment with ADs	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
2003	**Knudsen et al.**	Leading ordinary lives: a qualitative study of younger women's perceived functions of antidepressants	Denmark	Qualitative: interviews, re-interviews; community-based sample recruitment through pharmacies	Depression, OCD, Anxiety, Eating disorder/Depression	SSRIs	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
2003	**Kwon et al.**	Antidepressant use: Concordance between self-report and claims records	USA	Longitudinal depression study, Cross-sectional analysis	Depression	Adherence to antidepressant medications	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
2003	**Lin et al.**	Enhancing adherence to prevent depression relapse in primary care	USA	RCT, n= 386 primary care patients at high risk for recurrent depression, interviews at baseline	Depression	Pragmatic & 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	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
2003	**Manning & Marr**	'Real-life burden of depression' surveys - GP and patient perspectives on treatment and management of recurrent depression	UK	Qualitative: survey, narrative synthesis; standard deviation	Recurrent depression	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.	GPs may benefit from educational programmes that promote awareness of current guidelines for treating depression.

2003	**Masand, Prakash**	Tolerability and adherence issues in antidepressant therapy	USA	Lit. review, Commentary	Depression	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
2003	**Moore Darlene**	The impact of antidepressant use on self-efficacy and athletic performance in female student athletes	USA	Dissertation				
2003	**Posternak & Zimmerman**	How accurate are patients in reporting their antidepressant treatment history?	USA	Diagnosis of MD at baseline, treated with antidepressants; TRAQ, Structured Clinical Interview for DSM-IV	depressive symptomatolog y	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)	not found
2003	**Roeloffs et al.**	Stigma and depression among primary care patients	USA	CIDI-12, PAQ, utilization variables, statistical analyses: cross-sectional logistical regression models	Current depressive disorder	Stigma of depression	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
2003	**Scheibe et al.**	Are there gender differences in major depression and its response to antidepressants?	Germany/ Canada	Systematic literature review & research report; retrospective	Major depression, unipolar depression	Antidepressants (SSRIs, TCAs, SNRIs, MAOIs, & 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	Not found

2003	**Sleath, Wurst, & Lowery**	Drug information sources and antidepressant adherence	USA	Mixed method: qualitative interviews + statistical analysis: SPSS version 10.1	Depression	Available and popular sources of antidepressant information. Influence of self-obtained information about AD on treatment adherence	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
2003	**Sleath, Rubin, & Huston**	Hispanic ethnicity, physician-patient communication, and antidepressant adherence	USA(New Mexico)	Mixed method: qualitative audio-taped interviews + statistical analysis; linear regression	Depression	Hispanic patients respond and adhere to AD treatment differently than non-Hispanic people	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
2003	**Solberg et al.**	When depression is the diagnosis, what happens to patients and are they satisfied?	USA	Questionnaires, administrative record search, comparisons, chart audits, statistical analysis	Patients who met criteria for new depression cases	Effectiveness of available treatment options, which includes organized multifaceted and collaborative care approaches	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
2003	**Sullivan et al.**	Patient beliefs predict response to paroxetine among primary care patients with dysthymia and minor depression	USA	RCT; DSM IV, Prime-MD major depression mode, 17-item HAM-D; PAB scale, Hopkins Symptom Checklist; statistical analyses: t-Test and chi-square	Mild depression or Dysthymia	paroxetine or placebo; patients' beliefs were examined as predictors of treatment adherence and depression remission	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.	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
2003	Wiens Juliana	Depression and decision making: a material-discursive analysis of antidepressant use in women	Canada	MA THESIS				

2004	**Bann et al.**	Assessing patient beliefs in a clinical trial of *hipericum perforatum* in major depression	USA	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	MDD	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	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
2004	**Bhugra & Hsiao-Rei Hicks**	Effect of an educational pamphlet on help-seeking attitudes for depression among British South Asian women	UK	Qualitative fieldwork and focus groups, test of feasibility and acceptance by patients and doctors to be applied in real-world situations	Depression and suicidality	South Asian women suffer disproportionately high rates of suicide and attempted suicide. An educational pamphlet about depression and suicidality was introduced	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
2004	**E Boath, E Bradley & C Henshaw**	Women's views of antidepressants in the treatment of postnatal depression	UK	Qualitative: interviews, case notes, questionnaires; qualitative analysis + p-value assessed	Postnatal depression	Women are likely to choose options of self-medication in postnatal depression, which may be clinically ineffective	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
2004	**Bollini et al.**	Understanding treatment adherence in affective disorders: a qualitative study	Italy	Qualitative; 8 separate focus groups	Depression	Patients' models of depression, perceptions of the disease, treatment options, main causes of non-adherence; helpful interventions	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

2004	**Dinos et al.**	Stigma; the feelings and experiences of 46 people with mental illness	UK	Qualitative: narrative interviews	Authors relied on patients' own reports of their diagnoses as the most relevant description of their illnesses	Experiencing stigma, forms of stigma and forms of mental illness, types of stigma, perceived consequences of stigma, positive outcomes and/or lack of stigma	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	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
2004	**Frankenberger et al.**	Effects of information on college students' perceptions of antidepressant medication	USA	Mixed: 2 summaries of information, 4-part response packet, BDE-II + statistical analysis	DSM-IV-TR	Commercial advertising vs scientific information about depression and its treatment accessible to college students; influence of general perceptions	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
2004	**Garfield, Francis & Smith**	Building concordant relationships with patients starting antidepressant medication	UK	Prospective, naturalistic study, audiotaped interviews, data transcribed verbatim and coded to allow qualitative analysis	Depression	Work on a concordant approach responsive to the patients' needs	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.
2004	**Grime & Pollock**	Information versus experience: a comparison of an information leaflet on antidepressants with lay experience of treatment	UK	Qualitative; semi-structured interviews typed and fully transcribed with qualitative data analysis software program	Depression	6 commonly asked questions about AD in the Depression Alliance leaflet were used as a framework for analysis	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

2004	**Halter M J**	The stigma of seeking care and depression	USA	Attitudes Toward Seeking Professional Help Scale & Attribution Questionnaire	Depression	Seeking help in depression hindered by the mechanisms of the disorder. Stigmatization is a leading cause of under-diagnosis and under-treatment	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.	National focus on mental health should get the attention of policy makers. Researchers should study and develop successful interventions to minimize stigma and change general views on depression.
2004	**Haslam et al.**	Patients' experiences of medication for anxiety and depression: effects on working life	UK	Qualitative: focus groups,	Depression	Prevalence of anxiety and depression has increased, leading to extensive use of medication	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
2004	**Higgins, Livingston & Katona**	Concordance therapy: an intervention to help older people take antidepressants	UK	RTC	Depression in older people	Concordance Therapy over 3-4 sessions; 9 patients received treatment as usual; Main outcome measure: adherence at 1 month.	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
2004	**Rabheru Kiran**	Special Issues in the management of depression in older patients	Canada	Narrative review	SSRIs, venlafaxine, mirtazapine	Depressive disorders and management of treatment in older patients often complicated by the presence of comorbid medical and psychiatric conditions	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
2004	**Schwenk et al.**	Treatment outcome and physician-patient communication in primary care patients with chronic, recurrent depression	USA	Research report from a national probability sample; retrospective and self-report telesurveys; interviews	Chronic, recurrent depression	Description of findings of a national survey of primary care patients who were selected specifically for chronic and recurrent depression	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

2004	**Swan et al.**	"Coping with depression": an open study of the efficacy of a group psychoeducational intervention in chronic, treatment-refractory depression	UK	Brief report from uncontrolled group case series. EQ5D - + statistical analysis	Chronic or recurrent depressive disorder, BDI-II, BSI, global severity index, EQ	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.	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
2004	**van Schaik et al.**	Patients' preferences in the treatment of depressive disorder in primary care	The Netherlands	Systematic literature review	Depressive disorders	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.	Attention should be paid to the validation of preference measures, making comparability btw. Studies feasible;
2005	**Aikens et al.**	Adherence to maintenance-phase antidepressant medication as a function of patient beliefs about medication	USA	Survey + multivariate statistical analysis	Depression	Maintenance phase of treatment with antidepressants: factors influencing adherence	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	Determine whether patients' perceptions about medication determine treatment outcome, to improve clinical management of depression
2005	**Ashton et al.**	Antidepressant-related adverse effects impacting treatment compliance: results of a patient survey	USA	Survey	Depression	The impact of adverse effects on compliance and quality of life	This survey of patients with mild to severe depression suggest that compliance /efficacy can be promoted	Future studies to confirm this hypothesis may provide physicians with suggestions for making treatments more acceptable to patients.
2005	**Badger & Nolan**	Attributing recovery from depression. Perceptions of people cared for in primary care	UK	Purposeful sample, semi-structured interview	Unipolar depression, depressive symptoms	Personal accounts of attribution of recovery are largely absent from the literature	Ppl with depression consider their recovery multifactorial. Preferences for a 'portfolio' of care.	Mental healthcare practitioners should acknowledge and support a variety of approaches to treatment and strategy in promoting recovery

2005	**Bazargan, Bazargan-Hejazi, & Baker**	Treatment of self-reported depression among Hispanics and African Americans	USA	Mixed: Survey of random samples of 287 adults where over 48% reported to suffer from depression; statistical analysis	Mental disorders; untreated depression	There is an urgent need for aggressive intervention toward identifying and treating underserved minority individuals with mental disorders	The perception of discrimination and racism is significantly correlated with depression status in Hispanics and African Americans	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
2005	**Beck Cynthia et al.**	Psychotropic medication use in Canada	Canada	Mixed: Cross-sectional survey; Statistical analysis; SAS	CIDI-diagnosed disorders	Sedative-hypnotic, mood stabilizer, psychostimulant, & antipsychotic use; Prozac, Paxil, Effexor	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.	Data collection of treatment quality, icl. dosage and duration of pharmacotherapy and indication for use
2005	**Brown et al.**	Beliefs about antidepressant medications in primary care patients: relationship to self-reported adherence	USA	Observational study of medication adherence. Report, Statistical analyses	Depression	Beliefs about medicines in 192 primary care patients	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	Medication beliefs are important attitudinal variables that should be incorporated into self-regulatory models such as Leventhal's when studying adherence to ADs.
2005	**Chao et al.**	The mediating role of health beliefs in the relationship between depressive symptoms and medication adherence in persons with diabetes	USA	Cross-sectional design; Survey + multivariate statistical analysis SAS	MD; depressive symptoms and diabetes. PHQ-8 derived from PHQ-9. Morisky's and Horne's scales	How depression effects medication adherence and other self-care behaviors in diabetes	Subjects with greater depressive symptoms had lower adherence to their diabetes medication regimens	The findings from this study would benefit from development of strategies to improve the self-management of diabetes
2005	**Gonzales et al.**	Adherence to mental health treatment in a primary care clinic	USA	Prospective Cohort Observational study; questionnaire; statistical analysis; logistic regression	Depression	This is said to be one of few studies to prospectively identify predictors of nonadherence	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	Adherence to AD medications and to mental health referrals should be assessed through separate studies

2005	**Haslam et al.**	Perceptions of the impact of depression and anxiety and the medication for these conditions on safety in the workplace	UK	Qualitative, descriptive approach; focus groups; transcribed data analyzed by sorting and coding	Anxiety & depression; HAD questionnaire	Occupational health strategy. Early detection of mental health problems in workplaces is fundamental	Workers reported that symptoms and medication's adverse effects impacted their work performance.	Future quantitative studies in this area might focus on reported accidents at workplaces and link them with depression
2005	**Jorm, Christensen & Griffiths**	Belief in the harmfulness of antidepressants: Results from a national survey of Australian public	Australia	Survey; interview, vignette; statistical analysis	Depression	Sociodemographic characteristics, exposure to depression, ability to recognize depression, beliefs about: causes and alternative treatment and long-term outcomes with and without treatment; stigma	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
2005	**Karasz Alison**	Cultural differences in conceptual models of depression	USA	Purposive (snowball) sampling vignette, interview; Statistical hypothesis testing and descriptive analysis	Depression	Why do SA and individuals from other traditional societies rarely seek treatment for depression?	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
2005	**Kessing et al.**	Depressive and bipolar disorders: patients' attitudes and beliefs towards depression and antidepressants	Denmark	Antidepressant Compliance Questionnaire; statistical analysis	Depressive and bipolar disorders, ICD-10	Among patients discharged from hospital with depressive or bipolar disorders, older patients (aged above 40 years) had more negative views	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

2005	**Lauber, Nordt, & Rössler (a)**	Lay beliefs about treatments for people with mental illness and their implications for anti-stigma strategies	Switzerland	Representative sample, computer assisted telephone interviews, vignette; DSM-III-R; statistical analysis	Mental disorders: MD or schizophrenia	Research on public attitudes. Tel. interviews. Attitudes should not be mistaken for actual interpersonal behavior, but should be acknowledged as proxy measures of social behavior	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
2005	**Lauber, Nordt, & Rössler (b)**	Recommendations of mental health professionals and the general population on how to treat mental disorders	Switzerland	Mixed method: vignette and interview + statistical analysis	Mental health	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
2005	**Lin et al.**	The influence of patient preference on depression treatment in primary care	USA	Screening interview, assessment interview, final assessment in a statistical analysis	Depression & dysthymia	Matching treatment to patients' preference might affect treatment outcome	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
2005	**Maxwell, M.**	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	UK	Qualitative interviews; constant comparison method of analysis (Glaser & Strauss)	Depression	For both doctors and patients, the recognition and diagnosis of depression is a complex process involving social and moral reasoning	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

2005	**Ozmen et al.**	Public opinions and beliefs about the treatment of depression in urban Turkey	Turkey	Public survey	Depression	Opinions and beliefs about the treatment of depression; influence of demographic features, perception and causality of depression on people's perception	The beliefs that "psychological and social interventions are more effective than pharmacotherapy" and "antidepressants are harmful and addictive" must be taken into account in clinical practice and in anti-stigma campaigns	Studies are needed to understand the public's tendency to conceptualize depression as a psychosocial problem
2005	**Pound et al.**	Resisting medicines: a synthesis of qualitative studies of medicine taking	UK	Synthesis of qualitative studies on medicine taking	6 studies on psychotropic medications	The significance of the lay evaluation of medicines lies not simply in the fact that it occurs, but in the reasons why it occurs	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.	There is a need to accept that people are unlikely to stop resisting their medicines. Safer ways need to be found to administer medicines, and to monitor their effectiveness and acceptability to individual patients
2005	**Rapaport et al.**	Quality-of-life impairment in depressive and anxiety disorders	USA	Baseline Quality of Life Enjoyment and Satisfaction Questionnaire, demographic, and clinical data from 11 trials; regression analyses	Depressive and anxiety disorders	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	Patients with affective or anxiety disorders who enter clinical trials demonstrate significant quality-of-life impairment, although the degree of dysfunction varies	Individual perception of quality of life is an additional factor that should be subject of a complete assessment
2005	**Rieder-Heller, Matchinger, & Angermeyer**	Mental disorders - who and what might help? Help seeking and treatment preferences of the lay public	Germany	A fully structured face-to-face interview	Depression & schizophrenia	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	Public expectations differ from evidence-based psychiatric treatment	More effort should be put into psychoeducation; public knowledge about mental disorders and their treatment strategies needs to be enhanced

2005	**Sher et al.**	Effects of caregivers' perceived stigma and causal beliefs on patients' adherence to antidepressants	USA	Prospective, longitudinal analysis	Depression	Caregivers' attribution of depression to cognitive and attitudinal problems significantly predicted patients' decreased adherence	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	It is recommended to involve caregivers in treatment to improve their attitude toward persons with depression and with it, enhance patients' adherence and treatment outcome
2005	Singh, Reshmi	College students' depression treatment decision-making: A narrative of the trajectory of their antidepressant use.	USA	Dissertation Qualitative-Phenomenology				
2005	**Tatano Beck & Indman**	The many faces of postpartum depression	USA	Secondary analysis conducted on data collected from an earlier psychometric testing of PDSS	PDSS followed by DSM-IV diagnostic interview. convenience sample	Mother's responses in this sample support anxiety and irritability as major symptoms in PD	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	Clinician who treat new mothers need to be alert to the range of possible depressive symptoms so these mothers do not suffer in silence
2005	**Van Vorhees et al.**	Beliefs and attitudes associated with the intention to not accept the diagnosis of depression among young adults	USA	Cross-sectional study	CES-D; an internet-based public health depression screening program; statistical analysis	Beliefs and attitudes, views on social norms; past behavior; rejection of medication, disbelief in depression's biological causes, embarrassment	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	Policy makers should consider increased monetary value of physician's time and efforts in the process of detection, correct diagnosis and effective treatment of depression
2005	**Willhelm et al.**	Great expectations: Factors influencing patient expectations and doctors recommendations et the Mood Disorders Unit	Australia	Self-report questionnaires, CIDI, MDU, 2 principal component analyses,+ statistical analysis	DSM-III-R or DSM-IV major depression, current depressive symptoms and lifetime diagnoses for anxiety disorders	Help seeking behavior is complicated by the stigma of depression and the non-recognition of its symptoms	Patients' illness characteristics were found to be the strongest predictor of patients' expectations and doctor's recommendations	Clinicians should make use of resource lists of books or websites that provide information for patients and their families and friends: http://blackdoginstitute.org.au

2006	**Backenstrass**	Preferences for treatment in primary care: a comparison of nondepressive, subsyndromal and major depressive patients	Germany	the German form of the PHQ-9, univariate analysis	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 <20% of primary care patients accepted both therapy options and ca 12% refused both treatment options	The group of depressive patients could be differentiated from patients without the disorder regarding their preferences
2006	**Bulloch, Adair, & Patten**	Forgetfulness: A role in noncompliance with antidepressant treatment	Canada	Survey using data from the Alberta Mental Health Survey + statistical analysis with Stata Software	ADs	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	To confirm generalizability, a Canada-wide study would need to be conducted
2006	**Burroughs et al.**	Justifiable depression': how primary care professionals and patients view late-life depression? A qualitative study	UK	qualitative: semi-structured interviews;	Depression	Depression as most common mental health problem in elderly people and continues to be underdiagnosed and undertreated	The study highlights the complicated nature of the diagnosis and management of late-life depression	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
2006	**Chur-Hansen & Zion**	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'	Australia	Qualitative: in-depth, open-ended, semi-structured interviews	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	A quantitative study could address the question of the relative incidence of both positive and negative experiences with SSRIs.
2006	**Cohen et al.**	Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment	USA	Prospective nonrandomized cohort study; longitudinal psychiatric assessment; statistical analysis	Major depression	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.	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

2006	**de Groot et al.**	Depression treatment and satisfaction in a multicultural sample of type 1 And type 2 diabetes	USA	Convenience sampling, cross-sectional survey design; self-report questionnaires; statistical analysis	Depressive symptoms	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.	Longitudinal studies are needed to evaluate effectiveness of depression treatment in community samples
2006	**Givens et al.**	Older patients' aversion to antidepressants A qualitative study	USA	Cross-sectional, qualitative study; semi-structured interviews	Depression	Fear of dependence; resistance to view depression as illness; concerns that ADs will prevent natural sadness; prior negative experiences with AD medications	Many older patients resisted the use of ADs. Concerns reflected their concepts of depression and ADs.	Concerns expressed by older patients may be representative of larger groups. Larger studies utilizing survey methods may determine if these views are common
2006	**Granger et al.**	An assessment of patient preference and adherence to treatment with Wellbutrin SR	USA	A Web-based online survey; analysis with descriptive statistics	Depression	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	Associations btw. nonadherence and other variables, such as age, gender, and concomitant AD use
2006	**Gum et al.**	Depression treatment preferences in older primary care patients	USA	Multisite RCT comparing usual care to collaborative care	Depression in older primary care patients	Baseline assessment on demographics, depression, health information, prior depression treatment, potential barriers, and treatment preferences (medication, counselling). Outcomes assessed after 12 months	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.

2006	**Hanley & Long**	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
2006	**Karasz & Watkins**	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.
2006	**Kessing, Hansen, & Bech**	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
2006	**Lafrance & Stoppard**	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
2006	**Lavender, Khondoker, & Jones**	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

2006	**Lawrence et al. (a)**	Coping with depression in later life: A qualitative study of help-seeking in three ethnic groups	UK	Qualitative; in depth-interviews	Depression	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.	Efforts to socialize and remain active may provide a useful and acceptable adjunct to clinical interventions
2006	**Lawrence et al. (b)**	Concepts and causation of depression: a cross-cultural study of the beliefs of older adults	UK	Qualitative: In depth separate interviews	Depression	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.	Health and social care professionals need to be sensitive to language in depression in various ethnic groups
2006	**Lynch et al.**	Patients' beliefs about depression and how they relate to duration of antidepressant treatment. Use of a US measure in a UK primary care population	UK	Cross-sectional questionnaire survey, PDIQ, HADS, MARS; multiple regression	Depression	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	Longitudinal research is needed to establish cause and effect
2006	**Martin-Lopez et al.**	The strategy of combining antidepressants in the treatment of Major Depression: clinical experience in Spanish outpatients	Spain	Review of 3 databases, surveys	MDE DSM-IV; HAMD 17; statistical analysis, chi-square	SSRIs + TCAs	The strategy of combining AD medication seems to be dictated by trends and tendencies in prescription patterns	Further efforts to evaluate this strategy are required
2006	McKay, Bill	The use of antidepressants and counselling for depression: the lived experience of post-secondary students and counsellors	Canada	MSc THESIS				

2006	**Mitchell, A.J. (a)**	Adherence behaviour with psychotropic medication is a form of self-medication	UK	Narrative review	Depression, schizophrenia and bipolar disorder	The self-medication hypothesis states that patients decide to start, adjust or stop prescribed medication according to perceived health needs.	Significant influences upon self-medication 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
2006	**Mitchell, A.J. (b)**	Depressed patients and treatment adherence	UK	Commentary	Depression	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.
2006	**Moncrieff & Cohen**	Do antidepressants cure or create abnormal brain states?	UK	Review and summary of findings	Depression	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.	The term “antidepressant” should be abandoned.
2006	**Morgan et al.**	Difficulty taking medications, depression, and health status in heart failure patients	USA	Clinical evaluation, Questionnaires, 5-level Likert-scale question; statistical analyses: multivariable regression	Heart failure, depression	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

2006	**Naeem et al.**	Stigma and psychiatric illness. A survey of attitude of medical students and doctors in Lahore, Pakistan	Pakistan	Survey + statistical analyses (SPSS)	mental illness	Exploring stigma a) well spoken English and familiarity with English psychiatric terminology, b) medical professionals can influence the reduction of mental health stigma	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	The authors plan to further this work, by exploring attitudes of the lay public.
2006	**Olfson et al.**	Continuity of antidepressant treatment for adults with depression in the United States	USA	Data were drawn from the household component of the Medical Expenditure Panel Survey for 1996-2001	Antidepressant medication SSRI, SNRI	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	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	In efforts to improve adherence of AD medications, priority should be given to the socioeconomically disadvantaged populations
2006	**Ros, Leszek Tomasz**	Treatment of postpsychotic depression with sertraline in patients with schizophrenia - own experience	Hungary	Case report and commentary	Post-psychotic depression, drug-refractory depression	AD neuroleptic, Sertraline, imipramine, DSM-IV, HAMD	The authors found that both drugs sertraline and imipramine were effective but sertaline proved better than imipramine	not found
2006	**Tully et al.**	Why Am I Depressed? An Investigation of Whether Patients' Beliefs About Depression Concur With Their Diagnostic Subtype	Australia	BDI, questionnaire, interview; statistical analysis	Primary depressive disorder	The study suggests a need for greater focus on etiological factors and subtyping.	Patients can distinguish btw. differing causes for depression and patients' beliefs about their non-melancholic depression concur with the clinical subtyping diagnosis.	Continue to investigate patients' views about the causes of depression, as well as other aspects of mental health literacy, such as beliefs about help-seeking and treatment efficacy.

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 SSRIs, 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

2006	**Zimmerman et al.**	How should remission from depression be defined? The depressed patient's perspective	USA	Qualitative: interview, questionnaire	Major depressive episode, DSM I-V	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	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.
2007	**Akincigil et al.**	Adherence to antidepressant treatment among privately insured patients diagnosed with depression	USA	Retrospective, observational study; HEIDIS quality measures	Depression	Factors associated with poor adherence in a privately insured population using medical and pharmacy claims	Alcohol and other substance abuse increase risk of poor depression treatment outcomes	More research needed to clarify responsible mechanisms for adherence
2007	**Badger F. & Nolan P. (a)**	Use of self-chosen therapies by depressed people in primary care	UK	Qualitative: interviews and documented self-reported treatment stories	Depression	Use of complementary and alternative treatments are common among people with depression and doctors' familiarity with such treatments might be beneficial	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
2007	**Badger & Nolan (b)**	Attributing recovery from depression. Perceptions of people cared for in primary care	UK	A purposeful sampling; semi-structured interviews; Framework approach to data analysis;	Depression	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.	Doctors must aim to explore patients' beliefs about treatments and recovery. Addressing these can promote adherence and enhance recovery

2007	**Baldwin et al.**	Discontinuation symptoms in depression and anxiety disorders	Europe, Canada, and South Africa	Used data from all completed RCTs; evaluated with DESS checklist, statistical analysis	MDD, SAD, GAD	SSRI (escitalopram), venlafaxin XR, SNRI, paroxetine, placebo	Escitalopram showed a lower number of discontinuation symptoms than paroxetine or venlafaxine XR, confirming that discontinuation symptom profiles differ btw. antidepressants and btw. SSRIs.	This study did not examine whether tapering might demonstrate advantages compared to abrupt discontinuation. Further studies may focus on the effect of tapering
2007	**Bennett et al.**	Becoming the best mom that I can: women's experiences of managing depression during pregnancy	Canada	Constructivist grounded theory	Depression	When confronted with depression, the women employed strategies of overcoming barriers, gaining knowledge, and taking control.	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.	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.
2007	**Burra et al.**	Predictors of self-reported antidepressant adherence	Canada	Self-report questionnaires	Depressive disorders	A group of mood-disorder outpatients (n=80) were assessed for beliefs about ADs, self-efficacy, and reasons for nonadherence	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.	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
2007	**Buultjens & Liamputtong**	When giving life starts to take the life out of you: women's experiences of depression after childbirth	Australia	Qualitative: in depth interviews	Postnatal depression	Postnatal depression is a complex illness with varying degrees, reasons for onset and medical treatments.	Emotions and feelings of women were captured and it is hoped that health-care practitioners will gain a deeper understanding of this debilitating condition	It is hoped, in making the wider community aware of depression after childbirth, fewer women will suffer in silence
2007	**Cabassa, Lester, & Zayas**	"It's like being in a labyrinth": Hispanic Immigrants' perceptions of depression and attitudes toward treatments	USA	vignette, interviews; open-ended questions, IPQ-R, PARC-D, BAS, CES-D, NVIVO 2.0, Chi-square, t-test	Depression	The study examined how demographics, acculturation, clinical factors, and past treatment influenced their perceptions and attitudes	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	The study emphasizes the need to incorporate Hispanic immigrants' perceptions and attitudes into depression treatment

2007	**Cooper et al.**	Why people do not take their psychotropic drugs as prescribed: results of the 2000 National Psychiatric Morbidity Survey	UK	Data used from 2000 British Survey of National Psychiatric Morbidity; interviews,	Psychosis, early psychosis and depression	SSRIs; People reported that nonadherence was their decision because they did not want it or did not think the treatment was necessary	34.2% of participants reported incomplete adherence to their psychiatric medication. Reasons given: forgetting, losing, running out, reluctance to taking drugs and side effects	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
2007	**Cornford, Hill & Reilly**	How patients with depressive symptoms view their condition: a qualitative study	UK	Semi-structured interviews	Depression	HADS in a primary care settings. Patients' views about depressive symptoms differ from conventional medical views.	Differentiating depression from understandable reactions to life adversity was difficult for patients. Negative images of depression, i.e. depression is a 20-centrury phenomenon, were pervasive. Views about medication varied	The wide employment of techniques patients use to control their disorders, such as support from others, engagement in activities an working on relationships, doctors may recommend as alternative treatment to ADs
2007	**Dobscha, Corson, & Gerrity**	Depression treatment preferences of VA primary care patients	USA	RCT, DEP-PC, PHQ, Hopkins Symptom Check List, CIDI, AUDIT-C; statistical analysis	Depression, PTSD	Half of the veterans preferred ADs or ADs plus counselling, and one-quarter preferred watchful waiting	The results document depression treatment preferences of veterans and suggest that receiving treatment and clinical response do not relate to having particular preferences	Further study involving observation of actual clinical interactions and use of more sensitive measures of treatment to better clarify the relationships among preferences, treatment offered and received, and clinical outcomes
2007	**Eisenberg, Golberstein, & Gollust**	Help-seeking and access to mental health care in a university student population	USA	random sample, a Web-based survey, statistical analysis	MD, other depression, panic disorder, GAD	Greater investments in student mental health services may be necessary	Effective mechanisms to identify students with the most serious needs are crucial; health insurance plans and primary care clinics could help improve access to care	Investigate the roles of institution-level factors, such as policies and perceptions related to confidentiality and repercussions for being known to have a mental disorder
2007	Ellen, Steven	Depression and anxiety. Pharmacological treatment in general practice	Australia	GREY LIT.				

2007	**Frank et al.**	The patient experience of depression and remission: Focus group results.	USA	Qualitative: focus groups; audiotaped and transcribed; interpretive summary with qualitative methods	Depression, DSM-IV	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.	A comprehensive measure of early symptom remission should include the following constructs: irritability, sadness/depressed mood, negative thoughts, low energy/motivation, interest, and agitation.
2007	**Gardner et al.**	A comparison of factors used by physicians and patients in the selection of antidepressant agents	Canada	Matching surveys, focus groups; statistical analysis	Depression	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	Follow-up interventional studies are required
2007	**Gilchrist & Gunn**	Observational studies of depression in primary care: what do we know?	Australia	Systematic review of observational studies	Depression	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	Future research should be large enough to investigate risk factors for chronicity and relapse
2007	**Givens et al.**	Ethnicity and preferences for depression treatment	USA	Cross-sectional Internet survey, CES-D, statistical analysis: multivariable regression	Depression	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	Future studies should focus on identifying the most cost-effective approaches to the training of health professionals in patient-centered communication and cultural competence

2007	**Hansen & Kessing**	Adherence to antidepressant treatment	Denmark	Review	Depression	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
2007	**Hickie et al.**	Perspectives of young people on depression: Awareness, experiences, attitudes and treatment preferences	Australia	Mixed methods: survey and statistical aanalysis	Depression	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.
2007	**Holt, Martin**	Agency and dependency within treatment: Drug treatment clients negotiating methadone and antidepressants	Australia	Qualitative: interviews	Depression, opioids abuse,	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 "well-being"
2007	**Hunot et al.**	A cohort study of adherence to antidepressants in primary care: The influence of antidepressant concerns and treatment preferences	UK	A cohort study; self-report, MARS, statistical analysis	Depression	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

2007	**Iacoviello et al.**	Treatment preferences affect the therapeutic alliance: Implications for RCTs	USA	RCT comparing supportive-expressive psychotherapy with sertraline or pill placebo	MDD; DSM-IV, 17-HAMD, statistical analysis	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	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
2007	**Interian et al.**	A qualitative analysis of the perception of stigma among Latinos receiving antidepressants	USA	Qualitative - grounded theory approach and qualitative analysis	Depression	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	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
2007	**Johnston et al.**	Qualitative study of depression management in primary care	UK	Qualitative - grounded theory	Depression	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	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
2007	**Kates & Mach**	Chronic disease management for depression in primary care: A summary of the current literature and implications for practice	Canada	Review of RCTs	Depression	Primary care practices need to be able to regularly monitor patients during and after treatment of a depressive episode	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.

2007	**Lader, M.**	Pharmacotherapy of mood disorders and treatment discontinuation	UK	Review and commentary	Depression	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
2007	**Lafrance, Michelle N.**	A bitter pill: A discursive analysis of women's medicalized accounts of depression	Canada	Discourse analytic approach; semi-structured interviews	Depression	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
2007	**Leahy-Warren & McCarthy**	Postnatal depression: prevalence, mothers' perspectives, and treatments	UK	Review	Postnatal depression	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
2007	**Leydon, Rodgers, & Kendrick**	A qualitative study of patient views on discontinuing long-term SSRIs	UK	Qualitative	Depression	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.
2007	**Leykin et al.**	The relation of patients' treatment preferences to outcome in a RCT	USA	RCT, longitudinal analysis with Hierarchical Linear Modeling,	MDD; , DSM-IV, HRSD,	Treatment preference; ADs, cognitive therapy and placebo	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

2007	**Mitchell, A. J.**	Adherence behavior with psychotropic medication is a form of self-medication	UK	**Narrative review**	Depression, bipolar disorder, schizophrenia	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	When considering the patients' perspective in medication adherence, it is useful to consider the self-medication hypothesis. People appear to prefer to take medication "as required" (symptomatically) rather than prophylactically.	Not found
2007	**Mitchell & Selmes**	Why don't patients take their medicine? Reasons and solutions in psychiatry	UK	**Literature review**	Schizophrenia & depression	Over the course of a year, three-quarters of patients on psychotropic medication discontinue without informing the doctor	Before prescribing medication clinicians should acknowledge to the patient the difficulties taking ADs, outline realistic benefits and discuss possible adverse effects and consideration of treatment alternatives	It is suggested that methods are developed that help patients who have adherence difficulties. New research is required to discover which methods are effective
2007	**Molenaar et al.**	Does adding psychotherapy to pharmacotherapy improve social functioning in the treatment of outpatient depression?	The Netherlands	diagnosis with a semi structured interview, RCT	MDD, recurrent or chronic depression, dysthymia, DSM-III-R; 17-HDRS	SSRI: fluoxetine, TCA, amitryptyline, moclobemide (RIMA), COT (combined therapy), SPSP, statistical analysis ANCOVA	A partial support for the hypothesis found that a combination of psychotherapy and pharmacotherapy would show more effect in relieving depressive symptoms and improving social functioning than drugs alone	In a future article, the authors hope to clarify the issue about the long-term effects of combined treatment on social functioning
2007	**Okuyama et al.**	Mental health literacy in Japanese cancer patients: ability to recognize depression and preferences of treatment-comparison with Japanese lay public	Japan	Random sampling, structured interviews; vignette; statistical analysis	Depression in cancer patients	To examine Japanese cancer patients' (CP) ability to recognize depression and their preferences of its treatments	The results indicated that cancer patients' knowledge about mental illness and its treatment were insufficient.	Psychological education may reduce patient-related barriers to seek and to utilize optimal mental health care in cancer patients.
2007	**Parker & Crawford**	Judged effectiveness of differing antidepressant strategies by those with clinical depression	Australia	Survey on the Black Dog Institute Website; n=2692; quantitative analyses, SPSS	clinical depression; DSM IIIR& ICD 10-DCR	venlafaxine rated higher than SSRIs with fluvoxamine rated lowest in the SSRI class; TCA dothiepin superior to other TCAs	Many self-help strategies rated as strongly as professionally recommended strategies, with exercise being rated extremely highly.	It might be useful to study the highly rated alternative therapeutic strategies more closely: exercise, yoga/meditation, relaxation and massage

2007	**Prins et al.**	Health beliefs and perceived need for mental health care of anxiety and depression	The Netherlands	Systematic review	Depression	A majority of people view Ad as addictive and many perceive stigma and see practical and economic barriers to care	People who suffer from depression have more positive beliefs about biological etiology and medication treatment than healthy people. All patients prefer psychological treatment forms to medication.	More research is required into the specific needs of anxiety and depression patients. Open communication btw. Patient and health care provider could lead to valuable improvement in treatment
2007	**Sherwood, Salkovskis, & Rimes**	Help-seeking for depression: The role of beliefs, attitudes and mood	UK	CACO Cohort study; self-report questionnaires,	Depression	Threshold was measured for: help-seeking, beliefs about depression, current depression and self-management skills	Results showed lower thresholds for professional help-seeking in those who had previously received psychological treatment than in those treated with ADs only and non-clinical controls	Further research should clarify the extent to which help-seeking co-varies with depressed mood. More work is needed to reduce the stigma
2007	**Simon et al.**	Depressed patients' perceptions of depression treatment decision-making	Germany	Convenience sample; semi-structured interview	Depression	Patients' prior experiences with depression and treatment perceptions of the treatment decision-making process, needs and expectations about treatment. Assessed depression severity	Patients' lack of insights re. depression severity substantially delayed patient engagement in treatment seeking and decision-making. Patients expected GPs to be the source of objective information and provide emotional support	Shared-treatment decision making (SDM) approaches for depression treatment should be adapted based on depression severity and patient-identified needs
2007	**Slingsby et al.**	Physician strategies for addressing patient adherence to prescribed psychotropic medications in Japan: a qualitative study	Japan	Qualitative: semi-structured interviews; purposive sample; analysis; data collection; reflexive journal	Depression	Physicians across the world seek to overcome patients' misperceptions re. mental health diagnoses and psychotropic medications.	Physicians believed SSRIs decrease rather than reinforce patients' resistance. Participants believed that patients resisted the use of ADs because of held misperceptions	Given the efficacy of advanced communication and patient education strategies for treatment adherence in other countries, similar strategies deserve formal assessment in Japan.

2007	**Smardon, R.**	'I'd rather not take Prozac': stigma and commodifi cation in antidepressant consumer narratives	USA	Qualitative: narrative interviews	Depression	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	Tragically, the limited images of mental illness, healing and medicine that are circulated in the media tend to misrepresent the experiences of the mentally ill and distort the effectiveness of antidepressants.	Future research on pharmaceutical consumption ought to take seriously how antidepressant consumers incorporate media representations to tell their antidepressant narratives
2007	**Tentler et al.**	Factors affecting physicians' responses to patients' requests for antidepressants: focus group study	USA	Focus groups interviews and brief demographic questionnaires	not found	Patients' requests have a profound impact on prescribing, especially when prompted by direct-to-consumer-advertising (DTCA)	The most common affective responses to patients' requests are annoyance, empathy and frustration with time lost discussing the pros and cons of the DTCA-recommended drugs	Developing a model that includes relevant clinician, patient and contextual features can provide a framework for future research
2007	**Jürgen Unützer**	Late-life depression	USA	Vignette, review, commentary; PHQ;	Depression	More than 20 ADs have been approved by the FDA for the treatment of depression in older adults	Patients with depression that persists after one or more trails of medication for 8 to 12 weeks, and suicidal patients, who have had previous manic symptoms while on AD, or who have psychotic symptoms, should be referred for psychiatric consultation	Educational information (www.nimh.nih.gov/Health) Information /Depressionmenu.cfm), the American Association for Geriatric Psychiatry (www.aagpgpa.org), and the IMPACT Program for Late-Life Depression (http://impact-uw.org)

2007	**van Geffen et al.**	Evaluation of patients' experiences with antidepressants reported by means of a medicine reporting system	The Netherlands	Reports submitted to an internet-based medicine reporting system related to the use of ADs were analysed, statistical analysis	not found	Relevance of side effects was assessed by comparing the proportion of adverse effects that cause discontinuation of the initial AD use, incl. categories "discontinuation" and "switching to other treatment	Patients report the ineffectiveness and side effects of AD therapy as negative and leading to treatment discontinuation. Patients and HCPs differ n the nature of the reported side effects.	Patient experiences should be included in the evaluation of AD treatment in clinical practice
2007	**Wang et al.**	Gender specific correlates of stigma toward depression in a Canadian general population sample	Canada	Probability sampled population-based survey; depression stigma scale, statistical analysis	Depression	Generalizing the findings to other populations with different demographic and cultural compositions should be made cautiously	In multivariate linear regression models, correct identification of depression in a case description and agreement with health professionals bout treatments were associated with low stigma scores, regardless of gender	Improving mental health literacy may be one of the promising ways to reduce stigma associated with depression.
2007	**Weich et al.**	Attitudes to depression and its treatment in primary care	UK	Cross-sectional survey	History of an ICD-10 depressive episode in the year preceding the episode	Experience of moderate and severe depressive episodes	1) depression is a disabling, permanent state; 2) it is a medical condition responsive to support; 3) ADs are addictive and ineffective	People with moderate or severe depressive episodes have subtle and divergent views about this condition, its outcome, and appropriate help. Such beliefs should be considered in primary care as they may have a significant impact on help seeking and adherence to treatment
2007	**Winkler et al.**	Escitalopram in a working population: results fom an observational study of 2378 outpatients in Austria	Austria	Treatment with escitalopram were compared (mirror study design). Further clinical examination using SGI-S and CGI-I	Mood and anxiety disorders	Most of the patients in this study were treated with 10 mg/day of escitalopram	The results suggest that escitalopram is an efficacious and overall well-tolerated treatment in a naturalistic sample of working patients. A decrease in the days on sick leave is indicative of indirect cost-effectiveness of this treatment	Future observational trials should investigate, if escitalopram possesses similar efficacy in the continuation and long-term treatment of affective and anxiety disorders

2008	**Aikens, Nease, & Klinkman**	Explaining patients' beliefs about the necessity and harmfulness of antidepressants	USA	Interview and self-report measures; cross-sectional trial; multi-staged trial of medication and psychotherapy; statistical analysis	Unipolar nonpsychotic major depression	Young people view their depressive symptoms as mild and transient and feel unclear about the factors affecting their depression	Scepticism about ADs is strongest among younger patients who have never taken ADs	The present patient sample from this trial will be followed through the entire treatment course. The resulting data will help reveal how these key beliefs evolve during treatment and indicate which variables should be targeted to enhance adherence and outcome
2008	**An, S.**	Antidepressant direct-to-consumer advertising and social perception of the prevalence of depression: Application of the availability heuristic	USA	telephone surveys + statistical analysis	Depression	DTCA - Zoloft, Paxil, Prozac and Wellbutrin	The results of this study provide some cause for concern: it is possible for those with heightened perceived prevalence to self-diagnose and strongly insist on the prescription of the advertised drug from the physician	This study calls for more scholarly attention to the cognitive effects of DTCA
2008	**Cabassa et al.**	Azucar y nervios: Explanatory models and treatment experiences of Hispanics with diabetes and depression	USA	Purposive sample from RCT; focus groups, in depth semi-structured interviews; Data analysis: grounded theory	Depression	Depression was perceived as a serious condition linked to the accumulation of social stressors	Somatic and anxiety-like symptoms and the cultural idiom of 'nervios' were central themes in low-income Hispanics' explanatory models of depression. Perceived reciprocal relationship btw depression and diabetes illustrated multiple ways by which these two illnesses impact each other	More studies are needed to examine how low-income Hispanics and other underserved communities conceptualize and cope with these illnesses in order to develop better patient-centered interventions aimed at reducing the morbidity and mortality
2008	**Dijkstra, Jaspers & van Zwieten**	Psychiatric and psychological factors in patient decision making concerning antidepressant use	The Netherlands	Cohort study, questionnaire, statistical analysis	Anxiety & depression	It is important to increase insight into patients' decision making regarding the use of ADs	It is not so important whether ADs are really effective or discontinuation really leads to withdrawal effects; rather, it is important whether patients *think* the AD is effective or *think* that they will experience withdrawal symptoms	Data from this study increase our understanding of patient decision making, thereby empowering health care professionals to further offer services that are best for the patient

2008	**Katja van Geffen**	Initiation, execution and discontinuation of antidepressant therapy.	The Netherlands	Dissertation				
2008	**Hanson & Scogin**	Older adults' acceptance of psychological, pharmacological, and combination treatments for geriatric depression	USA	Community-dwelling non-depressed participants; vignette, statistical analysis	Depression	AD treatment in older patients is not necessarily their preference.	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
2008	**Harmer, C.J.**	Serotonin and emotional processing: Does it help explain antidepressant drug action?	UK	Review	Treatments for depression and their effects on emotional processing.	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.
2008	**Hwang et al.**	A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model	USA	Review and commentary	Depression	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
2008	**Lakey, Gerald F.**	"Feeling blue" in Spanish: A qualitative inquiry of depression among Mexican immigrants	USA	A qualitative inquiry; vignette, discussions	Depression	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

2008	**Levin et al.**	Life-threatening serotonin toxicity due to a citalopram-fluconazole drug interaction: case report and discussion	USA	Case report and lit. review: Medline search without date limitation	Co-morbid depression	Serotonin toxicity secondary to a citalopram-fluconazole drug interaction is an uncommon case of delirium. Two cases are presented	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
2008	**Löwe et al.**	Depression, anxiety and somatization in primary care: syndrome overlap and functional impairment	USA	Self-report questionnaire, measurement scales; statistical analysis	Overlap of depression, anxiety, and somatization; DSM-IV, ICD-10, GAD-7, PHQ-8, PHQ-15	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.	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
2008	**Martinez Pincay, Igda**	Latino perspectives on the treatment of depression: an exploratory study	USA	Dissertation				
2008	**Murawiec S.**	Symbolic function of medication – a case report	Poland	Qualitative: a case study, vignette	Depression	Citalopram, fluoxetine	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.	Not found
2008	**Nabeel et al.**	Depressed patients' preferences for education about medications by pharmacists in Kuwait	Kuwait	Cohort study; statistical analysis	Unipolar depression	Coaching by pharmacists is an effective way to improve drug knowledge and probably the attitudes of depressed patients.	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

2008	**Patten, Scott B.**	Confounding by severity and indication in observational studies of antidepressant effectiveness	Canada	Random, community residents, interviews, PHQ-9, statistical analysis	Depression, DSM-IV	This study found evidence for confounding by severity	AD medication use is confounded with symptoms severity. Observational studies are subject to bias as result	Randomization may be an essential design feature in studies assessing AD effectiveness
2008	**Pedrelli et al.**	Dysfunctional attitudes and perceived stress predict depressive symptoms severity following antidepressant treatment in patients with chronic depression	USA	Subsample of patients from RCT with fluoxetine; statistical analysis	MDD, dysthymia; DSM-III- R	Fluoxetine, HAM-D 17;	Patients with both high perceived stress and high dysfunctional attitudes prior to treatment reported more depressive symptoms at the end of treatment than patients with high perceived stress and lower dysfunctional attitudes.	Priority for future RCTs would be to investigate whether these patients may benefit from treatments that directly address dysfunctional attitudes and teach ways to cope with stress
2008	**Politis et al.**	Combination therapy with amisulpride and antidepressants: clinical observations in case series of elderly patients with psychotic depression	Greece	RCT	Psychotic depression, DSM-IV-TR	Combination of AD with antipsychotic agent; amisulpride, citalopram, mirtazapine	Combination of amisulpride and ADs improved psychotic symptoms. This is the first report of such combination therapy	Further controlled studies should help in verifying the positive results of the combination of amisulpride and AD medications
2008	**Prins et al.**	Health beliefs and perceived need for mental health care of anxiety and depression- the patients' perspective explored	The Netherlands	Systematic review	Depression and anxiety	Patients give multi-dimensional explanations for depression and see both psychological and medication treatment as helpful	People who suffer from depression have more positive beliefs about biological etiology and medication treatment than healthy people, or those with less severe symptoms	More research is required into the specific needs of depression and anxiety patients
2008	**Seedat, Haskis & Stein**	Benefits of consumer psychoeducation: A pilot program in South Africa	South-Africa	drop-out rates during paroxetine-treatment were surveyed	Depression	paroxetine and other SSRIs	Improved adherence attributed to an increased understanding of depression and the need to take medication, realization that patient is not alone, and a better understanding and acceptance of possible side-effects	As drop-out rates in South Africa are unacceptably high, psychoeducational programs may prove valuable in increasing adherence to treatment

2008	**Shigemura et al.**	Patient satisfaction with antidepressants: An internet based study	Japan	Online survey, statistical analysis: SPSS	MDD	ADs: fluvoxamine, milnacipran, paroxetine, TCA	Those on single medication perceived greater drug satisfaction with treatment than those on polypharmacy	Further studies should be conducted to better understand the variables related to AD satisfaction to provide successful treatment of depression
2008	**Sigurtsson, Olafsdottir, & Gottfredsson**	Public views on antidepressant treatment: Lessons from a national survey	Iceland	Self-report questionnaire, statistical analysis	Depression	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	Most Icelanders are willing to use ADs to treat depression and factor influencing this view is their own experience or that experience of close friends or relatives	The greatest challenge will remain to educate and motivate ppl who commonly lack motivation to seek treatment
2008	**Soudry et al.**	Factors associated with antidepressant use in depressed and non-depressed community-dwelling elderly: the three city study	France	face-to-face interviews, statistical analysis	Depression	3 groups were defined: non-depressed, high depressive symptoms and current MDD	In a large community-based elderly population, the influence of socio-demographic factors and general health characteristics on AD use varied with increased severity of depressive symptoms	Further studies are needed to clarify the relationship btw gender and cognition and AD use
2008	**Turner et al.**	Women's views and experiences of antidepressants as a treatment for postnatal depression: a qualitative study	UK	RTC, In-depth interviews, data analysed thematically	Postnatal depression	Most participants had negative views on ADs at the time of randomization	Women's views changed in response to their treatment options and experiences, views of relatives and friends and contact with health professionals	GPs should be aware that patients' views of ADs can change and that by listening and providing information, they could play a key role in this process
2008	**Vanelli & Coca-Perraillon**	Role of patient experience in antidepressant adherence: A retrospective data analysis	USA	Deidentified computerized pharmacy records; adherence was measured using Kaplan-Meier analysis	Mood and anxiety disorders	extended-release venlafaxine, controlled-release paroxetine, sertraline, fluoxetine, escitalopram, and/or citalopram	Prior AD treatment rather than the use of a particular medication was associated with AD adherence. Patients without previous experience with ADs faced twice the risk of nonadherence	Further study may explore the effects on adherence results in newly diagnosed patients who received short-term prescriptions

2008	**Wang & Lai**	The relationship between mental health literacy, personal contacts and personal stigma against depression	Canada	Cross-sectional study; self-report; data collected in a probability sampled population-based survey; statistical analysis	Depression	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	In the highly educated population, attitudes toward individuals with depression were that these people and unpredictable and dangerous.	Educational campaigns may have some positive effects on stigma of depression, but could be carefully designed
2008	**Wittkampf et al.**	Patients' view on screening for depression in general practice	The Netherlands	Qualitative: semi-structured in-depth interviews; double analysis with MAXqda2	MDD	All patients appreciated being approached for screening, but some did not accept the diagnosis	Some patients with undisclosed depression felt aversion to being diagnosed as having depression	In the context of screening for depression, it is recommended that that patients' view on depression be elicited before diagnosing and offering treatment
2008	**Zivin & Kales**	Adherence to depression treatment in older adults	USA	A narrative review	Depression	Adherence to depression treatment in older adults is associated with multiple factors	There is a pressing need to understand the characteristics of older depressed patients that lead to optimal treatment adherence, as well as understand the barriers to adherence	Strategies to improve patient adherence need to be multidimensional, including consideration of age-related cognitive and co-morbidity factors, environmental and social factors, functional status and belief systems.
2009	**Chakraborty et al.**	Attitudes and beliefs of patients of first episode depression towards antidepressants and their adherence to treatment	India	Assessment , questionnaire, statistical analysis SPSS	First episode unipolar depression	DSM-Iv, ICD-10, MINI, BDI, ADCQ	Most of the people value the doctor-patient relationship & their partners are also supportive re. diagnosis and treatment of depression; most ppl have erroneous beliefs re. ADs per se which influence the drug adherence	It is important to study the attitudes and beliefs of patients in various cultures, as identification and clarification of erroneous beliefs may help in treatment adherence
2009	**Cipriani et al.**	Depression in adults: drug and physical treatment	UK	Systematic review	Depression	Information relating to the effectiveness and safety of the following: AD drugs (TCAs), SSRIs, MOI, or venlafaxine	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	not found

2009	**Demyttenaere , Koen**	Compliance and acceptance in antidepressant treatment	Belgium	Review, discussion and commentary	Depression	Non-compliance with AD medications is common, and it is the greatest barrier to effective treatment of MDD	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	Doctors should actively seek to address these misconceptions as a matter of urgency
2009	**ten Doesschatte, Bockting, & Schene**	Adherence to continuation and maintenance antidepressant use in recurrent depression	The Netherlands	Prospective cohort study; self-reported non-adherence	MDD	Non-adherence to continuation and maintenance Ad treatment in recurrent depression is frequent and a potential risk of recurrence	Non-adherence ranged from 39.7% to 52.7%. 20.9 5 were always non-adherent, 48.4% were intermittently non-adherent and 30.8% were always adherent.	Doctors continuously have to be aware of this problem and should keep on discussing it with their patients.
2009	**Fullagar, Simone**	Negotiating the neurochemical self: anti-depressant consumption in women's recovery from depression	Australia	Qualitative study, Nvivo used to code and analyse comments	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	Despite the dominance of biomedical accounts, very few women attributed their recovery solely to medication or understood depression as caused by chemical imbalance only	In relation to health, patients are no longer passive recipients of others' expertise; they are urged to become active responsible consumers of medical services, products and pharmaceuticals
2009	**Goodman, Janice H.**	Women's attitudes, preferences, and perceived barriers to treatment for perinatal depression	USA	Questionnaire	Perinatal depression	Perinatal depression can lead to a chronic or recurrent depressive course throughout the woman's life	Understanding what prevents women from seeking or obtaining help for depression and determining their preferences for treatment may lead to better outcomes	Overall efforts to improve treatment rates for perinatal depression are needed
2009	**Hodges et al.**	Patient and general practitioner preferences for the treatment of depression in patients with cancer: How, who, and where?	UK	Questionnaire	depression & cancer	Options for how depression should be treated, who should deliver the treatment and where treatment should occur	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,	A model of service that allows a choice of the initial treatment modality and collaborative care btw primary care and cancer center nurse would meet these requirements

2009	**R. Liebert & N. Gavey**	"There are always two sides to these things": Managing the dilemma of serious adverse effects from SSRIs	New Zealand	in-depth semi-structured interviews	Depression	SSRIs	The article brings us to the assertion that SSRIs are linked to Two conflicting claims": that they may either increase or decrease harm	Deepen the knowledge about SSRIs to be able to engage in fuller and more meaningful dialogue about the use of these drugs
2009	**Madsen, McQuaid, & Craighead**	Working with reactant patients: Are we prescribing nonadherence?	USA	Questionnaires following medication evaluation to measure predictor variables, statistical analysis	MDD, BDI-II, HPRS, PAQ, follow-up assessment, descriptive statistics analysis	Patients that rate their doctor as more collaborative will report greater AD adherence than those who view their provider as less collaborative	The results suggest that the most relevant patient choice may be that of preferred role in the treatment regardless if more or less participative	Future studies in this area are necessary to determine if these findings can be generalized to other settings, particularly to primary care
2009	**Malpass et al.**	"Medication career" or "Moral career"? The two sides of managing antidepressants	UK	3 stages: a) Systematic search; b) critical appraisal; c) synthesis using techniques of meta-ethnography (Noblit & Hare, 1988)	Depression & anxiety	One obstacle to qualitative synthesis is the challenge of bringing together data grounded in different theoretical theoretical or methodological perspectives	This synthesis tried to conceptualize the interplay of the moral and medication careers of AD use	This requires further exploration through empirical work if we want to understand the processes by which the decision-making is negotiated
2009	**McPherson & Armstrong**	Negotiating 'depression' in primary care: A qualitative study	UK	Qualitative: purposive sampling, semi-structured interviews, audio-recorded and transcribed verbatim	Mild, moderate, & severe depression	GPs in this study often responded in non-medical ways incl. feeling unsympathetic, breaking confidentiality, and prescribing social interventions	If depression is not treatable as its causes are outside the medical domain, the GP appears powerless in consultations for depression, with the medical discourse failing in providing explanations or treatment cures.	Not found
2009	**Ööpik & Maaroos**	The preferences and rationale of family doctors in pharmacological treatment for depression	Estonia	Questionnaire-based survey	anxiety; anxiety with depression; mixed mood disorders	SSRIs, SNRIs,	The most important factors influencing drug selection were good effect, ease of administration, presence of specific clinical symptoms, speed of effect, and presence of co-morbid psychiatric disorders	Not found

2009	**Pohjanoksa et al.**	How and why do people with depression access and utilize online drug information: A qualitative study	Finland	Qualitative: focus groups	Depression	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	Internet is an important source of drug information, especially when fear of stigmatization or depression related symptoms limited information seeking from other sources	Health professionals should design online services and direct their clients to accurate and reliable sources of online drug information
2009	**Price, Cole, & Goodwin**	Emotional side-effects of SSRIs: qualitative study	UK	Qualitative: individual, and group interviews, searching patients' websites for relevant posts	Depression: BDI-II	Some people taking SSRIs, report that their experience of emotions is 'blunted'.	Robust evidence that some patients taking SSRIs experience significant emotional symptoms strongly attributed to AD medications	Clinicians should add emotional side-effects of ADs to the common adverse effects that they usually mention to patients
2009	**Prins et al.**	Primary care patients with anxiety and depression: Need for care from the patient's perspective	The Netherlands	Cross-sectional data derived from NESDA, multiple logistic regression analysis	Anxiety and depression, PNCQ,	Patients' confidence in professional help and their evaluation of received care positively influenced their perception of medication and counselling	Most patients with depression or anxiety expressed a need for counselling or information. Medication, practical support, skills training and referrals were less needed	Health professionals should be aware of the fact that there are differences in perceived needs for care between subgroups of patients
2009	**Sawada et al.**	Persistence and compliance to antidepressant treatment in patients with depression	Japan	Retrospective chart-review, 6-mos adherence to ADs was examined, statistical analysis	MDD: ICD-10, MPR; sulpride, paroxetine, fluvoxamine, sertraline, milnacipran, amoxapine, trazodone	Behaviors towards treatment might be subject to patients' social and cultural background	Low persistence and poor compliance to AD treatment were found to be problematic in patients with depression	Further investigations are needed to evaluate the interaction btw these two measures

2009	**Sinokki et al.**	The association of social support at work and in private life with mental health and antidepressant use: The health 2000 study	Finland	Cohort study; Self-assessment scales; population-based health survey; statistical analysis	Depression: DSM-IV, major mental disorders	Antidepressants	Low social support at work and in private life was associated with a 12-mos prevalence of depressive or anxiety disorders; low social support at work was linked with subsequent ADs use	To promote mental health at workplaces social support from supervisors and from colleagues should be regarded as an important resource for work. Practices for its utilization should be regarded as a target worth of priority.
2009	**de Toledo Piza Peluso & Blay**	Public stigma in relation to individuals with depression	Brazil	Cross-sectional study; structured questionnaire, vignette,	Depression: DSM-IV and ICD-10	Assessment of perceived negative reactions and discrimination, perceived dangerousness and emotional reactions in relation to the case introduced in vignette	This study indicated that persons with depression face a great amount of public stigma	Need to gain in-depth knowledge about the impact of stigma on the experiences of persons suffering from depression and implement anti-stigma programs in Brazil
2009	**van Geffen et al.**	Initiation of antidepressant therapy: do patient follow the GP's prescription?	The Netherlands	Retrospective study linking a general practice to a pharmacy dispensing database	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	Patients who received a first-time an AD prescription from a GP. 3 patient groups were identified: non-fillers, single Rx-fillers and patients who filled at least 2 consecutive prescriptions	Over 1 in 4 patients who receive first-time AD prescription decline the treatment; they either do not initiate the treatment at all or stop taking the drugs after the first 2 weeks	More research is needed into the implications of declining AD treatment
2009	**Vergouven et al.**	Improving patients' beliefs about antidepressants in primary care: A cluster-RTC of the effect of a Depression Care Program	The Netherlands	A cluster-RCT, comparison of 2 interventions to improve management of MDD in primary care;	Depression: DSM-IV	SSRI	The depression care program ameliorates beliefs about ADs in primary care	The study results encourage the implementation of depression care programs in order to improve beliefs about AD medications

2009	**Yen et al.**	Predictive value of self-stigma, insight, and perceived adverse effects of medication for the clinical outcomes in patients with depressive disorders	Taiwan	Project on self-stigma; cross-sectional and prospective research studying the self-stigma; statistical analysis	Depressive disorders: DSM-IV, CES-D, MABS, QAMD, statistical analysis	Self-stigma, Insight, Adverse effects of medication	Perceiving more severe adverse effects of medication increased the risk of non-remission of depressive symptoms; degrees of self -stigma and insight did not predict the severity of depressive symptoms, suicidal risk, or the level of drug adherence	It is important for clinicians to prevent the occurrence of and to help patients manage the adverse effects of medication
2010	**Amey, C.**	Suspected anti-depressant-induced switch to mania in unipolar depression: a first-person narrative	UK	A first-person narrative	Depression, mania; Tricyclic AD dosulepin	Author's own experience of psychotic mania	More understanding of AD-induced mania is needed in unipolar depression	Need for prompt specialist care for patients with depression reporting even mild, sub-threshold symptoms of mania
2010	**Aselton, P.**	The lived experience of college students who have been medicated with antidepressants.	USA	Dissertation				
2010	**Bennett et al.**	Pregnancy-related discontinuation of antidepressants and depression care visits among Medicaid Recipients	USA	Matched cohort study design; Medicaid claims data from all 50 US states were used; statistical analysis	Depression; ICD-9	Women who become pregnant, significantly reduce their ongoing depression care compared to non-pregnant controls	Pre-pregnancy, the AD use rate was 66%. During pregnancy, AD use dropped to 27% . Pregnancy was associated with discontinuation of any depression care among women receiving Medicare	Efforts are needed to mitigate these reductions
2010	**Birnbaum et al.**	Employer burden of mild, moderate, and severe major depressive disorder: Mental health services utilization and costs, and work performance	USA	Survey; interview, assessment of risk factors; statistical analyses	MDD	Cost effectiveness of MDD treatment: prevalence of mild depression and its potential to become more severe suggests focus on treatment effectiveness	Projected to the US-workforce, monthly depression-related worker productivity losses had human capital costs of nearly $2 billion.	Need for overall improvement of treatment quality, specifically in regard to MDD severity to improve care and better management of direct and indirect costs

2010	**Bob et al.**	Traumatic stress, dissociation, and limbic irritability in patients with unipolar depression being treated with SSRIs	Czech Republic	CACO study	Unipolar depression: DSM-IV	Establishing psychometric criteria to identify unipolar depressive patients with high seizure-like symptoms which may respond to anticonvulsant treatment	Seizure-like symptoms in depressive patients have significant association with depression, symptoms of dissociation, and traumatic stress	Not found
2010	**Britten, Riley, & Morgan**	Resisting psychotropic medicines: a synthesis of qualitative studies of medicine-taking	UK	Synthesis of qualitative research	Psychotic and depressive conditions	Patients' perspectives of psychotropic medications (continuation and update of work by 2005 Pound et al)	Cumulative evidence from qualitative studies indicates that patients' non-adherence to antidepressants is often a purposeful action.	Evidence of patients' active engagement with their medicines and the difficulties they often experienced identifies a need for greater support
2010	**Bulloch & Patten**	Non-adherence with psychotropic medications in the general population	Canada	Data from Canadian Community Health Survey: Mental Health & Well-Being; statistical analysis	Antipsychotics Sedative-hypnotics, Anxiolytics, Mood stabilizers, Antidepressant	A high frequency of non-adherence was found with all five classes of psychotropic medication	The reported reasons for non-adherence vary between medication types, forgetting being especially prevalent for antidepressants, mood stabilizers and antipsychotics.	The cognitive impairment in depression may introduce misclassification bias that would tend to underestimate the degree of non-compliance for respondents with some psychiatric diagnoses.
2010	**Carpenter et al.**	Ethno-cultural variations in the experience and meaning of mental illness and treatment: Implications for access and utilization	USA	Qualitative: ethnographic study	Psychotropic medications	How individuals diagnosed with severe mental illness understand mental health problems and respond to engagement with mental health services	Knowledge concerning the nature, course, and consequences of problems is produced in a personal, familial, and sociocultural context. Participants across the sample indicated the presence of psychiatric stigma.	Clinical alliances should take such existential struggles to heart, by expanding clinical discourse beyond symptoms and medication-based phenomena.

2010	**Dickinson et al.**	Long-term prescribing of antidepressants in the older population	UK	A qualitative study; interviews, recorded and transcribed; field notes were collected	Antidepressant medications	the benefits of ADs; understanding of depression and its treatment; barriers; discontinuation of ADs	GPs feel limited when considering alternative treatments for older patients with depression.	Exploring experiences of depression and recovery; identifying future goals with patients can be helpful. Age is no barrier to plans for discontinuation of medications.
2010	**Ezeobele et al.**	Depression and Nigerian-born immigrant women in the United States: a phenomenological study	USA	Qualitative: phenomenologic study: face-to-face, semi-structured, audio-taped interviews; open-ended questions	Depression	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	The findings from the present study revealed that depression is not acceptable according to Nigerian-born immigrant women living in the US. The women described depression as craziness and being associated with evil spirits or a curse.	Increase the awareness of nurses and other health care professionals of the need to focus on evidence-based, culturally specific research, and illuminate issues surrounding depression in this population.
2010	**Gabriel & Violato**	Knowledge of and attitudes towards depression and adherence to treatment: The Antidepressant Adherence Scale	Canada	Antidpressant Adherence Scale (AAS), patients on ADs, statistical analysis	Depression	Non-adherence to treatment can result from forgetting, carelessness, adverse effects, or stopping the drug when feeling better.	There is a relationship btw. poor adherence and the lack of knowledge about depression and its treatment, and the negative attitude to antidepressants, providing validity for AAS instrument.	Future research should include larger, more heterogeneous sample from various community clinics.
2010	**Holma et al.**	Treatment attitudes and adherence of psychiatric patients with MDD: A five year prospective study	Finland	Prospective study	DSM-IV MDD	Throughout the follow-up, most patients reported positive attitudes and good adherence	Among psychiatric MDD patients in long-term, follow-up, treatment attitudes and adherence to pharmacotherapy mostly positive, significantly predicted by personality features and social support.	Attention to patients with cluster B personality disorder, or poor social support, may be needed.
2010	**Interian et al.**	Adaptation of a motivational interviewing intervention to improve antidepressant adherence among Latinos	USA	Focus groups, preliminary, pilot, and adapt interventions, observation, participants' feedback, RCT in process	Depression	Poor AD adherence is a significant issue in depression treatment, and it tends to be more common among Latinos.	Qualitative methods helped generate data directly from participants' experiences. The focus of this study was the adaptation of a MI intervention.	Future design should focus on recruitment methods that can bring higher enrollment rates. The strategy calls for quantitative methods that confirm results of this study.

2010	**Kadir & Bifulco**	Malaysian Moslem Mothers' experience of depression and service use	Malaysia	Qualitative: structured clinical interviews, qualitative analysis	Depression	To explore depression symptoms using the Structured Clinical Interview for DSM-IV	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.	Attention to such views of depression can help develop services in Malaysia.
2010	**Keers et al.**	Stressful life events, cognitive symptoms of depression and response to antidepressants in GENDEP	8 European countries	GENDEP collected longitudinal data on the symptoms; statistical analysis	Major depression, MADRS; HRSD-17; BDI; LTE-Q	SSRI, escitalopram; TCA, nortriptyline; the occurrence of stressful life events	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.	Those reporting stress and therefore higher cognitive symptoms may benefit more from treatment with SSRIs than with TCAs
2010	**Kwan, Dimidjian, & Rizvi**	Treatment preference, engagement, and clinical improvement in pharmacotherapy versus psychotherapy for depression	USA	Participants randomly assigned to therapies and conditions; statistical analysis	MDD	AD, paroxetine, HRSD-17, BDI-II; ETI; WAI; CT	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.	These findings highlight the importance of addressing patient preferences in the treatment of MDD.
2010	**Lee et al.**	Antidepressant-induced sexual dysfunction among newer antidepressants in a naturalistic setting	Korea	Quantitative	DSM-IV depression	ADs: citalopram, venlafaxine, paroxetine, fluoxetine, mirtazapine; ASEX, BDI, STAI	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.	The study suggests the need for clinicians to consider the impact of pharmacotherapy on patients' sexual functioning.
2010	**Malpass et al.**	Concordance between PHQ-9 scores and patients' experiences of depression	UK	Mixed methods: PHQ-9, in-depth interviews; follow up, 4-stage-analysis with software package ATLAS	Depression	Patients experience severity questionnaires as 'validating' their illness experience and reducing their sense of stigma	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.	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.

2010	**Mendel et al.**	'What would you do if you were me, doctor?': Randomised trial of psychiatrists' personal v. professional perspectives on treatment recommendations	Germany	Randomised experimental design; depression case and schizophrenia case vignettes; statistical analysis	Depression, schizophrenia	To study whether this question really leads psychiatrists to reveal their personal preferences.	Psychiatrists chose distinctly different therapies when deciding in the self role compared with the regular recommendation role and the question 'What would you do if you were me, doctor?' apparently did not motivate psychiatrists to reveal their true personal preferences.	Psychiatrists should try to find out why individuals are asking this question and, together with the individual, identify the most appropriate treatment option.
2010	**Ragan & Kane**	Meaningful Lives: Elders in Treatment for Depression	USA	Descriptive qualitative approach; open-ended interviews	Depressive disorder	Elders in treatment for depression with interpersonal psychotherapy and medication were interviewed to better understand their day-to-day lives	The major themes identified were independence, spirituality, family, depression, medical comorbidities, and motivation. Potential treatment strategies were derived from these themes	Developing the role of the clinician as coordinator of health care and the appropriateness of motivational interviewing as a treatment strategy
2010	**Serna et al.**	Duration and adherence of antidepressant treatment (2003 to 2007) based on prescription database	Spain	Retrospective cohort followed-up for 5 years	Depression	To estimate the duration of AD treatment and to analyse the factors: age, sex, polypharmacy and the type of drug	Only one out of five patients complied with treatment for over four months. Treatment periods were shorter in men. In chronic illnesses, patients with polypharmacy presented the best compliance.	Knowledge of the factors involved in good compliance with treatment in polypharmacy patients may help in clinical practice to implement strategies for other patients.
2010	**Shigemura et al.**	Predictors of antidepressant adherence	Japan	Internet-based survey; statistical analysis	Depressive disorder	To identify the psychosocial/pharmacological predictors of AD adherence	Nearly 1/3 of participants reported low adherence. LA was predicted by lower age, worker or student status, neutral/negative doctor-patient relationship, and higher daily dose.	This study is unique in Japan. Further studies would be helpful in estimating AD adherence.
2010	**Vega et al.**	Addressing stigma of depression in Latino primary care patients	USA	Depression screening: PHQ-2 and PHQ-9; medical records were reviewed; statistical analysis	Depression	To develop a validated stigma checklist to assist physicians in addressing depression in Latino patients	Patients reporting higher levels of perceived stigma were less likely to disclose their depression diagnosis to their family and friends and less likely to take the AD medication. They were not able to manage their depression.	Doctors should be aware of the strong relation btw stigma and treatment for depression and address stigma btw. Latino patients.

2010	**Wade, Johnson, & McConnachie**	Antidepressant treatment and cultural differences - a survey of the attitudes of physicians and patients in Sweden and Turkey	Sweden/ Turkey	Questionnaires; HADS, CGI, SDS scales; statistical analysis; Fisher's exact test and 2-sample t-tests	Depressive or anxiety disorders symptoms and response to AD medications in Swedish and Turkish patients	The 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.	In countries populated by diverse ethnic groups, it is important that physicians are aware of cultural differences in patients' presentations and expectations.
2011	**Abdullah & Brown**	Mental illness stigma and ethno-cultural beliefs, values and norms: an integrative review	USA	An integrative review	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.	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.
2011	Ballon, Diana	Fear of falling, fear of failing. Antidepressant users - and prescribers - need more guidance around withdrawal	Canada	GREY LIT.				
2011	**Cohen & Hughes**	How do people taking psychiatric drugs explain their "chemical imbalance?"	USA	Qualitative: interviews transcribed verbatim; recorded medication histories	Self-reported: depression, anxiety, bipolar, ADHD, borderline personality disorder, PTSD, and others	SSRI+ benzodiazepine	The most frequent explanation for believing that one had an imbalance was that medication changed or relieved distressful symptoms.	It remains unclear who will expose laypersons and professionals to messages that encourage critical thinking about psychoactive drug effects and the origin and relief of psychological distress.

2011	**Cook & Wang**	Causation beliefs and stigma against depression: Results from a population-based study	Canada	Random selection survey; case vignette; causation questionnaire; stigma scores analysed statistically	Depression	This study focused on 3 depression etiologies: a biological model, a psychosocial model, and a medical model.	Endorsing un-related cause of depression (allergy, virus, "being a nervous person", weakness of character) was associated with increased stigma.	Importance of mental health education and promotion with appropriate language discourse.
2011	**Griffiths et al.**	Does stigma predict a belief in dealing with depression alone?	Australia	Data collected from national survey. Vignettes; logistic regression analyses	Depression	Higher levels of personal stigma predicted belief in the helpfulness of dealing alone with depression and suicidal ideation.	Personal stigma is associated with the belief in the helpfulness of self-reliance in coping with depression.	Public health programs should acknowledge the importance of providing evidence-based self-help programs for those who believe in self-care.
2011	**Hansson, Chotai, & Bodlund**	Patients' beliefs about the cause of their depression	Sweden	Open-ended questions and statistical analysis of the results	Depression	Patients' beliefs about causes of their depression affect coping strategies, their help-seeking behaviour, treatment preferences and adherence.	The analysis of patients' beliefs emerged into 16 different categories of explanation. Primary care patients often gave multi-causal explanations of their depression. Biological explanations were rare.	Patients' beliefs about their illness are important in the patient-doctor encounter when developing treatment strategies.
2011	**Kikuchi et al.**	Subjective recognition of adverse events with antidepressant in people with depression: A prospective study	Japan	Self-administered questionnaires; statistical analyses	Depressive illness	A prospective study to specifically investigate subjective recognition of antidepressant adverse effects	It is still challenging to exactly tell adverse effects from symptoms of depression itself.	Evaluation of multiple longitudinal assessment points is needed to better elucidate the interaction of btw. severity of depression and bias in subjective attribution of AEs to ADs.
2011	**Lynch et al.**	Are patient beliefs important in determining adherence to treatment and outcome for depression? Development of the beliefs about depression questionnaire	UK	Cross-sectional study; Questionnaires, Leventhal's CSM model; statistical analysis	Depression	Leventhal's theory postulates that there are six underlying dimensions on which health beliefs are based.	Beliefs about depression are multifactorial but there are reproducible underlying dimensions, which allow them to be reliably measured and classified.	It is important to determine whether the beliefs affect the treatment choices and outcome. Comparisons of different questionnaires within one population would give more information on how the questionnaires compare.

2011	**Mahtani-Chugani & Sanz**	Users Perception of Risk and Benefits of Mood Modifying Drugs	Spain	Narrative review of qualitative research	Major and minor depressions	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.	The review provides some explanations how and why patients make decisions about AD medicine taking. Health care professionals need to take into account the personal beliefs, fears and motivations for taking or refusing ADs.	Future research efforts should be directed towards how health care professionals should contribute in supporting patients who need mood modifying drugs and how to make social changes to reduce stigma surrounding mental health problems.
2011	**Malpass et al.**	I didn't want her to panic': unvoiced patient agendas in primary care consultations when consulting about antidepressants	UK	Qualitative: interviews; case studies; thematic analysis	Depression	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.	The concept of the 'good patient' is problematic for patients presenting with depression, whose low self-esteem and indecision may make contributing as an active partner challenging.	It is important for GPs to explore the degree to which patients wish to be involved in decision making, discriminating between passivity as preference and passivity as a symptom.
2011	**Mergl et al.**	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	Germany	Randomized, placebo-controlled trial	Depression	Depressed patients receiving their preferred treatment responded significantly better than those who did not receive their preferred therapy.	Patients' relative preference for medication vs. psychotherapy should be considered when offering a treatment because receiving the preferred treatment conveys an additional and clinically relevant benefit.	Account for mediating factors such as treatment satisfaction
2011	**Mounce, S.**	The lived experiences of women with postpartum depression and medicine.	USA	Dissertation				

2011	**Rizo et al.**	A rapid, Web-based method for obtaining patient views on effects and side-effects of antidepressants	Canada	Report of systematic search of many URLs	Depression	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.	Given the increasing number of patient narratives about drug experiences on open access forums, this rapid novel method will have increasing utility in post-marketing surveillance and in comparing the effects of psychiatric medications.	Self-reported off-label use of ADs (i.e. for pain) could have biased the results of this study as compared to RCTs.
2011	**Sanyal et al.**	The utilization of antidepressants and benzodiazepines among people with MD in Canada	Canada	Data drawn from 2002 Canadian Community Health Survey; statistical analysis	Major depressive episode	Clinical guidelines recommend monotherapy with ADs; polypharmacy with benzodiazepines remains an issue.	The overall prevalence of AD and BDZ utilization was 49.3% in respondents who experienced a MDE in the previous year.	To better understand patient- and physician-based factors associated with the combined use of ADs and BDZs.
2011	**Schofield et al.**	Patients' views of antidepressants: from first experiences to becoming expert	UK	Qualitative interview study; qualitative analysis	Depression; mixed depression & anxiety	A wide range of factors that helped shape patients' decisions about whether or not to take, and continue with AD medication	Patients becoming experts through a process or trial and error in taking AD medications	To address how patients can best be encouraged to take a more self-determining role in their use of medication in their collaboration with GPs
2011	**Sennfeld et al.**	Bupropion in the treatment of MDD in real-life practice	Portugal	Qualitative: case reports; discussion	MDD	Bupropion is a second generation AD drug that inhibits reuptake of dopamine and norepinephrine and has no direct serotogenic effects	The 3 cases reported here demonstrate the efficacy of bupropion in patients with varying presentations of MDD	In patients with MDD it is fundamental to make the distinction btw. patients who have comorbid anxiety disorder anxiety and patients whose anxiety is part of MDD, in order to choose the AD correctly.
2011	**Sun et al.**	Mediating roles of adherence attitude and patient education on antidepressant use in patients with depression	Taiwan	Cross-sectional study design	Depression	To examine the role of adherence attitude to ADs and patients' education as mediators	Attitudes towards ADs were positively associated with AD use, association explained by the mediating variable, patients education about ADs	Adequate patient education and an understanding of patients' adherence attitude to AD use

2011	**Sundell et al.**	Antidepressant utilization patterns and mortality in Swedish men and women aged 24-30 years	Sweden	Data on purchased medicines from the Swedish Prescribed Drug Register; statistical analysis	Depression	To compare AD utilization patterns and mortality in relation to AD use in patients aged 20-34 years	Almost twice as many Swedish women than men aged 20-34 purchased ADs in 2006. Discontinuation rates were high, mortality rates were elevated in those using mood stabilizers and antipsychotics	Health care providers need to acquire an increased awareness of attitudes to treatment.
2011	**Tallon et al.**	Involving patients with depression in research: survey of patients' attitudes to participation	UK	Data from trial database; qualitative analysis; coding themes and subthemes + statistical analysis	Depression	Recruitment to RCTs is often difficult in primary care, and particularly in mental health research.	Participants benefited from the enhanced support and feedback they received as part of the trial	Understanding both GP and patient attitudes to participating in mental health research is crucial to finding effective strategies for improving recruitment to such trials.
2011	**van Geffen et al.**	The decision to continue or discontinue treatment: experiences and beliefs of users of SSRIs in the initial months-A qualitative study	The Netherlands	Semi-structured qualitative interview study; audiotaped and transcribed verbatim		To explore the experiences and beliefs of SSRI users in relation to initiation and execution of treatment	Feelings of psychological dependency on the AD and denial of the disease, rather than side effects, were seen as the underlying reasons for nonadherence	Health care professionals should be more supportive at the start and during the first months of SSRI treatment by eliciting patients' considerations to either continue or discontinue treatment
2011	**Vlahiotis et al.**	Discontinuation rates and health care costs in adult patients starting generic versus brand SSRI or SNRI antidepressants in commercial health plans.	USA	Cohort study, observational design; statistical analysis	Depression and anxiety disorders	There are suggestions that some generic antidepressants are not as safe or effective as the brand alternatives	Comparing patients initiating antidepressant therapy with a brand versus generic medication: no significant difference in the likelihood of discontinuation of medication during the first 180 days of SSRI or SNRI therapy	Specific implications for cost management strategies like step therapy, and are important for health care payers who have investments in patient health.
2012	**Aikens & Klinkman**	Changes in patients' beliefs about their antidepressant during the acute phase of depression treatment	USA	Multi-stage trial; statistical analysis	Unipolar major depression	Citalopram; tested medication beliefs in relation to adherence, side effects, and response during the acute phase of treatment	Patients' medication perceptions became more pro-adherence as treatment proceeds	Future interventions should focus on the association btw. harm perceptions and actual side effects

2012	**Al-Jumah & Qureshi**	Impact of pharmacist interventions on patients' adherence to antidepressants and patient-reported outcomes: a systematic review	Saudi Arabia	Systematic review	Depressive illness	To explore different types of pharmacists interventions used in order to enhance patients' adherence to ADs	Pharmacists' interventions can improve patient adherence to AD medication	To assess the clinical outcomes of innovative pharmacists' interventions
2012	**Alderson et al.**	How patients understand depression associated with chronic physical disease - a systematic review	UK	Mixed-method systematic review; thematic analysis	Depression	A narrative synthesis of qualitative and quantitative data	Patient beliefs have implications for engagement with depression screening	To understand fully how people comprehend depression associated with a physical illness and how this influences help-seeking and engagement with health care services
2012	**Baumeister, H.**	Inappropriate prescriptions of antidepressant drugs in patients with subthreshold to mild depression: Time for the evidence to become practice	USA	Narrative review	Subthreshold and mild depression	Researchers continue to judge the prescription of ADs for sub-threshold and mild depression as adequate treatment	Clinicians favor well merchandised, easy to prescribe AD drugs for patients with sub-threshold to mild depression which is no different than placebo	Need for a more differentiated, evidence-based clinical and research practice
2012	**Berkowitz et al.**	Vicarious experience affects patients' treatment preferences for depression	USA	RCT	Depression	Both, personal past experiences and the experiences of others can significantly affect attitudes toward treatment	Patients with vicarious experiences of depression express more acceptance of pharmacotherapy	Focus on strategies that utilize knowledge of patient characteristics to boost treatment adherence
2012	**Buus, Johannessen, & Stage**	Explanatory models of depression and treatment adherence to antidepressant medication: A qualitative interview study	Denmark	In-depth, qualitative interviews; illness narratives; thematic and statistical analysis	Depression	To gain detailed insight into patients' personal accounts of depression	The patients' reasons for adhering to ADs included a range of diverse psychosocial issues. Increasing number of informants were in doubt about the effects of their ADs	Clinicians should engage with patients who do not profit from antidepressant medications and collaborate toward finding alternative forms of treatment

2012	**Cruz et al.**	Duration and compliance with antidepressant treatment in immigrant and native-born populations in Spain: a four year follow-up descriptive study	Spain	Retrospective cohort study; statistical analysis	Mental illness	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	Immigrants of all origins present higher percentages of early discontinuation of AD treatment	The need to investigate the causes in greater depth to introduce new strategies. Need of qualitative studies assisting the quantitative research
2012	**Dunlop et al.**	Depression beliefs, treatment preference, and outcomes in a randomized trial for MDD	USA	RCT; statistical analysis	MDD	CBT; escitalopram; tested associations btw. beliefs and preferences, beliefs and outcomes, and preferences and outcomes	The only study that has evaluated both beliefs about depression and treatment preferences as predictor of outcome. Conceptualizations of illness and treatment appear to be unrelated to treatment response	Studies with other scales that could more fully capture belief structures that may more adequately predict preference, and treatment outcomes.
2012	**Fawzi et al.**	Beliefs about medications predict adherence in older adults	Egypt	Multiple study measures: GAM, MARS; statistical analysis	ICD-10 depressive disorder	To investigate the variables associated with adherence to ADs in older Egyptians	Specific beliefs about ADs can predict adherence.	Understanding cultural variations in medication adherence has great potential usefulness for clinicians
2012	**Hansen & Cabassa**	Pathways to depression care: Help-seeking experiences of low-income Latinos with diabetes and depression	USA	Qualitative	Depression	Adherence to depression care focused on interpersonal aspects of care, evaluated symptom relief, and improved functioning.	Community outreach and education on the risk factors and symptoms of depression can increase awareness and promote treatment initiation.	Inform future research that allows for hypothesis generation and theory development of the psychosocial and cultural influences of Latinos with co-morbid health and mental health disorders.
2012	**Hansson, Chotai, & Bodlund**	What made me feel better? Patients' own explanations for the improvement of their depression	Sweden	Questionnaire; HADS, GAF, Contactus programme; statistical analysis	Depression	To investigate previously depressed patients' beliefs about the cause of their improvement	Believing in the helpfulness of professional help correlated with a better treatment outcome; the coping strategy to rest and relax correlated with a worse outcome	Patients' beliefs, knowledge and enrolment in the diagnostics and treatment are important to consider in primary care

2012	**Himmerich & Wranik**	Choice of treatment with antidepressants: Influencing factors	Germany	Systematic review	Unipolar depressive disorders	The challenge of efficacious treatment lies in matching of the individual patients	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.
2012	**Houle et al.**	Treatment preferences in patients with first episode depression	Canada	Treatment acceptability and preferences measures; statistical analysis	Depression	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.
2012	**Jylhä et al.**	Do antidepressants change personality? - A five year observational study	Finland	Observational and naturalistic study; interviews; statistical analysis	MDD; a variety of ADs were used	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
2012	**Kikuchi et al.**	Coping strategies for antidepressant side effects: An Internet survey	Japan	Web-survey; statistical analysis, SPSS	Depression	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
2012	**Knudsen et al.**	Changes in self-concept while using SSRI antidepressants	Denmark	Qualitative, interviews, narrative analysis	Depression	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

2012	LeClair, A. M.	Medicated life in the pharmaceutical era: mental health, antidepressants & young adult identity	USA	Dissertation				
2012	Liekens, S.	Patients' Beliefs Towards Antidepressants: Narrative Review of the Literature [Doctoral Thesis]	Belgium	Dissertation				
2012	**Littrell, J.L.**	Taking the perspective that a depressive state reflects inflammation: Implications for the use of antidepressants	USA	Review	Depression	The possibility that inflammation creates depression by blocking cell division in astrocytes in the PFC remains a possibility	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.
2012	**Murata et al.**	Risk factors for drug nonadherence in antidepressant-treated patients and implications of pharmacist adherence instructions for adherence improvement	Japan	DAI-10 scale to measure patient's subjective responses to treatment; statistical analysis	Melancholic depression, non-melancholic depression, bipolar depression	The incidence of side effects with ADs may be a risk factor for AD non-adherence	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
2012	**Partridge, Lucke, & Hall**	Public attitudes towards the acceptability of using drugs to treat depression and ADHD	Australia	Survey; statistical analysis	Depression; ADHD	SSRIs, psychostimulants (methylphenidate)	Most members of the public found ADs acceptable in treatment of depression, but were much less positive toward the use of drugs for ADHD	Qualitative studies could explore why drug treatment was found unacceptable in ADHD
2012	**Reavley & Jorm**	Belief in the harmfulness of antidepressants: Associated factors and change over 16 years	Australia	Surveys; statistical analysis	Depression	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

2012	**Seekles et al.**	Personality and perceived need for mental health care among primary care patients	The Netherlands	Cross-sectional data from NESDA; statistical analysis	DSM-IV diagnoses of anxiety and/or depression	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.	It is important to investigate the association btw. personality traits, common mental health disorders and mental health care utilization.
2012	**Singh et al.**	Antidepressant use amongst college students: Findings of a phenomenological study	USA	Qualitative: longitudinal, phenomenological research methodology	Depression	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.	Recommended individualized and effective mental health care for college students
2012	**Vega et al.**	Differences in depressed oncologic patients' narratives after receiving two different therapeutic interventions for depression: a qualitative study	Spain	Qualitative: grounded theory; videotaped focus groups; ATLAS software	Depression; cancer	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.	Further studies with different types of samples are needed for a better understanding of the psychological mechanisms provided by narrative therapy (NT).
2012	**Zimmerman et al.**	Symptoms differences between depressed outpatients who are in remission according to the HAMD who do not consider themselves to be in remission	USA	Interviews; statistical analysis	DSM-IV MDD, HAMD, CUDOS	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.
2012	**Acosta, Rodriguez, & Cabrera**	Beliefs about depression and its treatments: Associated variables and the influence of beliefs on adherence to treatment	Spain	BMQ, DAI,	Depression	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.

2013	**Aggarval et al.**	Barriers to implementing the DSM-5 Cultural Formulation Interview: A qualitative study	USA	Interviews, open-ended questionnaires, qualitative data analysis	Psychiatric diagnosis excl. acute suicidal ideation, intoxication, dementia, mental retardation or florid psychosis	This is the first study to report implementation barriers to the cultural formulation	This paper points to new research directions based on clinically applied medical anthropology and cultural psychiatry.	By triangulating views of patients, clinicians, and experts, studies will contribute to qualitative research and improved service delivery.
2013	**Agyapong V.I.O.**	Epidemiology, aetiology and management of major depression with comorbid alcohol use disorder-a review of the literature	Ireland	Review	Depression, alcohol-induced depression, dual disorder	Depression and AUD co-occur at levels greater than expected by chance in clinical and epidemiological samples.	Treatment must involve multiple interventions, including the use of antidepressants and other adjunctive pharmacological and psychological therapies.	Provide better understanding of the etiological relationship between the two disorders, determine the efficacy and safety of AD drugs use in dual disorder; new strategies
2013	**Anderson & Roy**	Patient experiences of taking antidepressants for depression: A secondary qualitative analysis	UK	Qualitative: qualitative analysis of 80 in-depth interviews	Depression	ADs appear to occupy a central place in many people's lives	People's experiences with ADs use have a major impact on treatment continuation and treatment outcome	Studies needed on depressed patients' beliefs about their depression and treatment; how they relate to different stages of illness; their interactions with health care and their adherence to ADs
2013	**Balan, Moyers, & Lewis-Fernandez**	Motivational Pharmacotherapy: Combining motivational interviewing and antidepressant therapy to improve treatment adherence	USA	Review /commentary	Depression	Motivational pharmacotherapy integrates motivational interviewing into psycho-pharmacology sessions in order to increase treatment adherence	Motivational pharmacotherapy results in a patient-clinician interaction that is more patient-centered, collaborative, and personalized than standard psycho-pharmacology.	The complete treatment manual is available at www.nyspi.org/culturalcom petence

2013	**Bet et al.**	Side effects of antidepressants during long-term use in a naturalistic setting	The Netherlands	Naturalistic (NESDA) cohort study ; statistical analysis	Depression and co-morbid depression	Side effects are usually underreported in clinical trials and large scale naturalistic studies are restricted to 6 months of use	During long-term use, side effects to ADs are common	Clinicians should be aware that antidepressant-induced side effects are persistent.
2013	**Coppens et al.**	Public attitudes toward depression and help-seeking in four European countries baseline survey prior to the OSPI-Europe intervention	Multi-cultural: 4 European countries	Survey, statistical analysis	Depression	Findings indicate a moderate degree of personal stigma toward depression and help-seeking.	Several country differences in attitudes were found. It is important to improve public mental health literacy in Europe in order to enhance the use of depression care.	Public media campaigns aiming to improve mental health literacy are essential to enhance depression care.
2013	**Corruble et al.**	Efficacy of agomelatine and escitalopram on depression, subjective sleep and emotional experiences in patients with MDD: a 24-wk double-blind RCT	Multi-country	Double-blind, international, randomised study; statistical analysis	Moderate to severe MDE in a context of MDD	Agomelatine; escitalopram; placebo; emotional blunting	Agomelatine and escitalopram had similar, high antidepressant efficacy. 2 ADs with different mechanisms of action can affect emotional processing in different ways; therefore, it may be associated with more or less risks of residual emotional problems	Not found
2013	**DeJean et al.**	Patient experiences of depression and anxiety with chronic disease: A systematic review and qualitative meta-synthesis	Canada	Systematic review and qualitative meta-synthesis	Depression, anxiety; chronic conditions	Patients may be reluctant to acknowledge depression or anxiety as separate condition	The relationship btw. chronic conditions and depression or anxiety can be experienced as independent or inter-related (with either one causing the other)	More qualitative research is needed to specifically address screening for depression or anxiety, and their effects on the chronic diseases and their outcomes
2013	**Fullagar & O'Brien**	Problematizing the neurochemical subject of anti-depressant treatment: The limits of biomedical responses to women's emotional distress	Australia	Qualitative: empirical; feminist approach; discourse analysis	Depression	Critique of scientific and market oriented rationalities underpinning neurochemical recovery that ignore the social conditions that enable the self to change	This research revealed the limitations of biomedical-scientific rationalities that position drug therapies as a thinkable solution to the neurochemically deficient self that 'is' depressed	This is a contribution to the growing number of critical discourses that question the normalization of psychopharmacology and search for alternatives in the areas of women's health, the mental health consumer movement and critical psychiatry.

2013	**Garrido & Boockvar**	Perceived symptom targets of antidepressants, anxiolytics, and sedatives: The search for modifiable factors that improve adherence	USA	Survey, statistical analysis	Mood-disorders; MDD, anxiety, comorbid physical conditions	Identifying modifiable factors, such as beliefs, may improve adherence to mood disorder medications	Latino respondents who perceived their antidepressant /sedative/anxiolytic medication to be only for non-mood reasons had higher adherence than those who perceived their medication to be for mood improvement	Healthcare providers can discuss the non-mood benefits of medications for mood and anxiety disorders with patients without decreasing adherence.
2013	**Gaudiano, Hughes, & Miller**	Patients' treatment expectancies in clinical trials of antidepressants versus psychotherapy for depression: a study using hypothetical vignettes	USA	Vignettes, questionnaires; statistical analysis ANOVA	BDI II depression	Depressed patients read vignettes describing hypothetical clinical trials of ADs vs. placebo, ADs vs ADs, and psychotherapy vs. psychotherapy	Patients reported greater overall acceptability for psychotherapy over ADs. Patients had significantly greater expectancies for symptom reduction compared with the placebo-controlled design	Test expectancies for improvement and treatment preferences in studies of combined treatments and in studies with designs directly comparing psychotherapy vs. ADs, as they may differ.
2013	**Glattaker, Heyduck, & Meffert**	Illness beliefs and treatment beliefs as predictors of short and middle term outcome in depression	Germany	Prospective cohort study; statistical analysis	ICD 10 MDE, recurrent depressive disorder	Investigating illness beliefs in people with depression might be less relevant because mood may influence illness and treatment beliefs	The findings highlight the significance of illness beliefs and treatment beliefs	Future studies should aim to implement those efforts into the context of mental illnesses (CSM, Leventhal et al., 1980, 2001)
2013	**Kales et al.**	Racial differences in adherence to antidepressant treatment in later life	USA	Prospective, observational study; interviews at baseline; statistical analysis	Clinically significant depression	No differences found in baseline function with the exception of the executive function. White subjects had less impairment	The results demonstrate racial and gender differences in AD adherence in older adults	Depression treatment interventions for older adults should take into account the potential impact of race and gender on medication adherence
2013	**Lewis-Fernandez et al.**	Impact of motivational pharmacotherapy on treatment retention among depressed Latinos	USA	Intervention/Treatment/ sessions; Motivational Interviewing Training; statistical analysis	DSM-IV MDD	U.S. racial/ethnic minority groups show higher non-adherence with outpatient AD therapy	It is feasible to integrate pharmacotherapy for MDD and motivational interviewing into a novel motivational pharmacotherapy approach	Test if motivational pharmacotherapy is more efficacious than standard antidepressant therapy

2013	**Liekens et al.**	Instructional design and assessment. A depression training session with consumer educators to reduce stigmatizing views and improve pharmacists' depression care attitudes and practices	Belgium	Randomized, clustered, comparative design; statistical analysis, ANOVA	Depression	To measure the impact of a depression training day	A continuing-education depression training day that involve consumer educators may improve the care delivered to people with depression.	Advanced training in mental health care is essential in preparing pharmacists to provide pharmaceutical care for this population
2013	**Misri et al.**	Factors impacting decisions to decline or adhere to antidepressant medication in perinatal women with mood and anxiety disorders	Canada	Questionnaires, short-structured diagnostic interview; statistical analysis	Moderate to severe mood disorders and anxiety	Specific quantitative and qualitative factors in decisions to adhere or decline ADs in antenatal women with moderate to severe mood disorders and anxiety	Significantly different course of illness was observed in adherers vs. decliners. Pregnant women experienced significantly divergent illness trajectories depending on acceptance or rejection of ADs therapy.	Replicate this study with a larger sample size and determine if some ADs are more likely to be continued or discontinued than others in pregnancy.
2013	**Moncrieff, Cohen & Porter**	The psychoactive effects of psychiatric medication: The elephant in the room	UK	Review, commentary	Psychiatric disorders	Dependence, and the need of support for people wishing to withdraw from AD medications	Use of psychiatric drugs is only worthwhile if the benefits outweigh the harms however, what is considered harmful or beneficial varies according to psychological symptoms in placebo-controlled trials.	Extensive research is needed to clarify the range of acute and longer-term mental, behavioral, and physical effects induced by psychiatric drugs
2013	**Munizza et al.**	Public beliefs and attitudes towards depression in Italy: A national survey	Italy	Tel. survey; questionnaire; statistical analysis	Depression	Barriers to the disclosure of depressive symptoms linked to concerns about ADs that are seen as potentially harmful and addictive.	Depression is seen as a reaction to significant life events and should be overcome with the support of significant others, help of health professionals (mainly psychologists) and a variety of strategies.	A “shared decision making” approach to treatment selection should be adopted

2013	**Ngo et al.**	A qualitative analysis of the effects of depression and antidepressants on physical and work functioning among antiretroviral therapy clients in Uganda	Uganda	Mixed methods: Qualitative: interview, thematic analyses of narratives	Depression, HIV, AIDS	Qualitative data from the interview transcripts used to illustrate the lived experience of the participants	Respondents attribute their depression to health problems, inability to work, financial concerns, and lost relationships. More rigorous quantitative evaluation is coming a the next phase of this research	It is critical that more research is conducted to develop effective strategies to integrate mental health treatment into HIV/AIDS care.
2013	**Nitzan et al.**	Consenting not to be informed. A survey on the acceptability of placebo use in the treatment of depression	Israel	Survey, questionnaire; statistical analyses with SPSS	Depression	Investigation of opinions of healthy students regarding acceptability of placebo treatment if they were to experience depression	70 % answered that they would agree to treatment with placebo as a first-line treatment if they were diagnosed with depression. This is the first survey to clarify the opinions of laypersons re. option of receiving placebo in the treatment.	The results will hopefully promote further discourse among physicians and health care professionals re. legitimacy of placebo treatment.
2013	**Park & Ahn**	Direct-to-consumer (DTC) antidepressant advertising and consumer misperceptions about the chemical imbalance theory of depression: The moderating role of scepticism	USA	Survey online; statistical analysis	Depression	Exposure to direct-to-consumer advertising of ADs may shape common misperceptions about the chemical imbalance theory	The study revealed that consumers hold a few common misperceptions about the chemical imbalance theory	Future studies may replicate these research findings with a nationally representative sample
2013	**Patel et al.**	An exploration of illness beliefs in mothers with postnatal depression	UK	Qualitative: face-to-face, semi-structured interviews	Postnatal depression PND	Illness beliefs: unmet expectations, identifying stressors in their life context, antidepressants, uncertain futures, etc.	Participants' narratives were conflicting as mothers were torn btw. their desire to be good mothers and internal struggles giving them feelings of not being good mothers	Health-care professionals need to try and improve accessibility to non-pharmacological interventions when mothers seek help with PND
2013	**Pilkington, Reavley, & Jorm**	The Australian public's beliefs about the causes of depression: Associated factors and changes over 16 years	Australia	2011 national survey; statistical analysis	Depression	Biological conceptualizations of depression are increasingly prevalent	Australian public largely believes in multifactorial causation; certain subgroups significantly attribute depression to the weakness of character	Future efforts to improve public knowledge about the causes of depression need to specifically target these populations

2013	**Simon, Peterson, & Hubbard**	Is treatment adherence consistent across time, across different treatments and across diagnoses?	USA	Data extracted from electronic medical records; statistical analysis	Depression	Data analyses examined individual patients' consistency of adherence behavior for the same and to a different depression treatment	Adherence behavior was most consistent within specific treatments, less consistent across depression treatment and even less consistent across treatment for different conditions.	Examining the relative importance of provider-level and treatment-level influences on adherence is a priority area for future research
2013	**Torres-Lopez et al.**	Follow up of patients who start treatment with antidepressants: treatment satisfaction, treatment compliance, efficacy and safety	Spain	Proposal for observational longitudinal cohort study; statistical analysis	Depression	AD prescription in the primary care setting by evaluating compliance, clinical effectiveness, safety, and treatment satisfaction	The empirical identification of predictors of poorer adherence to medication will allow these predictors to be considered together with the patient during treatment, facilitating good compliance	Devising a scale specifically designed to evaluate satisfaction with AD treatment could be of interest in healthcare outcome research
2013	**Treuer et al.**	Use of antidepressants in the treatment of depression in Asia: Guidelines, clinical evidence, and experience revisited	6 Asian countries	Evaluation of the current use of AD treatment based on review of treatment guidelines, publications, and local clinical experience	MDD	Appropriate use of SSRIs in the personalized treatment of MDD	Among the MDD treatment guidelines in Asian countries, some adopt relatively conservative strategies and major differences were found in their AD treatment approach	Treatment guidelines need to evolve from being consensus based to evidence-based.
2013	**Vilhelmson, Svensson, & Meeuwisse**	A pill for the ill? Patients' reports of their experience of the medical encounter in the treatment of depression	Sweden	Internet-based reports; narrative experience, qualitative content analysis	Depression	A biochemical understanding of mental ill health may win as it relieves people of responsibility for their circumstances; can result in a sense of powerlesness	Dynamics happening in the medical encounter may still be highly affected by a medical dominance, instead of a patient-oriented perspective. This may contribute to a questionable medicalization and/or pharmaceuticalization of depression	It is crucial to patrol the boundaries of medicalization and especially the ones of pharmaceuticalization
2013	**Wittink et al.**	Towards personalizing treatment for depression	USA	Internet based questionnaire; statistical analysis	Depression	To describe and demonstrate a method to develop	Values markers may provide a foundation for personalized medicine and emphasize patient-centred care	Next step should assess whether values markers are predictive of treatment initiation and adherence

2013	**Yang et al.**	Response to antidepressants in MDD with melancholic features	South Korea	Observational study; statistical analysis	DSM-IV MDD with and without melancholic features	SSRIs	The findings suggest a faster and more evident response to pharmacotherapy in melancholia compared to other depressive syndromes, particularly with SSRIs	Clinicians should take into account the growing knowledge of differences in pharmacokinetics, response rates, and functional impairments in melancholic depression
2014	**Aljuma, Hassali, & AlQhatani**	Examining the relationship between adherence and satisfaction with antidepressant treatment	Saudi Arabia	Observational, non-experimental survey; statistical analysis	DSM-IV MDD	General patient overuse and harm beliefs showed a direct positive correlation with the side effects domain	High treatment satisfaction scores among patients in Saudi Arabia with MDD, which correlated with adherence and patient beliefs about the necessity of treatment.	Further research is recommended in order to investigate other factors that may influence treatment satisfaction
2014	**Bosman et al.**	Adherence of antidepressants during pregnancy: MEMS compared with three other methods	The Netherlands	Observational study; statistical analysis (logistic regression); MEMS	MDD during pregnancy	Searching for an inexpensive and easy method to implement daily for assessing medication adherence during pregnancy	Adherence to ADs during pregnancy using MEMS is 86%.Pill counts is a good alternative	Owing to the small number of patients in this study, further investigation is recommended as mandatory
2014	**Burnett-Zeigler et al.**	The association between race and gender, treatment attitudes, and antidepressant treatment adherence	USA	Assessment with depression and adherence scales HADS-A, ASI-R; statistical analysis	Clinically significant depression	Examined the associations btw. treatment attitudes and beliefs with race/gender differences in AD adherence	Attitudes are potentially modifiable through improved patient-provider communication, culturally sensitive psycho-education and therapeutic interventions	Further explore adherence in African-American women, other treatment attitudes and beliefs that may be related to poor adherence
2014	**Buus, N.**	Adherence to antidepressant medication: A medicine-taking career	Denmark	Qualitative: Prospective semi-structured interview study based on an interactionist conception and data were analysed thematically		Study of medicine taking is controversial as it often reveals a discrepancy btw. health care professionals' advice and patients' actual behavior.	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

2014	**Cabassa et al.**	Primary health care experiences of Hispanics with serious mental illness: a mixed-method study	USA	Mixed-methods: focus groups, structured patients interviews; statistical analysis, triangulation	Serious mental illness SMI	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	Combination of perceived stigma and racism are critical targets for improving the primary health care of Hispanics with SMI	Anti-stigma and cultural competence training programs can help raise providers' awareness of these issues and help shift maladaptive attitudes and biases.
2014	**De las Cuevas, Penate, & Sanz**	Risk factors for non-adherence to antidepressant treatment in patients with mood disorders	Spain	Scales and subscales, questionnaires; statistical analysis ANOVA	Depressive disorders	Adherence to prescribed psychotropic medications is relevant given that diagnosis of mental disorder is well established	A new profile of patients emerges when all of the scores are put together. It correlates the adherence to medication to a positive attitude towards medication and a higher cultural level and the lack of adherence to higher personal perception of side-effects.	Patients' health beliefs and attitudes need to be assessed in order to improve adherence.
2014	Dickson, Matthew E.	Expectations and beliefs associated with different treatment modalities for depression.	USA	Dissertation				
2014	**Elnazer & Baldwin**	Treatment with citalopram, but not with agomelatine, adversely affects sperm parameters: a case report and translational review	UK	Case report and translational review	Mixed depressive & anxiety disorder; citalopram, agomelatine	Investigations of the effects of antidepressant drug administration on sperm production; possible underlying mechanisms.	This case report indicates that citalopram treatment can be associated with impaired semen quality, with particular effects on motility and morphology, but agomelatine treatment was not associated with similar effects.	Further pre-clinical and clinical studies of the effects of antidepressants on spermatogenesis
2014	**Fosgerau & Davidsen**	Patients' perspectives on antidepressant treatment in consultation with physicians	Denmark	Qualitative: video recording, conversation analysis	Depression	Patients were more likely to express their perspectives on medications in consultations with GPs than with psychiatrists.	Patients' perspectives on ADs were deeply affected by the way ADs were looked on by society at large. That means that a shared decision making could also involve a third voice (i.e.media)	Physicians listen to and explore patients' concerns and take responsibility for patients

2014	**Gibson, Cartwright, & Read**	Patient-centered perspectives on antidepressant use	New Zealand	A narrative review	Depression	High rates of ADs prescribing in Western countries have coincided with increasing doubts about their effectiveness	Studies reporting patients' negative rather than positive experiences of ADs. Possibly there are fewer positive experiences or that those with negative experiences tend to be more active in reporting those to researchers.	It would be important to have more studies that investigate the positive experiences in order to better understand the complex mixture of views
2014	**Hartley et al.**	Narratives reflecting the lived experiences of people with brain disorders: Common psychosocial difficulties and determinants	UK	First person narratives from 6 focus groups and 77 qualitative studies	7 brain disorders: AD, depression, epilepsy, MS, Parkinson's disease, schizophrenia, stroke	The strength of the methodology and the narratives provide the opportunity for the reader to empathise with people with brain disorders	First-person narratives illustrate realities for people with brain disorders facilitating a deeper understanding of their every-day life experiences.	Data from quantitative studies would also be valuable
2014	**Izquierdo et al.**	Older depressed Latinos' experiences with primary care visits for personal, emotional and/or mental health problems: a qualitative analysis	USA	Qualitative, grounded theory analysis	Depression	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	Distinctive results included the finding that caregiving was associated with difficulties accessing primary care for mental health problems	The findings may have implications for primary care providers and support for older depressed Latinos in patient-centered care for chronic depression
2014	**Jaffray et al.**	Why do patients discontinue antidepressant therapy early? A qualitative study	UK	Qualitative : interviews audio-recorded and transcribed verbatim	Depression	Patients' views on ADs are influenced by their perceptions of ownership, knowledge and support	Health care professionals would benefit from exploring patient knowledge and views on depression and ADs at an early stage of treatment	Treatment adherence could be improved by intervention to address perception at the same time
2014	**Jumah et al.**	Factors associated with adherence to medication among depressed patients from Saudi Arabia: a cross-sectional study	Saudi Arabia	Non-experimental cross-sectional design; statistical analysis	MDD	Low adherence to AD medication and severity of depression had a negative correlation	The study indicated that he majority of patients with MDD reported low adherence (52.9%)	Examine the impact of interventions targeting factors that correlate with adherence to ADs

2014	**Katona, Bindman, & Katona**	Antidepressants for older people: What can we learn from the current evidence base?	UK	Review	Depression	How effective are antidepressants in older people?	The most consistent evidence is for the effectiveness of continued AD treatment in those depressed patients who respond well to acute treatment	There remains a clear need for more research to identify effective treatments for resistant depression
2014	**Kirino, Eiji**	Escitalopram for the management of MDD: a review of its efficacy, safety, and patient acceptability	Japan	Review	MDD	SSRI, escitalopram	Because MDD recurs readily, it is important to select AD drugs that allow high therapy continuity for pharmacological treatments. The effects of escitalopram indicate that this AD drug is appropriate for first-line therapy	Additional longer-term, comparative studies that evaluate specific efficacy, tolerability, health-related quality of life, and economic indices are needed
2014	**Lafrance, M.N.**	Depression as oppression: Disrupting the biomedical discourse in women's stories of sadness.	Canada	Re-analysis of interviews previously collected for studies from 2006 and 2007, 2009	Depression	The superficiality of medication as solution, and the readiness with which ADs are prescribed, was described by several participants	In highlighting and circulating counter-stories, we provide alternate ways of understanding and responding to women's experiences of depression	Not found
2014	**Lam & Sun**	Stigmatizing opinions of Chinese toward different types of mental illnesses: A qualitative study in Hong Kong	Hong Kong	Qualitative: Focus group interview, audio-taped, transcribed verbatim	Mental illness: depression, mania, bipolar disorders, schizophrenia	For depression, it was usually regarded as a minor psychological problem which many people suffered from in life	While there are different stereotypes for different mental illnesses, the perceived risk of aggressive behaviors determine the public's acceptance. Stigmatizing opinions do not generalize across different mental illnesses.	Future interventions among Chinese should reduce the public's exaggeration of the aggressive image of psychotic patients.
2014	**Mikocka-Walus & Andrews**	Attitudes toward antidepressants among people living with inflammatory bowel disease: An online Australia-wide survey	Australia	Cross-sectional online survey; descriptive statistics; simple content analysis	Mental health problems comorbid with IBD	ADs; inflammatory bowel disease due to the widespread evidence that ADs may improve immuno-regulatory activity	ADs found to be accepted by IBD respondents with co-morbid mental health symptoms. Disease activity improved in only 25% of AD users; improvement in psychological well-being reported by nearly 90% of participants	Future clinical trials on ADs will likely be accepted by people living with IBD and in need of mental health care

2014	**Moradveisi et al.**	The influence of patients' preference/attitude towards psychotherapy and antidepressant medication on the treatment of MDD	Study conducted in Iran	Data based on RCT testing effectiveness of behavioral activation vs ADs; statistical analysis	MDD	In Iran, most patients have only access to AD medications, not to psychotherapy	High scores on psychotherapy preference vs ADs attitude predicted dropout from ADs. Patients' preferences and attitudes toward depression treatment influence dropout from ADs	Investigate the effects of preference/attitude for BA (behavioral activation) and ADs in other cultures and settings
2014	**Powell, Overton, & Simpson**	The revolting self: An interpretative phenomenological analysis of the experience of self-disgust in females with depressive symptoms	UK	Qualitative: interviews and Interpretative Phenomenological Analysis	Depression	To obtain an informed understanding of self-disgust.	Self-disgust is a consuming negative psychological phenomenon, associated with depression, problems with eating, physical appearance, interpersonal relationships, and self-persecution	The 'self' is a psychological phenomenon that deserves further empirical and therapeutic considerations.
2014	**Ramirez & Badger**	Men navigating inward and outward through depression	USA	Grounded theory study	Depression in men	Understanding depression in men remains poor. Depression in men is underdiagnosed.	This study advances our understanding of men and depression by providing meanings to the behaviors men express when depressed.	Based on these findings, further research can lead to better screening tools and early diagnosis of depression in men.
2014	**Read, Carthwright, & Gibson**	Adverse emotional and interpersonal effects reported by 1829 New Zealanders while taking antidepressants	New Zealand	Questionnaire; the study fully relied on self-report; statistical analysis	Depression	This study aimed to survey the largest sample of AD recipients to date. It reports participants' experiences of 20 biological, emotional and interpersonal adverse effects	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	The ethical principle of informed choice suggests that patients should be informed about adverse effects prior to starting ADs.
2014	**Read et al.**	Beliefs of people taking antidepressants about causes of depression and reasons for increased prescribing rates	New Zealand	Online survey; statistical analysis	Depression	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.	Clinicians may want to consider spending a little time exploring their patients' understandings of the origins of their problems.

2014	**Serrano et al.**	Therapeutic adherence in primary care depressed patients: a longitudinal study	Spain	Observational and longitudinal study; statistical analysis with SPSS 19.0	Depression	Patients with a higher level of therapeutic adherence are those who have a better perception of the effects of the medication, showing earlier remission	The analysis of factors associated with greater adherence to AD treatment shows that personality factors and beliefs surrounding medication do not influence therapeutic compliance	It is important to make use of the relationship between the PC doctor and the patient in order to provide personalized information about medication, its effects and therapeutic response.
2014	**Speerfork et al.**	Different biogenetic causal explanations and attitudes toward persons with major depression, schizophrenia and alcohol dependence: is the concept of a chemical imbalance beneficial?	Germany	Cross-sectional study, population survey, case vignettes; statistical analysis	Depression, schizophrenia, alcohol dependence	All three biogenetic causal beliefs were associated with more fear in all three illnesses	'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	A discussion-based strategy targeting sharply defined groups of recipients could probably serve well the pressing need to de-stigmatize mental illness.
2014	**Stanners et al.**	Depression diagnosis and treatment amongst multimorbid patients: a thematic analysis	Australia	Qualitative study: Semi-structured interviews, digitally recorded and transcribed; qualitative analysis	Depression and 2 or more chronic conditions	All participants described depression as developing subsequent to a life event that resulted in the loss of their identity	Beliefs about depression, about themselves, and about symptom causation and treatment efficacy strongly affected the diagnostic and treatment process	Suggesting that psychotherapy/which is rarely offered/may be beneficial in these circumstances
2014	**Tahirkheli et al.**	Postpartum depression on the neonatal intensive care unit: current perspectives	USA	Review	Post-partum depression	The diagnosis of PPD is complicated by not only a lack of understanding but also varying definitions of the diagnosis itself.	By implementing regular screenings for PPD, we can target mothers who need intervention earlier and reduce their chances of developing PPD symptomatology.	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.

2014	**Van Grieken et al.**	Patients' perspectives on how treatment can impede their recovery from depression	The Netherlands	Qualitative: interviews, transcripts, coding procedures and constant comparative method of analysis	MDD	From the patients′ perspective, characteristics of professional treatment may impede or slow down their recovery, engagement in treatment and clinical outcome.	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.	Each individual patients′ perspective is unique and clinicians may learn from this study about the importance of paying attention to 'minimal cues' concerning the patients′ feelings about diagnosis, treatment, and outcome.
2014	**Ward, Mengesha, & Issa**	Older African American women's lived experiences with depression and coping behaviors	USA	Qualitative: phenomenology	Depression	Older women believed they experienced a number of situations and events from childhood through adulthood that caused their depression	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
2014	**Wouters et al.**	Antidepressants in primary care: patients' experiences, perceptions, self-efficacy beliefs, and nonadherence	The Netherlands	Self-report; statistical analysis	Depression	Being convinced of efficacy was associated with lower intentional nonadherence	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
2014	**Wouters et al.**	Primary-care patients' trade-off preferences with regards to antidepressants	The Netherlands	Questionnaire; statistical analysis	Depression	TCAs, SSRIs, SNRIs, tetracyclic ADs	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.
2014	**Wu et al.**	Individual counseling is the preferred treatment for depression in breast cancer survivors	USA	Survey; statistical analyses	Breast cancer survivors; depression	Highlighted the need to consider patient preference in the treatment of co-morbid depression in women with cancer.	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.

2014	**Yau et al.**	Non-continuous use of antidepressant in adults with MDDs-a retrospective cohort study	Hong Kong	Retrospective cohort study; electronic patient records	Depression	Major reasons for non-continuous ADs use: defaulting follow-ups, side effects, feeling improved in condition, concerns about stigma	Non-continuous AD 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.	Collaborative multidisciplinary approach utilizing various health care professionals to provide systematic psychoeducation on depressive illness and drug aspects should be explored.
2015	**Amarasuriya, Jorm, & Reavley**	Depression literacy of undergraduates in non-western developing contest: the case of Sri Lanka	Sri Lanka	Survey, vignette, questionnaire, coding open-ended questions; statistical analysis	DSM-IV MDD	A majority of undergraduates recognized the problem as a mental health problem, only 17.4% recognized it as depression	Undergraduates are likely to consider the help of informal options such as parents and friends more than the help of professionals. They might also seek religious help for their problem.	Depression literacy initiatives must improve the depression literacy while also improving the undergraduates' awareness of professional help, especially with regard to medications.
2015	**Ambresin et al.**	What factors influence long-term-antidepressant use in primary care? Findings from the Australian *diamond* cohort study	Australia	Cross-sectional analysis, survey about ADs use; statistical analysis	Depression, PHQ-9	The study presents a comprehensive examination of the characteristics of long-term ADs users in primary care.	Long-term ADs use of 2 years or more is not uncommon in primary care. It occurs within the context of complex mental, physical, and social morbidities. Whilst most long-term use is associated with a history of recurrent depression, there remains opportunity for treatment re-evaluation and timely discontinuation.	There is evidence to suggest that GPs could be more actively involved in considering treatment discontinuation: this is an important focus for future research.
2015	**Anderson et al.**	Starting antidepressant use: a qualitative synthesis of UK and Australian data	UK/ Australia	Qualitative interpretive approach, thematic analysis with constant comparison, NVivo	Depression	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'	This is the first paper to explore in-depth patient existential concerns about start of ADs using multi-country data. People need additional support when they make decisions about starting ADs. Many feel intimidated by the prospect of taking ADs	Health professional can use these findings to better understand and explore with patients their concerns about starting ADs

2015	**Arco, L.**	A case study in treating chronic comorbid OCD and depression with behavioral activation and pharmacotherapy	Australia	Single case study	OCD, MDD, measures: OCI-R, DASS-D, DASS-A, DASS-S, BDI	OCD is difficult to treat, and more so when comorbid with MDD	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.
2015	**Atkins et al.**	Elderly care recipients' perceptions of treatment helpfulness for depression and the relationship with help-seeking	Australia	Cross-sectional study, survey; statistical analysis	Depression	There were no significant differences in beliefs in the helpfulness of any of the types of treatments/interventions for depression btw. those who were and who were not currently experiencing depression	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.
2015	**Bayliss & Holttum**	Experiences of antidepressant medication and CBT for depression: A grounded theory study	UK	Qualitative: Grounded theory, semi-structured interviews	Depression	Systematic, socially situated account of people's experiences of ADs and CBT	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)
2015	**Blandin et al.**	No evidence in favor of a more deleterious impact of a major depressive episode on verbal memory in older patients with antidepressant response	France	GPs' assessment +statistical analysis	Hippocampal toxicity may be independent of age in depressed patients with AD treatment response	Any kind of antidepressant	This study suggests that older patients who suffered from a depressive episode have equivalent odds of recovering from their memory impairment than younger patients	Further studies should explore the immediate recall and use attention and executive tasks to further characterize the impact of a depressive episode on working memory in the elderly

2015	**Brown-Bowers et al.**	Postpartum depression in refugee and asylum-seeking women in Canada: A critical health psychology perspective	Canada	Theoretical article	Postpartum depression (PPD)	A critical psychological approach involves questioning the belief that diseases and symptoms are objective entities that exist outside of subjective interpretation or cultural context.	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.	Utilization of midwifery model will increase social support for migrant maternity care
2015	**Chambers et al.**	The self-management of longer-term depression: learning from the patient, a qualitative study	UK	Qualitative: semi-structured, in-depth interviews, Interpretative Phenomenological Analysis	Long-term or chronic depression	Self-management strategies in depression: Powerful agents: hope, confidence and motivation; engaging in a wide range of chosen activities can contribute to emotional, mental, physical, social, spiritual and creative wellbeing	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	There is greater scope for improving the ability of services to engage with this.
2015	**Demyttenaere et al.**	What is important in being cured from depression? Discordance between physicians and patients (1)	Belgium	Prospective, non-interventional study; statistical analysis	Depression	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.	Not found

2015	**Demyttenaere et al.**	What is important in being cured from depression? Does discordance between physicians and patients matter? (2)	Belgium	Meta-regression analysis	Depression	Previous study (1) showed that what physicians and patients consider to be important in being cured from depression is different	Outcomes with standard AD drugs are still suboptimal and discordance btw. what patients and physicians consider important in the definition of cure from depression significantly influences clinical outcomes at 6 months, mainly for anxiety, positive affect and social relationships in quality of life.	Not found
2015	**Hudson et al.**	Reduction of patient-reported antidepressant side effects, by type of Collaborative Care	USA	Prospective study, pragmatic, multisite, comparative-effectiveness trial; statistical analysis	Mostly treatment resistant depression	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)	Patients in the TBCC group reported fewer antidepressant-related side effects, which may have contributed to improved quality of life.	Not found
2015	**Jacob, Rahman, & Hassali**	Attitudes and beliefs of patients with chronic depression toward antidepressants and depression	Malaysia	MADRS, ADCQ, ACQ; statistical analysis	Depression	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	It was observed that Malay patients had more positive attitudes and beliefs toward depression and ADs. Malaysia is a multiracial country made up of 60% Malays, more than 20% Chinese, and less than 10% Indian. By constitutional law, all Malays are Muslims.	Most patients had erroneous views with regard to perceived harmful effects of ADs. Patients' beliefs and attitudes influence their adherence, preference for treatment and outcome.

2015	**Kasteenpohja et al.**	Treatment received and treatment adequacy of depressive disorders among young adults in Finland	Finland	Questionnaire, SCID interview, final diagnostic assessment, DSM-IV Structured Clinical Interview; statistical analysis	Depressive disorders checked on severity (MDD or not)	Delays in help-seeking and discontinuation of treatment seem to create a barrier to proper care.	A lack of adequate treatment of depressive disorders is an ongoing problem although the results on treatment among young adults are better than in most previous studies and encouraging.	More efforts of future health care are needed to reach out to individuals with less education who present a higher risk of suicidality, complications and social exclusion.
2015	**Kim & E-O Im**	Korean-Americans' knowledge about depression and attitudes about treatment options	USA	Cross-sectional, correlational design: Self-report survey; statistical analysis: SPSS 20; descriptive and inferential statistics, t-test	Depression	Pilot study to explore first generation's Korean-Americans (KA) knowledge about depression and attitudes towards various treatments	First-generation KA's feel a stigma toward seeking Western mental health treatment such as ADs and prefer lifestyle modifications, especially exercise. Within the Oriental medical model, depression is considered as an imbalance in the flow of Qi (energy), Yin (cold) and Yang (hot) within the person.	Compare Hwa-byung to depression and test the effects of exercise on depression and Hwa-byung in the population of interest.
2015	**King et al.**	Role of patient treatment beliefs and provider characteristics in establishing patient-provider relationships	USA	Deductive parallel convergent mixed method design with cross-sectional data; statistical + qualitative text analysis	Depression	The relationship btw. patient treatment beliefs and patient-provider-relationships by gender, race, and current depression	Patients who trusted their provider reported greater bond, openness and shared decision making.	PC environments in which individuals feel safe sharing psychological distress are essential to early identification and treatment. Attentiveness and active listening may influence the effectiveness of depression intervention.
2015	**Lesen et al.**	Beliefs about antidepressants among persons aged 70 years and older in treatment after a suicide attempt	Sweden	Interviews, BMQ specific for ADs were analysed 1 year later; statistical analysis	Depression in older age	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)	Beliefs about ADs tended to be more positive than negative in older persons taking ADs in the aftermath of a suicide attempt.	Studies using objective measures of adherence are called for

2015	**Lossnitzer et al.**	A patient-centered perspective of treating depressive symptoms in chronic heart failure: What do patients prefer?	Germany	Standardized interview statistical analysis	Depressive disorder (PHQ-9; comorbid and chronic heart failure, anxiety (GAD 7)	SSRI; SNRI	The findings underscore the patients' need to talk about the disease and its consequences within the context of their life – not only about subjects directly affecting their heart disease. Many patients have objections to ADs as they worry about adverse effects or negative medication interaction.	Investigate if supportive talks over an extended period of time could reduce depressive symptoms (at least in minor depression) and ease the overall symptom-burden by treating CHF and depression simultaneously
2015	**McCarrier et al.**	Patient-centered research to support the development of the symptoms of MDD Scale (SMDDS): Initial qualitative research	USA	Qualitative: interviews, cognitive semi-structured interviews, preliminary version of SMDDS (Symptoms of MDD Scale); qualitative analysis, ATLAS ti	DSM-IV-TR and DSM 5 MDD, recent MDE, HAMD > 18 at screening	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	The current version of SMDDS also assesses emotional, psychological, and somatic symptoms commonly experienced in MDD but not identified by the DSM-IV-TR or DSM-5: anger, frustration, irritability, loneliness, nervousness, shortness of breath, aches and pain, and self-dislike	When finalized and qualified by the FDA, the SMDDS will be made publicly available and is intended to be suitable for implementation. Assessing treatment benefit from the patient perspective has the potential to support product labeling claims beyond currently available for MDD.
2015	**Mert et al.**	Perspectives on reasons of medication nonadherence in psychiatric patients	Turkey	Self-report, statements of relatives, information on patients' files; statistical analysis	Psychiatric diseases: DSM 5 bipolar, schizophrenia and depression	To evaluate factors resulting in medication nonadherence; patients' views on nonadherence were examined	The leading factors for medication nonadherence: "not willing to use medication", "not accepting the disease", "being disturbed by side effects", "feeling well"	It is recommended to evaluate medication adherence in future studies through more specific methods such as pill counting and biochemical analysis
2015	**Moradveisi, Huibers, & Arntz**	The influence of patients' attributions of the immediate effects of treatment of depression on long-term effectiveness of behavioral activation and antidepressant medication	Study conducted in Iran	Randomized study: behavioral activation, AD medication (sertraline); statistical analysis; additional analyses	Depression	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.

2015	**Novick et al.**	Antidepressant medication treatment patterns in Asian patients with MDD	6 Asian countries	Prospective, observational, statistical analysis	MDD; HAMD-17,	Median time to discontinuation was 70 days; patient-reported nonadherence was 57.5%, and clinician-reported nonadherence was 14.6%	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.	Not found
2015	**Read et al.**	Beliefs of people taking antidepressants about the causes of their own depression	New Zealand	Online survey; statistical analysis	Depression	beliefs about the causes of their own depression: chemical imbalance, family stress, work stress, heredity, relationship problems and distressing events in childhood	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	Exploring patients' beliefs may enhance the doctor-patient relationship and selection of appropriate treatment modality.
2015	**Read et al.**	Understanding the non-pharmacological correlates of self-reported efficacy of antidepressants	New Zealand	Online survey questionnaire; statistical analysis	Depression	2 outcomes were measured: i) perceived reduction in depression, ii) perceived improvement in quality of life	**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.**	Prospective studies are essential as it is difficult to draw firm conclusions about the meanings of some findings, incl. causality.
2015	**Ridge et al.**	"My dirty little habit": Patient constructions of antidepressant use and the 'crisis' of legitimacy	UK/ Australia	Qualitative secondary analysis; qualitative interpretive approach: thematic analysis and constant comparison (NVivo)	Depression	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	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	Professionals might help patients make better choices by illuminating the moral issues as severely ill patients may over-look the live-saving nature of the medications when distracted by moral concerns.

2015	**Samples & Mojtabai**	Antidepressant self-discontinuation: Results from the collaborative psychiatric epidemiology surveys	USA	Survey data, self-reported ADs use; statistical analysis	SSRIs, TCAs, DSM-IV anxiety disorders, mood disorders, and substance use disorders	To examine the extent and correlates of self-discontinuation of AD medications without physician advice or approval.	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.
2015	**Sari & Gencöz**	Shame experiences underlying depression of adult Turkish women	Turkey	Qualitative: purposive sampling; semi-structured interviews; Interpretative Phenomenological Analysis	DSM-IV Depression	In depth-analysis of shame experiences of women diagnosed with depression	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
2015	**Tundo, de Filippis, & Proietti**	Pharmacologic approaches to treatment resistant depression: Evidences and personal experience	Italy	Systematic review	MDD, TRD (treatment resistant depression)	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.
2015	**Vargas et al.**	Toward a cultural adaptation of pharmacotherapy: Latino views of depression and antidepressant therapy	USA	Qualitative: interviews, open coding, iterative analytical approach; NVivo	DSM-IV MDD, HAMD-17	Participants' narratives focused on modifiable barriers to treatment; examined were views about depression and AD treatment	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.

2015	**Whiters et al.**	Perspectives of Vulnerable US Hispanics With Rheumatoid Arthritis on Depression: Awareness, Barriers to Disclosure, and Treatment Options	USA	Semi-structured interviews; statistical analysis	Hispanics with rheumatoid arthritis and depression	Despite the high prevalence of depression among vulnerable Hispanics with rheumatoid arthritis, many do not disclose it or seek treatment.	Depression was perceived as a long-term, severe problem leading to suicide. It was associated with weakness and character flaws, contributing to stigma and reduced likelihood of disclosure.	Use, duration, and goals of AD therapy should be clarified. Providers should strive to establish trust and conduct in-person depression screening to facilitate disclosure.
2016	**Akioyamen et al.**	Effects of depression pharmacotherapy in fertility treatment on conception, birth, and neonatal health: a systematic review	Canada	Systematic review	Depression	While AD medications are currently used during conception, gestation and post-partum, considerable uncertainty exists re. benefits and harms to mothers and their offspring.	Women receiving treatment for infertility are especially vulnerable to symptoms of depression and adverse perinatal outcomes. Currently, no studies address whether pharmacotherapy for the treatment of depression in women undergoing assisted reproduction affects their health or that of their off-spring long-term.	Decisions re, the treatment of depression should be made taking into account clinical presentation and illness severity. It appears that much like AD use in fertile women, there are risk associated with both AD use and untreated depression.
2016	**Barr et al.**	Competing priorities in treatment decision-making: A US national survey of individuals with depression and clinicians who treat depression	USA	Online cross-sectional surveys; convenience sampling approach; collaboRATE; statistical analysis	Depression	Identify information priorities for consumers and clinicians making depression-treatment decisions and assess shared decision-making (SDM) in routine depression care	While clinicians know what information is important to consumers making depression treatment decision, they do not always address these concerns. This adversely affects the quality of depression care.	Development of decision support interventions can improve levels of shared-decision-making and provide clinicians and patients with a tool to address the existing misalignment in information priorities.
2016	**Bortolato et al.**	Cognitive remission: a novel objective for the treatment of major depression?	Brazil	2 multicenter RCTs	Cognition; major depression,	Antidepressants, Cognition,Cognitive enhancers, Erythropoietin, Lisdexamfetamine dimesylate, Novel targets, Vortioxetine	The management of cognitive dysfunction remains an unmet need in the treatment of MDD.	It is hoped that the development of novel therapeutic targets will contribute to ‘cognitive remission’, which may aid functional recovery in MDD

2016	**Brinijah & Antoniades**	"I'm running my depression": self-management of depression in neoliberal Australia	Australia	Qualitative: interviews,	Depression	It was explicated how people with depression came to self-manage their illness within a neoliberal setting	Few would consider self-medicating with alcohol and other drugs, adjusting prescription dosages without the input of a qualified health professional or reducing interactions with health services as optimal practiced for people with depression.	Instead, such practices highlight that the self-management within a neoliberal context, without giving sufficient acknowledgement to the importance of a therapeutic relationship, a feeling of being cared for, may do more harm than good to human health.
2016	**Castonguay, Filer, & Pitts**	Seeking Help for Depression: Applying the Health Belief Model to Illness Narratives	Study conducted primarily in UK	Collected illness narratives among people living with depression	Major depressive disorder	The analysis of depression narratives yielded insight about the path to seeking help, as well as what people experienced while navigating the help-seeking process.	The main barrier preventing help-seeking was fear of the unknown treatment process. Interpersonal cues to action served to reduce uncertainty by providing guidance and confirmation that help was needed.	Interventions should target friends and family of depressed individuals and provide information regarding the treatment process to effectively reduce uncertainty and drive help-seeking.
2016	**Chaitanaya et al.**	Reasons for poor medication adherence in patients with depression	India	Prospective, observational study, MMAS-8	Depression	To assess the reasons contributing to non-adherence to anti-depressants in India	The overall non-adherence rate to ADs found in this study was high	Pharmacist instructions may improve adherence in depression.
2016	**Economou et al.**	Attitudes towards depression, psychiatric medication and help-seeking intentions amid financial crisis	Greece. Findings from Athens	Telephone interviews, Personal Stigma Scale; statistical analysis	Major depression	Financial crisis has yielded adverse effects on the global population, as evidenced by elevated rates of major depression.	Attitudes to psychiatric medications were found to be particularly negative and influenced help-seeking intentions.	Research on mental health effects of the global recession should encompass studies investigating the stigma attached to mental disorders and its implications.
2016	**Gibson, Cartwright, & Read**	Conflict in men's experiences with antidepressants	New Zealand	Qualitative: In-depth, qualitative interviews; thematic analysis	Depression	While men's experiences of depression and help seeking are shaped by gender, there is little research which examines their experience of using ADs	This study has a number of implications for men using ADs, for those who prescribe ADs, or who work with men to facilitative their recovery from depression. Using ADs involves considerable conflict for men.	Professionals who work in men's mental health should have discussions about sources of conflict that men experience with ADs and to facilitate their better understanding of treatment choices.

2016	**Gibson, Cartwright, & Read**	In my life antidepressants have been…': a qualitative analysis of users' diverse experiences with antidepressants	New Zealand	Qualitative: online survey, thematic analysis	Depression	The study explores diversity in the experience of ADs users.	Considerable diversity in participants' responses incl. positive (54%), negative (16%), and mixed (28%) experiences with ADs.	Mental health professionals need to recognize that ADs are not 'one size fits all' solution.
2016	**Hanson et al.**	Attitudes and preferences towards self-help treatments for depression in comparison to psychotherapy and antidepressant medication	UK	Quantitative: questionnaire about treatment options; statistical analysis	Depression	Investigating preferences and attitudes toward different self-help treatment for depression in comparison to psychotherapy and ADs	Psychotherapy and guided help were found to be the most acceptable and preferred treatment options.	Future research should focus on understanding why unguided self-help interventions are deemed to be less acceptable than guided self-help interventions.
2016	**Huijbers et al.**	Discontinuation of antidepressant medication after mindfulness-based cognitive therapy for recurrent depression: non-inferiority RCT	The Netherlands	Non-inferiority RCT; statistical analysis	Depression	Mindfulness – based cognitive therapy and maintenance antidepressant medication both reduce the risk of relapse in recurrent depression, but their combination has not been studied.	Clinician who supports the process of discontinuation should be also trained in the mindfulness model to manage difficulties that come up. Many psychological factors may influence discontinuation, placebo-controlled studies may inform on psychological and physical barriers patients encounter.	Further qualitative research on the barriers and facilitators that patients experience during the discontinuation process might help better tailor interventions to help them.
2016	**Janakiraman, Hamilton, & Wan**	Unravelling the efficacy of antidepressants as analgesics	Australia	Case study and commentary	Depression	Knowledge of psychopharmacology is important in the management of chronic pain. Depression and anxiety are known to enhance the perception of pain.	Several ADs are efficacious in the management of chronic pain. TCAs along with gabapentin and pregabalin are recommended by recent-evidence based guideline as the first choice of treatment and SNRIs (duloxetine, venlafaxine) as the second-choice treatment in painful neuropathy.	Controlled data to support the use of SSRIs as pain stimulants are sought.

2016	**Lu et al.**	Beliefs about antidepressant medication and associated adherence among older Chinese patients with MD: A cross-sectional survey	China	Quantitative: BMQ (beliefs about medication questionnaire); statistical analysis	Depression	Antidepressants non-adherence among people with depressive disorder is a major, ongoing public health issue. Also, the global increase in the ageing population is presenting unprecedented health-care challenges.	Specific beliefs about ADs can predict adherence among Chinese elderly with depressive disorder.	For better adherence behavior, special attention should be directed at elderly depressed patients with negative attitudes towards AD medication who have had previous episodes of depression.
2016	**Stanton & Randal**	Developing a psychiatrist-patient relationship when both people are doctors: A qualitative study	New Zealand	In-depth, semi-structured interviews; thematic analysis	The sample includes doctors with experience of severe illness diagnoses who are barely mentioned in the research	To better understand the complexities of developing an effective psychiatrist - patient relationship when both people involved are doctors	When a psychiatrist has a doctor as a patient there is risk of adverse effects on the quality of care and even harm	This study shows that when a doctor engages with a psychiatrist, extra care needs to be taken of the therapeutic relationship. The strategies also have the potential to be useful for regular non-doctor-patients