

Stressful events and circumstances reported by patients prior to being prescribed antidepressants

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ABSTRACT

AIMS: This study investigates the extent to which those who receive a prescription for antidepressants perceive psychosocial stressors to be significant in their difficulties.

METHODS: This study draws on a survey of adults prescribed antidepressants. It analyses 1,683 responses to an open-ended question that enquired about difficult events and circumstances participants experienced in the time leading up to receiving an antidepressant prescription.

RESULTS: Sixty-five percent of respondents described experiencing one or more stressful events or circumstances, with 19 % reporting two and 20% reporting three or more. The most frequently reported stressors identified by participants were categorised as: relationship difficulties (19%), life transitions (19%), losses (18%), work related difficulties (15%) and participants' own or others' health issues (15%). Other less frequently reported stressors included isolation, academic difficulties, abuse and violence and financial difficulties.

CONCLUSIONS: Findings are that stressful life events or circumstances are significant for a large number of who are given a prescription for antidepressants. It is important for GPs to be aware of significance of these psychosocial stressors in their patients' lives and make treatment recommendations that address these difficulties. Conclusions need to be interpreted in the light of limitations arising from the sampling method.

General practitioners are central in the treatment of depression, with some estimates suggesting that up to 30–50% of patients in family practice experience depression.¹ It is therefore not surprising to learn that GPs deliver around three-quarters of the treatment for mental health disorders in New Zealand.²

There are a range of treatments commonly used for the treatment of depression, with the two most common treatments being antidepressants and talking therapy. Current clinical guidelines do not endorse antidepressants as a first line treatment for mild depression,³ which is reported to be the depression most commonly seen by GPs.⁴ There are also doubts about the effectiveness of antidepressants for all but very severe depression.⁵ In spite of this, antidepressants continue to be prescribed at high

rates across New Zealand, with an estimated one in nine adults receiving antidepressant prescriptions every year.⁶

Biological causal explanations for depression have been widely endorsed by health professionals working in primary care and these beliefs are likely to impact on treatment choices.⁷ Research has consistently shown that health professionals who recognise social rather than biological causes of depression are more likely to recommend talking therapy rather than medication.^{8,9}

With the current dominance of biochemical causal explanations of depression, there has been rather less attention paid to the role of social factors in recent times. However, both previous and current research has established strong links between depression and various stressful life events and circumstances.^{10,11,12} It is not known to what extent

New Zealanders who receive a prescription for antidepressants perceive themselves to be struggling with stressful events or circumstances in their lives and what the nature of these stressors might be.

This article describes the findings from a large-scale survey and addresses the question of the extent to which stressful events and circumstances are experienced as significant by those seeking an antidepressant prescription for self-described depressed mood. It also explores the range and the relative frequency of the forms of adversity that they report.

Methods

This study draws from a 47-question anonymous online survey. While the broader study investigated New Zealand adults' attitudes and beliefs about depression and antidepressants, this article draws primarily from just one open-ended question. Following a specific question about whether a loved one had died in the two months prior to first being prescribed antidepressants (to which 7.3% responded 'yes'), participants were asked to 'Please describe any other experiences or problems that you were having at this time'.

Recruitment

Ethics approval for the study was obtained from the University of Auckland Human Participants Ethics Committee. Following this, an anonymous questionnaire was placed online using a survey website that guarantees the protection of data. The study was promoted in the New Zealand media via media releases, interviews with the researchers and advertisements. Participants self-selected against the published criteria of the study that required that they be New Zealand based, over the age of 18 and had received a prescription for antidepressants in the past five years. The survey was opened to participants in March 2012 and was closed in January 2013 when there had not been any new completed surveys for some weeks.

Participants

This survey yielded 1,829 surveys for analysis. Females constituted 76.6% of the sample. The modal age group was 36–45 (24.2%); 16.3% were 18 to 25, and 15.9% were 56 or older. A large majority (92.1%) identified as 'New Zealand/European'; 2.9% as Māori, 1.2% as Asian, 0.4% as Pacific

Islander and 3.5% as 'Other'. In terms of education, 49.6% had a university degree; 26.1% gained a diploma or certificate after high school, 17.2% completed high school and 7.1% did not complete high school. Annual income (in New Zealand dollars) ranged from less than \$10,000 (15.0%) to more than \$100,000 (7.7%). The modal income was \$40,000 to \$59,999 (22.1%).

Data analysis

Initially the data was filtered to meet the criteria for this analysis. Of the 1,829 participants who completed the survey, only 1,683 participants who had reported depressed mood in the period prior to receiving an antidepressant prescription were included in this analysis. Of this number, 1,299 (77%) answered the question that asked participants to describe 'any experiences' occurring around the time that they were prescribed antidepressants.

Content analysis was used to establish the nature and frequency of any experiences identified by participants.¹³ The unit of analysis was selected as a theme, which identified a particular participant's description of an event or circumstance.¹⁴ An initial coding of these experiences was used to generate a list of categories that contained common content. After identifying over-arching categories of experience, the complete data set was coded under one or other of the established categories in the form of frequency counts together with exemplars that reflected the range of events contained within a single category. Where more than one type of experience was described in a participant's response (eg a loss and relationship difficulties), these experience types were counted separately for the purpose of analysis. In cases where a single type of experience was repeated for a participant (eg several different losses), this was coded only once to represent the presence or absence of that particular type of experience. The number of experiences described by each participant was also separately coded as "0 experiences", "1 experience", "2 experiences" and "3 or more experiences" in order to capture cumulative adversity. Some participants specifically noted an absence of events at the time or described something that did not seem to be an external occurrence. These responses were coded separately. The last step in the analysis was to check for internal and external consistency. The second author

independently coded 10% of participants' responses. Consistent with the recommendations in the literature, any consistency problems were resolved.¹⁵

Results

Frequency of reported stressful events

Of the 1,683 participants, 1,095 (65%) indicated that they had experienced one or more stressful events or circumstances in the period leading up to receiving an antidepressant prescription. The other 35%, who did not report any stressful events or circumstances, included both the 23% who did not answer the question at all and 12% who did respond to the question but reported no stressful events or only internal events (eg "a crisis of identity") or other symptoms (eg "a panic attack"). Twenty-six percent reported only one stressful event or circumstance, 19% reported two and 20% reported three or more. The most common types of events or circumstances reported were relationship difficulties, life transitions and losses.

Table 1: Number and percentages of stressful events described by participants.

Number of stressful events	
0	588 (34.9%)*
>1	1,095 (65.1%)
1 only	444 (26.4%)
2 only	314 (18.7%)
>3	337 (20.0%)
Frequency of event types	
Relationship difficulties	321 (19.1%)
Life transitions	321 (19.1%)
Losses	309 (18.4%)
Work-related difficulties	261 (15.5%)
Health problems	255 (15.1%)
Isolation	130 (7.7%)
Academic difficulties	117 (7.0%)
Abuse and violence	95 (6.5%)
Financial difficulties	90 (5.3%)
Other	100 (5.9%)

*Includes 384 not responding to the question.

Relationship difficulties

Relationship problems were described by 19% of participants. The majority of these described stress related to 'difficult' family members: "I had been under a great deal of stress with a particularly difficult child". A large number also described conflict between family members: "I had a falling out with family members and they had told me I was not worth knowing". Some also spoke of burdensome family responsibilities: "I had been going to my father's house every day during that time to make sure he was okay as he is 85, doesn't drive and won't accept help from anyone else". Many responses also included conflict or dissatisfaction that occurred in the context of intimate relationships: "Marriage difficulties—felt unloved, and trapped in the sense that there seemed to be nothing I could do that would effectively change the situation and leaving the marriage was not an acceptable option to me either". Several participants described infidelity as the source of marital dissatisfaction while others described a lack of communication, support or closeness with their intimate partner. Some participants also reported friendship difficulties as a source of stress.

Life transitions

Life transitions were described as a source of distress for 19% of participants. The majority of responses in this category included transitions within living circumstances such as moving to a new house, city or country: "Had moved from the South Island to the North Island...was trying to cope with two small children on my own in a new town with no car". Some described moving out of the family home or moving back into their family home. New roles and responsibilities were also described as stressful for a large number of participants in this category. These transitions included events such as unplanned pregnancies or having a new baby: "Caring for a premature, difficult baby. Stuck at home all day by myself, finding it hard to cope and hating my new life". Children moving out of the family home also featured in some participants' responses: "My daughter had left home to go to university...I felt redundant as a mum after my daughter left". Transitions in the context of education were also described by a smaller number of

participants. These largely focused on the demands of leaving school or university: “Concerns after finishing a first degree and future career/life direction”.

Losses

Events categorised as ‘losses’ were described by 18% of participants. Many participants described the death of family members—most often parents. Some participants described a single death event. For example, “My partner died traumatically”. Others described multiple deaths. For example, “I’ve been a mess for too long... after the death of both my partner and son died, they died within three months of each other, my partner dropped dead in front of me and my son coming up 21 hung himself over a girl”. Some deaths occurred suddenly while others appear to have been preceded by a long period of illness, with some participants having been a caregiver for the person who had died. In some cases, participants reported that their antidepressant prescription had been given only days following the death of a loved one: “[I] was still grieving at the time of the consultation.”

While death featured strongly in this category, the majority of losses described were those that related to the end of an intimate relationship: “My husband had left me for another woman after 10 years of marriage”. A smaller number of participants who described loss events spoke about a job loss as a source of distress. This included some descriptions of voluntarily leaving a job, however, the majority had been made redundant or been dismissed: “Replaced at a couple of days’ notice from position I had held for ten years”. A small number of participants in this category discussed a miscarriage or abortion as the source of their distress.

Work-related difficulties

Work-related stressors were described by 15.5% of participants. The majority of participants in this category described general workplace difficulties. Their responses included difficulty performing or attending, criticism or lack of support. For example, one participant wrote: “My manager was very unsupportive and demanding and unpredictable (sometimes he was really nice, sometimes he would yell and scream at everyone)”. Difficulty maintaining a work/life balance was described

by a number of participants and included descriptions of work demands competing with other demands in life. For example, “Work was interfering with life, eg I was on call for my son’s 21st birthday party”. Stress in the workplace seemed for most participants to reflect more chronic than acute circumstances: “Work stress for years. It had all just got too much and I couldn’t even get out of bed to go to work one day”. Many also spoke of the pressured nature of their work: “Work related pressures—sales targets”. A smaller number of participants described a range of workplace bullying and harassment experiences. There were also various descriptions of dissatisfaction with ones’ job. For example, “I was under a lot of pressure at work, which despite my senior status I found neither fulfilling or enjoyable, which spilled over into me being moody and difficult to live with”.

Health problems

Either one’s own or another person’s health problems were described as being a source of stress for 15% of participants. Nearly half the participants in this category described chronic or recurring illnesses and health conditions. For example, “I have had chronic pain from rheumatoid arthritis for nearly 20 years [...]. I take so many pills I didn’t want another one”. Many participants described the impact their physical health problems were having on their ability to engage in various aspects of life: “the viral infection, which had a huge effect on my ability to exercise, socialise or to perform well in my job”. However, more participants in this category described others’ health problems as significant sources of stress rather than their own. These problems were most often described in relation to one or both parents. Health issues of a child were also described by many participants, with half of these participants describing concerns with their child’s mental health. The majority of those describing their intimate partners’ health issues also described mental health concerns. The health problems of other family members and friends also featured in participants’ responses. In terms of others’ physical health, serious or chronic health conditions of others featured more strongly than acute conditions. The majority described cancer and stroke, while dementia and

disability were also reported: “My father had a massive stroke and is now severely debilitated. In many respects he did die”. The majority of participants’ descriptions of acute conditions related to others undergoing surgery, while injuries and heart attacks were also commonly described. A number of participants wrote about several family members having health problems at the same time as each other for example: “I went through my [...] mother having two heart attacks, my brother having a stroke and my partner being in a motorcycle accident that broke both their legs”. Some wrote of their experience of powerlessness in accessing help for a family member’s mental health problems: “Admitted to adolescent mental health unit [...]. Lack of treatment options or intervention—feeling really disempowered”.

Isolation

Limited social support or connection was described by nearly 8%. Participants attributed isolation or lack of support from friends and/or family to a variety of different factors, including physical health problems, work, location or family circumstances: “[I was] a first time mother, living in an isolated area with little support”. Some participants described their intimate partner as absent or unavailable for support, for example: “Home life was stressed as I was mainly raising my son alone while husband was away on business”.

Academic difficulties

Academic difficulties were described by 7%. The majority of these difficulties occurred within the context of tertiary education while others occurred within the context of secondary education or another unspecified context. Most participants emphasised the pressure of studying: “studying was very intense and placing time pressures and stress on myself was affecting my relationships”. Many also described some aspect of education not going well, including difficulties meeting expectations: “being unable to submit any work felt like I was letting myself and everyone else down”.

Abuse and violence

The event category “abuse and violence” was described by 6%. This included abuse and violence within the context of family, intimate partner relationships as well as

other relationships. Of participants who were victims themselves, by far the majority were female. Relatively equal proportions of participants described physical, sexual and emotional abuse. Within the family context, many participants described abuse from parents and grandparents. While some of these events appeared to have occurred some time ago, participants seemed to see them as having current impact. “I had commenced psychotherapy to begin to deal with issues due to having been sexually abused by my step-father through my childhood”. Most participants described abuse, violence or intimidation from people known to them: “I was sexually assaulted by a boyfriend who I had come to rely on heavily”. Fewer participants spoke of experiencing violence at the hands of a stranger.

Financial difficulties

Financial difficulties were described by 5%. Some participants spoke about an on-going inability to meet their financial responsibilities: “Was earning about \$35–\$45K and it was mostly used to pay day care, so there was not much left when this was paid.” The majority, however, described financial difficulties related to a specific event of financial adversity such as losing their job or closing a business: “My husband and I were as a last resort forced to leave our business and were left with no assets, finances and owing a mortgage after 30 years of saving and working”.

Other difficulties

This category included a miscellaneous range of events and circumstances that did not fit easily into any other category. Responses from nearly 6% of participants were coded here.

Discussion

This study suggests that many people who receive a prescription for medication are experiencing stressful events or circumstances at the time. About two-thirds of participants (65%) described dealing with at least one stressful circumstance or event and 39% were experiencing more than one. The five most frequent stressors were relationship difficulties, life transitions, losses, health issues and work-related stress. When considering these categories, it is not surprising that loss events featured

prominently in participants' responses. The association between depression and the occurrence of loss events has garnered substantial empirical support.^{12,16,17} The additional finding that 7% specifically reported the death of a loved one within two months prior to being prescribed antidepressants is germane to the ongoing debates about the overlap or distinction between depression and grief.¹⁸ Many other psychosocial difficulties were also described as chronic circumstances embedded in the context of people's everyday family and work life. While the family is often thought of as a sanctuary from the stresses of modern life, this analysis suggests that it may also be experienced as a significant source of unhappiness for many people. While research often points to the way that relationships with others may contribute to resilience and the ability to cope with stressful life events,¹⁹ these may equally operate as a pervasive and chronic form of adversity. There may be value in including family members in interventions aimed at addressing these kinds of problems.²⁰

It would also appear that common life transitions can also be experienced as a source of stress. The psychological impact of these 'normal' life changes may be underestimated by medical professionals. The availability of support to help those dealing with common transition points such as leaving school²¹ or having a new baby²² may go some way towards preventing or minimising the impact of depression.

New Zealand is particularly known for the long hours spent and the stress experienced in a work context.²³ In a context where difficult work conditions are seen as 'normal', the effects of this on psychological wellbeing may be frequently overlooked. Prevention of stress and intervention in the workplace may be a useful adjunct to other treatments for depression.²⁴

There is also a need for future research to explore the link between depression and one's own and others' health issues. Participants identified both of these as significant sources of stress. While there is relatively limited literature linking depressive symptoms to one's own chronic health issues,²⁵ there is even less literature exploring the impact of others' health issues

beyond that of caregiving roles.²⁶ This may be a particularly important issue given the cutbacks to health services and the likely burden this will have on family caregivers.²⁷

When considering the findings of other event categories, further points of similarity and difference were noted in relation to existing research. For example, financial difficulties did not feature as strongly as might have been expected given the substantial empirical attention this factor has received.^{28,29} This finding may well reflect the bias in the sample towards those with a higher income, which is discussed further under limitations of the study.

The "abuse and violence" event category was also relatively under-represented given the well-established association between these stressors and depression.¹⁷ Although participants had been asked to write about events that occurred around the time they were experiencing depressed mood, some referred to more longstanding issues or issues from their past—the majority of which were experiences of abuse and violence in childhood and adolescence. It seems that while these stressors occurred in their past, they continue to be seen by people as having an effect on the present. In New Zealand the availability of funding for therapy for historical sexual abuse is a valuable resource for professionals dealing with those who have had these experiences.

Social support and connection has long been recognised as a buffer in relation to stress¹⁹ but its absence registers less strongly as a source of stress than might have been expected. It may be, however, that isolation or lack of social support was implicit in a range of responses, which related to problematic interpersonal relationships with family members, intimate partners and work colleagues. This makes it likely that the relatively low frequency of stressors recorded under limited social connection underestimate this as a source of stress.

Given that a large proportion of participants have described chronic stressors and multiple stressors, the cumulative impact of life events should be considered. In this study, over half of the participants reporting described multiple stressful life events, either occurring over a long time, in quick succession or concurrently.

Limitations

Despite this being the largest sample size in a study specifically investigating antidepressant use in New Zealand, there was a risk of self-selection bias in the sample. There have been concerns about participation being limited by lack of access to the internet, however, it is recognised that this survey method has become increasingly acceptable over time and that its suitability depends on internet access, which varies considerably from one country to another.³⁰ In New Zealand, 80% of households are reported to have access to internet.³¹ Nonetheless, an Australian study conducted by Paige et al suggested the highest number of antidepressant users are in the age range of 65–74 years, a group poorly represented in our sample.³² This may reflect older peoples' reluctance to engage with new communication technologies and suggests that the experiences of this group require further investigation.

There are a number of other groups whose views are relatively poorly represented in this study. As noted above, the income of our sample was higher than the New Zealand average, which in 2012 was \$29,000.³³ This is a significant weakness given the association between low living standards and psychological distress.³⁴ Paige et al also found highest antidepressant use among those with lowest incomes, so this remains a group whose experiences also need to be investigated further.³² Māori and Pacific Island people are also under-represented in the sample although they are thought to be over-represented in mental health statistics more generally.³⁵ This may suggest the limits of an online survey for accessing the views of this group but it may be partly accounted for by the lower prescribing rates of antidepressants to Māori and Pacific Island people.³⁶ As the next largest group in New Zealand, Asians are also under-represented in this sample. One of the contributors to this may be the stigma associated with mental health problems thought to prevent this group making use of mental health services although their views about antidepressants in particular are not well-understood.³⁷

It is well-recognised that GPs might prescribe antidepressants for a wide variety of problems, which they believe have a depressive component ranging from adjustment problems and anxiety (including panic and obsessive compulsive disorder) to depression linked to drug and alcohol use,⁴ and the use of the single criteria of depressed mood to define the sample in this study does not reflect these subtle distinctions. Antidepressants may also be prescribed by GPs for other unrelated conditions such as pain or other physical problems.³⁸ However, in answer to a different survey question analysed in this article, only 0.5% of participants (n=9) reported that they had received antidepressants for a problem unrelated to psychological distress. Nonetheless, the study remains limited by relying on respondents' self-identification as having depressed mood around the time of antidepressant prescribing, and conclusions cannot be drawn specifically about the relationship between a formal diagnosis of depression and these stressful life events.

Limitations might also arise from our assumption that the 384 who did not respond to this question had not experienced any stressors. The fact that participants responded less frequently to all the open-ended questions in the survey suggests that some non-responses were more to do with convenience than having had no stressors to report. This, together with our exclusion of 'internal events' such as identity crises suggests that the frequencies reported in this study may well be underestimates.

Conclusion

It is important for GPs to be aware of the salience of stressful life events and circumstances that patients seeking antidepressants see as significant, and to recognise the common forms these take. This will enable them to engage more effectively with their patients' needs during consultations and to consider interventions that target these issues more directly as an alternative, or adjunct, to antidepressant treatment.

Competing interests:

Nil.

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