

M. J. Martín¹
M. García-Toro²
F. Campoamor³
A. Pareja⁴
I. Aguirre⁵
J. Salvá⁶
M. Roca⁷

Use of antidepressant treatment. Patients' perception

¹ Prolonged Psychiatric Care Unit. Hospital Dr. Rodríguez Lafora Madrid (Spain)

² Department of Psychiatry. Hospital Son Llatzer Palma de Mallorca (Spain)

³ Department of Pharmacy. Hospital Son Dureta Palma de Mallorca (Spain)

⁴ Department of Preventive Medicine. Hospital Son Llatzer Palma de Mallorca (Spain)

⁵ Department of Psychiatry. Hospital Son Dureta Palma de Mallorca (Spain)

⁶ Department of Psychiatry. Coordinator of Mental Health Hospital Son Dureta. Palma de Mallorca (Spain)

⁷ Psychiatry. Illes Balears University. Hospital Joan Balears Hospital Joan March Palma de Mallorca (Spain)

Introduction. A major determinant of response to antidepressant drugs is how the patients use them. Our objective is to take a look over the antidepressants use in a real sample.

Methods. In determining which factors may be relevant for treatment good use, social, demographic, disease and treatment-related data were gathered from 550 patients, who were currently taking antidepressants for any motive. The questionnaire included two items, the patients' perceived difficulty of following treatment and the level of acknowledged non-compliance by the patient, which may be considered as both an indirect and guiltless way of approximating the patients' real use of treatment.

Results. Compliance was poor among the less educated, as well as those living in rural areas and in patients receiving concomitant treatment for organic diseases. Use was good in 61.5% and was particularly good among those with an affective disorder (69.8%). Among patients who did not respond to treatment, the incidence of non-compliance (49.1%) was higher than for those achieving improvement (31.2%).

Conclusions. It's important to explore and reinforce a good use of antidepressants in clinical settings and to be sure this type of treatment is necessary if the indication is not clear.

Key words:

Use of treatment. Patients' perception. Antidepressant. Treatment response. Compliance.

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Uso de los tratamientos antidepresivos. La percepción del paciente

Introducción. Un determinante fundamental de la respuesta al tratamiento antidepresivo es cómo el paciente lo

toma. Nuestro objetivo es observar el uso de los antidepresivos en una muestra real de pacientes.

Métodos. Para determinar que factores pueden ser relevantes para un buen uso del tratamiento se recogieron datos sociales, demográficos, relativos a la enfermedad y al tratamiento de 550 pacientes que estaban siendo tratados con antidepresivos por cualquier motivo. El cuestionario elaborado incluía dos ítems, la dificultad percibida por el paciente para seguir las indicaciones del tratamiento y el nivel de reconocimiento de falta de cumplimiento, lo que puede ser considerado como una forma indirecta y poco culpabilizadora de aproximarse al uso real del medicamento por parte del paciente.

Resultados. El cumplimiento fue peor en el grupo con un nivel inferior de educación, así como en aquellos que vivían en zonas rurales y en los que recibían otro tratamiento concomitante para enfermedades orgánicas. El uso era bueno en el 61,5 % y, particularmente bueno, entre aquellos diagnosticados de un trastorno afectivo (69,8 %). Entre los pacientes que no respondían al tratamiento, la incidencia del no-cumplimiento (49,1 %) era superior a aquellos que sí referían haber mejorado (31,2 %).

Conclusiones. Es importante explorar y reforzar un buen uso del tratamiento antidepresivo en todos los dispositivos asistenciales y estar seguro de que este tipo de tratamiento es necesario si la indicación no está clara.

Palabras clave:

Uso del tratamiento. Percepción del paciente. Antidepresivos. Respuesta al tratamiento. Cumplimiento.

Correspondence:

María José Martín Vázquez
Prolonged Psychiatric Care Unit
Hospital Dr. Rodríguez Lafora
Ctra. Colmenar viejo, km 13.900
28049 Madrid
E-mail: mjose.martinva@salud.madrid.org

INTRODUCTION

In the field of mental health, good use of treatments is a major health care concern, since the effectiveness of psychopharmacologic drugs is reduced greatly when patients fail to comply with treatment.¹ Inadequate treatment adherence is believed to be an underlying cause of many cases in which depression becomes chronic and that it is a major compound of good use of the antidepressant treatment.

Factors that influence the treatment use include drug efficacy and possible adverse effects, hypochondrial and conversive symptoms that are related to increased complaints about adverse effects,² therapeutic regimen,^{1,3} and depression itself.⁴ Psychiatric history, age, and sex do not seem to influence adherence, while a low socioeconomic status, over-prescribing on the part of the physician, and the stigma of mental disease and psychiatric treatment have all been related to treatment compliance.⁵ One of the most common factors considered when prescribing antidepressants is the avoidance of specific side effects,⁶ what could improve patients' perception of the treatment.

From the long-term point of view, inadequate adherence to treatment may be more due to fear of becoming dependent on the drug than to its undesirable effects,⁷ as well as to denial of disease or a need for checking whether the problem persists.⁸

In the literature on this topic, figures for poor adherence to antidepressants, among patients with affective disorders, vary between 10-30% and 60%.^{9,10} These figures do not appear to have changed after the introduction of newer drugs, with reduced undesirable effects.

A majority of physicians underestimate the problem of non-compliance. Despite the growing use of clinical guidelines, treatment algorithms, newer drugs with less adverse effects and other improvements in therapeutics, there continues to be a relevant difference between the efficacy of antidepressants seen in clinical trials and that seen in clinical practice. This difference may stem from a lack of information.¹¹

Adherence seems to be directly related to a patient's awareness of having been told about a drug's adverse effects by their physician: the less they remember about it, the worse their adherence is. In addition, it appears that there is a discrepancy between the instructions that physicians say they give to their patients and those that the patients actually recall being given.¹²

On average, poor compliers have been found to stop taking their medication after only 43 days, even if the response to the medication is positive. However, poor compliance is seen after only 15 days if they develop an adverse effect, after 20 days if their condition worsens, and after 40 days if the response is lesser than they expected.¹³

Psychiatrists tend to presume that non-adherence among patients with chronic depression is uncommon, and place it around 16%. However, when asked if they made some mistake in the way they took their medication the day before, 1 out of every 3 patients admits some mistake, and 8% acknowledge that mistakes occur «very often». Aspects that have been shown to influence a good use include the treatment's efficacy and the daily number of pills to be taken. Factors associated with a good adherence in-

clude the presence of family members, emotional stability, positive relationship with the physician, and a perceived improvement with the drug. However, adherence decreases as the duration of therapy lengthens. Other studies have found adherence to be as low as 39.7%, with older patients, and those with higher scores on the scale of chronic disease, having better adherence.¹⁴ Over 43% of patients do not comply with their long term treatments, and 75% fail to introduce the life habit changes recommended by their physicians.¹⁵

In order to be able to improve the use of antidepressant drugs, we think it is important to define those factors, sociodemographic or related with the diagnosis or course of the disease, which are relevant to this problem. Our aim is to find out how many patients on antidepressants remember to take their drugs and also consider that doing so is not difficult. We believe such patients can be presumed to have a better use of treatment. For doing so, we have developed a brief questionnaire that explores both the degree of forgetfulness in taking their medication, that patients themselves acknowledge, and the level of difficulty that they attribute to complying with therapeutic instructions. We have chosen to explore both aspects in the belief that inquiring about easiness, in a way that causes the least guilt for the patient, will allow us to get a picture as close as possible to the reality of this difficult problem.

METHODS

Data were gathered from 550 patients receiving antidepressants for any cause, visiting, during the month of May, 2005, any of the psychiatric resources of the public health network of the island of Mallorca, which is staffed by 16 psychiatrists (3 of which were following their training as specialists, but were at least in the 3rd year of their training). In order to ensure that data were taken from all practices, and that those practices with more patients were not over-represented, each physician was asked to pass the questionnaire to, at most, five patients per day. To verify that subject selection was random, patients should be the first five subjects under antidepressant therapy, seen each day. We considered the possibility that this plan for subject selection could be a source of bias, since punctuality in keeping appointments and adherence to instructions can be linked to one another, but decided that the fact that we were selecting patients seen at any level of care, and not only as outpatients, meant we could presume that bias would be small.

We wanted to observe the use of the treatment made by the patients and the relationship between this and what the psychiatrist thought he or she were treating, in a naturalistic clinical setting, so we decided not to interfere more in therapeutic alliance with standardized interviews, as many patients were under treatment during a long time.

A questionnaire was developed, including social and demographic variables, primary and secondary diagnoses, number of recurrences, present and past treatments, time with the present treatment, response, and concomitant somatic diseases. The study physicians met three times to reach a consensus on the questionnaire, and this was then tried out in a pilot study including a total of 50 patients, whose data were not included in this final analysis.

In order to measure the use of the treatment, the questionnaire included two questions, each of which had five possible answers: one asked about whether the patient forgot to take the drug (choices were: never; almost never; some days; almost every day; always need to be reminded), and the other questioned the degree of difficulty that the patient found in taking the drug, as well as his or her attitude towards it (choices were: finds the treatment easy and convenient; easy but sometimes forgets; needs an effort but tries; does not try; thinks the treatment is unnecessary). The questionnaire was developed with the effort to not evoke feelings of guilt, in the hope of avoiding, as much as possible, that the results would be biased by the patients wish to offer a «good» image in front of the psychiatrist, who was also usually their own one.

According to their answers, patients were classified into three levels of use. «Very Good Use», included only those subjects answering that they never forgot their medication and that they found the therapy easy to follow and convenient. A broader category of «good use» included also those who said they almost never forgot to take their medication, while all other subjects were classified into the «bad or doubtful use» group.

Data were analyzed using the SPSS statistical program (version 11.0 in Spanish). The null hypothesis would be rejected if $p \leq 0.05$. This is supposed to be a good significance level due to the population size (550 patients). Pearson's χ^2 was used for quantitative variables, and Student's t for qualitative ones.

Factors considered in the analysis were both socio-demographic factors (sex, age, occupation, marital status, place of residence, education level and place of birth) and disease (no factors [sex, age, occupation, marital status, residence (urban, rural, and place of birth) native or immigrant, education level and disease]) process factors (primary and secondary diagnoses, prior episodes and their treatment, present treatment, duration of present treatment, whether treatment was started by the general practitioner or the psychiatrist, response, and co-existence of somatic diseases). The relationship between each of these factors, and the answers to the questions on forgetfulness and perceived difficulty for following treatment, were analyzed.

RESULTS

We took data from 550 patients; though in some cases there were some invalid responses (we did not take in con-

sideration three protocols in which information was insufficient). We accepted to enter the analysis correctly completed questionnaires and those in which only one item was invalid.

Of all subjects who answered the question on perceived difficulty for adhering to therapy ($n = 542$), 62.4% (338) considered that their treatment was easy to follow and convenient, while another 22.3% (121) said that their medication was easy to take, but they sometimes forgot to take it. Only 15.3% (83) answered that intake of the treatment required considerable effort, that they did not even try or that they thought the treatment was unnecessary. To the question about forgetfulness ($n = 540$), 42% (227) declared that they never forgot to take their medication, 22.7% (123) said they seldom forgot, and 35.2% (190) acknowledged that their intake was poor (Table 1).

When both variables were combined ($n = 540$), we discovered that 37.6% (203) of all patients can be presumed to have a high degree of good use of treatment (meaning that they find treatment easy to follow and convenient and they declare that they never forget to take the medication). If good use is defined less strictly and patients who say they seldom forget are included, the percentage of subjects with good use grows to 52.4% (283).

We grouped all participants (550) into three diagnostic categories; 13 patients had to be excluded because of incomplete data on their primary diagnosis or because they provided no answer to the question on how often they forgot to take their medication. Out of all patients for whom data were available (537), 38.4% (206) had a depressive disorder and 35.9% (193) had an anxiety disorder. The remaining 25.7% (138) were grouped into a third group («other») that included subjects whose main diagnosis were psychotic, personality or feeding disorders, or substance abuse. A bad use of treatment is less common among subjects with affective (30.1%) or anxiety (31.1%) disorders than among those with other diagnoses (48.6%). (Figure 1).

As for the relationship between use of treatment and response to it (Table 2, Fig. 2), we retrieved data from 532 subjects (for 18 subjects, data on response was lacking). Among subjects that did not improve with treatment (116; 21.8% of all subjects), use of treatment is more frequently poor or doubtful (49.1%) than among subjects who do respond to treatment. Of those patients who improved, but did not achieve complete remission of disease (351, 66%), 33.3% took it bad, while only 20% of patients with complete remission of disease (65, 12.2%) had referred a misuse. The differences between the groups were found to be significant ($p < 0.001$).

When social and demographic factors were considered, differences were significant ($p < 0.005$) for education level and place of residence. Subjects with no or only primary studies represented 68.7% of all patients, but represented

Table 1 Perceived difficulty for good use of the treatment

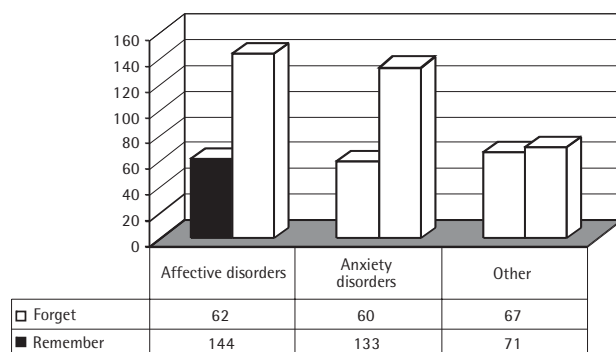
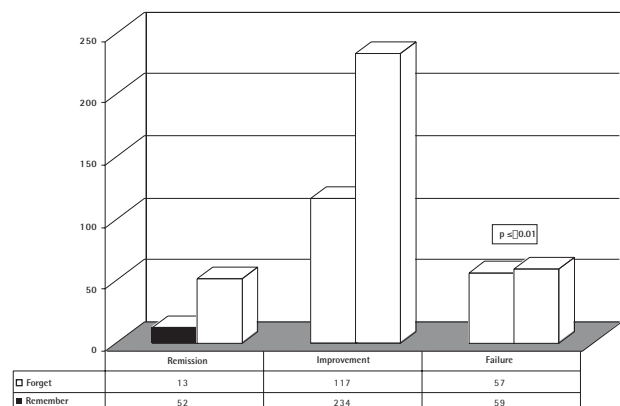
The patient finds that treatment is:	n = 542	The patient forgets:	n = 540	Estimated use	n = 540
Easy and convenient	62.4% (338)	Never	42% (227)	Very Good a + 1	37.6% (203)
		Almost never	22.7% (123)	Good a + (1 or 2)	52.4% (283)
Easy, but sometimes forgets	22.3% (121)	Some days	26.7% (144)	Fair or poor (b through e) + (3 through 5)	47.6% (257)
Needs an effort, but tries	5.7% (31)	Almost all days	2.4% (13)		
Doesn't try	6% (33)	Always needs to be reminded	6.1% (33)		
Unnecessary	3.5% (19)				

77.3% among the group with the worse use of treatment, while the same figures for subjects living in rural areas are 35.8 and 54.7%, respectively.

Use of treatment was also worse among subjects with co-existent organic disease, 41.4% of whom acknowledge forgetting to take their drugs, against 30.8% among subjects without somatic disorders ($p = 0.04$).

DISCUSSION

Social and demographic factors that are associated with forgetfulness include low social and cultural levels, and living in rural areas. This suggests that the use of treatment is related both with the education level and with the accessibility to specialized care (psychiatric practices in our island

**Figure 1** Relationship between use of treatment and type of disorder ($n = 537$).**Figure 2** Relationship between use of treatment and response to it ($n = 532$).**Table 2** Use of treatment and response

	Remission	Improvement	Failure	N (%)
Remember	52 (9.7%)	234 (43.9%)	59 (11.1%)	345 (64.8%)
Forget	13 (20%)	117 (33.3%)	57 (49.1%)	187 (35.2%)
	65 (12.2%)	351 (66%)	116 (21.8%)	532 (100%)

are located in major towns). It has been reported elsewhere that up to 50% of patients leave the physician's office without having fully understood the instructions provided for their treatment.¹⁶

Use of treatment is also worse in patients with concomitant organic disease. This is probably best understood as a consequence of the increased complexity of treatment, due to the association of psychopharmacological drugs with other therapies. Moreover, the coexistence of other diseases and drugs increases the probability of adverse drug effects and drug interactions, as well as the appearance of hypochondriac depressive symptoms, which could be related with non-compliance.² Another possibly involved factor is that presence of somatic suffering may lessen the relevance that the patient gives to his or her psychological problems, and the feeling that both go together and improvement in the somatic disease will improve all conditions. Whichever way, it must be remembered that depression is associated with a poor adherence to any medical treatment, as well as with a higher morbidity and mortality.⁴ Non-compliance with therapy for somatic disorders may be due to an unrealistic lack of hope for improvement caused by depression, as well as to the tendency for social isolation and cognitive function deterioration that often accompanies depression.¹⁷

The fact that response to treatment was better among patients who use better the treatment too is an expected result, but it is important to keep this in mind while prescribing. Patients should be informed not only of the benefits expected from treatment, but of the time that may pass before those benefits become apparent to the patient. In addition, the possible adverse effects and drug interactions should be provided. Up to 72% of physician's declare having told their patients to keep taking the treatment for at least 6 months, yet only 34% of patients remember actually having been told so, with non-adherence being higher among those who have not spoken with their physicians about the duration and adverse effects of treatment.¹²

Considering all of the above, we believe that the question of use of the drug treatment should be specifically addressed in all patients, and that insisting on this issue should be mandatory in all cases in which response is inadequate. We believe that for an issue as difficult to measure as «good use», the combination of variables such as forgetting to take medications and ease of the therapy, allows us to create a picture that is closer to the truth than either of them taken separately.

Differences in the treatment use observed between different diagnoses could be due to the variable severity of each disease or to the pertinence of the drug's indication. For example, antidepressants are more effective in affective and anxiety disorders, so that when they are used in these indications, patients may become more aware of get-

ting better, therefore, improving their use of the antidepressant treatment.

Given the scope of the problem of non-adherence, and its practical implications, it is necessary to adequately measure use of treatment, in order to gather information which may be used to plan programs that address this problem in the general population. Measuring the effect that any intervention may have on the therapeutic use of psychopharmaceuticals of patients with chronic disorders is difficult and furthermore, the size of the effect is likely to be moderate, whatever the complexity of the intervention.¹⁸ There are no clear indications of which interventions may be effective.¹⁹ However, these difficulties should not keep us from trying to address this issue, considering its relevance for the success of treatment.

Emphasizing the importance of a good use of antidepressant drug treatment is especially relevant for those patients more likely to take it poorly, which would be those whose major psychiatric diagnosis is neither an affective nor an anxiety disorder, with a lower sociocultural level, taking other drugs for concomitant organic diseases and/or living in rural areas with more difficult access to specialized care. In these patients, it is particularly important to insist on the relation between good treatment use and therapeutic response. Psychiatrists should inquire whether their patients adequately follow instructions, and offer them the chance to work together to solve difficulties that may arise during antidepressant treatment.

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