

# Patients' experiences of medication for anxiety and depression: effects on working life

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**Background and objectives.** The prevalence of depression and anxiety has increased in recent years, leading to extensive use of medication. This study used a qualitative, in-depth approach to investigate patients' experiences of taking medication prescribed for these conditions. Sampling from a range of occupational sectors, the research explored the impact of medication on working life.

**Methods.** The research involved nine focus groups with sufferers of anxiety and depression to investigate the personal experiences of mental ill-health and the impact of psychotropic drugs. A further three focus groups were conducted with staff in human resources, personnel, occupational health, and health and safety departments, to explore the organizational perspectives on psychotropic medication in the workplace. Focus groups were held at Loughborough University and at workplace settings throughout the UK. Results were presented to an expert panel (comprising practitioners and researchers in health care and occupational health) to consider implications for practice.

**Results.** Physical symptoms associated with anxiety and depression included: nausea, headaches, dizziness, trembling, insomnia and lack of energy. Psychological symptoms involved: poor concentration, emotional distress and lack of motivation. Non-compliance was widespread due to side effects, lack of improvement in symptoms or because medication made patients feel worse. Patients did not feel well informed about their medication. People took less than the prescribed amount or stopped taking the medication. Concerns about dependency caused patients to cease medication prematurely.

**Conclusion.** Patients felt ill informed about their medication and would have welcomed more information. Drawing on the results, the authors outline areas for improvement in the care of patients with anxiety and depression.

**Keywords.** Anxiety, compliance, depression, patient information, psychotropic medication.

## Introduction

As the incidence of psychiatric illness increases,<sup>1</sup> the number of prescriptions for psychotropic medication has increased sharply. Middleton *et al.*<sup>2</sup> reported that the number of antidepressant prescriptions increased >2-fold between 1975 and 1998 and, in 1998, a total of 23.4 million antidepressant prescriptions were issued by GPs in the UK. Lawrenson *et al.*<sup>3</sup> investigated UK prescribing patterns and noted that between 1991 and

1996 there was a 40% increase in the prescribing rate of tricyclic antidepressants compared with a 460% increase for selective serotonin reuptake inhibitors (SSRIs).

A paucity of knowledge exists concerning the effects of prescribed medication on working life. Psychotropic medicines impair performance on a range of laboratory measures, including attention, vigilance, memory, problem solving and motor coordination. However, it is unclear how these effects translate to performance in the workplace.<sup>1,4,5</sup> Lack of treatment for psychiatric illnesses may be a greater problem in terms of work performance than the side effects of medication.<sup>1</sup> Demyttenaere<sup>6</sup> has argued that poor compliance with antidepressant medication is widespread, even with the newer well-tolerated antidepressants. People with depression or anxiety are likely to experience a range of symptoms that would impair performance at work. Anxiety is characterized by worry, restlessness, fatigue, poor concentration, irritability and sleep disturbance.

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Depression involves depressed mood, sleep disturbance, fatigue, poor concentration, thinking and decision making. Depression often co-exists with anxiety<sup>7</sup> and the symptoms may lead to impaired work performance. This research collected new and in-depth data on anxiety and depression and the use of psychotropic medication among working people. The aim was to improve understanding of how mental health problems and the treatment for these conditions impact on working life.

## Methods

Focus groups were used to collect detailed information on the personal experiences of people with anxiety and depression. The sampling strategy was to recruit sufferers in employment by publicizing the study either through the employer or through specialist services to generate a convenience sample of people who had suffered with anxiety and/or depression drawn from a wide range of occupational sectors. The research team used a wide range of recruitment techniques including: liaison with established contacts in organizations; contact with bodies with responsibility for health and safety; contact with trades unions; mail shots, telephone calls and e-mails to organizations; advertisements in national and local newspapers, professional publications and local radio; and distribution of posters to organizations.

### Research participants

Twelve focus groups were conducted in total. Nine focus groups involved people with personal experience of anxiety and/or depression in the previous 2 years and who had taken prescribed medication for these conditions during that period. These groups comprised:

- Individuals sampled from a variety of work sectors: health care, social services, education, manufacturing, engineering, retail, service industries (six focus groups)
- Individuals attending anxiety management courses. Participants in these courses came from a wide range of occupations (three focus groups)

A further three focus groups were conducted with staff having responsibility for human resources, personnel, occupational health, and health and safety. These individuals were drawn from a wide range of occupational sectors. The aim of these groups was to examine organizational policy and practice relating to workers with anxiety and depression. The results from the 12 groups were presented to a panel of nine invited experts. The panel members comprised trades union representatives, practitioners and researchers in the disciplines of general practice, occupational medicine, health and safety, health, and clinical psychology and psychiatry. The results were presented for discussion and comment and to consider the implications of the findings for health policy and practice.

### Research instruments and analyses

Two focus group interview schedules were developed, one for employees and the other for organizational representatives. The schedule for employees covered: how anxiety/depression impacts on work; whether medication affects work performance; and compliance with medication. The schedule with organizational representatives covered: policies, practices and support offered to employees experiencing anxiety and depression. Both schedules were piloted and refined in the light of pilot studies (only slight changes to the wording of some questions were made). Each focus group discussion lasted for ~90 min and was recorded on tape, with the agreement of participants. The recorded material was fully transcribed. The transcribed data were analysed by the sorting of verbatim material into emergent themes using the method described by Knodel.<sup>8</sup> The reliability of the analysis was ensured through systematic review of the data by three members of the research team. The findings are summarized under themes along with illustrative quotes.

## Results

Demographic profiles of participants ( $n = 74$ ) in the three samples are shown in Tables 1–3.

TABLE 1 *Anxiety management group participant details*

Group	Gender	Employment	Age range
Group 1	Female	Secretarial	18–55
	Female	Sales	
	Female	Unemployed	
	Female	Unemployed	
	Female	Photographic assistant	
	Female	Care assistant	
	Female	Sales consultant	
	Female	Pre-vocational tutor	
Group 2	Female	Scientific officer (NHS)	28–63
	Female	Retired	
	Female	Administrator (SME)	
	Female	Veterinary surgeon	
	Female	Retired	
	Male	Car mechanic	
	Male	Electrician	
Group 3	Male	Programme area manager/ lecturer	22–55
	Male	Primary school head teacher	
	Female	Unemployed	
	Male	Researcher	

TABLE 2 *Profile of employees and managers groups*

Group	Gender	Employment	Age range
Education	Male	Teacher	35–60
	Male	University administrator	
	Male	Teacher in higher education	
	Female	Registrar in primary school	
	Male	Support technician—university	
	Male	Teacher—primary school	
	Female	Teacher—special school	
Support workers	Female	Finance and admin in university	29–53
	Female	Bank	
	Female	Council worker	
	Female	University administrator	
	Female	Enquiry officer—police station	
	Female	Public sector	
	Female	University administrator	
Mixed group	Female	Car leasing—payroll	30–56
	Male	Food manufacturing	
	Female	Advisory teacher	
	Female	Accounts department of a coach company	
	Female	Civil service—personnel department	
	Female	Social worker	
	Male	Freelance lecturer	
Managers	Female	Front line manager—food company	33–58
	Female	Personnel manager in NHS	
	Male	Health and safety	
	Female	Head teacher of a primary school	
	Male	Works in higher education	
	Male	Health and safety manager in a publishing company	
	Female	Lawyer in civil service	
Mixed group	Female	Veterinary surgeon	45–54
	Male	Deputy governor of a large prison	
	Male	Computing services at a university	
	Male	Computing services at a university	
Health care	Female	Locum staff grade psychiatrist	28–54
	Female	Consultant psychiatrist	
	Male	Former GP	
	Female	SHO in medicine	

*Experience of anxiety and depression and the impact on working life*

Participants noted that they were initially unaware that they were exhibiting symptoms of anxiety and depression. It was often family, friends and colleagues who recognized the signs before the

affected person. One participant who was a doctor had experienced symptoms for 15 months before he realized that the problem was depression. Participants were typically unaware that they were suffering from anxiety and depression, until a crisis occurred.

TABLE 3 *Organizational representatives*

Group	Gender	Employment
Organizational group 1	Male	Occupational health nurse—manufacturing
	Male	Occupational health physician—manufacturing and retail
	Female	Occupational health and safety advisor—manufacturing and construction
Organizational group 2	Male	Training manager—human resources development
	Male	Hospital human resources manager—supporting managers and staff
	Female	Counselling and support unit manager—staff welfare and consultancy service to managers on welfare issues
	Female	Human resources manager in SME
	Female	Senior human resources advisor—health care, mental health and community
	Female	Personnel officer—education, strategy and development
	Female	Senior personnel officer—education
Organizational group 3	Male	Occupational health nurse—manufacturing heavy industry
	Male	Occupational health nurse—manufacturing heavy industry
	Male	Union health and safety representative—social services
	Female	Occupational health nurse—manufacturing
	Female	Health and safety officer—borough council
	Female	Occupational health nurse—health care
	Female	Occupational health nurse—ambulance service
	Female	Nurse specialist (occupational health)—health care
	Female	Occupational health nurse—health care
Female	Occupational health nurse specialist—civilian and service employees	

Symptoms of anxiety and depression identified by participants included physical problems such as nausea, headaches, dizziness, trembling and lack of energy. Some people initially thought their symptoms stemmed from a physical illness. The physical symptoms were combined with tiredness, lack of concentration, extremes of emotion and lack of motivation. Individuals experienced confusion and difficulties with decision making. A female administrator explained how her symptoms affected her:

“I couldn’t actually get out of bed in the morning and I’d frequently roll in at half nine, ten o’clock, and we’re supposed to start at nine o’clock. But I just could not get out of bed. It was really, really hard . . . dragging yourself into work. On a really bad day I’d be throwing up and shaking and I just couldn’t come into work.”

Some people, such as this 40-year-old special needs teacher, experienced sudden episodes of crying:

“I would sit and cry in staff meetings, sit in a staff meeting and tears would just stream down my face and people would just not see.”

Sleep patterns were generally erratic and disturbed. This created a cycle whereby people were tired at work

and found the pressures intolerable. Some respondents used alcohol to alleviate the insomnia. A 55-year-old male primary school headteacher said:

“I started having one drink, then another at night—to knock me out so that I could sleep but even then I’d wake up at three o’clock in the morning with my mind racing—and then crawling to work, not hung over but just exhausted.”

People found they were unable to concentrate, they forgot things and found it difficult to absorb information, often not being able to complete work. A 35-year-old female locum psychiatrist described how her inability to concentrate impaired her work performance:

“You can’t concentrate, you feel it all piling up, it’s all building up yet, if you’re like me, you feel the world depends upon you and you still keep going and you feel worse about yourself because you are . . . sinking deeper and deeper.”

Most respondents felt that their condition impaired their work performance. A 48-year-old female lawyer working for the civil service explained how anxiety impacted on her work:

“. . . your productivity really goes down, you worry all the time, you don’t sleep you get up in the

morning and you're worn out its just day after day you're going down gradually and the amount of work you can do properly is getting less and less and less."

A 43-year-old female consultant psychiatrist told of how her condition prevented her from making decisions at work:

"I get very indecisive, which isn't good when you are meant to make decisions and then I can feel myself getting pushed into making hasty and perhaps wrong decisions. I can't focus my thoughts on things . . . and get terribly irritable and that causes problems in relationships, not only with colleagues, but also with patients and their families which are more difficult to repair."

A 51-year-old male lecturer explained how his severe symptoms impaired his ability to work:

"There were times when I felt physically dreadful. I was having severe chest pains, headaches that went down my back, trembling fits when I woke up in the morning—which then led me to go into work feeling full of trepidation and anxiety about what was going

to happen once I got there. On occasions I was suffering so much from the physical signs of anxiety, my staff would just put me in my office, and say 'Don't come out, you're not fit to be out of your room, why have you come in to work?' and I'd say 'well this has got to be done, that has got to be done' and they'd say 'well just shut your door and just do paper work.' So it did seriously affect my work a year ago and then I was off for seven months."

Impairment of work performance was reported across all the occupational sectors represented in the sample.

#### *The effects of prescribed medication for anxiety and depression*

Table 4 lists the range of psychotropic medication that the participants had been prescribed. Table 5 shows the number and percentages that had received each class of drug.

The side effects of medication were described as being similar to the symptoms of anxiety and depression, including confusion, dizziness, nausea and difficulties

TABLE 4 Summary of psychotropic medication

Drug group	Drug	Proprietary name
SSRIs	Citalopram	Cipramil
	Fluoxetine	Prozac
	Fluvoxamine maleate	Faverin
	Paroxetine	Seroxat
	Sertraline	Lustral
Benzodiazepines	Diazepam	Valium
	Lorazepam	Ativan
	Temazepam	
Antidepressants	Venlafaxine	Efexor
	Mirtazapine	Zispin
	Nefazodone hydrochloride	Dutonin
	Flupentixol	Fluanxol
Tricyclics	Imipramine hydrochloride	Tofranil
	Amitriptyline hydrochloride	Lentizol/Triptafen/Triptafen-M
	Dothiepin hydrochloride	Prothiaden
	Doxepin	Sinequan
Antimanic	Lithium citrate	Li-Liquid/Priadel
	Lithium carbonate	Camcolit/Liskonum/Priadel
$\beta$ -Blockers	Oxprenolol hydrochloride	Slow-Trasicor (modified release) Trasidrex (with diuretic)
	Pindolol	Visken Viskaldix (with diuretic)

TABLE 5 Number and percentage of respondents who were prescribed each class of drug

Drug group	<i>n</i>	Percentage
SSRIs	39	72%
Benzodiazepines	16	30%
Antidepressants	8	19%
Tricyclics	5	9%
Antimanic	3	6%
β-Blockers	2	4%
Not known	12	22%
None	2	4%

Note: many participants had been prescribed more than one class of drug.

with decision making. A female university administrator explained how the medication affected her:

“I just felt like I was behind a screen in my head all the time, it sounds really weird, like there was a fog behind my eyes. I felt unsteady standing and my colleague told me that I’d got a slight speech impediment as a result of taking them. I used to pronounce my <esses> more than normal. Which made me self-conscious. I did try Prozac once and it made me so ill. . . . I turned green for a week and just had to be off work.”

A woman who worked on the enquiry desk at a police station described how she felt when taking her medication:

“ . . . when I was on Prozac . . . it’s like there is a wall there, you can see what you’re doing . . . but you just feel like you’re distant . . . dislocated from everything.”

Organizational representatives noted that occupational health staff should identify the implications for work of medication:

“It is a company requirement people should notify Occupational Health . . . there is an important Health and Safety aspect to it, because psychotropic drugs do affect people’s ability to do machinery type jobs.” (occupational nurse, manufacturing company)

Some people experienced exaggerated symptoms of anxiety while they were taking medication; a 54-year-old female head teacher commented:

“When I had Prozac I had these horrible sensations that made me want to grit my teeth all the time a sort of charging sensation up and down my legs.”

The side effects of medication may be apparent as soon as the treatment is started, but the symptoms may not improve for a week or two. Individuals often felt worse and discontinued the medication. Shaking and severe weight loss caused several participants to stop their medication.

#### *Non-compliance with medication*

Non-compliance with medication for anxiety and depression was common. Individuals took less than the prescribed amount of medication and often discontinued treatment because of side effects or because their symptoms had not improved. A 25-year-old woman, who worked for a car leasing firm, described how medication made her feel worse:

“I found that really hard, because I felt so awful . . . the tablets give you some nasty side effects of nausea. . . . it seems crazy that a tablet that’s meant to help with those symptoms actually can make it worse to start with.”

Fear of addiction or dependency was also a major issue. Many participants experienced symptoms on occasions when they had forgotten to take their medication or stopped the treatment, and they identified these symptoms as signs of dependency.

“They kept saying that you can’t get hooked on them, but I am because I feel ill if I don’t take them, physically ill.” (female tutor providing training courses for unemployed people)

Patients who found their medication beneficial felt that they had developed a psychological dependency and worried about how they would cope when they had to finish taking the drugs. They saw the psychological dependency as a second hurdle to get over when the time came to discontinue treatment. Patients were generally not happy about taking medication and they would often stop as soon as their symptoms began to improve:

“I’ve had two periods where I’ve had time off work. The first time I took the Seroxat and I did want to get off it quickly and the second time I went to the doctor and he said ‘I think you gave up too quickly the first time round you must take it for a good period after you believe you’re feeling better’ and I don’t think I’ve quite achieved as long as he said he wanted me to stay on it but there is with me a desire to get off it.” (46-year-old, male health and safety manager in the NHS)

#### *Patient information*

Patient satisfaction relating to information provision varied considerably. Some respondents felt their GP was extremely helpful:

“I’m very lucky, my GP is wonderful and he really does take time, and I often think to myself

‘Thank goodness, I’m blessed’, because if I had a GP who would just be fobbing me off all the time, goodness knows what might have happened to me. I’ve got so much to thank him for, pointing me in this direction for the right type of treatment. But I think that this is a pretty sad affair that sometimes people don’t get the right type of care, at the time when they really need it.” (46-year-old, female accounts worker)

However, many felt that they were not given sufficient information by their GP about the side effects, “They leave you to read the instructions, they don’t actually talk to you about it.”

Patients suggested that leaflets provided with medication were comprehensive in detailing the range of possible side effects ‘almost to the point of terrifying’. However, the extent of the information presented in these leaflets could vary considerably depending on the brand of drug provided by the pharmacist. The expert panel group felt that leaflets provided with the medication were often unhelpful to patients. An occupational health expert described them as: “not really an information leaflet. It’s a cover my back leaflet for the manufacturer”.

Many respondents would have welcomed more information from their GPs. As a 58-year-old male health and safety officer put it:

“I don’t think there is enough explanation. I’ve seen three GPs and none of them actually explained what the tablets were that they were giving me. Just take them they’ll make you feel better after a few weeks.”

There seemed to be confusion about how long it would take for the medication to take effect. It was suggested by patients that it took most medication 4 weeks to be effective; one person said that it seemed to take Prozac 2–3 weeks to ‘kick in’. There was also discussion about the dosage of medication; many people were very concerned about becoming dependent on their medication and took less than prescribed. One woman was prescribed a dose of three tablets but only took one. She suggested that people could take their medication every other day. When patients were given information about their medication, they felt more able to comply with the prescribed course, they had more confidence in their treatment and valued the time that health professionals had given. Many felt ill prepared for their medication, such as this female 50-year-old mental health social worker:

“When you start off on these tablets, the first week or so, you have exaggerated symptoms of anxiety. So you’re on this tablet to help you, which initially makes you feel worse, and I didn’t realize that, and I was told later on that if I kept on that tablet, like, a few months later I might have been feeling better on

it, because I would have got over the initial side effects.”

When respondents were admitted to hospital, they found that staff were able to take the time to explain fully what to expect from the medication, including the possible side effects. Self-help groups were also identified as a good source of information. Individuals often sought out their own information, from books and the Internet. Patients acknowledged that GPs had limited time to pass on information, as this 32-year-old male assembly line worker for a confectionery manufacturer explained:

“I’d been to my GP so many times, they have never explained to me about the side effects. And it has really affected my life completely. I can understand them being under pressure, they listen to you, write your prescription and that’s it. And not talk to you. They never used to tell me [about side effects] until I had loads of problems. And then I bought a book and read for myself, and there are a lot.”

There was an understanding that GPs could not be expected to be specialists in mental health, and that primary care resources were limited, as a 33-year-old male researcher put it:

“... dealing with the GP is fine, he’ll prescribe you Prozac but it wasn’t until I came on this course [anxiety and depression management course] and got proper psychiatric professionals in the depression field that I really felt I started to progress. It’s not a criticism of GPs but it’s an observation that their understanding is limited by their generalization. It’s just the reality of the health service, there isn’t enough time to spend huge amounts of time and money on every person.”

The issue of patient information and compliance was considered by the expert panel. They felt that GPs need to ‘sell’ the benefits of medication to their patients, giving full and detailed information about the condition and the effect of the medication prescribed. They noted that the benefits of medication may not be seen immediately and patients may experience heightened anxiety initially and should be prepared for this possibility. A GP stated:

“It’s very hard when I’m starting someone on antidepressants to tell them they will probably feel worse for the next couple of weeks. It’s going to take a couple of weeks for them to work and if that hasn’t been sold they will get tangled up and they’ll think ‘oh the tablets are making me more tired and I feel worse’. The important thing is the way it is sold. It is important to give information very early on in the process so people are aware of what those tablets are going to do to them and what they are not going to do to them.”

*Patient monitoring*

The expert panel felt that poor compliance is less of a problem with more recent drugs that have fewer side effects. Lack of compliance was thought to be associated with the early stages of treatment, when patients may feel worse, and also later when patients start to feel better and decide they no longer need the medication. It was believed that compliance problems could be countered through careful patient monitoring, as a GP remarked:

“In the early stages . . . that’s the time when they are still feeling rotten and they’ve got the side effects of the drugs. In my practice I see people 1 to 2 weeks after they have started the medication and then at 4 weeks. An issue for us is keeping people on their medication after they feel better. Keeping them on the medication after they feel better for 4 to 6 months will reduce the risk of their relapse for up to 2 years.”

Most patients reported that their drug regimens were reviewed on a regular basis and this varied from weekly, to monthly, 3 monthly and 6 monthly reviews. Consistency in treatment was felt to be important; however, it was often the case that the same GP could not be seen. Patients suggested that GPs did not always seem familiar with the medication or range of services available to patients. Some thought they were being prescribed medication without any questioning or further exploration from their GP. Many felt that the selection of drug treatments involved trial and error by their GPs, as a female council worker described:

“... I was never really sure what was happening. They just kept giving me different things and saying ‘Well we’ll find one eventually’.”

It was often only when the opportunity arose to see a specialist, i.e. psychiatrist or psychologist, that they felt treatment options were discussed and the possible causes underlying their illness were addressed. Access to such services varied considerably among participants. A respondent who had been prescribed medication for several years eventually asked her GP about counselling:

“I took the tablets basically as prescribed, I’d reached the point where the doctors said ‘I don’t think there’s anything much else that we can do’. I said at that stage how about counselling and he said ‘oh yes we could try that’ and I wish in retrospect I’d asked about three years previously because I would say the counselling did me far more good than any of the tablets.” [48-year-old female veterinary surgeon]

**Discussion**

Adopting a qualitative methodology, this study explored the impact of anxiety and depression and the medication prescribed for these conditions on working life. The study relied on volunteers and it is reasonable to assume that patients who had experienced problems with medication may be more likely to participate in such a study than those who had a satisfactory experience. However, this study provides insight into the problems faced by sufferers of anxiety and depression and the factors determining poor compliance with medication.

The main finding to emerge from this study is that the reported initial side effects of medication have as much negative impact on respondents’ ability to work as the symptoms of anxiety and depression. This finding concurs with a growing body of evidence suggesting that even newer generation antidepressants are by no means free of side effects. Recent research has documented a range of side effects associated with serotonin-boosting medications, including facial and whole-body tics, sexual dysfunction, insomnia, dizziness, nausea, dyspepsia and anxiety.<sup>9,10</sup>

While a few respondents felt well informed about their medication, most people believed that they were not given sufficient information regarding mechanisms by which the medication works and the possible side effects. Many were unprepared for the fact that their medication could make them feel worse initially. When they were given accurate information, patients were more likely to comply with the treatment regimen. Health professionals in the expert panel felt that GPs need to ‘sell’ the benefits of medication to counter poor compliance. The results of this study suggest that effective information provision (explaining possible effects on work performance and implications for safety) and patient monitoring are essential at the start of treatment and later on when patients feel better and are tempted to discontinue their medication prematurely.

Demyttenaere<sup>6</sup> has argued that poor compliance with antidepressant medication is widespread, and is a major obstacle to the effective management of depression. Demyttenaere suggests that physicians should ensure they choose an effective antidepressant with minimal side effects and explore the patient’s beliefs and attitudes. Frank<sup>11</sup> noted that barriers to patient adherence include lack of knowledge regarding the nature of depression and methods of treatment and negative attitudes toward medication. The present results suggest that addressing common misconceptions about medication combined with regular patient monitoring may enhance compliance and improve treatment outcomes.

Patient information leaflets issued with medication were thought to be comprehensive in detailing side effects, but the extent of information could vary



considerably depending on the brand of drug provided by the pharmacist. It was also felt that the purpose of these leaflets was as a disclaimer for drug companies rather than information for the patient. Members of the expert panel noted that patients are influenced by information gathered from the Internet, official information sources (e.g. Royal College of Psychiatry leaflet) and family and friends. Information from family and friends often related to older generations of psychotropic drugs, giving patients inaccurate perceptions and expectations. A recent study<sup>12</sup> examined the informational content of websites of pharmaceutical companies and concluded that information about antidepressants is limited and makes it difficult for patients to gain accurate information. There is a need to develop accessible information leaflets to assist GPs in their consultations when prescribing medication for anxiety and depression. This is important as it is well recognized that patients are not always able to take in all the information that is given verbally.

In addition to compliance problems at the start of a course of medication, patients further on in their treatment tended to cease medication once they started to feel better, often due to concerns about addiction. The dependency effects were confirmed by health professionals who took part in the expert panel. They acknowledged that patients experience both a psychological dependency and a physical discontinuation reaction with SSRIs and other modern antidepressants. A discontinuation syndrome has indeed been identified for SSRIs and other new antidepressants.<sup>13</sup> After even gradual withdrawal from these agents, the syndrome presents with gastrointestinal or flu-like symptoms, disrupted sleep and sensory disturbances, as well as irritability, crying spells and anxiety. A characteristic SSRI discontinuation syndrome exists consisting of: dizziness, nausea, lethargy, headache, problems with balance, sensory abnormalities, and aggressive and impulsive behaviour.<sup>14</sup> Tamam and Ozpoyraz<sup>15</sup> recently concluded that physicians prescribing SSRIs should be familiar with these symptoms, reassure patients that this is a reversible condition and ensure gradual tapering schedules.

Given the time constraints that GPs work under, the development and evaluation of accessible patient information leaflets should be a high priority for primary care research and practice. At a practical level, practice nurses or primary care mental health workers can assist GPs in the care of patients with anxiety and depression and information provision can also be supplemented through NHS Direct. Given the interaction between work and mental health, occupational health staff and employers also have a role to play

in supporting people at work with mental health problems. Adequate information provision and careful patient monitoring, which addresses the potential impact on performance and safety at work and the patient's attitude toward medication, is likely to offer important benefits in terms of compliance, patient satisfaction and clinical effectiveness.

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