# APPENDICES

## Appendix 1: Search strategy for MEDLINE

Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) 1946 to 20 July 2018

|  |  |  |
| --- | --- | --- |
| **Search ID#** | **Query** | **Items found** |
| 1 | DEPRESCRIPTIONS/ | 143 |
| 2 | \*INAPPROPRIATE PRESCRIBING/ | 1564 |
| 3 | (deprescrib\* or de prescrib\* or deprescrip\* or de prescrip\*).ti,kf. | 268 |
| 4 | or/1-3 | 1844 |
| 5 | (barrier\* or enabler\* or facilitator\*).mp. | 272543 |
| 6 | (acceptance or adherence or nonadherence or compliance or attitude\* or belief\* or satisfaction or preference\* or choice or perspective\* or perception\* or suspicio\* or reservation or doubt or trust\* or distrust\* or mistrust\*).mp. | 1850470 |
| 7 | or/5-6 | 2063572 |
| 8 | 4 and 7 | 443 |
| 9 | ((cease or cessation\* or continuation or discontinu\* or dropout or drop out or interrupt or interruption or taper\* or reduce or drug holiday or (stop\* adj (taking or using)) or withdraw\* or terminat\* or deprescrib\* or de prescrib\* or deprescrip\* or de prescrip\*) and (antidepress\* or anti-depress\* or psychotropic or SSRI or (serotonin adj2 inhibitor\*)) and (acceptance or adherence or nonadherence or compliance or attitude\* or belief\* or satisfaction or preference\* or choice or perspective\* or perception\* or suspicio\* or reservation or doubt or trust\* or distrust\* or mistrust\* or barrier\* or enabler\* or facilitat\*)).ti,ab,kf. | 1621 |
| 10 | exp ANTIDEPRESSIVE AGENTS/ | 135533 |
| 11 | exp NEUROTRANSMITTER UPTAKE INHIBITORS/ | 134711 |
| 12 | (psychotropic\* or antidepress\* or anti depress\* or ((serotonin or norepinephrine or noradrenaline or nor epinephrine or nor adrenaline or neurotransmitt\* or dopamine\*) and (uptake or reuptake or re-uptake)) or noradrenerg\* or antiadrenergic or anti adrenergic or SSRI\* or SNRI\* or TCA\* or tricyclic\* or tetracyclic\* or heterocyclic\*).ti,kf,hw. | 140742 |
| 13 | (Agomelatine or Alnespirone or Amoxapine or Amersergide or Amfebutamone or Amiflamine or Amineptine or Amitriptylin\* or Amitriptylinoxide or Amoxapine or Aripiprazole or Atomoxetine or Tomoxetine or Befloxatone or Benactyzine or Binospirone or Brofaromine or Bupropion or Butriptylin\*or Chlopoxiten or Cianopramine or Cilobamine or Cilosamine or Cimoxatone or Citalopram or (Chlorimipramin\* or Clomipramin\* or Chlomipramin\* or Clorimipramine) or Clorgyline or Clovoxamine or Dapoxetine or Deanol or Dibenzepin or Demexiptilin\* or Deprenyl or Desipramine or Desvenlafaxine or Dibenzepin or Dimetacrin\* or (Dosulepin or Dothiepin) or Doxepin or Duloxetine or DVS 233 or Enilospirone or Eptapirone or Escitalopram or Etoperidone or Femoxetine or Fluotracen or Fluoxetine or Fluparoxan or Furazolidone or Fluvoxamine).ti,kf,hw. | 42116 |
| 14 | (Harmaline or Harmine or Hyperforin or Hypericum or John\* Wort or Idazoxan or Imipramin\* or Iprindole or Iproniazid\* or Ipsapirone or Imipraminoxide or Isocarboxazid\*or Lesopitron or Levomilnacipran or Lithium or Lofepramin\* or (Lu AA21004 or Vortioxetine) or Lu AA24530 or LY2216684 or Maprotiline or Medifoxamine or Melitracen or Metapramine or Methylphenidate or Mianserin or Milnacipran or Minaprine or Mirtazapine or Moclobemide or Monocrotophos or Nefazodone or Nialamide or Nitroxazepine or Nomifensine or Norfenfluramine or Nortriptyline or Noxiptilin\*).ti,kf,hw. | 70431 |
| 15 | (Opipramol or Oxaflozane or Paroxetine or Phenelzine or Pheniprazine or Pipofezin\* or Pirandamine or Piribedil or Pirlindole or Pivagabine or Pizotyline or Propizepine or (Protriptylin\* or Pertofrane) or Quinupramine or Quipazine or Reboxetine or Ritanserin or Rolipram or Scopolamine or Selegiline or Sertraline or (Setiptiline or Teciptiline) or Tandospirone or Teniloxine or Tetrindole or Thiazesim or Thozalinone or Tianeptin\* or Toloxatone or Tranylcypromine or Trazodone or Trimipramine or 5 Hydroxytryptophan or 5 HT or Tryptophan or Hydroxytryptophan or Venlafaxine or Viloxazine or Vilazodone or Viqualine or Zalospirone or Zimeldine).ti,kf,hw. | 74161 |
| 16 | (Alaproclate or Caroxazone or Diclofensin\* or Fenfluramin\*).ti,kf,hw. | 3119 |
| 17 | or/10-16 | 337940 |
| 18 | long term.ti,kf,hw. or ("long term use" or over time).ab. | 371007 |
| 19 | TIME FACTORS/ | 1126451 |
| 20 | (cease or cessation\* or continuation or discontinu\* or dropout or drop out or interrupt or interruption or taper\* or reduce or drug holiday or stop or stopping or withdraw\* or terminat\*).ti,kf,hw. | 149118 |
| 21 | (stop using or stop taking or stopping treatment).ti,ab,kf. | 1866 |
| 22 | DEPRESCRIPTIONS/ | 143 |
| 23 | INAPPROPRIATE PRESCRIBING/ | 2248 |
| 24 | (deprescrib\* or de prescrib\* or deprescrip\* or de prescrip\*).ti,ab,kf. | 403 |
| 25 | or/18-24 | 1570715 |
| 26 | ATTITUDE TO HEALTH/ | 80299 |
| 27 | HEALTH KNOWLEDGE, ATTITUDES, PRACTICE/ | 96889 |
| 28 | "PATIENT ACCEPTANCE OF HEALTH CARE"/ or PATIENT COMPLIANCE/ or MEDICATION ADHERENCE/ or PATIENT PARTICIPATION/ or PATIENT SATISFACTION/ or PATIENT PREFERENCE/ or TREATMENT REFUSAL/ or HEALTH PERSONNEL ATTITUDE/ | 313817 |
| 29 | CONSUMER PARTICIPATION/ | 15832 |
| 30 | DECISION MAKING/ or exp CHOICE BEHAVIOR/ or UNCERTAINTY/ | 139559 |
| 31 | PROFESSIONAL-PATIENT RELATIONS/ | 25185 |
| 32 | SOCIAL STIGMA/ | 5494 |
| 33 | SELF CONCEPT/ or SELF EFFICACY/ or "SENSE of COHERENCE"/ | 69779 |
| 34 | (barriers or facilitat\*).ti,ab,kf. | 543461 |
| 35 | ((patient\* or consumer\* or clinician\* or physician\* or psychiatrist\* or GP or GPs or therapist\* or nurse\* or pharmacist\* or practitioner\*) adj3 (acceptance or adherence or nonadherence or compliance or attitude\* or belief\* or satisfaction or preference\* or choice or perspective\* or perception\* or suspicio\* or reservation or doubt or trust\* or distrust\* or mistrust\*)).ti,ab,kf. | 169629 |
| 36 | or/26-35 | 1238128 |
| 37 | 17 and 25 and 36 | 1880 |
| 38 | ATTITUDE TO HEALTH/ or HEALTH BEHAVIOR/ | 119704 |
| 39 | EMPIRICAL RESEARCH/ or GROUNDED THEORY/ or QUALITATIVE RESEARCH/ or HERMENEUTICS/ | 43720 |
| 40 | INTERVIEW/ or PERSONAL NARRATIVES/ | 31361 |
| 41 | FOCUS GROUPS/ or INTERVIEWS AS TOPIC/ or "SURVEYS AND QUESTIONNAIRES"/ | 463347 |
| 42 | qualitative.af. | 202966 |
| 43 | (questionnaire\* or survey\* or focus group\*).mp. | 1094229 |
| 44 | (ethnological or ethnograph\*).mp. | 9470 |
| 45 | (purpos\* adj4 sampl\*).ti,ab,kf. | 11611 |
| 46 | (life adj (story or stories or experience\*)).ti,ab,kf. | 5552 |
| 47 | OBSERVATIONAL STUDY/ or OBSERVATIONAL STUDIES AS TOPIC/ | 53089 |
| 48 | ((patient\* or consumer\*) adj2 (experience\* or account\*)).ti,ab,kf. | 87994 |
| 49 | (narrative\* or discours\*).ti,ab,kf. | 42629 |
| 50 | observational.mp. | 162636 |
| 51 | exp SOCIOLOGICAL FACTORS/ | 599011 |
| 52 | (social\* or societ\* or cultural\* or transcultural\*).af. | 2886447 |
| 53 | or/38-52 | 4257284 |
| 54 | 8 or ((9 or 37) and 53) | 1543 |
| 55 | remove duplicates from 54 | 1540 |
| 56 | (rodent\* or rat or rats or mouse or mice or animal model\*).ti. | 1303648 |
| 57 | (smoking or tobacco or nicotine).ti. or smoking cessation.mp. | 113870 |
| 58 | (antibiotic\* or antimicrob\* or antifung\* or statin\*).ti. | 165454 |
| 59 | or/56-58 | 1575966 |
| 60 | 55 not 59 | 1234 |
| 61 | limit 60 to english language | 1143 |
| 62 | \*ANTIDEPRESSIVE AGENTS/tu [Therapeutic Use] | 12577 |
| 63 | 36 and 53 and 62 | 546 |
| 64 | 63 not 54 | 412 |
| 65 | remove duplicates from 64 | 412 |
| 66 | 65 not 59 | 409 |
| 67 | limit 66 to english language | 388 |

## Appendix 2: Characteristics of included studies

| **Lead author and year of publication** | **Country** | **Aim** | **Setting** | **Perspective**  **(inclusion criteria)** | **Sample**  **(Age (years), Gender)** | **Antidepressant and depression details** | **Method of data collection** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Karp, 19931  (Journal article) | USA | To explore the symbolic meanings attached to taking anti-depressant medications | Not reported | Patients’  (officially diagnosed [with depression] and treated by mental health professionals) | N=20  20s n=4, 30s n=6, 40s n=8, 50s n=2  8 males,  12 females | TCAs  long histories [unspecified duration] of depression n = 10; hospitalised due to depression n= 13 | In-depth interviews |
| Knudsen, 20022  (Journal article) | Denmark | To examine how younger women see themselves within the context of using SSRI antidepressants, based on a user perspective | Not reported (patients are not hospitalised, but most are under care of psychologist or psychiatrist) | Patients’  (younger women receiving SSRIs) | N=12  21 to 34  12 females | SSRIs  Duration of SSRI use: 1 to 4 years | In-depth interviews |
| Pollock, 20023  (Final report of the Concordance Fellowship) | UK | To contribute to a greater understanding of patient and professional concepts of depression and its treatment as a prerequisite for developing concordance in the clinical encounter and enabling patients to participate in decisions about how their illness should be managed | Primary care | Patients’ (recently diagnosed with mild to moderate depression)  GPs’ | Patients N=32  <19 n=2, 20-29 n=4, 30-39 n=5, 40-49 n=10, 50-59 n=6, 60-69 n=5  9 males,  23 females  GPs N=19 | Class of antidepressant not reported.  25 out of 32 participants were taking antidepressants at time of initial interview, 16 out of 32 at second interview | Semi-structured interviews |
| Hoogen, 20064  (MA thesis) | USA | To examine how women come to understand the reasons for and the sources of their depression after they undergo medical antidepressant treatment | Not reported | Patients’  (women aged 18 or older who are currently taking a prescription antidepressant for depression) | N=4  20 to 72  4 females | Mentioned in quotes: Prozac, Lexapro, Celexa, Wellbutrin  Duration of use: 1 year to “years” | Semi-structured interviews |
| Verbeek-Heida, 20065  (Journal article) | Netherlands | [to focus on] the dilemmas involved in continuing or stopping the use of SSRIs from the perspective of the users and explore why these dilemmas tend to be solved by continuing rather than stopping | Primary care | Patients’  (SSRI users) | N=16  mean age 51 (range 30 to 80)  7 males,  9 females | SSRIs  Average duration of SSRI use: 4.5 years (range 6 months to 10 years).  All using SSRIs at time of interview. 9 had previously attempted to stop taking SSRIs. | Interviews |
| Holt, 20076  (Journal article) | Australia | To demonstrate the anxieties that [methadone maintenance treatment] MMT clients may have when taking prescription drugs, and the ways that clients negotiate or challenge their prescription regimens, particularly when they experience problems in treatment | Not reported | Patients'  (with history of illicit opiate or stimulant use, and current or recent experience of drug treatment and report a clinical diagnosis of (or treatment for) a common mood or affective disorder) | N=77  mean age 37  39 males,  38 female | Many of these people had been prescribed antidepressants (most commonly SSRIs) to cope with depression and many had been prescribed a number of different antidepressants over time.”  “Participants often had extensive ‘medication careers’” | semi-structured interview |
| Johnston, 20077  (Journal article) | UK | To explore the beliefs and attitudes of GPs, patients, and patients’ supporters (friends, family, and carers) about the nature of depression and its management. | Primary care | Patients',  GPs’,  Supporters’ (friends, family, carers) | Patients N=61  18 to 83  17 males,  44 females  GPs N=32  Supporters N=18 | Number who had ever been treated for depression n=40 (1 uncertain) | Semi structured interviews |
| Leydon, 20078  (Journal article) | UK | To explore patient experiences of and beliefs about their long-standing SSRI use and understand the barriers and facilitators to discontinuation | Primary care | Patients’  (All participants receiving prescriptions for an SSRI for 12 months or more, and deemed well enough by their GP) | N=17  28 to 64  7 males,  10 females | SSRIs  Average duration of off SSRI use: 4 years (range 1-11 years)  3 patients had stopped medication at time of their interview | semi-structured interviews |
| Wilson, 20079  (PhD thesis) | New Zealand | Understanding of how women come to take control of their recovery [from depression], and some of the things they have discovered from having their own agency during this process | Not reported (Four women experienced time in psychiatric wards or hospital) | Patients’  (women with past seriously disrupted by depression and whose lives were no longer  seriously disrupted and who have discovered things to help them to cope with or overcome depression) | N=18  32 to 70  18 females | Mentioned in quotes: Aropax, Prozac“  “Many of the women who sought help from their GP found that they were offered some kind of medical treatment, usually antidepressant medication. Whilst many found it inappropriate and unhelpful, there were some who found that medication enabled them to begin to crawl out” | Interviews with minimum prompts and encouragers (all participants)  Focus group for 5 participants (also individually interviewed) who had experienced depression but also practiced as "professionals" [counsellors] |
| McMullen, 200910  (Journal article) | Canada | [to analyse] how people fashion accounts of their decisions to quit taking antidepressants without their doctors’ permission | Not reported | Patients’  (women who had begun a course of antidepressants, but who had decided to quit taking them) | N=6  23 to 39  6 females | Paroxetine n=1, venlafaxine n=1, not reported n=4 | Semi-structured interviews |
| Aselton, 201011  (PhD thesis) | five college campuses, USA | To describe college students‟ lived experience after being medicated with antidepressants, and to determine what other non-medical methods they have used to deal with the symptoms of depression and stress | Not reported | Patients’  (undergraduate college students in the Northeast United States who have taken antidepressants at some point in their adolescent or college years) | N=13  19 to 22  5 males,  8 females | In this study, the term antidepressants referred to “newer class of antidepressants” (SSRIs e.g. Prozac, Celexa, Paxil) as well as those that work on other neurotransmitters (e.g. Wellbutrin, Cymbalta, Effexor and Buspar) | semi-structured interview via email |
| Dickinson, 201012  (Journal article) | UK | To explore the attitudes of older patients and their GPs to taking long-term antidepressant therapy, and their accounts of the influences on long-term antidepressant use. | Primary care | Patients  (aged ≥75 years whose records indicated they had been prescribed an antidepressant continuously for at least the previous 2 years)  GPs  (doctors whose patients had participated in the study) | Patients N=36  75 to 91  10 males,  26 females  GPs N=10 | TCAs n=22,  12 SSRIs n=12, other antidepressants (names not specified) n=2  22 had prescription ≥5 years, 11 had prescription < 5 years. [Note: this equates to 33 patients when there were 36 in the study] | semi structured interviews |
| McKinney, 201013  (Journal article) | Canada | [To focus] on psychiatric medication experiences among a sample of North American university students to explore a new cultural and social landscape of medication ‘compliance.’ | Not reported | Patients’  (participants had to have taken, or were currently taking, a psychiatric medication for a mental health problem) | N=22  19 to 24  Gender not reported | A significant number of the participants suffered from mild to moderate depression and took an SSRI antidepressant. situational or transient | Interview (no further information provided) |
| Iden, 201114  (Journal article) | Norway | To examine decision-making among doctors and nurses in nursing homes on the treatment of patients with depression using antidepressants | Nursing homes | GPs (working full or part-time in nursing homes) and registered nurses working in nursing homes | N=24 (16 GPs, 8 nurses)  30-70  6 males, 18 females | Not applicable | Focus groups |
| Schofield, 201115  (Journal article) | UK | To explore and compare the factors that influence patients’ decisions about their treatment across three localities in England, chosen for their diversity and including one ethnic minority (South Asian) participant group | Primary care | Patients’  (participants had been prescribed antidepressants for depression or mixed anxiety and depression in the past year) | N=61  23 to 95  18 males,  43 females | Stopped antidepressant use n=11  Intending to stop antidepressant use n=11  Cyclical use n=17  Long-term use n=22 | Semi-structured interviews |
| Buus, 201216  (Journal article) | Denmark | To gain detailed insight into depressed patients’ personal beliefs about their illness and antidepressant treatment in the first twelve months after a hospital admission, and to explore how these beliefs were related to their self-reported level of adherence to treatment with anti-depressants | Participants were recruited from general psychiatric wards | Patients’  (a discharge diagnosis of a depressive episode/ disorder (ICD-10 F32.0-F33.9) and a prescription for antidepressant medication) | N=16  median age 49.5  (range 22-69)  6 males,  10 females | Antidepressant medication at discharge:  SSRIs n=4  SNRIs or NaSSAs n=7  TCAs n=9  Lithium n=2  Neuroleptics n=4  Taking more than one psychotropic drug n=15  Number of informants reducing or forgetting to take antidepressant medication (>5 days): 1 month n=2; 4 months n=2 2; 8 months n=5; 12 months n= 6 | Semi-structured interview |
| Bayliss, 201517  (Journal article) | UK | To build a preliminary grounded theory of the psychological processes involved in combined treatment with antidepressant medication and CBT, from the perspective of participants. | Secondary care mental health services | Patients’  (diagnosed with depression, and who had experienced CBT and antidepressant medication) | N=12  22-58  7 males,  5 female | Current medication: bupropion, citalopram, escitalopam, fluoxetine, paroxetine, mirtazapine, St John's wort Aripiprazole.  Begun medication before CBT n=12;  discontinued medication during CBT n=2; discontinued medication after referral for CBT but before CBT started n=1  Time since onset of depression: 18 months to 44 years | Semi-structured interviews |
| Eveleigh, 201518  (PhD thesis) | Netherlands | To explore the attitudes of these specific patients, using long-term antidepressants without a proper current indication, towards the discontinuation of these drugs and to explore their attitudes towards the discontinuation advice they had received when participating in the Prescribing ANtiDepressants Appropriately (PANDA)study | Primary care | Patients’  (assigned to the intervention group in the overtreatment trial of the PANDA-study (patients using antidepressants long-term (≥ 9 months) without a current indication for continued usage).These patients had received the recommendation, via their own GP, to discontinue their antidepressant use) | N=16  mean age 57 (range 33-81)  5 males,  11 females | 7 patients intended to comply with the discontinuation advice during the PANDA study, 3 patients actually discontinued their antidepressant (during or after the PANDA study)  PANDA inclusion criteria were patients using any antidepressants, with exception of MAOIs, long-term (≥ 9 months). | Semi-structured interviews |
| Nygaard, 201519  (Journal article) | Denmark | To gain insight into how pregnant women, who were diagnosed with depression, accounted for and managed their decision about taking or not taking antidepressants during their pregnancy. | Hospital | Patients’  (pregnant women diagnosed with depression (validated by a GP or a psychiatrist), who were currently taking antidepressants or had stopped taking antidepressants shortly before or during pregnancy) | N=8  21 to 37  8 females | Took antidepressants before becoming pregnant and continued use during the entire pregnancy n=3  Discontinued taking antidepressants 1–6 months before pregnancy - felt that they were in a stable and tolerable mental state (Three of these participants stated that they would not have stopped taking antidepressants if they had not planned pregnancy) n=5  Two of the five participants who discontinued relapsed into depression during pregnancy and resumed treatment with antidepressants  Years since first depression ranged from : <1 year to 11 years | Semi-structured interviews |
| Weaver, 201520  (Doctor of Clinical Psychology thesis) | UK | To investigate how people describe their experiences of change retrospectively 24 months after participation in mindfulness based cognitive therapy (MBCT) and encouragement to taper maintenance antidepressants, with a particular focus on how experiences of MBCT and antidepressants contribute to a restructuring of the self and illness experience. | Primary care | Patients’ (completed an 8 week course of MBCT (attending at least 4 out of 8 sessions) and asked during the course to reduce and then stop their antidepressant) | N=42  25 to 72  11 males,  31 female | Reduced/ never stopped antidepressant n=7;  Stopped n=18;  Stopped/resumed n=10;  Never stopped n=7 | Semi-structured interviews |
| Bosman, 201621  (Journal article) | Netherlands | To gain insight into possibilities to prevent unnecessary long-term antidepressant use, the motivations and barriers of patients and GPs to continue or discontinue antidepressants | Primary care | Patients’  (an antidepressant prescribed for anxiety and/or depressive disorder(s) and:  used antidepressant for >6 months; antidepressant prescriptions by the GP; patient in remission from their anxiety and/or depressive disorder(s); age ≥18 years)  GPs’ | Patients N=38  30 to 68  10 males,  28 females;  GPs N=26  Patient-GP dyads N=30 (only 20 dyads could be analysed, including 20 patients and 14 GPs) | SSRI (with addition of atypical antipsychotic n=1, methylphenidate n=1 or NaSSA n=1): overall n=26; in dyads n=11  SNRI (with addition of lithium n=1): overall n=10; in dyads n=8  TCA: overall n=2; in dyads n=1  Duration of antidepressant use:  1 to 4 years: overall n=7; in dyads n=3  5 to 9 years: overall n=8; in dyads n=6  10 to 14 years: overall n=7; in dyads n=2  15 to 19 years: overall n=10; in dyads n= 7  > 19 years: overall n=6; in dyads n= 2 | Semi-structured interviews |
| Johnson, 201722  (Journal article) | UK  (Scotland) | To explore factors influencing GPs’ use of antidepressants and their doses to treat depression | Primary care | GPs | N =28  median age 43  (range 33 to 60)  14 males,  14 females | Not applicable | Semi-structured interviews |

CBT cognitive behavioural therapy; MAOI monoamine oxidase inhibitor; NaSSA noradrenergic and specific serotonergic antidepressant; SNRI serotonin and norepinephrine reuptake inhibitor; SSRI selective serotonin reuptake inhibitor; TCA tricyclic antidepressant

## Appendix 3: CASP quality assessment

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study** | **Was there a clear statement of the aims of the research** | **Is a qualitative methodology appropriate** | **Was the research design appropriate to address the aims of the research?** | **Was the recruitment strategy appropriate to the aims of the research?** | **Was the data collected in a way that addressed the research issue** | **Has the relationship between researcher and participants been adequately considered** | **Have ethical issues been taken into consideration?** | **Was the data analysis sufficiently rigorous?** | **Is there a clear statement of findings?** | **How valuable is the research?** |
| Karp 19931 | Yes | Yes | Yes | Yes | Yes | Can't tell | Can't tell | Yes | Yes | Valuable |
| Knudsen 20022 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Valuable |
| Pollack 20023 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Valuable |
| Hoogen 20064 | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Valuable |
| Verbeek-Heida 20065 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Valuable |
| Holt 20076 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Valuable |
| Johnston 20077 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Valuable |
| Leydon 20078 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Valuable |
| Wilson 20079 | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Valuable |
| McMullen 200910 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Valuable |
| Aselton 201011 | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Valuable |
| Dickinson 201012 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Valuable |
| McKinney 201013 | Yes | Yes | Can't tell | Can't tell | Can't tell | Can't tell | Yes | Can't tell | Yes | Valuable |
| Iden 201114 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Valuable |
| Schofield 201115 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Valuable |
| Buus 201216 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Valuable |
| Bayliss 201517 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Valuable |
| Eveleigh 201518 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Valuable |
| Nygaard 201519 | Yes | Yes | Yes | Yes | Yes | Can't tell | Yes | Can't tell | Yes | Valuable |
| Weaver 201520 | Yes | Yes | Yes | Can't tell | Yes | Yes | Yes | Yes | Yes | Valuable |
| Bosman 201621 | Yes | Yes | Yes | Yes | Yes | Can't tell | Ye | Yes | Yes | Valuable |
| Johnson 2017 22 | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Valuable |

## Appendix 4: Comprehensiveness of reporting assessment (consolidated criteria for reporting qualitative research checklist)

|  |  |  |
| --- | --- | --- |
| **Reporting criteria** | **No. (%)**  **(n=22)** | **References of studies reporting each criterion** |
| **RESEARCH TEAM AND REFLEXIVITY** |  |  |
| Characteristics of research team: |  |  |
| Interviewer or facilitator identified | 17 (77) | 1,2-6,8-11,14,16,18-22 |
| Credentials | 11 (50) | 7,9,12,14,15,18,19,21,22 |
| Occupation | 14 (64) | 2,3,4,7,9,12,14,15,18,19,21,22 |
| Gender | 21 (95) | 1-4,6-22 |
| Experience and training | 10 (45) | 1,7,9,11,12,14-16,18,21 |
| Relationship with participants: |  |  |
| Relationship established before study started | 4 (18) | 1,9,11,20 |
| Participant knowledge of interviewer | 12 (55) | 2,4,5,7,9,12,15,17,19-22 |
| Interviewer characteristics (e.g. bias) | 14 (64) | 1-5,9-14,18,20,22 |
| **STUDY DESIGN** |  |  |
| Methodological theory identified | 21 (95) | 1,2,4-22 |
| Participant selection: |  |  |
| Sampling method (for example, purposive) | 21 (95) | 1-12,14-22 |
| Method of approach | 19 (86) | 1-4,6-12,14-17,19-22 |
| Sample size | 22 (100) | 1-22 |
| Number or reasons for non-participation | 11 (50) | 3, 7-12,16,18-20 |
| Setting: |  |  |
| Setting of data collection | 16 (73) | 2-6,9,11,12,15-22 |
| Presence of non-participants | 3 (14) | 9,11,18 |
| Description of sample | 22 (100) | 1-22 |
| Data collection: |  |  |
| Interview guide | 22 (100) | 1-22 |
| Repeat interviews | 9 (41) | 1-4,9,11,13,16,19 |
| Audio or visual recording | 18 (82) | 1-6,8-12,14,16,18-22 |
| Field notes | 6 (27) | 3,4,7,9,11,12 |
| Duration | 19 (86) | 1-4, 6-11,14-22 |
| Data saturation | 7 (32) | 7,11,12,15,18,19,21 |
| Transcripts returned to participants | 3 (14) | 9-11 |
| **DATA ANALYSIS AND FINDINGS** |  |  |
| Data analysis: |  |  |
| Number of data coders | 12 (55) | 3,7,8,9,10,11,12,14,16,18,22 |
| Description of coding tree | 2(9) | 9-11 |
| Derivation of themes | 19 (86) | 2-5,7-12,14-22 |
| Use of software | 12 (55) | 3,5,6,8,9,11,12,16,18,20-22 |
| Participants’ feedback on findings | 5 (23) | 2,4,9,16,17 |
| Reporting: |  |  |
| Participant quotations provided | 22 (100) | 1-22 |
| Data and findings consistent | 22 (100) | 1-22 |
| Clarity of major themes | 21 (95) | 1,2,4-22 |
| Clarity of minor themes | 21 (95) | 1-12,14-22 |

## Appendix 5: Definitions of subthemes

#### Definitions of subthemes of patient barriers to discontinuation

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| **PSYCHOLOGICAL AND PHYSICAL CAPABILITIES** |
| **DEPENDENCE**1,2,5,9,12,13,15,17,18,20  Experience of dependence (physical or psychological) on antidepressants |
| **EXPERIENCE OF PROBLEMATIC DISCONTINUATION ATTEMPTS**5,8,9,12,15-18,21  Problematic experiences (self or others) of discontinuing antidepressants |
| **LIFE CIRCUMSTANCES DIFFICULT**4,5,12,13  Life circumstances are difficult, and antidepressants have a role in helping during this time |
| **ROUTINE**1,4,12,21  Taking antidepressants is an automatic, regular action |
| **INTERMITTENT NEED**6,11,13,15  Intermittent need for antidepressant use, with a history of stopping and restarting antidepressants |
| **COPING STRATEGIES INEFFECTIVE**20,21  Coping strategies were ineffective in helping discontinuation of antidepressants |
| **PERCEPTION OF ANTIDEPRESSANTS** |
| **POSITIVE EFFECT**1,4,5,12,13,18,21  Experience of a positive effect of antidepressants |
| **NATURAL/BENIGN CHARACTERISATION**1,18  Continues antidepressant as they view it as a natural, benign, substance |
| **LACK OF CONCERN OVER SIDE EFFECTS**12  Lack of concern over side effects |
| **FEARS** |
| **FEAR OF RELAPSE**1-5,8,15-21  Fear relapse of depression if antidepressants are discontinued |
| **FEAR OF WITHDRAWAL EFFECTS**8,12,15,17,18,21  Fear of withdrawal effects |
| **FEAR – MISCELLEANEOUS**3,5,8,12,18,19  Fear of effect of discontinuation on fetus, relationship with partners, fear of stopping without expert support |
| **INTRINSIC MOTIVATORS AND GOALS** |
| **SELF-IDENTITY (DISABLED, “GOOD MOTHER/DAUGHTER”, OLD)** 4,12,15,19  Discontinuing antidepressants is not seen as a valid option due to patients’ perception of themselves |
| **THREAT TO STABILITY**12,13,15,16  Discontinuing antidepressants would be a threat to stability |
| **IRRATIONAL**1,8,18  Continuing to take antidepressants despite acknowledging the medication has no beneficial effect or is no longer required. |
| **GOAL PRIORITY IS BENEFIT OF CONTINUING TO SIGNIFICANT OTHERS**4,21  Continuing antidepressant medication for the benefit of significant others |
| **GOAL IS MANAGEMENT RATHER THAN CURE**25  Feeling better is goal rather than total recovery |
| **THE DOCTOR AS A NAVIGATOR TO MAINTENANCE OF DISCONTINUATION** |
| **DOCTOR’S WORK PRACTICES**8,12,15,17  Experience of Dr focussing on physical, rather than mental, health, or Doctor not performing a review of antidepressant medication |
| **DOCTOR’S WORK ISSUES – LACK OF TIME**8,17,21  Patient’s feeling that their Doctor does not have the time to help them discontinue antidepressant medication |
| **DOCTOR RECOMMENDS CONTINUATION**1,9,15  Doctor recommends continuing antidepressant medication in response to patient asking about discontinuation |
| **DOCTOR’S RESPONSIBILITY TO INITIATE DISCUSSIONS ABOUT DISCONTINUATION**5,12,21  Patient’s assumption that their Doctor would be responsible for informing them to discontinue if appropriate |
| **LACK OR INADEQUACY OF DOCTOR SUPPORT/GUIDANCE**5,18,21  Patient dissatisfaction with Doctor’s knowledge, help or advice on antidepressant discontinuation |
| **PERCEIVED CAUSE OF DEPRESSION** |
| **LONG TERM CONDITION AND TREATMENT**5,12,15,18  Acceptance of depression as a chronic condition and/or requiring long term treatment with antidepressants |
| **ETIOLOGY – BIOCHEMICAL**1,4,5,16,18,21  Belief that depression is caused by a chemical imbalance in the brain |
| **ASPECTS OF INFORMATION THAT SUPPORT DECISION-MAKING** |
| **INCONGRUENT INFORMATION ABOUT DISCONTINUATION OF ANTIDEPRESSANTS**5,19  Patients receive contradictory information about discontinuing antidepressants |
| **INSUFFICIENT INFORMATION ON HOW TO DISCONTINUE, AND OF RISKS AND BENEFITS OF DISCONTINUATION**5,8,19  Patients receive insufficient information about how to discontinue antidepressants, and the potential effects associated with discontinuation |
| **SIGNIFICANT OTHERS – A HELP OR A HINDRANCE** |
| **PRESSURE TO CONTINUE**4,18,19  Partner requests patient continue antidepressant medication |

#### Definitions of subthemes of patient facilitators to discontinuation

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| **PSYCHOLOGICAL AND PHYSICAL CAPABILITIES** |
| **CONFIDENCE IN CAPABILITY TO DISCONTINUE**1,10,18,20  Self-confidence in ability to discontinue antidepressants |
| **COPING STRATEGIES EFFECTIVE**9,17,20  Coping strategies were effective in helping patient discontinue antidepressants |
| **LIFE CIRUCMSTANCES STABLE**10,13,21  Stable life circumstances are needed for, or enabled, discontinuation |
| **ACCEPTABLE EXPERIENCE OF DOSE REDUCTION**8,11  Acceptable experience of dose reduction of antidepressant |
| **KNOWLEDGE TO TAPER**10,21  Patient knew, independent of health care professional involvement, that antidepressants should be tapered in order to discontinue safely |
| **PERCEPTION OF ANTIDEPRESSANTS** |
| **INEFFECTUAL**1,3,6,8-11,16,17  Patient did not experience, or was uncertain of, any beneficial effect from antidepressants |
| **EXPERIENCE OF UNACCEPTABLE SIDE EFFECTS**1,6,9-11,15-17,21  Experience of unacceptable side effects of antidepressants |
| **NEGATIVE/UNNATURAL CHARCTERISATION**10,11,17,21  Antidepressant medication viewed with negative or unnatural connotations |
| **UNHAPPY ABOUT LONG TERM USE**3,8,15,18  Patient was unhappy about prospect of long term treatment with antidepressants |
| **FEARS** |
| **FEAR OF ADDICTION**5,10,15,17,18,21  Fear of addiction to antidepressants |
| **FEAR OF POTENTIAL SIDE EFFECTS**1,5,10,18,19  Fear of potential side effects |
| **INTRINSIC MOTIVATORS AND GOALS** |
| **SELF-IDENTITY (HEALTHY, TRUE-SELF, “GOOD MOTHER/DAUGHTER”)**1,2,5,8,10,11,15,19,20  Discontinuing antidepressants allows patient to perceive themselves as “healthy again”, “reclaiming their true self,” or “being a good daughter/mother” |
| **DESIRE TO FUNCTION WITHOUT ANTIDEPRESSANTS**1,11,15,18,21  Patient wishes to function without the use of antidepressants |
| **FEELING BETTER**5,8,10,21  Patient feels better and therefore wishes to discontinue antidepressant use |
| **SELF-STIGMA OF TAKING ANTIDEPRESSANTS**15,18  Patient perceives stigma in taking antidepressants |
| **THE DOCTOR AS A NAVIGATOR TO MAINTENANCE OF DISCONTINUATION** |
| **DOCTOR’S SUPPORT/GUIDANCE**3,8,11,13,18,21  Doctor gives support and guidance of discontinuation process |
| **DOCTOR RECOMMENDS/APPROVES DISCONTINUATION**3,5,7,18,19  Patient initiates discontinuation in response to Doctor’s recommendation to do so or Doctor approval of patient’s suggestion to discontinue |
| **PERCEIVED CAUSE OF DEPRESSION** |
| **ETIOLOGY – LIFE CIRCUMSTANCES, SEASONAL**10  Recognising depression is caused by life circumstances or is seasonal and therefore antidepressant treatment is inappropriate |
| **ASPECTS OF INFORMATION THAT SUPPORT DECISION-MAKING** |
| **INFORMATION ON HOW TO DISCONTINUE AND WHAT TO EXPECT**3,21  Information on process of discontinuation and withdrawal effects |
| **SIGNIFICANT OTHERS – A HELP OR A HINDRANCE** |
| **PRESSURE TO DISCONTINUE**1,10,15  Pressure from significant other is initiating factor in discontinuing antidepressants |
| **SUPPORT/GUIDANCE**19,21  Support and guidance of significant others can be needed or is helpful |
| **SUPPORT OF OTHER HEALTH PROFESSIONALS** |
| **SUPPORT**19,21  Support and guidance of other health professionals can be needed or is helpful |

## Appendix 6: References for appendices 2, 3, 4 and 5

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