Original Article

Difficulties related to medication therapy for anxiety disorder

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ABSTRACT

This study aimed to comprehend difficulties of people with anxiety disorder referred to follow a medication therapy. This is a cross-sectional descriptive study with a qualitative approach, developed in 2012 with 32 people attended in an ambulatory service at the interior of São Paulo state – Brazil. The data was collected by semi-structured interview recorded and submitted to thematic content analysis. The difficulties to follow pharmacotherapy were represented by the categories: "To have insufficient knowledge about the diagnosis and medication therapy", "To be unsatisfied with the treatment effects", "To wish more than a prescription", "To present fears and worries related with the treatment" and "To identify impediments to follow the medication prescription". This study identified aspects subject to intervention, through interventions focused in listening, education, autonomy and abilities for safety in the use of prescribed medications.

Descriptors: Anxiety Disorders; Medication Adherence; Psychotropic Drugs; Outpatients; Psychiatric Nursing.

INTRODUCTION

Anxiety disorders are associated with high suffering, limitations, and direct and indirect costs[1]. They are the predominant mental disorders and they are associated to high load of the disease. Up to 33.7% of the population is affected by an anxiety disorder throughout life[2].

Pharmacotherapy is an efficacious treatment modality for anxiety disorders, because it reduces symptoms and increases quality of life of individuals[3]. Still, it assumes the leading role in the treatment of these disorders, considering the insufficient structure of public services for health regarding the offer of non-

pharmacological therapeutic strategies[4]. In short duration treatments for anxiety disorders, benzodiazepines can be applied, however, its prolonged use is counter-indicated due to dependency risk[5-6]. Antidepressants are recommended as first line treatment for anxiety disorders[7]. Still, half of patients with antidepressant prescription interrupt medication treatment on the first six months[8-10].

The barriers for the medication adherence need to be known and carefully explored so the treatment is well succeeded[8].

The stronger predictors for antidepressant adherence are related to experiences, beliefs, attitudes, difficulties, individual characteristics and satisfaction[11]. To increase the positive results related to the treatment, health professionals should comprehend and recognize such aspects[12].

Most of studies about antidepressant treatment adherence is conducted with people with depression and uses quantitative methods focused in specific factors. However, there are particularities of subjective experiences that cannot be quantified. Thus, there are gaps in the literature about the perspective of individuals with anxiety disorders in the pharmacological treatment and, this knowledge could offer subsidies to optimize assistance to these people.

This study aimed to comprehend the difficulties of people with anxiety disorder referring to the conduction of a medication therapy.

METHODS

A cross-sectional, descriptive study with a qualitative approach. It was developed in a Mental Health Nucleus (NSM), of the Brazilian Unified Health System and, located at a city at the interior of São Paulo state – Brazil.

The eligible population for the study was composed by all patients who had a medical consultation scheduled at the place during 01 of January to 31 of March in 2012, who met the following inclusion criteria: to have a diagnosis of some type of anxiety disorder (established by the psychiatric physician from the study location), and to have a prescription for continuous medication use to treat Anxiety Disorders. Patients were excluded from the study if younger than 18 years, incapable to verbally communicate in Portuguese and without their phone and address update in the medical record.

Initially, we conducted a survey of medical records of all patients with a scheduled consultation during the study period (January to march of 2012). From those, 40 met the study inclusion criteria. It was not possible to invite eight patients, because their contact information was outdated in the records and they did not come to the service during the study time. All 32 patients who met the inclusion criteria who had their contact information on the record were invited to participate in the study through telephone contact or when they came to the service. The first author conducted the data collection and a semi-structured interview was performed, recorded, and guided by a script developed by the researchers, constituted by two parts. On the first, we investigated the information about their demographic and socioeconomic profile and, at the second, there were open questions to obtain information about their difficulties related to the conduction of the

medication therapy. We added new questions with the intention to clarify and to fundament the experience, according to their answers. The interviews were conducted in a private place, during an average of 30 minutes. All participants were interviewed after signing the Free and Informed Consent Form. Two researchers analyzed the data and they were guided by the thematic analysis[13]. At first, the data were gathered and organized. Through analysis of the material, empirical categories were established. After, an articulation of the empirical material with the literature was conducted. The thematic analysis is used to identify, analyze, and communicate patterns and meanings (themes) within the data. In the present study, an inductive analysis was conducted to identify the latent themes[14].

The project was developed after the approval by the Ethics in Research Committee of the Nursing School of Ribeirão Preto, at Universidade de São Paulo (protocol CAAE: 00825412.6.0000.5393) and the recommendations and principles from the Helsinki Declaration, and the Brazilian norms for research with human beings were respected.

RESULTS

Thirty-two people participated in the study. From those interviewed, 26 (81.2%) were female, 18 (56.2%) were between 50 and 69 years, 18 (56.2%) were married, 22 (69.7%) did not have an employment and 22 (69.7%) had a family income of one to three minimum wages.

Difficulties related to following the medication therapy

The analysis of testimonials of the study participants about difficulties experienced while following a medication therapy resulted in the construction of the categories presented below.

To have insufficient knowledge about the diagnosis and medication therapy

Study participants affirmed that the adherence to medication therapy is troubled by insufficient knowledge about anxiety disorders and pharmacological treatment. The comprehension about the disorder and treatment was considered necessary to justify the need for the medication and, therefore, to fundament motivations for adherence.

Everything still is very obscure to me. (…) It's complicated. You already are unwell, then you take a medication that you don't know for what it serves and doesn't improve anything. And you don't understand anything else, it turns into a snowball (…) then, you say: well, I don't even know what I have, is this medication really to cure this? (P12)

The information is a right of the patient as citizen that not always is fully respected in health attention. In the present study, complaints were identified about the restricted and superficial guidance and the lack of knowledge about the diagnosis and its finality, utility, effects and, action mechanisms of the medications.

You know, I have doubts, for what those medications work? How do they act? Do you understand? (...) for what does it serve to my disease, you know? (P11)

I don't know what I have (…) I don't know what are those medications for. (P29)

I don't know really well what those medications are for…It didn't help her saying that it is for phobia, right? She has to explain better (…) it's my right to know. (P7)

The not resolved doubts in the health service can lead the patient to look for explanations in other information sources, that could be considered more clear and accessible, although not always safe.

I thought that I needed only the diazepam because people talk so much about the diazepam, that it knocks me out, makes me sleep. Even this I've read on the internet. Then, I kind of believed only in it and I've stopped to take the other medication.(P15)

The interviewed also mentioned the lack of information between family members who predispose them to criticism, unbelief regarding the diagnosis and truth about the symptoms, incomprehension, judgements, baseless worries and advices, and stigma.

No, they not only criticize me because they think that I don't have anything, you know? (…) They tell me that depression and anxiety are rich people's disease. They say: "Ah, start to drink. Drink a "pinga", that you forget that you are sick". Many people come and tell me that I've been stuffing myself with medication for no reason, you know. At the time that I've stopped to take the medication, it was a bit because of that. (P14)

To be unsatisfied with the treatment effects

Another difficulty pointed by people with anxiety disorders is the dissatisfaction with the pharmacological treatment effects that not always attend the expectations of consumers. The patients felt dissatisfied when noticing that the medication does not propitiate immediate effects and for considering the effects limited and, for feeling little convinced about its efficacy.

I say that only the medications are not working for me. (P7)

I used to take. Then, I paid attention about ten days, more or less, but that anxiety you know, that agony, did not go away. (P12)

You know, I don't know if it's working (...) So, I think that maybe the medication is not working out, you know. (P22)

Testimonials contained the reduction of benzodiazepines' therapeutic effects. When developing tolerance to benzodiazepines, some patients increased the medication dose to obtain the same effect experienced before.

The clonazepam is losing its effect (...) It is not having effect. These days I took two at once (...) I think that he is really week. (P5)

Ah, I end up taking it, even with the doctor saying to take only one, but I end up taking another one. (P23)

There are times that it doesn't make much effect (…) I end up taking one more. (P24)

The clonazepam I think it stops making effect, only that dose. I even took like, two more to see if would have effect. And it did a better effect. (P25)

The dissatisfaction with the medication treatment was also found in the presence of adverse events

that were noted as a motive to discontinue the treatment or decrease the medication dose between patients.

The sertraline, sometimes I stop taking it, because it used to give me a lot of heartburn, you know. (P9)

To wish more than a prescription

The patients referred to difficulties related to dissatisfaction related to the attention provided in the health service. The participants wished that clinical encounters would not be limited to the medication prescription. They manifested the desire to obtain more than a prescription, prevailing with focus and finality of many provided consultations.

Sometimes the person needs to be heard more than to take the medication itself. (P16)

He (doctor) likes more is to do a little prescription (laughs). Poor him, I like him a lot, but he is too disconnected. (P26)

The consultation is always the same thing you know (…) she (doctor) is only linked to the prescription you know, to stay prescribing medicine. Each time I come here, she prescribes the same medicine, you know, or she prescribes the other one. But like, it just stays like this. (P27)

Referring to consultations, they related mechanical actions, not individualized by the health professionals. The patients did not feel truly comprehended and attended in their own individual needs, and they judged the knowledge about the patient as it should precede the prescription.

I think it lacks to better understand the patient, to analyze better before start prescribing the same medications. (P10)

He did not care much about what we said. So, I also didn't tell everything to him (…) he prescribed the same medications that I take today (…) it stayed like that. (P17)

The restrict attention to the medication prescription and excessively turned to this finality was demonstrated as little productive, and it could harm the adherence to the medication. In times, the adherence monitoring itself and the opinions about the medication were disregarded.

I think that he (doctor) should listen to me more, right? (…) he (doctor) "firmed his feet" and said that it was that medication, and he wasn't going to change it (…) Then I stopped to take sertraline by myself because I couldn't handle anymore. (P23)

Does not stay explaining things no (...) He prescribed, then never asked anymore how am I taking it. (P25)

To present fears and worried related with the treatment

The medication treatment was cited as target of fears and worries experienced by the interviewed. While some patients worried about the risks and harmful effects of medications, considered "strong" or "dangerous", other individuals questioned the effectiveness and the presence of active principles in the medication.

I was even afraid of this medication not having its effect because there is flour in the middle. Like we used to give in the past to patients who were addicted to medicines. (P10)

They (medications) are very strong. It can only be it. (P16)

I read the indications of all medicines that she prescribed me (…) these medicines that are dangerous. (P30)

In some testimonials, we identified fears and worries related to the risk of medications to cause dependence.

I don't know, but this medicine, too much medicine like this is even dangerous to become an addiction, a dependent. (P13)

Because like, I know that these medicines all creates addiction, understood? (P15)

The study participants also manifested worries related to the need to keep the treatment indefinitely, because they desired to have a "more natural" life and to do not need the medication for "the whole life" to control anxiety.

I have wish, hope (...) that one day stop taking these medicines, but I don't know if this will be possible (…) it's the wish to have a more natural life, you know? (…) to be able to control the anxieties. (P2)

I didn't want to have to take it (the medication) for the whole life. It's bad. (P31)

To identify impediments to follow the medication prescription

The study participants pointed difficulties that impeded the rigorously following of the medication prescription. Such impediments consisted in restrictions in the patient's aptitude to administer his own medication, the lack of access to medications and the lack of knowledge of the prescribed therapeutic scheme.

When there is no medicine in the health unit, I can't buy. I can't be taking out the money that is short and counted to pay the bills, to pay these medicines because they are expensive. (P5)

These things to have to take in the right time I can't do it. (P6)

I don't remember. The head blanks. Then, sometimes I remember only on the next day. And this leave me bad because on the next day I don't wake up very well. Yesterday night I forgot to take it. (P14)

Sometimes I forget the names ah, such complicated names. (P21)

I never remember its milligrams, right? I can't memorize. (P26)

We highlight that few individuals identified strategies for the practicability to follow the prescription, such as verbal and written orientations, strategies to facilitate the organization and memorization, as well as adaptation at the medication time.

I think that to do a little schedule for the patient to take the medicine, like, in a sheet of paper, helps a lot. (P10)

I sometimes do a little confusion (…) then, I put everything there in the table, I write in a paper the times that I need to take it and I go one like this. (P16)

I don't forget to take it anyways because it stays close to the water gallon at home. Then when I drink water I check if it's on time and I take it. I also leave some inside the bag because I go out, I go a lot to my brother's, then I take it there. (P20)

He (doctor) prescribed for me to take it at night, but I've already took it at four, five in the afternoon, at the time that I remember. (P26)

DISCUSSION

In this study, the lack of knowledge about the disorder and the treatment was pointed as a barrier to adherence of medications, revealing the need to comprehend about their own health condition to fundament choices related to treatment.

Health professionals need to explore the conceptions of patients about the medication treatment[12] to offer psychoeducation to attend demands and interests of the target public, and that are comprehensible and culturally adapted. The psychoeducation, linked to pharmacological treatment, have better results than the medication treatment exclusively for mental disorders[15]. It is still emphasized the importance to involve and guide the family to reach better results[16].

The dissatisfaction with treatment effectiveness, identified among study participants, can be related to the characteristics of antidepressants and benzodiazepines commonly used in anxiety treatment[17].

The antidepressants are considered the first line treatment and produce positive results, but usually, they require about four weeks to reduce the anxiety symptoms[1,7,17], which can frustrate patients at the beginning of treatment and to favor the abandonment of pharmacotherapy, because, without this information, the user can conclude earlier that the medication is ineffective. Besides, a significant proportion of patients do not respond to the first line pharmacotherapy agents in a satisfactory manner[7]. The orientation about the time to start the therapeutic effects of antidepressants and the magnitude of these effects can favor perceptions and realistic expectations about the treatment and reduce frustrations or early conclusions.

Benzodiazepines produce fast effects in the reduction of anxiety symptoms, but the prolonged treatment of these medications causes tolerance and dependence[5-6]. On the present study, there were patients who elevated the dose of benzodiazepines to keep their effects, exposing themselves to dependence risk. Thus, it is necessary for the nurse to assess, sensitizes, and to guide the patients and family members about the rational use and safe of these medications.

The dissatisfaction with the medicament treatment was also found in the presence of side effects, which can compromise the maintenance of treatment[17]. Thus, the early identification, guidance, and interventions related to side effects can contribute for the patient to have a higher repertory of actions to manage these undesirable effects in a safe way.

In the present study, one of the barriers to follow the medication treatment was the reductionist attention, focused on the medical prescription and that does not propitiate listening, comprehension and welcoming of individual necessities of patients. Thus, it is seen the desire of the patient to perceive himself involved in the treatment, to be heard and to not be a have simply a depositary of interventions.

Regarding this, the literature points the mental health treatment, when marked by labels, vertical

relationships and approaches that does not consider the opinion and the maturity of clients can be a stigmatizing experience[18]. Besides, the quality of the relationship with the health professional can interfere in the treatment adherence[19].

Another difficulty identified by interviewed was the fears and worries related to the medication treatment. People with anxiety disorders can be predisposed to have more worries, because the content of thoughts of the referred people can be focused in interests oriented to the future, that are manifested as worries and anticipation of physical or psychological threats[20]. On the other hand, for those people, fears, uncertainties and worries regarding the medication can be particularly anguishing because anxious individuals tend to present intolerance to uncertainty, that is, they have more difficulty to deal with unpredictability and ambiguous situations[21].

The study participants also reported difficulties limiting or impeding the following of medication prescription. Within these difficulties, the inaptitude of the patient to administer his own medication and the lack of knowledge about the prescribed medication therapy were highlighted. In respect to that, the literature points that anxious individuals tend to present impaired attention and losses in the executive functioning and episodic memory[22], which can impair the following of the prescription, especially when there are polypharmacy and complex therapeutic schemes[17]. The flaws when providing the medication also affect the pharmacological treatment continuity, as it corroborates with the literature[23]. The nursing assessment about these barriers can contribute for interventions that focused decisive factors to follow the medication treatment.

CONCLUSION

The results of the present study filled the gap in the literature related to difficulties to follow the medication therapy between people with anxiety disorder. Such difficulties involved lack of knowledge about the diagnosis, and treatment, worries, fears, and dissatisfaction about medication effects, flaws in providing medicines, inaptitude to administer their own medication and the need of attention not reduced to medicalization.

The identified difficulties are passive of interventions to be attenuated. Thus, it is necessary to be the target for investigations and therapeutic approaches.

The nurses, through listening, multi-criteria assessment of patients' difficulties and promotion of knowledge, and realistic expectations about the medications can favor adherence, the rational and safe use of those, as well as the reduction of risk, frustrations, and dissatisfactions.

Finally, findings of our study point that the reductionist attention with limited objectives to pharmacotherapy can impair the adherence to medications.

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