



## Prevalence of and factors associated with midlife women taking medicines for psychological distress

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### Abstract

The aim of this study was to explore the extent of and factors associated with the use of medicines for psychological distress among midlife Australian women. Data were gathered from a baseline sample of 13,961 women and a follow-up study using semi-structured telephone interviews in New South Wales, Australia, between August and December 1997. Logistic regression was used to identify factors associated with medicine use. Qualitative comments regarding women's experiences of and attitudes to medicine use were analysed thematically. The respondents were 322 women aged 46-50 with low mental health scores who took part in the baseline survey of the Women's Health Australia study. Thirty-six percent of women who reported a recent period of psychological distress used medicines to help them cope. Taking medicines for distress (either prescribed or non-prescribed) was significantly associated with a lower mental health score on the MHI-5 (OR=0.98, 95% CI 0.96-1.00) and an increasing number of negative life events (OR=1.14, 95% CI 1.05-1.24). Taking medicines prescribed by a general practitioner was associated with being dissatisfied with one's family relationships (OR=0.52, 95% CI 0.30-0.91), or having gone through menopause in the past year (OR=1.68, 95% CI 1.00-2.81). Qualitative data (n=117) highlighted several concerns about use of prescribed psychotropic medicines, including a belief in natural remedies, unacceptable side-effects, fear of dependency, a belief that medicines cover up problems that need to be solved and that doctors prescribe too readily. While over one third of the midlife women took medicines to help them cope with a period of distress, many expressed negative views about the use of prescribed psychotropic drugs. Taking a partnership approach with women, exploring their attitudes to both the distress and the medications is essential if doctors are to achieve the objectives of quality use of medicines and patient satisfaction.

### Keywords

*women, psychotropic medicines, general practitioners, consumers, consumer perspectives*

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### Introduction

Concern has been expressed since the 1970s about high prescription rates of psychotropic medicines for women to treat depression, anxiety and insomnia. Studies have put the female to male ratio of prescribed psychotropic drug use at

2:1 both in Australia (ABS, 1992; Hancock, Walsh, Henry et al., 1992) and overseas (Catalan, Gath & Bond, 1988; Van Der Waals, Mohrs & Foets, 1993). Women are also more likely than men to use psychotropic medicines long term (Ettorre & Riska, 1993; Mazza, Dennerstein & Ryan, 1995).

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- Citation:** Outram, S., Murphy, B., & Cockburn, J. (2006). Prevalence of and factors associated with midlife women taking medicines for psychological distress. *Australian e-Journal for the Advancement of Mental Health*, 5(3), [www.auseinet.com/journal/vol5iss3/outram.pdf](http://www.auseinet.com/journal/vol5iss3/outram.pdf)
- Published by:** *Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet)* – [www.auseinet.com/journal](http://www.auseinet.com/journal)  
Received 9 January 2006; Revised 17 November 2006; Accepted 17 November 2006

There are three main reasons for concern with the high rates of prescription of psychotropic medicines for women. First, there can be side-effects in individuals who take these medicines. It is now acknowledged that benzodiazepines, once thought to be benign, have serious side-effects including tolerance and dependency when taken on a longer term basis (Montgomery & Tyrer, 1988). Use has also been associated with cognitive impairment, including subtle psychomotor deficits, memory and concentration difficulties, mental confusion and lack of coordination (Foy, O'Connell & Henry, 1995), adverse mood including depression (Bradley, 1991), and sleep effects including disturbed sleep and nightmares (Bradley, 1991).

Second, there is concern about the medicalisation of women's health. Feminist writers have highlighted the ethical issues in using medicines to help women cope with negative social situations such as domestic violence, unhappy marriages and even previous sexual abuse, instead of helping the women change their circumstances (Koumjian, 1981; Mazza & Dennerstein, 1996).

Third, the cost of medicines is one of the highest items in national health budgets and is rising. In Australia for example, while the use of benzodiazepines has been plateauing or even decreasing at a population level (with the exception of older people) (Mant, Whicker, McManus et al., 1993), the use of antidepressants has been increasing (Commonwealth Department of Health and Family Services, 1998). The defined daily dose per thousand (DDDs/1000) of the Australian population more than doubled between 1990 and 1997. In the year ending March 2000, the cost to the Australian Government of drugs to treat mental disorders was \$335 million, an increase of 23.8% over the previous 12 months (Commonwealth Department of Health and Aged Care, 2000). Similar trends have been seen in UK and US populations.

Some doctors have argued that in this 'medicated society' patients expect a prescription (Commonwealth Department of Health and Aged Care, 2000), and that high rates of prescription are due to patient demand. However evidence indicates that although patients do request medicine, the prescriptions (particularly

new prescriptions) are most often initiated by general practitioners (GPs) (Sleath, Svarstad & Roter, 1997). GPs think that patients expect a prescription more often than the patients actually do (Cockburn & Pit, 1997). Patient demand for prescriptions may not only be overestimated but also perpetuated by this belief, together with GPs' wish to maintain a good doctor-patient relationship (Stevenson, Greenfield, Jones et al., 1999). In a recent study of GP consultations, there was little evidence of active involvement in shared decision making about medicines between patients and doctors (Stevenson, Greenfield, Jones et al., 2000). Yet, even in the areas of prescribed medicines, where a doctor might be expected to have special knowledge, the patient is increasingly recognised to have valuable knowledge to bring to the consultation.

### *Who is prescribed psychotropic medicines?*

In addition to female gender, the prescription of psychotropic medicines is associated with older age (Hancock et al., 1992; Harris, Silove, Kehag et al., 1996; Joukamaa, Sohlman & Lehtinen, 1995; Mazza, Dennerstein & Ryan, 1995), being unemployed (Harris et al., 1996; Joukamaa et al., 1995; Mazza et al., 1995) and being married (Mazza et al., 1995). Women's experience of 'domestic' violence in childhood and adulthood may be implicated in the higher rates amongst women than men (Mazza et al., 1995). Other factors shown to be associated with prescription of psychotropic medicines in a midlife sample of Canadian women were chronic health problems, poor mental health, problems with work and money, problems with husbands and children, and role dissatisfaction (Kaufert & Gilbert, 1986).

Indeed, exploration of medication use for psychological distress is particularly relevant for midlife women. Both UK and Australian evidence suggests that the prevalence of psychological disorders, particularly affective and anxiety disorders, is higher in women than in men (Jenkins, Lewis, Bebbington et al., 1997; McLennan, 1998), peaking in midlife between ages 45-54 (Kane, 1991; McLennan, 1998). Correspondingly, women also have higher rates of help-seeking for psychological distress than do men (Bebbington, Meltzer, Brugha et al., 2000; Verhaak, 1995), again particularly in the 45-54 age group (Bebbington et al., 2000).

Understanding of the factors that motivate midlife women in their medication use is therefore needed.

Likewise, understanding of the factors that inhibit women in taking prescribed medications is also required. Non-adherence ranges from 30-60% and inadequate adherence accounts for reduced therapeutic benefit in at least 50% of patients (Roter, Hall, Merisca et al., 1998). It has been estimated that around 15% of patients do not even redeem prescriptions (Beardon, Gilchrist & McKendrick, 1993). Patient adherence to antidepressant treatment may be particularly poor, with one study reporting that 53% of patients had discontinued their antidepressant treatment by six months (Demyttenaere, Enzlin, Dewe et al., 2001).

Not surprisingly, belief about medicines (degree of perceived necessity versus concerns about side-effects and dependency) is one of the strongest predictors affecting adherence (Horne & Weinman, 1999). In an Australian community-based study, 33% of respondents said that they would not comply with a benzodiazepine script if offered. The most common reason given was that they didn't believe in this type of medicine (Hancock, 1991). Qualitative studies have similarly demonstrated that attitudes regarding necessity, side-effects and dependency, as well as orientation towards medicines, influence adherence (Britten, 1994; Conrad, 1992). Importantly, unvoiced agendas commonly lead to unwanted prescriptions and subsequent non-adherence (Barry, Bradley, Britten et al., 2000), again highlighting the importance of effective doctor-patient communication.

While there has been some previous research in this area, there have been repeated calls for more research to better understand consumer experiences and incorporate a consumer voice into mental health problems (Brown, Lumley, Small & Astbury, 1994; Consumers' Health Forum of Australia, 1999; Karp, 1996). The 1999 Consumers' Health Forum concluded that 'a significant finding is the lack of publications which directly address consumers' use or experiences of medicines' (Consumers' Health Forum, 1999). Building on previous research, and focusing on midlife women for whom psychological distress is particularly prevalent

(Jenkins et al., 1997; Kane 1991; McLennan 1998), this study used both quantitative and qualitative methods to investigate the use of medicines for psychological distress. In particular, the present paper aims to describe:

- a) the self reported use of prescribed and non-prescribed medicines to cope with a recent episode of psychological distress;
- b) the factors associated with women's use of medicines, both prescribed and non-prescribed, for psychological distress;
- c) the factors associated with women's use of medicines prescribed by the GP for psychological distress; and
- d) women's perceptions and experiences in using medicines to help them cope with psychological distress.

## Method

### *Sample and procedure*

Baseline data for this study was collected as part of the Australian Longitudinal Study on Women's Health (now called Women's Health Australia or WHA). WHA is a federally funded interdisciplinary longitudinal research project designed to track the health of three cohorts of women over at least twenty years. In the WHA survey, random samples of women aged 18-23, 45-50 and 70-75 years in 1996 were selected from the database of the Australian Health Insurance Commission (Medicare), the most up-to-date sampling frame available. Randomisation was carried out using the RANUNI function in SAS 8.20. The midlife cohort (45-50 years) comprised 13,961 women.

The present paper reports on a follow-up study of the mid-life cohort of women who had participated in the baseline WHA study. A random sample of 400 women aged 45-50 living in New South Wales who scored <52 on the Mental Health Index (MHI-5) of the SF-36 (Ware & Sherbourne, 1992) at baseline was drawn for the follow-up study. Scores <52 were seen to represent psychological distress. Trained interviewers administered a comprehensive semi-structured telephone interview that explored women's perceptions of the causes of their distress, reasons for seeking help, and use of medicines to cope. Interviews were conducted approximately 12 months after baseline data

collection. Interview duration ranged from 30 to 50 minutes. The present paper focuses on women's use of medicines to help cope with distress.

### **Measures**

#### **Structured questions**

In the section of the questionnaire addressing coping strategies for the recent episode of psychological distress (in the past 12 months), respondents were asked an open question, 'What did you do to help yourself feel better?' Responses were recorded and women were then prompted from a list of strategies such as exercise, smoking or eating more, meditation and prayer, talking to someone (including a GP), and taking medicines. If the woman said she had taken medicines, she was asked for the name of the medicine. If she could not remember the name, she was asked if she could find the name written somewhere. The medicines used were coded according to MIMS (MIMS Annual, 1997) as being primarily used as anti-depressants, anxiolytics, sedatives, anti-psychotics, analgesics, hormonal preparations, vitamins and 'natural' preparations, and 'other'. Later, when asked what help was given by a doctor if they talked to one, 'prescribed medication for psychological distress' was one option. Again responses were probed and coded.

Sociodemographic and health related details were recorded at baseline. Health-related variables assessed included severity of psychological distress (MHI-5) (Ware & Sherbourne, 1992), number of negative life events (adapted from Norbeck) (Norbeck, 1984), satisfaction with family relationships (Spanier, 1976), and menopausal status.

#### **Qualitative data**

Women talked about their experiences of and feelings toward using medicines to cope with psychological distress and their views about the prescription of psychotropic medicines. Comments arose in response to questions about the use of medicines for coping, discussion with GPs about feelings, and help offered by GPs, as well as at other times when women were discussing their experiences. Because the methodology recognised the value of story telling in maintaining a narrative line, the women were encouraged to continue talking

about relevant areas even though it extended beyond the exact question being asked. These comments were recorded in writing.

### **Analysis**

Quantitative data were analysed using the SAS software program. Two dichotomous dependent variables were used: (1) taking any medicines for psychological distress (yes/no) and (2) having been prescribed by a GP medicine for psychological distress (yes/no). For each of the two dependent variables, univariate associations with sociodemographic and health-related variables were explored using chi-square for categorical variables and t-test for continuous variables. Fisher's exact test was used when chi-square was not valid. Variables that had univariate associations at  $p=0.25$  were entered into each of the regression analyses. Backward stepwise logistic regression was used to identify characteristics associated with each of the two dependent variables, while controlling for other variables that had a similar level of association. Odds ratios and 95 per cent confidence intervals (CIs) were calculated, and significance was determined by CIs not overlapping 1.

All qualitative data were entered into a Word document by respondent ID number. Comments about medication use were just one of the domains analysed: they included comments about GPs, psychiatrists, partners, family and friends. Once entered into different domains, the comments within the psychotropic medicines domain were read and re-read and thematically analysed using constant comparison methods (Strauss & Corbin, 1991). A hierarchical coding scheme was developed. Initial themes were generated and coding undertaken by the primary author (SO). The third author (JC) independently coded some comments with a high degree of agreement. The emerging results were continually discussed by these two authors throughout analysis and writing.

### **Results**

#### **Respondents**

From the women randomly selected to take part in the WHA at baseline, 13,961 women responded, giving a response rate of 54%. Although this response rate could be seen as low, it compares well with other similar longitudinal

studies (Kaldenberg, Koenig & Becker, 1994; Yammarino, Skinner & Childers, 1991). Respondents were similar to the Australian population of 45-50 year old women (ABS, 1996) in marital status, parity, and some aspects of employment. However, they had higher educational levels and fewer were unemployed, suggesting that women of higher socioeconomic level are over-represented in the WHA study.

For the follow-up survey 322 interviews were completed (of the original 400 women randomly selected), giving a response rate of 81%. Significantly more non-responders than responders worked at home or were retired, were of non-English speaking background, did not have ancillary or private health insurance, took medicine for ‘nerves’ and to sleep, and reported that, apart from family, they did not have anyone close by on whom they could depend. For this paper, data were analysed on 309 women, as 13 women reported no recent episode of distress.

**Table 1. Types of medicines used by women for psychological distress**

Medicines	n	%	
Antidepressants	60	19.4	
Anxiolytics	23	7.4	
Natural (e.g., vitamins, evening primrose oil)	11	3.6	
Sedatives	8	2.6	
Hormone Replacement Therapy	4	1.3	*(2.8)
Antipsychotic	1	0.3	
Other (eg pain relief)	13	4.2	

Note. N=309. n's add to >111 due to multiple medicines. Some missing data where women could not remember the type of medicine. \*When women were asked later about actions doctors took, 2.8% said that the doctor had prescribed HRT.

**Table 2. Factors associated with women taking medications (prescribed or non-prescribed) for a recent episode of psychological distress**

	N	p	Adjusted Odds Ratio (95% CI)
Total number	309		
MHI-5 <sup>1</sup>		0.135	0.98 (0.96-1.00)
Life events summary scores <sup>2</sup>		0.002	1.14 (1.05-1.24)

Note. Statistical test=backward stepwise logistic regression  
 1. Odds ratio associated with one unit change in scale  
 2. Odds ratio associated with one extra life event per year

**Use of medicines to cope with psychological distress**

Women were asked what they did to cope with the recent period of distress. One hundred and eleven women (35.9%) reported using medicines (either prescribed or non-prescribed) to help them cope. Talking to someone was the most commonly reported strategy, with keeping busy, exercise and prayer also more common than using medicines as coping strategies.

Table 1 shows the medicines that were taken. Of the 309 women, 29.8% had taken one or more prescribed psychotropic medicines, including antidepressants (most common), anxiolytics, sedatives or antipsychotics. The main ‘natural’ remedies were vitamins and evening primrose oil.

The GP was the health professional most often seen by women and was the source of most of the prescribed medicines, with 159 (51.5%) of the women talking to their GP about their difficulties. Of these, 87 (54.7%) were prescribed medicines, and 26 women (16.4%) said that prescribing medicine was the only action taken by the GP in response to their problems. Twenty-seven women (8.7%) had talked to a psychiatrist about their problems, with twelve of these (44.4%) being prescribed medicines by the psychiatrist.

**Factors associated with taking any medicine to help cope with distress**

The variables found in univariate analyses to be associated at p<0.25 with taking any type of medicines (either prescribed or non-prescribed) were: employment status (p=0.008); going through menopause in the last year (p=0.101); satisfaction with family relationships (p=0.066); negative life events (p=0.001); physical health score (p=0.013); mental health score (p=0.060); and social support variables: number of people on whom one can depend (p=0.089); family and friends understand you (p=0.040); can talk about your deepest problems with at least some of family and friends (p=0.108). These variables were entered into a stepwise logistic regression, and those found to have CIs not overlapping 1 were retained in the final model (see Table 2). Taking any type of medicine was found to be independently and significantly associated with a lower mental health score on the MHI-5

(OR=0.98, 95% CI 0.96-1.00), and with an increasing number of negative life events (OR=1.14, 95% CI 1.05-1.24).

**Factors associated with being prescribed medicines for distress by the GP**

The variables found in univariate analyses to be associated at  $p < 0.25$  with being prescribed medicine for psychological distress were: employment status ( $p=0.033$ ); menopausal status ( $p=0.118$ ); going through menopause in the last year ( $p=0.040$ ); satisfaction with partner or closest relationship ( $p=0.201$ ); satisfaction with family relationships ( $p=0.250$ ); negative life events ( $p=0.127$ ); physical health score ( $p=0.051$ ); and mental health score ( $p=0.075$ ). These variables were entered into a stepwise logistic regression, and those found to have CIs not overlapping 1 were retained in the final model (see Table 3). Being prescribed medicine by a GP was significantly and independently associated with being dissatisfied with one’s family relationships (OR=0.52, 95% CI 0.30-0.91), and having gone through menopause in the past year (OR=1.68, 95% CI 1.00-2.81).

**Women’s perceptions of psychotropic medicines**

One hundred and seventeen women made further comments during the course of the interview about using medicines for psychological distress. The comments can be divided into three categories: there were a few positive comments (11), some ambivalent ones (15), but the overwhelming majority were negative (121). It must be emphasized that the same woman sometimes reported both positive and negative feelings and experiences, so there could be more than one theme in each comment.

**Table 3. Factors associated with women being prescribed medication by a GP for a recent episode of psychological distress**

	N	p	Adjusted Odds Ratio (95% CI)
<b>Total number</b>	309		
<b>Menopause in past year</b>		0.05	
No			1.00
Yes			1.68 (1.00-2.81)
<b>Satisfaction with family</b>		0.022	
Dissatisfied			1.00
Satisfied			0.52 (0.30-0.91)

Note. Statistical test=backward stepwise logistic regression

**Positive comments**

Women talked about the positive effects that taking medicines had on the symptoms they had experienced. They ‘evened me out’ said one woman and other women saw them as necessary for life to continue: ‘If it wasn’t for medicines I would not still be here.’

When talking about a relaxant to help her through premenstrual tension (PMT), one woman said she felt happy to take a drug in ‘a small dose’ because ‘having a nervous problem, in a way it really is a type of sickness and it does help.’

**Ambivalent comments**

Women with ambivalent attitudes expressed a desire not to be taking medicines because of dependency or side-effects, but felt that the benefits outweighed the concerns. The relief of symptoms was deemed worth the worry.

*Zoloft stops me bottoming out—with anxiety, panic attacks. I resisted taking medicines because I didn’t want to be like my mother.*

Women who had been using medicines over a long time talked about potential problems, expressing the belief that they ‘should’ come off them, but they were worried about the consequences.

*I don’t want to be on (medicines) for a very long time but I want to find an appropriate time in my life to get off them. Maybe I’m scared, you read about it, the doctor hassles you every time you get a script. But I’ve had many nervous breakdowns. I panic when I try to take myself off them. It’s very hard to pick a time to do it. At work I’m responsible for 20 people. I’ve had a job for 10 years and I’m proud of it. I might get sick and have to have a month off.*

Others saw them as appropriate only at specific times such as ‘when really necessary’, or in ‘extreme situations’ (husband dying, child very ill) or ‘when the doctor OKs it.’

**Negative comments**

Negative comments were organised into five themes: not believing in medicines—natural is better; fears of addiction and dependency; side-effects experienced; medicines as a barrier to solving the problem; and doctors’ over-reliance on prescribing medicines. These themes are not mutually exclusive, with the comments of many women incorporating multiple themes.

**Natural is better.** Many women said that they didn't like to take any medicines, for example 'I don't believe in tablets', and many that they preferred natural remedies. This indicated a general orientation away from medicine use.

*Doctors are too quick to hand out pills. They're not for me, I'm very anti-pills. I respect my body and my organs. I think twice about taking pills, even Panadol.*

**Addiction and dependence.** Beliefs and fears that these medicines are addictive and will make them dependent, or indeed have already done so, were expressed. The conclusion reached by many women was that medicines do more harm than good in the long term. Fears about addiction were often associated with the desire to use natural therapies: 'I felt addicted to them; it's difficult to cope during withdrawal.'

**Side-effects.** Many women complained of the unpleasant side-effects experienced, sometimes recently, often many years ago. The side-effects mainly referred to altered cognitive function such as tiredness and inability to think, but also included horrific nightmares and headaches. One woman said that she 'fought antidepressants' because 'they make you feel stupid...like a zombie.' Her comments below illustrate a lack of clear communication between the GP and patient:

*I had twins and was put on Valium and Tryptanol. I was like a zombie. I woke up and the kids were down the street. I threw the tablets out and never had them again. I had gone to the doctor for a tonic and he prescribed drugs.*

**Medicine as a barrier to solving problems.** Many women wanted to find out the cause of their distress and to overcome it. They saw change as having to come from within, and that psychotropic medicines were not going to solve their problems.

*I took Prozac for one week and felt euphoric. When I found out what they were—an addictive drug for severe depression—I threw them out. You feel that's an easy way out. I would rather change my life to start to feel better.*

The following statement, from a woman who was on Serepax for ten years, then stopped eight years ago, supports the contention that psychotropic medicines can be used to keep women in their feminine roles.

*I had very poor confidence. I thought the tablets would keep me calm, I could smile on the outside, not*

*say the wrong thing in social situations. I wanted everyone to like me.*

Entwined here was a theme of self-reliance; that people ought to be able to do without medicines and should be able sort their own problems out.

*They are bad because they are only a cover up, not solving the problem. You have to pull yourself out of it.*

Women wanted to understand what was happening to them, to their bodies and emotions in order to understand them better and therefore have an idea of what was appropriate for them to do about it: 'I wanted to see what I was really like.'

**GPs' reliance on prescribing medicines.** Overall, women had very definite ideas about what they wanted and did not want from GPs. Although women were often happy with their present doctor, most were very critical of doctors in general who they often perceived as having little understanding of emotional and mental health problems and a strong desire to 'hand out pills.'

*I was not happy with medicines; I preferred to have the GP listen. I appreciated being given advice without feeling as though I was being judged.*

The themes above were often combined. The following quote includes not wanting medicine, wanting natural remedies, wanting to understand the cause of the problem and querying the role of menopause in emotional distress.

*I wanted to have hormone levels done but the doctor refused. I was very disappointed. I was offered antidepressants instead. I didn't want drugs; I wanted to know why I felt unhappy and tense. I dislike drugs and like to treat things naturally. Being more aware of my body helps me to cope.*

## Discussion

### Strengths and limitations

Self-report is not a perfect measure of medicine use but has been shown to be reasonably accurate as an estimate of prevalence in community samples when compared to biochemical measures (Hancock, Hennrikus, Henry et al., 1991). However, because no clinical measure of psychiatric disorder was used, we cannot make conclusions about the appropriateness of the use of medicines in response to a particular problem. It is not known,

for example, whether those women who were most distressed were the ones who were most satisfied by the prescription of psychotropic medicines. It might be that the women currently using medicines were satisfied with their doctors and did not express negative attitudes to the use or prescription of medicines.

There is also a possibility of bias in the sample, given that non-responders tended to have less than usual social support and increased likelihood of taking sedatives. The latter suggests that the rates of medicine use reported in this study might be an under-estimation of actual prevalence for this cohort. The relatively low levels of social support amongst non-responders is an indication of higher need among this group, further suggesting bias toward the inclusion of high functioning women in the study. Importantly, the high response rate of 81% supports the overall representativeness of the sample.

Consistent with previous qualitative studies (Britten, 1994), participants in this study gave many more details of negative than positive interactions. Yet, when asked directly, half of the women who were prescribed medicines by their GP for this recent episode said that this was very helpful and another quarter said that it was somewhat helpful. While this may be an indication of bias in questioning and reporting, it is also true that people often have a need to talk about an unpleasant experience and, by doing so, make sense of the experience. The positive aspects of the medicines, being taken for granted, perhaps do not need to be discussed. Consistent with this latter interpretation, the comments recorded were usually spontaneously offered in response to neutral questions such as 'Did you talk to your GP?' Rogers and Pilgrim (1997) also reported differing results using qualitative and quantitative methods with the same respondents (users of psychiatric services). They noted that using both methods can bring out some of the complexities in people's experience, with qualitative analysis providing more complex data allowing for ambivalence and mixed feelings.

Overall, this study provides important information about women's concerns and practices regarding the use of psychotropic medicines for common mental health problems.

Few previous studies have shed light on women's experiences and beliefs about psychotropic medicines—beliefs that could interfere with the quality use of medicines.

#### ***Extent of use and types of medicines used***

In total, 55% of women who consulted a GP about their distress reported that they were prescribed medicine to help with this distress. While not directly comparable, surveys of Australian general practice samples provide some comparison: for example, 52% of patients diagnosed with depression or anxiety in a sample of general practices in Sydney were treated with psychotropic medicines (Harris et al., 1996). Given that we do not know if the women in the present sample had a diagnosed condition or not, the prescription rate reported here is relatively high. Indeed, it is likely that the actual use of psychotropic medicines was higher than reported because of the way the question focused on the most recent episode of distress. If a woman had already been taking tranquillisers, sleeping tablets or antidepressants, she may not have identified their use as something she did specifically to cope with this episode.

#### ***Factors associated with use of medicines for psychological distress***

Use of medicines (either prescribed or non-prescribed) to help cope with psychological distress was significantly associated with lower mental health scores and increased negative life-events. Both these factors represent indicators of need, therefore it is not surprising that they predicted overall medicine use. Given that most studies have not asked women about the broad range of medicines, including herbal and natural remedies, these findings provide important new information about medicine use amongst midlife women.

#### ***Factors associated with the prescription of medicines for psychological distress by a GP***

Prescription of medicines by GPs to help cope with women's distress was significantly associated with dissatisfaction with family relationships and having gone through menopause in the past year. Kaufert and Gilbert (1986) similarly reported that problems with family predicted the use of prescribed psychotropic medicines. Notably, some of the

medicines women took for psychological distress are specifically for menopausal symptoms, most particularly HRT and various natural therapies. Further, menopause might represent a trigger point for women to consult their GP, hence increasing the opportunity for receiving a prescription. Even though the numbers here are small, the relationship between emotional health and menopause was a recurring theme weaving in and out of the stories women told as they tried to make sense of their distressing feelings.

***Women's perceptions of psychotropic medicines***

Of the themes that emerged in the qualitative data, some are concerns common to many prescribed medicines (not liking to take tablets, wanting to use natural therapies, unpleasant side-effects and fears of addiction) while others appear to be more specific to psychotropic medicines (they cover up the symptoms and do not solve the problems, an indication of poor care by doctors). This pattern supports previous findings (Britten, 1994). All themes have implications for acceptance of and adherence to medicines, doctor-patient relationships and an effective response to mental health issues in general practice.

***Preference for natural medicines***

The preference for natural medicines reflects the increasing use of natural health therapies including herbal and vitamin therapies in Australia (ABS, 1999). In particular, women aged 45-50 have been found to be the most frequent users of non-mainstream health care (Lloyd, Lupton, Wiesner & Hasleton, 1993). Previous research suggests that community members have more positive attitudes toward the use of herbal and natural remedies for mental health problems than do health professionals (Jorm, Korten, Jacomb et al., 1997). While we do not know the extent to which GPs ask about natural medicines, indications are that they are somewhat uneasy discussing natural therapies with their patients (Pirota, Cohen, Kotsirilos & Farish, 2000).

That natural medicines are largely seen as non-drug, and therefore safe, is part of a larger trend of public confidence in natural therapies. However the safety of these 'natural' medicines is being increasingly challenged as side-effects

and interactions with other (prescribed) medicines are documented (Walter & Rey, 1999). For example it is recommended that people taking St John's Wort (*Hypericum perforatum*), a widely used natural therapy for depression, should avoid prescribed antidepressants (National Prescribing Service Newsletter, 2000). The belief that natural is always better (or at least safer) may indicate an incorrect belief that is amenable to change through education. However those like Benkert, Graf-Morgenstern, Hillert et al. (1997) who think that negative attitudes are 'largely the result of patients having insufficient knowledge about the necessity and efficacy of pharmacological treatment or of unfortunate experiences with psychotropic medicines' (Benkert et al., 1997), and offer patient education as a remedy, are being oversimplistic. Others make a case for greater mental health literacy with the implication that by educating the public (potential patients), people will come to hold the same (positive) beliefs about psychotropic medicines as those held by experts (Jorm, Korten, Jacomb et al., 1997). The situation is more complex than a transfer of knowledge. These beliefs may be part of a larger value orientation, not amenable to logical scientific argument, which may involve complex elements of resistance to modern scientific medicine (Daly, 1997).

***Concerns about side-effects and addiction***

While concern about side-effects is a primary reason for non-adherence to many medicines (Warner, Silk, Yeaton et al., 1994), psychotropic medicines are commonly seen to have more side-effects than other drugs (Benkert et al., 1997). Many women in the present study talked about past problems with the side-effects of benzodiazepines, particularly drowsiness, that interfered with their ability to look after their children. For these women the side-effects were not worth the benefits. One of the reasons people take medicines is in order to have some control over their social situation—family responsibilities or work (Conrad, 1992; Cooperstock & Lennard, 1979). When side-effects interfere with these functions people are less likely to adhere to the advised regime, as evidenced in the present study.

There is a widespread fear of dependency and addiction from many drugs—analgesics, sleeping tablets, medicines for medical conditions such as asthma, as well as legal and illegal social drugs (Horne & Weinman, 1999). While there might be no basis for fear of physical dependency with the newer class of antidepressants, many women of this age are understandably cautious after the, by now widely publicised, benzodiazepine experience. Benzodiazepines were advertised as being safe and non-addictive (as antidepressants are currently). There was little evidence that the women in this study discriminated between different types of psychotropic medicines.

#### *Not a solution*

A strong theme running through the interviews was the perception that psychotropic medicines covered up the problem but did not help the women to deal with the cause of distress. There is a strong belief in the lay community that mental health problems (depression in particular) are caused by social events and that counselling, rather than psychotropic medicine, is the most appropriate treatment (Jorm et al., 1997; Priest, Vise, Roberts et al., 1996). Consistently, women in this study commonly perceived the origin of their problems in their everyday life and social relationships and tended to see it as their individual responsibility to solve their problems. Women also wanted to understand what was happening to them in this stage of their life.

#### *Menopause and psychological distress*

There are conflicting research findings and perceptions amongst doctors and women about the association between menopause and mental ill-health; however, most longitudinal research has consistently reported no association with 'natural' menopause (Avis, Brambilla, McKinlay & Vass, 1994; Dennerstein, Smith & Morse, 1994). In this study women reported negative experiences of being offered HRT when distressed, and of unsuccessfully asking for it to treat distress.

#### *Role of GPs*

It has been said that in writing a prescription for medicine, the doctor shows that the patient's problems have been taken seriously, that there is symbolic value going beyond the effect of the medicine (Henry-Edwards & Pols, 1991).

Prescribing medicine can be seen as legitimising the illness, making it seem real rather than imagined (Garro, 1994). This was not so with most of the women in this study. Women wanted assistance to understand their feelings rather than being prescribed medications that cover up their emotions and problems. Miles (1988) found a similar attitude in women interviewed in the UK. Indeed, there is a large body of literature that indicates that the quality of the doctor-patient communication is the key factor determining patient satisfaction (Buetow, 1995; Lewis, 1994). In situations where antidepressants are required, giving patients the opportunity to discuss side-effects and other concerns has been shown to increase adherence to the prescribed regime (Peveler, George, Kinmonth et al., 1999). Importantly though, doctors are aware of the difficulties inherent in prescribing psychotropic medicines (McGrath, 1999).

The present findings have important implications regarding GP education. With regard to the prescription of tranquillisers and hypnotics in particular, physicians have good theoretical knowledge, but difficulties in communicating this to the patients (Bendtsen, Hensing, McKenzie & Stridsman, 1999). It has therefore been suggested that improvement in the rational use of psychotropic medicines, particularly benzodiazepines, can be achieved by offering doctors education in communication and negotiating skills, and encouraging referral for non-pharmacological treatment (Bendtsen et al., 1999). Our findings further support this approach.

#### *Conclusion*

The present study has highlighted the factors associated with and women's concerns about the use of medicine for psychological distress. The findings suggest that many women do not want to be prescribed medicines by GPs, preferring to discuss their problems. This is not surprising, given that the commonly stated causes of women's distress (family and relationship problems) are not amenable to change by medicines. The increasing prevalence of mental health problems, particularly depression, and the widespread use of pharmacological antidepressant medicines to treat this condition highlight this area as particularly important. In order to achieve the objectives of quality use of

medicines and patient satisfaction, it is imperative that patients' views are better known and acted upon. Studies such as this can inform practitioners of possible reasons for non-acceptance of and non-adherence to prescribed medicines.

### Acknowledgements

Women's Health Australia (WHA) is a national initiative and was conceived and developed by groups of inter-disciplinary researchers at the Universities of Newcastle and Queensland. WHA is funded by the Commonwealth Department of Health and Aged Care. Presently, researchers involved in the project are based at numerous Disciplines, Departments and Faculties in six universities across Australia. The authors also acknowledge the contribution of Associate Professor Margo Schofield in the development of the present study. Professor Jill Cockburn supervised the PhD of which this study is a part, and commented on earlier drafts of the paper. An inspiring teacher, mentor and researcher, she sadly passed away in October 2004.

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