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Exploring Lived Narratives of Antidepressant Use and Withdrawal: A Qualitative Evidence Synthesis

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Abstract

There has been a concurrently growing number of cases of depression coupled with an exponential increase in the prescriptions of antidepressants to tackle the situation all over the world. Even though they are widely used, several people have complained of poor efficacy of these drugs. Wholesome integration of individual experiences with antidepressants as well as discontinuation is unrepresented to a large extent in literature. Mental health nurses are in an excellent position to both facilitate and enhance the use and adherence to medication considering their wide participation in patient care. The purpose of this review was to understand the perceptions of people, who have been prescribed to take antidepressants, the perceptions about the prompting of the drug, the use throughout the day, and the withdrawal. A qualitative meta-synthesis was undertaken based on literature findings following exhaustive search of articles in Ovid MEDLINE, EMBASE, PsychINFO, and Cochrane with latest retrieval in May 2021. The reviewer then used the titles and abstracts to screen purposes, and the full-text utilized two independent reviewers to screen and retrieve data. Thematic synthesis has also been implemented to find out the common patterns and the appraisal of quality has also been done using the already identified criteria. A combination of 27 research articles that included 2,937 subjects were used. Four major themes were identified, i.e., lack of choice in the treatment, stigma of the biochemical explanations of depression, distorted sense of self during the medication taking period, and the difficult withdrawal process commonly called a rollercoaster.

Keywords: ***Antidepressant therapy, depression management, qualitative synthesis, psychiatric nursing, medication discontinuation, patient experiences, mental health practice.***

1.Introduction

Over the past few decades, mental health care in the world has experienced quite a remarkable change especially regarding identification and treatment of depression illnesses. Depression is currently one of the most diagnosed mental illnesses in the world, with an estimation of 3.8 percent of the global population occurring as per the world health organization (WHO). In this increased awareness, pharmacological interventions and primarily antidepressants have become overwhelming in the treatment arena. Prescriptions of antidepressants have skyrocketed in most of the developed nations. To exemplify, the evidence collected in the United States revealed that over 13 percent of adults claimed using antidepressant medication within a 30-day time frame between 2015 and 2018. On a similar note, close to one out of six adults in the United Kingdom received antidepressants in 20172018, and a sizeable percentage of individuals was prescribed with antidepressants to use at long-term. Such tendencies are also replicated in other parts of the Western world, as there has been a strong inclination toward medicalized reactions towards mental distress(1).

Nevertheless, this soaring rate of antidepressant prescription performs alarming concerns about what depression is, which belief is built on the choice of antidepressant, and the actual experiences of the individuals dealing with these drugs. Although the standards psychiatric approach considers depression to be a manifestation of neurochemical imbalances mainly shortage of serotonin and other neurotransmitters, such a theory has been cast into doubt more often. More recent studies have not been able to prove the monoamine hypothesis and this has since been the scientific basis used to justify prescription of selective serotonin reuptake inhibitors (SSRI) and similar medication. Besides, clinical testing has only given the limited evidence to support the effectiveness of antidepressants where a number of studies have shown that antidepressants are not much more effective than placebo when it comes to the treatment of mild to medium instances of depression. However, these drugs still are a fall back in clinical practice and tend to be endorsed in clinical practice guidelines on moderate-severe depressive episodes.

The mismatch between increasing rates of prescriptions and the increasing criticism of the biochemical model highlights an important contradiction in the modern mental health care. It implies a gap between scientific data, practice, and experience of those people being treated. Although there is an apprehension of efficacy and side effects, the medical system usually poses antidepressants as the first, and at times only, line of attack in depression. More often than not, the person in need of dealing with emotional distress is hurried through the process of diagnosis and medicating before having a chance at alternative treatment options or lengthy consultations. This is more alarming, considering the fact that little has been given to the long term effects of antidepressant taking such as possible dependency, dulling of emotions, the physical and mental stress of withdrawal.

Moreover, the framing of depression may hide the socially, psychologically and environmentally multi-dimensional aspects of mental suffering. Instead of taking emotional pain as an acceptable reaction to something that happens in life (trauma, loss, isolation, social-economic pressures, etc.) the medical model usually medicalizes and psychologizes such an experience and makes a person see this state as a symptom of a pathologically functioning brain. Such a model endangers disabling the personal narratives, stigma, and a passive role of the patient, where the process of recovery is related to the compliance with pharmacological treatment but not to the improvement of a person in the sense of enriching of his or her life.(2)

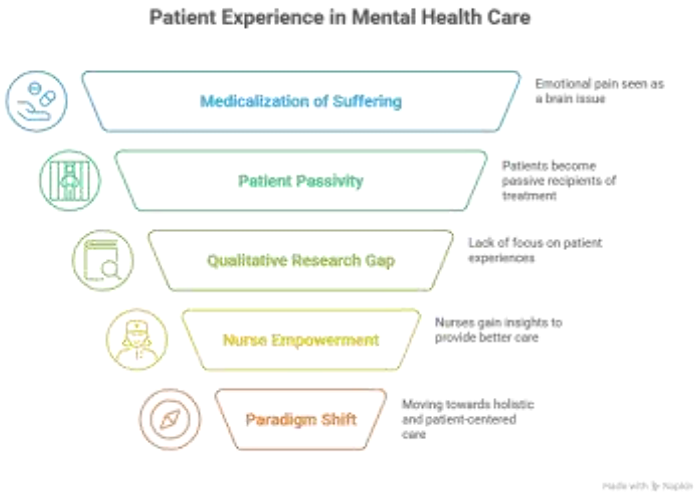

FIGURE 1 Patient Experience in Mental Health Care

The need to discern the opinions of the ones affected by the intake of antidepressants the most, shifts, in this case, the need to understand better the opinion of the patients involved. Even though there exists big-scale research on prescription patterns, adherence rates, and negative consequences, qualitative research that examines experiences of patients is an underrepresented part of the body of literature. Nevertheless, these accounts provide necessary clues to how people experience, fight, tolerate, or assimilate antidepressant treatment to themselves. They illuminate the following question: How do individuals interpret their diagnosis? What are the factors that encourage them to start or quit medicines? Does stigma have a role in their decision-making? And what are their experiences of the emotional, relationship and identity effects of long-term medical use of drugs?

These questions are not the questions of an academic exercise. It has some practical implications of health practitioners, especially mental health nurses, who are usually on the frontlines of provision of healthcare. Although nurses are essential in patient education, monitoring patient adherence and discontinuation support, they are embedded into systems where medication-based organisms are extremely attractive. The knowledge of patient experiences may enable nurses to feel empowered to deliver more detailed, caring, and patient-centered care, as well as to promote more comprehensive care, where psychological treatment, social interventions, and community support are considered.

In this qualitative synthesis by Crowe et al., there is an acute need to get a detailed insight into patient experiences of antidepressant use, initiation, long usage, and the attempts at discontinuation. This review distils recurrent themes and patterns based on a wide range of voices, due to nearly 3,000 participants across 27 qualitative studies in more than 5 countries(3). In this way, it will provide an alternative version of the biomedical discourses that present a significant challenge to the suggestion that drugs are an adequate or effective universal response to

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depression. It stresses the importance of the fact that antidepressants do not fit all and that, in most cases, the process of journeying through drug treatment is a confusing, conflicting, and stigmatizing experience as well.

In short, the introduction of this research sets up an investigative question of the practical implication of using antidepressants in health care practice. It places the debate into a wider context about the reality of depression, short-comings of pharmacological medicine and the necessity of focusing on experience in practice as well as research. With prescription rates steadily increasing, it is increasingly important to turn to the experiences of those who have already crossed this bridge and against their will and express the need to shift the paradigm of mental health care towards the more encompassing, educated and respectful paradigm of care.

2.The Only Option Available

The most striking aspect of the summary of the findings of the qualitative research about the use of antidepressants is the feeling that in case of many people antidepressants are not an option among several possible possibilities but it is rather a default or even a unique solution that may be proposed when one addresses the help in face of depression. In many reports, the direct contacts with mental health services were reported by the individuals to be clinical ones where even seemingly right care delivery process would be around quick medicalization of their emotional distress and typically, with little time to discuss, explore other options of intervention, or co-decide interventions. This tendency was particularly seen in cases when the people were applying to the medical workers when they were in the state of acute crisis, overcome by emotions, or in the psychological collapse. During these times of extreme vulnerability, individuals were often being influenced into taking the advice of starting medication not due to any strong belief of its usefulness but through desperation and being in need of a quick solution. It was a popular story that antidepressants are the life raft in the turbulent water. This acceptance could however be marred with ambivalence since people were forced to accept the medication without an in depth towards its implications, side effects as well as effects(4).

Most participants remembered consultations which did not seem to get to the pain of emotional experiences, which were being seen as hurried or routine. One of the common themes throughout these descriptions was that clinicians did not have the time to listen to the underlying sources of their discomfort, whether that was some form of trauma, interpersonal conflict, chronic stress, and socio-economic difficulty, but they consulted diagnostic checklists and symptom inventories to define a plan of action. This procedure usually ended up in a prescription of antidepressant drug which was given as the main solution of the intricate emotional distress. Patients were disgruntled and disappointed that very little chatter was done about the alternative treatment methodologies, including counseling, lifestyle interventions, peer support or non-medical coping mechanisms. Some stated that they felt intimidated to agree with the prescription or risk not getting future care and some even stated that they felt pressured. Under such circumstances, the threat of denial of treatment instilled a feeling in the individuals that they have a dilemma; to accept the medication or put themselves at the risk of not getting a chance of accepting the medication again. The experience of such encounters served as a source of long-term disempowerment as patients reported that they were not consulted about their own capabilities in assessing their mental health and ability to be in charge of decisions impacting their treatment.

The second aspect of this experience of one path only was the lack of follow-up or planning of care in collaboration after initial prescription. Several respondents have reported that after getting on antidepressants, they were not consistently checked up on and advised in gauging the effectiveness of the medicine being administered to them. Rather, medication may have turned into a permanent part of their treatment regimen inadvertently than intentionally. Without explicit communication over the aim of treatment, its timeframe or other resources, antidepressants became some sort of permanent cure instead of a short-term support. This fixed form of treatment made most people feel that their needs have been over generalized. Their inner battles, whether highly personal or based in the context of their life was simplified as neurochemical imbalances that could be corrected, a conception that became more and more inadequate or dehumanizing over time(5).

Also of interest was the fact that not every participant had a negative attitude towards antidepressants; some reported their positive effects in regards to early relief or stabilization of mood symptoms, especially in the aftermath of a psychological crisis. To the patients who had been experiencing constant sorrow, anxiety, or even emotional turmoil, the drug offered a feeling of order, calm or even hope. Nevertheless, such advantage was usually accompanied with reservations. Many of the participants discovered that the improvement of their symptoms was not grounds enough to state that they were healed or that their life issues were resolved.

Antidepressants, by suppressing the emotional storm did not deal with the incomplete trauma, relationship disorders or existential problems. Others started to doubt that the drug was assisting them to evade their issue of facing painful yet important realities. It created an uncomfortable insight: that the actual care that they were supposed to be getting in order to heal them was somehow causing emotional stagnation or even suppression in certain patients.

In the background of this theme, one of the most troubling among them is the apprehension that the drugs are not applied to treat the condition but to hide the symptoms. A number of these people referred to the way they have felt their pain being numbed or covered up rather than being examined and comprehended. It was coupled with the feeling that antidepressants are the simplistic solution to the complex problem and are more like a bandage on the gaping wound(6). This group of people did not discard medication completely but told me that they would like it to be part of a more comprehensive, individual approach toward treatment. Sadly most of them found that this integrated care was not readily available particularly in the overstretched governmental systems where doctors are under pressure to administer pharmacological remedy as the most efficient approach.

In such setting, the participants encountered critical obstacles to display personal preferences or promote their treatment course. Others even referred to being termed as non-compliant or difficult after they asked questions regarding the necessity or what the medication would do to them. Some others learnt that they were not serious about their mental health when they said that they did not want to take antidepressants. This process even more solidified the notion that antidepressants were more than an option among options but a morally charged duty, something a person had to accept as an alternative in order to be called a valid, responsible patient. Ironically, this sabotaged the empowerment and self determination that are key bases of resonant mental health care.

In brief, the theme of that being the “only choice that exists” encompasses a common phenomenon where antidepressants are marketed not as a cooperative approach to care, but as one, single and predestined solution, which may be offered swiftly, authoritatively and without much questioning exercise. There are people who embraced this course because they needed or hoped to do so, and there are others who came to believe that they had been deprived the opportunity to gain a more satisfactory account of what they really wanted, and instead had had their experience translated into a biomedical framework that could not reflect the complexity and depth of their emotional lives. It is this mismatch between provider expectations and patient expectations that has resulted in persistent ambivalence, low trust, and in most instances permanent dissatisfaction over care. There is an audience to these studies, and it speaks to the necessity to reconsider the cultural norms of default prescribing and undertake a more pluralistic approach (patient-centered and narrative-focused), validated by patient stories and emphasis on the possibilities of non-pharmacological routes to recovery.

3.Methods

In order to adequately investigate the lived experience of subjects using antidepressants, the researchers embarked on meta-synthesis of qualitative studies, where they intended to discover common themes and patterns in the experience that would cut across various populations and settings. Such an approach was selected because of its power to synthesize and reinterpret previous qualitative studies and, therefore, it was able to go more in-depth into the issues than the separate studies would provide. The meta-synthesis was done according to the recommended guidelines by the Cochrane Collaboration, namely, by referring to the framework proposed by Noyes et al. (2020), and the meta-synthesis procedure was registered on the PROSPERO database (registration number 257513) with an indication of its transparency and the level of methodological quality.

3.1 Strategies of Search and Identification of Literature

The search of the literature was implemented in a direct and thoughtful manner to find all topical studies published in earlier times until May 2021. The researchers engaged the services of an experienced medical librarian to come up with a specific search algorithm that would retrieve qualitative literature about the personal experiences of taking and stopping antidepressants. There are four large electronic databases were investigated it is Ovid MEDLINE, EMBASE, PsychINFO, and the Cochrane Library. The underlying criteria of the choice of these databases were the broad scope of health, psychology, and evidence-based medicine related literature. The keywords used in the search also included controlled vocabulary. The key words were antidepressants, SSRIs, and more general terms of antidepressants medication, combined with words signifying qualitative investigation, namely, qualitative research, qualitative methods, narrative, and interviews. The restriction criteria that were

implemented by using the Boolean operator made sure that only those studies were extracted which did not only address the focus of antidepressant but also the qualitative research methodology.

3.2 Inclusion/ Exclusion Criteria

A rigid list of eligibility was created to help in the selection of studies in the synthesis. Peer-reviewed journal articles written in English were only taken into consideration since 1987 and the latest by May 2021. The selection of the year 1987 as the beginning of an era was associated with the rise in the global prescribing of SSRIs and the establishment of the direct position of antidepressants as a leading treatment scenery. The studies that needed to be included were those based on qualitative design and included adult samples of the population, namely, 18-65 years old. This age limit was not an accident but an attempt to include only the cases with characteristics that are not specific to children, teenagers or elderly patients, as depression in these groups usually has some peculiarities to it developmental, cognitive, and comorbidity issues which would complicate the analysis. To ensure that the focus of the literature review was well kept on individual lived experience, only studies highlighting patient narratives and perspectives were amassed(7). Research that was mixed methods and failed to report the qualitative data and separate it and research that only targeted pregnant/postpartum women, conference abstracts, editorials, systematic reviews, and grey literature, including those in the form of dissertations, were excluded.

3.3 Selection Procedure and Screening

The process of choosing the studies occurred to follow a two-stage screening procedure. First, all titles and abstracts (n = 236) were looked through by one researcher and duplicates (n = 2) and obviously irrelevant records excluded. Out of this initial screening, 188 records were retrieved consisting of 48 records that were identified to be retrieved in full text. During the second step, two independent reviewers reviewed the full-text articles based on the eligible criteria set. Judgment conflict would be solved by discussion and agreement. Out of 48 studies that were found, 21 were discarded due to various issues such as unavailability of patient-centered data, inability to match the criteria of a qualitative study, or they targeted a population not in the desired age group. In the end, 27 studies involving a total composite of 2,937 participants were included in the synthesis. Significantly, a single study represented more than half of the sample (n = 1,747), but without any minimal sample size limit (small to large).

TABLE 1 Methods

Category	Details
Study Design	Meta-synthesis of qualitative studies
Databases Searched	Ovid MEDLINE, EMBASE, PsychINFO, Cochrane Library
Search Period	1987 – May 2021
Inclusion Criteria	Adults (18–65), qualitative method, English, peer-reviewed publications
Exclusion Criteria	Children, elderly-only, postpartum, mixed-methods (without separate data), grey literature
Total Studies Included	27 qualitative studies
Total Participants	2,937 individuals (70% female)
Appraisal Tool	CASP (Critical Appraisal Skills Programme) checklist
Synthesis Method	Thematic synthesis (Thomas & Harden, 2007)

3.4 Assessing Quality, and Credibility

After the process of selecting the articles, the methodological quality of each study was assessed with the usage of the Critical Appraisal Skills Programme (CASP) qualitative checklist, one of the most commonly used tools to evaluate the credibility of qualitative studies. Some of the important areas evaluated in the checklist include clarity of the research purposes, suitability of the methodology employed, recruitment plan, data collection process, relationship between researcher and the research participant, ethics, quality of the data analysis and the value of the results. All studies reflected basic methodological strength, yet not all of them were clear on the nature of the relationship between the participants and the researchers, and a few also failed to report on how they respectively obtained ethical approvals. However, the literature was not discarded, as this was to guarantee representation

across the world and the worldviews in question. The ability to cover variations in qualitative approaches applied in the chosen studies even enhanced the range of the synthesis that ranged between grounded theory, thematic analysis, constant comparative method, narrative inquiry, and discourse analysis.

3.5 Data extraction and Coding

The extraction of data was done thoroughly and salient data of every study were neatly placed in structured data tables. These also comprised country of origin, sample size, gender of participants, qualitative method employed, specified objectives and primary results. The structured comparison of the themes became a possibility due to this extraction and allowed determining consistent patterns between geographically and methodologically various research studies. Received qualitative results were the expressions of the participants, as well as the personal meaning of the authors. After that, these data were imported to a thematic synthesis framework with the next level of analysis.

3.6 Thematic Synthesis Approach

Thematic synthesis, which was the central part of the analysis and which can be found described in a work by Thomas and Harden (2007), is about the possibility to accumulate findings made in various studies where the qualitative methods are involved, and at the same time be able to create a new layer of interpretations. This approach includes three steps: (1) a line-by-line coding of textual information (both quotes of participants and interpretive summaries), (2) formulating descriptive themes (a grouping of codes), and developing analytical themes that will go beyond the scope of the original studies. Thematic synthesis is particularly applicable in studying the psychosocial phenomena that might be complicated, such as the usage of antidepressants, wherein a wide range of subjective experiences need to be abstracted into thematic image collections.

The researchers concluded their research process with the synthesis of coded data, which resulted in four major themes (1) no alternative available but antidepressants, (2) stigma of the so-called biochemical deficit model, (3) a feeling that it makes me an opposite person, and (4) vicious circle when people attempt to quit acutely on medication. These themes were the similar emotional, psychological and relational characteristics, which were re-occurring in the various narratives of participants, which provided the wider implications of antidepressant therapy in both an individual and the context of the healthcare system as a whole.

4.Results

The findings of this qualitative synthesis provide deep and multifaceted understanding of the experiences of lived by people prescribed antidepressants and reach quite a broad spectrum of emotional, psychological, and relational reactions. Among the 27 studies used, which represented 2,937 individuals and 10 different countries, including UK, Netherlands, New Zealand, the USA, Australia, Denmark, Canada, and Malaysia, four main thematic stories were revealed: the sole treatment available is antidepressants, stigma is associated with the biochemical basis of depression, the loss of identity as a biochemical subject in the event of withdrawal, and the condition of the drug cessation. These strands entwined to make a true picture of how individuals manage the use of antidepressants, particularly, when placed within clinical traditions that tend to naturalize distress and constrain therapeutic options.

4.1 The Only Method of Treatment: Antidepressants

There was a prevailing theme among most studies showing that there was an unspoken message that antidepressants were not one among many but an avenue that was availed to people when they sought emotional relief. Most participants remembered having the feeling that their symptoms were quickly diagnosed through a medical perspective, and as a result of those suspicions, their medications were prescribed quickly without further discussion of their background, the circumstances, and their individual taste. Some people fell under this pressure of urgency or despair, at least when it comes to psychological crisis sessions, and they took the medication hoping to end the intense pain as soon as possible. Nevertheless, this adherence was frequently wandered by angst because many claimed to be given no alternative such as counseling, shared support, or even fairly informative discourse on what the drug would or would not accomplish. Quite a number of them reported feeling their clinical experiences as time-pressured and impersonal with the process being transactional instead of being collaborative. Others claimed to be treated like a patient, with the doctors using standardized checklists or symptom scores, unrelated to the nature of their experience. In worse cases, they would be compelled to take drugs onceEveryone was made to feel obliged to take drugs on risk of being refused or denied any other intervention that could help them- i.e. psychological therapy.

4.2 Stigma the Biochemical Explanation

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The second topic of this scale was internalization of stigma itself, based on the phenomenon of the so-called biochemical deficit as the cause of depression. As noted by the participants, they were frequently conveyed the message that their emotional difficulties were caused by the neurochemical imbalance, in the form of either deficiency in serotonin or other neurotransmitters. Although this model may initially have been reassuring, it was in the end a model which led to the belief that there was a difference and defectiveness. And there are a lot of people who related to this explanation and felt broken or flawed in a way. When presented in favor of the biologically abnormal model of psychiatry, chemical imbalance story turned patients into biologically second-rate and requiring lifelong pharmaceutical guidance. This perception mostly compromised individual agency where the interviewees said that wording bred passivity, reliance, and even embarrassment. Medical discourse was not always consistent with a personal experience of depression, which introduced a cognitive dissonance between medicialized identity and socio-emotional events including grief, relationship antagonism, or existential angst that people ascribed their own sufferings to. Therefore, it is not uncommon to find stigma against the participants not only externally, but also internally because they had difficulties in trying to come to terms with this forced classification of mentally ill.

4.3 Emotional Flattening and Identity Disruption

The second experience that left a lot of participants greatly embarrassed was the feeling of intense change in the sense of self during antidepressants administration. Although others initially feel the release of emotional extremity, the overall experience of medication may be reflected as emotional anesthesia, emotional sterility, reality apathy and absence of genuineness. They often described themselves on being numb, flat or hollow. Not only did they experience a diminishment of the painful reactions, but in the joyful and enriching features of the emotional life as well, in the expression of joy or creativity, passions, or even the capacity of crying tears. This flattening did not occur in all aspects of life and it only occurred in interpersonal areas. Numerous of them claimed that they became unavailable emotionally to their relatives and friends, less empathic, or lost their interest in social life. To some, this shift was minuscule; to others, that was spine-chilling and scarily disturbing. They wrote about a mismatch between the way they were remembering themselves before using medication and the people they felt they had become--salty and even grief over their pre-self. Such experiences presented patients with dilematic issues: although the antidepressants relieved some of the experience of depressions they seem to also reduce the essential elements of personality, identity and relatedness.

TABLE 2 Results

Theme	Description
1. Antidepressants as the Only Option	Participants often felt medication was the default or only treatment offered, especially in crisis.
2. Stigma of Biochemical Explanation	Being told they had a chemical imbalance led many to feel defective, increasing internalized stigma.
3. "Not Myself" – Emotional Disconnection	Long-term use led to feelings of numbness, emotional flattening, and a loss of personal identity.
4. Vicious Cycle of Discontinuation	Attempts to stop medication often caused distressing withdrawal symptoms, reinforcing continued use.

4.4 Vicious Cycle of Discontinuation

Lastly, a differential theme appeared that focuses on the difficulties of discontinuing medication used in antidepressants. Numerous of the participants, who had indicated that they wanted to end it, got in this so-called vicious cycle. The first efforts to withdraw medication often provoked extreme withdrawal effects, which could include dizziness, fatigue, feelings of nausea, brain zaps, as well as emotional instability, in the form of irritability, anxiety, or panic attacks. In other instances, the symptoms were worse than the previous instances of depression, which prompted them to seek treatment. The withdrawal effects were usually so hard that one would develop the fear of being discontinued yet he or she would want to stop using medication. The absence of understandings and advises given by medical experts aggravated the situation. A lot of respondents said that their prescribers did not even mention about the possible occurrence of withdrawal symptom or they gave advice that was too simple e.g.

stop the medication or cut it in half without proper tapering regimens. Some were found to have been misdiagnosed where withdrawal symptoms were observed as a relapse causing resumption of or escalation of prescriptions. Such cycle made the patients feel entrapped since they felt that they have to take medicine not because they think it would help them but because the side of not taking it seems more scary and unforeseen.

4.5 Reflection of the Trend on the Four Topics

Looking at these four themes, there is a certain pattern of emotion that can be observed by many people who start using antidepressants, and that is being hopeful or trustful in the expert opinion of doctors, feeling increasingly ambivalent, emotionally disengaged and frustrated, and eventually trapped. Despite the claim that some people had truly benefited during medication, particularly at the acute phases of depression, the chronicle of the stories over a long span of time was characterized with twists that could not be maintained within the confining forms of antidepressants as miracle versus ineffective drugs. What was created instead was that of a gray picture, where individuals struggled with conflicted emotions, unfulfilled needs, and a lack of control in a system that encouraged a pharmacological approach rather than patient-centered treatment.

5.Conclusion and Future work

In this general synthesis of qualitative studies, a complex and concerning picture of the phenomenon of experience of using and abandoning antidepressants emerges. The stories of the participants, representing different cultural and medical environments, reflect very similar perspectives of landscape of treatment practices, which happened to be the medical model, viewing depression as a result of neurochemical implication and antidepressants as the main remedy. Although symptom reduction and temporary functional gains were noted by some users, emotional flattening, confusion of identity, stigma, and an usually paralyzing medication dependence was experienced by many users. These testimonies point to a persistent contradiction between clinical privileging of a more reductionist way of talking about depression and, on the other hand, lived depression. The one thing which stands out in these stories, however, is the inability of antidepressants, though useful in certain cases, in many times touching on delivering on the psychosocial, relational, and existential causes of the distress. Rather, they threaten to pathologize emotional hurt and to deprive it of the subjective meaning by making it an issue of biological dysfunction.

One of the main points of this synthesis is the realization that such an act as seeking help to overcome depression is not only a medical transaction; it is a very human act that can and should be perceived as empathic, curious, and open to complexities. But to most of the participants, first contact in clinics also came with the initiation of a narrowtherapeutic direction, where antidepressants were not presented as one of the potential helping means, but as the only possible, or even the necessary step. This eroded the capacity of the individual to make empowered choices on their care. Many felt that they were oppressed to be heard or believed when they doubted the reasoning of medication or when they wanted to consider alternatives such as psychotherapy, peer support group, lifestyles changes or whatever. With this type of system, mental care is no longer healing space but compliance space- where patients are forced to conform to biomedical story to be eligible to receive care. It is possible that this process can propagate subconscious feelings of helplessness and dependency, instead of injection of hope, autonomy or agency.

The biochemical explanation of depression is also important as the definition that shapes the identity as well as the social perceptions. Although this story is highly encouraged to lower the blame and raise help-seeking, it can indirectly become a source of stigma where people are viewed as biologically impaired or permanently ruined. The stories provided within the reviewed articles prove that this message is internalized by a great number of people and they feel inferior, ashamed, or worth nothing. The explanation also refocuses the individual as an active agent in his or her recovery to one practicing passive receipt of correction, which itself presents a theoretical dilemma in the context of care models defined by recovery, empowerment, and person-ends approaches to care. In addition, it does not appeal to the people who think that their suffering is a rational, even a motivating reaction on the life misfortune, rather than the result of a neurochemical disorder. Through this, the biochemical model might not only assist people in making coherent and caring stories about their suffering.

Perhaps the most alarming of them all is the repeated cases of reports of improper preparation and assistance when one tries to quit antidepressants. They were not carefully weaned out of the substance as is the recommended practice, but instead many received poor or even flawed information and this exposed them to crippling withdrawal effects. On many of them, such symptoms confused the clinicians into believing that they experience a relapse and

consequently re-prescribed people and made them even more dependent on medicine. This process, the so-called vicious cycle, proved to be especially demotivating because it caused people to remain in the treatment regimens, which they no longer wished or did not see much use in most cases. The lack of formally established procedure of discontinuation or awareness of the withdrawal, as a valid physiological response that should not be ignored and deserves the necessary attention by policymakers and clinical educators, is a significant gap in mental health service delivery. Patients have not only the right to treatment, but also they have the right to safe and supported means of ending treatment when and where the patient needs it.

The collection of these facts questions the widespread assumption that antidepressants are a safe, universally suitable or a unique effective cure of depression. Rather, they indicate the significance of providing a wider range of care, which contains psychological therapy, social interventions, lifestyle-based approaches, and even spiritual and existential perceptions of emotional mental anguish. The existence of such a model would only impose a cultural change within mental health systems and would replace biomedical reductionism with holistic, pluralistic, and relational views of the matter. By this, it does not imply discontinuing the use of medication, but instead, it means putting it back in its place, which is one of the options that are available to address this issue, and whose advantages, drawbacks, and risks ought to be communicated clearly to recipients of their care.

Lastly, this synthesis has some implications that are beyond the individual clinical encounter. They demand a complete change of the system in how we think about, finance and provide mental health care. The training programs should learn arguments to prepare healthcare providers with the skills and attitudes that can help patients toward diverse recovery paths. Any form of public health communication needs to stop seeing more complex domains of life as packaged chemical packages and instead opt into a more wholesome picture of the life of the emotions. Funding of research should focus on measuring the effects of multi-modal intervention that combines or incorporates medical, psychological and community supports. And most importantly, those with depression should also be heard; not as patients to be handled, but as individuals who have so much to describe about the negatives and positives of modern day psychiatric care.

To sum up, although antidepressants have long provided certain relief, the overuse of the pills and the cultures of clinics devoted to them has provided little help to meet the needs of the entire human condition. This synthesis lets be heard the experiences of people who have been marginalized or flattened in the prevailing medical discourse. We are presented with the well-written stories that allow us to re-conceptualize depressions as something more than a chemical deficiency that needs correction and instead, that this is a deeply human situation that requires one to understand, empathize, and choose. It is through listening, and listening with care, humility and no agenda, that we finally have a chance to build a system of care that cures not just symptoms, but people.

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Conflicts of interest

The authors have no conflicts of interest to declare

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