

Patient-Reported Barriers To Antidepressant Adherence Among Young Adults With Major Depressive Disorder: A Narrative Review

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Abstract

Major depressive disorder (MDD) is one of the most common causes of disability in young adults globally, and antidepressant drug therapy is a first-line treatment for moderate-to-severe cases. Although antidepressants are effective, rates of non-adherence are significantly lower in older adults compared with non-adherence in younger adults (ages 18-25 to 18-35 years), with early discontinuation of treatment reported in up to 50% of younger adults after the first 6 months of treatment. This narrative review aims to summarize the patient-reported impediments to antidepressant adherence specific to young adults, based on qualitative, cross-sectional, and systematic review studies published in PubMed, Scopus-indexed journals and PLOS/BMC/Frontiers platforms. Six domains of barriers are identified: (1) intolerable and stigmatizing side effects, particularly sexual dysfunction, weight gain, and emotional blunting; (2) negative beliefs about the necessity to take psychiatric medication, dependency, and the “chemical imbalance” explanatory model; (3) internalized and social stigma associated with taking psychiatric medication during a developmentally identity-forming period; (4) inadequate patient-provider communication and limited shared decision-making; (5) structural and logistical barriers, including cost, insurance discontinuity, and appointment access, which disproportionately affect young adults transitioning out of their parents' coverage and pediatric care; and (6) developmental factors unique to young adulthood, such as symptom-driven self-discontinuation once feeling better, competing life transitions, and low engagement with routine follow-up. Considerations for clinical practice and methodological limitations, such as the underlying evidence base, including the heterogeneity of adherence measurement and the lack of studies limited to a narrow age range of 18-25 years, are discussed. Findings agree with multi-level adherence interventions, which are tailored to each child's developmental level, rather than single factor.

Keywords: Antidepressant adherence; major depressive disorder; young adults; medication non-adherence; patient-reported barriers; stigma; treatment discontinuation

1. Introduction

Major depressive disorder (MDD) is a prevalent and disabling psychiatric illness in youth that has been increasing in prevalence over the last 30 years. The GBT 2021 study found that the number of people experiencing depressive disorders aged 15–39 years jumped from 96.7 million in 1990 to 158.7 million in 2021, representing a 62.9% increase, and disability-adjusted life years (DALYs) increased by 60.5% between 1990 and 2021 [9]. Complementary symptom-based analyses of the adolescent and youth population (aged 10-24) also show an increase in the incidence, prevalence and DALY burden of MDD, although relative increases tended to be greatest in the 20-24 age group [10,11]. National surveillance data in the United States showed prevalence of depression increased to 13.1% of youth and adults in 2021-2023 from previous estimates and was more common in younger age groups [12].

Antidepressant pharmacotherapy, particularly selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs), continue to be the mainstay of MDD treatment. The therapeutic effect of these agents, however, relies on their correct and continuous administration over a sufficient period of treatment and non-adherence will reduce the therapeutic effect at a population level. Low adherence rates for antidepressants have been reported and generally fluctuate between approximately 10% to 60% depending on the definition and measurement used, with many patients prematurely discontinuing antidepressant treatment: up to 50% of patients reported prematurely discontinuing antidepressant treatment within six months of starting treatment [1,7]. Early discontinuation is not a harmless event, but is correlated with symptom relapses, symptom recurrence, higher frequency of emergency room visits, hospitalization, higher risk of suicide, and significant direct and indirect economic burden of health care systems [1].

Mature adults are a populace of specific concern with regard to antidepressant non-adherence. Data from the cross-sectional surveys indicate that low adherence rates to SSRIs are exaggerated in patients aged <35 years as well, and some studies report rates >50% in these age groups [22]. These increased vulnerabilities are likely related to a combination of developmental,

psychosocial and structural factors which are unique to young adult populations: psychiatric diagnoses and medication use may be more stigmatizing in young adulthood, insurance coverage, housing and healthcare setting may be a frequent and recurring issue, and side effects may be more salient to youth specifically, for example sexual dysfunction and weight gain, which may be more of a factor in treatment decisions than in older adults [6,19,22]. These barriers as reported by the patients, rather than as inferred by clinicians or administrative data should be understood to develop adherence support interventions that are acceptable and effective for this age group.

2. Methods

This is a narrative review and not a systematic review and/or meta-analysis. Literature was identified by structured searches in PubMed, journal platforms indexed in the Scopus database (PLOS ONE, SAGE journals, Frontiers, BMC, Springer Nature and ScienceDirect), combined with citation tracking of important qualitative and systematic reviews concerning adherence to antidepressants. The search terms included a variety of combinations of the words "antidepressant," "adherence," "non-adherence," "discontinuation," "barriers," "young adults," and "major depressive disorder. Qualitative studies that directly asked patients about their experiences of barriers to antidepressant adherence, systematic literature reviews on antidepressant adherence and side-effect burden, studies of a young-adult sample or young-adults as a subgroup, and valid adherence-measurement literature relevant to interpretation of the underlying evidence were prioritized. Given the relative dearth of literature specifically focusing on an 18-25 age group, the review also considers studies of general adult MDD populations that report age-stratified results or have results that could be conceptually extrapolated to the young adult population.

3. Epidemiological and Conceptual Context

Conventional definition of adherence is the extent to which a patient's medication-taking behavior matches the prescribed regimen agreed to with a healthcare provider, including initiation, implementation (correct dose and timing), and persistence (continued adherence over the intended time period). Failure to take an antidepressant drug may thus be seen as late initiation, missed doses or reduced doses, periods of drug-free treatment and full premature withdrawal. Insight, perceived health benefit, routine, patient-provider relationship, reminders, and social support were identified as barriers in a widely cited qualitative study among outpatients with MDD, and logistical and social-cultural barriers were found to be facilitators [1]. These five domains (plus developmental) framework will be used to structure Section 5 of this review, with an extra domain to include factors specific to the young-adult developmental stage.

For this literature, patient-reported adherence measurement is a methodological precondition. Among the validated self-report instruments used across the studies reviewed here, 5-item Medication Adherence Report Scale (MARS-5) had acceptable internal reliability (Cronbach's alpha) ranging from 0.67 to 0.89, and test-retest reliability of 0.97 in the original sample for validation, while the 8-item Morisky Medication Adherence Scale (MMAS-8) showed good internal consistency (alpha = 0.697) and high test-retest reliability ($r = 0.940$) in a Persian-language validation study of hypertensive patients [13,14]. They are widely used in these instruments in psychiatric samples, but cross-population validity, especially in young psychiatric samples with these instruments, has not been studied extensively enough.

4. Patient-Reported Barriers to Antidepressant Adherence

The barriers described below are drawn from qualitative interview studies, cross-sectional surveys, and systematic reviews in which patients themselves -- rather than clinicians or chart abstractors -- identified reasons for reduced or discontinued antidepressant use. They are presented thematically; in practice, they are interacting and cumulative rather than mutually exclusive.

4.1 Intolerable and Stigmatizing Side Effects

Medication-specific adverse effects are consistently reported as one of the strongest proximal barriers to antidepressant adherence. A systematic review of the association between antidepressant side effects and adherence in adults with depressive disorder revealed that there was a correlation between these two across all of the studies included, with agitation, anxiety, gastrointestinal disturbance, sexual dysfunction, sleep disruption, dizziness, and headache being commonly reported adverse

drug reactions associated with reduced adherence, whereas dry mouth, constipation, sedation, and weight gain were adverse drug reactions commonly reported with tricyclic antidepressants and associated with increased adherence [5]. Although side effects were not always a reason for stopping the treatment, they were reported as detrimental to patients' quality of life and often were a contributing factor to sub-optimal dosing as physicians lowered the dose to maximize tolerability, extending the depressive episode [5]. Side effects of particular interest in young adults are sexual dysfunction. When asked, in a cross-

sectional survey of young adult men (the YAMAN study) [6,22] about which side effects of antidepressant medications they experienced at least once a week, those who reported having had erectile dysfunction with antidepressant medication, anorgasmia with antidepressant medication, or low libido with antidepressant medication reported these side effects at almost the same frequency (71%, 71%, and 70%, respectively). The same study found that, after exposed to common side-effect profiles, the young adult participants were significantly more likely to report intentions to continue taking sexual-function-sparing agents, bupropion or mirtazapine, than SSRIs, highlighting that side-effect profile plays an active role in shaping prospective adherence intentions beyond its role in retrospective adherence discontinuation [6]. In related survey studies of patients who self-reported depression, antidepressant-induced sexual dysfunction has also been identified as one of the most common adverse effects leading to antidepressant discontinuation and to a decrease in quality of life, and patients may try managing their sexual dysfunction on their own, for example by adjusting dose or discontinuing the drug before communicating with the prescriber [20,21]. Other symptoms that cause adverse effects that patients consider when determining whether to use the medication or not are weight gain and fatigue; studies indicate that patient expectations may be improved by being directly asked about expectations and by preferentially prescribing drugs with fewer side effects on weight gain, sexual function or sedation [20].

4.2 Beliefs about Medication, Illness, and Dependence

Beyond directly experienced side effects, patients' underlying beliefs about antidepressants shape adherence independently of clinical variables. Analyses of patient-generated drug-review data found that non-adherence is only weakly associated with personal and clinical variables but strongly associated with patients' beliefs and attitudes toward medication, including perceptions of necessity, fear of dependence, and beliefs that medications are overprescribed or harmful [1]. In the qualitative study by Ho and colleagues, negative attitudes -- defined as patients' emotional responses toward MDD and its treatment, including a basic dislike of taking pills -- emerged as a distinct barrier theme separate from concrete side effects [1]. Fear of dependence or addiction to psychiatric medication, concern about long-term use altering one's personality or sense of self, and a belief that psychological rather than pharmacological approaches are more "authentic" solutions to depression have all been reported in qualitative syntheses of patient experience [1]. A qualitative synthesis of antidepressant use and discontinuation experiences further noted that many patients' explanatory models of depression are better aligned with a diathesis-stress framework than with a purely biomedical "chemical imbalance" model, and that biogenetic explanations, while intended to reduce blame, have been associated in some studies with increased stigma rather than decreased stigma [19].

4.3 Stigma: Internalized and Social

One of the more consistent replicated barriers across cultural contexts is stigma -- either experienced (anticipated) or internalized (self-stigma). The authors themselves pointed to this counterintuitive finding, noting that perceived stigma predicted treatment discontinuation only in older outpatients in this early study, which would suggest a role for perceived stigma beyond being simply a correlate of illness severity, but rather a determinant of adherence; thus, the authors recommended additional research to understand the role of perceived stigma across the adult lifespan, even in younger individuals [2]. Literature review of qualitative work carried out among Malaysian MDD outpatients identified that stigma would be a factor that could deter adherence due to the lack of convenience and discomfort in taking medication in front of friends, patients had to keep their diagnosis confidential and family members would actively discourage medication use for a longer period of time; literature review of qualitative work done showed that stigma imposed on mental illness could create a strong desire to discontinue continued use of antidepressant medicines as soon as possible, independent of clinical response [1]. Antidepressant use was perceived as a sign of more serious illness, weakness, or an inability to cope with stressors of life, and this was stronger among Latino patients than among any other group, with fear of social consequences and conflict with cultural values that promote self-reliance adding to this impression [3,4]. Stigma-related barriers reported in these general-adult samples are likely exacerbated -- although not necessarily exaggerated -- in younger cohorts, as young adults tend to be developmentally more attuned to how they are perceived by peers and society and are more focused on developing a sense of identity.

4.4 Patient-Provider Communication and Shared Decision-Making

This module examines how effective communication between patients and providers contributes to creating a shared vision and the importance of shared decision-making. Another consistent barrier domain is healthcare-provision and system-related factors, such as insufficient patient education, lack of shared decision-making, visit duration and lack of follow-up continuity [1]. Past studies on SDM to treat depression in primary care identified that while patients felt they should take an active role in the primary-care depression management process, they also wanted to have the final say on the intervention they would receive, and that trust between the patient and provider was a key prerequisite for SDM to be effective [15]. The same body of research, however, noted that SDMs practices in routine depression care are neither consistently nor regularly used,

and that while SDMs interventions are consistently and reliably associated with increased patient knowledge and involvement, evidence of their direct association with increased adherence and symptom outcomes is less consistent [15]. There is a cluster-randomized controlled trial of an SDM intervention in primary care which did not increase consultation time, but did lead to a significant improvement in patient-rated involvement, physician-assessed adherence, and patient satisfaction, and a non-significant reduction in depression severity beyond usual care [17]. These texts together indicate that the quality of the therapeutic relationship and how patients feel they are truly engaged in deciding on treatment are provider-level factors that can be changed to increase adherence.

4.5 Structural, Logistical, and Economic Barriers

Logistical and structural barriers -- including cost of medication, insurance coverage gaps, transportation to appointments, the need for repeated clinic visits for prescription renewal, and difficulty navigating a fragmented mental healthcare system -- have been repeatedly identified as barriers distinct from, and additive to, patient attitudes and side effects [1]. These barriers are disproportionately salient for young adults, many of whom are navigating transitions out of parental insurance coverage, pediatric-to-adult care handoffs, unstable early-career employment, and first-time independent management of prescriptions and refills without established routines. A study examining sociodemographic determinants of psychiatric medication non-adherence among adults experiencing homelessness -- an extreme but illustrative case of structural vulnerability -- found that employment and insurance status were independently associated with the odds of depression-medication non-adherence, underscoring that socioeconomic instability interacts with adherence behavior in complex, sometimes counterintuitive ways that merit further qualitative exploration [8].

4.6 Developmental Factors Specific to Young Adulthood

Some barriers seem to be more specific to the development of young adults than others, if not unique to them. First, symptom-driven self-discontinuation (SDSD) -- quitting a drug when someone feels better -- has been well documented in the general adherence literature and may be more prevalent in young adults with little illness experience, without a long-term relationship with a prescriber, and newly diagnosed with a condition [1]. Second, competing developmental transitions -- first university, first job, leaving a family home, new romantic relationships, and new adult daily routines -- interfere with the usual cues (such as a routine of a family home) that support regular taking of medication during adult life [1]. Third, side-effect salience seems to be developmentally weighted -- the YAMAN survey results, in which sexual dysfunction was the most important side effect that influenced decisional non-adherence among young men, reflect that concerns central to young-adult identity and relationships -- sexual function and reproductive function, physical appearance and cognitive sharpness -- may carry more decisional weight than other side effects would for older patients for whom those issues are less salient [6,22]. Fourth, the proportion of young people seeking mental health services and participating in routine follow-up are still relatively low, even though rates of depression keep increasing among this population, so that this may reduce the likelihood of clinicians noticing and intervening in the emergence of non-adherence before the end of the treatment episode [9,12].

4.7 Digital and mHealth Approaches as an Emerging Response

Since young adults are nearly every smartphone user, digital adherence-support tools have garnered increasing research attention as a potentially viable, low-cost mitigation measure to some of the above challenges, especially missing medication and lack of routine. A systematic review and meta-analysis of mobile-application interventions for medication adherence for chronic diseases indicated that app-based interventions had a greater effect size than simpler electronic reminder modalities (e.g., alarm devices or SMS) or motivational interviewing, educational, or general psychological interventions reported in previous meta-analyses [18]. The same review warned that many adherence apps were lacking of a clear behavior change theoretical basis, which could reduce their usefulness in the eyes of some users, and therefore their actual use [18]. This evidence is more from populations with chronic physical disease than from MDD populations, but indicates a potential direction of adherence support that is consistent with how young adults typically utilize technology and is worthy of further examination in psychiatric populations.

5. Discussion and Clinical Implications

This synthesis has several potential implications for clinical practice and health-system design. Proactive, structured counselling regarding the possible adverse effects, before use and not just when a complaint is raised, may help minimize the shock of adverse effects (e.g. sexual dysfunction, weight change, emotional blunting, etc.) and subsequent self-discontinuation, especially if accompanied by detailed discussion of a sexual-function-sparing alternative if clinically appropriate [5,6,20]. Second, integrating SDM into the routine of depression care, recognizing the importance of trust building and patient negotiation over options instead of one best possible option, could increase satisfaction and adherence, but research evidence

suggests it needs to be done well, with fidelity, to be effective [15,17]. Finally, stigma does occur at the internalized and social level, so interventions that help normalize medication use, ensure the confidentiality of daily life (e.g., dosing schedules that do not require patients to visibly administer their medication), and involve family members as facilitators, rather than unintentional barriers, might be especially useful for young adults who are consolidating their social identity [1,2,3,7]. Fourth, in view of the evidence of the association between structural instability and non-adherence, health systems that treat young people should expect and be proactive in addressing gaps in coverage and/or access to care that typically occur when young people transition from pediatric to adult health services and from parent to adult insurance coverage [8]. Finally, digital adherence tools are a promising, yet under-specified opportunity, and the field of intervention research needs to incorporate theory-based mHealth tools that are specifically evaluated within young-adult MDD research populations and not extrapolated from chronic-disease studies alone [18].

7. Conclusion

Antidepressant non-adherence among young adults with major depressive disorder arises from an interacting set of patient-reported barriers spanning medication tolerability, illness and treatment beliefs, stigma, the quality of the patient-provider relationship, structural and economic constraints, and developmental factors specific to this life stage. No single intervention is likely to address non-adherence in isolation; rather, the evidence points toward multi-component, developmentally tailored strategies that combine proactive side-effect management, genuine, shared decision-making, stigma-reduction efforts, structural support during life-stage transitions, and emerging digital adherence tools. Future primary research restricted specifically to the 18-25-year age band, using standardized adherence measures and longitudinal designs, is needed to quantify the relative contribution of each barrier domain and to test the effectiveness of developmentally tailored adherence interventions in this population.

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