ORIGINAL ARTICLE

Medication information for Flemish inpatients with major depression: evaluation and construct validity of the Consumer Information Rating Form

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SUMMARY

Background and objectives: Evaluating the quality of written medication information is a major topic of concern when patient pamphlets are developed. The objective of this study is to evaluate a patient pamphlet on selective serotonin reuptake inhibitors (SSRIs) by calculating Flesch-Douma readability scores and by applying the Consumer Information Rating Form (CIRF) to Flemish inpatients with major depression taking SSRIs.

Methods: The pamphlet was evaluated by calculating Flesch-Douma readability scores. The study enrolled patients with major depression taking SSRIs. Patient received a SSRI pamphlet and completed a self-administered structured

questionnaire consisting of the adapted CIRF and the Hospital Anxiety and Depression Scale. Construct validity was explored by means of factor analysis and Cronbach's alpha.

Results and discussion: The Flesch-Douma readability scores showed that the pamphlet was easy to read, had much interest in the reader and was very popular. The sample of 96 patients consisted of doubtful/definite cases in terms of anxiety (10.65 ± 4.90) and doubtful cases in terms of depression (8.91 ± 5.23). Using the CIRF, patients assigned positive scores to comprehensibility, utility and design quality of the pamphlet. Factor analysis on the original CIRF confirmed the three original factors ($P < 0.001$). Cronbach's alpha of factors ranged from 0.69 to 0.83.

Conclusion: The SSRI pamphlet is of good quality. Our study supported the construct validity of the CIRF to Flemish inpatients with major depression.

Keywords: consumer information rating form, major depression, pamphlet, patient education, written patient information

Received 18 July 2008, Accepted 12 December 2008

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INTRODUCTION

High-quality medication information is essential in any strategy to promote health literacy, shared decision-making, medication adherence and self-management (1, 2). Since 1999, it has been mandatory that medicines sold within the European Union (EU) are accompanied by a patient information leaflet. But which criteria does written medication information (defined as any written

materials on medicines for patients) have to meet? In the EU, the requirements for patient information leaflets are specified in Directive 92/27/EEC (31 March 1992): the package leaflet must be written in clear and understandable terms for the patient and be clearly legible in the official language(s). The Action Plan of the U.S. Department of Health and Human Services states that materials should be scientifically accurate; unbiased in content and tone; sufficiently specific and comprehensive; presented in an understandable and legible format that is readily comprehensible to consumers; timely and up-to-date; and useful (i.e. the material enables the consumer to use the medicine properly and appropriately, to receive the maximum benefit and to avoid harm) (3). Similar descriptions of the characteristics of written information can be found in the international literature (4–7). To be effective, patient pamphlets must be noticed, read, understood, believed and remembered (4).

Evaluating written medication information can be carried out from different perspectives (5, 8, 9). For this purpose, indirect and direct tests have been developed to evaluate written information from multiple perspectives (9). The best known indirect method are the readability formulae based on word and sentence length to estimate reading comprehensibility (10). Readability formulae have their limitations and take no account of the acceptance of the audience. Readability formulae are based on word and sentence length. They fail to assess reading comprehension and design of the material and do not take account for the readers' psychological and cultural background (11–13). To gain insight in the consumers' perceptions, beliefs, comprehension, recall and behaviour, a variety of direct methods have been used: individual interviews, focus groups and self-administered questionnaires (9). The involvement of healthy volunteers in the evaluation of patient information leaflets is mandatory in the EU (so-called consumer testing).

The Consumer Information Rating Form (CIRF) was developed as a direct method for evaluating consumers' perceptions of written patient information (9). It includes perceptions on comprehensibility, utility and design quality. Two studies demonstrated the validity and reliability of the CIRF (9, 14). The first study involved a small convenience consumer sample ($n = 24$) in the USA (9). The second study included a larger sample of

Australian consumers ($n = 282$) taking prescription medication for a rheumatology/pain condition or for hypertension (14). These studies evaluated the CIRF in populations of English-speaking patients admitted to acute hospitals and in community pharmacies. One may question the validity of the use of the CIRF when this instrument is employed in new populations with different characteristics.

The provision of information is one of the tasks of a pharmacist. Pharmacists of the Flemish Society of Hospital Pharmacists (division of psychiatry) noticed the need of patient-friendly written information on psychotropic drugs. In the context of a continuing education course in the period 1995–1998, a group of hospital pharmacists started to develop pamphlets on psychotropic drugs. They continued the development of the pamphlets until now and are updating them on a regular basis. Nowadays, about 30 pamphlets are available including antidepressants, anxiolytics, antiepileptics, antipsychotics, hypnotics and mood stabilizers. The pamphlet is one A4 paper printed on both sides. The pamphlets are structured in an identical way: they are composed of several questions and provide detailed answers to each question. The questions are based on the following framework: what is this medicine, how do you use the medicine and information concerning safety issues. The content of the pamphlets is based on the summary of product characteristics and was discussed among peers. The pamphlets are available from the Flemish Society of Hospital Pharmacists (division of psychiatry). Nurses as well as psychiatrists and pharmacists use the pamphlets when patients need information on their psychotropic drugs.

The aims of this study are two-fold. First, this study aims to evaluate the readability and the acceptance of a patient pamphlet on SSRI (Selective Serotonin Reuptake Inhibitor) antidepressants designed by the Flemish Society of Hospital Pharmacists (division of psychiatry) based on an indirect and a direct method by using readability formulae and the CIRF questionnaire, respectively. Second, this study aims to explore the construct validity of the CIRF to a population of Dutch-speaking inpatients with major depression.

The added value of this study is the exploration of the construct validity of the CIRF to patients

with different characteristics. This is the first study in which patients with a mental health problem are involved and the first time the CIRF is used in a non-English language other than English. The findings can support the further use of the CIRF in the evaluation of written medication information.

METHODS

Indirect evaluation

The Flesch readability formulae were applied to the patient pamphlet on SSRIs (10). The formulae assess three parameters: 'reading ease', 'human interest' and 'quick reading' test. The scores for the three parameters were calculated according to Douma using coefficients adapted to Dutch (see Appendix 1) (15, 16).

Direct evaluation

Patient sample. As psychiatric inpatients have a need for medication information, it is essential to evaluate the quality of medication information provided to this patient population (17). Seven Flemish psychiatric hospitals participated in this study. The local investigators were pharmacists and included patients in the study in collaboration with the staff of the hospital wards (nurses and psychiatrists) according to the inclusion criteria. Patients were eligible if they were at least 18 years old, were Dutch-speaking, and had the primary diagnosis of major depression at the moment of hospital admission. Patients took an SSRI antidepressant (i.e. citalopram, escitalopram, fluoxetine, fluvoxamine, sertraline or paroxetine). In Belgium, half of the patients taking antidepressants get a prescription for a SSRI antidepressant (18). If patients complied with the inclusion criteria, they were asked by the local researcher to participate a few days prior to hospital discharge. When they consented to participate, they received the pamphlet and a structured questionnaire. There was no time restriction to read the pamphlet and to complete the questionnaire. After the patient finished the questionnaire, study documents were returned to the local investigator. All study materials were handled anonymously. This study was approved by the coordinating Ethics Committee of the 'Broeders van Liefde' hospitals.

Structured questionnaire. Patients received a SSRI pamphlet and a self-administered structured questionnaire consisting of several parts: adapted CIRF questionnaire, HADS questionnaire and patient demographic data form.

The SSRI pamphlet is a patient information pamphlet written by hospital pharmacists employed in psychiatric hospitals (see Appendix 2). The pamphlet is composed of eight questions and provides detailed answers to each question: 'Why do I get SSRI prescribed?', 'What are SSRIs?', 'Are SSRIs safe?', 'How do I take my SSRI?', 'What do I feel after taking my SSRI?', 'Are there any side effects?', 'Can I use alcohol?' and 'I feel better, can I stop them?'. There were no separate pamphlets on the individual SSRIs as they are considered to make up one pharmacological class.

The original CIRF consists of three main questions: the 'comprehensibility' of the information (five items measured on a 1–5 Likert scale), the 'utility' of the information (composed of quantity and usefulness of six items measured on a 1–3 Likert scale for each dimension), and the 'design quality' of the information (six items measured on a 1–5 Likert scale). The adapted CIRF is composed of the original CIRF by adding an additional question on the intended future use of the information received (three items measured on a 1–5 Likert scale) (14). Furthermore, an extra item exploring bias was added to the 'design quality' question. The adapted CIRF was translated into Dutch using a forward backward translation procedure (19).

The HADS is a validated self-report scale for detecting states of depression and anxiety. It contains two 7-item scales: one for anxiety and one for depression. All 14 items are rated on a 4-point scale from 0 to 3. Scores are totalled for each subscale (i.e. anxiety and depression) and have a range of 0–21 for each subscale (20, 21). In their original study, Zigmond and Snaith recommended cut-off values for both subscales of the HADS: non-cases (≤ 7); doubtful cases (8–10); and definite cases (≥ 11) (21).

Patient demographic data included gender, age, education, occupation and SSRI use.

Data analysis. Descriptive statistics examined demographic characteristics of the sample. Mean and standard deviation were computed for each item of the adapted CIRF and the HADS.

Previous studies have indicated that the 17 items of the original CIRF can be grouped into three questions: comprehensibility, utility and design quality (9, 14). To explore the construct validity of the CIRF to Flemish inpatients with major depression, the items of the original CIRF were subjected to factor analysis. Factor analysis is a technique that extracts as many factors as there are questions in the set of items that make up the CIRF. As previous studies identified three factors, the number of factors was preset to three in our analysis (9, 14). If each item loads on its corresponding question, this would support the use of the CIRF to our patient population. For factor analysis to be appropriate, the Kaiser-Meyer-Olkin measure of sampling adequacy needs to exceed 0.5 and Bartlett's test of sphericity needs to be statistically significant (i.e. $P < 0.05$) (22). The factor analysis was performed by principal component analysis with varimax rotation (23).

The reliability of the CIRF concerns the degree of reproducibility or consistency of the empirical results of the CIRF. Reliability was tested by calculating a Cronbach's alpha coefficient for each factor of the CIRF (24). This measure gives the average of all possible split-half reliabilities of a factor. To obtain a split-half reliability, factor items are randomly divided into two groups, which are then correlated with each other. A value of Cronbach's alpha of 0.7 or more is considered to be adequate for basic research (25).

The data were analyzed using SPSS 15.00 (SPSS Inc., Chicago, IL, USA) for Windows (26).

RESULTS

Indirect evaluation

Calculations of the readability scores are included in Appendix 1. The pamphlet had a 'reading ease' score of 70 on a scale from 0 (very difficult) to 100 (very easy). A score of 70 indicates that the pamphlet is in between normal and fairly easy to read and corresponds with an age level of 12–15 years. 'Human interest' had a score of 56 on a scale from 0 (dull) to 100 (dramatic), showing much interest for the reader. Scores for the 'quick reading' test are scaled from 0 (formal) to ≥ 36 (very popular). The pamphlet had a 'quick reading' score of 42, corresponding with a very popular pamphlet.

Table 1. Demographic characteristics ($n = 96$)

Characteristics	Number of patients (%)
Age (Mean $\pm$ SD) (years)	39.61 $\pm$ 12.80
Female	$n = 64$ (66.7%)
Education	
Primary school	$n = 4$ (4.2%)
Lower secondary school (12–15 years)	$n = 15$ (15.6%)
Upper secondary school (16–18 years)	$n = 32$ (33.3%)
Education higher than secondary school	$n = 43$ (44.8%)
Occupation	
Student	$n = 9$ (9.4%)
Household	$n = 6$ (6.3%)
Blue collar worker	$n = 5$ (5.2%)
White collar worker	$n = 55$ (57.3%)
Retired	$n = 5$ (5.2%)
Unemployed	$n = 3$ (3.1%)
Other	$n = 13$ (13.5%)
Prescribed SSRI	
Citalopram	$n = 4$ (4.2%)
Escitalopram	$n = 31$ (32.3%)
Fluoxetine	$n = 10$ (10.4%)
Fluvoxamine	$n = 2$ (2.1%)
Paroxetine	$n = 19$ (19.8%)
Sertraline	$n = 21$ (21.9%)
2 SSRI's	$n = 1$ (1.0%)
Unknown	$n = 8$ (8.3%)

SD, standard deviation; SSRI, selective serotonin reuptake inhibitor.

Direct evaluation

Descriptive analysis. 114 patients participated, of which 96 questionnaires were eligible for analysis. Questionnaires of 18 patients were excluded due to incomplete responses. Patient characteristics are described in Table 1. Patients tended to be middle-aged women and had completed secondary school or higher education. The majority of participants were white collar workers. Patients were prescribed escitalopram (32% of patients), sertraline (22%), paroxetine (20%) or another SSRI.

The mean and standard deviation for each item of the adapted CIRF are given in Table 2. With respect to 'comprehensibility', patients scored the pamphlet as easy to read, understand and locate information; but as less easy to remember and

Table 2. Consumer rating of patient pamphlet using the adapted CIRF

Item	Mean $\pm$ SD
Comprehensibility ^a	
Read	4.22 $\pm$ 0.82
Understand	4.23 $\pm$ 0.75
Remember	3.64 $\pm$ 0.86
Locate information	4.09 $\pm$ 0.76
Keep	3.84 $\pm$ 0.83
Total (range 5–25)	20.02 $\pm$ 3.10
Future use ^b	
Read ^c	4.47 $\pm$ 0.78
Use ^c	4.31 $\pm$ 0.77
Keep ^c	4.02 $\pm$ 1.15
Total (range 3–15)	12.80 $\pm$ 2.13
Utility ^d	
Benefits	3.03 $\pm$ 0.77
Contraindications	3.01 $\pm$ 0.92
Directions	2.96 $\pm$ 0.79
Precautions	3.05 $\pm$ 0.77
Adverse effects	2.99 $\pm$ 0.96
Storage	2.56 $\pm$ 1.01
Total (range 6–24)	17.60 $\pm$ 3.30
Design Quality ^e	
Organization	4.00 $\pm$ 0.77
Attractiveness	3.59 $\pm$ 0.99
Print size	4.14 $\pm$ 0.98
Tone	4.14 $\pm$ 0.98
Helpfulness	4.03 $\pm$ 0.85
Bias ^c	4.02 $\pm$ 1.00
Spacing	4.15 $\pm$ 0.95
Total (range 7–35)	28.06 $\pm$ 4.69

CIRF, consumer information rating form; SD, standard deviation.

^aScale ranges from 1 to 5 (1 = very hard, 2 = pretty hard, 3 = in between, 4 = pretty easy, 5 = very easy).

^bScale ranges from 1 to 5 (1 = very unlikely, 2 = somewhat unlikely, 3 = unsure, 4 = somewhat likely, 5 = very likely).

^cExtra items added to the original CIRF. Combination of the 4 items and the original CIRF is called the adapted CIRF.

^dComposite scale: (1 = not so useful, 2 = fairly useful, 3 = very useful) + (0 = too little or too much information, 1 = right amount of information).

^eScale ranges from 1 to 5 (1 = low quality $\rightarrow$ 5 = high quality)

keep. Regarding the 'future use' of the pamphlet, patients reported that they were likely to read, use and keep the pamphlet. The information in the pamphlet was rated as useful and had been provided in a sufficient amount; but the topic 'storage' was found to be somewhat less useful than the

other topics. Apart from attractiveness, all design topics were scored to be of good quality.

Table 3 summarises the scores on the HADS including the distribution over no case, doubtful and definite case; but also the mean score and the range of scores observed in our population.

Exploration of construct validity. The construct validity of the original CIRF to our patient population was assessed by comparing the factors generated by the factor analysis with the original questions (see Table 4). The Kaiser-Meyer-Olkin measure of sampling adequacy was 0.777, thus exceeding the benchmark of 0.5. Also, Bartlett's test of sphericity was significant ($\chi^2 = 598,768$; $df = 136$; $P < 0.001$). Both tests confirmed the appropriateness of performing a factor analysis. Sixteen of the 17 items loaded on the corresponding question, supporting the construct validity of the CIRF. The only exception was the item 'benefits', which loaded on the corresponding question of 'utility', but also cross-loaded on the question of 'design quality'.

Table 4 also shows that values of Cronbach's alpha ranged from 0.69 to 0.83, equalling the benchmark of 0.7. This points to a high reliability of the CIRF questions.

These results support the construct validity of the CIRF in a population of Dutch-speaking inpatients with major depression.

DISCUSSION

A first aim of this study was to evaluate a patient pamphlet on SSRI antidepressants. Our direct and indirect evaluation supported the quality of the pamphlet in terms of readability. The results of the indirect evaluation based on readability formulae were corroborated by the direct evaluation of the consumer's opinion on the readability of the pamphlet in our study. Both methods have their value in producing and evaluating written medication information. While formulae are practical tools to evaluate readability during the conception phase of a pamphlet, direct evaluation can be used to confirm the results of readability scores from the consumer's perspective before the pamphlet is distributed. Additionally, direct evaluation showed that the pamphlet was likely to be used in the future and had a satisfying utility and a good design quality. These

Table 3. Results of the hospital anxiety and depression scale ($n = 96$)

	Non cases (0–7)	Doubtful cases (8–10)	Definite cases (≥11)	Mean score ± standard deviation	Lowest score observed	Highest score observed
Anxiety	$n = 26$	$n = 21$	$n = 48$	10.65 ± 4.90	0	21
Depression	$n = 43$	$n = 16$	$n = 37$	8.91 ± 5.23	0	20

Spearman's rho correlation coefficients for Anxiety scores and Depression scores is 0.795 ($P \leq 0.001$; 2-tailed).

	Factor 1	Factor 2	Factor 3
Read	0.820		
Understand	0.771		
Remember	0.789		
Locate	0.757		
Keep	0.543		
Organization		0.565	
Attractiveness		0.768	
Print size		0.738	
Tone		0.641	
Helpfulness		0.647	
Spacing		0.758	
Benefits	0.439		0.591
Contraindications			0.606
Directions			0.599
Precautions			0.706
Side effects			0.540
Storage			0.651
Factor name	Consumer comprehensibility rating scale	Consumer design quality rating scale	Consumer utility rating scale
Eigenvalue	5.056	2.337	1.612
Variance explained	29.74%	13.75%	9.48%
Cronbach's alpha	0.830	0.823	0.690

Table 4. Factor solution of CIRF

Total: 52.97%

Factor loadings smaller than 0.4 are not included in the table.

results show that the SSRI pamphlet was well accepted by patients taking antidepressants.

A second aim of this study was to explore the construct validity of the CIRF to Flemish inpatients with major depression. The factor analysis on the original items of the CIRF showed that 16 of the 17 items loaded on the corresponding question, supporting the use of the CIRF to this population. The items corresponded with the same three subscales as in previous studies:

consumer comprehensibility, consumer utility and consumer design quality (9, 14). The total variance explained approximates the variance explained in the Australian study, which was much lower than in the US study (9, 14). The differences between these three studies may be attributed to the nature and the size of the consumer samples. In the US study a convenience sample of 24 persons of a consumer evaluation panel evaluated a selection of patient information leaflets. In the Australian

($n = 282$) and the current ($n = 96$) study, patients evaluated information on their own medication. In the last two studies, consumers may score the written medication information differently as the information may potentially influence their own behaviour to medicines (14). Finally, the Cronbach alpha scores supported the reliability of the three CIRF subscales.

Our patient sample consisted of patients with a major depression who got an SSRI antidepressant prescribed. Half of the Belgian patients who need an antidepressant, get a SSRI prescribed (18). In Belgium, the prescription of SSRIs does not have restrictions in hospitals as well as in ambulatory care. Reimbursement data of the National Social Insurance Agency in Belgium (RIZIV, Rijksinstituut voor Ziekte- en Invaliditeitsverzekering) showed that the amount of SSRI prescribed (expressed as Daily Defined Dose) has doubled in the last decade while the population remained stable. All age groups received SSRI antidepressants (27). This means that young patients as well as older patients can get an SSRI prescribed. Additionally, first line pharmacotherapy comprises of SSRI antidepressants as well as tricyclic antidepressants (28).

Regarding the demographic characteristics of our patient sample, about half of them are white collar workers. This high percentage of white collar workers may be due to the willingness to participate in the study. This may be a confounding factor for which we did not control in our study.

This study measured the HADS score in this patient population. The scores on the HADS subscales showed that, in addition to depressive symptoms, anxiety symptoms are present in this patient population (see Table 3), corroborating international evidence that anxiety and depression often coexist (29).

This study included hospitalized adult patients with major depression. They evaluated the patient pamphlet a few days before hospital discharge. Following discharge, patients are again responsible for their own medication intake and, therefore, the information of the pamphlet can support patients in taking their medicines. This entails that patients in an acute phase of depression (i.e. at the moment of hospital admission) are no part of this study. The HADS was completed at the time of the pamphlet evaluation which explains the moderate scores on the HADS.

These results are valid for inpatients only as no ambulatory patients were enrolled. While pamphlets are available on other groups of antidepressants (e.g. tricyclic antidepressants), our analysis studied the pamphlet on SSRI antidepressants as SSRIs make up half of the antidepressant use by Belgian patients (18). Further research is needed into the use of the CIRF in other patient populations in different settings.

CONCLUSION

Our study indicated that the SSRI pamphlet, on the one hand, had good readability scores and, on the other hand, was well accepted by patients with major depression taking SSRI antidepressants. Also, our study supported the construct validity of the CIRF to Flemish inpatients with major depression.

ACKNOWLEDGEMENTS

This research was supported by a grant of the Institute for the Promotion of Innovation through Science and Technology in Flanders (IWT-Vlaanderen). We would like to thank Professor Ines Krass for her permission and advice on the use of the CIRF. We would also like to thank the Flemish Association of Hospital Pharmacist (division of psychiatry) for their constructive collaboration and the use of the SSRI pamphlet.

The authors have no conflicts of interest that are directly relevant to the content of this manuscript.

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APPENDIX 1. FLESCH-DOUMA READABILITY FORMULAE (10, 15, 16)

Reading ease score	Style description	Education level
90–100	Very easy	Primary school: 4 th year
80–90	Easy	Primary school: 5 th year
70–80	Fairly easy	Primary school: 6 th year
60–70	Normal	Lower technical school
50–60	Fairly difficult	Upper secondary school
30–50	Difficult	Higher education
0–30	Very difficult	University

Reading ease score = $207 - (Z+W)$ with $Z = (\# \text{ words}/\# \text{ sentences}) \times 0.93$ and $W = (\# \text{ syllables}/\# \text{ words}) \times 100 \times 0.77$.

SSRI pamphlet: $207 - [(644/84) \times 0.93 + (1086/644) \times 100 \times 0.77] = 70$.

Personal interest score	Style description
60–100	Dramatic
40–60	Highly interesting
20–40	Interesting
10–20	Mildly interesting
0–10	Dull

Human interest score = $PZ + PW$ with $PZ = [(\# \text{ personal sentences} \times 100)/\# \text{ sentences}] \times 0.32$ and $PW = [(\# \text{ personal words} \times 100)/\# \text{ words}] \times 3.7$.

SSRI pamphlet: $[(26 \times 100)/84] \times 0.32 + [(81 \times 100)/644] \times 3.7 = 56$.

Quick reading test score	Style description
0–20	Formal
21–25	Informal
26–30	Fairly popular
31–35	Popular
≥ 36	Very popular

Quick reading test score = $(\# \text{ points}/\# \text{ words}) \times 100$.

With points accorded for capitals, italic, bold or underlined words, numbers, punctuation marks, symbols and the beginning and the end of a paragraph.

SSRI pamphlet: $(271/644) \times 100 = 42$.

APPENDIX 2. SSRI PAMPHLET

Patiëntenfolder nr. 2

ANTIDEPRESSIVA: SSRI'S***Waarom werd mij een SSRI voorgeschreven?***

Eén op vijf personen is wel eens depressief in de loop van zijn leven. Je voelt je dan vaak droevig, leeg en teneergeslagen. Je mist energie en de interesse voor je werk of hobby's neemt af. Je valt moeilijk in slaap of wordt vroeg wakker. Als die symptomen enkele weken duren en ze je normale leven in de war sturen, kunnen SSRI antidepressiva (SSRI's) helpen.

Wat zijn SSRI's?

SSRI's zijn geen kalmeermiddelen of slaaptabletten.

Ze zijn een groep geneesmiddelen die helpen bij depressie. SSRI staat voor Selectieve Serotonine Reuptake Inhibitor. Dat betekent dat ze werken op één van de belangrijkste chemische stoffen in de hersenen bij depressie, namelijk serotonine. De SSRI's zijn even effectief als de andere groepen antidepressiva. Duizenden mensen nemen deze geneesmiddelen en kunnen nu een normaal leven leiden. Momenteel neem jij:

Zijn SSRI's veilig?

SSRI's zijn veilig als je als je het voorschrift van je dokter goed volgt.

Licht echter steeds je dokter in:

- wanneer je lijdt aan epilepsie of diabetes of als je problemen hebt met je lever of nieren;
- over welke geneesmiddelen jij op het ogenblik inneemt;
- of je zwanger bent of wenst te worden;
- als je borstvoeding wenst te geven.

Je hebt een doktersvoorschrift nodig als je je SSRI antidepressivum wilt halen bij de apotheker.

Bewaar je geneesmiddel buiten het bereik van kinderen en geef het nooit door aan anderen.

Hoe moet ik mijn SSRI innemen?

Hou je steeds aan de voorgeschreven dosis en volg de richtlijnen van je dokter goed op. Ben je eens vergeten je SSRI in te nemen, dan kan dit nog na enkele uren, maar neem geen dubbele dosis. Je neemt je SSRI tijdens de maaltijden.

Wat voel ik na de inname van mijn SSRI?

Je kan je wel wat opgewonden voelen de eerste week. Ook je slaap kan beïnvloed worden. Het duurt toch twee tot vier weken vooraleer je je echt beter voelt. Geef vooral niet op! Je zal je na enkele weken veel kalmer voelen en je zult je beter kunnen concentreren. Alle dagen zullen echter niet gelijk zijn, maar dat is normaal. Geef je geneesmiddel de tijd om te werken!

Zijn er bijwerkingen met SSRI antidepressiva?

In het begin kun je je wat ongemakkelijk voelen. De klachten zijn meestal niet ernstig en ze verdwijnen na ongeveer een week. Bekijk de volgende tabel om te weten wat je moet doen als je één van de bijwerkingen ondervindt. Let wel! Niet iedereen heeft daar last van.

BIJWERKING	WAT IS HET?	IS DIT NORMAAL?	WAT MOET IK DOEN?
Nausea en braken	Je voelt je misselijk.	Ja	Neem je geneesmiddel tijdens of na de maaltijd. Raadpleeg je dokter als het te erg wordt.
Insomnia	Je kan niet goed slapen.	Ja	Bespreek het met je dokter.
Slaperigheid	Je voelt je slaperig.	Ja	Pas op bij het besturen van voertuigen of machines.

BIJWERKING	WAT IS HET?	IS DIT NORMAAL?	WAT MOET IK DOEN?
Hoofdpijn		Ja	Vraag je apotheker een middel op basis van paracetamol.
Rusteloosheid	Je voelt je opgewonden en je hart klopt sneller. Je kan ook meer zweten.	Ja	Raadpleeg je dokter als het te erg wordt.
Seksuele disfunctie	Je komt moeilijk tot een orgasme.	Ja	Spreek erover met je dokter.
Andere bijwerkingen			Indien je nog een andere bijwerking zou voelen, bespreek dat dan zo snel mogelijk met je dokter.

Mag ik alcohol drinken?

In het begin van je behandeling met je antidepressivum is het beter om geen alcohol te drinken. Nadien, als je je reeds wat beter voelt, is het je toegelaten met mate te drinken, maar laat in geen geval na je geneesmiddel in te nemen.

Ik voel me beter. Mag ik nu al stoppen?

Neen, nu je je beter voelt, mag je niet plots stoppen. Anders gaan je klachten zeker terug de kop opsteken. Je zal je SSRI nog minstens 4 tot 6 maanden verder nemen. Dat is niet schadelijk! Je geneesmiddel veroorzaakt geen verslaving.