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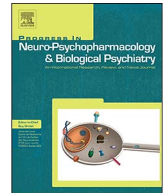

Would I take antipsychotics, if I had psychotic symptoms? Examining determinants of the decision to take antipsychotics

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ABSTRACT

Poor adherence to treatment in schizophrenia is mainly associated to patients-related factors. However, social negative representations of schizophrenia and its treatment may also contribute to patients' decision to take or not to take antipsychotics. A web-based study on 1,807 participants was conducted during which participants imagined that they had a particular chronic illness based on clinical vignettes (mental illnesses: schizophrenia, depression; somatic illnesses: multiple sclerosis, rheumatoid arthritis). Participants rated their subjective distress and perceived social stigma associated with each illness. They also rated the perceived treatability of the illness, their belief in the effectiveness of treatment, and their treatment preference regarding medication. Results show that schizophrenia was considered more distressful, less treatable and associated with higher social stigma than somatic illnesses. Medication was less preferred for treating schizophrenia compared to somatic illnesses. Perceived treatability of illness and belief in the effectiveness of pharmacological treatment were the factors driving preference for medication in schizophrenia and depression, respectively; these factors had weaker influence on preference for medication in somatic illnesses. Our study points out more severe negative representations of mental illnesses in general, and their treatment, particularly schizophrenia. These attitudes are not confined to patients, and may influence patients' decisions to take psychotropic drugs.

1. Introduction

Clinicians who work with patients diagnosed with schizophrenia are usually faced with the seeming paradox that although antipsychotics are effective drugs for symptoms of schizophrenia (Leucht et al., 2012), patients show poor medication adherence. One may argue that this situation is not paradoxical when considering evidence that effectiveness of antipsychotics has been overestimated (Morrisson et al., 2012). Nevertheless, several patient-related factors are usually cited to account for non-adherence, particularly poor insight into illness, negative attitudes towards antipsychotics, side effects (Beck et al., 2011; Sendt et al., 2015), and to some extent cognitive impairment and forgetfulness. Other studies have also shown that positive attitudes towards psychotic symptoms (gain of illness) account for poor adherence in a subgroup of patients (Moritz et al., 2016, 2014, 2013b). For instance, after taking drugs for their illness some patients reported that they missed the voices they had heard before taking the drugs or that they regret having lost a personal feeling of importance (Moritz et al., 2014).

However, other factors can influence the decision to take antipsychotic drugs. According to Coleman's social theory (Coleman, 1990), individual choices are affected by system level norms, so that the individual's action is a reflection of conformity to the larger society's norms. Moreover, external social forces such as norms, values or attitudes regulate behavior. For instance, accepting to take drugs for schizophrenia implies to agree (at least partially) with a biological model of schizophrenia (e.g., receptor imbalance, brain dysfunction). The majority of psychiatrists (91.3%) in fact adhere to such a view (Colombo et al., 2003). This is also true for some patients with schizophrenia, particularly those presenting with acute psychotic symptoms (Colombo et al., 2003; Kinderman et al., 2006). In contrast,

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a large group endorses alternative, non-biological illness models (Borras et al., 2007; Colombo et al., 2003). Importantly, these alternative models are not specific to patients but also predominate in the general population (Angermeyer et al., 2005). For instance, up to 61% of patients or nurses adhere to biological models of schizophrenia; this percentage drops to respectively 43% and 9% when informal careers or social workers are asked. Furthermore, the psychological model of schizophrenia (i.e., considering schizophrenia as a disorder situated on the continuum of emotional distress and amenable to psychotherapy) is largely endorsed by patients (up to 47%) and social workers (37%), whereas only 5% of psychiatrists agree with it (Colombo et al., 2003). These social representations of schizophrenia that are widespread in the general population may heavily impact patients' own model of their illness and may account for their poor adherence to pharmacological treatment. Specifically, non-biological conceptions of schizophrenia may represent an obstacle for adherence to both pharmacological treatment and psycho-education programs that are grounded on a medical model (Borras et al., 2007). For some patients, being prescribed medication may also feel as if subjective causal factors such as childhood abuse are negated or doubted by clinicians, which may foster mistrust to the clinicians (Moritz et al., 2009).

The literature on factors influencing care seeking and decision to take psychotropic medication in people with mental illness (Corrigan et al., 2014; Hamrin et al., 2010) also shows that both the severity of illness and the experienced distress associated with the illness increase the propensity to accept taking medication (Faraone et al., 2007; McNeal et al., 2000). In contrast, stigma of mental illness that includes several kinds of stereotypes and prejudices against mental illnesses, reduces care seeking and treatment participation and prompt active avoidance of social contact by anticipating social discrimination and labeling (Corrigan et al., 2014; Hamrin et al., 2010). Labeling symptoms as relating to mental disorder may also activate social stereotypes about mental illness (Sattler et al., in press) and be a signaling moment in which people reject care seeking in order to avoid stigma. Finally, apart from the attitudes towards mental illness, two studies have revealed intriguing findings: Patients with schizophrenia have better adherence for non-psychotropic drugs than patients without any psychiatric illness (Kreyenbuhl et al., 2010; Owen-Smith et al., 2016) and patients with both schizophrenia and HIV infection have a better adherence to non-psychotropic compared to psychotropic drugs (Kalichman et al., 2015). This suggests that there may be something unique about adherence to psychotropic drugs. Again, negative attitudes towards psychotropic drugs are widespread in the general population (Schomerus et al., 2014); it is not specific to patients with schizophrenia and could contribute to patients' non-adherence. To conclude, the literature reviewed above points out psychological and social factors that influence representations of mental illnesses and psychotropic drugs. However, to the best of our knowledge studies investigating factors driving treatment decision in schizophrenia have only considered the perspective of people with personal experience of the illness. By doing so, they might have confounded specific patients-related factors with more general social factors. This might lead to attribute negative attitudes to “unthankful” patients, which are in fact shared by the general population. To make a step forward in understanding the motives for non-adherence, we think it useful to switch the perspective and to consider this crucial question: “Would I take antipsychotics, if I had psychotic symptoms?” Asking this question to people without mental illness has the advantage of examining factors beyond specific attitudes and preoccupations of patients. The counterpart is that it requires gathering the answers from a large sample of participants. To this end, a web-based study represents a suitable and convenient way that avoids the more time-consuming method of face-to-face interview and provides good data quality when certain precautions are met (Gosling et al., 2004; Moritz et al., 2013a, 2013b; Skitka and Sargis, 2006).

The aim of the present study was to investigate several factors supposed to impact the decision to take or not antipsychotics in people facing with psychotic symptoms, namely factors making illness severe (course of illness and intensity of symptoms) (Sanderson and Andrews, 2002; Sartorius, 2009), subjective experience of illness (subjective distress, perceived social stigma, perceived treatability), attitudes[1] towards treatment (belief in the effectiveness of treatment) and name of illness. We invited participants to adopt a first-person experience of schizophrenia and to indicate which treatment they would choose. To examine whether the factors driving treatment decision were confined to schizophrenia, we compared first-person experience of schizophrenia to first-person experience of other chronic illnesses. We posited the following hypotheses:

H1. Subjective experience of schizophrenia is more negative and distressful than experience of other chronic somatic illnesses at comparable level of severity.

H2. Negative subjective experience of mental illness is not confined to schizophrenia but also concerns chronic mental illnesses in general.

H3. Participants are less prone to accept medication for treating mental illness compared to somatic illnesses.

H4. Negative attitudes towards mental illnesses and their treatment more likely predict decision to take medication in mental than in somatic illnesses.

H5. Naming chronic illnesses before presenting their symptoms reinforces negative subjective experiences of mental illness and negative attitudes towards psychotropic drugs (H5a) and in turn influences treatment decision (H5b).

2. Methods

The study was conducted over the Internet. Participants were recruited via WiSoPanel (Göritz, 2009, 2007), a participant pool with German-speaking members who had registered to be invited to participate in web-based studies (http://www.wisopanel.net). In total, 12,134 people received the link to the study, and responses were collected within one week. The participant pool was recruited using diverse sources and channels, both online and offline, thus reducing the likelihood of bias. The pool holds people from all walks of life and resembles the general population in typical demographic characteristics. People signed up for the pool to take part in studies of all kinds and topics. Thus, selection bias with regard to an affinity to the study topic at hand was unlikely. Moreover, all eligible members of the pool were invited to the study at hand. Thus, there was no self-selection bias on the level of this individual study as this study is based on a census rather than a sample of the participant pool. After a short description of the purpose of the study (see Section 2.2.) all participants gave their informed consent. The investigation was carried out in accordance with the latest version of the Declaration of Helsinki.

2.1. Study design

Our study design included for each participant a comparison between one mental illness and one somatic illness. Each illness was presented four times portraying different levels of illness severity, so that each participant was asked to consider eight clinical vignettes.

In addition to schizophrenia (SZ), recurrent depression (RD) was included as an other prominent psychiatric disorder in order to test H2. Multiple sclerosis (MS) and rheumatoid arthritis (RA) served as somatic illnesses and were selected as being both chronic somatic illnesses, the former affecting the nervous central system, the latter not. All four

[1] In the present paper, the cognitive dimension of attitudes was explored but not their behavioral and emotional components.

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