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Adherence to anti-depressant medication: A medicine-taking career

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ABSTRACT

The study of medicine taking is controversial as it often reveals a discrepancy between healthcare professionals' advice and patients' actual behaviour. Qualitative researchers have examined depressed people's adherence to prescriptions of antidepressants by exploring the meaning they impute to the medicine and their use of the medicine in the wider context of their everyday lives. This paper contributes to this area of research by means of a prospective research study focussing on depressed patients' perspectives on taking medicine and how they change through time. The study included consecutive semi-structured interviews with 16 people four times during the year following an admission to hospital for depression. Data were collected in 2008–2009 in the Region of Southern Denmark. The study was based on an interactionist conception of social career and data were analysed thematically. Findings indicated that participants were confronted with recurrent challenges related to being depressed and taking medicine, and they learned how to manage these challenges in a post-admission career with two distinct stages: the basic restitution stage and the frustrated search stage. Medicine-taking depended on a number of career moving tensions and problems. The basic restitution stage was characterised by the participants' readiness to take medicine in accordance with healthcare professionals' prescriptions and advice. Half of the participants experienced being challenged by unacceptable prolonged mental, social, and/or physical distress, and they moved to the frustrated search stage, which was characterised by an alternative perspective on taking medicine that included increased self-regulation and less involvement of healthcare professionals and next of kin. Healthcare professionals played a very peripheral role in most participants' lives and unsatisfactory interactions often isolated participants and left them to solve their own problems.

1. Introduction

This paper is a report on a prospective interview study of Danish depressed patients' views on taking anti-depressant medication. The prescription of medicine is a common healthcare intervention, but it embraces an intractable clinical challenge, because many patients have difficulties following prescriptions and conforming to treatment regimes (WHO, 2003). Medicine taking is controversial because it often indicates a fundamental mismatch between clinicians' therapeutic advice and patients' actual illness behaviour (Horne et al., 2005). This mismatch was first conceptualised as patients' level of *compliance* to doctors' prescriptions. However, this term was criticised for implying and legitimising a paternalistic relationship between, on the one side, authoritative and rational doctors and, on the other side, irrational and uncritical patients (Malpass et al., 2009). Later, *adherence* was suggested as an alternative, more acceptable concept. Like compliance, the concept of adherence carries paternalistic connotations, but it seeks to emphasise the patients' perspective by stressing that treatment regimes must be negotiated and agreed upon by patients and healthcare providers (WHO, 2003).

A central social science approach to studying adherence and medicine taking has been to explore the meaning patients impute to medicine and to using medicine in the wider context of their everyday lives. This focus on patients' perspective has emphasised the personal and situated rationality in self-regulated use of medicine, see for instance (Conrad, 1985). Pound et al. (2005) reviewed and synthesised 37 qualitative studies of lay experiences of medicine taking. The synthesis indicated that people are actively engaged in managing their medicine taking and that they to varying degrees resist taking medication out of concerns about the medicine *per se*. The authors suggest that this latter finding should not be interpreted as proof of patients' misperception of their medicine, but, on the contrary, as evidence of legitimate worries about medicine, which is not entirely effective and has adverse effects (Pound et al., 2005). The present paper will contribute to a

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better understanding of medicine users' situated and evolving reasons for adhering to prescribed treatment by focussing on depressed patients' views on medicine taking and how they change over time.

2. Background: depression and taking antidepressants

Depression is most often a persistent relapsing-remitting illness that causes severe impairment of social and occupational functioning (National Institute for Health and Clinical Excellence (NICE), 2009). The most common treatment of depression is antidepressant medication, but treatment efficacy is often reduced because 30–60% of patients discontinue taking the prescribed antidepressant medication within the first 12 weeks of treatment (Lingam and Scott, 2002; WHO, 2003). Antidepressants are controversial because their invention and use are intrinsically linked to changing diagnostic classifications, the pharmaceutical industry, and Western culture (Horwitz and Wakefield, 2007). Moreover, antidepressants are not highly effective. The effect of taking an antidepressant drug increases with the severity of the depression, and under naturalistic conditions it is estimated that about 1/3 of patients experience complete remission, 1/3 will experience a partial remission, and 1/3 will not respond to the medication or will experience unacceptable adverse effects (Sundhedsstyrelsen, 2007). It generally takes several weeks before a user begins to feel eventual effects of taking antidepressants. In order to reduce the risk of relapse, patients are generally recommended to take antidepressants for six months after remission (National Institute for Health and Clinical Excellence (NICE), 2009). Depending on the patient's symptoms, antidepressants can be supplemented with mood-stabilising medicine, anxiety medication, and/or antipsychotic medication.

Aiming at understanding medication taking and adherence to antidepressant treatment regimes, qualitative researchers have explored and interpreted the situated rationality of patient's views on taking antidepressants. These studies have been based on interview data eliciting and exploring personal accounts of concerns and motives for taking – or not taking – the medicine. In a meta-ethnography, Malpass et al. (2009) reviewed and synthesised 16 papers from 11 studies of patients' experiences of taking antidepressants and concluded that patients embark on two distinct "journeys" on which they must cope with decisions about taking antidepressant treatment and cope with the moral aspects of taking the medication.

Qualitative studies indicate that some people accept taking antidepressants and regard the medicine as an effective and socially legitimate treatment. However, research also indicates that people are often worried about adverse effects and dependency to the medication (Grime and Pollock, 2003; van Geffen et al., 2011). Moreover, people are often uncertain about the character of the problems they experience, whether to categorise their illness experiences as symptoms of depression, or stress, fatigue, etc., which makes them uncertain about the relevancy of initiating treatment with antidepressants (Givens et al., 2006; Leydon et al., 2007; McMullen and Herman, 2009). Experiences of adverse effects, uncertainty about treatment effects and a negative view of healthcare professionals and the assistance they provide seem to influence levels of adherence negatively (Anderson and Roy, 2013; Badger and Nolan, 2006; McMullen and Herman, 2009; van Geffen et al., 2011). Patients in long-term treatment can be afraid of reducing or stopping taking antidepressant medicine because it could create a psychological imbalance and relapse into depression (Buus et al., 2012; Dickinson et al., 2010). In addition to these clinical issues, levels of adherence have been described as influenced by general sociocultural beliefs about medicine taking as something that ought to be minimised and by the stigma imputed to depression and the treatment of depression (Maxwell, 2005; Verbeek-Heida and Mathot, 2006). These influences can create a paradoxical situation where patients search for a sense of normality, which is created by an "abnormal" agent: the antidepressant medication (Garfield et al., 2003; Karp, 1993).

People's beliefs about antidepressants are not static (Malpass et al., 2009); variation and change caused by the course of the disease, by illness careers, by people's prior experiences etc. make it challenging to provide valid accounts of people's beliefs. One strategy to address such challenges has been to strategically recruit interview respondents at specific periods of the antidepressant treatment: at the initiation of treatment (Garfield et al., 2003; van Geffen et al., 2011) or after receiving long-term treatment (Dickinson et al., 2010; Verbeek-Heida and Mathot, 2006). Another strategy has been to construe temporal changes of interview respondents' views on the basis of their retrospective accounts (Grime and Pollock, 2003; Karp, 1993, 2006). Hitherto, only two studies have included follow-up interview data (Garfield et al., 2003; Maxwell, 2005), but in each study the analysis of the follow-up data was made with a minimal emphasis on understanding change. The original research strategy in the present study was to collect and analyse prospective data on peoples' views on taking antidepressants.

The purpose of the present paper was to examine people's perspectives on taking antidepressants and how their perspectives change during a 12-month period after a hospital admission for depression.

3. Methods

The study design was consecutive semi-structured interviews (Holstein and Gubrium, 1995) four times during a one-year period. These interviews were supplemented by a diagnostic interview (SCAN) (Wing et al., 1998) and self-report measures: Antidepressant Compliance Questionnaire (ADCQ) (Kessing et al., 2005), Beck Depression Inventory II (BDI-II) (Beck et al., 2005), and Symptoms Checklist 92 (SCL-92) (Derogatis, 2007). Detailed results from the diagnostic interview and the questionnaires will be published in a separate paper.

4. Theoretical perspective

The study was designed within an interactionist perspective (Atkinson and Housley, 2003). From this perspective, it is asserted that the meaning of objects, events, and situations are imputed on to them through people's interactions with them. Identity and situational understanding are formed by an interactive meaning-making process, which is based on people's situated expectations to others and the negotiated and situated responses from others. A person perceives his/her environment through a personal perspective, which is an ordered set of ideas, a worldview, through which his/her actions flow reasonably (Becker et al., 1977).

Interactionist analyses of careers concern the dialectic relationship between social actors and social organisation and a core assumption is that this relationship is sequenced and creates typical stages that limit the person's perspective. An examination of the subjective aspects of a career entails an exploration of how a person's perspective changes, as he or she passes from one stage to another and adapts to change (Becker, 1963; Hughes, 1937). In the present study, it was hypothesised that depressed persons are confronted by recurrent challenges related to being depressed and taking medicine, and that they learn to manage these challenges. Furthermore, the temporal changes to the depressed person's perspectives on taking medicine will follow a sequenced pattern,