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

Niels Buus

Institute of Public Health, University of Southern Denmark, JB Winsløws Vej 9B, 5000 Odense C, Denmark

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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.

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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
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 (Sundhedstyrelsen, 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 anti-psychotic 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 con-tinuing the medication. 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 characteristic 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, 2008; 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,
which can be analysed as a career. This paper will focus on the organisation of verbal accounts of changing perspectives on taking medicine, and on the identity-related, moral (Goffman, 1991), aspects of these perspectives.

5. Setting, sample and interviews

The study was conducted at a regional healthcare trust in Southern Denmark in 2008–2009. Participants were recruited into the study from three general psychiatric wards at two general hospitals that admitted patients from urban and suburban areas. The Danish healthcare system is a public healthcare system financed by means of general taxes.

Purposeful, non-probability sampling was used to recruit adult persons discharged with a diagnosis of a depressive episode/disorder (ICD-10 F32.0-F33.9) (WHO, 1993) with a prescription for antidepressant medication and who were able to reflect on and articulate their experiences. This meant that patients suffering from severe additional mental illness, such as a personality disorder, or severe cognitive impairment were excluded. Clinical nursing staff invited eligible patients to participate in the study during a five-month period. The inclusion period was concluded at this point because preliminary analyses indicated that the dataset was both detailed and extensive and that it would match the available resources for data collection and data analysis. It was estimated that 38 patients were discharged with a depressive episode/disorder diagnosis during the inclusion period. Fifteen patients (40%) were excluded and 7 (30%) of the eligible patients declined to participate. The sample included 16 participants and there were no dropouts during the study. The study sample is described in more detail in Buus et al. (2012).

Participants were interviewed using a tripartite semi-structured interview guide designed to encourage narrative accounts of participants' perspectives on depression and anti-depressants in the wider context of their everyday life. The author performed all the interviews, which took place 1, 4, 8 and 12 months after discharge.

In the first part of the interviews, the participants were encouraged to give narrative accounts of their experiences of living with sadness and/or depression. There was a particular emphasis on eliciting the participants' understanding of how their problems with sadness/depression had started (and maybe evolved) and what had happened during the period leading up to the admission, during the admission, and after discharge. The narrative accounts from the first part of the interviews were used as the outset to further explore the issues in part two and three, which added to the creation of situated and comprehensive descriptions of the participants' perspective.

The second and third part of the interviews were focused on exploring participants' explanatory models of illness (Kleinman, 1980) and the participants' social careers (Becker, 1963; Hughes, 1937) through illness and treatment. The focus on explanatory models entailed an exploration of the patients' perspectives on: causes of illness episode, timing of symptoms, pathophysiology, the course of illness, and treatment options. The focus on careers entailed an exploration of patients' perspectives on interactions with family members, friends and acquaintances, work colleagues, healthcare professionals, and their medicine.

The same interview guide was used for all the consecutive interviews. However, during the follow-up interviews the interviewer would emphasise examining the most recent period and systematically ask questions about changes to the narrative accounts. After each interview, the interviewer would listen to the interview and write a résumé, which was used during the subsequent interviews to clarify eventual ambiguities and to ask follow-up questions about the participants' particular situation and perspective.

The average length of the 64 interviews was 72 min (range: 30–147). Research assistants transcribed the interviews verbatim and the author independently checked accuracy between sound and text.

6. Analysis

The thematic analysis had four iterative stages (Miles and Huberman, 1994), which all contributed to memo-writing and theorising on how the participants perceived their illness and the treatment of the illness in the context of their everyday lives.

First, the résumés written after each interview were used to develop and test initial ideas about the participants' perspectives. This was done by organising story lines, plots and sub-plots in the narrative accounts and, when it was possible, having them validated by the participant during the subsequent interview. Second, story lines, plots and sub-plots were used as the outset for coding narrative forces, actants (Greimas, 1983), influencing the participants' understanding and actions. The identification of narrative forces was used to depict a structural organisation of the participants' narratives and to allow a systematic comparison of subsequent interviews with the same participant. Third, each participant's performance in the particular interview context was also coded/analysed. The interactional analysis led to a further “complication” (Coffey and Atkinson, 1996) of the data by emphasising how the participants positioned themselves and negotiated their actions and understanding through their storytelling (Reissman, 1993). Fourth, a matrix display was created in order to create an overview and an outset for systematic synchronic and diachronic cross-participant comparisons. The matrix included central variables, such as ideas about the medications' effectiveness, expressed level of acceptance/scepticism towards taking antidepressant medication, etc.

Reflections on findings from the four analytical steps were worked up in the evolving memos, which were used to write the results section in the present paper. A continual exploration of outliers was a central part of the comparative analysis, which led to the formulation and rejection of many preliminary interpretations before reaching a balanced and contextualised description of the participants' perspectives on taking antidepressant medicine at different stages. Finally, the selection of data extracts in the results section reflects the ambition of providing a balanced interpretation and including quotes from different participants.

7. Ethics

In line with Danish legislation the regional research ethics committee and the Danish Data Protection Agency were notified about the study; neither agencies had any objections to the study. All participants gave their consent to participate based on written and verbal information about the study. Data were handled confidentially and the data extracts reported in this paper were anonymised.

8. Results

The participants' perspectives on their everyday lives taking anti-depressant medication were characterised by continual uncertainty regarding depressive symptoms and the effects of the medicine, which required extensive — and sometimes anxiety provoking — interpretative work. The analysis identified a medication-taking career with two distinct stages, the basic restitution and the frustrated search. Career movement was caused by
experiences of prolonged psychosocial distress, which changed the participants’ perspectives and management of medicine. The categorisation of participants’ perspectives on taking antidepressant medication in Fig. 1 reflects the stages at the time of interview. Fig. 1 also indicates career movement in the one-year data collection period: an increasing number of participants moved from basic restitution to frustrated search.

Some of the participants had previously experienced depressive episodes and had extensive insight into their illness and into taking antidepressant medication. All participants described how they had initially been at the basic restitution stage and some participants described how they at a later point in time had moved to the frustrated search stage. Therefore, basic restitution was regarded as the initial stage, but it was not assumed a priori that participants would be at basic restitution at the beginning of the data collection because of their prior experiences of illness and treatment.

8.1. The basic restitution: accepting and committing

The basic restitution stage was characterised by the participants’ readiness to take the prescribed medicine, which was perceived as an integral and acceptable part of the treatment of depression. The readiness to take the medication was linked to an expectation regarding the medicine’s therapeutic effects and to a strong belief in the authority of the prescribing therapists and healthcare professionals. This set of expectations was a central part of a highly conventionalised sick-role in which taking medicine was taken for granted and the medicine per se legitimised the participants’ illness behaviour.

Events and actions were successfully interpreted in ways that emphasised the participants’ personal control over the situation. Discomfort and potential signs of depressive symptoms were largely normalised; in particular by comparing present symptoms of these participants were sceptical towards taking antidepressants because they saw medicine as the primary means of recovery. Most of these participants were sceptical towards taking antidepressants and experienced some relatively mild adverse effects, but they continued to take the medication in accordance with professional advice, mainly because they saw medicine as the primary means of recovery. Most of these participants were sceptical towards taking antidepressants and experienced some relatively mild adverse effects, but they continued to take the medication in accordance with professional advice, mainly because they saw medicine as the primary means of recovery.

Participant 13 had no prior personal experience of treatment for depression, and she described a need for a healthcare authority to normalise her experiences of depressive symptoms by interpreting them in a less distressing way. Her interactions with the professionals at the emergency room included reassuring consultations and/or prescription of additional medicine, which was in line with her expectations of a delimited and effective medical intervention. After starting to take Lithium to augment her antidepressant treatment, she gradually felt less impatient and distressed. The participants at the basic restitution stage continued taking the medication in accordance with professional advice, mainly because they saw medicine as the primary means of recovery. Most of these participants were sceptical towards taking antidepressants and experienced some relatively mild adverse effects, but they continued to take the medication in accordance with professional advice, mainly because they saw medicine as the primary means of recovery.

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<th>Participant no., gender, agea and discharge diagnosis</th>
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Age is indicated as a five-year interval to protect anonymity. F33 = Major depressive disorder, recurrent. F32 = Major depressive disorder, single episode BDI-II cutoffs: 0–13: minimal depression, 14–19: mild depression, 20–28: moderate depression, and 29–63: severe depression.

* = First-time treatment with antidepressants in present depressive episode. # = First hospital admission for depression.

Fig. 1. Career movement and basic demographic and clinical details.
them as equivalent to taking vitamins. One participant (3), who came out of a family with severe mental illness, found taking antidepressants stigmatising and she continued to put pressure on her general practitioner to authorise phasing out of the medicine even though she feared a relapse of depression.

The experienced tensions and problems did not cause career movement. These participants experienced distressing setbacks, but they managed to control the situation by accepting and using the healthcare professionals’ treatment offers. Their situations were generally experienced as tolerable and in time depression slowly receded into the background of their lives.

8.2. The frustrated search: desperation and increasing self-regulation

The participants’ perspectives on depression and medicine taking changed if they were challenged by prolonged mental, social, and/or physical distress in the period after the discharge, and they would initiate alternative actions for managing their experienced problems. Eight of the participants experienced such prolonged distress as unacceptable and moved to the frustrated search stage. In the following three sub-sections, the career moving tensions and shifts will be described in relation to medicine, healthcare professionals and moral issues.

8.2.1. Self-regulating medicine: carelessness and hypothesis testing

Taking antidepressants was very precarious for the eight participants at the frustrated search stage. Most of these participants experienced severe adverse effects of the medicine, and three participants had dangerously overdosed themselves by accident. All participants were uncertain about the overall therapeutic effects of the medicine, but only two participants (4 and 16) stopped taking all their antidepressant medication; the remaining participants did not dare to reduce or stop taking the medication because of fear of relapse.

Some participants described their rejection of the treatment regime as initially linked to carelessness. For instance, a couple of participants would not be bothered about taking a dosage of medicine if they realised it after having gone to bed or just after leaving the house in the morning.

Participant 16 had previously been treated with antidepressants, but this time she experienced severe adverse effects of the medicine, which included a substantial weight gain and tiredness. At the time of the 2nd interview, she was at the basic restitution stage. She had been prescribed two antidepressants during the admission, but she was ambivalent about taking both. On the one hand she experienced adverse effects, but on the other hand she would not risk relapsing into depression. This meant that she was reluctant about asking her GP for changes. In the following data extract, she normalises the adverse effects by comparing them to a worse situation and she emphasises the risks of reducing medicine by drawing on her first-hand experiences from the admission.

Interviewer: Have you considered asking your GP if there might be an alternative [to the medication]?

Participant 2 (2nd interview): No, I haven’t. I tried some other ones and I didn’t take more than 3–4–5 tablets before I gave up. It felt like fire burning out into my arms and I couldn’t take it. I haven’t had that with Noritren [Nortriptylin]. I have dry mouth and they give you the shakes and things like that. (. . .) I’d like to get rid of one of the medicine, but what if I get worse? I saw someone [during the admission] reducing their medicine and they ended up feeling awful.

She remained convinced that one of her two antidepressants was stressing her and gave her restless evenings and nights. She
eventually asked her general practitioner to reduce the prescribed dosage, but he refused and told her that there was nothing to do but to continue. By the time of the 3rd interview, she had moved to the frustrated search, as she reacted to the GP’s disheartening response and decided to solve the problems by halving the dosage on her own:

**Interviewer (3rd interview):** Do you still get Mirtazapin?

**Participant 2:** Yes, but we’ve halved it, or rather, I’ve been allowed to halve it.

**Interviewer:** How come you say it like that?

**Participant 2:** I found out that when I go to bed something is stressing me. I wake up and I can’t settle again. So, I am sure it’s not good for me

**Interviewer:** How do you feel after reducing to half dosage?

**Participant 2:** I stress about until I find rest

**Interviewer:** So its still there?

**Participant 2:** Yes

Participant 2 remained convinced that the medication caused her restlessness and she continued to believe this in spite of her “test” indicating that it did not. The participants often blamed the medicine having adverse effects rather than considering other reasons for their distress, such as their depressive illness. In line with the accounts in the previous data extracts, most respondents legitimized their self-regulation by depicting it as an understandable and necessary response to an unsustainable situation.

### 8.2.2. Interacting with healthcare professionals

During the admission, hospital based psychiatrists would be responsible for prescribing medicine. After discharge, general practitioners assumed treatment and prescription for most of the participants. A few participants had a transitional period in the specialised mental health services. Some participants deliberately sought to reduce their interactions with their therapists, while other participants had very few consultations because of their own specialised mental health services. Some participants deliberately

At the 1st interview, Participant 12 was at the basic restitution stage, medication was altered in accordance with Participant 12 wishes. At the new hospital in a different town, and he was pleased to get a second view on his illness and his medication. At the new hospital, the medication was altered in accordance with Participant 12 wishes. At the 1st interview Participant 12 was at the basic restitution stage, and he reflected back on what he believed to be a dangerous lack of responsiveness:

**Participant 12 (1st interview):** It could have been good if they [at the usual hospital] had been better at listening to my complaints regarding the medicine. I believe that the last admission could have been avoided if I’d stopped taking that Seroquel [Quetiapine] and started taking something else. Because the tiredness, I had, added to weaken the whole system.

At first, Participant 12 was pleased to have his medicine reorganised and he started using psychiatrists at the new hospital as his primary therapists. At the second interview, he had started self-managing his medicine, moving to the frustrated search, because he felt bad and — paradoxically — by reducing the medicine, he could prove to himself that things were good. In hindsight, he believed that his own reduction added to his distress. After the 2nd interview, he was readmitted to the new hospital where the psychiatrists wanted to augment the antidepressant treatment with Lithium, because they believed he suffered from a bipolar disorder. Lithium made Participant 12 feel tired and after discharge he decided to stop taking all the medicine augmenting his antidepressant treatment without consulting any professionals. After consulting the Internet, he argued that Lithium was fundamentally harmful to the body and had too many adverse effects and that he might as well test if he could do without it:
Interviewer: How come you took this decision without talking to the doctor?

Participant 12 (3rd interview): It was probably because the doctor would be against it. I think I have an appointment in about a month from now. I thought that if I stopped them I could see if it reduced my tiredness, and if there are no problems, then there is no reason to take them.

Participant 12's perspective on taking medicine changed and his self-regulation increased gradually and was kept hidden from healthcare professionals and his wife whom he was convinced would not approve of his decisions. Participant 12 planned on informing his doctor, but cancelled appointments meant that this had still not happened at the 4th interview. Most participants would eventually inform their therapists of their self-regulation and typically be met by cautionary comments.

Out of the eight participants on the frustrated search stage, six participants described seeing their therapist, but four of them regulated their own medicine in spite of regular contact with the therapist. Three participants lost contact with their therapist: two decided to stop seeing their therapist after a period of missed and/or cancelled appointments and a psychiatric consultant ended contact with a participant after she had complained about an erroneous prescription. The participants on the frustrated search gradually stopped collaborating with their therapists, allegedly because they did not offer sufficient and appropriate solutions to the participants' problems: the therapists were seen as unimportant or simply adding to their problems.

8.2.3. Moral issues of self-regulation

Management of the depressive illness was very precarious for all participants. Disclosure of returning depressive symptoms and need of help was regarded as a personal defeat. Although most of the participants said that they where not ashamed of the illness, they preferred not to talk about their illness and they only rarely involved their next of kin in their thoughts and actions. For participants living with partners, medicine taking was often described as a source of tension, because they expected that their partners regarded adherence to the treatment regime as necessary for preventing relapse and self-regulation as unnecessary risk-taking. There were no reports of quarrelling, but descriptions of cautious and sometimes suspicious surveillance.

Two participants on the frustrated search stage described a particular type of self-regulation, which was linked to a strong sense of a moral turning point regarding taking control of the treatment of depression. These participants (6 and 12) described how they had been prescribed many different types of medication in increasing dosages and how they had come to understand this response from their therapists as a decisive part of their problems. Both decided to reorganise their medication drastically, and on their own initiative they reduced their medicine to only include one, the same, antidepressant [Nortriptylin], which they did not dare reduce because they believed it to be effective. In case something unforeseen happened after stopping taking the medicine, both participants had informed a trusted person about the reorganisation. Participant 6, was the only participant who self-regulated her medicine at all four interviews and at the first two interviews she regulated one of her medicines. She described that whenever she felt bad and consulted a therapist, who was never the same because of institutional reorganisations, the only response was to prescribe more medicine. She felt more and more certain that this response added to the problem rather than to its solution:

Participant 6 (2nd interview): It is good that you can get medicine when you have pain and medicine when you are depressed. But I don't think it is a solution to just add more and more medicine because you go crazy because you're doped all the time. I think I taking something like 29 pills a day.

In between the 2nd and the 3rd interview, Participant 6 decided to reorganise her medication and used her sister as a trusted person, who was the only one knowing about this complete and abrupt withdrawal. Her sister helped her by text-messaging frequently:

Participant 6, 3rd interview: The decision just emerged: I had to say either or (...) I felt so bad. Had it not been for my sister who texted me all the time, I would not have been here. I don't think so (...) I was going mad. I had to revise my life and find out "what is it you want". It was so hard. I didn't sleep for four days after stopping taking Seroquel [Quetiapine]. I didn't. I could not find rest. I had them, but I was stubborn and said "no, Hell no, it shouldn't be like that."

Participant 6 understood the decision to reorganise the medicine as a decisive turning point where she had to manage severe withdrawal symptoms, and she prevailed because of her obstinacy. Neither of these two participants solved all problems related to their illness, but they solved what they saw as a problematic and unnecessary medication and that induced a strong sense of personal power and reclamation of social identity.

Most participants experienced adverse effects of the medicine, and in most situations they were able to manage and tolerate them in everyday life. Dry mouth, for instance, was managed by chewing gum and by always having a water bottle within reach. However, some adverse effects were experienced as intolerable if they threatened a particular person's identity. For example, some participants found weight gain or sexual disturbances stigmatising and intolerable (while others did not care much about it). Experiences of such identity-threatening adverse effects added significantly to the participants' eagerness to get off the medicine. Most participants were impatient to get back to their old life, and for a few participants it was very hard following a regular treatment regime for an illness they were desperately eager to get rid of.

9. Discussion

The present study adopted an interactionist conception of an antidepressant-taking career and explored the idea by means of a prospective design, which focused on how the participants' perspectives evolved through a one-year period after an admission for depression. The analysis identified two distinct stages: The basic restitution stage, in which participants perceived control of their situation by taking antidepressants as prescribed by healthcare staff, and the frustrated search stage, in which the participants' perspective on illness and treatment changed and they tried to solve some of their problems by self-regulating their antidepressants. The non-conformity/non-adherence of the frustrated search stage may be linked to less effective social control as the influence of healthcare authority became increasingly peripheral in everyday life, more or less planned experimenting with self-regulation could be kept secret from family and healthcare professionals, and self-regulation gradually became morally acceptable for users. Thus, the conceptualization of antidepressant use as a career can add to a more nuanced understanding of some of the social influences on taking antidepressants.

The present study was founded on assumptions about a staged relationship between individuals and social organisation, and such a notion of antidepressant-taking careers has been put forward
before. Malpass et al.'s (2009) meta-ethnography concluded that patients manage antidepressants by passing through two parallel careers: A "medicinal career", where they cope with decisions about taking antidepressants, and a "moral career", where they cope with the moral aspects of taking the medication. First, however, it could be argued that Malpass et al.'s two careers were to a large degree an artefact of sampling studies from two distinct research traditions: a clinical tradition focussing on attitudes to medicine and medication-management and a social science tradition focussing on illness careers and identity. Second, Malpass et al. (2009) described a sequence of benchmarks in an individual's moral careers, but the conception of "career" was not explicit, and the epistemological/theoretical status of the interpretative synthesis was indeterminate.

In Karp's (1993) seminal interview study, the interviewee's experiences of taking antidepressants were also conceptualized as a career. However, Karp emphasized that the interviewees went through two initial stages as they resisted taking antidepressant treatment but eventually accepted medicine (in the widest sense). Such elaborate beginner stages were not observed in the present study and it may be an implication of the present study's recruitment strategy to use a hospital admission as a sampling index point. Compared to Karp's sample, the sample in the present study was most probably more acutely and severely ill, and they would therefore more readily conform to the treatment regime. Karp described how after a while the interviewees would be disenchant and lose faith in the medical model and in antidepressants because of poor treatment effects and many adverse effects. Contrary to Karp's disenchant interviewees, the most prominent moral turning point identified in the present study — the point where medicine was regarded as part of the problem and a self-initiated reorganization was carried out — was not a wholesale rejection of medicine, but a personal appropriation by experienced users. These differences can be attributed to different research designs and sampling strategies. Finally, in line with Karp's career, the present study identified psychosocial distress as creating career movement, but the present study specified experiences and interactions related to increasing self-regulation as the defining difference between a conforming, basic restitution, medication taking stage and a deviant, frustrated search, medication taking stage.

A key challenge to studying people's perspectives on taking antidepressants is that they change through time. The participants in the present study were recruited at the same index point, but six participants had been prescribed antidepressants for the first time during the particular illness episode and for eight participants it was the first admission to a psychiatric hospital. So despite the clearly defined index point, the participants were at significantly different stages in their overall illness careers and represented a relatively heterogeneous sample. In this light, the sample and the follow-up period were limited, and caution must be taken, when comparing the findings to other studies. However, Veerbeek-Heida and Mathot's interview study (2006) gives some indication of what the characteristics of the basic restitution stage would be in a longer timeframe. Their interviewees had taken antidepressants for 4.5 years on average and they had found a stable balance. However, they would prefer to discontinue taking the medicine, but they chose to continue taking the medicine, rather than discontinuing and risking relapse. As lay persons have strong normative expectations about resisting and minimizing the use of medicine (Pound et al., 2005), their acceptance of taking medicine may be reduced in time and the stability of the basic restitution stage will be subverted and cause moral stress.

Eight participants in the present study moved from one stage to another during a one-year period. This was surprising, because 30–60% of patients are reported to discontinue taking the prescribed antidepressant medication within the first 12 weeks of treatment (Lingam and Scott, 2002; WHO, 2003). van Geffen et al. (2011) interviewed 18 antidepressant users three months after the start of therapy and the interviewees that had discontinued redeeming prescriptions were not convinced of the necessity of using antidepressants and appeared to have a strong desire to discontinue treatment. It is very likely, that levels of depression impinge on people's perspectives on the acceptability and necessity of antidepressants, which, in turn, impinges on the length of the period before people initiate self-regulation. In terms of the present study that would entail that passing between stages would occur sooner. In addition to analyzing a heterogeneous sample of participants, the consecutive interviewing meant that the participants were continually re-configuring their narratives, which, compared to interview studies of informal social careers based on cross-sectional interviewing, such as (Becker, 1963; Karp, 1993), resulted in relatively complicated data. People's perspectives on taking antidepressants are dynamic because their lives touch social order at other points than when they use antidepressants and because they must interpret recurring biological changes. Caution must be taken before suggesting further distinct stages of how people learn to use antidepressants.

The study was an exploration of the participants' perspectives primarily based on interview data. An interactionist conception of interviewing implies viewing the interview responses as products of situated interpretative practice (Holstein and Gabrium, 1995). The way in which the participants and the interviewer oriented to the concrete interview situation would unavoidably have activated some particular considerations, and the interview data must be considered within this particular research setting. For instance, the participants' post hoc justifications of potentially blameworthy actions would be articulated to make the actions appear understandable and legitimate for themselves and for the interviewer. McMullen and Herman (2009) and van Geffen et al. (2011) observed very similar patterns of justification among participants who had stopped taking their antidepressants and who positioned themselves as being responsible and rational drug users. Therefore, the interviews could have been combined with multi-sited fieldwork in order to enable a fuller and more complex account of how people experience and manage taking antidepressants in their everyday lives. A final "clinical" limitation is that people typically overestimate their level of adherence because of unacknowledged slips or forgetfulness, and such un-intended non-adherence can only be studied to the extent that a person becomes aware of it. Combining the indirect self-reported level of adherence with more objective indirect measurements, such as pill counts or prescription refills, could add to our understanding of self-regulation and non-adherence.

10. Conclusion

The study contributes to a better understanding of the dynamic and staged social influences on the individual antidepressant users and their striving to make the best of their complicated and challenging lives. Antidepressant medicine is not highly effective and many frustrated users will search for and initiate alternative ways of managing their experienced problems. Trusting relationships between healthcare professionals and antidepressant medication users are regarded as a crucial influence on medicine taking practices. However, qualitative studies have documented unsatisfactory interactions between antidepressant medication users and healthcare professionals, e.g. Anderson and Roy (2013), Leydon et al. (2007) and van Geffen et al. (2011). The present study indicated that healthcare professionals played a very peripheral role in most participants' lives, and that unsatisfactory interactions often
isolated participants and left them to solve their own problems. Therefore, healthcare professionals are challenged to expand their traditional role as therapists and to start accepting and accompanying patients who would otherwise be alone in their private and precarious search for solutions.

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