

Patients' Representations of Antidepressants: A Clue to Nonadherence?

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Objectives: Antidepressants are prescribed frequently to chronic pain patients due to their pain relief effects. This medication raises major adherence issues. Despite the adverse effects, little is known about the factors that may jeopardize adherence in chronic pain patients. We carried out a qualitative study to investigate chronic pain patients' representations of antidepressants as compared with pain-free controls.

Methods: One hundred thirteen chronic pain patients recruited in a multidisciplinary pain clinic and 62 matched controls were questioned with standardized semistructured interviews. The interviews were submitted to content analysis.

Results: Ambivalence emerged as an important aspect of "patients" and controls' views about antidepressants. Antidepressants were described as potent chemicals acting in the brain, possibly causing effects on cognition, emotions, and personality, and inducing dependence and loss of control. Positive effects were mentioned, but when respondents related their own views and experiences, the statements became less favorable. Another key point was that neither the representations of the patients and nor those of the controls comprised the analgesic properties of antidepressants.

Discussion: Chronic pain patients' representations differed only little from those of controls. Antidepressants were not considered as addressing somatic problems. Thus, the prescription of antidepressants for chronic pain may be mistaken for a denial of the "reality" of pain. Although this study did not assess medication adherence, it is possible that patient representations have a bearing on adherence. Clinically, this suggests that these representations should be elicited and addressed, taking into account the patients' own models of pain.

Key Words: antidepressants, adherence, chronic pain, representations

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Antidepressants have pain relief effects on neuropathic pain, as numerous clinical studies have observed. Moreover, these medications have been reported as being

effective in relieving pain associated with several chronic pain syndromes.^{1–3} The prescription of antidepressants to chronic pain patients is often associated with a variety of other prescribed and nonprescribed drugs.⁴ In such patients, nonadherence issues and the inappropriate or excessive use of medication have been described.^{5–7}

In clinical use, antidepressants are associated with a delay in efficacy and a relatively high incidence of adverse effects¹ that jeopardize patients' adherence.⁸ Studies of depressed patients revealed high rates of nonadherence to all classes of antidepressants.^{8,9} Nonadherence is likely a multifactorial phenomenon.⁷ Depressed patients frequently cite fear of dependence and adverse events, along with feeling better, as reasons for treatment discontinuation.^{8,10} Nonadherence may be unintentional or intentional. Patients may not think of taking drugs merely in terms of obeying a doctor's prescription. Instead, patients weigh the advantages and disadvantages of taking medication within the context of their everyday lives.^{11–13} This perspective implies that nonadherence may be a rational decision, based essentially on the patients' own experiences and representations. Representations consist of socially constructed and shared knowledge based on the experience and models of thought transmitted through education and social communication.^{14,15} As a form of practical knowledge, representations help us to master our environments and to understand and explain our universe.¹⁵ Patients' representations of their illness are one important aspect of the patients' decision-making processes regarding their treatment, along with the interaction between the patients' illness and their perceptions of treatment.¹⁶ These elements influence the way in which patients organize new information that they receive (ie, whether to incorporate it with or without changes or discard it).¹⁵ There is then the question of the similarities and differences between these representations, the scientific model used by the patients' doctors, and the way in which these characteristics can influence adherence to the prescription. In the scientific model, physicians may consider the prescription of antidepressants to chronic pain patients. However, the patients' opinions regarding the use of this type of medication for their chronic pain problem has not been studied. This is a relevant question because long-term pain has been identified as a major reason for patient consultation.¹⁷

On the basis of these observations, we carried out a qualitative analysis designed to lead to a better understanding of chronic pain patients' representations of

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antidepressants. Indeed, better insight into why pain patients adhere to an antidepressant treatment may be as clinically relevant as the knowledge that antidepressants have analgesic effects.¹⁸

Studies have shown that in general populations, representations of psychotropic drugs in general are mostly negative, with most individuals referring to real or presumed somatic and/or psychologic harmful effects.^{19,20} This analysis thus included a matched control group to investigate whether chronic pain patients have specific representations about antidepressants and, if so, whether these patients share their representations with lay people in general, that is, with pain-free nonpatient controls. We hypothesized that the representations of antidepressants would not differ in both groups, as these drugs are usually associated with psychologic difficulties or mental diseases and not with chronic pain problems.

MATERIALS AND METHODS

Population

Consecutive chronic pain patients newly referred to the Geneva Multidisciplinary Pain Center were recruited. The Center is an outpatient facility to which chronic refractory pain patients are referred by their physicians for evaluation and treatment. To ensure that the investigation included a representative sample of patients attending the center,²¹ the recruitment process extended over a 12-month period. The sample of patients had to represent a range of sociodemographic characteristics (sex, age, educational and employment status, and origin) and a variety of chronic pain problems (etiology, duration, intensity, and medication intake) that might influence patients' experiences with antidepressant intake.

Patients who reported pain associated with cancer or who were unfamiliar with the French language were excluded. Of the 118 eligible patients, 113 (96%) accepted to participate.

Pain-free nonpatient controls were recruited from the general population and selected to match the patients' sociodemographic characteristics except for employment status. As is usually the case in qualitative studies, the number of participants included was determined by inductive sampling (ie, by the need to encompass the range of possible responses and to achieve theoretical "saturation"²²). Sixty-five participants allowed to reach the point where no new categories or themes emerged from the content analysis of the interviews. The protocol was approved by the local Ethics Committee, and written informed consent was obtained from all participants.

Procedure

Participants were questioned using standardized semistructured interviews,^{22,23} which were conducted on a one-on-one, face-to-face basis onsite at the treatment facility. Open-ended questions assessed patients' and controls' representations of medication in general and of antidepressants in particular, including their concerns about antidepressants, and the sources that they used to

obtain information about antidepressants. A few general questions addressed participants' views on medication. For example, they were asked "According to you, what is medication?" and "When you take medication, what do you do to get information about it?" Most of the interview then focused on antidepressants, with questions designed to elicit participants' views on antidepressants, starting from their general representations ("According to you, what is an antidepressant?"). The interview then investigated specific points, such as the uses and modes of action of antidepressants, and the adverse effects and risks of this type of medication when these issues had not been spontaneously mentioned. Participants were then asked about their experiences with antidepressants and their readiness to take/continue an antidepressant treatment.

Two experienced members of the research team who were not involved in the patients' care conducted the interviews. We chose to ask the patients to respond to open-ended questions instead of relying on multiple choice questionnaires. As patients' representations were the major end point in this study, the method of investigation needed to provide an opportunity to assess the patient's own representations and to consider his/her way of thinking and reasoning. The purpose of a semistructured interview may be specifically to gain access to these processes. The issue in this study is not to evaluate the proximity of these representations with a definition supplied by the scientific knowledge as might be proposed in a structured questionnaire. Such a procedure would mainly call up recognition memory.²⁴ Some information might not be accessible to recall memory but may be recognized when presented among others in a questionnaire. Furthermore, items included on a questionnaire might inhibit a further search for alternative answers.²⁴ The patients' own definitions may thus allow for a more thorough assessment of their understanding of the concepts investigated in this study.

Patients and controls were asked about their current analgesic and antidepressant intake. It should be stressed that these questions related to the participants' representations and thus focused on how they reported their intake while not measuring their actual ingestion of the medication. Their responses were recorded according to precoded categories using the trade names of the drugs. As all the patients had been recently referred, their medical records were available for a reliability check regarding reported current medication intake. Previous antidepressant intake was generally investigated as being present or absent, and such reports relied only upon the participants' own memories.

Analysis

The interviews were audiotaped and transcribed. The transcripts were then analyzed using a manual data indexing technique to identify key themes.²⁵ The qualitative analysis began with individual close readings and annotations of the interview transcripts by 2 researchers working separately. The systematic analysis continued

throughout the data collection and coding process, using the constant comparative method,²⁶ which consists of analyzing the interviews by comparing one response with earlier observed responses. This was followed by a discussion and comparison of the readings of the data, which were subsequently used to establish analytical categories and themes. These categories and themes served as the basis for a final grid, which was then used independently by 3 researchers to analyze the transcripts to maximize theoretical sensitivity and rigor.²⁷

The results of the separate analyses showed excellent between-raters agreement ($K > 0.90$). Disagreements were solved by consensus. The final grid provided a basis to assess and compare the number of people who mentioned the various categories derived from content analysis in both groups. This comparison allowed for the identification of dominant categories and themes, that is, patterns of responses. We also compared the responses of the participants according to their sociodemographic characteristics and to their antidepressant intake to examine the possible influence of these variables on the patterns of responses. In addition, we compared the patients' responses according to the characteristics of their chronic pain problems, including their current medication intake. χ^2 tests for categorical data and a t test for continuous data were used to examine differences between pain patients and controls on demographic factors.

RESULTS

Population

The sociodemographic characteristics of the chronic pain patients (N = 113) and the controls (N = 65) are presented in Table 1. Comparison of the sociodemographic variables showed no statistically significant differences between the patient and control groups except for the employment status, as expected.

In the patient group, musculoskeletal pain prevailed (69%); the median pain duration was 3 years; the mean present pain intensity was 76/100 mm (visual analog scale) and the current analgesic intake was high (90.3%). Table 1 shows that most of the patients' current analgesic medication included nonsteroidal anti-inflammatory drugs and weak opioids.

As for antidepressants, 37 patients (32.7%) and only 5 (7.6%) controls reported current intake. Patients' medical records showed similar reported current intake (N = 37) and prescribed antidepressant medication (N = 38). The similarity between the responses of the patients and the data from their medical records is noteworthy as it shows that recall biases were not a major concern for reported current intake; however, it cannot be considered as evidence of actual antidepressant ingestion. We also asked the participants whether they had ever used antidepressants; the reported intake rose to 62% in patients and 31% in controls. Whereas 24% of the patients reported pain, and 16% cited pain and depres-

TABLE 1. Sociodemographic Characteristics

	Patients (N = 113)	Controls (N = 65)
Age (y; ns)		
Mean (SD)	46.2 (14)	44.3 (16.2)
Range	19-89	18-86
Sex (ns)		
Female/male	59/54	36/29
Educational status (ns)		
Elementary school	36	23
Qualified worker	42	17
High school	18	12
University	17	13
Employment status ($P < 0.01$)		
Full time	15	42
Part time	20	11
Retired	10	9
Unemployed	4	1
Sick leave	20	0
Disability pension	44	2
Origin (ns)		
Swiss	56	40
Other European	44	22
Other	13	3
Pain etiology		
Musculoskeletal	78	5
Neuropathic	21	20
Persistent somatoform disorder	8	
Visceral pain	6	
Median pain duration (y)	3 (min = 1 – max = 39)	
Mean pain intensity		
VAS mm (SD)	76 (19)	
Current analgesic intake		
NSAIDs	53	
Weak opioids	44	
Strong opioids	10	
Anticonvulsivants	14	
Muscle relaxants	14	
Current antidepressant intake	37	5
Antidepressant intake "ever"	70	20

Numbers are raw data.

ns indicates differences between patients and controls are nonsignificant; NSAIDs, nonsteroidal anti-inflammatory drugs; VAS, visual analog scale.

sion as the reason for antidepressant intake, all controls reported depression as the reason for intake.

Representations of Medication in General

Fifteen categories were derived from content analysis. Seven referred to a dimension that might be labelled as "healing aspects" or "perceptions in favor of taking medication" and 8 pertained to a second dimension that might be labeled as "fear-raising aspects" or "doubts about medication."

The patients' most frequent replies showed ambivalence toward medication. Such replies included the following: medication as relieving pain, bringing temporary relief rather than cure, having adverse effects, possibly causing dependence, being dangerous for the organism, and being best avoided (Table 2).

The controls shared the dominant representation regarding medication as relieving pain. They also stressed the risk of dependence (Table 2). However, they had more

TABLE 2. Themes of the Representations of Medication

	Patients N = 113 (% of Responses)	Controls N = 65 (% of Responses)
Healing aspects		
Pain relief	86 (76%)	43 (66%)
Treatment	31 (27%)	27 (42%)
Cure	16 (14%)	21 (32%)
Germ killer	12 (11%)	7 (11%)
Through chemical action	26 (23%)	34 (52%)
Through "natural" action	10 (9%)	7 (11%)
Psychologic help	5 (4%)	5 (8%)
Fear-raising aspects		
Adverse effects	30 (27%)	5 (8%)
Dangerous for the organism	27 (24%)	5 (8%)
Dependence	28 (25%)	12 (18%)
Drug/poison	12 (11%)	4 (6%)
Body gets used to them	15 (13%)	3 (5%)
Better to avoid them	56 (50%)	21 (32%)
Not always efficient	26 (23%)	10 (15%)
Effects are only temporary	14 (12%)	4 (6%)

As more than one response was possible, the total is higher than 100%.

positive perceptions of medication. Indeed, they put more emphasis on medication as "a means to cure" and less stress on adverse effects or "dangers for the organism," although a third of these respondents considered it "better to avoid drugs."

Representations of Antidepressants

Issues cited in the interviews were organized into 5 main themes: "psychosocial effects," "chemical effects in the brain," "crutch effects," "danger and addiction," and "somatic effects" (Table 3). The term "effects" covers both the indications and side effects of antidepressants, as, in their answers, the respondents spoke more frequently about the side effects than about the medications' purpose while often not clearly distinguishing these 2 aspects.

Ambivalence emerged as an important aspect of patients and controls' views on antidepressants. A concern over the possibility of combined positive and negative physical, psychologic, and social effects was expressed in an overwhelming majority of the interviews in both groups.

Positive and Negative Psychologic and Social Effects

Respondents commonly referred to antidepressants as indicated for psychologic problems such as uneasiness, irritability, and anxiety, which the participants described as the result of negative life events and interpersonal problems. In such circumstances, antidepressants were viewed as possibly "helping to cope with emotions," "restoring moods," or "inducing soothing effects," but antidepressants were also thought to lead to a "loss of drive" and thus of capacity to deal efficiently with life problems: "To be calmer, or so that you accept more than you'd like to...it makes you do things you wouldn't

TABLE 3. Key Themes of the Representations of Antidepressants

	Patients N = 113 (%)	Controls N = 65 (%)
Psychosocial effects		
Soothing effects	50 (44%)	24 (37%)
Restore mood	44 (39%)	41 (63%)
Negative life events	35 (31%)	18 (28%)
Madness	33 (29%)	17 (26%)
Irritability	23 (20%)	9 (14%)
Uneasiness	22 (19%)	14 (22%)
Modify personality	17 (15%)	12 (18%)
Anxiety	16 (14%)	19 (29%)
Violent impulses	15 (13%)	2 (2%)
Loss of drive	11 (10%)	5 (8%)
Interpersonal problems	10 (9%)	13 (20%)
Social stigma	7 (6%)	10 (15%)
Chemical effect		
Act on the brain	36 (32%)	34 (52%)
Potent medication	18 (16%)	10 (15%)
Chemical action	16 (14%)	26 (40%)
Remedy an imbalance	13 (12%)	12 (18%)
Related to dosage	12 (11%)	10 (15%)
Crutch effect		
Help but no cure	20 (18%)	24 (37%)
Lessen emotional impact	20 (18%)	17 (26%)
Additional treatments are required	18 (16%)	18 (28%)
Do not solve problems	16 (14%)	25 (38%)
Conceal problems	9 (8%)	10 (15%)
Danger/addiction effects		
Dependence	53 (47%)	48 (74%)
Dangerous medication	23 (20%)	11 (17%)
Aggravate problems	20 (18%)	6 (9%)
Abuse	11 (10%)	16 (25%)
Somatic effects		
Adverse effects	63 (56%)	27 (42%)
Pain	23 (20%)	2 (3%)

As more than one response was possible, the total is higher than 100%.

normally do. It helps accept a situation that normally I wouldn't accept. I don't know if it's a good thing or not" (Patient 39, female, age 52, fibromyalgia). Antidepressants also conjured up representations of more severe problems: "Antidepressants are for insane people, so it's not easy to get them for pain..." (Patient 108, male, age 64, low back pain). This medication was also described as possibly inducing a "loss of control" and "personality changes": "It is a pill that makes you happy, that makes you feel in a good mood... but I'm afraid it would make me lose control like neuroleptics do and I'd dribble" (Patient 106, female, 47 y, low back pain).

Chemical Effects in the Brain

The above-mentioned description paralleled the depiction of antidepressants as potent agents acting on neurons, on chemical transmissions in the brain to stop negative influxes and false information or to correct an unbalance. As chemicals, antidepressants were viewed as medications that are best avoided, and the respondents also emphasized that the human body is not designed to continuously receive a chemical substance.

Crutch Effects

Respondents stressed that antidepressants do not solve, but only mask problems. They described antidepressants as being “a spare wheel,” or “rose-colored glasses”: “*All the same, I don't think the body is made to have chemicals in it all the time... I think you should be able to struggle a bit on your own, and, as far as I'm concerned, antidepressants are like crutches when you have a cast. When the cast is taken off, you should be able to get rid of the crutches*” (Control 31, female, age 53). Thus, the medications were considered to help but not to cure the problems. Respondents felt that, in some instances, the medications even prevented their cure. The need for additional treatments was often mentioned.

Danger and Addiction

Limitations and fears about antidepressants were mentioned in both groups even before a specific question about adverse effects and/or risks was asked. In response to the question “According to you, what is an antidepressant?” this patient explained: “*It's for sick people... for people who become completely depressed, a bit crazy... so to say... it acts completely in the centre of the head... it puts you in another world... it's kind of a drug, isn't it?*” (Patient 12, female, age 55, neuropathic pain). Both groups mentioned dependence as a major risk. As antidepressants were viewed as a help but not a cure, participants were concerned about having to take them all their lives to mask the symptoms. The risk of abuse and of a potential worsening of the problem while taking antidepressants was also mentioned. Part of the danger was seen as being due to their action within the brain, and effects such as “inhibiting the brain functions” or “inducing brain atrophy” were feared: “*I told myself 'where are you going to stop?' Dependence, hemorrhoids, drowsiness, inhibition of the brain*” (Patient 95, male, age 53, low back pain).

Five patients—and no controls—responded that antidepressants involved neither adverse effects nor risks; and only 3 patients and 2 controls responded that antidepressants had no more and no less adverse effects or risks than any other medication.

Somatic Effects

Patients and controls emphasized somatic adverse effects, referring to symptoms and problems such as the “destruction of brain cells,” “cardiac problems,” “sexual problems,” and “weight gain.” The main difference between the groups concerned pain as an indication as mentioned by 23 patients: 13 referred to the consequences of pain and only 10 to pain relief. Patients did not refer to pain relief owing to antidepressants as a decrease in pain intensity but rather as a way to get used to the pain or an aid to help them to think less about the pain: “*It helps me... maybe to forget my pain a bit... not being on the edge of tears all the time because I think about the situation I'm in and I don't really know how to get out of it*” (Patient 98, female, age 43, low back pain).

The comparison of the most frequent replies in terms of the categories derived from content analysis showed similar patterns of response in the participants, chronicity and intensity of pain, sex and age notwithstanding. This comparison also showed that the participants with a higher educational status put a particular emphasis on the chemical effect of antidepressants on the brain and also on their crutch effect. The pattern of responses was very close in those patients having an analgesic intake and those having no such intake, be it nonsteroidal anti-inflammatory drugs or opioids. This pattern was also close in the participants with no antidepressant intake and in those having a current antidepressant intake who nevertheless stressed even more strongly the somatic effect of antidepressants.

Willingness to Take/Continue to Take Antidepressants

In line with the ambivalence associated with antidepressants, patients provided few clear-cut responses, except for a straight refusal in a quarter of them (23%). Possible acceptance was riddled with “ifs and buts”: for psychologic problems, if life were ever so difficult (25%); in case of severe problems, if no other means were available (28%); and acceptance for use to combat pain if the medications' analgesic efficacy were demonstrated (24%): “*To try?... if it is better than cortisone, then yes... but I think I should have an MRI... there could be something torn*” (Patient 58, male, age 35, neck pain). None of the controls mentioned an acceptance for use to combat pain, and their responses were equally divided in the other 3 categories.

DISCUSSION

The key points of this study are that the representations of both groups, chronic pain patients and control participants, about antidepressants are ambivalent. These representations do not include the analgesic properties of antidepressants; the few mentions of pain as an indication refer to the consequences of pain or to a way to get used to the pain rather than to a decrease in pain intensity.

To our knowledge, whereas numerous studies have addressed the issue of depressed patients' and general populations' representations of antidepressants, chronic pain patients' views on antidepressants have neither been documented before, nor compared with those of pain-free healthy controls. Most of the respondents expressed concerns about possible combined positive and negative psychologic effects. Antidepressants were described as potent chemicals acting in the brain, often perceived as a crutch rather than a cure, possibly causing deleterious effects and inducing dependence. Positive effects were mentioned, but when respondents related their own views and experiences, the statements became unfavorable [ie, they did not experience the expected positive effects—better mood or less pain—or they experienced or witnessed negative effects (“*feeling in another world,*” “*be driven to commit suicide,*” ...)].

Another expression of this ambivalence was the majority of “ifs and buts” responses to the question about the participants’ readiness to take antidepressants (except in those with a current intake). Moreover, the conditions for accepting antidepressants were related to the description of a mental state that neither patients nor controls had personally experienced. When faced with a prescription for antidepressants, patients may find it hard to act against their representations. Nonadherence would then be a way to regain inner coherence.

Our results parallel those of opinion poll studies on psychotropic drugs that underscored their harmful psychologic effects.^{19,20} These results also corroborate the reasons for nonadherence in depressed and nondepressed patients: cited reasons for early discontinuation were adverse effects, fear of dependence, lack of efficacy, and the will to solve problems without drugs.^{8–11}

The ambivalence toward medication has already been observed in diverse settings and for various drugs.^{13,16,28} As for the representation of drugs in general, however, it is noteworthy that our results stressed that people who had a frequent and/or regular medication intake mentioned more fear-raising aspects than controls in whom there was no or only occasional intake. This raises the issue of adherence in patients who are prescribed medication on a daily basis for a chronic condition.^{29–32} It suggests the need to negotiate the prescription with regard to the risks and the benefits of the drugs, as described in the textbooks and as perceived by the patients. This implies the need to investigate how patients view the purpose and also the expected positive and negative main and side effects of the drugs to decrease possible dilemmas related to ambivalent representations.

The 2 groups showed differences in employment status and antidepressant intake, with most of the controls working and more than half of the patients being on sick leave or on disability. As for current antidepressant intake, it was as much as 4 times higher in patients than in controls. These results parallel findings in the literature indicating that chronic pain is associated with employment status³³ and with depression,³⁴ and also that antidepressant medication is recommended in chronic pain conditions.^{1–3}

Only some patients mentioned pain as an indication for antidepressants. This response was less frequent than expected when compared with their reported antidepressants intake. The issue may be whether they actually regarded “pain” as the indication or whether they considered the prescription of antidepressants as related to their “pain problem” as a whole. In the interviews, the mention of pain as an indication alluded more often to the alleviation of its consequences than to the antidepressants’ intrinsic analgesic properties. This raises the question of whether this indication is so much at odds with the patients’ representations of antidepressants that it could not be incorporated. According to the patients’ preexisting representations, new information may be incorporated, modified, or discarded.^{14,15} There is then a problem regarding the similarities and differences

between these representations and the models of the prescribing physicians.^{35–37} When patients and physicians do not share a common understanding about the indication of a medication, there is a risk that patients will judge the therapy offered as irrelevant.

Adherence to the prescription may thus depend on the closeness between patients’ representations and physicians’ explanations.^{38,39} Moreover, patients use sources of information other than physicians (eg, patients and controls rely heavily on patient information leaflets that point to antidepressant indications that have a clear psychologic, if not psychiatric, connotation⁴⁰).

In the context of chronic pain, where the causes of pain persistence often remain elusive, a prescription for antidepressants may be seen as a “delegitimation” in reference to the refutation of the patient’s experiences with pain and suffering.³⁶ Even when antidepressants are prescribed because of their analgesic effects, the patients’ representations may lead them to think that the physician does not truly believe they are in pain. Within the context of a biomedical model, it may be difficult for patients to understand that a painful sensation, often precisely localized in their body, might be relieved by a medication that is described as acting in the brain, on cognition, and on emotions. However, the effect on the brain may not be the issue, or at least not the only issue. Indeed, acetaminophen, another centrally acting analgesic, has never been described as raising adherence issues similar to those of antidepressants. It may be hypothesized that acetaminophen does not trigger negative reactions because patients are not aware of its central actions; or because it is most commonly used and familiar enough to prevent fearful or negative representations and reactions. In this context, it may be of interest to examine how pain patients react to the prescription of acetaminophen also because it is an over-the-counter drug, and chronic pain patients may perceive its prescription as a trivialization of their pain problem.

This study has limitations. It was conducted in an ambulatory pain center; this may have biased some responses (eg, in particular, the definition of medication as painkillers). However, neither this context nor the definition of medication as painkillers worked as “reminders” regarding the analgesic properties of antidepressants. The setting may have led patients or controls to provide responses considered as socially desirable in this context; nevertheless, it corresponds partly to any prescription setting in daily clinical practice where patient adherence raises frequent concerns. Our patient population report severe chronic pain and has experienced various treatments with little benefit. Thus, our study may raise generalization issues. Yet the representations of antidepressants mentioned by patients and controls were similar, suggesting that these representations were not linked to chronic pain. Although this study did not assess medication adherence, it ascertains the type of representations that may contribute to preclude or jeopardize adherence.

In conclusion, this study confirms that lay people’s representations about antidepressants are at best ambivalent—be they chronic pain patients or not. The study also

indicates that the patients' representations are a potentially influential source of resistance to medical recommendations and prescriptions, however informed and evidence-based these may be. The fears antidepressants raise are related to their effects on cognition, emotions, personality, and sense of control. These medications are not considered to address somatic problems. Thus, when the cultural background of both the patient and the therapist is dominated by dichotomous mind-body views, a prescription of antidepressants for chronic pain may be mistaken for a denial of the "reality" of the pain. The very name of a medication may sound antithetic to patients with regard to their symptoms. Although this study did not assess medication adherence, it is possible that patient representations have a bearing on adherence. Clinically, this suggests that these representations should be elicited and addressed, taking into account the patients' own models of pain.

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