

Forms of resistance to medications within New Zealand households

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Although considerable research documents resistance to medicines, much of this focuses on specific types of medication, particularly psychotropic medication, and seeks to classify users of medication, frequently as resisters or rejecters. However, this research tends to overlook the varieties and subtleties of resistance to medications that can occur. In this paper, we explore the varied forms of resistance to medications reported by lay people taking diverse forms of medication. Data were gathered within fifty-five diverse households using multiple methods. Findings document the wide range of ways that medications are resisted. These are discussed in terms of the variability of resistance, its functionality and the logic of care that resistances can manifest.

[medications, drugs, households, resistance, medication-taking, New Zealand]

Medications are ubiquitous in contemporary western societies, appearing in a diversity of forms and having wide availability and use. In everyday use, they are embedded in complex social, familial and healthcare relationships, and have diverse and complex meanings (Van der Geest & Whyte 1989; Cohen et al. 2001). Medications can represent relief from suffering or the maintenance of health, but are also implicated in construction of identities, relationships of care, healing and home-making, and matters of morality (e.g., Britten 1996; Doran et al. 2005; Pound et al. 2005; Shoemaker et al. 2007). As Van der Geest and colleagues argued (Van der Geest et al. 1996; Van der Geest & Hardon 2006; Whyte et al. 2002), medications have social lives as well as pharmacological lives, functioning in ways that exceed their purely medicinal purposes.

The differing meanings given to medications are important for the ways people use and interact with them (Shoemaker et al. 2007). Usage of psychotropic drugs, for example, was shown by Helman (1981) to be related to their symbolic meaning, as 'tonic', 'fuel' or 'food'. Research examining lay understandings of medications reveals they can invoke ambivalence, desire, antipathy, faith and suspicion (Doran et al. 2005). Van der Geest (2010) identifies the ways that medications take meanings from their functionality, tangibility, technological commodification and exchange value, provid-

ing metonymic connections to illness and health care providers, determining identities and relationships, and providing empowerment for users. But these issues also provide the basis for resistance to medications, when people seek empowerment and autonomy by limiting or refusing to take medicines, in viewing medicines as symbolic of dependence and oppression, or by preferring 'natural' remedies over 'artificial' technologically produced commodities, which are regarded as 'foreign' and 'alien' to proper care of the body and treatment of illness (see also Van der Geest & Whyte 2003).

Other research has attempted to classify the takers of medication. Bajcar (2006) found that, although some people with chronic illness made sense of their medication-taking, many others found medication-taking problematic or were unable to make sense of it at all. Fainzang (2005) documented religious group differences in several medication-taking practices, finding for instance, that Muslims use self-medication rarely, and that Protestants use self-medication more than Catholics, seeing it as a means of demonstrating responsible caring for health. Dowell and Hudson (1997), in an analysis of interviews with chronic illness patients in general practice, identified passive users (taking medications as directed), active users (modifying the prescribed regime by balancing benefits and drawbacks, and limiting intake), and rejecters (who did not take medications, tolerated symptoms, used alternatives, or returned for further consultation). Pound et al. (2005), from a meta-synthesis of qualitative research on medications, present a very similar categorisation, describing passive accepters (trusting and taking medications as prescribed), active accepters (accepting medications but through careful evaluation), modifiers (evaluating medications, actively modifying the regime), and rejecters (rejecting medications).

In fact, resistance to medications has been widely noted in most research on this topic; Pound et al. concluded there was "considerable reluctance to take medicine and a preference to take as little as possible" (2005: 133). Britten et al. (2010) explored resistance in a meta-synthesis of qualitative studies on psychotropic drugs, concluding that resistance had multiple bases – concerns about efficacy, side-effects and risks, dependency, loss of control, self-esteem and identity, and stigma. Fainzang (2005) examined psychotropic medications, reporting how different religious groups expressed different forms of resistance to them.

Most of this research has been conducted with a specific focus, on specific groups, such as older people or chronic illness sufferers, on specific medications, frequently psychotropic drugs, or on multiple drug regimes. Limited research has examined how lay people understand medications more generally. The aim of this paper is to explore how resistance to medications is accomplished by people living together within households. Medications are understood here as social and material objects, and medication-taking as a practice within a social setting, the household.

Methodology

This multi-disciplinary project used households as the sampling unit since we have little knowledge of what happens with medications once they find their way into homes

(except, Fainzang 2003). Fifty-five households were purposively sampled from four cities across New Zealand to include a variety of household compositions and ethnicities, households where chronic illness was present, households with children under twelve years, and households where either CAM or dietary supplement use was prominent. This sampling classification proved rather arbitrary since most households included several of these, with for example, prescription medications, alternative medications and dietary supplements being relatively common. Defining medication was also potentially problematic. We used the term very broadly, to include anything taken for therapeutic reasons – to treat, cure, or prevent symptoms and illness, and to sustain health. Hence we sought discussion about anything that participants understood as medication-like, covering prescription and over-the-counter pharmaceuticals, dietary supplements, food additives, alternative medications and elixirs. We specifically excluded illicit drugs from consideration.

Data collection involved a range of methods, including mapping the home and locating all medications, photographing those locations, asking participants to produce all medications and discuss them, keeping a medication use diary, keeping a diary reflecting on medications in everyday life, and completing a photo-elicitation project to show the world of medications. These methods were chosen to add depth to the data. In particular, mapping and producing all medications in the household extended discussions as the materiality of the products demanded remembering and accounting, for why they were there, what they meant, and how they were used. For the analysis reported here, members of the research team individually identified instances of resistance to medications from the dataset and forwarded these to the first author, who drafted the initial analysis. This was then revised and confirmed by the other authors in discussion.

Resisting medications

Resistance to medications occurred in a wide variety of forms. We describe these below, with illustrative quotations, to show how resistance varies according to the understandings and meanings that medications hold, the nature of medications involved, and the contexts of medication-taking.

Supporting previous research (e.g., Pound et al. 2005), we found considerable general resistance to medications, frequently expressed as a reluctance to take them at all. Many of our participants made comments such as “Even if I do [have ailments] I still won’t take pills” (Tony¹), “I’ve never had a Disprin in my life. I’ve only taken Codeine after an operation because I had to for the pain. I’ve never been inoculated and I’ve never touched any of that other crap” (Jim), “So I’m like, I’d rather either try and wait it out as much as I can or, you know, just any other alternative rather than taking drugs” (Paul), or “Obviously if something has been prescribed by the doctor I will take it, but otherwise I’m trying to avoid anything.” (Bethany).

Resistance was frequently mentioned within households where alternative medication use predominated, as in the Bates household:

Jason: Taking stuff for us is like a last resort. We'll suffer pain and discomfort for a fair amount of time before we go, "Oh, I've gotta sort this out." Like, I'll even go to the doctor and not cash in the prescription if I don't like what I've been given ... I don't know whether Tristan's the same like that but if I'm sick I won't take anything.

Tristan: Oh, yeah, I don't like taking pills ... I do when I have to ...

Candy: Yeah, I'm pretty much the same and then I hate going to the doctor cos they tend to just give you a prescription for painkillers no matter what you go there for.

Such households frequently made reference to the 'unnatural' nature of allopathic medications, and that such medicines were potentially damaging or only treated symptoms and not the underlying cause, in line with earlier findings (e.g., Britten 1996).

Resistance could be extremely strong, as in the case where inoculation for Swine flu was resisted strenuously, even though this placed the person's employment as a paramedic under threat:

Jim: I asked the question, "What if I don't? [have the inoculation]" And it meant I couldn't be [in the team] if I didn't ... They wouldn't let me do what I wanted to do unless I'd been immunised so I just lied about it.

More often, resistance was focussed on specific drugs or classes of drugs. Frequently, antibiotics were targeted in this way, possibly reflecting concerns about their over-prescription and overuse (Prosser 2010):

Warren: I don't like taking antibiotics. Like a lot of people at work I know, or a lot of people I know, if they get a chest infection or a cold or something, it's straight down with antibiotics. I never do that. I don't think things like that need antibiotics. I think antibiotics should be saved for dire emergencies.

As in much previous research (e.g., Britten et al. 2010), psychotropic medications were particularly problematic. Here, resistance was commonly related to side-effects and dependency. Sophie, for example, comments "Because I wanted to function as a functioning member of society ... so in order to get well I had to actually ditch the medication." Viv said about her psychotropic medication, which she had taken for over twenty years: "I've hated them. I've always hated them ... I've never been a pill taker ... I had to fight and fight and fight to come off them ... lithium was like the drug from hell."

Not surprisingly, side-effects of drugs were a major point of resistance, across a wide range of medication types. For example:

Jenny: I have Erythromycin as an antibiotic that every time I took it my stomach was sore ... and I knew it was that because I'd take it and straight afterwards I'd feel that way. And the latest drug I took which was Ceclor. So those two in particular I won't take. That and they say I'm allergic to morphine because during my transplant they gave me morphine. They said I was hallucinating. So those are three that I know to stay away from.

Other accounts, often linked to chronic illness, produced resistance by positioning medications as necessary, but taken with reluctance. For example:

Jenny: I've been on dialysis for 19 years so that's 19 years worth of prescription drugs. That's a long time. But, yeah, I think at times I've had a love/hate relationship with the medications in terms of I know I have to take them but I get sick of taking them or I feel tired or I feel like they're causing other problems so that it's a necessary evil in my life. Sometimes that's the way I see it and then other times it's routine.

In these cases medications were controlled and only taken as or if necessary. One way to manage this was to minimise the dosage (here, for epilepsy medication):

Billie: I was prescribed a higher dose but I just decided that I would try and keep it as low as possible ... And also just because of the way it affected me I didn't want to be, you know, like, on the higher dose and kind of ... and so I really did that on my own ... And so if I'm getting the dizziness I just have to keep increasing the dose.

These practices were often substantiated by periods of testing (Dowell & Hudson 1997), and such accounts were often justified by claims of personal bodily knowledge contrasted with medical expertise, parallel to Bajcar's (2006) problematic experiences of sense-making, and linked to personal control over illness (Van der Geest 2010).

People also discriminated between medications, and would take some forms but not others, even though the medications in question may be within the same category (such as over-the-counter allopathic drugs):

Fred: I try not to take them ... The only ones I really do take is my asthma and Ventolin and Flixotide ... I've been doing it for so long that I judge my need.

Interviewer: But that's not your approach generally. It sounds like both of you are in agreement that you're ...

Fred: If you don't need to ...

May: We try not to take it if we can help it.

In this case, the approach to medication-taking was shared within the household. However, in other households, there were marked discrepancies in resistance between household members, as when Tristan said to his wife, "I s'pose I do take antibiotics, though ... I don't think I'm ... I'm not as much against them as you are," or the comments in the James household between another married couple:

Interviewer: And you don't have any ailments that you need to medicate ...

Tony: No. Even if I do I still won't take pills.

Jessica: I'm very unlike Tony because when, I don't like taking pills either but I can't see the point in suffering when it can actually fix you.

Tony's resistance was reinforced by his wife in a later diary-based interview:

Jessica: And then you've got my husband who just won't take pills at all.

Interviewer: Really? Just nothing?

Jessica: He took Voltaren once because it's a different name on it and his doctor told him to take it because he had a really bad ... the lump on his neck or something ... and he took Voltaren for two weeks but he didn't know it was Voltaren, and if he'd known it was Voltaren he wouldn't have taken it. He thinks you should just ride it out and not put stuff into your body that ... he thinks taking pills means you're breaking down your body's immune whatever. Which I find odd because to me I take Voltaren occasionally if I've got a really ... because it works. It's a great thing.

Medications were also resisted because their use could mask the 'true cause' of the problem, as when Candy did not take pain relief "because I wanted to know when I was actually getting better rather than masking the injury." Medications could also mask bodily function:

Bethany: I'm probably very traditional but I try to avoid all medications if I can and I've had a few years ago quite major surgery and stuff and I had a lot of pain prior to that and a lot of people said I did the wrong thing but I refused to take much medication. It was very hard but I believe that if you take a lot of painkillers and anti-inflammatories and things you actually don't know what your body's telling you. I believe that you need to understand your body and if you take too much stuff that disguises things.

Resistance was complicated, with inconsistencies and contradictions in how it was accomplished. Many people would resist one form of medication but accept another, offering rationales and 'rules' that justified their choices.

Janice: I'd rather do that with naturopathic products than get a drug. Like people have said to me about my heart, "Are you on drugs to help that?" And I thought, well, why would you be? It's not a disease, it's just a degeneration.

Interviewer: So the allopathic system is for repairs?

Janice: Yeah, exactly!

Interviewer: And the other one's for strengthening?

Janice: Yeah ... I mean, obviously things change. I mean, if something happened ... I suppose if I got cancer I would go straight for the allopathic stuff.

Often, there were notable inconsistencies in the resistance expressed. Melanie, for example, took psychotropic medication reluctantly, and often did not adhere to her regime, because she felt like "they're poisoning my body." But she did not similarly resist medications for heart disease and diabetes, which she described as "the medical ones" distinguishing them from her "psych ones." During the discussion about the medications within the Archer household, Bruce recounted all the pills he takes regularly:

Bruce: Cholesterol pills ... Those ones keep my blood thin so I won't have a heart attack ... They're just an extra gout tablet I have every day just to keep things right ... These are for my diabetes ... Oh, this is something for blood pressure, I think ... These ones look after my liver ... I don't know what they do but I have some of them every day anyway ... I just do what the man says and have a couple a day or whatever he says.

However, when asked about taking pain relief, Bruce said: "No, none of them. Don't do that shit."

Resistance also arose out of daily experience, as Van der Geest (2010) has argued. We have seen this previously with side effects, but it could also arise from gaining information from friends or media. Bethany was taking calcium supplements to increase bone density:

Bethany: ... about two months ago there was a lot of stuff in the press about how there was a link between Calcium intake and heart attack, cancer and all this and I thought, no, I'm dumping the lot. I'm not taking this anymore. I don't want all that. We decided about two months ago we went off all.

Discussion

From this analysis, it is clear that resistance to medications is complex and varied, presenting in various forms, specific to the context, and offering a variety of positions and locations to resisters. We do not have the opportunity to examine all of these in a brief paper, and we find other instances of resistance not discussed here, including those bound up with caring for family members, and moral action within everyday healthcare activities. However, this does show how findings that classify people into categories, as resisters or rejecters of medication (Dowell & Hudson 1997; Pound et al. 2006), provide an over-simplified analysis of how resistance functions. Although our findings support the existence of considerable generalised resistance to medications (e.g., Britten et al. 1996, 2010; Pound et al. 2005), we also find resistance to be very nuanced and situationally-specific, dependent on the nature of the medications taken, when they are taken, and why they are taken. As we see, people resist some forms of medication and uncritically accept others. They alter their understanding of a medication and consequently change their use of it, towards either accepting or resisting. People resist with differing strategies, in different ways, at different times, and in regard to different forms of medications; resistance can be highly variable and personal. This supports previous research (Armstrong & Murphy n.d.; Britten 2010; Van der Geest 2010) that has also argued that resistance is complex and variable, illustrating similar processes to those shown here – that resistance can arise from attempts to minimise risk, maximise effect, from personal experiences, from reinterpreting identities, and from appeals to expertise. And, as Armstrong and Murphy (n.d.) note, such resistance in no way indicates a loss of agency or the outright rejection of professional

advice and intervention, but arises from a host of reactions, including reluctance to be medicalised or pharmaceuticalised, to accept illness labels and forms of treatment regarded as inappropriate, or to accept identities that may be labelled as passive, immoral or failing.

This research also reveals, albeit somewhat obliquely in this brief commentary, that households provide an interesting site for the negotiation of resistance to medications (see also Hodgetts et al. 2010). Although not a major focus here, the analysis also indicates the diversity of meanings that medications can have for people and how these can change over time, with consequences for use and consumption. Frequently, failure to use medications as prescribed or intended is regarded as a failure of adherence, but in this research, we placed the medicalising concept of adherence to one side, to take a more critical view on how people understand and use medications in their homes. Therefore, it is important to note that, in the variety of resistances to medications evidenced here, people are not acting irrationally, as is often promoted in adherence research. Resistance to medications is generally functional. Even though some forms of resistance appear contradictory, some underlying logic can always be articulated. These participants acted within particular lay logics where medication-taking was constructed as a rational performance connecting the meanings and understandings of specific medications, in context, with bodily states and medication practices; they are “holders of a different kind of expertise” (Armstrong & Murphy n.d.: 8). We concur with Webster et al. (2009) in considering that our participants act within a logic of ‘lay pharmacology’, where resistance serves a variety of functional purposes as people seek to sustain wellness and wellbeing.

Notes

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1 All participant and family names are pseudonyms.

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