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# ‘*The lesser of two evils*’ vs ‘*medicines not Smarties*’: constructing antipsychotics in dementia

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## Conflict of interest

The authors declare that they have no conflict of interest.

## Author roles in research/writing of manuscript

Saleh Almutairi completed the data collection and revised the manuscript critically for important intellectual content. Dilbagh Gill completed the analysis and revised the manuscript critically for important intellectual content. Parastou Donyai designed and managed the study, including analysis and interpretation of data and drafted the manuscript. All authors approved the final version to be published.

## Conflict of interest

We have no conflict of interest to declare.

## Abstract

**Background and Objectives:** Because antipsychotics are associated with an increased risk of morbidity and mortality, they should only be prescribed in dementia in limited circumstances. But antipsychotics *are* prescribed to a large proportion of residents in formal care settings despite guidance and warnings to the contrary, justifying a study into how professionals define and in turn create realities about antipsychotic usage in dementia.

**Research Design and Methods:** 28 professionals with a role in the care and management of patients with dementia in care homes were recruited and interviewed in this qualitative study. A gap in the literature about the social construction of antipsychotics in dementia prompted the use of critical discourse analysis methodology.

**Results:** Antipsychotics were portrayed in two distinct ways; as ‘*the lesser of two evils*’ they were conceptualized as the less harmful or unpleasant of two bad choices and as ‘*medicines not Smarties*’ (a brand of sweets/candy) they were conceptualized as prescribed too frequently and indiscriminately. The first resource could be used to defend the prescribing of antipsychotics and uphold the prescribers’ privilege to do so while the second enabled the speaker to reject their own wilful involvement in overprescribing.

**Discussion and Implications:** When prescribers draw on ‘*the lesser of two evils*’ paradigm to sanction the overprescribing of antipsychotics, implicit assumptions about these medications as being the best of bad choices should be recognized and challenged. Future studies should target specific normative beliefs about antipsychotic prescribing consequences, to change the lexicon of common knowledge which perpetuates bad practice.

Key words: Dementia, psychiatry, qualitative research, prescribing, critical discourse analysis

## Background and Objectives

There was an estimated 46.8 million people living with dementia worldwide in 2015 (Alzheimer’s Disease International, 2015). The prevalence of dementia in people aged 60 and over is 6.9% in Western Europe and 6.4% in North America (Alzheimer’s Disease International, 2015). Dementia is characterised by loss of memory, mental agility, understanding, speech and judgement. However, dementia can also lead eventually to non-cognitive symptoms impacting on temperament and social behaviours (Cerejeira, Lagarto, & Mukaetova-Ladinska, 2012). It can be challenging for carers and others when a person with dementia experiences agitation, aggression, irritability and outward expressions of hostility (Leggett, Zarit, Taylor, & Galvin, 2011; Ory, Hoffman, Yee, Tennstedt, & Schulz, 1999; Tremont, 2011; Zimmerman et al., 2005). In specific and limited circumstances, antipsychotic medications are permitted to be prescribed to treat patients whose non-cognitive symptoms are severe and become unmanageable. Although effective in controlling some of the challenging behaviours of dementia, antipsychotic medications can result in a number of common side-effects including sleep disturbance, blood pressure changes, anticholinergic effects (e.g. dry mouth, urinary incontinence, constipation, blurred vision), Parkinsonism, and weight gain. Generally speaking, atypical antipsychotics such as risperidone, olanzapine and quetiapine are preferred to older (first generation) antipsychotics but in the UK, risperidone is the only antipsychotic licensed for short-term use in dementia. The use of atypical antipsychotics in dementia is controversial because of an association with an increased risk of morbidity as well as mortality (Ballard, Creese, Corbett, & Aarsland, 2011; Huybrechts et al., 2012; Schneider, Dagerman, & Insel, 2005). For this reason, in the US, no antipsychotic is approved for the treatment of dementia-related psychosis and since 2008 a ‘Black Box Warning’ must appear on package inserts of both atypical and first-generation antipsychotics to warn about the increased risk of mortality in elderly patients with dementia-related psychosis (Food and Drug Administration, 2008).

There have been longstanding warnings about the use of antipsychotic medications in dementia by medicines regulators in the United Kingdom, Europe and the US (Medicines & Healthcare Products Regulatory Agency, 2005; European Medicines Agency, 2008; Food and Drug Administration, 2008). In the UK, guidelines advocate a range of non-pharmacological interventions for managing the non-cognitive and behavioural symptoms of dementia, supporting first-line medication use only where patients are severely distressed or there is an immediate risk of harm, and only on meeting some specific requirements (National Institute for Health and Care Excellence, 2006). In the US too, the American Alzheimer’s Association and the American Geriatric Society recommend the use of antipsychotics only where non-pharmacological options have failed and there is a threat to life (Alzheimer’s Association, 2011; Samuel, 2015). The American Psychiatric Association recommends the nonemergency use of antipsychotics only where symptoms are severe, dangerous and/or cause significant patient distress and again on meeting a number of other prerequisites (Reus et al., 2016).

While the use of antipsychotic medications might be warranted in limited circumstances, in the UK it is estimated that only 20% of 180,000 patients with dementia prescribed an antipsychotic each year may actually benefit from them (Banerjee, 2009). A landmark report investigating the use of antipsychotics for people with dementia in the National Health Service in England found that inappropriate use could be resulting in an additional 1,620 cerebrovascular events and another 1,800 deaths each year (Banerjee, 2009) – this led to the launch of the national dementia strategy in England (Department of Health, 2009). The inappropriate prescribing of antipsychotic medications in dementia is also evidenced in the United States

(Samuel, 2015) where in 2012 the Centers for Medicare and Medicaid Services, part of the US Department of Health and Human Services, also launched a partnership programme to improve comprehensive dementia care and reduce antipsychotic prescribing (Centers for Medicare & Medicaid Services, 2017).

The prescribing and use of antipsychotics is particularly high in formal institutions providing care for older people. In the US formal care institutions include community and Veterans Administration (VA) nursing homes and in the UK, nursing homes, residential homes (providing personal care only) or a combination of both. While in the US antipsychotics are thought to be prescribed to approximately 20-35% of residents in formal care settings (Chen et al., 2010; Gellad et al., 2012; Kamble, Sherer, Chen, & Aparasu, 2010), this figure is around 20-25% for residents in UK care homes (Department of Health, 2009; Maguire, Hughes, Cardwell, & O’Reilly, 2013) A qualitative study with old age psychiatrists in England uncovered a range of views about psychotropic prescribing in dementia (Wood-Mitchell, James, Waterworth, Swann, & Ballard, 2008). Psychiatrists thought there were pressures on them to prescribe, felt societal and systemic influences maintained high prescribing rates, guidelines were not implementable, and care homes not designed and trained to deal with problematic behaviours (Wood-Mitchell et al., 2008).

When the views of nursing staff were explored, the results were dichotomised as benefits of, versus barriers to, reducing antipsychotic use (Simmons et al., 2017). What is particularly noteworthy is that the benefits of reducing antipsychotic usage (e.g. improvement in patients’ quality of life, families’ sense of satisfaction and reduction in falls) were couched mainly in relation to the detrimental effects of antipsychotics while the barriers (e.g. resistance by families, symptom worsening or returning, lack of alternatives) were couched in relation to the usefulness of antipsychotics. There has been little work to date to examine health professionals’ construction of antipsychotics in tackling the behavioural symptoms of dementia from a discourse analytic perspective. This is despite literature on the social construction of dementia itself (Bartlett, Windemuth-Wolfson, Oliver, & Dening, 2017; McInerney, 2017; McParland, Kelly, & Innes, 2017; Peel, 2013; Zeilig, 2014). This paper uses the definition of discourse analysis developed by Potter & Wetherell (1987) which focuses on talk as social practice, and on the resources that are drawn upon to enable those practices. Under this definition, discourse analysis focusses on how language is used to *create* reality, within a social constructionist epistemology which views knowledge as socially contingent and fluid – further explained in the Research Design and Methods section. Understanding how people conceptualise antipsychotics is significant because it allows for negative or misleading constructions to be uncovered and questioned rather than blindly accepted.

Prosser (2010), taking a discourse analytic approach, analysed media coverage of prescribed medicines finding two competing discourses as ‘marvellous medicines’ and ‘dangerous drugs’. The ‘good news stories’ presented the beneficial properties of medicines with use of powerful adjectives (‘*super-effective, wonder drug, brainwave pill, miracle cure’*). The ‘adverse news stories’ instead presented medicines as maligned, warning about hazards and negative consequences. The coverage was judged to be ambiguous, uncertain and contradictory. Prosser (2010) argued the way in which medicines are socially constructed leads to implicit assumptions about modern medicines that could shape opinions. The premise of the current paper is that health professionals’ construction of antipsychotics in dementia could have a role in constructing realities about these medicines which if misleading, can contribute to their inappropriate prescribing and use. The aim of this paper is to explore professionals’ deliberations about antipsychotic prescribing in dementia using critical discourse analysis (Potter & Wetherell, 1987; Wetherall, Taylor, & Yates, 2001) within a social constructionist approach. Social constructionists view language as constitutive of the truth and therefore give language a key role in negotiating and defining realities (Burr, 2015). The research question is “How do health professionals and care home managers use language to describe and construct antipsychotic medications when discussing their use in dementia?”

## Research Design and Methods

### Design

Professionals with a role in the care and management of patients with dementia in care homes were recruited using purposive sampling. Recruitment was completed by posting letters to publicly-available addresses (e.g. GP practices) or through known contacts and already-recruited interviewees. A doctoral student (second author) carried out in-depth semi-structured face-to-face interviews using interview schedules (piloted first with 3 volunteers) that focused first on general descriptions of dementia and disease progression, before considering beliefs about and professional experiences with antipsychotic prescribing and use in dementia. Participants were recruited until no new concepts emerged to inform the study (i.e. sampling saturation). The interviews were audio-recorded.

### Sample

The sample of 28 participants (17 female) consisted of care-home managers (CHM) (n=5), general practitioners (GPs) (n=5), community psychiatric nurses (CPNs) (n=7), psychiatrists (n=5), geriatricians (n=2), pharmacists (n=2), a memory-clinic nurse, and a social worker.

## Data analysis using discourse analysis

The interviews were transcribed verbatim into password-protected documents, removing sensitive information to keep data anonymised/de-identifiable. The doctoral student ensured data integrity in consultation with the author by checking the transcripts against the audio files. A critical discourse analysis was undertaken jointly by a Masters-level student of pharmacy (first author) and the senior author. The focus was to identify concepts key to critical discourse analysis, namely; interpretative repertoires and subject positions (*discourse resources*); how these resources were used to build descriptions, accounts and arguments (*discourse processes*); and how different subject positions were embedded in different interpretative repertoires, including identifying ideological dilemmas (Wetherall et al., 2001). Interpretative repertoires, the common-sense way in which people talk about the world, are composed of the lexicon of common knowledge, the cultural ideas, explanations and ‘terms and metaphors’ people draw on to build explanations, descriptions, accounts and arguments (Potter & Wetherell, 1987). Because of the fluid nature of talk, people can take up subject positions to define themselves and their identity through their discourse (Wetherall et al., 2001). And since these everyday discourses are full of inconsistencies they can result in ideological dilemmas, complex and contradictory use of interpretative repertoires (Billig, M., Condor, S., Edwards, D., Gane, M., Middleton, D.J. and Radley, 1988).

A detailed, line-by-line scrutiny was conducted by reading each interview numerous times and considering the whole data before examining small chunks of text (e.g. parts of sentences) in relation to the research question, interpretative repertoires, subject positions and ideological dilemmas. There was a particular focus on rhetorical choices made by the participants to depict antipsychotics. The analysis was tabulated and rhetorical choices and subject positions grouped according to concepts they conveyed. Then, the next interview was read and re-read and considered for additional or supporting material to add to concepts already generated, and so on. Although each transcript was treated as a separate case, these were brought together to identify patterns within a single interview and across the data set. The focus of analysis was the external world of discourse and its meaning and effects, and of how specific words, descriptions and explanations were brought together and used through the language employed to account for actions and events. The repertoires were identified with relevant quotes selected to portray these. Data validation was demonstrated in data triangulation (collecting data from 8 participant sub-groups), description of study procedures, and audit trails.

## Compliance with Ethical Standards

The University’s Research Ethics Committee (UREC 1217), and the local NHS Research & Development office (letter of access granted 22/06/2012) and Primary Care Research Partnership (reference TV85) reviewed and approved the research. Written consent from each participant was obtained before the interviews.

# Results

Two distinct interpretative repertoires were identified. In one, antipsychotic medications were typically portrayed as ‘*the lesser of two evils*’ while in the other as powerful ‘*medicines not Smarties*’. Each of these representations is part of a different kind of resource drawn upon to talk about antipsychotics. In the first, antipsychotics were conceptualised as an aid to patients and their carers; as devices that enable the delivery of care. In the second, antipsychotics were portrayed as substances that are used far too casually and frequently with little regard for their adverse effects or reference to usage guidelines. Both repertoires are described here.

## Antipsychotics as ‘*the lesser of two evils*’

There is a proverb ‘*Of two evils choose the less*’, attributed to Aristotle (Speake, 2015), which is the basis of a commonly-used English idiom ‘*the lesser of two evils*’ (Ayto, 2010). The meaning conveyed is that the less harmful or unpleasant of two bad choices or possibilities should be chosen.

One of the ways in which language was used to construct antipsychotic medication as *‘the lesser of two evils’* was in reference to the state of patients with dementia, with two contrasting representations of the patient as a vulnerable individual and the patient as a threat. These representations were deployed during the interviews to build up arguments to support the choice to use antipsychotics in order to treat patients (and to counter alternative choices). With the first, the patient was portrayed as vulnerable, for example, when their safety was shown to be compromised because they ‘leave things on the stove’ (see Supplementary material (SM), extract 1). The use of these specific words describes an individual struggling to cope with everyday life which makes them a danger to him/herself. The description infers that antipsychotics prevent accidents and harm that can arise as a result of the patient’s actions. In the context of ‘*the lesser of two evils*’ antipsychotics are presented as a more desirable choice than the *status quo* which is leaving the patient vulnerable to unsafe acts. The ‘evil’ of the patient coming to harm as a result of their own behaviour is pitched against any presumed ‘evil’ that might arise from using antipsychotics.

The interpretative repertoire ‘*the lesser of two evils*’, however, also pitches the use of antipsychotics against arguably less obviously-harmful situations. For example, the medication helps ‘improve quality of life’ for the patient who experiences ‘24 hours a day agitated and fearful’ due to the progressive nature of their illness (SM, extract 2). Here the harm associated with the vulnerable patient’s diminished quality of life or being constantly agitated and fearful is presented as more harmful than harm which might arise from using antipsychotics.

In contrast to being vulnerable, patients were also portrayed as individuals who pose a threat to those around them, something which needs managing because again the *status quo* is a less desirable choice to antipsychotic usage. Here antipsychotic medications were characterized as a tool for managing uncontrollable and disruptive patients who are ‘hitting other patients or the staff’, ‘trying to break down the window’ or have ‘ripped a radiator of the wall’ (SM, extract 3). In this regard, antipsychotics are portrayed as helpful to the carer at home or within a care-home when faced with an even more harmful option of not being able to deal with an aggressive patient. Consequently, those caring for the patient with dementia, as well as health professionals helping these carers (through prescribing antipsychotics), were another group of people referred to as part of the construction of antipsychotic medications as ‘*the lesser of two evils*’.

The interviewees paraphrased quotes to illustrate the families’ willingness to accept risks associated with antipsychotic medication usage for the benefit of being able to cope with the patient at home – thus presenting the decision to use antipsychotic medication as *their* (the families’) choice. For example, in reference to reducing the dose of an antipsychotic, one family member is quoted as saying ‘please don’t touch anything’ as ‘I wouldn’t be able to cope, she’d have to go into a home’ (SM, extract 4) which conveys the dichotomised choice; being unable to cope with the patient versus maintaining the dose of an antipsychotic medication and any associated adverse consequences. These particular representations portray the relatives and carers (not the health professionals) as being in charge of decisions to start or continue antipsychotics, with health professionals merely helping carers to cope.

For example, where a nurse states ‘the doctor said, well we have to respect the fact that he’s doing a very, very hard job keeping her at home’ (SM, extract 4), it suggests that the decision to use antipsychotic medications comes primarily from, and is allowed to come from, the carer. In another extract, the nurse participant describes a scenario where if a patient ‘wasn’t on these’ medications, ‘her husband wouldn’t be able to manage her at home’ and thus ‘she would have to go into residential care’ (SM, extract 5). The patient removed from their loved ones is then described as becoming distressed, disorientated and ‘quite aggressive’. This culminates in the speaker concluding that these drugs are sometimes *‘the lesser of two evils’* by helping the patient to remain with their families and stopping a downward spiral of distress and aggression which might otherwise ensue. Thus prescribing an antipsychotic is portrayed as helping to deliver care by helping both the patient and their carer avoid alternative consequences.

From a critical discourse analytic perspective, when participants employed ‘*the lesser of two evils*’ repertoire, they were not merely expressing their attitude but actively constructing people and situations and mobilising these in a way that legitimises the prescribing of antipsychotics. They did this by presenting the use of antipsychotics as a choice between potential harm that might arise from medication versus leaving things as they are, for example, not dealing with a vulnerable patient whose behaviour puts their life at risk or whose diminished quality of life warrants action. Or not dealing with the patient who poses a threat to others, and whose behaviour justifies the prescribing of an antipsychotic, which is presented as a choice made primarily by carers with the support of the health professionals.

## Antipsychotics as powerful ‘medicines not Smarties’

The Oxford Dictionary of Word Origins refers to ‘Smarties’ as follows.

## ‘THE LESSER OF TWO EVILS’ VS. ‘MEDICINES NOT SMARTIES’

> *“The sugar-coated chocolate sweets called Smarties were launched in 1937. Because of their similar appearance to pills, doctors are sometimes accused of handing out drugs ‘like Smarties’.”* (Cresswell & Oxford University Press., 2010)

Smarties are a brand of sugar-coated, inexpensive sweet/candy popular in many countries. The sweets are small meaning a hexagonal tube contains about 48 of them. The reference to drugs being handed out ‘like Smarties’ reflects the commonly-held belief that Smarties are shared out, no doubt owing to their similarity to ‘pills’, but also their inexpensive nature and pack size. But unlike sweets, drugs produce pharmacological effects including unwanted adverse effects which restrict their use, or ‘ought to’ restrict their use. The meaning conveyed when it is stated that drugs are handed out ‘like Smarties’ is that drugs are being prescribed commonly or indiscriminately.

The way in which language was used to construct antipsychotic medication as powerful ‘*medicines not Smarties*’ was in reference to their potent clinical and social adverse effects on patients and also via a negative representation of health professionals who prescribe and use these medications. For example, one care-home manager expressed that the patient taking antipsychotics becomes ‘extremely sleepy’, is at a greater ‘risk of falling’ and begins to ‘feel really sick’ (SM, extract 6). To portray their opposition to the use of antipsychotics, they employed a rhetorical question ‘There’s not an awful lot of plusses are there?’ In the context of ‘*medicines not Smarties*’ here antipsychotics are portrayed as medicines with a range of adverse effects which limits their use.

Another CHM stated ‘I do not like antipsychotic drugs for people with dementia’ as these ‘are not getting the best out of them’ (SM, extract 7). They expressed that these drugs ‘deskill them, in all their long life skills’, reflecting a view of the adverse social effects of antipsychotics (SM, extract 8). The participant used powerful imagery to construct their disapproval exemplified by ‘I don’t believe in my old people sitting in one big circle’, ‘looking into each other’s eyes and doing nothing’ (SM, extract 9). Within the ‘*medicines not Smarties*’ repertoire, these representations act as arguments for why these medications should not be prescribed commonly or indiscriminately. The representation of antipsychotics as potentially harmful is also supported by a GP’s choice of words that antipsychotics ‘dampen their natural reflexes’ and ‘calms them too much’ and consequently ‘you lose a little bit of the person’s personality’ which can therefore ‘take away’ from the patient (SM, extract 10).

The adverse effects of antipsychotic medication were also juxtaposed against non-pharmacological activities that might ‘enhance’ the patient’s state. A CHM chose to speak in the first person, a tool to portray the patient’s perspective ‘When my wellbeing is adequately taken care of, my behaviour will not be a destructive one’ (SM, extract 11). Particularly, some GPs and nurses suggested that those using medication as a first resort may be less pro-active and prefer ‘somebody to start on an antipsychotic’ rather than exploring other methods of managing behavioural symptoms in patients. Thus another way in which language was used to construct antipsychotic medication as powerful ‘*medicines not Smarties*’ was in reference to health professionals who decide to prescribe and use these medications – in effect, the people who do the ‘handing out’ of medicines ‘like Smarties’.

A nurse stated ‘I know the realities’, ‘staff are lowly paid, poorly motivated’ and ‘are very overworked’ (SM, extract 12) suggesting there may not be a desire to explore alternative solutions for the patient. Noticeably, this speaker alleges care home staff want ‘to increase medication all the time’ to ‘make their life easier’. Another nurse referred to ‘these are powerful drugs’ which should not be handed out *‘too readily like Smarties’* (SM, extract 13) signifying an unwarranted relaxed attitude toward the prescribing and use of antipsychotics by others. Such portrayals were consistent amongst GPs, one of whom said ‘reaching for a prescription pad and pen is very easy to do’ and not ‘much thought has gone into’ initiating antipsychotics (SM, extract 14). GPs expressed prescribing of antipsychotics ‘should always be justified’ with one acknowledging their own role: ‘it’s still used as the easy option’ as ‘it’s something as doctors, we do, we just prescribe a medicine’ (SM, extract 15), suggesting that bad habit also plays a role.

The other way in which participants used language was to portray their own role in the (over)prescribing and use of antipsychotic medications, which involved the dismissal of guidelines. This is exemplified by one GP who, in a colloquial manner, states ‘I tend to throw them out and hope I get the gist of it’ (SM, extract 16), while another clearly states ‘I’ve not read any guidelines’ moving on to say that most of the prescribing is based on ‘what the consultants’ say (SM, extract 17). Here, if the speaker implicates themselves as someone who prescribes antipsychotics ‘like Smarties’, then they do so unwittingly because they have not read the guidelines relating to antipsychotic use or are following consultant advice.

From a critical discourse analytic perspective, when the participants employed the ‘*medicines not Smarties*’ repertoire, they were actively constructing people and circumstances and mobilising these constructions in a way that questions the legitimacy of antipsychotic prescribing. This repertoire portrays antipsychotics as potent substances with a multitude of clinical and social adverse effects, which indicates that their use ought to be limited. Antipsychotics were portrayed as being used too frequently either for the convenience of those who provide care for patients with dementia, where it is easy to prescribe out of bad habit, or because prescribers have not read or understood the guidelines associated with antipsychotic prescribing in dementia or are following consultant advice.

The two interpretative repertoires identified here, antipsychotics as ‘*the lesser of two evils*’ and ‘*medicines not Smarties*’ appear to be contradictory, yet they were drawn upon by the same individuals in different sections of an interview and used as social resources. Interpretative repertoires enable people to “*justify particular versions of events, to excuse or validate their own behaviour, to fend off criticism or otherwise allow them to maintain a credible stance in an interaction*” (Burr, 2015). The first repertoire is a resource that can be drawn upon to defend the prescribing of antipsychotics because it depicts the benefits of medication and its utility in helping people to care for patients with dementia. The second repertoire is a resource that can be used to put distance between the speaker and the decision to knowingly sanction the overprescribing of antipsychotics, since it depicts medication as potent substances used too readily by others for convenience or from ignorance.

## Discussion and Implications

When antipsychotics were described as ‘*the lesser of two evils*’, they were conceptualised as the less harmful or unpleasant of two bad choices or possibilities; as a mechanism for delivering care to helpless, vulnerable patients or to support carers who struggle to cope effectively with aggressive patients. The ‘other evil’ in this sense was pitched as physical harm that patients would suffer as a result of their vulnerability, harm from a diminished quality of life, or from experiencing fear or agitation, as well as harm that carers would suffer as a result of not being able to cope with the disruption or unmanageability of an aggressive patient at home or within a formal care setting. When antipsychotics were described as ‘*medicines not Smarties*’ they were conceptualised as prescribed too frequently or indiscriminately. They were depicted as having potent clinical and social adverse effects on patients, accompanied by a negative representation of health professionals who prescribe and use antipsychotic medications. The adverse effects were couched in term of potent medications which result in drowsiness, salivation, deskilling, dulling of interactions and even loss of patients’ personality, while the negative representation of health professionals who administer antipsychotics was conveyed in descriptions of unmotivated or overworked staff or those acting out of bad habit, or lacking knowledge.

One of the aims of critical discourse analysis is to shed light on representations circulating in everyday discourses. In this way, the current study is similar to that of Prosser (2010) whose examination of newspaper stories unearthed a dichotomous representation of ‘marvellous medicines’ versus ‘dangerous drugs’. The discourse resources described in the current study are not expected to be new because their validity relies on their use by other people in other contexts. For example, a qualitative study published a decade ago focussing on benzodiazepine prescribing (also contentious) describes this as doing something that is ‘*the lesser evil’* (Anthierens, Habraken, Petrovic, & Christiaens, 2007), while another on the same topic highlights the ‘*medicines not Smarties*’ repertoire. That the repertoires described in this study are in line with findings in other studies about the (over)prescribing of medicines acts to verify their soundness as common discourse resources. Another aim of critical discourse analysis, however, is to identify *how* discourse resources are used to construct and reconstruct social realities and the distribution of power. Therefore, another important point is *how* these identified repertoires are used as discourse processes to depict decisions in relation to antipsychotic usage i.e. the way in which individuals or groups are characterised as benefiting from or sanctioning antipsychotic usage. This is completed here with reference to the existing critical literature on the meaning of medicines and dementia.

In their seminal paper examining medicines as metaphors and metonyms Van Der Geest & Whyte (1989) described medicines as being more than simply biochemically efficacious – it is not simply that medicines *are* powerful, they argue, but that people *believe* them to be powerful. Thus the key to their ‘charm’ is their ‘concreteness’ – that they have a concrete presence and are portable. This means that by virtue of containing the power of healing in them (versus e.g. psychotherapy where a psychologist needs to administer treatment), medicines become “democratic” such that “anyone who gains access to them can apply their power”. Thus doctors have it in their gift to *transfer* the power of medicines through prescribing. In addition, Van Der Geest & Whyte (1989) argued that medicines can become vehicles of individualization, especially where a treatment can be carried out privately focussing on the individual body, and particularly “when sickness might reflect poorly on the patient or family”. Whether dementia reflects poorly on the patient or their family is a cultural matter also worth considering.

The literature points to discourses that construct dementia as ‘the tragedy discourse’ and the ‘living well discourse’, with the criticism that such a consideration divides people with dementia into those living well or successfully with the condition and those no longer able to maintain society’s notion of living well, thus living in the shadows (McParland et al., 2017). Zeilig (2014) examining dementia as a cultural metaphor argued that the framing of dementia operates on two levels; it is generalized as a vast, natural or monstrous force that we must fight, and also located as a very specific condition that affects individuals in extreme ways. In both cases, the effect, Zeilig argued, is to make us feel both terrified and powerless. Zeilig even argued that dementia can be considered a metonym, a figure of speech in which a word for a part of a subject is taken for the whole. In this case, she argued, the word dementia can be taken to mean *a complex, unknowable world of doom, ageing, and a fate worse than death*.

With this depiction of dementia in mind, consider now that Van Der Geest & Whyte (1989) argued that medicines have a metonymic association with *medical doctors who prescribe them, with laboratories that produce them, with medical science that forms their ultimate ground*. In this sense, it can be argued that antipsychotics embody the last remnant of medical comfort that *can* be imparted to shield the patient from the impending doom of dementia. Thus if doctors can be persuaded to *transfer* the power of antipsychotic medicines to carers then the powerless patient can be treated with due care and consideration, with antipsychotics portrayed as having a calming effect by allaying agitation, fearfulness, disorientation and aggression. Thought of in this way, ‘*the lesser of two evils*’ portrays antipsychotics as the less harmful or unpleasant of two bad choices or possibilities because they *can* empower carers to deliver compassionate care. Drawing on this repertoire therefore acts as a resource not only to defend the prescribing of antipsychotics but to uphold the prescribers’ privilege to do so. The apparent contrast between guidelines, which advocate limiting the use of antipsychotic medication to severe circumstances, versus a belief that symptoms which result in patient suffering and distress necessitate pharmacological treatment, is also highlighted in a study of caregiver perspectives about the management of dementia (Kerns, Winter, Winter, Kerns, & Etz, 2017). The authors of that paper highlight that this preference is expressed despite clear enunciation of side-effects and the potential risk for harm from antipsychotics (Kerns et al., 2017), which is also reported elsewhere (Cornegé-Blokland, Kleijer, Hertogh, & Van Marum, 2012).

In ‘*the lesser of two evils*’ repertoire the effectiveness of antipsychotic medication is similarly emphasised in preference to the portrayal of their side-effects (in contrast to ‘*medicines* *not Smarties*’ where side-effects are a main focus). Etkin (1992) argued that because the interpretation of signs or symptoms of illness and medication effects is embedded in cultural meanings, there can be disagreement about what is primary and what is secondary to effective treatment such that a medicine’s ‘side effect’ might be embraced by another paradigm as a requisite part of a process in which therapy is under way. Take for example the portrayal of antipsychotics as ‘*the lesser of two evils*’, where the effect of medication is to ‘improve quality of life’ by dealing with someone who is ‘24 hours a day agitated and fearful’. Here a *calming* effect of antipsychotics is taken to indicate their effectiveness. Yet this same effect is instead portrayed as a side-effect through ‘*medicines not Smarties*’ where for example it is stated ‘I don’t believe in my old people sitting in one big circle’, ‘looking into each other’s eyes and doing nothing’. While the calming effect of antipsychotics is represented as the very sign of the medication working as ‘*the lesser of two evils*’, this effect of antipsychotics is rejected through the interpretative repertoire ‘*medicines not Smarties*’ in preference for a more negative representation of their effects, of a sedentary and motionless existence. On the one hand, antipsychotics can act as the antidote to the impending demise of those with dementia and on the other these potent substances can intoxicate them. Drawing on the second repertoire acts to distance the speaker from others who overuse these medications and to enable the speaker to reject their own wilful involvement in overprescribing.

How people think and speak communicates and corroborates their understanding of social phenomena; it also has a role in constructing and verifying their version of reality, which in turn has the potential to impact on their own, and others’ actions and behaviours (Burr, 2015). Thus one of the applications of critical discourse analysis is to enable the scrutiny of power and constructions of truths so that these can be used to rethink or reconfigure roles, relationships, or institutional practices. The current study highlights two dominant discourse resources which health professionals’ draw upon to either sanction the prescribing of antipsychotics or to distance them from such prescribing. Regardless of what the speaker is *doing* with their speech, they reflect a shared understanding that antipsychotic prescribing is a *choice* that is taken. Identifying these interpretative repertoires can inform health professionals to their own and others’ intentions when they contemplate prescribing decisions. When prescribers draw on ‘*the lesser of two evils*’ paradigm to endorse the inappropriate prescribing of antipsychotics, implicit assumptions about these medications as being the less harmful of two bad choices need to be challenged. Future studies could focus on challenging the common repertoires that construct and validate inappropriate antipsychotic prescribing and use in dementia. Recall that interpretative repertoires examine the common-sense way in which people talk about the world, and are composed of the lexicon of common knowledge which people draw on to build explanations, descriptions, accounts and arguments. Therefore from a behavioural change perspective (Abraham & Michie, 2008) a future intervention would focus on changing normative beliefs about prescribing behaviour and also the consequences of overprescribing to bring about a wholesale change in the cultural ideas, explanations and terms and metaphors which become available for people draw on.

## Conclusion

The social nature of medication has been a field of study over the past few decades but to our knowledge this is the first critical discourse analytic study of health professionals’ depiction of the prescribing and use of antipsychotics in dementia. Two interpretative repertoires depicted antipsychotics as ‘*the lesser of two evils*’, the less harmful or unpleasant of two bad choices or possibilities, or as ‘*medicines not Smarties*’, potent substances prescribed too frequently or indiscriminately. These repertoires reflect a shared understanding that antipsychotic prescribing is a *choice* that is taken. The first repertoire is a resource that people might draw upon to defend the overprescribing of antipsychotics because it emphasises the benefits of medication and its utility in helping people to care for patients with dementia. The second can be used to distance the speaker from wilful involvement in the overprescribing of antipsychotics. Uncovering these repertoires and their uses allows them to be questioned rather than blindly accepted. The findings could help practitioners, researchers and policy makers to understand and challenge the effects of these discourses on the inappropriate prescribing of antipsychotics in dementia through formal training and future interventions.

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# Supplementary material

## '*Lesser of two evils*' vs '*medicines not Smarties*': constructing antipsychotics in dementia

## Interview extracts as illustrative material

Extract 1: CHM interview 5, page 1, lines 12-13: *"They've already showed, displayed symptoms of not coping at home or the family not being able to keep them safe. Incidents where they go out at night, they leave things on the stove."*

Extract 2: GP interview 26, page 2, lines 75-76 *"I would say so, that the benefit outweighs. It must be terrible to be 24 hours a day agitated and fearful, so I think it's perfectly reasonable to try medications to improve quality of life."*

Extract 3: GP interview 10, page 1-2, lines 37-44 *"Well, my experience, I mean the sort of things that I reserve antipsychotics for are uncontrollable difficult symptoms. I mean if somebody's wandering and they're harmless, that's fine. If someone's talking to everyone they meet or paranoid, but they're OK, not bothered about that. But when someone, when they start hitting the other patients, or hitting the staff or start trying to break down the window. We had someone the other week who ripped a radiator off the wall. Think of that, ripped a radiator off the wall. You know, what's the alternative? Are you going to put a waist, put a straitjacket on them? So these drugs, when they work, and they don't always do, they will reduce that often quite aggressive behaviour."*

Extract 4: CPN interview 11, page 4, lines 115-121 *"I saw a chap on Friday he said, I said, what do you think about trying to, because she's on quite a high dose, do you want, trying to reduce the dose you know, talked again about the stroke risk he said, absolutely not, please don't touch anything, I'm able to cope now, if it was altered I wouldn't be able to cope she'd have to go into* *a home, please don’t tinker with it at all, it’s at a really good level. So I come back and fed that back to her doctor and the doctor said, well we have to respect the fact that he’s doing a very, very hard job keeping her at home and home is where she wants to be, home is where he wants her to be. I don’t know it’s, what do you do?”*

Extract 5: CPN interview 11, page 2, lines 71-77 *“It’s funny I was just talking to one of our consultants about a lady that I visit, if she wasn’t on these, the medication, at the level she’s on, her husband wouldn’t be able to manage her at home. But I think if he couldn’t manage at home then she would have to go into residential care and if she was in residential care they would need far higher doses of the medication to manage her. She’s very distressed, she’s quite disorientated, she doesn’t know where she is, she’s quite aggressive when she’s disorientated. So in some people’s cases it, it’s the lesser of two evils.”*

Extract 6: CHM interview 1, page 2, lines 64-68 *“Well any medicine that works on the brain is going to have side effects on the brain, so it can actually give you more of the behaviours that you don’t want, if it doesn’t suit. It can make them extremely sleepy, can put them at a risk of falling if they are sleepy, it can exacerbate other symptoms that they have, make them feel really sick. There’s not an awful lot of plusses are there?”*

Extract 7: CHM interview 2, page 1-2, lines 45-49 *“I do not like antipsychotic drugs for people with dementia. Because one, you are not getting the best out of them, they become very dopey, sometimes you see them salivating, you see them very sleepy and drowsy. And what you then doing for them is taking their skills away from them. By providing them with wonderful environment that will enhance them, you don’t need medication for them. And by training the staff that are looking after them, you don’t need all that.”*

Extract 8: CHM interview 2, page 3, lines 97-100 *“The downside to it is because you deskilled them, in all their long life skills that they’ve got. Skills of having, looking after themselves, skills with cooking, skills with knitting or sewing, skills with washing themselves and so on. Or going out, socialising, you take that away from them when you use drugs on them.”*

Extract 9: CHM interview 2, page 2, lines 90-91 *“I don’t believe in my old people sitting in one big circle, looking into each other’s face, or into each other’s eyes and doing nothing.”*

*Extract 10: GP interview 28, page 3, lines 116-119 “By taking an antipsychotic it actually dampens their natural reflexes, their natural, the way they would react naturally. So, it treats the aggression but it also calms them too much and I think you lose a little bit of the person’s personality by giving them. You take away.”*

Extract 11: CHM interview 2, page 2, lines 57-62 *“We use antipsychotic drugs to manage behaviour, instead of managing behaviour with activity, with communication, with taking them out and getting their wellbeing. When my wellbeing is adequately taken care off, my behaviour will not be a destructive one. You will enhance me, I’ll be able to do things myself, or even by the time I cannot do it by myself and someone is assisting me to do it, I’ll be able to comply, compliant with you doing things for me without belting you.”*

Extract 12: CPN interview 12, page 1, lines 29-42 *“One of the things I do find as an, as a nurse, people in nursing homes, residential homes, will often phone us and want an increase or somebody to start on an antipsychotic to deal with the behaviours rather than looking at ways of deal, rather than at ways of managing the behaviours. It’s something I feel quite strongly about, years ago I did a lot of support care work as a support worker and so I’ve worked on both sides. I’ve worked in care homes and things so I know the realities. In the care homes often staff are* *lowly paid, poorly motivated, often the staffing numbers you know there might be three to a whole room of people, obviously it’s very difficult for care staff in the residential homes, the nursing homes, to actually manage the behaviours like we can. I think training could be better in a lot of nursing homes. Incidentally it’s very hard when staff are very overworked in these places, I see both sides of the argument. And, as I said, we have a lot of sort of slight disagreements with nursing homes because they want us obviously to increase medication all the time and they’d like people to be sedated to make their life easier rather than looking at ways to work with the behaviours.”*

Extract 13: CPN interview 11, page 2, lines 67-68 *“These are very powerful drugs that work on the brain it’s not, you don’t want to hand them out too readily like Smarties.”*

Extract 14: GP interview 10, page 3, lines 113-115 *“Well, reaching for a prescription pad and a pen is very easy to do. And you’re in a hurry, and the nurse on the ward says, oh Mrs Smith is terrible. Fine, let’s give her some quetiapine. That’s very, very easy to do and maybe not much thought has gone into it.”*

Extract 15: GP interview 7, page 4, lines 133-134 *“They should always be justified but I think it’s still used as the easy option. Because it’s something as doctors, we do, we just prescribe a medicine.”*

Extract 16: GP interview 7, page 2, lines 63-66 *“I suspect I have read them a long time ago. I can’t remember them. I mean I’ve just, I read guidelines, but I don’t, I mean I’ve kept about 50 guidelines there that are the most ones I refer to often, but other ones, after I’ve not referred to it for a long time I tend to throw them out and hope I get the gist of it.”*

Extract 17: GP interview 28, page 4, lines 154-157 *“I’ve not read any guidelines. I just go according to what the consultants say to me so I’m not, I know there are NICE guidelines about antipsychotic risk. I mean, I’d, I’ve not read any but I think the reason we don’t get involved with reading those is because a lot of our prescribing is based on secondary care advice.”*