

Experiences of Medication Adherence Among People with Schizophrenia: A Qualitative Systematic Review

Nisakorn Pothimas, Patraporn Tungpunkom,* Thidarat Kanungpiarn, Karin Hannes

Abstract: Schizophrenia is a chronic mental illness that affects thought processes, perception, and behavior, and antipsychotic medications are important to control psychotic symptoms. People with schizophrenia who adhere to neuroleptic medication are less likely to relapse than those who do not. This paper reports on a meta-synthesis of qualitative research exploring medication adherence experiences among people with schizophrenia. Published articles written in English from 1999-2019 were searched (January 1999-December 2019), from electronic databases, including CINAHL, PubMed, Science Direct, Scopus, PsycINFO, ProQuest, Dissertations and Theses, and the Thai National Research Repository. Twelve studies were included in the final review.

Major components that affect medication adherence in people with schizophrenia positively or negatively were gentle pressure, trust and social support, a positive attitude toward disease and treatment, a sense of understanding of the beneficial and negative impact of medication, and financial constraints. We suggest a gentle medication adherence approach that departs from a joint responsibility between the family network and health providers to push people with schizophrenia towards medication uptake and help them develop coping mechanisms to deal with important side effects. Family members and health care providers should consider the patient's concerns about what is perceived as a normal life and a potential future life, taking into account social stigma and financial barriers.

Pacific Rim Int J Nurs Res 2021; 25(2) 229-241

Keywords: Antipsychotic medication, Literature review, Medication adherence, Medication compliance, Meta-synthesis, Patient experience, Qualitative, Schizophrenia

Received 16 May 2020; Revised 21 September 2020;
Accepted 30 September 2020

Introduction

Approximately 21 million people are affected with schizophrenia throughout the world.¹ The rate of incidence is 15.2 per 100,000 persons,² the mean ages at onset for males and females is 23 and 25 years, respectively,³ and the prevalence of median lifetime was 4.0 per 1000.^{2,4} Schizophrenia is a chronic mental

Nisakorn Pothimas, RN, PhD., Instructor, Faculty of Nursing, Naresuan University, Phitsanulok, Thailand. E-mail: nisakonp@nu.ac.th

Correspondence to: Patraporn Tungpunkom,* RN, APPMH, PhD., FAAN, Associate Professor, The Thailand Centre for EBHC: a JBI Affiliated Group, Faculty of Nursing, Chiang Mai University, Chiang Mai, Thailand. E-mail: patraporn.t@cmu.ac.th

Thidarat Kanungpiarn, RN, M.N.S., Instructor, Boromarajonani college of Nursing Surin, Surin, Thailand. E-mail: neng_thidarat@hotmail.com

Karin Hannes, MSc, PhD., Associate Professor, Research Group SoMeTHin'K (Social, Methodological and Theoretical Innovation / Kreative), CESO, Faculty of Social Sciences, Belgium. E-mail: Karin.hannes@kuleuven.be

disorder that frequently induces relapse, and negatively impacts on quality of life of both patient⁵ and family.⁶ A first choice of treatment to diminish psychotic symptoms and prevent relapse for the long-term illness course is a neuroleptic medication regime.⁷ Therefore, adherence to the drug over time is important and a core factor in preventing relapse of people with schizophrenia,⁷ and adherence lowers the annual total cost of re-hospitalization. Several studies have documented that the direct costs of relapse compared to non-relapse is approximately two to four times higher.⁸⁻¹⁰

The term adherence is defined as “the extent to which a person’s behavior, taking medication, corresponds with agreed recommendations from a health care provider.”¹¹ Adherence requires the patient’s agreement with these recommendations, while “compliance” is described as a patient passively following the doctor’s orders. In this case, the treatment plan is not based on a therapeutic alliance.¹² In practice, the terms “adherence” and “compliance” are used interchangeably.

Medication adherence is an important problem for those with schizophrenia. However, adherence rates differ amongst studies. Poor medication adherence rates of 39% and 35% have been reported, particularly during the first and second years of the illness.¹³ Likewise, other studies¹⁴⁻¹⁷ showed the rates of non-adherence ranging from 30–70%. On the other hand, a study¹³ reported good adherence rates at first- and second-year follow-up (51% and 44%, respectively). Additionally, some studies¹⁴⁻¹⁷ demonstrated adherence rates ranging from 13–60%.

Previous studies indicate that the factors associated with medication adherence can be classified into three categories: clinical, personal, and social support variables. First, clinical variables such as the severity of psychotic symptoms affect drug compliance of patients. Those with less severe psychotic symptoms tend to comply with medications.¹⁸ Second, personal variables play a vital role in affecting compliance behavior,¹⁹ e.g.,

people’s self-insight in their illness¹⁹ and positive attitudes toward medication.²⁰ Positive attitudes toward medication include people’s believe in medication for recovery²⁰ and coping with stressful life events.²¹ Finally, social support variables include the support of family and friends to help them adhere to neuroleptic drugs.²² Medication non-compliance variables can be classified into the same three categories; (a) clinical factors such as the severity of psychotic symptoms increase drug non-compliance.^{18,23-26} (b) personal variables such as poor insight,^{18,23,25-27} drug abuse,^{25,26} loss of work,²⁵ poor functioning,^{23,25} negative attitudes towards antipsychotic medications,²⁸ the stigma of taking antipsychotic medication that affects non-adherence to taking medication and, (c) social support factors such as an increased risk for non-compliance for those living alone.²⁷

It is crucially important to understand and further inform practice and policy the motives and reasons why people with schizophrenia opt out of treatment or do not fully engage with their treatment programs. Therefore, we undertook a systematic overview of the literature on this topic in the absence of a review on medication adherence experiences in people with schizophrenia in the Cochrane Library or Joanna Briggs Institute (JBI) Database of Systematic Reviews and Implementation Reports. The review focuses on people with schizophrenia who continue to take medication to understanding their perspectives about factors that help or impede them from adhering to medication based on their point of view. Here, we differ from another review on the topic²⁹ that focused on experiences of patients and how medication impacts on their mental state and behavior. Therefore, the specific review objective was to synthesize primary studies exploring lived experiences of medication adherence in people with schizophrenia and develop a line of argument to inform practitioners and policymakers on potential strategies to improve drug compliance behavior for such people.

Methods

This review followed the steps addressed in the protocol published at DOI: 10.11124/JBISRIR-2016-2538 and was registered with PROSPERO number 2538.³⁰ We searched for research evidence over a 20-year timespan (January 1999–December 2019), using the following eligibility criteria:

Inclusion criteria: This review examined studies involving people ≥ 18 years diagnosed with schizophrenia spectrum disorders in primary studies exploring medication adherence experiences among people with schizophrenia and hospitalized in any facility or living in the community. The study types were any qualitative study on medication adherence of experiences of individuals with schizophrenia, using research methodologies including, but not limited to, phenomenology, grounded theory, and ethnography. Opinion pieces and editorials were excluded from this review.

Exclusion criteria: Research papers that included patients diagnosed with an organic brain disorder, intellectual disability, alcohol use disorder, or substance abuse were excluded.

Search strategy: A JBI three-step search strategy was used to search for published and unpublished research papers in the English language from 1999 (the year the first study on the topic appeared to be published after scoping the literature) to 2019. Firstly, the initial search was limited to MEDLINE and CINAHL using prior search terms to identify text words in their titles, abstracts, and index terms. These search terms were experiences; medication adherence, medication compliance, medication concordance; qualitative study, descriptive qualitative study, phenomenology, grounded theory, ethnography; schizophrenia, schizoaffective, schizophreniform, undifferentiated schizophrenia; antipsychotic medication, antipsychotic treatment, antipsychotic drug; hospital, inpatient unit, outpatient unit, community, health care facility, group home, living with family, half-way house, and residential area.

A second search using keywords and index terms, described above, was conducted across CINAHL, PsycINFO, Science Direct, PubMed, Scopus, ProQuest, and Thai National Research Repository. Unpublished and grey literature were searched from grey literature (<http://www.greylit.org/>), open grey literature (<http://www.opengrey.eu/>), and Dissertation and Theses. A third search based on the reference lists of the included studies was conducted to identify additional studies. Details of our search strategies are provided in **Table 1**.

Study Selection: The citations of relevant studies were uploaded into EndNote bibliographic software, and duplicate studies were removed. Two reviewers worked independently to screen titles and abstracts and map the studies against the review's inclusion criteria. When disagreement arose, a third reviewer was consulted before making a final decision. The papers that matched the eligibility criteria were retrieved in full text. We imported their details into the Joanna Briggs Institute Qualitative Assessment and Review Instrument (QARI).³¹ The full text of eligible research papers was retrieved and appraised in detail against the inclusion criteria.

Assessment of methodological quality: Two reviewers independently critically appraised 12 research studies for quality of methodology using QARI. Disagreements that occurred between them were resolved by discussion or with a third reviewer. The JBI Critical Appraisal Checklist consists of 10 items with four response rates (yes, no, unclear, and not applicable) (**Table 2**). The score of “yes” is equal to 1. The rest of the answers equal to zero. The decision to exclude based on cut-off scores of less than 70% of the Critical Appraisal Checklist items. The results of the critical appraisal of each study are presented in **Table 3**.

Data Extraction: JBI-SUMARI³² was the standardized data extraction tool for using to extract twelve included studies by two reviewers independently. The data extracted included the populations, context,

culture, geographical location, study methods, and the phenomena of interest related to the review question and specific purpose. Findings and their illustrations were extracted and assigned a credibility level, ranging from unequivocal, credible, or unsupported. However, based on the JBI approach, the finding that has not had the illustration accompanied was not be extracted; therefore, the findings contained only the unequivocal and credible level.

Data Synthesis: JBI-QARI software was used to pool qualitative research findings. The synthesis process involved the aggregation or synthesis of findings (generally referring to statements made by the authors of primary studies) into categories based on similarity in meaning. These categories were then subjected to a meta-synthesis to produce a single comprehensive set of synthesized findings presented as lines of actions health care practitioners could follow up on in stimulating people with schizophrenia to adhere to prescribed medicines. The synthesis is primarily meant to inventory and describe the components related to medication adherence based on the patients' points of view rather than to advance theory.

Assessing Confidence: The final synthesized findings were graded following the ConQual approach³³ for establishing confidence in the output of the qualitative research synthesis. Two major markers were used to assess the level of confidence in review findings, dependability, and credibility. To score dependability, we answered five specific questions related to the appropriateness of methodology, methods, and implementation of the research methods, regardless of paradigm, and rated studies following the guidelines proposed in the ConQual conceptual paper (**Table 4**). Each review finding starts at a high confidence level. If the response to a question is 4–5 “yes,” the paper remains at the current level. If the answer is 2–3 “yes,” it will move down one level (i.e., from high to moderate), and if the answer is 0–1 “yes,” it will move down two levels (i.e., from high to low or from moderate to very low).³³ We assigned a dependability

rank on the aggregate level across primary study findings for the synthesized findings. The credibility criterion is focused on the believability of the findings. If a synthesized finding only contained primary study findings labelled as unequivocal, it received the highest credibility level. Review findings generated from a mix of unequivocal/credible primary study findings were downgraded. Review findings built on a mix of credible/unsupported findings or unsupported findings only received the lowest credibility level. The overall confidence we have for our synthesized findings ranges from low to moderate. The summary of findings is detailed in **Table 5**.

Findings

Study inclusion

A total of 4,405 relevant studies identified by a literature search using keywords and text terms previously described were located. Four duplicated papers were removed, resulting in 4,401 records. After the evaluation of abstracts against inclusion criteria, 17 full research studies were retrieved for detailed examination. After reviewing the full text, five research studies were excluded because they did not fully reach the eligibility criteria (PICO: Population/patient, the Phenomenon of Interest, Context), Outcomes of this review. The remaining 12 studies were subjected to a quality assessment. All 12 papers met the quality assessment. See PRISMA flow chart (**Figure 1**).

Characteristics of included studies

Of the 12 studies, four used phenomenology, one used narrative, two used grounded theory methodology, four studies used qualitative content analysis, and one study used a qualitative thematic analysis. Eleven studies conducted in-depth interviews to elicit the data. Only one study used a combined approach of an in-depth interview with participant observation. The total number of participants was 131 (105 with schizophrenia, 19 with schizoaffective disorders, and seven with schizophrenia plus schizoaffective).

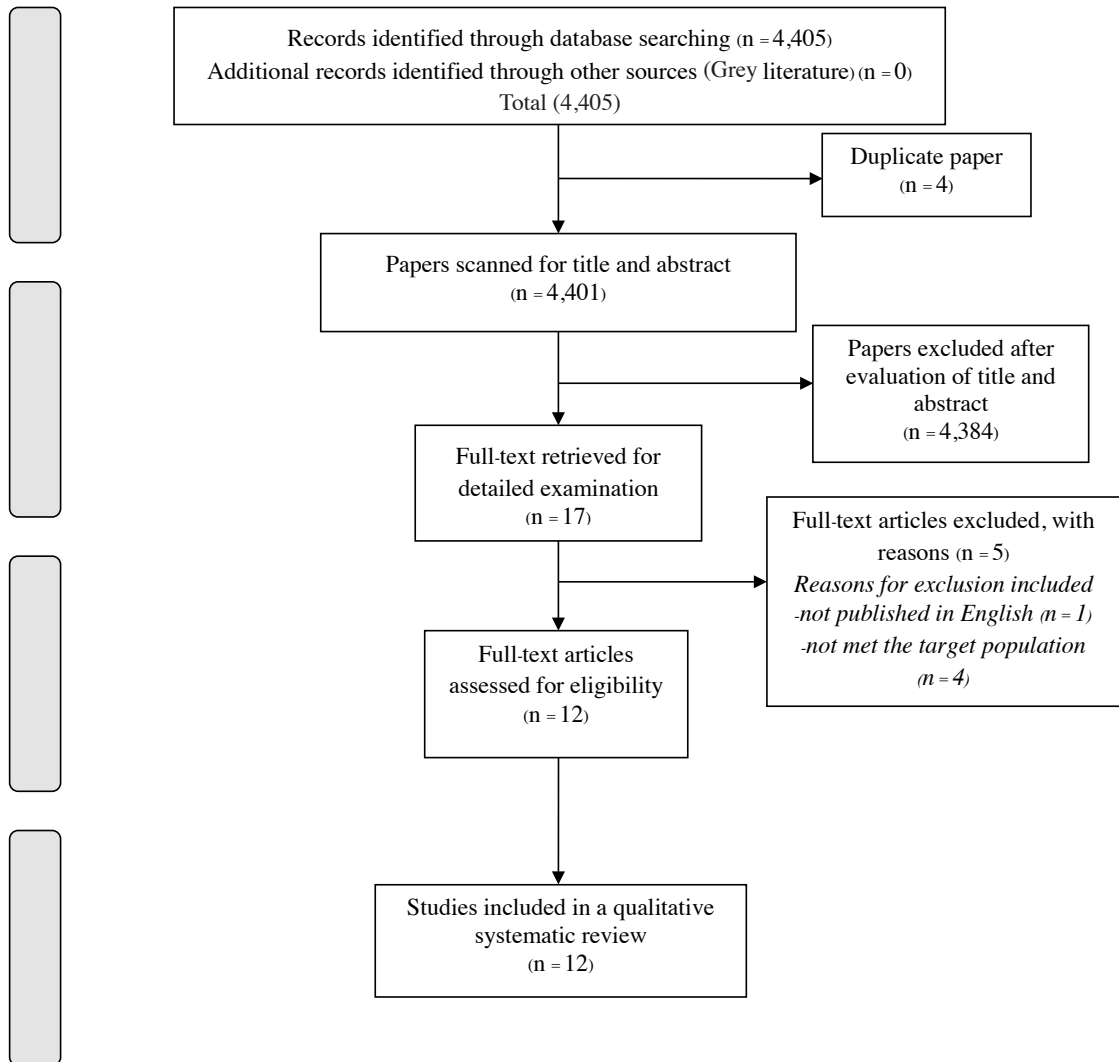


Figure 1. PRISMA flow diagram: search and study selection.

These qualitative studies were conducted in Asia (Taiwan 1, Iran 1), Europe (England 2, Scotland 1), Africa (Nigeria 1), North America (Canada 1), and the United States of America (4). The details of the characteristics of the included study can be found in **Table 6**.

Results of meta-synthesis of qualitative research findings

This section presents the findings from the synthesis process as applied to medication adherence

in schizophrenia. It should be read as a transparent audit trail of how findings were clustered together and lead into an argument line. The arguments are further situated in a general discussion. Eighty-five findings have been assigned to one of the following nine categories. These included *Trusted relationship*, *Family Bonding*, *Peers' support*, *Phases in adopting a constructive attitude towards the disease*, *Phases in adopting a constructive attitude towards treatment programs*, *Beneficial impact from the medical treatment*

plan, Psycho-social experience of abnormality, Physical experience of abnormalities, and Financial barriers influencing adherence. This resulted in four synthesized findings. In line with the JBI approach, the synthesized findings are presented in a declamatory form, addressing action lines rather than highlighting a theme.³⁴ The brief details of each synthesized finding and the final four lines of action for health care practitioners are presented below. The details of synthesized findings, derived from the nine categories with findings and illustrations (themes and metaphors extracted from the primary studies) can be found in **Table 7**.

Synthesized finding 1: Caregiver, peers, and health care providers should consider themselves allies in adopting a strategy of gentle pressure on the patient to stimulate initiation and continuation of or changes in medical treatment programs. This finding consisted of 3 categories, and 20 findings.^{35-37,39-44} Category one was the *Trusted relationship*. This comprised 14 findings, First antipsychotics: Passivity and pressure,⁴⁰ Relationship with healthcare providers,³⁶ Relationship alliances,³⁹ Blind adherence,³⁷ Distrustful nonadherence,³⁷ Emphasize taking medications as prescribed,⁴¹ Patient choice and responsibility for medicine management,⁴² Knowledge and information,⁴³ Other sources of support,⁴³ Responses to unsupportive involvement,⁴⁴ Supportive contributions,⁴⁴ Unsatisfactory relationships,⁴⁴ Supportive relationships,⁴⁴ and Ideal wishes for support by providers.⁴⁴ Category two was named *Family bonding* and consisted of 3 findings, Firm and ongoing family support,³⁵ Cultural values: the concept of filial piety,³⁵ Continuation without perceived need: external pressures.⁴⁰ Category three was labelled *Peers' support* and was composed of three findings, Remind each other of the importance of complying with medication regimen,⁴¹ Report non-compliant behaviors,⁴¹ and Ensure medications are taken as scheduled.⁴¹

Synthesized finding 2: Health care providers should acknowledge that acceptance and a constructive attitude of patients towards their disease and self-control over medical treatment evolves over time. This finding

consisted of 2 categories (category four and five) and 15 findings.^{36-37,39,41,44} Category four was entitled *Phases in adopting a constructive attitude towards the disease* and comprised four findings, Accepting there was no cure,³⁶ Knowing the illness,³⁶ Discovering my illness,³⁹ and Here's what I can do.³⁹ Category five was labelled *Phases in adopting a constructive attitude towards treatment programs* and entailed 11 findings, Informed adherence,³⁷ The process of alliance with medication,³⁹ Starting treatment,³⁶ View need to comply with prescription regimen,⁴¹ Arrange for re-hospitalization when needed,⁴¹ Provide accurate information,⁴¹ Development of a personal rationale for taking medications,⁴⁴ Learning about distinctive environmental contributions to illness,⁴⁴ Continual development of health and medication beliefs,⁴⁴ Learning ways to adapt,⁴⁴ and Grief over loss of independence in the face of illness.⁴⁴

Synthesized finding 3: Health care providers should inform persons who benefit from medication as well as those within their immediate social environment on how to deal with the potential negative physical and psycho-social impacts of being diagnosed with and treated for schizophrenia. This synthesized finding consisted of 3 categories (category six, seven, and eight), and 49 findings.^{35-42,44-46} Category six was *Beneficial impact from medication* and had 33 findings, Benefits of antipsychotic medication treatment,³⁵ Sticking with medication,³⁶ Assuming personal responsibility,³⁶ Subjective benefits: persevering in spite of side effects,⁴⁰ Medicating the fear,³⁹ Learning from nonadherence,⁴⁰ Managing the loss, pain, and anger,³⁹ Keeping the stranger at bay,³⁹ Subduing the psychotic stranger within,³⁹ Hope for the future,³⁵ Symptom control,⁴⁵ Disease burden,⁴⁵ Restoration of health and wellness,⁴⁵ View medications positively,⁴¹ Promotes normalcy,⁴¹ Prevented readmission to hospital,⁴¹ To treat mental illness,⁴¹ To calm person,⁴¹ To promote individual's ability to work,⁴¹ Promoted quality of life,⁴¹ Alleviated thought disorders,⁴¹ Promoted sense of normalcy,⁴¹ Believed symptoms of schizophrenia are alleviated,⁴¹

Believe medications have positive effects,⁴¹ Grateful,⁴¹ Hopeful medications will prevent relapse of schizophrenia,⁴¹ Acknowledge need to take medications despite experiencing side effects,⁴¹ Desire to feel healthier,⁴¹ Desire to work/manage activities of daily life,⁴¹ Recreational pursuits,⁴¹ Desire to relate with significant others,⁴¹ Reflection of how medications are helpful and hindering,⁴⁴ and Fear as an infiltrating extension into daily occupations.⁴⁴ Category seven was named *Psychosocial experience of abnormality*. It was composed of four findings, namely Threats to self-esteem,⁴⁰ Catalysts of medication discontinuation,⁴⁶ Intentional abandonment of medication,⁴⁶ and Betwixt and between: Seized by life with mental illness.⁴⁴ Category eight was *Physical experience of abnormality* and contained 12 findings, Predicament of medication taking,³⁶ Intentional non-adherence,³⁷ Experience of medication,³⁸ Treatment burden,⁴⁵ Patient knowledge and awareness of medications,⁴² Awareness of self-response to missing doses of medication,⁴⁴ Learning to recognize and manage side effects of medications,⁴⁴ Angst arising from a need to avoid intense psychosis,⁴⁴ Worry over whether medications will work or its effects will fade away,⁴⁴ Uneasiness in consideration of potential medication dose adjustments,⁴⁴ Fear as a result of negative side effects and remaining symptoms,⁴⁴ and Uneasiness around addiction or abuse.⁴⁴

Finally, **synthesized finding 4:** In severe poverty cases, health care providers should check whether the lack of financial means impacts adherence. This synthesized finding consisted of one category Financial barriers influencing adherence and one finding, Experience of poverty.³⁸ The elaborated synthesized findings are in **Table 7**.

Discussion

This review identified several studies reporting on lived experiences of medication adherence in persons with schizophrenia conducted in different geographical regions and settings, including hospitals, rehabilitation,

health clinics, homes, and community settings. An important insight from our study is that peers seem to impact patients' adherence to medication positively. Therefore, strategies used in home and community settings to encourage adherence could be studied more intensively in follow-up research to inspire others. Moreover, we expected that participants questioned in a hospital setting chosen by the researchers were at high risk of presenting socially desirable answers to please the staff, suggesting that more energy could be invested in studying adherence from an observational perspective. Our synthesized findings reflect the experiential learning curve that persons with schizophrenia move through to accept their disease and their medical treatment program. Overall, persons with schizophrenia tend to continue to take their medicine if they experience a beneficial effect from them.

On the other hand, medication side effects are among the main reasons people with schizophrenia abandon their treatment. This finding is congruent with a recently published narrative meta-synthesis study,⁴⁷ revealing that medication side effects are indeed a major obstacle in the adherence to the medication process. While this is close to common sense, it can be influenced by several factors. Our review indicates that relationships based on trust and joint decision-making in an open communication atmosphere about what the patients may expect and social support from the person's home network act as a push factor for medication adherence, even when side effects are experienced.

In general, persons with schizophrenia develop trust in their doctors and therefore tend to follow their advice. However, we also found cases that broke this pattern. In cases of severe side-effects from a new medication, it was proposed that patients could move from trusting to distrusting their practitioners. This dynamic is presented in a study by Leutwyler et al.³⁷ An honest, informative account of what will happen to patients if they stop taking medications or switch to a new medicine is essential to stimulate adherence. Using testimonies from other patients could also be a

useful strategy to consider. We also found that many people with schizophrenia learn about their disease and their medication effects via trial and error. And this reflects that some actively explore what happens when they stop taking their medication. It might make their illness worse than before; therefore, it takes more time for them to recover to their functional level. However, removing the medicine gives partial relief for some patients, particularly in cases where the side effects impact daily life functioning. Again, the storyline from peers on successful adherence cases is potentially more effective than the regular psychoeducation when provided in hospital settings. Examples of such information programs include videos made by those who successfully coped with their disease and treatment program and living a full life or creating databases with a collection of narratives from peers.

This is congruent with the predictive quantitative research results generated in other studies exploring the potential of illness insights, symptoms, and medication side effects. These studies found that a better understanding of the illness and adverse effects positively impacted drug adherence of those with schizophrenia.¹⁸ Negative attitudes towards psychotropic drugs were associated with non-adherence to the medication by participants.²⁸ Acceptance of the disease as part of their identity from significant others gives them a sense of normality and strengthens patients' motivation for long-term medication adherence.

A small proportion of our data suggests that social stigma and a negative self-perception lead to a negative impact on medication adherence. This finding is in line with quantitative research results indicating that half of patients with schizophrenia experience discrimination from their family, in intimate relationships, employment, and health care providers. Eighty-eight percent wanted to conceal their mental disorder from others, although the association between stigma and medication compliance was not statistically significant.⁴⁸ Our synthesis also found that trusted relationships

with caregivers and health care providers help those with schizophrenia accept the need for medication at the beginning of their illness. However, patient medication continuation requires understanding and long-term support from family members and professional guidance for managing medication side-effects which affects their routine in regular activities. The findings also reveal the importance of relationships and trust among people with schizophrenia, health care providers, and family caregivers. A good relationship and trust increase the likelihood of adherence to medicine. This result is congruent with findings from other studies that reported that people with schizophrenia who live alone tend to have poor adherence over long periods of treatment.²⁷ Likewise, a study⁴⁷ claimed that one of the barriers to continuing taking medication is the lack of family support. Based on the findings, the opportunity of persons with schizophrenia to talk or complain with health care providers about the problems related to taking medication will enable them to get an insight into the needs of medication adherence and help them learn how to live with mental illness. This also enhances their hopes of moving their life forward. This is in line with the finding from a narrative meta-synthesis,⁴⁷ revealing that the interrelationship between patients and nurses will help patients talk about their concerns, hence stimulating adherence to medication. Our synthesized findings suggest that a lack of money for patients adversely impacts adherence and is an issue that needs political attention. This is especially true for people living in developing countries where health insurance coverage is not financially affordable to many citizens.⁴⁹

Finally, our four synthesized findings are proposed to improve the life and well-being of people with schizophrenia. The call for thorough attentiveness of patients' experiences relevant to their illness, benefits, and side-effects of medicine requires a change in focus on what we talk about with patients and their relatives, why, and how. People with schizophrenia

tend to tolerate side-effects better in a supportive climate at home, from a paradigm of hope that enables them to conceptualize a normal, valuable life. It reflects the power of social attachment and the potential of joint decision-making programs in deciding on treatment programs.

Limitation of the review

Our last synthesized finding was developed from only one category based on findings from only one study. We assume that similar issues might be at play in other developing countries. It reflects the importance of context that needs to be considered in synthesis since it impacts medication adherence differently. When poverty becomes the main mechanism of non-adherence, the problem becomes political rather than personal. This should be accounted for in upcoming synthesis efforts.

Conclusions and Implications for Nursing Practice

Findings from this review illuminate the often subtle internal and external factors that act as a mediator for non-adherence, or on the other hand, a facilitator for medication adherence for people diagnosed with schizophrenia. Our review findings suggest that caregivers and health care providers should consider themselves allies in adopting a gentle pressure strategy to stimulate initiation and continuation of or changes in medical treatment programs. This should be done in an atmosphere of open communication, trust, and joint decision making. Health care providers should be aware that patients' acceptance and constructive attitude towards their disease and self-control over medication treatment evolve over time. In working and communicating with patients, they should preserve time to address denial issues and the patient's concerns about their current situation and future perspectives.

Moreover, health care providers should inform those who benefit from medication as well as the people within their immediate social environment on how to deal with potential negative physical and psycho-social impacts of being diagnosed with and treated for schizophrenia. This adds to a sense of control over the disease of all partners involved. This might help in reshaping patients' perception of a normal life. Furthermore, health care providers should check whether a lack of finances impacts adherence to treatment of persons with schizophrenia. If so, they should refer them to the appropriate services to discuss potential financial support programs.

Acknowledgments

The authors acknowledge the Thailand Centre for Evidence-Based Health Care for providing workshop training to novice members of the team for conducting reviews and for hosting Prof. Karin Hannes from the Faculty of Social Sciences, KU Leuven in Belgium as a visiting fellow, which enabled her to share methodological advice in the final phases of the review project and contribute to the discussion part.

Conflict of interest

This study did not receive financial support. None of the authors has a conflict of interest.

References

1. World Health Organization. Schizophrenia. [Internet] 2014 Oct 4 [cited 2015 June 16]. Available from: http://www.who.int/mental_health/management/schizophrenia/en/
2. McGrath J, Saha S, Chant D, Welham J. Schizophrenia: a concise overview of incidence, prevalence, and mortality. *Epidemiol Rev.* 2008;30:67–76. doi:10.1093/epirev/mxn001.
3. Morgan VA, Castle DJ, Jablensky AV. Do women express and experience psychosis differently from men? epidemiological evidence from the Australian national study of low prevalence (psychotic) disorders. *Aust N Z J Psychiatry.* 2008;42(1): 74–82. doi:10.1080/00048670701732699.

4. Saha S, Chant D, Welham J, McGrath J. A systematic review of the prevalence of schizophrenia. *PLoS Med.* 2005;2(5): 413–33. doi:10.1371/journal.pmed.0020141.
5. Solanki RK, Singh P, Midha A, Chugh K. Schizophrenia: impact on quality of life. *Indian J Psychiatry.* 2008;50(3): 181–6. doi: 10.4103/0019-5545.43632.
6. Brady N, McCain GC. Living with schizophrenia: a family perspective. *Online J Issues Nurs.* 2005;10(1):112–48.
7. The National Health Service. Schizophrenia treatment. [internet] 2014 Nov 11 [cited 2015 June 14]. Available from: <http://www.nhs.uk/Conditions/Schizophrenia/Pages/Treatment.aspx>
8. Ascher-Svanum H, Zhu B, Faries DE, Salkever D, Slade EP, Peng X, et al. The cost of relapse and the predictors of relapse in the treatment of schizophrenia. *BMC Psychiatry.* 2010;10(2):1–7. doi:10.1186/1471-244X-10-2.
9. Hong J, Windmeijer F, Novick D, Haro JM, Brown J. The cost of relapse in patients with schizophrenia in the European SOHO (schizophrenia outpatient health outcomes) study. *Prog Neuropsychopharmacol Biol Psychiatry.* 2009; 33(5):835–41. doi:10.1016/j.pnpbp.2009.03.034.
10. Almond S, Knapp M, Francois C, Toumi M, Brugha T. Relapse in schizophrenia: costs, clinical outcomes and quality of life. *Br J Psychiatry.* 2004;184(4):346–51. doi:10.1192/bjp.184.4.346.
11. World Health Organization. Adherence to long-term therapies: evidence for action. Geneva: World Health Organization; 2003.
12. Osterberg L, Blaschke T. Drug therapy: adherence to medication. *N Engl J Med.* 2005; 353:487–97. doi: 10.1056/NEJMr050100.
13. Quach PL, Mors O, Christensen TØ, Krarup G, Jørgensen P, Bertelsen M, et al. Predictors of poor adherence to medication among patients with first-episode schizophrenia spectrum disorder. *Early Interv Psychiatry.* 2009;3(1):66–74. doi:10.1111/j.1751-7893.2008.00108.x.
14. Adelufosi AO, Adebawale TO, Abayode O, Mosanya JT. Medication adherence and quality of life among Nigeria outpatients with schizophrenia. *Gen Hosp Psychiatry.* 2012; 34(1):72–9. doi:10.1016/j.genhosppsych.2011.09.001.
15. Dassa D, Boyer L, Benoit M, Bourcet S, Raymond P, Bottai T. Factors associated with medication non-adherence in patients suffering from schizophrenia: a cross-sectional study in a universal coverage health-care system. *Aust N Z J Psychiatry.* 2010;44(10):921–8. doi:10.3109/00048674.2010.493503.
16. Amr M, El-Mogy A, El-Masry R. Adherence in Egyptian patients with schizophrenia: the role of insight, medication beliefs and spirituality. *Arab J Psychiatr.* 2013;24(1):60–8. doi:10.12816/0000100.
17. Ngui AN, Vasiliadis HM, Tempier R. Factors associated with adherence over time to antipsychotic drug treatment. *Clin Epidemiol Glob Health.* 2015;3(1):3–9. doi: 10.1016/j.cegh.2013.11.001.
18. Kao YC, Liu YP. Compliance and schizophrenia: the predictive potential of insight into illness, symptoms, and side effects. *Compr Psychiatry.* 2010;51(6):557–65. doi:10.1016/j.comppsy.2010.03.007.
19. Meguid M, Essawy HI, Sabry WM, Khalifa DA, Bastawy MA, Ali RR. Understanding medications non adherence in a sample of Egyptian patients with schizophrenia in relation to illness severity and insight. *J Psychiatry.* 2015;18(5):1–7.
20. Perkins DO. Predictors of non-compliance in patients with schizophrenia. *J Clin Psychiatry.* 2002;63(12):1121–212. doi:10.4088/JCP.v63n1206.
21. Yamada K, Watanabe K, Nemoto N, Fujita H, Chikaraishi C, Yamauchi K, et al. Prediction of medication non-compliance in outpatients with schizophrenia: 2-year follow-up study. *Psychiatry Res.* 2006;141(1):61–9. doi:10.1016/j.psychres.2004.07.014.
22. Tranulis C, Goff D, Henderson DC, Freudenreich OF. Becoming adherent to antipsychotics: a qualitative study of treatment-experienced schizophrenia patients. *Psychiatr Serv.* 2011;62(8):888–92. doi:10.1176/appi.ps.62.8.888.
23. Brain C, Allerby K, Sameby B, Quinlan P, Joas E, Karilampi U, et al. Drug attitude and other predict of medication adherence in schizophrenia: 12 months of electronic monitoring (MEMS1) in the Swedish COAST-study. *Eur Neuropharmacol.* 2013;23(12):1754–62. doi: 10.1016/j.euroneuro.2013.09.001.
24. Liu-Seifert H, Osuntokun OO, Feldman PD. Factors associated with adherence to treatment with olanzapine and other atypical antipsychotic medications in patients with schizophrenia. *Compr Psychiatry.* 2012;53(1):107–15. doi:10.1016/j.comppsy.2010.12.003.
25. Nose M, Brabui C, Tansella M. How often do patients with psychosis fail to adhere to treatment programmes? a systematic review. *Psychol Med.* 2003;33(7):1149–60. doi:10.1017/S0033291703008328.

26. Kamali M, Kelly BD, Clarke M, Browne S, Gervin M, Kinsella A, et al. A prospective evaluation of adherence to medication in first episode schizophrenia. *Eur Psychiatry*. 2006;21(1):29–33. doi:10.1016/j.eurpsy.2005.05.015.
27. Tsang HWH, Fung KMT, Corrigan PW. Psycho-social and socio-demographic correlates of medication compliance among people with schizophrenia. *J Behav Ther Exp Psy*. 2009;40(1):3–14. doi:10.1016/j.jbtep.2008.02.003.
28. Gaebel W, Riesbeck M, von Wilmsdorff M, Burns T, Derks EM, Kahn RS, et al. Drug attitude as predictor for effectiveness in first-episode schizophrenia: results of an open randomized trial (EUFEST). *Eur Neuropharmacol*. 2010;20(5):310–6. doi:10.1016/j.euroneuro.2010.02.001.
29. Thompson J, Stansfeld JL, Cooper RE, Morant N, Crellin NE, Moncrieff J. Experiences of taking neuroleptic medication and impacts on symptoms, sense of self and agency: a systematic review and thematic synthesis of qualitative data. *Soc Psychiatry Psychiatr Epidemiol*. 2020;55(2):151–64. doi: 10.1007/s00127-019-01819-2.
30. Pothimas N, Tungpunkom P, Kanungpiarn T. Experiences of medication adherence among people with schizophrenia: a systematic review protocol of qualitative evidence. *JB I Database Systematic Rev Implement Rep*. 2016;14(3):51–7. doi:10.11124/JBISRIIR-2016-2538.
31. The Joanna Briggs Institute. JBI QARI Critical Appraisal Checklist for Interpretive & Critical Research. [Internet] 2014 [cited 2017 Dec 6]. Available from http://joannabriggs.org/assets/docs/jbc/operations/criticalAppraisalForms/JBC_Form_CritAp_IntCrit.pdf
32. The Joanna Briggs Institute. JBI-QARI Data Extraction Form for Interpretive & Critical Research. [Internet] 2014 [cited 2017 Dec 6]. Available from: https://joannabriggs.org/assets/docs/jbc/operations/dataExtractionForms/JBC_Form_DataE_IntCrit.pdf
33. Munn Z, Porritt K, Lockwood C, Aromataris E, Pearson A. Establishing confidence in the output of qualitative research synthesis: the ConQual approach. *BMC Med Res Methodol*. 2014;14(108):1–7. doi:10.1186/1471-2288-14-108.
34. Hannes K, Lockwood C. Pragmatism as the philosophical foundation for the Joanna Briggs meta-aggregative approach to qualitative evidence synthesis. *J Adv Nurs*. 2011;67(7):1632–42. doi:10.1111/j.1365-2648.2011.05636.x.
35. Chang Y-T, Tao S-G, Lu C-L. Qualitative inquiry into motivators for maintaining medication adherence among Taiwanese with schizophrenia. *Int J Ment Health Nurs*. 2013;22(3):272–8. doi:10.1111/j.1447-0349.2012.00864.x.
36. Dumas, RE. The lived experience of taking neuroleptic medication by persons with schizophrenia [dissertation]. Arizona: The University of Arizona; 1999.
37. Leutwyler HC, Fox PJ, Wallhagen M. Medication adherence among older adults with schizophrenia. *J Gerontol Nurs*. 2013;39(2):26–34. doi:10.3928/00989134-20130109-02.
38. Meshach OE, King KM, Fulton JA. Poor adherence to antipsychotic medications among schizophrenia patients in Nigeria. *Int J Cult Ment Health*. 2014;7(3):246–58. doi:10.1080/17542863.2013.783091.
39. SemarDC. Making my own acquaintance: a phenomenological study of taking antipsychotic medication for schizophrenia [dissertation]. Connecticut: University of Connecticut; 2000.
40. Tranulis C, Goff D, Henderson DC, Freudenreich O. Becoming adherence to antipsychotics: a qualitative study of treatment experienced schizophrenia patients. *Psychiatr Serv*. 2011;62(8):888–92. doi:10.1176/ps.62.8.pss6208_0888.
41. Dash-martyr JM. Perceptions of the stressors influencing medication compliance of individuals recovering from a mental illness while living in supportive housing [Thesis]. Buffalo, NY: D'Youville College; 2003.
42. Stewart DC, Anthony GB, Chesson R. 'It's not my job. I'm the patient not the doctor': patient perspectives on medicines management in the treatment of schizophrenia patient. *Educ Couns*. 2010;78(2):212–7. doi:10.1016/j.pec.2009.06.016.
43. Phillips L, McCann E. The subjective experiences of people who regularly receive depot neuroleptic medication in the community. *J Psychiatr Ment Health Nurs*. 2007;14(6):578–86. doi:10.1111/j.1365-2850.2007.01145.x.
44. Kurtis, SD. Medication adherence, social support, and recovery: perspectives of individuals with schizophrenia spectrum disorders and their families [dissertation]. Maryland: Towson University; 2012.
45. Fewster, CA. A comparative investigation into the factors affecting adherence to treatment in a forensic schizophrenic population [dissertation]. Manchester: The University of Manchester; 2008.

46. Zarea K, Fereidooni-Moghadam M, Hakim A. Adherence to medication regimen in patients with severe and chronic psychiatric disorders: a qualitative study. *Ment Health Nurs.* 2016;37(11):868-74. doi:10.1080/01612840.2016.1239147.
47. Salzmänn-Erikson M, Sjödin M. A narrative meta-synthesis of how people with schizophrenia experience facilitators and barriers in using antipsychotic medication: implication for healthcare professionals. *Int J Nurs Stud.* 2018;85:7-18. doi:10.1016/j.ijnurstu.2018.05.003.
48. Brain C, Sameby, Allerby K, Quinlan P, Joas E, Lindström E, et al. Stigma, discrimination and medication adherence in schizophrenia: results from the Swedish COAST study. *Psychiatry Res.* 2014;220(3):811-7. doi:10.1016/j.psychres.2014.10.016.
49. Maan CG, Munnawar Hussain MS, Heramani N, Lenin RK. Factors affecting non-compliance among psychiatric patients in the Regional Institute of Medical Sciences, Imphal. *IOSR-PHR.* 2015;5(1):1-7.

ประสบการณ์ความร่วมมือในการรักษาด้วยยาของผู้ที่เป็นโรคจิตเภท: การทบทวนวรรณกรรมเชิงคุณภาพอย่างเป็นระบบ

นิศากร โพธิมาศ ภัทราภรณ์ พุ่งปันคำ* อิดารัตน์ คณึงเพียร Karin Hannes

บทคัดย่อ: โรคจิตเภทเป็นโรคทางจิตเรื้อรังที่ส่งผลกระทบต่อกระบวนการคิด การรับรู้ และพฤติกรรม ยาต้านอาการทางจิตจึงมีความสำคัญในการควบคุมอาการทางจิต ผู้ที่เป็นโรคจิตเภทที่ให้ความร่วมมือในการรักษาด้วยยาจะมีการกลับเป็นซ้ำของอาการทางจิตน้อยกว่าผู้ที่ไม่ให้ความร่วมมือในการรักษาด้วยยา วัตถุประสงค์ของการทบทวนวรรณกรรมอย่างเป็นระบบในครั้งนี้ เพื่อสังเคราะห์ประสบการณ์ของความร่วมมือในการรักษาด้วยยาของผู้ที่เป็นโรคจิตเภท งานวิจัยที่ตีพิมพ์เป็นภาษาอังกฤษตั้งแต่ ปี พ.ศ. 2542-2562 จะได้รับการสืบค้น (ตั้งแต่ มกราคม 2542-ธันวาคม 2562), ในฐานข้อมูลต่างๆ ได้แก่ CINAHL, PubMed, Science Direct, Scopus, PsycINFO, ProQuest Dissertation and Theses, และคลังข้อมูลงานวิจัยไทย งานวิจัยจำนวน 12 เรื่องผ่านเกณฑ์การคัดเลือกเพื่อการทบทวน

องค์ประกอบที่สำคัญที่ส่งผลต่อความร่วมมือในการรักษาด้วยยาของผู้ที่เป็นโรคจิตเภททั้งทางด้านบวกและด้านลบ ได้แก่ การกีดกันแบบประนีประนอม ความไว้วางใจและการสนับสนุนทางสังคม ทักษะการตัดสินใจและการรับรู้โรคและการรักษา ความเข้าใจถึงประโยชน์และผลกระทบทางลบของยา และข้อจำกัดทางการเงิน ดังนั้นผู้วิจัยเสนอแนะแนวทางความร่วมมือในการรักษาด้วยยา โดยมาจากการเข้ามามีส่วนร่วมระหว่างครอบครัวและผู้ให้บริการด้านสุขภาพ เพื่อปรับการรับประทานยาของผู้ที่เป็นโรคจิตเภทแบบค่อยเป็นค่อยไป และช่วยผู้ป่วยให้สามารถจัดการกับผลข้างเคียงของยาที่ได้รับประทานได้ สมาชิกในครอบครัวและผู้ให้บริการด้านสุขภาพควรคำนึงถึงตัวผู้ป่วยเกี่ยวกับความต้องการมีชีวิตที่ปกติ และชีวิตที่เป็นไปได้ในอนาคต โดยคำนึงถึงเรื่องการถูกตีตราจากสังคม และอุปสรรคทางการเงินร่วมด้วย

Pacific Rim Int J Nurs Res 2021; 25(2) 229-241

คำสำคัญ: ยาต้านอาการทางจิต การทบทวนวรรณกรรม ความร่วมมือในการรักษาด้วยยา การสังเคราะห์ห่อหุ้ม ประสิทธิภาพของผู้ป่วย วิจัยเชิงคุณภาพ โรคจิตเภท

นิศากร โพธิมาศ อาจารย์ คณะพยาบาลศาสตร์ มหาวิทยาลัยนครสวรรค์

E-mail: nisakonp@nu.ac.th

ติดต่อที่: ภัทราภรณ์ พุ่งปันคำ* รองศาสตราจารย์ ศูนย์ความรู้เชิงประจักษ์ในการดูแลสุขภาพแห่งประเทศไทย คณะพยาบาลศาสตร์ มหาวิทยาลัยเชียงใหม่ E-mail: patraporn.t@cmu.ac.th

อิดารัตน์ คณึงเพียร อาจารย์ วิทยาลัยพยาบาลบรมราชชนนีสุนทร

E-mail: neng_thidarat@hotmail.com

Karin Hannes รองศาสตราจารย์ นักวิจัยด้านระเบียบวิธีวิจัยและนวัตกรรมทางสังคมศาสตร์ มหาวิทยาลัยคาทอลิก เลอเฟิน ประเทศเบลเยียม

E-mail: Karin.hannes@kuleuven.be