Response to issues concerning the article “Treatment compliance and noncompliance in psychoses”

Sir,

We thank the authors immensely for their interest shown in our article “Treatment compliance and non-compliance in psychoses”[1] and more so for their incisive evaluation. We prefer to respond to all issues raised in the letters to the editor.[2-4]

We are aware of the concept of adherence and have alluded to it in the introduction. Although the word noncompliance denotes the conformity of patient behavior to treatment recommendations, it does not degrade noncompliant patients as uncooperative and untrustworthy. It is true that in the article persistence with medication use was considered central for compliance/adherence with treatment. The first component of adherence, namely, initiation of first dose of medication was not focused as the cases had already approached for treatment and were in treatment for sometime. Compliance is akin to the second component of adherence-implementation of treatment regimen. The third component, discontinuation can denote noncompliance. Hence, in clinical practice adherence and compliance are used interchangeably though academic scrutiny may not agree with it. It reminds the adage “call the rose by any name it smells the same” but it is true roses themselves vary in their fragrances.

Focus of the present study was to simultaneously study reasons for compliance and/or noncompliance so that a comprehensive list of factors could be arrived at.

We have brought out the point that relapse of a symptom as a factor for compliance. It is interesting to note that “consequences” of noncompliance (not noncompliance per se) as a factor for compliance and “consequences” of compliance (not compliance per se) as a factor for compliance. This was one of the advantages of this study which focused on compliance and noncompliance simultaneously.

Although outpatient records are not considered accurate for research purposes, in the present study, the dependent variable compliance/noncompliance could be detected easily based on the visit to treatment center. However, after case selection, each patient was assessed individually using structured questionnaires to elicit influence of independent variables on the dependent variable. Patients with improper, inaccessible, and incomplete records were excluded from the study.

We agree that use of validated scales for obtaining data would have increased the strength of the study. This point has been reflected in the article. However, the present study has helped to prepare a comprehensive list of factors influencing compliance and noncompliance and categorize them into various domains which has not been done in earlier studies.

The study did not use diagnostic criteria for selection of sample. Cases having psychotic features were selected and then those patients who qualified for the study were assigned diagnoses based on ICD 10. The aim of the study was not to know which disorders had more compliance or noncompliance. Psychosis was selected because psychopathologically this condition interferes with ordinary demands of life, and such patients invariably seek intervention at least during the active phase of illness and are usually advised long-term treatment.

We, therefore, agree to the letter and reiterate that the present study helped to arrive at a comprehensive list of factors influencing compliance and noncompliance which was not available in earlier studies.
We do realize that identifying psychosis in a defined area of community, then advising treatment for them, to follow them up at their place of stay, to study adherence through tablet counts and confirmation through electronic devices, monitoring serum drug levels and using validated instruments for noncompliance or validate the proposed instrument would have added to the strength of the study. In future, e-pharmacy and e-follow-up may change the dynamics of compliance. Currently, we have used clinic-based population but care was taken to define compliance based on operational definition as per the literature and select the cases which fulfilled the inclusion criteria.

At the most, points of deficiencies in the study are limitations of the study which have been acknowledged by us in the article and does not warrant rejection of the findings lock stock and barrel. We do realize compliance is a complex and dynamic issue. We have tried to chisel pebbles out of a complex rock of compliance.

The strength of the study lies in (1) a fairly large sample, (2) sample which is drawn from different treatment settings, (3) construction of a scale of factors of compliance and noncompliance based on literature and provisions for an open ended question to allow for extra questions, (4) classifying factors according to domains, and (5) extraction of factors from both compliant group and noncompliant group simultaneously.

Some important findings not reported in earlier studies are: comorbidity of physical illness being a factor in treatment compliance of psychiatric patients, importance of treatment by proxy, role of remission of symptom contributing to compliance and noncompliance needing proper psych education, domain differences in groups of compliance and noncompliance, and suggestions to psychiatrists about some measures to improve compliance based on the study findings.

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Conflicts of interest
There are no conflicts of interest.

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