Recovery in Schizophrenia: Perspectives from Psychiatrists in the Philippines

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ABSTRACT

Background: A reliable and socially validated definition of recovery in schizophrenia is essential to decrease stigma associated with the illness. This study aimed to define recovery in schizophrenia in the Philippine context, determine its specific elements, and describe methods of assessment in clinical practice.

Methods*:* We invited a group of purposively selected Filipino psychiatrists to participate in six simultaneous roundtable discussions to gather their opinions and perspectives on recovery in schizophrenia. Transcripts of the discussions were then subjected to framework analysis.

Results and Conclusion: Most Filipino psychiatrists were of the considered opinion that recovery in schizophrenia is possible, and their vision of a recovered patient resembles a combination of psychological and medical models. The mini-FROGS tool was deemed generally applicable in the Philippine setting except for *self-esteem and sense of independence* primarily because it is difficult to evaluate. The SWN was received with mixed reactions among the psychiatrists. Spirituality as an element of recovery and the family-oriented culture of the Filipinos were emphasized as important considerations in assessing patients. Other suggestions were given to tailor-fit these tools to the Philippine context.

Keywords: schizophrenia; mental health recovery; mini-FROGS; Subjective Well-being Under Neuroleptics (SWN); Philippines

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INTRODUCTION

The Diagnostic and Statistical Manual of Mental Disorders Third Edition defined remission in schizophrenia as "free of all signs of the illness (whether or not on medication)".[1] Full remission or recovery, described as a complete return to premorbid functioning of patients, was considered possible but it was rare that the concept was met with rampant skepticism among clinicians.[1] Some of them even questioned the original diagnosis when such event was said to be occurring.[1] In the Fifth Edition of DSM, recovery in schizophrenia was given a more hopeful tone, with few reported cases to have recovered completely.[2] In the past, Emil Kraepelin described schizophrenia as the kiss of death.[3] More recently, patients and doctors have developed a more positive perspective on the course of schizophrenia to counter the stigma related with the illness.[3]

In a study by Andresen et al, four models of recovery were presented.[4] The medical model views recovery as "a return to a former state of health", and thus involves the symptoms, hospitalization, medication, and assessments of the functioning of the patients.[4] The rehabilitative model regards patients with schizophrenia as continuously disabled but are able to return to a semblance of their previous life through therapy.[4] The empowerment model sees mental illness as having no biological foundation and merely as "a sign of severe emotional distress in the face of overwhelming stressors."[4] Hence, medication is not necessary for recovery so long as patient remains optimistic.[4] Lastly, the psychological model focuses on the "establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination."[4] This model identified four components: hope, self-identity, meaning in life, and responsibility.[4]

Given these different perspectives, Liberman and Kopelowicz called for a more inclusive and consensually validated definition because it was said that using reproducible and reliable terms on recovery decreases the stigma associated with the illness.[5] This definition should also be parallel with the normative behaviour of the community wherein it is to be applied.[5] Only then will this be socially valid.[5] Moreover, tools for diagnosis such as the Functional Remission of General Schizophrenia (FROGS) scale[6], the mini-FROGS scale[7], and the Subjective Well-Being Under Neuroleptics short form (SWN)[8] were developed by Western countries. Hence, these may not be socially valid in the Philippines.

This paper, then, aims to define recovery in schizophrenia in the Philippine context, to determine its specific elements, and to describe the methods of assessment in local clinical practice.

METHODS

To address the objectives, six simultaneous roundtable discussions participated in by a group of purposively selected Filipino psychiatrists were held on 28-29 April 2018 in Makati City. Participants were identified by a core group of practicing psychiatrists based on a) years of practice and b) venue of practice (i.e., public or private) to ensure diversity in perspectives on recovery in schizophrenia.

The core group, who also acted as facilitators, prepared a set of questions for discussion to address the forum objectives.

Table 1. Discussion guide questions

Objectives	Guide Questions
Define recovery in schizophrenia in the Philippine context	1. Do you believe that a patient with schizophrenia can recover?
	2. What is your vision of a patient with schizophrenia who has recovered?
Determine the specific elements of recovery	3. What are your thoughts about the applicability of the four items in the Mini-FROGS in the Philippine setting?
	4. Are there other elements that you look for that indicate recovery in your patient?
Describe method of assessment of recovery in local clinical practice	5. How do you determine your patient's level of functionality in each of the four items of the Mini-ROGS? a. Travel and communication b. Management of illness and treatment c. Self-esteem and sense of independence d. Respect for biological rhythms
	6. Would you be willing to use the SWN for your patients? Why or why not?
	7. How do you assess your patient's well-being?
	8. How do you assess recovery in your practice?

Proceedings of the discussions were audio-recorded for processing and analysis. Assigned facilitators and documentors also concurrently took notes of salient points of the discussion. At the end of the session, the facilitator, with support from the documentor, provided a recapitulation of major discussion points for validation by the participants. Discrepancies, errors, or refinements pointed out by participants were corrected on-site.

Documentors (CHT, JCM, DNO, MLR, ATS, CJT) prepared a transcription of audio-recordings and field notes from their respective groups. These were then validated by senior members of the team (CTA, MPS, CVB, MED, MAG, MSH, BSP, ELT).

Data derived from transcripts of discussions, together with field notes, were subjected to framework analysis where responses were coded to the discussion questions and objectives. This was done at two levels: first, by individual groups (coding performed by CHT, JCM, DNO, MLR, ATS, CJT, and validated by CTA and MPS), followed by analysis in the aggregate (coding performed by CHT and validated by CTA and MPS).

All small group discussion attendees provided prior consent for participation, and documentation of their responses.

This project was funded by Johnson & Johnson (Philippines), Inc. The funder did not have any direct role in the analysis and interpretation of data derived from the small group discussions.

Results

Profile of participants

A total of 47 Filipino psychiatrists participated in the round table discussions, with around seven to 10 participants in each small group. Among them, 23 came from the public sector, 19 from the private sector, and five from both.

Figure 1. Clinical experience of the participants

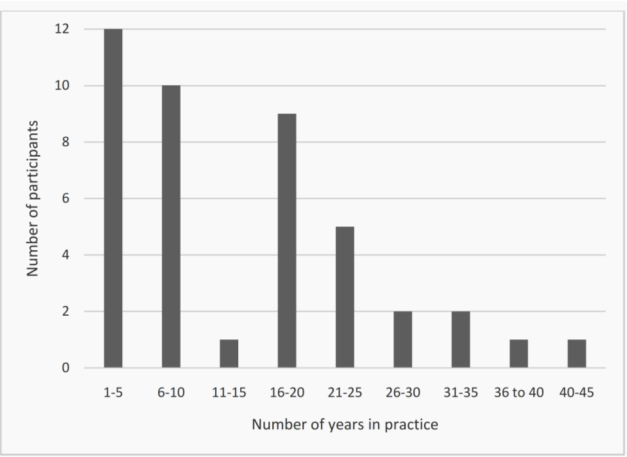

Figure 1 shows the frequency of participants in terms of their number of years in practice. Their clinical experience ranged from one year up to 42 years, with a mean of 14 years and mode of two and 20 years (n = four). Four participants did not give information on this.

Recovery in schizophrenia in the Philippines

Five of the six groups expressed their belief that recovery from schizophrenia is possible. In these groups, recovery was most often perceived as a combination of the elements of the medical and psychological models of recovery. Hence, the recovered patient was envisioned as follows:

- has symptoms at a minimum and under control (compliance to medication)
- has an understanding and insight of his/her illness
- can take responsibility for his/her illness with minimal assistance from others
- has returned to his/her normal level of functioning
- is productive and responsible enough to be reintegrated into the society
- can make decisions of his/her own and see self-actualization as the final goal

Simply put, a recovered patient can be described as "somebody like us" (Private, 42 years in practice). A private sector doctor in practice for 18 years believed that patients experiencing delusions can still be considered recovered as long as they do not act on them (i.e. he/she recognizes what is real

and what is not). Even patients who are not well-groomed can be considered recovered if they can redeem their reputation by explaining their unkempt appearance (Public, 27 years in practice).

Moreover, insight and acceptance were said to be insufficient in themselves to pronounce recovery because these only capture the patient's adaption to the illness. Adaptation to the environment should also be considered by measuring the everyday functionality (Private, eight years in practice). Another notable statement by a private sector doctor practicing for 35 years pointed out the importance of spirituality in recovery. He claimed that pastors and priests play a significant role to achieve this.

The importance of giving hope for recovery to patients and their families through psychoeducation was also emphasized. One doctor said that: "There is a need for doctors to level up their programs for the patients. Although they do believe that recovery is possible, it is not a common practice in the Philippines to target recovery for patients because most of them only settle on reducing the symptoms." (Private, 42 years in practice)

The only group which answered "No" defined full recovery as being free from any medications. Furthermore, a private sector doctor in practice for 14 years asserted that biopsychosocial recovery is possible but biological recovery is not. Given the genetic basis of the disease, she said that patients with schizophrenia will have the disease for a lifetime, in contrast with infectious diseases where elimination of the etiologic agent may be achieved.

There was also one doctor who "...believes that recovery is possible, but it cannot be helped to cast doubts on the diagnosis whenever a patient is said to be recovering." (Public, four years in practice)

Elements of recovery in schizophrenia

Two groups considered the Mini-FROGS[7] as generally applicable in the Philippines. The other three groups considered it applicable except for the third item (i.e. self-esteem and sense of independence) while the last group regarded it as overall inappropriate in the local setting.

Travel and communication. Besides being basic necessities of a person, these are considered good indicators of recovery from schizophrenia. Not only are they needed for consultation, but they are also important in evaluating the productivity and social life of the patient. However, it was suggested that travel and communication be separated because they are assessed differently. For travel, the distance, mode of transportation, purpose, and ease of navigation should be specified.

Management of illness and treatment. This will account for whether the patient has already gained insight on the illness through psychoeducation, and whether he/she is aware of warning signs of relapse. Compliance to medication is also affected by the financial capability of the patient, thus it was advised that this be asked in connection with the other.

Self-esteem and sense of independence. This item met mixed reaction among the participants. Self-esteem was said to be important because social stigma remains rampant in the country. However, it is a broad and a culturally dependent concept that makes it difficult to evaluate. The Philippines as an archipelago complicates it further because each region has a different view on how it is defined (Private, 10 years in practice).

Related to self-esteem is the ability to handle criticism. The participants thought that expecting this from patients may be too much because even normal people have difficulty doing it. Another issue raised was the inappropriateness of this question in the Philippines because families are usually the source of criticism for patients here. Since the tool is to be answered by relatives, there can be bias in the assessment (Public, four years in practice).

On the other hand, sense of independence may be influenced by the close family ties promoted by the Filipino culture. This criterion was made for a more individualist country rather than a collectivist country such as the Philippines, where family plays a big role in the patient's independence. For instance, patients at age 21 are not really expected to live by themselves already (Public, 20 years in practice). In some cases, the families themselves set restrictions on the functionality of the patients. The clinicians should first clarify whether the family permits the

patient to do activities of daily living before assessing them (Public, four years in practice & Private, six years in practice).

A clear local definition of self-esteem and sense of independence needs to be established first. It was also suggested that the former be replaced by adaptation to stress and the latter by initiative.

Respect for biological rhythms. This refers to the routine and structure of the patient. It was considered as one of the best indicators of recovery since it is related to functionality. To make it more thorough, it was proposed that exercise frequency, substance abuse, health choices and nutrition, and meal schedules be included in the criteria for this item.

Aside from these, the following elements were also identified as indicators for recovery:

- Spirituality
- Self-care and grooming
- Empathy (especially towards fellow patients)
- Anger management and impulse control
- Social network (long-term relationships)
- Sense of belongingness and integration to society
- Happiness and satisfaction of the patient and his/her family
- Initiative, motivation, and hope
- Adaptation to stress and environment
- School, work, and other psychosocial activities
- Judgment and decision-making skills

Assessment of recovery in local clinical practice

To assess recovery from schizophrenia, the patient is compared to the doctor's vision of a recovered patient. This is done by evaluating the specific elements of recovery identified earlier. Improvement of the patient can also be checked by asking the patient to rate how he/she feels during the first and the last day of consultation, and then comparing the answers.

Doctors assess the functionality of patients in the four items of the Mini-FROGS by employing the following methods.

Travel and communication. Functionality in travel is usually defined as the ability to go from one place to another. This is assessed by:

- How the patient went to the clinic
- Ability to travel alone without any difficulties
- Ability to travel with other people without causing them any burden
- Ability to follow simple rules while travelling
- Complexity of the transportation mode used
- How he/she responds to hypothetical situations given by the doctor (e.g. going to an unfamiliar place, getting lost)

One group had a different perspective on the functionality of travel. They said that it is not about checking whether patients can get from one place to another but about their thought process and decision-making. Basically, it is concerned about the complexity of travelling itself and how patients troubleshoot when necessary.

Functionality in communication is assessed by:

- Quantity and quality of conversation with the doctor (i.e. how the patient talks and how much information is shared)
- Ability to get the message across in any form of communication
- Ability to use different modes of communication (personal, text messaging, social media, etc.)
- How the patient feels when interacting with other people (Is he/she afraid to talk with them? Can he/she build new relationships?)
- How he/she responds to hypothetical situations (e.g. replying to overwhelming messages in social media)

Management of illness and treatment. The ability of the patient to manage the illness and treatment is assessed by:

- Attitude towards the illness (taking responsibility and initiative for his/her actions)
- Level of compliance to medications
- Level of knowledge and insight of the illness (recognizing signs of relapse)
- Level of openness to the doctor regarding symptoms
- Level of knowledge on his/her rights as a patient with schizophrenia and how he/she exercises them
- Health choices of the patient
- Patient's foresight/prediction of relapse and his/her response to this
- Proactive approach in the management of the illness (learning about it on his/her own, interest)

One of the important points on treatment was given by a public sector doctor practicing for more than 20 years. He said that compliance to medication does not necessarily mean the patient has already accepted the illness, and that sometimes, this is only done to relieve symptoms.

Meanwhile, to prove the possibility of gaining interest on one's illness, one doctor said that there are patients who become members of support groups for schizophrenia (Private, 18 years in practice).

Self-esteem and sense of independence. Many participants disagreed with the use of this item in the Philippine setting. Self-esteem and sense of independence are difficult to score, but they may be assessed relatively by:

- Patient's reaction to criticisms and stigma
- Level of self-sufficiency and financial independence
- Level of self-knowledge on his/her strengths and weaknesses
- Willingness to do things and make decisions on his/her own
- Interest [in the illness] is possible for high functioning patients, some of them are even members of support groups. (Private, 18 years in practice)

Respect for biological rhythms. This is assessed by:

- Patient's self-care and physical fitness (exercising)
- Patient's basic biological functionality (eating, sleeping, taking a bath)
- Ability to follow a schedule of activities
- Ability to follow or be incorporated in the "family routine" which is very applicable in the Philippines

Some patients prefer not to exercise, so for a public sector doctor in practice for 22 years, this is just a plus point but not a crucial factor to consider. On the other hand, the age and work of the patients should be regarded according to a public sector doctor with one year of experience. This is to account for normal variations in biological rhythms. For example, young patients tend to sleep later than the older ones. In terms of work, there are patients with night shift jobs.

Another tool that can be used to assess recovery of patients is the SWN[8]. Three groups expressed their willingness to use this for the following reasons:

1. It gives specific objectives during patient assessment.
2. It can be answered by patients while waiting for their consultation.
3. It can be used to assess the patient's progress.
4. It can serve as an avenue for further discussion, especially for patients who find it difficult to open up.

Meanwhile, the other three groups showed hesitation in using it because:

1. It is too Westernized.
2. Some of the items are abstract.
3. The measurement scale is quite difficult to operationalize.

The following suggestions on how to improve and tailor-fit it to the Philippine setting were given:

- Translate it to the native language of the patient
- Make it in question form
- Shorten the measurement scale into 3-4 points or simply "Yes" or "No"
- Group the items into physical, social, and cognitive
- Add more hypothetical family situations to make it sound more local (Public, 4 years in practice). Instead of saying "My body is a burden to me", rephrase it into "Am I a burden to my family?" (Public, 27 years in practice)
- Develop an SWN app that patients can answer using their devices (Private, 18 years in practice)

During consultations, the patient's well-being is not usually given much attention throughout the assessment. A private doctor practicing for 38 years called for her colleagues to rethink whether they truly consider in the assessment of the illness how patients really feel. Doctors tend to assess using their own sense of recovery, sometimes disregarding the actual well-being of the patients.

When they do assess patient's well-being, the following are done:

- Observing the physical appearance and grooming of the patient and his/her relatives
- Observing the verbal and non-verbal cues of the patient
- Asking the patient how he/she is or how his/her sleep was, and contextualizing his/her answer of "I'm okay" or "I'm good"
- Asking what he/she feels about himself/herself, mood, and relationships with others
- Asking whether he/she is happy or satisfied with his/her life

The ABC method (A for appearance, B for behavior, and C for communication) can be used first before proceeding to the symptomatic questions (Public, 28 years in practice).

DISCUSSION

The perspective of most psychiatrists in the Philippines that recovery in schizophrenia is possible is consistent with the recent trend of a more positive approach in the treatment of the illness. Leucht mentioned that despite recovery rates being low for patients with schizophrenia, it is still achievable through the support and hope given by clinicians.[9] In a study in Malaysia by Dahlan et al, it was found that good social support was the strongest factor to affect functional remission.[10] This, too, was emphasized during the discussion conducted for this paper. Through psychoeducation, clinicians can help patients not only to gain insight of the illness but to accept and own it as well. Acceptance will lead the patients towards recovery.

According to the findings of Andresen et al, the psychological model corresponds to most of the beliefs of consumers.[4] They enumerated five phases of psychological recovery: moratorium, awareness, preparation, rebuilding, and growth.[4] These phases involve learning about the illness, relationships with peers, taking responsibility for actions, and working towards personal goals.[4] In the growth phase, the patient can still show symptoms of the illness, but he/she knows how to manage them.[4] Meanwhile, the medical model takes into consideration the level of functionality of the patients.[4] Together, these two models resemble the vision of a recovered patient of the Filipino psychiatrists.

Recovery has also been described in relation with management of the illness. Compliance to medication was regarded as a basic indication of recovery because it helps the patients maintain their symptoms at a minimum. The role of medication was demonstrated in a study by Williams et al wherein patients got improved scores in both the patient- and

provider-rated surveys after receiving paliperidone palmitate (PP).[11] Anderson et al also found that patients treated with injectable paliperidone palmitate had improved adherence and were 2.5 times more likely to achieve remission than those under oral atypical antipsychotic therapy.[12]

Two of the most important findings of this study are the emphasis on spirituality as an element of recovery and the family-oriented culture of the Filipinos in connection with the sense of independence. Participating psychiatrists repeatedly suggested that these should be considered in assessing recovery of Filipino patients. Moreover, these two aspects are not commonly seen in any literature involving recovery in schizophrenia. Hence, this strengthens the need to localize the definition of recovery.

Time has also been noted an essential component of recovery. For Liberman et al and Whitehorn et al, good performance in terms of psychopathology and psychosocial functioning should be sustained for two years to regard a patient as recovered, while Torgalsboen et al set it to five years.[5] However, this has not been touched upon in this paper because the focus of the discussions was to establish a definition of recovery to be adopted in clinical practice where the goal is to maintain the patients in the state of recovery for as long as possible. For the sake of a clear-cut definition, further studies can be done to establish this.

This project utilized facilitated roundtable discussions to pool the opinions of psychiatrists in the Philippines. This method gave all participants an equal chance to voice out their stand about the topic in an unrestrictive manner while also having a structured flow of conversation. It also allowed them to highlight the key points of the discussion, to debate on particular ideas, and to resolve these conflicts right away. However, one of the disadvantages of using this method is the presence of a dominant personality in a group that can affect the judgment of the other participants and sway them to agree to his/her views. The discussion is also influenced by the seating arrangement of the participants. The first one to talk may convince the next ones to take a similar stand. Lastly, limited time given to answer all the questions could have prevented the group to exhaust all their ideas on the topic. These limitations, however, were managed through skilled facilitation of the discussion.

One of the strengths of this project lay on the equal representation of both the public and private sectors, and the wide range of clinical experience of the participants. Hence, it can be said that this pioneer undertaking on recovery in schizophrenia in the Philippines was able to provide a general overview of how clinicians in the country perceive recovery of patients from the illness. It also opens further discussion on the topic to address other issues raised during the forum. For instance, broad ways to assess patients using the mini-FROGS and SWN were given by the participants. Another discussion can be done to develop a standard way of assessing patients using these tools.

Declaration of Interest

This project was funded by Johnson & Johnson (Philippines), Inc. The findings presented in this study do not necessarily correspond to the opinions of the funder.

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