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ACTING FOR RELIEF: COPING WITH SCHIZOPHRENIA AND NUISANCES CAUSED BY DRUG TREATMENT[1]

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ABSTRACT
In assessing patients, the discomfort caused by the drug treatment of schizophrenia can be as intense as the symptoms of the disorder. This study aimed to identify how patients cope the nuisances caused by schizophrenia and drug treatment. The qualitative approach, the Grounded Theory method, and the Symbolic Interactionism perspectives were used. 36 people with schizophrenia in community treatment and 36 family members participated of the study. Taped interview and observation were used for data collection. The collected data were transcribed and later analyzed in three phases: open, axial and selective coding. It was observed that the person with schizophrenia has a constant desire to get relief for the suffering experienced. The patient complies with treatment to alleviate symptoms of schizophrenia, or prioritize the relief of discomfort due to pharmacotherapy, which can expose him/her to the risk of worsening the disorder. In association with adherence or non-adherence, the individual can implement other strategies, such as searching for non-pharmacological treatment, spirituality and consumption or interruption of psychoactive substances. Understanding these coping strategies used by the patient is essential to subsidize the care provided to this clientele.

Keywords: Schizophrenia. Psychiatric Nursing. Medication Adherence. Treatment Refusal.

INTRODUCTION

Schizophrenia is a chronic, potentially disabling condition that has a great impact on the sufferer, the family, and society. In addition to the subjective experience of psychotic symptoms, the disorder affects the quality of life of the individual and is associated with significant functional impairment[1]. The treatment of schizophrenia is composed of pharmacological therapy, psychotherapy and sociotherapy. With the Psychiatric Reform movement, the treatment occurs predominantly within the community[2] and, in this context, a major challenge is the adherence of the patient to the pharmacological therapy[3]. The pharmacological treatment is critical for the control of the schizophrenia, however, from the evaluation of the patients, the impairments caused by the pharmacological treatment can be as severe as the symptoms of the disorder[4]. The discomfort caused by the pharmacotherapy is not limited to the side effects, although such effects stand out among the leading causes of non-adherence to treatment[3,5] and are experienced by most patients at some time during treatment.

Antipsychotic drugs are the medications of first choice for the treatment of schizophrenia. The side effects of these medications may vary according to the antipsychotic drug, and there are significant differences in the manifestation of adverse effects among individuals. Regarding the side effects that may occur with the use of antipsychotic drugs, extrapyramidal effects, agranulocytosis, weight gain, metabolic alterations (dyslipidemia and insulin resistance)[6], sedation, fatigue, orthostatic hypotension, dry mouth, hypersalivation, nausea and vomiting, reduced seizure threshold, reduced libido, impotence, amenorrhoea and gynecomastia are prominent.

The lack of adherence to pharmacological treatment may cause exacerbation of the symptoms, poorer prognosis, readmissions and high costs. Furthermore, when not recognized by healthcare professionals, non-adherence to the

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medication may predispose unnecessary adjustments in the treatment, such as including additional drugs, an increase in the dosage or even the substitution of the antipsychotic drug[3]. Unnecessary adjustments justified by the ineffectiveness of medications that, in reality, were not used properly can compromise patient safety regarding the pharmacological treatment.

Nursing interventions should involve the resources and strategies adopted by the individuals in coping with the challenges imposed by chronic conditions such as schizophrenia, especially with regard to treatment adherence[7]. Working towards patient safety and effectiveness of drug treatment entails recognizing the behavioral repertoire of the patient in coping with the limitations caused by schizophrenia and the difficulties related to the medication adherence[8]. During the implementation of the interventions, nurses should reinforce the healthy behavior of the patient seeking adaptive coping strategies. They should therefore include the monitoring of the patient regarding the pharmacological treatment and the promotion of adherence to the medication. For the development of these actions, the nurse needs to comprehend the perspective of the patients regarding the schizophrenia and the treatment, as well as their needs, goals, conflicts, resources and coping mechanisms.

This study aimed to comprehend how patients with schizophrenia cope with the discomfort caused by the disorder and by the pharmacological treatment, from the perspective of the patients and their family members.

METHODOLOGY

This is a qualitative study using the Grounded Theory (GT) as the methodological framework for indicating procedures that allow a consistent theoretical explanation of the phenomenon studied[9]. Symbolic Interactionism was adopted as the theoretical framework. According to this theoretical perspective, behavior is directed by the definitions that the individual makes of the reality in the present. Such definitions are derived from social interactions, where active individuals influence each other[10].

The study was developed with users of three community mental health services, pertaining to the public health system and located in the State of São Paulo, Brazil. From July 2008 to October 2010, the collection and analysis of data were carried out simultaneously, as recommended by GT. Recorded open interviews and observation were the main strategies for obtaining the data. The interviews with the patients were initiated using the following guiding questions: “In your daily life, do you face any difficulty related to schizophrenia?” and “Do you face any difficulties related to the pharmacological treatment of the schizophrenia?” For the family members, the guiding questions were: “Do you believe that your family member faces any difficulty related to schizophrenia?” and “Do you believe that your family member faces any difficulties related to the pharmacological treatment of the schizophrenia?” The guiding questions only directed the point of the study to be explored. New questions were then added in order to clarify and substantiate the experience.

A total of 36 patients and 36 family members were selected to participate in the study, using a theoretical sampling process, as recommended by GT. The criteria for the inclusion of patients in the study were: to have a medical diagnosis of schizophrenia, to be using psychotropic medication(s), and to be able to express themselves verbally. The criteria for inclusion of the family members in the study were: to be mentioned by a study participant with schizophrenia as the family member most involved in their treatment, and to be able to express themselves verbally. The inclusion of the family members in this study is justified due to their potential to contribute to the comprehension of the phenomenon investigated, considering that they play an important role in the patient care and exert a significant influence on the behavior related to coping with the disorder and treatment[11].

The data collection was performed after approval by the Research Ethics Committee (HCRP Process No. 10183/2007), all study participants signed the Terms of Free Prior Informed Consent, and the recommendations for the development of research with human subjects were followed. To preserve the anonymity of the study participants, the

respondents were identified throughout the study, with the letter "P" for the patients and "F" for the family members, plus a number that corresponds to the order in which the interviews were carried out.

The data analysis process occurred through open, axial and selective coding, as indicated by GT. In the open coding, the data were fragmented into units of meaning that were compared with each other for similarities and differences. Provisional categories and subcategories originated from this process. In the axial coding, the categories were interconnected, and each of the interpretations made were taken to the study field for their review or validation. The selective coding resulted in the construction of a theoretic model based on the data.

RESULTS AND DISCUSSION

The interpretation of the data of the present study was guided by the theoretical framework of symbolic interactionism, therefore, it was assumed that the experience of the disorder and the pharmacological treatment involves individuals in symbolic interaction. In their interactions, people with schizophrenia assign meaning to the experience of having the disorder and following the pharmacological therapy. All the elements that interfere in coping with schizophrenia and the discomfort related to the pharmacotherapy are defined and redefined in a dynamic and interactive process. The definitions that the patient makes in each situation determine the decision making in relation to the coping strategies adopted.

The person with schizophrenia suffers from the symptoms of the disorder and seeks alternatives for coping with this suffering. Among the resources identified for alleviating the suffering caused by schizophrenia, the interviewees highlighted the pharmacological treatment. Pharmacological treatment symbolizes a promise of relief from the symptoms of the disorder, however, is not without damage. Such damage is not limited to the side effects that can occasionally be present. The psychotropic drug is associated, as a symbol, to the presence of a disorder. In this way, the act of continuously ingesting the medication makes the individual feel compelled to reaffirm and to acknowledge the schizophrenia. Therefore, due to being strongly linked, the medication can be as undesirable as the schizophrenia. The medication may, in addition, be the target of fears and concerns for the patients and family members.

> You say you take a medicine for the psychiatric emotional system, there are people who get scared: "he's crazy". (P2)

> The medication, it means the disease, right? It proves that you have the disease. (P5)

> I am afraid of the medicine because I don't know the effect, or what it is for, I take it without knowing what is being treated. (P14)

Thus, motivated by the desire to reduce both the suffering caused by the disorder as well as the discomfort resulting from the pharmacotherapy, the person with schizophrenia acts in different directions, however, with a constant goal: to obtain relief.

Adhering to the pharmacotherapy to alleviate the suffering caused by the schizophrenia

The people with schizophrenia highlighted the drug as an adequate resource to obtain relief from the symptoms caused by disorder. Therefore, adherence to drug therapy is a form of coping to minimize the suffering, the limitations and the distress caused by the symptoms of schizophrenia. The behavior of adherence occurs when patients prioritize obtaining relief from the symptoms of schizophrenia, even if they suffer with potential discomfort caused by the medication.

> To take the medication for a while, has a certain burden, right? It has its good effect, but it also has a heavy burden, right? It is the good side and the bad side. There is a cost for this benefit [...] but at the end of the process, what's left for me is gain. (P7)

Adherence to the medication may represent a normal and routine act, an obligation, a dependency, a sacrifice, or an opportunity to collaborate with the treatment itself.

> I regard it as normal. (P1)

> When we're all right, I say: now, I can help the doctor help me, so I take the medicine correctly. (P6)

> It's normal, I have to take it and I am taking it, it is normal for me. (P7)

> I never complained about the medication. I always accepted the medication. It may have made me feel bad, but I accepted it. I accepted it without complaint. (P33)

> I really depend on the medicine. (P10)

The meanings attributed to the medication and the motivation for adherence are changeable. Over time, the same patient can be certain, insecure, and inconsistent regarding the adherence, or can perceive him/herself without alternatives.

> He is taking it correctly, and he always comes to the consultations. But, in the beginning, it was a little difficult. (F9)

> At first I did not take it, then I saw that I was hurting myself, right? Now I don't stop anymore. (P35)

> Ah, as they are giving this injection, I can't be here just laying around. (P4)

> I'm going through this, I don't see a way out at all. Why not try? (P5)

This finding reveals the tenuous border between adherence and non-adherence to the pharmacological treatment. Therefore, it is important to continuously monitor the motivation and behavior related to the pharmacotherapy, even with patients who previously maintained an apparently unchanged pattern of behavior. Patients can adhere to treatment, for a varied time period, without being convinced of the need and usefulness of the antipsychotic drugs[5]. These situations can be occasional emergencies or long-lasting.

> Ah, I don't really agree. I told the doctor that I do not like to take medicine. (P8)

The concept of adherence may correspond to a diversity of meanings. It is desirable that adherence to treatment is comprehended as the result of a collaborative effort between the health professional, the patient[12] and the family members, which requires the active participation of those involved.

Seeking relief from the discomfort caused by the pharmacological therapy

There are times when a person with schizophrenia considers the sufferings and discomfort of the pharmacotherapy intense and difficult to bear. This evaluation leads the individual to seek relief from the discomfort caused by the drug, interrupting the treatment or implementing measures to minimize the side effects of the medication.

Non-adherence among people with schizophrenia is high, as approximately 50% of patients do not take the medication as prescribed[3,13]. The desire to interrupt the pharmacotherapy appears to intensify when patients experience side effects, believe that the medication is ineffective or unnecessary, and/or when they wish to see and test themselves without the medication.

> She says she doesn't need {the medication}, right? She thinks the medicine is not necessary, because it conceals the disease a lot, right? (F5)

> I'm not taking medicine. I took it, but it made me feel bad. (P25)

> I'm seeing that she stopped taking them all because it was making her feel very bad. Instead of improving it's getting worse. (F25)

> It happened at least twice, I stopped taking it, though it was wrong. But I have given myself the right, to feel how what I'm like without any medicine. (P10)

The worsening or improvement of the symptoms may also predispose the patient to not adhere to the prescribed drugs, as exemplified in the statements below.

> When we have those difficult problems and can not solve them, we have no strength to take medicine. (P6)

> The difficulty that exists is exactly to think that, when he's feeling well, he doesn't need the medicines. (F29)

> Several times, several times I stopped on my own. The "voices" told me to stop taking it, I stopped. (P35)

The behavior of non-adherence was linked to different needs and motivations and was expressed in different ways. Non-adherence to treatment for chronic morbidities is a complex problem. To try to understand it, it is necessary to consider the subjectivity, needs and difficulties of the patient, rather than the

precision with which he/she follows the recommendations of the healthcare team[12].

Different motivational or external factors are associated with non-adherence to treatment and deserve a detailed and individualized evaluation. Among these different factors, the side effects are prominent among the main reasons for the discontinuation of the pharmacological therapy[5].

> I took a bunch of Thorazine that gave me a racing heart at night, sometimes I took one less, broke them up, you know, changed the scheme. (P2)

Strategies to minimize side effects may come from the patient exclusively or they may be suggested by a third party and do not always imply the interruption of the treatment. Varied behaviors adopted in partnership with the healthcare team for the patient to maintain treatment, safely and without too much discomfort were cited in this study.

> He {the physician} said: "do not take and lie down". [...] I'm playing smart, I finish dinner and take it {medication}. Understand? I finish dinner and take it. (P2)

> He {the physician} cut down one medicine, because I was sleepy. (P13)

> Because of the Haldol, my body became twisted so I had to go there to CAPS and they gave me an injection of Biperiden to straighten the body. (P34)

> He took that medicine that's called Haldol and I began to realize that this medicine was making him lose control because he sometimes twisted his jaw and ground his teeth. Until one day the doctor decided to change the medicine. (F36)

The quality of the access to the healthcare services can mean that the attempt to mitigate the side effects occurs with or without the guidance and science of the team accompanying the patient.

> I took it one day and I felt bad. [...] Then I said, as I don't have a consultation soon, I'll have to give it up now. Later I'll talk to the doctor and I will have to explain it to him. I'm quitting because it's making me feel very bad. (P10)

The literature recommends that professionals advise the patients about the side effects, detect such effects early, evaluate the difficulties and intensity of the discomfort for each patient and, where possible, implement actions to minimize or eliminate the side effects[5,13]. In addition to the strategies directly related to adherence or abandonment of the treatment, the individual identifies other ways to seek relief from the discomfort caused by the disorder and its treatment, as the following category shows.

Identifying other forms of relief

The patients experience a conflict in that, to reduce the symptoms of the schizophrenia, they exposes themselves to the discomfort associated with the pharmacological treatment, and to reduce this discomfort, they run the risk of experiencing an exacerbation of the schizophrenia symptoms. Faced with this impasse, in combination with adherence or non-adherence to the medication, the patient may employ other adaptive or dysfunctional strategies to obtain relief from the suffering related to the schizophrenia symptoms and the side effects of the medication.

> If there was an alternative situation to the medicine, which avoided this {the symptoms}... And that did not bring so many adverse health effects, you know? (...) or I put up with it... or I run about looking for another way that can... you know, seeking an alternative to try, understand? (F7)

The coping strategies used by each patient need to be known by the healthcare professionals so that constructive behavior is reinforced and harmful ways of coping are addressed, discouraged or replaced. In the present study, some alternatives to obtain relief from the suffering caused by the schizophrenia were highlighted, in addition to the medication, as revealed in the subcategories below.

Non-pharmacological treatment and daily activities

One of the resources for coping with the suffering experienced by people with schizophrenia is the non-pharmacological treatment procedures.

> We have family group therapy at the hospital. It's great because you learn to deal with the situation, you see that it's not only you who has this problem. (F12)

> What helped me to be more uninhibited, to converse better, were the groups that I've done up

to now. If it were not for the groups I do not know if I would be here today! (P16)

I really like making carpets and then selling them. (P36)

However, the desire to participate in these therapeutic practices is often not realized due to lack of access to these forms of treatment in the public healthcare services.

What he {the patient} needs, he is not working his mind. Nowadays, this is my challenge. It's this I need to do with him. I think that it is this that everyone needs, understand? (F7)

What we have not yet found is an activity for her {the patient}. An activity so that she can spend time with other people. (F8)

The inclusion of non-pharmacological therapeutic practices in the psychiatric treatment has better results than pharmacological treatment alone, as this helps to reduce readmission rates and increases the adherence to the pharmacological treatment and the social functioning of the patients[14-15]. Therefore, it would be desirable to have greater access to non-pharmacological treatment practices in the public healthcare network. From the perspective of the patients and family members, daily activities can also be therapeutic, such as: household chores, work, study, leisure, sports, contact with animals, and interaction with other people.

I go out with the dog, I go to a little park I know to take a walk and clear my head, when I'm hearing a lot of voices, then I say "oh I'll go out with him a bit so I do not hear the voices so much". (...) At SESC I do swimming there. Sunbath a bit, swim a little, to clear the head, swimming is good. (P34)

Participation in these social activities should be encouraged, as psychosocial rehabilitation is favored by the use of the resources available in society. Many everyday activities can be therapeutic and have a common purpose of engaging with lifestyles considered normal. Furthermore, the act of attending public and impersonal places may be an attempt to get closer to other people, in a comfortable and non-threatening context, where the patient is in the company of others, without the demand for intimate social interaction[16].

Spirituality

Spirituality was identified as a way of seeking greater socialization, strength, relief and serenity to cope with the suffering.

I rely on the Catholic religion, to give me relief, to support me, understand? I rely on it. The prayers are very useful. We calm the spirit, I understand it like this, I interpret it like this. (P11)

There in the Church, there it's very nice [...] there was a lot of ladies, I think that he {the patient} was the only man there and they looked after him. (F24)

However, there were patients who presented more expressive symptoms, while trying to assimilate religious doctrines.

[...] there, he {the patient} starves himself because he says God tells him not to eat. Then he walks about naked, because God walked naked. (F33)

I know a gentleman called Henri Cristo [...] He appeared on the TV, saying he was the reincarnation of Jesus, right? And I bought his books and I was alienated, because I read those books. [...] I had problems with religion, becoming too fanatical. (P10)

Religion is often present among psychotic patients, as the content of hallucinations and delusions or as a coping strategy in situations of suffering[18].

From the comprehension of some patients and family members, there is a link between treatment and spirituality, so that healthcare professionals and medications can be conceived as divine instruments to help the people.

I believe that medicine was a science, it was a... the medicine was left on the Earth by God. So, it was to help us, right? And it is really helping me. (P6)

I went to church too, right? At the Universal Church, there they expel the demon, right? Ah! He {"a spirit"} never more appeared here. He's gone away. I started taking medicine, they gave me a cocktail of medicine in the hospital, I took the cocktail, the voice disappeared immediately, as if the power of God was in the medicine, you know. It seems that God put power in the medicine, understand, I stopped hearing the voice. (P34)

In the concept of other individuals, religion and psychiatric treatment do not have any relationship. In such cases, the cause attributed to the symptoms observed determined the

resolution being sought, i.e., if the individual considered that the symptoms were caused by the schizophrenia, the treatment was necessary, however, if the patient considers that the origin of the symptoms was spiritual, the treatment was evaluated as worthless.

> He {the patient} went with us to the church, but I think that religion does not have the power to heal. It's good, to get advice, to pray, but, it does not have the power to heal. (F34)

> Once he decided to go to the Universal Church, and there they said he did not have to take the medicine because Jesus healed [...] Then, it was a big confusion. He stopped {taking the medication} and became completely crazy. (F22)

Among the patients, there was mention of the belief in the possibility of a cure through faith. The miraculous cure represented the definitive relief from the suffering caused by the schizophrenia with the pharmacological treatment.

> The minister says that God heals, that God does this. (...) he thinks like this, that he will go once and everything will be resolved. That he no longer needs to take the medicine. (F3)

> Only when God sets me free, then I will say, I can stop. But at the moment, I can not stop, no. (P6)

The cure of schizophrenia through spirituality can be expected with certainty and immediacy, predisposing the patient to non-adherence, or conceived as a hypothetical event dependent on divine will.

The literature suggests that non-psychotic religious involvement, especially in group practices, can have a positive impact on the course of the schizophrenia by providing support and increasing social skills, constructive life goals, self-confidence and the sense of belonging. Thus, careful data collection is recommended to facilitate the distinction between psychotic religious experiences (indicating that the patient is symptomatic) and healthy religious involvement[17], as this information can be valuable in the planning and implementation of integral care for the individual.

Decisions about use of other psychoactive substances

Commonly, healthcare professionals recommend that people with schizophrenia refrain from using other psychoactive substances, but in everyday life, it is up to patients to decide on the consumption or interruption of such substances. Given the difficulties experienced in living with the disorder and treatment, some patients try to take refuge in the consumption of alcohol and other drugs. This use, besides compromising the pharmacological treatment, makes the person with schizophrenia experience harmful effects from these substances.

> Ah, my brother once said to me: "There is nothing wrong with you, stop this stuff, drink whiskey" [...] And I stopped the Haldol and started drinking alcohol. (P2)

> He gave me a lot of work, because he took drugs, then it was all together there, right? (F13)

> At six years of age, I drank a glass of whiskey and I already smoked. I mixed drink and medicine, it did not give the result that it had to give [...] I watch TV until the early hours of the morning. Then I light a cigarette in bed, and there is a hole this size. I burned the bed. (P29)

> The doctor himself, where he {the patient} did an x-ray, said he would have to stop smoking because he has severely damaged lungs. (F29)

Studies indicate a possible relationship between the abusive use of alcohol or other drugs and clinical morbidities[18], violent behavior, and a decreased likelihood of adherence to the antipsychotic medication[3]. There are individuals who go in the opposite direction, depriving themselves of psychoactive substances to prevent the damage that they cause and so that the pharmacotherapy will be successful.

> Oh, at first I felt bad, right? Like, I enjoyed drinking a beer and that [...] But I can't, right? It hinders the treatment. I stopped, right? Because I needed to stop completely. Today, I even think it's good, right? (P1)

> I go out to places and I cannot drink a glass of beer, nothing. I have to watch the others drinking, it makes me want to drink. (P3)

> I do not drink, I do not drink. I drank before starting the treatment and stopped. (P7)

The strategies used by the person with schizophrenia for coping with the suffering and discomfort caused by the disorder and treatment, are extremely varied. However, even considering different behaviors, the patients have the same goal: to obtain relief from the suffering and discomfort experienced. The comprehension of how the patients elect coping strategies is important for the planning of individual therapeutic projects.

FINAL CONSIDERATIONS

In a dynamic and interactive process, the person with schizophrenia continuously interprets the reality of living with the disorder and following the pharmacological treatment. By adhering to the treatment, the patient reduces the symptoms of the schizophrenia, but is troubled by the continued use of the medication and may experience its side effects. If the individual opts for non-adherence, he/she obtains relief from the discomfort caused by the medication, however, is exposed to the risk of the disorder worsening. The patient is in constant conflict and needs to choose which will be their priority: the reduction of the suffering caused by the schizophrenia or the minimization of the distress experienced with prolonged use of the medication.

Over time, the person with schizophrenia presents varied motivations and coping strategies to try to resolve this conflict. The individual adopts different lines of action, with adaptive or dysfunctional coping methods, however, retains the constant desire to obtain relief from the suffering they experience. The coping strategies employed by the person with schizophrenia need to be comprehended in an individual and deep way, since different motivational, interactional and situational elements impact on the decision of the individual. The comprehension of the coping strategies employed by the person with schizophrenia provides support for interventions, with the aim of expanding the behavioral repertoire of the individual, strengthening adaptive coping strategies, minimizing risks, and acting to reduce harmful behavior. Thus, the results of this study indicate important elements that should be considered in the planning of nursing care for the person with schizophrenia.

AGINDO EM BUSCA DE ALÍVIO: ENFRENTAMENTO DA ESQUIZOFRENIA E DOS INCÔMODOS OCASIONADOS PELO TRATAMENTO MEDICAMENTOSO

RESUMO

Na avaliação dos pacientes, os incômodos acarretados pelo tratamento medicamentoso da esquizofrenia podem ser tão intensos quanto os sintomas do transtorno. Este estudo objetivou compreender como pacientes com esquizofrenia enfrentam os incômodos ocasionados pelo transtorno e pelo tratamento medicamentoso. Pesquisa utilizou abordagem qualitativa, referencial metodológico da Teoria Fundamentada e pressupostos do Interacionismo Simbólico. Participaram do estudo 36 pessoas com esquizofrenia em tratamento comunitário e 36 familiares. Entrevista gravada e observação foram empregadas na coleta dos dados. Os dados coletados foram transcritos e, posteriormente, analisados em três etapas: codificação aberta, axial e seletiva A pessoa com esquizofrenia tem desejo constante de obter alívio para os sofrimentos vivenciados e experimenta ambivalência em relação à adesão aos psicotrópicos. Ora o paciente adere ao tratamento, para atenuar sintomas da esquizofrenia, ora deixa de aderir por priorizar o alívio dos incômodos decorrentes da farmacoterapia, se expondo ao risco de agravamento do transtorno. Em associação com a adesão ou não adesão, o indivíduo experimenta outras estratégias, como a busca de tratamento não farmacológico, a espiritualidade e o consumo ou interrupção de substâncias psicoativas. A compreensão das motivações relacionadas à seleção das estratégias de enfrentamento utilizadas pelo paciente é fundamental para subsidiar a assistência fornecida a esta clientela.

Palavras-chave: Esquizofrenia. Enfermagem Psiquiátrica. Adesão à Medicação. Recusa do Paciente ao Tratamento.

ACTUANDO EN BUSCA DEL ALIVIO: ENFRENTAMIENTO DE LA ESQUIZOFRENIA E INCÓMODOS CAUSADOS POR EL TRATAMIENTO MEDICAMENTOSO

RESUMEN

En la evaluación de los pacientes, las molestias causadas por el tratamiento medicamentoso de la esquizofrenia pueden ser tan intensas como los síntomas del trastorno. Este estudio tuvo el objetivo de comprender cómo pacientes con esquizofrenia enfrentan las molestias causadas por el trastorno y por el tratamiento medicamentoso. La investigación utilizó el abordaje cualitativo, referencial metodológico de la Teoría

Fundamentada y presupuestos del Interaccionismo Simbólico. Participaron del estudio 36 personas con esquizofrenia en tratamiento comunitario y 36 familiares. Entrevista grabada y observación fueron utilizadas para recolección de datos. Los datos recolectados fueron transcriptos y, posteriormente, analizados en tres etapas: codificación abierta, axial y selectiva. Se evidencia que la persona con esquizofrenia tiene constante deseo de obtener alivio para los sufrimientos vividos y experimenta ambivalencia en relación a la adhesión a los psicotrópicos. Ora el paciente adhiere al tratamiento para aliviar los síntomas de la esquizofrenia, ora deja de adherir por priorizar el alivio de las molestias decurrentes de la farmacoterapia, exponiéndose al riesgo de agravamiento del trastorno. En asociación con la adhesión o no adhesión, el individuo experimenta otras estrategias, como la búsqueda de tratamiento no farmacológico, la espiritualidad y el consumo o interrupción de sustancias psicoactivas. La comprensión de las motivaciones relacionadas a la selección de las estrategias de enfrentamiento utilizadas por el paciente es esencial para subsidiar la atención provenida a esta clientela.

Palabras clave: Esquizofrenia. Enfermería Psiquiátrica. Adhesión a la Medicación. Rechazo del Paciente al Tratamiento.

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