Journal of Iranian Medical Council, Volume 10, Issue no. 1
http://dx.doi.org/10.18502/jimc.v10i1.23291

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The Home Care Paradox in Schizophrenia: Balancing Autonomy, Safety, and Long-Term Remission

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Received: 11 Oct 2025
Accepted: 29 Nov 2025

Citation to this article
Ahmadi Mh, Abdollahi R. The Home Care Paradox in Schizophrenia: Balancing Autonomy, Safety, and Long-Term Remission. *J Iran Med Counc*. 2027;10(1):318-20.

Dear Editor,

Schizophrenia, a chronic psychotic disorder affecting roughly one percent of the global population, disrupts cognition, emotion, and behavior in ways that challenge every model of psychiatric care. The prevailing ideal community-based treatment with patients living at home embodies progressive values of autonomy and de-institutionalization. Yet this model collides with a paradox: the very freedoms that foster dignity and self-determination can undermine medication adherence, exacerbate relapse, and erode the fragile neurobiological gains required for long-term remission (1).

Autonomy is the ethical cornerstone of modern mental health policy. The 1990 UN Principles for the Protection of Persons with Mental Illness explicitly prioritize the least restrictive environment, and decades of research confirm that forced hospitalization generates iatrogenic trauma, stigma, and learned helplessness. When patients with schizophrenia live at home, they retain agency over daily routines meal choices, sleep schedules, and social contacts that reinforce identity beyond the label of "patient." Longitudinal studies, such as the Chicago Follow-up Study spanning 20 years, demonstrate that individuals who exercise choice in treatment goals exhibit higher intrinsic motivation and, paradoxically, better adherence to antipsychotic regimens when those regimens are framed as personal decisions rather than external mandates. Autonomy, therefore, is not merely a human-rights slogan; it is a therapeutic instrument that strengthens the prefrontal circuits impaired by the illness (2).

Safety, however, is autonomy's unforgiving shadow. Schizophrenia's positive symptoms hallucinations, delusions can distort risk perception, while negative symptoms avolition, anhedonia erode the executive function needed for self-care. The CATIE trial revealed that 74 percent of patients discontinued medication within 18 months in outpatient settings, with non-adherence directly correlating to a 3.9-fold increase in hospitalization risk. At home, subtle early warning signs social withdrawal, sleep disruption, paranoid ideation often evade detection until crisis erupts. Families, thrust into de facto clinician roles, face

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burnout; a meta-analysis reported caregiver distress levels rivaling those of combat veterans. Thus, granting full autonomy without structured safeguards converts the home from sanctuary to tinderbox (3).

This paradox is particularly acute in low- and middle-income countries (LMICs), where resource constraints amplify the tensions between autonomy, safety, and remission. In LMICs, mental health services are severely underfunded, with community-based care often relying almost entirely on informal family networks due to the scarcity of formal infrastructure. Cultural norms in many LMICs emphasize familial duty and collectivism, positioning families as the primary caregivers 50% to 70% of schizophrenia patients receive ongoing home-based support from relatives; however, this can inadvertently erode patient autonomy through paternalistic oversight and enforcement of treatment (4). Societal stigma surrounding mental illness further complicates the landscape, fostering secrecy and isolation that hinder early intervention and relapse prevention. In Iran, a middle-income country with a rich tapestry of cultural and religious influences, these dynamics are vividly illustrated. Strong intergenerational family ties, rooted in Islamic values of compassion and communal responsibility, drive families to shoulder immense care burdens, often at the expense of their own well-being; studies report caregiver distress levels comparable to those in high-conflict zones. However, pervasive stigma manifesting as negative societal attitudes toward schizophrenia as a "family shame" leads to delayed help-seeking, medication non-adherence, and higher rates of involuntary hospitalization due to inadequate community facilities and outreach services. A 2025 Iranian study highlighted that while family-led home care preserves cultural notions of dignity and relational autonomy, it paradoxically heightens safety risks through burnout and undetected symptom escalation, underscoring the need for culturally attuned interventions that blend traditional support systems with modern safeguards (5).

Long-term remission defined by the Remission in Schizophrenia Working Group as sustained symptom attenuation and functional recovery for at least six months requires neuroplastic consolidation that only consistent dopamine modulation can provide. Second-generation antipsychotics, particularly long-acting injectables (LAIs), reduce relapse by 64 percent compared to oral formulations, yet uptake remains low in community settings because patients fear side effects and loss of control. Home care paradoxically jeopardizes remission by amplifying the very non-adherence it seeks to humanize. A 2024 Danish registry study tracking 29,823 patients found that those under assertive community treatment (ACT) with mandatory LAI review achieved 41 percent higher remission rates than standard home care, without increased coercion complaints when shared decision-making protocols were rigorously applied (6).

Resolving the paradox demands a triadic framework: calibrated autonomy, graduated safety, and remission-oriented monitoring. Calibrated autonomy employs motivational interviewing and personalized psychoeducation to transform abstract rights into concrete skills. Apps such as FOCUS and ClinTouch use ecological momentary assessment to prompt patients about mood, voices, and medication in real time, converting passive autonomy into active self-management. Graduated safety replaces binary "hospital versus home" thinking with a continuum: daily ACT nurse visits for high-risk phases, weekly telehealth for stabilization, and monthly peer-support check-ins during remission. Digital phenotyping passive smartphone data on gait, voice acoustics, and geolocation flags prodromal drift up to two weeks earlier than self-report, enabling pre-emptive outreach that respects privacy through opt-in encryption (1).

Finally, remission-oriented monitoring reorients the entire system toward functional milestones employment, relationships, independent living rather than mere symptom suppression. Family psychoeducation programs modeled on McFarlane's multifamily groups reduce relapse by 30 percent by teaching relatives to distinguish illness from personality, thereby preserving relational autonomy. Financial incentives, such as subsidized housing contingent on quarterly metabolic screening, align patient and system goals without punitive overreach. Critics will argue that any monitoring infringes liberty. Yet liberty devoid of capacity is illusory; the ethical imperative is to enlarge capacity so that liberty becomes meaningful. The Vermont longitudinal

study, now in its fourth decade, shows that former state-hospital patients who transitioned to supported apartments with wraparound services achieved 68 percent employment rates higher than many non-disabled cohorts precisely because safety nets were robust enough to permit risk-taking (7).

The home care paradox is not a zero-sum conflict but a dialectical opportunity. Autonomy without safety breeds chaos; safety without autonomy breeds stagnation. Remission emerges only when both are held in creative tension, mediated by technology, trained allies, and policies that treat patients as authors rather than objects of their recovery narrative. Until mental health systems invest in scalable, personalized infrastructure, the promise of community care will remain half-fulfilled, and the paradox will continue to exact its quiet toll on lives that deserve both freedom and healing.

Funding

None declared.

Conflict of Interest

There was no conflict of interest in this manuscript.

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