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Adherence to the therapeutic regime in person with type 2 diabetes

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Abstract

Background: It is expected that people with diabetes, throughout their lives, integrate and initiate a range of behavioral, therapeutic or preventive actions, suggesting the confirmed risk of occurring a globalized noncompliance, deteriorating their quality of life and an exponential economic impact. Objectives: to determine adherence to prescribed therapeutic regimen; and identify sociodemographic, clinical and psychosocial variables that influence adherence to the therapy. Methods: Was conducted a study quantitative, cross-sectional, non-experimental, descriptive, correlational study, with a sample of 102 people with diabetes type 2, aged 40 to 85 years, mostly male (51.96%). The evaluation protocol includes: social-demographic and clinical questionnaire, Diabetes Self-care Scale, Questionnaire about the knowledge of Diabetes, Depression, Anxiety and Stress Scale. Also resorted to HbA1c to directly assess adherence. Results: It appears that there is no statistically significant association between socio-demographic variables, sex and age and adherence. Single individuals, residents in urban areas, pensioners and those with the 3rd stage of schooling or more, adhere better to treatment. The variables such as, blood glucose monitoring, specific diet fulfillment and knowledge, reveal a statistically significant effect on adherence ($p < 0.05$). Anxious, depressed and stressed individuals adhere less. Conclusion: The evidences underlines the urgent need to recognize the importance of measuring patient adherence to a diabetes treatment plan for the maintenance of glycemic control. We suggest the reinforcement of educational programs in people with type 2 diabetes in order to enhance greater adherence to self-care.

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Keywords: Diabetes type 2 insulin-dependent, self-care, knowledge, adherence to therapeutic regimen, therapeutic education.

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1. Introduction

Diabetes Mellitus (DM) is one of the major public health problems worldwide, not only due to the increasing number of affected people, but according to its relation with disability and premature mortality, and not neglecting the costs involved in its treatment and prevention. It is a chronic disease in fast expansion, reaching even the characteristics of a pandemic set. The World Health Organization (WHO, 2011) argues that diabetes and its complications have a significant economic impact in patients, their families and in national health systems, considering that there are 346 million people with diabetes in 2011, and predicting that diabetes' deaths will double between 2005 and 2030. Portuguese set proves to be a matter of concern as well. DM is increasingly common in our society: its prevalence rises according to the age and extents to both genders. The prevalence of diabetes in the Portuguese population in 2012 was 12.9%, considering ages between 20 and 79 years old, which corresponds to a total of about 1 million people (Boavida et al., 2012). It is described consistently as one of the most demanding and complex chronic diseases in a behavioural and psychological point of view, being undeniable the relations between the psychological aspects of the patient and the disease, not forgetting its impact on the patient's bounds with his family and society. This impact occurs when diagnosis takes place. When it is diagnosed during adulthood, the disease is often experienced as a loss of physiological balance and a limitation in lifestyle. When it is diagnosed at a later stage, the patient identifies diabetes as the beginning of his end and it is regarded as a sign of aging (Figueirola & Peralta, 2003). It is a disease that is a heavy psychological burden to the patient and his family, and can become unwieldy to manage, in some moments of life, plus the fact that dealing with this disease is different from other chronic illness (Welch, Weinger & Jacobson, 2008), because it requires daily self-management which definitely contributes to the control of the metabolic situation. Thus, it is important to understand that the goals of metabolic control cannot be achieved at the expense of psychological well-being of the patient. When the treatment plan is determined, it becomes essential that beyond the biological and medical aspects, the importance of evaluating the patient's psychological processes should be attended, because biopsychosocial health of the patient is a decisive condition to encourage self-care with the disease (Anthony, 2010). Therapeutic obedience is established as a key element in the control of chronic disease. Its absence appears to have a considerable impact on the incidence and prevalence of many chronic diseases. Chronic diseases and diabetes in particular have nowadays a major impact on global health, representing in developed and developing-stage countries an economic burden. Diabetes is for that reason responsible for a huge number of mortality and morbidity in these countries and it is expected that the economic impact of chronic diseases will continue to grow until 2020, when they will represent 65% of total health expenses (Bugalho & Carneiro, 2004). According to WHO (2003), in developed countries, 50% of chronically ill patients do not adhere to the therapies. This percentage increases exponentially when we face to developing-stage countries, where the lack of resources and the absence of equity in health care access promotes the therapeutic adherence into a problem. The concept of adherence, most recently used, indicates an active participation by the patient and the existence of collaboration and interaction patterns in relation to health care. It requires compliance by the patient to the recommendations of the health professionals, both working as active partners in the treatment plan (WHO, 2003; Bugalho & Carneiro, 2004); it implies the active and voluntary participation of the patient, who shares the responsibility of treatment with a team of health professionals; it allows the existence of an agreement between both agents, respecting their beliefs and desires (Bugalho & Carneiro, 2004). In the opinion of Haynes, Acklooe, Sahota, McDonald, Yoo (2008) and WHO (2003) there is only an adherence plan when the behaviour of a patient in taking medication, diet commitment, and / or changes in lifestyles, will coincide with the advice of a health professional, i.e. it is the degree of conformity between the recommendations done and the patient's behaviour to the proposed therapeutic regimen. Several studies have shown that patients want to feel included in the clinical process increasingly, demanding for more information and requiring more interaction with healthcare professionals. So it is required a biopsychosocial approach that regards patients as active partners in their treatment plan (Cabral & Silva, 2010). A good obedience to the treatment means loyal connection in the entire process of the treatment plan, as well as the adoption of therapeutic behaviours and their conservation. This extended commitment is difficult and changes completely the pace of daily life, especially in diseases that evolve asymptomatically. This difficulty is compounded by the complexity of treatment regimens (Bugalho & Carneiro, 2004), leading many patients to an attitude of non-adherence. According to Telles-Correia Barbosa, Mega and Monteiro (2008) non-adherence occurs when the patient behaviour does not coincide with the recommendations of health professionals, not just confining to the differences