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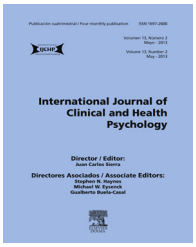

ORIGINAL ARTICLE

A longitudinal study of symptoms beliefs in hypertension

Genoveva Granados-Gámez[a], **Jesús G. Roales-Nieto**[a,*], **Ana Gil-Luciano**[b], **Emilio Moreno-San Pedro**[c], **Verónica V. Márquez-Hernández**[a]

[a] *Universidad de Almería, Spain*
[b] *Universidad Autónoma de Madrid, Spain*
[c] *Universidad de Huelva, Spain*

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Descriptive survey study

Abstract A longitudinal study was conducted to assess the presence of beliefs about symptoms related to hypertension and the time since diagnosis in which they appear. A randomly selected sample of hypertensive patients (67% women, mean age 53.27 years and range 20-65) was divided into four groups according to the time from diagnosis. All patients ($N = 171$) were interviewed at the beginning (initial assessment) and 12 months later (final assessment) and the patients ($n = 75$) who did not report beliefs about symptoms at the initial assessment were interviewed in a follow-up schedule. The results showed that 56% of patients reported beliefs about symptoms at the initial assessment, and this percentage increased to 77% at the final assessment ($p < .001$) finding significant differences between the two groups with a more recent diagnosis and the two groups of long-standing patients. Longitudinal analysis of the group with the recent diagnosis showed that the critical period for the emergence of beliefs was the first year from diagnosis. This period could be decisive in order to prevent them. Healthcare professionals should pay attention to the emergence of these beliefs, as they could negatively affect treatment adherence.
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PALABRAS CLAVE
Creencias;
hipertensión;
síntomas;
adherencia;

Un estudio longitudinal de las creencias sobre síntomas en hipertensión

Resumen Se realizó un estudio para evaluar creencias sobre síntomas relacionados con la hipertensión y el tiempo transcurrido desde el diagnóstico. Una muestra elegida al azar de pacientes con hipertensión (media de edad 53,27 años, rango 20-65; 67% mujeres) se dividió

* Corresponding author: Departamento de Psicología, Universidad de Almería, 04120 Almería, Spain.
E-mail address: jgil@ual.es (J.G. Roales-Nieto).

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estudio descriptivo mediante encuesta

en cuatro grupos de acuerdo al tiempo transcurrido desde el diagnóstico. Se entrevistó a todos los pacientes ($N = 171$) al comienzo del estudio (evaluación inicial) y 12 meses después (evaluación final). A los pacientes que no informaron creencias en síntomas ($n = 75$) se les entrevistó cada tres meses de acuerdo a un programa de seguimiento. Los resultados indicaron que en la evaluación inicial el 56% de los pacientes informó creencias en síntomas, elevándose al 77% en la evaluación final ($p < .001$), y diferencias significativas entre los grupos con menor y mayor tiempo desde el diagnóstico. El análisis longitudinal del grupo de pacientes de reciente diagnóstico mostró que el primer año es el período crítico para la emergencia de creencias en síntomas, información que resulta clave para planear la prevención. Los profesionales de la salud deberían prestar atención a la emergencia de creencias en síntomas dado que pueden afectar negativamente a la adherencia al tratamiento.
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Arterial hypertension is one of the main risk factors for cardiovascular and cerebrovascular events and one of the main causes of death and disability in developed countries (Arrebola-Moreno et al., 2014; Lloyd-Jones et al., 2010; Sharp, Aarsland, Day, Sønnesyn, & Ballard, 2011). Arterial hypertension is defined as values >140 mmHg of systolic blood pressure and/or >90 mmHg of diastolic blood pressure (Mancia et al., 2013). Although effective treatment is available, a large number of studies show that treatment is poorly followed by hypertensive patients (Chobanian, 2009; Egan, Zhao, & Axon, 2010; Márquez, Granados, & Roales-Nieto, 2014; van Onzenoort et al., 2010). Many factors related to patients' beliefs and perceptions about the illness and its treatment have been explored as variables related to poor treatment adherence (AlGhurair, Hughes, Simpson, & Guirguis, 2012; Alhalaiqa, Deane, Nawafleh, Clark, & Gray, 2012; AlHewiti, 2014; Marshall, Wolfe, & McKevitt, 2012; Rajpura & Nayak, 2013, 2014; Ross, Walker, & McLeod, 2004; Ruppar, Dobbels, & De Geest, 2012).

Even though hypertension is considered an asymptomatic condition, several studies have been oriented to explore patients' beliefs about hypertension since the seventies. The association of symptoms with hypertension has been explored in several studies. Some studies (Baumann & Leventhal, 1985; Brondolo, Raymond, Rosen, John, & Kostis, 1999; Kottke, Tuomilehto, Puska, & Salome, 1979) have not found any relationship between symptoms reported and blood pressure (BP), arguing that hypertension has no specific symptoms that could be useful to the patient for an estimation of his/her blood pressure. As well, some studies (Baumann & Leventhal, 1985; Brondolo et al., 1999; Kottke et al., 1979) have not found any significant relationship between reported symptoms, mood states and fluctuations in systolic pressure.

Other studies (Kruszewski, Bieniaszewski, & Krupa-Wojciechowska, 2000; Meyer, Leventhal, & Gutman, 1985) have found that a high percentage of hypertensive patients reported symptoms which they believed that were associated to high blood pressure and, consequently, they used them to estimate their blood pressure and to make decisions about the treatment followed. This pattern of behaviour can be considered as *beliefs about false symptoms* that could interfere with treatment, that is, it would be a mistaken generalization of what Leventhal and his associates called ''common sense use of symptoms'' as indicators of disease (Meyer et al., 1985). Studies that have explored the presence of these beliefs in hypertensive patients and their role in estimating blood pressure show that the percentage of patients who use symptoms to estimate their blood pressure varies from 50% to 92% (Cantillon et al., 1997; Kjellgren et al., 1998).

Beliefs about symptoms associated with hypertension can negatively affect adherence to treatment, as several studies have shown (Alison, Leventhal, & Leventhal, 2013; Cantillon et al., 1997; Granados & Gil Roales-Nieto, 2005, 2007; Granados, Roales-Nieto, Moreno, & Ybarra, 2007; Kjellgren et al., 1998; Marshall et al., 2012; Ross et al., 2004) and knowledge of the variables associated with their development and maintenance could be of interest to improve adherence. Most patients showing this type of beliefs interpret the perception of symptoms as a sign that their BP is high, which could have the risk of changing their treatment themselves. And vice versa, they interpret the absence of symptoms as a sign that their BP is controlled. For example, in a study with 163 hypertensive patients with pharmacological treatment, we found that 55.5% of the patients with beliefs about symptoms reported failures in their treatment adherence, while this only happened in 25.7% of the patients that did not report beliefs about symptoms (Granados et al., 2007). This relationship between non-adherence to treatment and symptom beliefs was statistically significant ($\chi^2 = 9.74$, $p < .01$; CI 95% = 1.56 - 8.28), with a relative risk of 2.15 (CI 95% = 1.20 - 3.86) that the presence of beliefs was associated with failures in treatment adherence.

Also, a recent study has shown that the modification of beliefs about false symptoms, using a feedback procedure, brought an improvement on treatment adherence (Roales-Nieto, Granados, & Márquez, 2014).

Nonetheless, the emergence of these beliefs and their maintenance over time has not been sufficiently explored. Only one study provided longitudinal data, reporting that 71% of 65 newly treated hypertensive patients already showed beliefs about symptoms (e.g., headache, feeling

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