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A PSYCHOLOGICAL READING FOCUSED ON THE BELIEFS OF PATIENTS WITH CHRONIC PATHOLOGIES ABOUT DISEASE: IMPLICATIONS FOR CLINICAL PRACTICE

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ABSTRACT. A good communication between physician and patient requires the understanding, by the physician, of the patients' beliefs and ways of thinking about the processes associated with their disease. The present study aimed to characterize the beliefs of patients with chronic pathologies, on three dimensions of the disease process: perceived evolution of the disease, impact of the disease on patient's life and treatment adherence. The participants were 205 patients (79.5% women) with chronic pathologies, recruited from a Public Health Center and a Hospital in Abrantes, Portugal. The patients' beliefs on the three above-mentioned dimensions of the disease process were collected through an individual and semi-structured interview based on Piaget's clinical method and were classified according to the Developmental Model of Joyce-Moniz and Barros. The results show that: a) pragmatic beliefs about the usefulness of treatment or the own capabilities to respond to its demands prevail in the patients' decision to adhere or refuse the medical treatment; b) simple and concrete beliefs, focused on sensory and physical symptoms which impose themselves in a peremptory and overwhelming way, dominate their judgments about the impact of the disease on their life and c) it is the experience in daily life of the somato-emotional symptoms that the most patients perspective in their beliefs about the perceived evolution of the disease. These results have implications for clinical practice to the extent that by allowing physicians a better understanding of the patients' perspective, the physician can adapt his language to the patients' beliefs in order to promote a better communication between them.

Keywords: Beliefs, chronic pathologies, disease process, physician-patient communication.

Introduction

A good communication between physician and patient requires the understanding, by the physician, of the patients' beliefs and ways of thinking about the processes associated with their disease. According to several authors, these beliefs can significantly influence the generation, development and confrontation with the biomedical processes as well as the adherence to medical treatment and the experience of concomitant emotional processes (Baum & Posluszny, 1999; Friedman, 1991; Groarke, Curtis, Coughlan, & Gsel, 2005; Hafen, Frandsen, Karren, & Hooker, 1992; Rodin & Salovery, 1989; Taylor, 1990). Concretely, the physician must focus on those beliefs and ways of thinking and communicate accordingly (Joyce-Moniz & Barros, 2005).

The importance of this procedure is highlighted by the finding of Conrad (1987) that the physician tends to speak about the disease in biomedical terms while the patient's beliefs about the disease usually reflect a personal experience. This may generate discrepancies between ways of thinking and consequently, difficulties in the

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patient's decision to adhere or refuse the proposed or prescribed treatment. According to Rapoff and Christophersen (1982), the estimates of non-compliance of medical prescriptions are generally high and many patients leave the office without knowing for sure how to follow the prescribed treatments, among other reasons, because physicians do not adapt their speech to the patients' levels of understanding (Burns, Austin, & Bax, 1990; Svarstad, 1976).

Also, physicians have great difficulty in evaluating the treatment adherence of patients. Therefore, their estimates do not reflect the reality regarding the treatment adherence because they are usually based on disease severity and treatment efficacy without taking into account the patients' beliefs and ways of thinking (DiMatteo, Hays, & Prince, 1986; Goldberg & Rubin, 1998).

The present study aimed to characterize, according to the Developmental Model of Joyce-Moniz and Barros (2005), the ways of thinking of patients with chronic pathologies about the processes associated with their disease. More specifically, the aim of this study was to characterize the beliefs of these patients, on three dimensions of the disease process: perceived evolution of the disease, impact of the disease on patient's life and treatment adherence.

Method

Participants

The participants were 205 patients (79.5% women) with chronic pathologies, recruited from a Public Health Center and a Hospital in Abrantes, Portugal, aged from 24 to 74 years, with a mean age of 55 years (*SD* = 10.11). Regarding education level, 2% of the sample had no formal education, 85.8% reported primary school education only, 7.8% had secondary school education, and 4.4% were university graduates. Despite the predominance of lower levels of education, all participants were literate. At the time of the study, 34.6% were working and 65.4% were unemployed, retired or homemakers. All participants were receiving medical treatment for symptom management.

The criteria for inclusion in the study were established as following: 1) being between 18 years old and 75 years old; 2) having a chronic pathology diagnosed by the assistant physician; and 3) suffering from somatic and/or psychological symptoms associated with the chronic condition. A medical or cognitive disability that would prevent participation in the study was an exclusion criterion.

Instruments

An identification sheet of the patient was used for the collection of socio-demographic data. The patients' beliefs about the processes associated with their disease were collected through an individual and semi-structured interview based on Piaget's clinical method. Each interview was recorded with the patient's permission.

Procedure

This study was approved by the Ethics Committee of the Abrantes Hospital and the Abrantes Public Health Center. At an early stage, the researcher proceeded to the personal and individual contact with the physicians of the aforementioned Public Health Center and Hospital, for the following purposes: a) present succinctly the objectives of the study; b) ask their collaboration through the referral of patients who meet the inclusion criteria previously defined.

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The verbal explanation was accompanied by a written document, given to each one of the physicians, with the explanation of the study's purposes, the criteria for patients' inclusion and the request for collaboration. After the acceptance of physicians to collaborate, it was agreed with them the form of referral of patients for the session with the researcher.

Participants were, therefore, referred by their assistant physician to an individual session with the researcher, in which they were informed about the objectives and conditions of the study, after which informed consent was obtained. Then, data regarding socio-demographics and patients' beliefs about the processes associated with their disease were collected using the instruments above-mentioned. Concretely, data regarding patients' age, sex, work status and education level were collected using the identification sheet of the patient. The patients' beliefs relating to the perceived evolution of the disease, the impact of the disease on patient's life and the treatment adherence were collected through the following questions, respectively: *How do you think that has been the evolution?; How these symptoms have affected your life?; What have influenced your decision to follow the treatment recommended by your physician?* Then, the patients' beliefs were classified according to the five levels of the Developmental Model of Joyce-Moniz and Barros (2005), ordered from the most simple and concrete (level 1) to the most complex and abstract (level 5), for each of the three aforementioned disease dimensions (Tables 1, 2 and 3). Finally, the most frequent level(s) on each of the three disease dimensions were analyzed.

Table 1. Levels of beliefs relating to the perceived evolution of the disease (Joyce-Moniz & Barros, 2005).

Level	*Description*
5	The perceived evolution of the disease focuses on the progressive decrease of existential autonomy.
4	The perceived evolution of the disease focuses on the progressive decrease of physical and intellectual capabilities to fulfill duties and responsibilities.
3	The perceived evolution of the disease focuses on the progressive decrease of socio-emotional and relational activities.
2	The perceived evolution of the disease focuses on the increasingly functional impairment of the body.
1	The perceived evolution of the disease is intertwined with the experience in daily life of the somato-emotional symptoms.

Table 2. Levels of beliefs relating to the impact of the disease on patient's life (Joyce-Moniz & Barros, 2005).

Level	*Description*
5	Focus on the somatic and psychic disturbing transformations that affect the sense of personal integrity (*e.g.*, loss of autonomy, impossibility to describe/define the experiences).
4	Focus on the somatic and psychological dysfunctional processes that affect the sense of individual order and duty (*e.g.*, difficulties in reasoning, decreased ability to work).
3	Focus on the somatic processes considered deficient relating to little differentiated psychological processes that affect the sense of relational life (*e.g.*, less contact with friends).
2	Focus on the concrete consequences of the disease, which can be attributed to reduced functional performance or to reduced response to hedonic needs (*e.g.*, less strength and opportunity to do things, decreased sexual desire and pleasure).
1	Focus on the motor and sensory experience of suffering, which imposes itself in a peremptory and overwhelming way (e.g., fatigue and pain that limit the response to basic needs).

Table 3. Levels of beliefs relating to the treatment adherence (Joyce-Moniz & Barros, 2005).

Level	*Description*
5	The treatment adherence depends on the relationship between the instrumental obligations, the experienced symptoms and the existential imperatives, in a context of integration of the medical meanings with the own beliefs of decision-making autonomy.
4	The treatment adherence depends on the accurate assessment of own capacities for comply with it, after analysis of the clinical and scientific rationality of treatment, considered the terms of medical diagnosis.
3	The treatment adherence depends on the self-confidence in the required physical and psychological capabilities and on the affective proximity of the help resources, in the context of uncertainty about the effectiveness of treatment.
2	The treatment adherence depends on the own instrumental capabilities to respond to its demands, which are legitimised by its objective usefulness.
1	The treatment adherence depends on its physical, family and financial costs, in view of the suffering, but without integrating the implications of the diagnosis in the treatment.

Type of study

This is an exploratory and qualitative study based on the Developmental Model of Joyce-Moniz and Barros (2005).

Results

Results revealed that: a) the level 1 was the most frequent on the perceived evolution of the disease and on the impact of the disease on patient's life dimensions; b) the level 2 was the most frequent on the treatment adherence dimension (Table 4).

Table 4. Relative frequency of patients who have used predominantly each level of beliefs relating to perceived evolution of the disease, impact of the disease on patient's life and treatment adherence.

Levels of beliefs	*Perceived evolution of the disease* %	*Impact of the disease on patient's life* %	*Treatment adherence* %
1	53.4	92.3	8.5
2	20	6	86.8
3	5.3	1.7	1.9
4	19.3	0	2.8
5	2	0	0

Discussion/conclusions

The results of the present study clearly show that the majority of patients use the levels 1 or 2 on the three dimensions of the disease. Pragmatic beliefs about the usefulness of treatment or the own capabilities to respond to its demands prevail in their decision to adhere or refuse the medical treatment. Simple and concrete beliefs, focused on sensory and physical symptoms which impose themselves in a peremptory and overwhelming way, dominate their judgments about the impact of the disease on their life. And it is the experience in daily life of the somato-emotional symptoms that the most patients perspective in their beliefs about the perceived evolution of the disease.

These findings have similarities with that of Pimm, Byron, Curson, and Weinman's trial on arthritis patients and with the results of Stone et al.'s study relating to patients' treatment adherence. Concretely, Pimm et al. (1994) found that pain,

fatigue, stiffness and other sensory and physical symptoms were the aspects that affected more the patients' lives. According to Stone et al. (2001) patients adhere less to the most complex and demanding treatments. It is the case of the simultaneous prescription of several drugs, each one with different instructions (Sarafino, 1990).

This psychological reading of the patients' ways of thinking about the processes associated with their disease has implications for clinical practice to the extent that by allowing physicians a better understanding of the patients' perspective, the physician can adapt his language to the patients' pragmatic, simple and concrete beliefs in order to promote a better communication between them.

Despite the contributions of this study, it is important to note some of its limitations. First, the majority of female patients that participated in the study make it difficult to generalize the results for male patients. Also, the predominance of patients with lower education levels makes it difficult to generalize the results for patients with higher education levels. Therefore, it is important to include a more balanced sample regarding these socio-demographic variables in future studies.

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