

# Illness perceptions, adherence to treatment and health outcomes



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This essay provides a critical discussion of the relationship between illness perceptions, adherence to treatment and health outcomes. Firstly, the main components of an illness perception will be described, along with an outline of the variables that might affect one's beliefs about their physical condition. Evidence of the impact of illness perceptions on adherence and health outcomes will be critiqued. Finally, conclusions will be made based on the evidence as to the relationship between illness perceptions, adherence, and health outcomes.

## **Illness Perceptions**

Research suggests that people 'cluster' their perceptions about illness into five themes or categories, which together create their overall perception of the illness and thus how they treat or adjust to the illness (Leventhal, 1987): Identity (i. e. the label of the symptoms and the illness comprising these symptoms); Cause (i. e. perceptions about aetiology); Time-line (i. e. perceptions as to illness duration); Consequences (i. e. the anticipated effects and outcomes of the illness); and, Cure/Control (i. e. personal self-efficacy to recover or control the illness, as well as treatment efficacy to treat or control the illness). Together, these five components of illness perceptions form the Self-Regulatory Model (SRM) (Leventhal, Brissette, & Leventhal, 2003), also known as the Common Sense Model, the Illness Perceptions Model, and the Illness Representations Model. The SRM posits that illness perceptions help people form a 'common sense' understanding of symptoms, health risks, and any action required to address the illness.

Evidence supporting the SRM is vast and the five illness perception

constructs have been supported by research testing the model's factor

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structure (Broadbent, Petrie, Main, & Weinman, 2006; Figueiras & Alves, 2007; Moss-Morris, Weinman, Petrie, Horne, Cameron, & Buick, 2001). The Cure/Control component has been challenged by Horne (1997), who distinguished beliefs about personal efficacy and external beliefs about the anticipated efficacy of prescribed treatment or medical advice. These distinct beliefs are also known as self-efficacy (Bandura, 1995) and outcome expectancies (Maddux, Sherer, & Rogers, 1982), respectively. Horne's critique informed a revision of the SRM, which now distinguishes self-efficacy from treatment efficacy within Cure/Control perceptions (Horne & Weinman, 1999).

According to the SRM, when confronted with a threat to health or a change in health status, an individual makes efforts to self-regulate in order to re-establish a state of normality. This supports the Health Belief Model (Rosenstock, 1974), which was the first model within health psychology that attempted to conceptualise beliefs as predictors of health behaviours. Together, the SRM and HBM suggest that an individual's illness perceptions guide health-related behaviours, such as adherence to treatment, in an effort to re-establish their sense of health and well-being. The premise is that cognitive and emotional representations are activated by symptoms, with these representations causing a feedback loop whereby the individual forms an illness perception based on these symptoms, and then adopts the appropriate health behaviours. This is followed by an appraisal of the efficacy of those behaviours (Broadbent, Petrie, Main, & Weinman, 2006). Thus, health behaviours, including adherence to treatment, are based on rational appraisal processes.

Assessing an individual's illness perceptions can provide valuable insight into health and illness-related behaviours and outcomes (Figueiras & Alves, 2007), hence the development of the Illness Perceptions Questionnaire (Moss-Morris, Weinman, Petrie, Horne, Cameron, & Buick, 2002). This questionnaire was developed to inform how illness perceptions influence adaptation to illness and treatment (Griva, Myers, & Newman, 2000; Groarke, Curtis, Coughlan, & Gsel, 2005). Utilising this tool, it has been found that illness perceptions can explain a range of health outcomes, including coping (Scharloo, Kaptein, Weinman, Bergman, Vermeer, & Rooijmans, 2000), mood (Fortune, Barrowclough, & Lobban, 2004), and adherence to various medical recommendations (Jessop & Rutter, 2003).

## **Adherence**

One of the areas for which illness perceptions has offered greatest utility is in explaining adherence to medical advice and treatment. Adherence, also referred to as compliance and concordance, has been defined as “ The extent to which the patient's behaviour matches agreed recommendations from the prescriber” (Horne, 2006, p. 66). An implication particularly noteworthy of the term ‘ compliance’ is the argument that it places the health professional in an authoritarian position and the patient in a passive role. The term adherence, however, acknowledges that the patient has a choice and a responsibility in terms of their health and whether they adhere to treatment recommendations. The term adherence also takes account of the influence that illness perceptions can have over health behaviours and outcomes. Indeed, an understanding of illness perceptions offers the possibility of two forms of non-adherence – intentional (e. g. a conscious

decision to stop taking prescribed medication) and unintentional (e. g. forgetting to take prescribed medication) (ref). Intentional non-adherence is more likely to be influenced by illness perceptions, and is far more complex and problematic as the patient has wilfully decided to not adhere. This behaviour can range from total non-adherence to the modification of agreed medical regimens (i. e. partial non-adherence).

It has been estimated that between 30-50% of medicines prescribed for people with long-term conditions are not taken as directed (WHO, 2003). Thus, if illness perceptions can help illuminate reasons for non-adherence, efforts can be made to address this problem. Levels of adherence can be explained by all three phases of the feedback loop described earlier, whereby the individual first forms an illness perception, adopts the appropriate health behaviours, and then appraises the efficacy of those behaviours (Broadbent et al., 2006). If medication appears to not be working or even appears to be making a person feel worse via adverse side-effects, the individual might cease adherence. For example, in the case of cancer, some symptoms of radiotherapy are so severe that patients terminate treatment (Frytak and Moerter, 1981); their illness perceptions, especially around Cure/Control have provided them with a common sense reason to stop adhering. This is a frequently reported problem in terms of medication adherence since some illnesses are masked by medication, challenging common sense assumptions of illness being symptomatic (Heather et al., 2002). The other dimensions of illness perceptions also play a role. For example, regardless of side-effects, a person who perceives their illness to

be severe (Consequences) and life-long (Time-line) is more likely to adjust to medical advice (DiMatteo, Haskard, & Williams, 2007).

DiMatteo et al. (2007) conducted a meta-analysis of studies examining the relationship between illness severity (Consequences) and adherence. Across 27 studies, there was a statistically significant relationship between adherence and perceived illness severity ( $p < .001$ ), with greater perceived severity being associated with higher adherence. A 22% higher risk of non-adherence was reported among individuals who did not believe their medical condition to be of high severity. This provides support for illness perceptions impacting adherence, suggesting that the threat of an illness with severe consequences increases attempts to Cure/Control. The relationship between actual illness severity and adherence was also examined across 74 studies, demonstrating that among less serious illnesses (e. g. hypertension, arthritis, and cataracts), patients with poorer health are more likely to adhere than patients in better health. Interestingly, in individuals with more serious illnesses (e. g. cancer, HIV, and heart failure), patients who were in poorer health were significantly less likely to adhere. A possible explanation for this is that patients in poorer health because of more severe illness are confronted with additional personal and practical limitations that effect adherence (Brown, Dunbar-Jacob, Palenchar, Kelleher, Bruehlman, Sereika, & Thase, 2001). It is also plausible to infer that individuals with more serious illness experience feelings of hopelessness, depression, and negative affect, which ultimately impacts capacity or will to adhere, as has been found with HIV (Horberg et al., 2008).

The meta-analysis conducted by DiMatteo et al. (2007) provides interesting insight into the many factors associated with adherence, including illness perceptions and negative affect. However, the findings are purely correlational and thus limited in terms of making any causal inferences. It is possible that non-adherence resulted in poorer objective health, although the authors suggest that the temporal ordering of measurements within the studies (i. e. illness perceptions and mood measured prior to adherence) supports some causal interpretations.

## **Health Outcomes**

As indicated within the critiqued literature on adherence, illness perceptions can impact health outcomes directly through health-enhancing behaviours or indirectly via their influence on adherence. In terms of having a direct impact on health outcomes, this can occur when, for example, confusion surrounding the symptoms of a cancerous lump, in particular the misconception that cancerous lumps are always painful, delays seeking medical assistance (Arndt, Stürmer, Stegmaier, Ziegler, Becker, & Brenner, 2003; Lam, Tsuchiya, Chan, Chan, Or, & Fielding, 2009). Similarly, the slow-growing and progressive nature of some diseases means that they can frequently be asymptomatic during the early stages, as is often the case with prostate cancer (Chodak, 2006). Similar misattributions may also occur with neuromuscular or musculoskeletal diseases such as arthritis and myasthenia gravis (serious muscle weakness), whereby bone stiffness and changes in physical ability can be mistaken for natural ageing (Vincent, Clover, Buckley, Evans, & Rothwell, 2003). Thus, confusion pertaining to Identity and Cause of certain symptoms can delay help-seeking, leading to illness progression.

The literature comprises many examples of the interaction between illness perceptions, adherence, and health outcomes. For example, the threat appraisal (Consequences) associated with loss of physical function can facilitate adherence to physical rehabilitation and thus increase speed of recovery (Grindley, Zizzi, & Nasypany, 2008). These findings are likely to also be influenced by the high outcome efficacy associated with physical rehabilitation (ref). Understanding these direct and indirect influences that illness perceptions have over adherence and health outcomes provides opportunity for intervention in the improvement of health outcomes. Indeed, changing patients illness perceptions has been found to produce a number of positive health outcomes, including improved recovery from myocardial infarction (Petrie, Cameron, Ellis, Buick, & Weinman, 2002), improved quality of life (QoL) in people with cystic fibrosis (Sawicki, Sellers, & Robinson, 2010), and other self-regulatory interventions in illnesses as diverse as diabetes and AIDS (Petrie, Broadbent, & Meechan, 2003). The illness perceptions in some disease groups, such as asthma, have been studied extensively in different countries, increasing the external validity of the findings showing substantial effects of illness perceptions on self-management behaviours and increased quality of life (QoL) (Kaptein, Klok, Morris-Morris, & Brand, 2010).

## **Conclusions**

This essay has presented evidence supporting the influence that various illness perceptions can have on adherence to medical advice and a number of subsequent health outcomes. There is conclusive evidence that patient's beliefs and perceptions about their illness should be explored and



understood in efforts to increase adherence and overall health and well-being. Given the highly complex interaction between illness perceptions, adherence, and health outcomes, further research is needed to refine which illness perceptions are most adaptive to intervention, as well as how moderating factors such as objective disease severity and negative affect might impact such efforts.