Knowing Hypertension Awareness and Psychological Distress in Primary Prevention
To the Editor:

It is with great interest that I read the article titled “Hypertension Awareness and Psychological Distress” by Hamer et al., showing that an elevated risk of distress was observed in aware hypertensive participants but not unaware hypertensives. In this cohort, aware hypertensive participants included those being treated and untreated who could have different degrees of and/or reasons for psychological distress. In the United Kingdom, detected but untreated hypertensive patients were found with a decreasing trend from 29.7% in 1986 to 21.5% in 1995 and was higher in the elderly. It may be of additional interest to know whether patients who lost adherence to medication were at a higher risk of psychological distress for being labeled as hypertensive because of denial, educational reason, or financial reason or whether patients after the antihypertensive treatment were at a higher risk of psychological distress simply because of being labeled as hypertensives. Clinically, if a higher risk of psychological distress is observed among detected but untreated hypertensive patients, special prevention strategies in preventing psychological illness and noncompliance and withdrawal from treatment among these high-risk patients may be urgently needed.

On the other hand, studies including clinical trials have found that education level was inversely associated with psychological distress in addition to a positive association between psychological distress and risk of hypertension, in particular among patients diagnosed with hypertension but not treated previously with antihypertensive medications. Based on this assumption, it may also be interesting to know how education level or health literacy influences the degree of psychological distress and hypertension awareness in this cohort. Additional adjustment for education and/or social class in the regression model is suggested. Lastly, methodologically, although a cutoff of $\approx 3$ to 4 with General Health Questionnaire scores in identifying distressed people was common, the mean General Health Questionnaire score was also recommended as the best cutoff threshold.

In the present study, we did not see the mean values, which may help us to understand the score distribution among those 3 groups. Moreover, some studies revealed General Health Questionnaire score possibly in relation to female gender and/or education level. Therefore, potential mediators, such as education, occupation, and/or social class mentioned above from the social aspect should be taken into account when assessing psychological distress by General Health Questionnaire and clinical symptoms and perception, such as hypertension awareness or other self-reported diseases.

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None.

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