



Research Article

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Proposal of Categories for the Retrospective Documentary Study of Treatment Adherence

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Abstract

Background: Psychological studies of adherence to treatment have established; 1) indicators models -frequency of medical consultation, prevalence of medication intake over any other treatment, attendance at therapeutic and rehabilitation sessions-; 2) determining models -sex, age, income, level of instruction, reading comprehension, interpersonal relationships-; 3) mediating models-beliefs, attitudes, knowledge, intentions, and strategies.

Objective: Establishment of categories for the study of adherence to treatment in the literature published from 2015 to 2019, considering the occupational health climate.

Method: Documentary study with a selection of 38 indexed sources in repositories of Latin America - Dialnet, Latindex, Publindex, Redalyc and Scielo- considering the variables reported in the state of the art.

Results: The specification of the model included four explanatory hypotheses of the trajectories of dependency relationships among the six variables - demands, social support, control, effort, reward and adhesion - taken from the literature review.

Discussion: In relation to the models of indicators, the determinant models and the models of mediation, it is recommended to include the variables of work culture, quality of life and subjective well-being in the specified model to study the process that goes from the labor culture and it would culminate with the reinsertion of accident and disease cases.

Conclusion: The new specification of the model would include explanatory hypotheses of the trajectories of correlations between the variables used in the present work with the purpose of establishing differences between the organizations that provide social security with respect to the companies managed from labor flexibility, as well as their effects on the occupational health of its workers.

Keywords: Culture labor; Occupational health; Self-control; Stress; Treatment adherence

Introduction

Psychological studies of occupational health warn; 1) the preponderance of the Demand, Control and Social Support Model (MDCS) and Effort-Reward (MDER) Model; 2) the prevalence of stress when there are asymmetries between demands and self-control, as well as imbalance between efforts and rewards; 3) once

the worker has acquired an illness due to work stress, adherence to treatment emerges as a factor of quality of life and subjective well-being [1]. Occupational health models warn that stress can affect biomedical factors; is cardiovascular, cerebrovascular and ischemic heart disease that can lead to musculoskeletal disorders,

absenteeism, accidents, conflicts, insomnia, depression and anxiety [2]. Both models have shown that occupational health and self-care is determined by the type of employment. An increase in risk factors exacerbates the likelihood of illnesses, accidents or disorders related to work activity [3]. However, occupational health studies have focused more on prevention than on the study of adherence to the treatment of diseases, accidents or disorders, since workers can be rehabilitated and become productive again, it is necessary to study the adherence to treatment as a determining factor in the quality of life of workers with some disease, especially in those cases of older adults or terminal phase, imminent loss of limb or even life [4]. In this sense, the study of adherence to treatment also involves the investigation of grief factors in the face of an imminent loss of limb or human in organizations that operate with high risk and health effects [5]. Models that study grief as an expectation of imminent loss of life, limb or sanity pose phases ranging from denial to acceptance, rehabilitation and reconstruction of the meaning of existence [6]. However, adherence to treatment, unlike the process of mourning, implies a hope for the preservation of the quality of life, an expectation of well-being and indicates the restoration of occupational health [7]. The study of adherence to treatment is the link between an accident, illness, disorder and the reinsertion of the convalescent in a climate of tasks and relationships established by trust, commitment and satisfaction, as well as dedicated to entrepreneurship, innovation and competitiveness. However, adherence to treatment involves an internal negotiation of the employee with respect to the demands that organizations will endorse, involves establishing agreements and responsibilities between workers and leaders is not always feasible in traditional organizational cultures, but in adhocracy organizations [8]. Therefore, the objective of the present work was to establish the categories for the study of the adhesion to the treatment subtracted from the literature indexed to international repositories and published from 2015 to 2019. Therefore, the present work carried out a documentary study with a selection of indexed sources of Latin American repositories - Dialnet, Latindex, Publindex, Redalyc and Scielo - considering the key words; model, demands, control, social support, imbalance, effort and reward. Subsequently, the information was processed in matrices of content analysis to extract the explanatory variables of adherence to treatment. Finally, the model was specified based on assumptions of trajectories of dependency relationships between the variables.

The model will allow the empirical contrast of the hypotheses, as well as a new specification of the trajectories of correlations between variables in order to incorporate the findings of the literature and the questions of the state of knowledge.

Model of demands, control and social support (MDCS)

Adherence to treatment, from the MDCS, is the result of the asymmetries between labor demands and subjective capacity

control [9]. That is, it is a response to the external demands of treating a disease and personal resources. Thus, adherence to treatment refers to tangible and intangible opportunities for rehabilitation or healing, but it can also activate conflicts of relationships; disinterest, frustration, exhaustion, depersonalization or neglect [10]. Therefore, significant differences prevail between those who make decisions and those who execute them with respect to the process of adherence to treatment [11]. This is how the idealization of a treatment generates greater inspiration and satisfaction [12]. Commitment, as an indicator of self-control, increases adherence to treatment. Therefore, the demands external to a treatment are generated by the degree of commitment and self-regulated control by the patient regarding the idealization of their work, leaders and organization [13]. The MDCS warns that the organization can motivate the employee through a climate of relationships of trust and a climate of innovative tasks, but it is the employee's work history that will determine their degree of self-control reflected in their commitment and satisfaction with their environment of work [14]. In this sense, the MDCS does not explain the effect of the work culture on the performance of the weighted worker in their degree of effort and commitment in the process of adherence to a treatment.

Imbalance, effort and reward model (MDER)

Social and organizational support as predictors of adherence to treatment are explained by both models. Unlike the MDCS that emphasizes the importance of regulating demands and fostering personal control, the MDER maintains that it is the reward that, in correspondence with the effort, will generate a climate of transparent and reliable relationships, fostering the task climate, reducing conflicts to their minimum expression and encouraging adherence to treatment [15]. It is possible to observe that in the MDCS the increase in demand affects self-control and such asymmetry favors the diseases, accidents, conflicts and disorders that the MDER intends to solve with incentives of greater effort, since it implies a constant increase in demands. However, studies on occupational health warn that these are generated even in stressful work climates, since the lack of personal satisfaction is a risk factor for employees with expectations and transcendent abilities [16]. Emotional exhaustion is not only generated by excessive labor demand, but also by the routine or simplicity of the task climate. In addition, being associated with depersonalization, emotional exhaustion is a process that begins with fatigue and culminates with indifference to the workplace. It can even generate frustration, inhibitors of organizational social support for adherence to the treatment of an occupational disease [17].

Therefore, organizational social support; the flexibility, trust and diversity necessary to reduce stress and exhaustion are reduced by conflict of relationships and tasks [18]. Rodríguez and Hechanova [19] demonstrated that the climate of relationships determines

collaborative performance. This organizational social support predictor of adherence to the treatment of an occupational disease is a function of the task socialization of knowledge [20]. Therefore, the effectiveness of the expected results [21,22] affect the quality of labor relations, the avoidance of stress and exhaustion.

Studies of adherence to treatment in relation to work demands and self-control

This section presents the studies that report correlation or regression coefficients in which the relationship between labor demands and adherence to treatment through self-control is shown. These are models in which variables of different order interact, but a linear relationship prevails among the three variables. Park [23] showed that self-control defined as inconsistency in the intake of medications determined adherence to treatment because they suffered psychological burdens that not only affected their treatment but also influenced the deterioration of their quality of life. The determinant of adherence was self-management ($\beta = 0.15$, $p = 0.002$). That is, organizations that do not monitor the psychological burdens of their employees with high-risk functions and do not promote relationships of collaboration, support and solidarity seem to reduce the management of the health of their employees, guiding them towards the loss of adherence to the treatment of a disease or accident.

Nsitou, Ikama, Drame and Kaboru [24] from considering that adherence to treatment determines rehabilitation contrasted a model in which they demonstrated an effect of treatment cost on compliance ($B = 0.610$, $p = 0.0791$; $OR = 0.54$ (0.21 1.40) This is so because self-management supposes a labor, financial and family support to carry out the fulfillment of the measurement, therefore, the development of human capital is an effective response to The risks and threats of the environment in terms of health, such process is gestated from public investment in academic, professional and employment training and not only as prevention but also as a promotion of risk-free relationships.

Sajith, Pankaj, Pawar, Modi and Simariya [25] introduced the concept of poor adherence to treatment as a determinant of medication financing, although it prevails that of urban men in compliance with the distinction of other groups. That is, adherence to treatment seems to be the result of a patriarchal structure that favors a sector formed as human capital with high self-control compared to other sectors formed as social capital with high solidarity and collaboration. The three studies reveal that the structure of public health services, as well as the structure of academic, professional and work training to favor a civil sector determine the adherence to the treatment of diseases and the prevention of risks through the promotion of life styles of health free of risks. It is a strategy of training policies of self-control in which psychological variables such as beliefs or information processing

capacity, information perceptions or biases, knowledge or logics of verifiability and intentions or probabilities of making a decision that will be carried out complement the process of adherence to treatment. It is through such a process that the model of demands, control and social support, as well as the model of imbalance, effort and reward, turn out to be palliative institutional strategies in the face of illnesses and accidents. That is, the collective self-control of the first model and the personal self-control of the second model turn out to be insufficient to reduce the mediation of a public health system favorable to a sector with high incomes and quality of life estimated in urban services [10]. A new model of adherence to treatment based on public management, social and family support in relation to self-control that establishes a balance between the demands of the environment and institutional and personal resources would be supported by prevention strategies for excluded sectors, violated or marginalized and microfinance strategies for peripheral sectors to urban health services.

The psychological variables of beliefs, dispositions, knowledge and intentions would be influenced by the demands of the environment or risks to health such as the case of diseases and accidents in the occupational field. The emergence of a condition not only activate medical consultation or adherence to treatment through the intake of drugs, but also encourage financial and social support strategies that the State could incentive according to the level of development of the community or locality [26].

In this way, adherence to treatment would no longer be the result of urban health policies that favor those who have decision-making power centered on their personal and financial resources, but would also be the product of policies according to the needs and expectations of communities where prevail the formation of solidarity capital, the climate of support and collaboration to support a disease that is considered shared [27].

The state would no longer be only a promoter of self-management and self-control. Now a new social function of the State would be in the micro-financing of health services as human settlements move away from urban centrality and other non-favored sectors approach this sub-scheme to deal with their illnesses and accidents. Therefore, health services acquire a social feature not only because of the administration scheme but also because of the targeting of needs and supports to marginalized, excluded and violated sectors [1].

Specification of the treatment adherence model

The public health models used, the MDCSS and the MDER can not only be complementary in the prediction of stress, but also relate to the explanation of adherence to treatment for those cases of accidents, diseases, disorders or conflicts arising from the climate of relationships and the climate of tasks that promote trust, commitment, entrepreneurship, innovation and satisfaction. The

model includes four explanatory hypotheses of the trajectories of correlations between the variables reviewed in the literature. The association between demands and social support determines self-control and effort (hypothesis 1 and 2). As the worker is involved in greater demands of efficiency, effectiveness and effectiveness, the social support of colleagues, friends or family encourages self-control and regulates their effort, but if the latter is not even recognized then it will generate stress, although in the In opposite cases, the reward could anticipate adherence to the treatment of a disease, disorder, accident or conflict if the worker arrives at that instance (hypothesis 3 and 4). Unlike the predecessor models, the specified model states that the dependency relationships between the variables not only anticipate stress, but also adherence to treatment. The specified model would encourage the follow-up of cases of accidents, illnesses, conflicts and disorders associated with the climate of relationships and the climate of tasks.

Method

Because the new model assumes the relationship between socioeconomic variables such as per capita income, demographic

factors such as gender or age, institutional factors such as micro financing and psychological strategies such as dispositions, knowledge and intentions, it is necessary to carry out an exploratory study of the relationships reported between these variables in order to establish the parameters that indicate probabilities of adherence to treatment or determinant relationships of this variable. The universe of the data were index repositories such as Copernicus, Dialnet, Latindex, Pubindex, Redalyc and Scielo. The sample consisted of the literature selected intentionally, considering the inclusion of the key words of adherence to treatment, self-control and labor demands published from 2005 to 2019 (Table 1).

In order to be able to weigh the findings reported by the reviewed literature. It was categorized according to the relationships between organizational social support and adherence to treatment: type A literature with results of positive and significant effects; Type B literature with positive and spurious findings; Type C literature with results of null relationships between organizational social support and adherence to treatment; type D literature with negative results and type E literature with findings of unknown relationships, although theorized (Table 2).

Table 1: Descriptive of the information sample.

| | Adherence to treatment | Self-control | Labor demands |
|----------|------------------------|--------------|---------------|
| Dialnet | 35 | 30 | 26 |
| Latindex | 27 | 24 | 21 |
| Pubindex | 21 | 20 | 13 |
| Redalyc | 17 | 16 | 9 |
| Scielo | 10 | 11 | 4 |

Source: Elaborated with data study, N= 38

Table 2: Descriptive of the informative sample according to the type of literature.

| | A | B | C | D | E |
|----------|----|---|---|---|---|
| Dialnet | 10 | 7 | 5 | 3 | 2 |
| Latindex | 7 | 5 | 3 | 2 | 1 |
| Pubindex | 4 | 3 | 2 | 1 | 0 |
| Redalyc | 2 | 2 | 1 | 0 | 0 |
| Scielo | 1 | 1 | 0 | 0 | 0 |

Source: Elaborated with data study; Literature type A (e1 = Findings of significant relationships between organizational social support and adherence to treatment), Literature type B (e2 = Findings of spurious relationships between organizational social support and adherence to treatment), Literature type C (e3 = Findings of null relationships between organizational social support and adherence to treatment), Literature type D (e4 = Findings of negative relationships between organizational social support and adherence to treatment), Literature type E (e5 = Findings of unknown relationships between organizational social support and adherence to treatment)

The information was processed following the Delphi technique where pairs of experts in the subject evaluated extracts of the findings reported in the litter with the purpose of establishing the relationship between the variables, considering -1 for negative data, 0 for irrelevant data and 1 for positive data (Table 3).

In three rounds the experts qualified the extracts. At the first opportunity, they only catered the data, but with some suggestion of registration that was incorporated into the extract in order to

be able to qualify it again in a second round. Once the consensus was established, in the third round the judges compared their first qualification with the second and issued a new qualification in order to reinforce their criteria, or again issue new considerations. The estimation of the data was carried out considering the local privacy hypothesis test. It is a technique that, in relation to traditional hypothesis tests, offers the confidentiality and anonymity of the responses by inhibiting the inference of the respondents from a

reversible marketing process. In addition, in the traditional standard model the data is disturbed to ensure anonymity because it must be shared by the parties interested in subtracting the identity of the respondent by associating it with a social group or sector [28]. Consequently, the validity and reliability of the information is reduced to its minimum expression due to the distrust that the respondents perceive before the possibility of being identified. In the local privacy model, the data is disturbed in a way that does not affect the analysis of the data, guaranteeing the confidentiality and anonymity of the sources based on joint responsibility. In the traditional standard model the respondents reduced or amplified their responses in order not to be identified, but in the local privacy model it is a random response algorithm in charge of processing this data without having to alter the dimensions, volume or categories of data to avoid inference or association of respondents to a group [29]. The random response algorithm is compatible with iPhone or Google technology. Because the chi-square parameter is highly effective for non-parametric samples, the traditional standard model injects the disturbance into the data to ensure anonymity and confidentiality, but the local privacy model randomly injects the disturbance to each individual's responses, developing as many models as possible and thereby reducing measurement biases or errors [30]. The local priority technique injects Laplace or Gaussian noise to orient the responses towards a chi-square distribution and to establish the contrast of dependence hypothesis or model fitting [31]. The relevance of the local privacy model is that it is possible from its chi-square distribution not only to contrast models, considering the independence of the distributions and their adjustment, but also allow regression models to be carried out

with least squares ordinary unweighted [32].

In addition, the local privacy model offers minimum convergence rates in order to show the differences between privacy and statistical efficiency (Acharya, Canonne, Han, Sun & Tyagi, 2019 [33]. Consider datasets $x = (x_1; \dots; x_n) \in X^n$ in some data universe X , typically $X = (0; 1)^d$ where d is the dimensionality. Two datasets $x; x' \in X^n$ are neighboring if they differ in at most one element, i.e. $\exists i \in [n]$ such that $x_i \neq x'_i$ and $\forall j \neq i, x_j = x'_j$. From this nomenclature it is possible to advance in the hypothesis test since in the traditional standard model a null hypothesis can be rejected, limiting the error of choosing a false finding, but offering inconclusive hypothesis tests when designing them to avoid errors type 1. In contrast, the local privacy model allows the design of hypothesis tests aimed at contrasting null hypotheses to avoid type 2 errors or avoidance of non-rejection of false findings [34]. The information was processed in the qualitative data analysis package version 4.0 in order to be able to quantify distribution parameters and nonparametric relationships. The chi square was estimated and, based on these findings, an instrument was designed for the validity of the chi squared and the specification of the model.

Results

Table 3 shows the relationships between the selected extracts with respect to the three central categories of labor demands, self-control and adherence to treatment. It is possible to observe significant relationships to the extent that qualification rounds succeed one another, as well as a marked consensus in adherence to treatment (Table 4).

Table 3: Delphi technique.

| | Definition | Indicators | Coding | Weighing |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| Adherence on treatment | It refers to the financing strategies of medicines and compliance of intake from the medical prescription, family support, social and organizational | Information search data on the Internet, preventive courses in institutions, use of preventive or diagnostic health technology or purchase of medicines. | -1 for negative data, 0 for irrelevant data and 1 for positive data | High scores suggest adherence to treatment according to institutional policies and strategies |
| Self-control | It refers to dispositions, knowledge and intentions about financing, medication and social, family or institutional support regarding risks of an illness or injury. | Data of savings or channeling of financial resources to food, exercise, consultations, reviews or medical certifications, the purchase of medicines. | -1 for negative data, 0 for irrelevant data and 1 for positive data | High scores suggest a self-control derived from academic, professional and work training. |
| Labor demands | It refers to the institutional, financial, medical or family requirements of the occupational environment in case of illness or accident risks. | Medical history, interrelation with risk areas or personnel with dangerous work or handling of toxic substances. | -1 for negative data, 0 for irrelevant data and 1 for positive data | High scores show the effects of the dissemination and communication of risks in the media and public health institutions. |

Source: Prepared from the literature review

Table 4: Descriptive relationships between categories and informative extracts.

| E | M | S | A | C1 | | | C2 | | | C3 | | |
|----|------|------|------|-------|----|------|-------|----|------|-------|----|------|
| | | | | X2 | df | p | X2 | df | p | X2 | df | p |
| e1 | ,682 | ,143 | ,139 | 14,24 | 15 | <,05 | | | | | | |
| e2 | ,781 | ,120 | ,105 | | | | 13,25 | 14 | <,05 | | | |
| e3 | ,604 | ,137 | ,143 | | | | | | | | | |
| e4 | ,740 | ,146 | ,125 | | | | | | | 16,27 | 15 | <,05 |

| | | | | | | | | | | | | |
|----|------|------|------|-------|----|------|-------|----|------|-------|----|------|
| e5 | ,738 | ,122 | ,174 | | | | | | | | | |
| R2 | | | | | | | | | | | | |
| e1 | ,773 | ,145 | ,143 | | | | | | | | | |
| e2 | ,762 | ,187 | ,196 | 15,26 | 13 | <,05 | | | | | | |
| e3 | ,739 | ,190 | ,178 | | | | 14,35 | 14 | <,05 | | | |
| e4 | ,741 | ,163 | ,132 | 17,29 | 15 | <,05 | | | | 16,28 | 12 | <,05 |
| e5 | ,793 | ,132 | ,146 | | | | 12,12 | 13 | <,05 | 14,23 | 15 | <,05 |
| R3 | | | | | | | | | | | | |
| e1 | ,734 | ,136 | ,139 | 15,26 | 13 | <,05 | | | | 15,36 | 12 | <,05 |
| e2 | ,762 | ,148 | ,176 | | | | 14,25 | 12 | <,05 | 16,58 | 13 | <,05 |
| e3 | ,751 | ,156 | ,167 | 16,27 | 12 | <,05 | | | | | | |
| e4 | ,780 | ,139 | ,109 | 11,24 | 13 | <,05 | 11,43 | 12 | <,05 | | | |
| e5 | ,763 | ,130 | ,146 | | | | | | | 15,43 | 12 | <,05 |

Source: Elaborated with data study; E = Extract; R = Round, R1 = Evaluation, R2 = Feedback, R3 = Consensus. Literature type A (e1 = Findings of significant relationships between organizational social support and adherence to treatment), Literature type B (e2 = Findings of spurious relationships between organizational social support and adherence to treatment), Literature type C (e3 = Findings of null relationships between organizational social support and adherence to treatment), Literature type D (e4 = Findings of negative relationships between organizational social support and adherence to treatment), Literature type E (e5 = Findings of unknown relationships between organizational social support and adherence to treatment). M = Mean, S = Standard Deviation, A = Asymmetry. C = Category; C1 = Adherence of Treatment, C2 = Self-Control, C3 = Labor Demands.

Once the significant relationships between the categories established, we proceeded to estimate the structure of relationship and the informative extracts qualified by the expert judges were trajectories (Figure 1).

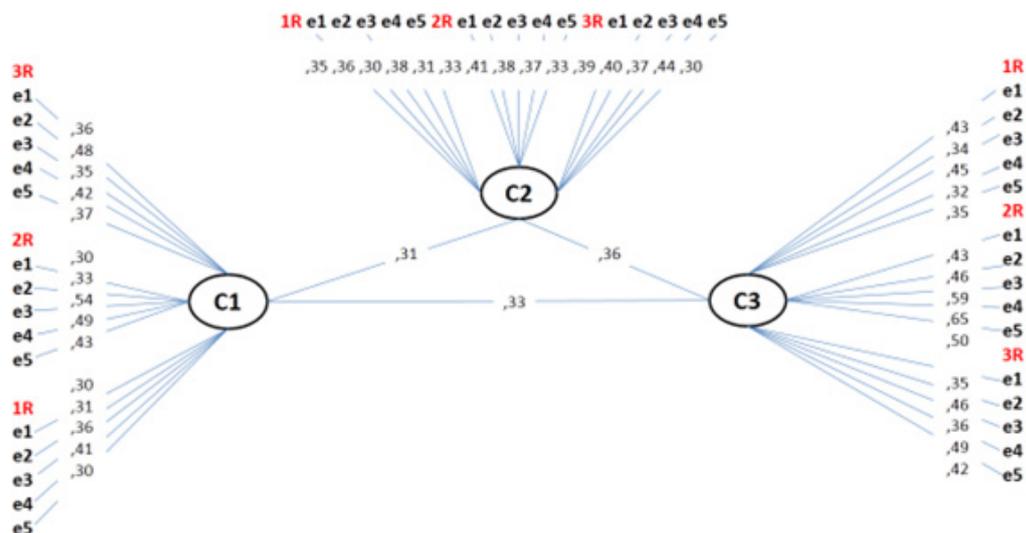


Figure 1: Structure of trajectories of relations between the categories with respect to the informative extracts.

Source: Elaborated with data study; E = Extract; R = Round, R1 = Evaluation, R2 = Feedback, R3 = Consensus. Literature type A (e1 = Findings of significant relationships between organizational social support and adherence to treatment), Literature type B (e2 = Findings of spurious relationships between organizational social support and adherence to treatment), Literature type C (e3 = Findings of null relationships between organizational social support and adherence to treatment), Literature type D (e4 = Findings of negative relationships between organizational social support and adherence to treatment), Literature type E (e5 = Findings of unknown relationships between organizational social support and adherence to treatment). C = Category; C1 = Adherence of Treatment, C2 = Self-Control, C3 = Labor Demands.

It is possible to appreciate that the structure of consensus is weak because the trajectories of relations between categories and extracts is close to zero, suggesting a spurious scenario. This indicates that the expert judges who qualified the informative

extracts seem to suggest the inclusion of other variables that the revised models do not include and that refer to perceptions of risk, usefulness, efficacy and adherence to treatment.

Discussion

This work has specified a model of the determinants of adherence to treatment from the review of the MDCSS and the MDER in order to explain the follow-up of cases of accidents or diseases arising from conflicting work climates in terms of their relationships as to your tasks. However, the model does not explain the subsequent processes of adherence to treatment, such as quality of life and subjective well-being. Carreón et al. [35] showed that subjective wellbeing is the result of a climate of tasks subordinated to the climate of relationships and in cases of illness or accident, adherence to treatment increased subjective well-being by empowering the employee with respect to the organization, not only the worker evaluated positively his reintegration in the company, but also contemplated other job offers with greater rewards. In this same sense, García et al. [36] demonstrated that the process of quality of life starts from the organizational culture and culminates with the reinsertion of the worker, as long as it circumscribes their expectations to the organizational culture.

However, adherence to treatment is not only a mediating variable between the organizational culture and the well-being of the worker, it also implies provisions in favor of self-care that are indicated by the frequency of medical consultations, medication intake, assistance to therapy and rehabilitation sessions [36]. However, adherence to treatment is more linked to social support than to the provisions of injured or sick workers. In this phase, institutionalism determines the follow-up of cases. Because social security is an institutional derivative, the organizations that offer social benefits are distinguished from companies that hire their employees for periods and thus define their quality of life [36]. Therefore, the relationship between adherence to treatment and quality of life would help explain the effects of the organizations' follow-up on the cases of their injured or sick workers [36-40]. Therefore, the specification of the model would include; 1) the organizational culture -climate, opportunities, risks, benefits, follow ; 2) capacities -provisions, adhesion, skills, knowledge-; 3) biopsychosocial support -quality of treatment, family support, therapeutic assistance -; 4) quality of life and 5) subjective well-being - expectations, needs-.

The present work to establish a structure of categories related to organizational support with regard to adherence to treatment suggests the observation of relationships between variables such as self-control and labor demands that the proposed model only explores, but its confirmation in the occupational health environment or Work psychological is pending. It means then that the established model acquires a consistent potential in the organizational diagnosis of its demands against workers' resources, as well as its effects on their health. In that sense, it is that organizations interested in balancing demands and resources

encourage adherence to treatment by promoting self-control in their talents. Alternatively, they reduce the risks of accidents and diseases through decision-making and responsible actions. To the extent that workers acquire that practical awareness of responsibility with their health from the challenges and challenges of their environment and in relation to their abilities, organizations would implement occupational health programs focused on the climate of relationships or social work support [41,42].

In the discussion on adherence to treatment, this process has been observed: 1) as an effect subsequent to the diagnosis of diseases or accidents arising from an imbalance between demands and resources; 2) as a consequence of social, family and organizational support; 3) as a subsequent phase to risk prevention and concomitant to self-control; but in the present work it has been directly related to the demands. Studies from the psychology of organizations and occupational health have established an indirect relationship between demands, capacities, accidents, diseases and adherence to treatment, but in this paper, we have explored the possibility that self-control is a mediating or moderating variable. A decrease or increase in self-control as a mediating or moderating variable in the relationship between organizational support and adherence to treatment would explain why organizations that foster personal responsibility prevent risks of accidents or diseases [44].

Conclusion

The objective of this study was to specify a model for the study of adherence to treatment in peri-urban areas and with marginalized, excluded and vulnerable sectors such as women, children and older adults, although the research design limited the findings to the informative sample is suggested the extension work to repositories like Scopus and WoS. Regarding health policies focused on adherence to treatment as a result of the formation of an intellectual capital that is guided by its self-control, it is necessary to include the State in the financing of medicines, as well as institutional and family support such as the pillars of lifestyles free of risks, health promoters and preventive of diseases and accidents.

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Conflict of Interest

No conflict of interest.

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