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Research Article

Comparison of Self-Focused Attention, Emotional Abuse, and Psychological Distress in Individuals with Hypertension and Healthy Individuals

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Abstract

Objective: Hypertension is a common and chronic condition that increases the risk of heart failure, stroke, kidney disease, and psychological issues. This study aimed to compare self-focused attention, emotional abuse, and psychological distress between individuals with hypertension and healthy controls.

Method: This descriptive, causal-comparative study was conducted in Miandoab. The sample included two groups: individuals diagnosed with hypertension (selected via purposive sampling) and matched healthy individuals. Participants completed the Self-Focused Attention Questionnaire (Woody et al., 1997), the Emotional Abuse Questionnaire (Norouzi, 2012), and the Kessler Psychological Distress Scale (Kessler, 2002). Data were analyzed using SPSS version 26 and the Kruskal-Wallis test.

Results: Results indicated significant differences in mean levels of self-focused attention, emotional abuse, and psychological distress between individuals with hypertension and healthy individuals ($P \leq 0.05$). Mean scores for these variables were higher in hypertensive individuals.

Conclusion: These findings suggest that addressing and reducing these characteristics is significant in managing and treating hypertension.

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Extended Abstract

Background and Objectives

Hypertension, or high blood pressure, is a prevalent chronic condition that significantly increases the risk of severe cardiovascular complications, including heart failure, stroke, and kidney disease. Often termed the "silent killer," hypertension progresses without obvious symptoms until irreversible organ damage occurs. Beyond its physiological effects, hypertension is closely linked with psychological factors such as anxiety, depression, and psychological distress, which may affect both disease onset and progression. Among psychological variables, self-focused attention—the tendency to focus attention inwardly on oneself and internal states—and emotional abuse—characterized by repetitive emotional maltreatment experienced during childhood or adulthood—are thought to impact mental health and may exacerbate hypertension. Emotional abuse includes behaviors such as labeling, humiliation, neglect, and family dysfunction, which induce chronic stress. Although psychological distress in hypertensive populations has been increasingly studied, limited research has directly compared self-focused attention, emotional abuse, and psychological distress between individuals with hypertension and healthy controls. The present study aimed to address this gap by examining and comparing these psychological and emotional factors in hypertensive patients and matched healthy individuals. Gaining a clearer understanding of these differences could inform comprehensive management approaches that consider both physical and psychological aspects of hypertension.

Materials and Method

This descriptive causal-comparative study was conducted in Miandoab and involved two groups: 100 clinically diagnosed hypertensive individuals and 100 matched healthy controls without hypertension. The hypertensive group was purposively selected from healthcare centers, and controls were recruited from patients' companions and healthcare staff, matched on age, gender, educational level, marital status, and socioeconomic status. Participants with other chronic illnesses, those taking medications affecting psychological or physiological states, or unwilling to participate were excluded.

Data were collected using three validated self-report questionnaires. The Self-Focused Attention Questionnaire measured inward attention and perception of social interactions. The Emotional Abuse Questionnaire assessed emotional maltreatment and its subcomponents. The Kessler Psychological Distress Scale (K10) evaluated recent symptoms of anxiety and depression. The psychometric properties of these instruments have been previously validated. Ethical considerations, including informed consent, confidentiality, and participants' right to withdraw, were strictly observed.

Due to non-normal data distribution, non-parametric Kruskal-Wallis tests were used to compare mean ranks of self-focused attention, emotional abuse, and psychological distress between groups.

Results

The analysis revealed statistically significant differences between hypertensive and healthy participants across all three psychological domains. Hypertensive individuals showed significantly higher overall self-focused attention, including self-concentrated attention and perceived social interaction, than healthy controls. Total emotional abuse scores were also significantly elevated in the hypertensive group, with specific subcomponents such as labeling, humiliation, and family disruption showing significant differences. However, other emotional abuse dimensions—including threats, distrust, neglect, and interference in friendships—did not differ significantly between groups. Psychological distress was markedly higher among hypertensive individuals, reflecting a greater prevalence of anxiety, depression, and related symptoms.

The Kruskal-Wallis tests confirmed robust differences in self-focused attention and its subscales. Emotional abuse differences, while significant overall, varied across subdomains. Psychological distress showed a strong and significant elevation in hypertensive individuals, reinforcing the established link between hypertension and psychological health challenges.

Discussion

These findings indicate that individuals with hypertension experience significantly greater self-focused attention compared to healthy individuals. Heightened inward focus may exacerbate negative cognitive patterns, such as increased self-

evaluative thinking and social anxiety, contributing to greater psychological burden. The tendency to internalize social failures can initiate a vicious cycle of increased distress and impaired social functioning, factors known to negatively affect cardiovascular health. Therefore, interventions designed to reduce maladaptive self-focused attention could play a beneficial role in hypertension management.

Regarding emotional abuse, the results suggest a meaningful association between greater exposure to emotional maltreatment and hypertension. Chronic psychological stress stemming from emotional abuse—especially during childhood—may foster maladaptive coping mechanisms and sustained physiological stress responses that increase vulnerability to hypertension and other psychosomatic conditions. Components such as family dysfunction, labeling, and humiliation seem particularly impactful. Nonetheless, the lack of significant differences in some subcomponents highlights the complexity of emotional abuse's effects and suggests the influence of resilience, cultural factors, and social support systems.

The elevated psychological distress observed in hypertensive patients is consistent with existing literature linking high blood pressure to anxiety, depression, and decreased quality of life. Psychological distress adversely affects mental health and may also physiologically dysregulate blood pressure via stress mechanisms. This dual impact emphasizes the necessity of integrated care approaches addressing both psychological and physical health in hypertensive populations.

Limitations of the study include the use of self-report measures, which may introduce response biases, and its cross-sectional design, which precludes causal inferences. Additionally, the geographically restricted sample limits generalizability. Future research employing longitudinal designs with more diverse populations is recommended.

Conclusion

This study provides clear evidence that hypertensive individuals exhibit significantly higher levels of self-focused attention, emotional abuse, and psychological distress compared to healthy counterparts. These psychological and emotional factors likely interact with physiological mechanisms influencing the onset and progression of hypertension. Consequently, comprehensive hypertension management should incorporate psychological assessment and targeted interventions aimed at reducing self-focused attention and psychological distress, while addressing the effects of emotional abuse. Collaboration between clinical psychologists, counselors, and healthcare providers is essential to develop educational and therapeutic programs tailored to hypertensive patients and their families. Such integrated approaches hold promise to improve psychological well-being and ultimately enhance clinical outcomes in hypertension care

Introduction

Health, as one of the most vital needs for humanity, faces numerous challenges alongside the advancements in industrial and technological fields. Hypertension emerges as a significant public health concern, playing an increasing role in the occurrence of problems such as heart failure, stroke, kidney failure, and psychological issues (Delavar et al., 2020). Hypertension, often referred to as the "silent killer," is a prevalent and asymptomatic condition caused by general or functional disorders, commonly classified as primary or idiopathic hypertension (Park et al., 2019). It is one of the most asymptomatic risk factors and is typically diagnosed only after irreversible complications, such as cardiovascular and cerebrovascular strokes, have occurred (Aghili & Seyedi, 2024).

Individuals with higher blood pressure levels exhibit poorer psychological performance and experience greater psychological distress, anxiety, and depression than others (Hong et al., 2020). Moreover, chronic stressful events associated with hypertension can increase the likelihood of psychological distress (Li et al., 2021). Psychological distress encompasses emotional states such as depression and anxiety that individuals may experience temporarily or permanently in response to specific stressful events (Goudarzi et al., 2021). Symptoms of psychological distress include reduced concentration, restlessness, diminished intellectual capacity,

sleep disturbances, isolation, and lethargy (Nemati et al., 2020). A meta-analysis of 21 studies on the relationship between anxiety, depression, and hypertension revealed a strong connection between these psychological states and elevated blood pressure (Pan et al, 2015). A quarter of hypertensive patients reported psychological distress in terms of depressive, anxiety, or stress symptoms (Loke & Ching, 2022). Women with uncontrolled hypertension had significantly higher psychological distress scores (Eghbali et al., 2022). Additionally, individuals newly diagnosed with hypertension exhibited more significant worry related to their blood pressure compared to non-hypertensive individuals (Green et al., 2022).

Another variable that may differ between individuals with hypertension and healthy individuals is emotional abuse. Emotional abuse, defined as degrading, manipulative, or neglectful behaviors by caregivers, is a common adverse experience for children and adolescents. This type of abuse often coincides with other forms of maltreatment (Hoffmann & Heim, 2024). Emotional abuse represents a repeated pattern of caregiver mistreatment that instills in children a sense of worthlessness, inadequacy, unlovability, and rejection (Baker, Brassard & Rosenzweig, 2021). Parental factors such as young age, prior abuse, attachment styles, family violence, psychological disorders, and addiction increase the likelihood of emotional abuse (Abdollahzadeh & Alizadeh, 2019). While research often examines the effects of sexual and physical abuse, the consequences of emotional abuse—one of the most common types of child maltreatment—are less studied (Gama et al., 2021). Furthermore, the relationship between emotional abuse and hypertension remains underexplored. Studies in Europe and the United States confirm that emotional abuse significantly increases the risk of developing hypertension in adulthood (Jiang et al., 2025). For example, a study in Germany identified a moderate association between emotional abuse in childhood and the development of high blood pressure and lung disease (Lepsy et al., 2022). Women with hypertension reported higher rates of emotional abuse compared to non-hypertensive women (Nguyen et al., 2022). Additionally, individuals who experienced emotional violence had a 51% higher likelihood of hypertension compared to those who did not report such experiences (Okyere et al., 2024).

Among the factors that can create psychological stress and predispose individuals to hypertension is self-focused attention. Self-focused attention refers to the process of directing attention toward stimuli related to oneself (Ivey, 2023). According to Clark and Wells (1995), when individuals encounter ambiguous situations under psychological stress, they begin processing information and tend to rely on internal sources of information (such as thoughts and feelings) and self-monitoring to navigate the ambiguous situation. This self-focused attention, however, reduces information-processing capacity, leading to external positive feedback and information being dismissed by inefficient thoughts (Kley et al., 2012). A review of previous studies demonstrates that reducing self-focused attention in patients with coronary artery disease significantly decreases their anxiety and worry (Dammen et al., 2022). Higher skills in switching attention were associated with increased depression scores when combined with greater tendencies for self-preoccupation (Ishikawa & Koshikawa, 2021).

Hypertension, like most chronic diseases, is closely linked to lifestyle, psychological health, and patients' quality of life. If not controlled promptly and appropriately, hypertension can lead to various diseases, significant disabilities, reduced productivity, and ultimately lower quality of life (Tan et al., 2024). While mortality from hypertension-related conditions has declined due to intervention programs, the holistic treatments and psychological aspects of these patients are often neglected. Any knowledge about factors contributing

to hypertension can aid in understanding cardiovascular diseases and identifying personality traits essential for psychological research. Therefore, studying and researching hypertension, its aggravating and mitigating factors, is necessary.

Method

Participants and Procedure

This descriptive study employed a causal-comparative design that included two groups from the same geographic area of Miandoab: 100 patients diagnosed with hypertension and 100 healthy individuals without a history of hypertension. The patient group consisted of individuals with a confirmed diagnosis of hypertension, while the control group was selected from patients' companions and healthcare staff. Inclusion criteria for the patient group included a confirmed diagnosis of hypertension, whereas for the control group, the absence of any history of hypertension was required. Exclusion criteria for both groups included the presence of chronic diseases (except hypertension), use of medications with significant physiological or psychological effects, and unwillingness to participate in the study. The patient group was selected using purposive sampling, and the control group was matched with the patient group based on age, gender, education level, marital status, and socioeconomic status.

Ethical Statement

This study was conducted by the ethical principles outlined in the Declaration of Helsinki. Before participation, all participants provided informed consent after being fully informed about the study's purpose, procedures, potential risks, and benefits. The confidentiality and anonymity of all participants were maintained throughout the research process. Participants were free to withdraw from the study at any time without any negative consequences.

Data collection was conducted using standardized questionnaires.

Self-Focused Attention Questionnaire: Developed by Kiropoulos and Klimidis in 2006, this questionnaire contains 10 items and measures two subscales using a 5-point Likert scale. Subscales include self-focused attention and perceived social interaction. Each item uses a 5-point scale to indicate the degree to which the respondent's focus aligns with the statements. In a study conducted by Noda et al. (2021), the Japanese version of the Self-Focused Attention Scale (J-SFA) was developed, and its validity and reliability were examined. The results demonstrated that the scale possesses high internal consistency (Cronbach's alpha = 0.90), and its factor structure was confirmed. In addition, both convergent and discriminant validity of the scale were supported. This study highlights the capability of the J-SFA scale to effectively measure self-focused attention in social contexts and its association with social anxiety. Haji Hosseini et al. (2023) reported Cronbach's alpha coefficients of 0.75 for self-focused attention and 0.86 for external attention, indicating acceptable reliability. Additionally, Kiropoulos and Klimidis (2006) confirmed the construct validity of this scale.

Emotional Abuse Questionnaire: The initial version of this questionnaire was developed by Norouzi (2015). Abdollahzadeh Rafi and Alizadeh (2019) conducted factor analysis on this questionnaire and identified nine factors: insult-labeling, creating distrust in oneself, threats, disrupting friendships, emotional neglect, humiliation, unkindness-rejection, coercion, and family disruption. Each item is scored on a Likert scale (0 to 4), with a maximum score of 160. Higher scores indicate more severe emotional abuse. Abdollahzadeh Rafi and Alizadeh (2019) found that this questionnaire has significant predictive validity, as it negatively correlates

with behavioral and emotional disorders in adolescents. Additionally, concurrent validity was established by finding notable correlations between the total score of Norouzi's Emotional Abuse Questionnaire and the emotional abuse subscale of a questionnaire by Mohammadi-Khani et al. (2003). Internal consistency was confirmed with a Cronbach's alpha of 0.962 (Abdollahzadeh Rafi & Alizadeh, 2019).

Psychological Distress Questionnaire (K10): The Kessler Psychological Distress Scale (2002), developed by Kessler et al., is a widely used tool for assessing psychological disorders in the general population. It is available in two versions: a 10-item form (K-10) and a 6-item form (K-6). The scale is scored on a Likert-type scoring system ranging from "never" to "always," scored from 0 to 4, with a maximum score of 40 in K-10. This 10-item form does not target a specific psychological disorder but provides an overall indication of anxiety and depressive symptoms experienced in recent weeks. Some researchers, such as Furukawa et al. (2003), demonstrate that the K-10 questionnaire has high validity and reliability, making it a robust tool for assessing psychological distress.

For instance, in a study conducted in Brazil, the K10 was utilized to screen psychological distress among elderly individuals. The scale demonstrated high internal consistency, with a Cronbach's alpha of 0.844. Furthermore, its concurrent validity was supported by a strong Spearman correlation coefficient ($\rho = 0.722$) with the SRQ-20, considered the gold standard for psychological screening (Perrelli et al., 2024). Similarly, Issazadegan et al. (2023) reported a Cronbach's alpha of 0.81 for the scale, further confirming its reliability.

Results

Descriptive statistics, as presented in Table 1, indicate that the mean scores for self-focused attention and its components (self-focused attention and perceived social interaction) are higher in the hypertensive group compared to the healthy group. As shown, the mean scores for emotional abuse and all its components (labeling, creating distrust, threats, damaging children's friendships, neglect, humiliation, rejection, coercion, and family disruption) are somewhat higher in the hypertensive group compared to the healthy group. Additionally, demonstrates that the mean score for psychological distress is higher in the hypertensive group than in the healthy group

Table 1: Descriptive Statistics for Self-Focused Attention, Emotional Abuse and Psychological Distress

Variable	Components (Mean ± SD)	Hypertension Group (Mean ± SD)	Healthy Group
Self-focused attention	Self-concentrated attention	17.1 ± 0.39	13.28 ± 0.30
	Perception of social interaction	16.28 ± 0.44	12.44 ± 0.32
Emotional Abuse	Labeling	17.98±0.76	15.08±0.63
	Creating a Sense of Distrust	12±0.38	11.46±0.45
	Threat	7.22±.39	6.32±0.30
	Damaging Children's Friendships	6.42±0.38	5.5±0.26
	Neglect	12.9±0.38	11.84±0.37
	Humiliation	5.6±0.31	5.5±0.3
	Rejection	9.04±0.37	7.9±0.34
	Coercion	5.6±0.31	4.5±0.26
	Family Disruption	5.58±0.28	4.6±0.22
Psychological Distress	Psychological Distress	25.24±0.91	18.02±0.82

To utilize parametric statistical tests, assumptions such as normal distribution and equality of variances be-

tween groups must be met. Since these assumptions were not satisfied in the present study, the p-values from the Shapiro-Wilk and Kolmogorov-Smirnov tests for all variables in both groups were less than 0.05 (Table 2). Consequently, the non-parametric Kruskal-Wallis test was employed as an alternative.

Table 2: Tests of Normality

		Kolmogorov-Smirnov		Shapiro-Wilk	
Variable	Group	Statistic	Sig	Statistic	Sig
Self-Focused Attention	Hypertension	0.114	0.001	0.939	0.001
	Healthy	0.118	0.001	0.943	0.001
Emotional Abuse	Hypertension	0.095	0.001	0.953	0.001
	Healthy	0.105	0.001	0.935	0.001
Psychological Distress	Hypertension	0.089	0.008	0.955	0.008
	Healthy	0.117	0.001	0.938	0.001

To examine differences in self-focused attention between individuals with hypertension and healthy individuals, the non-parametric Kruskal-Wallis test was conducted. The chi-square statistic for the overall self-focused attention variable ($\chi^2 = 52.4$) was statistically significant at the $p < 0.01$ level, indicating a meaningful difference in mean self-focused attention between the two groups. Additionally, chi-square test results for the two subcomponents of self-focused attention were also statistically significant ($p < 0.01$). These findings suggest that both self-concentrated attention and perception of social interaction are significantly elevated in individuals with hypertension compared to their healthy counterparts (Table 3 and Chart 1).

Table 3: Comparison of Self-Focused Attention Scores Between Patients with Hypertension and Healthy Individuals

Variable	Group Type	N	Mean Rank	Chi-Square	df	Sig
Self-Focused Attention	Hypertension	100	130.08	52.4	1	0.000
	Healthy	100	70.92			
Self-Concentrated attention	Hypertension	100	127.74	44.56	1	0.000
	Healthy	100	73.26			
Social Interaction Perception	Hypertension	100	126.24	39.87	1	0.000
	Healthy	100	74.76			

To examine differences in emotional abuse between individuals with hypertension and healthy individuals, the non-parametric Kruskal-Wallis test was conducted. The chi-square test statistic for the variable of emotional abuse (4.99) is significant at a p-value less than 0.05. Therefore, there is a statistically significant difference in mean emotional abuse between hypertensive individuals and healthy individuals. Among the components of emotional abuse, labeling, humiliation, and family disruption show statistically significant differences between the two groups. Individuals with hypertension exhibit higher levels of overall emotional abuse and its specific components compared to healthy individuals (Table 4 and Chart 1).

Table 4: Comparison of Emotional Abuse Scores Between Patients with Hypertension and Healthy Individuals

Variable	Group Type	N	Mean Rank	Chi-Square	df	Sig
Emotional Abuse	Hypertension	100	109.64	4.99	1	0.025
	Healthy	100	91.36			

Variable	Group Type	N	Mean Rank	Chi-Square	df	Sig
Labeling	Hypertension	100	113.48	10.15	1	0.001
	Healthy	100	87.52			
Creating a Sense of Distrust	Hypertension	100	105.20	1.37	1	0.249
	Healthy	100	95.8			
Threat	Hypertension	100	104.86	1.2	1	0.273
	Healthy	100	96.14			
Damaging Children's	Hypertension	100	102.98	0.427	1	0.371
Friendships	Healthy	100	98.02			
Neglect	Hypertension	100	105.92	1.76	1	0.184
	Healthy	100	95.08			
Humiliation	Hypertension	100	112.20	8.85	1	0.003
	Healthy	100	88.8			
Rejection	Hypertension	100	100.58	0.001	1	0.983
	Healthy	100	100.42			
Coercion	Hypertension	100	97.66	0.51	1	0.475
	Healthy	100	103.34			
Family Disruption	Hypertension	100	110.32	6.28	1	0.012
	Healthy	100	90.8			

Additionally, Table 5 indicates that the chi-square test statistic (29.59) for psychological distress is significant at a p-value less than 0.01. Therefore, there is a statistically significant difference in mean psychological distress between hypertensive individuals and healthy individuals, with those suffering from hypertension reporting higher levels of distress compared to their healthy counterparts (Table 5 and Chart 1).

Table 5: Comparison of Psychological Distress Scores Between Patients with Hypertension and Healthy Individuals

Variable	Group Type	N	Mean Rank	Chi-Square	df	Sig
Psychological Distress	Hypertension	100	122.74	29.59	1	0.000
	Healthy	100	76.26			

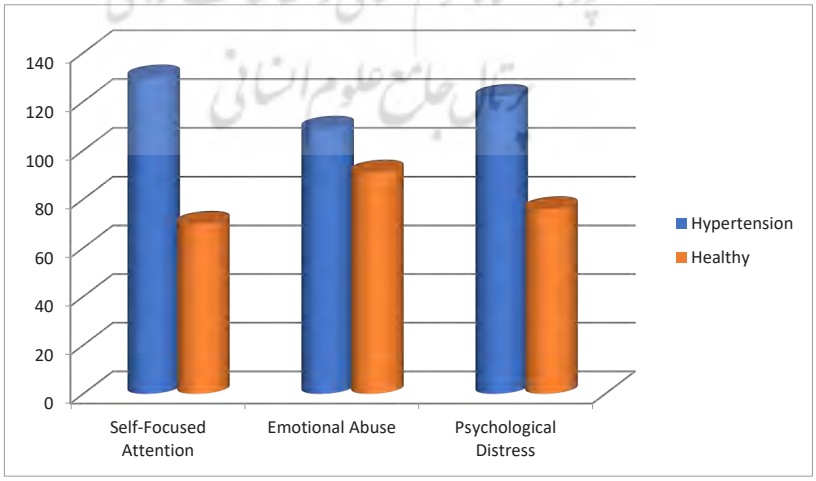

Chart 1: Mean Rank of Self-Focused Attention, Emotional Abuse, and Psychological Distress in Hypertensive and Healthy Individuals

Discussion and Conclusion

The present study was conducted to compare the levels of self-focused attention, emotional abuse, and psychological distress between individuals with hypertension and healthy individuals. The results of the study revealed that individuals with hypertension exhibit higher levels of self-focused attention compared to healthy individuals. This finding aligns with the research by Dammen et al. (2022), which demonstrated that addressing and treating self-focused attention can reduce cardiovascular and blood-related issues. It also resonates with the findings of Ishikawa and Koshikawa (2021), who reported that heightened self-focused attention is associated with depression. To interpret this finding, we can note that individuals who focus more on themselves generally display greater biases in self-related judgments. Those with physical and mental health challenges exhibit higher levels of self-focused attention. Patients suffering from illnesses like hypertension tend to anticipate negative evaluations from others and possess numerous self-centered metacognitions. Such individuals are characterized by deep attentional biases, which interfere with their ability to maintain satisfactory social functioning.

Also, Individuals with hypertension tend to be more self-sensitive, often believing they cannot engage appropriately and pleasantly in social interactions. This heightened self-focused attention amplifies self-evaluative thinking, contributing to negative cognitive patterns. Self-focused attention can intensify negative cognitions by altering attributional biases in individuals with illnesses, leading to a greater tendency toward self-blame in the context of social failures. This inclination to attribute social failures to oneself can be considered a function of self-focused attention. It fosters internal attributions for failures by increasing awareness of personal flaws, causing individuals to view themselves and their shortcomings as primary causes of adverse outcomes. Such self-awareness heightens the perception of underperformance, which, in turn, leads to increased anxiety and a heightened fear of negative evaluation.

The findings of the present study indicated that individuals with hypertension experience significantly higher levels of emotional abuse compared to healthy individuals. This aligns with the study by Nguyen et al. (2022), who found that women with hypertension reported higher levels of emotional abuse than healthy women. It is also consistent with Jiang et al. (2025), who identified emotional abuse as a contributing factor to elevated blood pressure in both European and American populations. One explanation for this association lies in the long-term psychological impact of early emotional abuse. Children exposed to emotionally abusive environments often grow up under chronic stress, both within the family and in broader social contexts. Such stressful family dynamics hinder the development of emotional security and parental bonding, leading to increased behavioral and emotional issues. Persistent parent-child conflict can result in maladaptive behaviors such as defiance, aggression, and disobedience, which may become embedded in personality traits over time. These patterns frequently carry into school settings, where affected children struggle with peer relationships and authority figures.

Later in life, these social and emotional challenges may persist into adulthood, contributing to interpersonal difficulties and sustained psychological stress. Chronic exposure to such stress is known to increase the risk of hypertension and other psychosomatic disorders. Emotional abuse also undermines a child's psychological stability, resulting in feelings of sadness, hopelessness, and depression. A particularly damaging dimension of emotional abuse is family dysfunction. Parents with psychological disorders are more prone to emotionally

abusive behaviors. Research has shown that mothers under high stress often demonstrate reduced warmth and increased irritability toward their children. Compared to non-abusive mothers, emotionally abusive mothers are more likely to experience depression, social anxiety, and low self-esteem. These findings highlight the long-term health consequences of emotional abuse, particularly when experienced during childhood. However, when analyzing specific components of emotional abuse—such as threats, distrust, rejection, neglect, and interference in children's friendships—no statistically significant differences were found between hypertensive and healthy individuals. This may be due to differences in personal coping styles, cultural perceptions of abuse, or the subjective interpretation of these experiences. It is also possible that some dimensions of abuse are perceived as less harmful and do not provoke strong emotional reactions. Furthermore, moderating factors such as age, lifestyle, and social support may influence how these dimensions affect individuals. Overall, while emotional abuse in general is strongly associated with hypertension, not all of its dimensions contribute equally to health outcomes, underlining the need for further dimension-specific investigation.

The results of the Kruskal-Wallis test revealed that the level of psychological distress is significantly higher in individuals with hypertension compared to healthy individuals. This finding aligns with the results of Loke and Ching (2022), who reported that one-fourth of patients with hypertension suffer from psychological distress. It is also consistent with the study by Eghbali et al. (2022), which demonstrated that women experiencing psychological distress struggle to manage their blood pressure effectively. Psychological distress can be described as a mental or emotional experience that disrupts an individual's daily life. It often leads to a negative perception of the environment, others, and even oneself. Symptoms such as sadness, grief, depression, anxiety, and distraction are indicative of psychological distress. Studies have shown that individuals with higher blood pressure tend to have lower quality of life and mental health compared to the general population, as well as experiencing greater death anxiety. Similarly, Huang et al. (2020) found that individuals with elevated blood pressure exhibit poorer psychological functioning, showing higher levels of psychological distress, stress, anxiety, and depression compared to others. Overall, the impact of hypertension on psychological constructs such as stress, anxiety, and psychological distress is undeniable, as confirmed by numerous studies (Huang et al., 2020). Psychological distress often causes individuals to perceive themselves as incapable of managing negative emotions. They respond angrily to stressful life events and frequently experience negative emotions such as sadness and anxiety. These emotional responses negatively affect their immune system, ultimately exacerbating their blood pressure. In summary, psychological distress not only influences emotional well-being but also has a direct physiological impact on blood pressure regulation, emphasizing the need for integrated approaches to managing both mental and physical health in hypertensive individuals.

Limitations

Among the limitations of this study is the use of self-report questionnaires, which may be subject to response bias. Moreover, the cross-sectional design prevents causal inferences between variables. Additionally, the sample was limited to a specific geographic area, which reduces the generalizability of the findings.

Recommendations

Based on the findings, it is recommended that counselors, clinical psychologists, and therapists organize educational workshops aimed at reducing self-focused attention and psychological distress in patients with hypertension. These workshops can provide tools and strategies to help patients manage their self-focused at-

tention and psychological distress effectively. Additionally, it is suggested to conduct educational workshops for families of patients with hypertension. These workshops can increase family members' awareness of the psychological and emotional challenges faced by patients and equip them to contribute to reducing emotional abuse and supporting the patients' emotional well-being. Through these collaborative efforts, both patients and their families can improve their coping mechanisms, ultimately enhancing the overall quality of life for those affected.

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