

## Correlates of psychological distress in elderly patients with congestive heart failure

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### Abstract

**Objective:** High levels of psychological distress have been reported in patients with congestive heart failure (CHF), resulting in increased morbidity and mortality. Yet, little is known about its associated factors. The purpose of this study is to identify the significant demographic, clinical and psychosocial correlates of psychological distress in CHF patients. **Methods:** Cross-sectional data were obtained from a sample of a consecutive series of hospitalized CHF patients ( $n = 227$ ) with measures of psychological distress, functional status, symptom status, social support and health perception. Objective clinical variables were obtained from the hospital records. **Results:** High levels of psychological distress, in particular, depression, were found in patients with CHF. In

hierarchical regression analysis, poorer perceived emotional-informational support, higher levels of fatigue, poorer health perception and not living with family were identified as the significant correlates of psychological distress. These correlates, in total, explained 49% of the variance for the scores of psychological distress. None of the objective clinical variables demonstrated a significant contribution that accounted for psychological distress in CHF patients. **Conclusion:** The findings highlight the importance of addressing social support for CHF patients. Assisting this vulnerable patient group to cope with fatigue and to cultivate a positive health perception are also highly prioritized treatment goals. © 2004 Elsevier Inc. All rights reserved.

**Keywords:** Anxiety; Chronic illness; Congestive heart failure; Depression; Psychological distress

### Introduction

Congestive heart failure (CHF) is a complex clinical syndrome resulting from inefficient myocardial pumping. As there are only very limited curative treatment regimes, CHF patients have to bear a chronic and life-threatening disease trajectory that is characterized by severe fatigue and dyspnea, deteriorating functional status, episodic adverse cardiac events and repeated hospital readmission [1]. Thus, it is not only physically debilitating, but also psychologically distressing. High levels of psychological distress, particularly depression, in CHF patients are well documented [2–5]. Studies examining the life experience of these patients show multiple negative emotions ranging from

anxiety, resignation, powerlessness to a strong sense of lacking of harmony and being disrupted in life [6–8].

Numerous studies suggest that anxiety and depression among hospitalized cardiac patients are predictors of poor symptom control and more functional decline in the postdischarge period [9–12]. Regardless of the disease severity, a high level of psychological distress is also a significant predictor of hospital readmission [13], poor quality of life [9,10,14] and high mortality [14–17] in cardiac patients. All these negative consequences highlight the need for a better understanding of the factors associated with psychological distress in CHF patients, especially when unrecognized distress can lead to the development of major clinical depression, which has a high prevalence in this vulnerable group [18–20].

The psychological adaptation of CHF patients to the disease course is a complex process, not only determined by the clinical status, but also influenced by demographic and social factors. However, the influence of such factors on the psychological status of CHF patients has seldom

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been examined. Rather, the focus has been placed on identifying the independent relationship of psychological status with either social or clinical variables, or on comparing characteristics of depressed CHF patients with nondepressed counterparts.

Among all the variables, the influence of social support on the psychological status of patients with cardiac disease or CHF has been studied. High levels of perceived social support confer protection from both depressive symptoms [21,22] and clinical depression [23]. Various types of social support also exert different psychological effects [24]. While emotional support determined higher life satisfaction and more positive affect in community-dwelling CHF patients, tangible support was found to relieve psychological distress. Other studies have demonstrated the influence of social network characteristics on the emotional status of cardiac patients: Those living alone [25] or without spouse [26] had greater psychological distress. These findings concur with the well-hypothesized buffering role of social support in helping CHF patients to cope with the stress associated with the debilitating disease.

The relationship between clinical and psychological status is less clear. For example, patients with CHF or other cardiac diseases who report more severe symptoms of fatigue and dyspnea have higher levels of psychological distress [24,27]. Whether such a relationship is mediated through the compromised functional status of the patients as a result of the clinical symptoms [7,8,28] or occurs when the debilitating symptoms diminish the sense of physical integrity of CHF patients [29] is unclear. As for functional ability, it appeared to have more evident relationship with psychological status when it was measured as patients' perception of limitation in performing daily functioning, rather than with objective methods [19,30]. This indicates the important role of the patients' perspective of their own health status in affecting psychological well-being. A number of studies support this proposition and provide inconclusive evidence with regard to the relationship between psychological distress and other objective clinical variables, such as ventricular ejection fraction, the number of comorbidities, the number of medication and the use of beta-blocker [20,31,32].

Among the demographic variables, the effect of gender on the psychological distress of CHF patients was consistently highlighted, with women reported higher levels of anxiety and depression than men did [33,34]. This effect was explained as a result of female patients' unfavorable anatomical and hormonal factors, higher vulnerability for comorbidity, as well as more negative perception of illness and symptoms [35,36]. In addition, gender role, which prescribed a set of socially acceptable behavior, attitude and traits for different genders [37], also led to sex differential in depressive symptom reporting, with females tending to disclose more of their psychological symptoms [38,39]. Although other demographic variables, including lower income, lower educational level and younger age, were

shown to expose cardiac patients to greater emotional disturbance [40], their effects were less conclusive for CHF patients [3,20,24].

Information about the relative importance of social, clinical and demographic factors in accounting for the psychological distress of CHF patients is important for identifying CHF patients who are at risk of developing psychological morbidity and for providing guidance for interventions to ameliorate adverse factors. The purpose of this study is to identify the social, clinical and demographic correlates of psychological distress of CHF patients. Nineteen variables that have been theoretically or empirically justified in previous studies as relevant are included. These variables are age, gender, marital status, living arrangement, educational level, income, number of comorbidities, years with CHF, number of medications, use of beta-blockers, functional status, health perception, dyspnea, fatigue, tangible support, affectionate support, social interactional support, emotional-informational support and size of social network.

## Methods

### Participants

Patients admitted with an index diagnosis of CHF as recorded in the hospital record were recruited from the medical unit of a university-affiliated hospital in Hong Kong. The validity of the diagnosis of CHF was ascertained by using the Framingham criteria, based on the patients' symptoms and radiological findings [41]. To be eligible, the patients were aged  $\geq 60$  years, Chinese speaking, able to communicate, with intact cognitive function, as indicated by the Abbreviated Mental Test score (Hong Kong version) of 6/10 [42], had no psychiatric illness and had not been planned for any surgery or invasive cardiac procedure. The age eligibility allowed a more representative sample for CHF patients, as the epidemiological trend of this disease usually demonstrated a striking rise from the age of around 60 onwards [43,44]. The different psychological reactions between the younger and older CHF patients [45], resulting from the somewhat differences in the disease etiology, role and social functioning, further prompts the need to exclude the minority younger CHF patients from analysis.

Of 553 CHF patients consecutively admitted to the study setting, 207 patients were excluded because of cognitive incompetence, sensory defect, language barrier, psychiatric illness or planned invasive cardiac procedure or surgery, including PTCA and cardiac catheterization, 17 died or were transferred to the intensive care unit during hospitalization, 34 were not screened because of early discharge, and 68 refused to participate. To determine the adequacy of the sample ( $n=227$ ) for performing multiple regression, the thumb rule of  $50+8m$ ,  $m$  being the number of potential correlates, was used [46]. As there was a total of 19

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