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Ekanem, M.A., Smith, J.M., Robertson, S. [orcid.org/0000-0002-5683-363X](https://orcid.org/0000-0002-5683-363X) et al. (2 more authors) (2017) Seeking counselling for mood disorders in a cardiac centre: a pilot survey of patients' views. *Annals of Nursing and Practice*, 4 (2). 1080. ISSN 2379-9501

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## Research Article

# Seeking Counselling for Mood Disorders in a Cardiac Centre: A Pilot Survey of Patients' Views

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**Submitted:** 06 March 2017

**Accepted:** 29 June 2017

**Published:** 30 June 2017

**ISSN:** 2379-9501

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**Keywords**

- Cardiac care
- Counselling, depression
- Mood disorders

**Abstract**

Research suggests a relationship exists between patients with ischemic heart trauma, and mood disorders and that there is therefore a need for psychosocial assessment and, where necessary, treatment for these disorders among heart attack patients [1]. Yet, assessment and treatment for mood disorders is rarely a priority in the cardiologist's office. Thus, counselling therapies for cardiac patients with co-occurring mood disorder are rarely considered or addressed in the cardiologist's office. This study sought to investigate whether cardiac patients would use counselling services if offered in the cardiologist's office. Results suggested mixed sentiments regarding counselling treatment for mood disorders in the cardiologist's office, particularly with regard to sex-differences. Discussion focuses on these sex-differences and the role aspects of 'gender' and 'masculinity' may play in accounting for such differences. The paper also discusses the significance of age differences. Implications for interdisciplinary collaboration are presented.

**INTRODUCTION**

The emergence of research suggesting the relationship between myocardial infarctions, ischemic heart disease/trauma, and mood disorders continues to abound [1-4]. In addition, there is evidence that depression is an independent risk factor for subsequent myocardial infarctions, disease complications, and increased mortality [2,5-7]. These data therefore suggest that a pressing need exists for psychosocial assessment and treatment for mood disorders and distress among cardiac patients [1]. Despite this identified need, a recent study indicates that while cardiologists recognize the reality of the relationship, mood disorders, and especially depression, are not screened for in the cardiologist's office [7]. Suggested factors preventing depression screening in the cardiologist's office include, time constraints and the propensity for cardiologists to view depression screening and treatment as 'low priority' compared to other aspects of their work [7]. Currently therefore, whilst it is recognized that cardiac patients with co-occurring mood disorders could benefit from therapeutic counselling services for screening and treatment purposes when in the care of their cardiologist, such services are not frequently offered or delivered in the cardiologist office setting.

A case has previously been argued for the role that various health professionals might play in facilitating access to counselling services within an interdisciplinary team, particularly in cases where the patient group are predominantly male as with cardiac disorders [8,9]. This work suggests that the

role counsellors might have as part of such a team could free up time for other team members, ensure the most appropriate use of skill sets within the clinical setting, and thereby optimize patient experience and treatment.

At present, however, little is known about patient desire or acceptability of counselling provision within the cardiologist office setting. This paper reports on findings from a pilot study survey on the desire for counselling, whether such a service would be taken up, and if the timing of such a service in relation to scheduled appointments is important. In discussing the findings, we pay particular attention to sex differences in survey responses and give some consideration to age differences.

**METHODOLOGY****Participants**

Two-Hundred (200) randomly selected implantable defibrillation patients from a cardiac centre at a local training hospital were invited to participate in this study. Of the 88 who completed and returned the survey, 67 (76.1%) were male and 21 (23.9%) were female. The mean age was ( $m=63.4$ ) years. Approximately 41% of patients live in rural Nebraska and Iowa towns. Ninety-seven percent (97%) of the defibrillator patients from this centre are Caucasian, and although the survey did not request racial identification data, it is expected that the sample accurately represents the population from which it emanates. All of the participants were defibrillator implant patients currently under cardiac care and observation.

## Instruments

A four (4) question *Counselling Survey* (see Figure 1) was developed for the purpose of this study. Using nominal data format, the four questions focused on the patients' decision to avail themselves of counselling services in the cardiologist's office if the services were offered. The researchers are aware that this instrument has not withstood the rigors of validity and reliability testing; however, they deemed it appropriate for this pilot study purpose.

## Procedure

After securing approval from the Cardiac Centre Research Committee and the local Institutional Review Board, the first author secured locater information for 200 implantable defibrillator patients. Implantable cardioverter defibrillator (ICD) patients have been identified as a group of patients with high prevalence rates for mood disorders. The Cardiac Centre administrators granted permission for the selection of only 200 of 500 ICD patients to be surveyed. A random table of numbers was used to select the 200 patients. The patients were sent a packet containing a letter explaining the purpose of study, invitation to participate, the actual survey, and a stamped-return envelope.

## RESULTS

Eighty-eight ( $n=88$ ) respondents returned surveys. This represents a 44% response rate which is just below average but acceptable for survey research that does not use reminders [10]. The responses for each question by sex are presented below.

As a result of the preliminary analysis of the data it is apparent that mixed sentiments abound, but before concluding the obvious, that more participants expressed sentiments of

rejection of counselling services, a further understanding of the data is warranted.

There were one hundred-twenty-eight (128) "yes" responses to the questions related to availing oneself and the benefit(s) of counselling services, along with the 201 responses to the contrary. Over 40% of patients therefore felt that they would benefit from counselling, would take advantage of the opportunity to talk to a counselling professional at the Cardiac Centre, and would be willing to add an hour to their visit to the centre in order to do so. Approximately 30% of patients would be willing to make a specific and separate visit to the Cardiac Centre to see a counselling professional. Men would be less likely than women to see themselves as benefiting from counselling or take advantage of opportunities to see a counsellor. Nevertheless, one third of men expressed positive sentiments about counselling, while over a half of the women responded positively to three of the four questions posed.

The responses to question one by age and sex are presented below.

It is apparent from Figure 3 that sex differences in positive responses to counselling remain across all age groups. However, the largest sex difference in positive responses is found within the over 75yr age group. Overall, the most positive responses to counselling were found within the 65-74yr age group with similar overall rates being found amongst the other two groups; though, as stated above, this overall rate hides significant sex-differences between these two groups.

## DISCUSSION

In this study as in others, [11] the voice of a group of older

**Counselling Survey**

Directions: Please answer the following questions by placing an "x" in the box that identifies your answer choice. When you complete the survey, please return it to us in the return envelope. Your responses will remain anonymous.

Demographics:

Gender:  Male       Female

Age:             <50       50-65  66-75  >76

1.      If a counselling professional were available at the Cardiac Centre to discuss any issues related to stress, anxiety, or depression would you take advantage of the services?
 

Yes                       No
2.      Would you stay an extra hour during your regular visits to receive counselling?
 

Yes                       No
3.      Would you come in to the Cardiac Centre at other times to receive counselling?
 

Yes                       No
4.      Do you feel counselling may be of some benefit to you?
 

Yes                       No

**Figure 1** Counselling Survey.

Question one: <i>If a counselling professional were available at the Cardiac Centre to discuss any issues related to stress, anxiety, or depression, would you take advantage of the service?</i>			
	Yes	No	
Male	23	41	= 64 male responses
Female	13	8	= 21 female responses
Total	36	49	= 85/88
Question two: <i>Would you stay an extra hour during your regular visits to receive counselling?</i>			
	Yes	No	
Male	22	41	= 63 male responses
Female	11	7	= 18 female responses
Total	33	48	= 81/88 (4 responded, "...I don't know")
Question three: <i>Would you come in to the Cardiac Centre at other times to receive counselling?</i>			
	Yes	No	
Male	17	44	= 61 male responses
Female	7	11	= 18 female responses
Total	24	55	= 79/88
Question four: <i>Do you feel counselling may be of some benefit to you?</i>			
	Yes	No	
Male	24	41	= 65 male responses
Female	11	8	= 19 female responses
Total	35	49	= 84/88

Figure 2 Survey Questions and Responses.

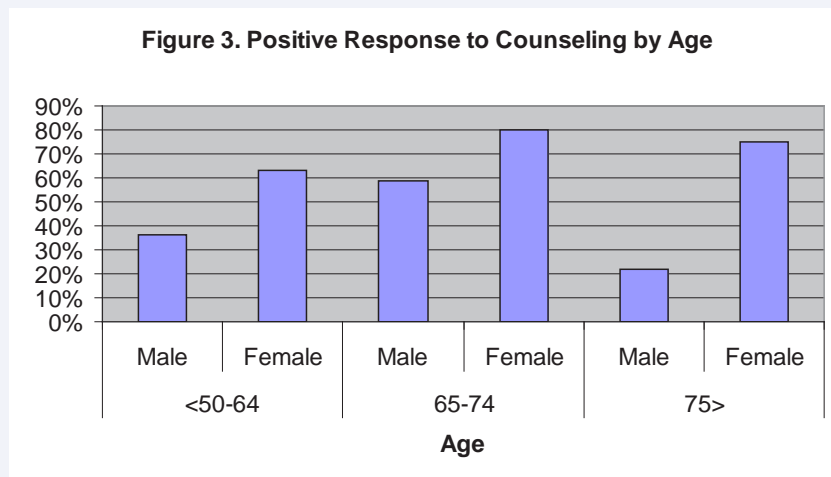
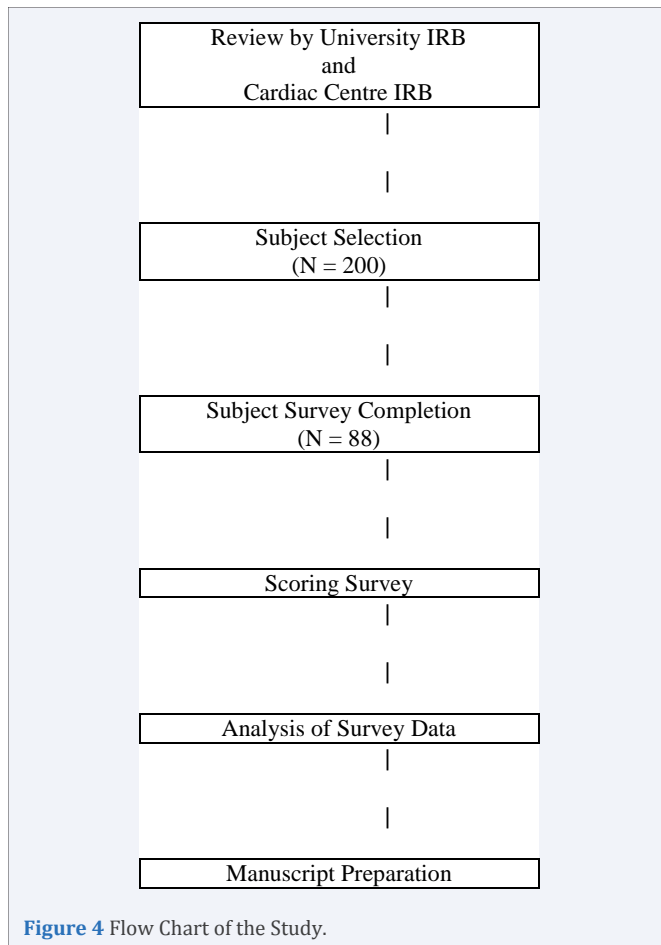


Figure 3 Positive response to counseling by age.

patients and their choice of counselling and psychological services suggested that a significant number would be amenable to counselling/psychological support services. Yet, this profile is not spread evenly across age and gender.

At all ages, and across all four questions, there is a significant difference in responses from men and women. Previous research has shown a variety of gender differences in men's and women's experience of cardiac events, use of cardiac rehabilitation services, and use of mental health services [12-14]. It could be that the gender differences in amenability to engaging with counselling services found in this study simply represent sex-differences in psychosocial morbidity in this group of patients; that is, there is less psychosocial morbidity amongst men therefore less need/desire to seek counselling services. Some previous research has suggested that this may be the case with greater psychosocial morbidity being found in women entering cardiac rehabilitation

programs [15]. Yet, it is also likely to be linked to constructions of masculinity where men are expected to be strong, rational, stoical and emotionally contained [16]. Such constructions carry with them a specific reluctance in some men to engage with mental health services [17] and even reluctance on the part of health professionals to label men as 'depressed' [18] – and conversely a possible tendency to over diagnose women. The most significant sex-differences in positive responses to counselling found in the over 75yr age group (Figure 3). Perhaps give some suggestion that such constructions of masculinity were more strongly held in the older generation of Midwestern-Americans who were required to be even more autonomous, self-sufficient, and less reliant on professional support for non-physical concerns. Despite this, one should not assume that such social constructions are permanent barriers to men's engagement, as other research around male depression has shown that, identities continue to



**Figure 4** Flow Chart of the Study.

form and re-form in light of personal ill-health experiences [19] and there is not a straight forward relationship between gender and engagement with mental health services [20].

Those who responded positively – over half of the women and a third of the men – may be at a point where desperation for relief from psychosocial symptoms has facilitated a break with conventional suspicion for mental health care providers. In addition, physicians have previously indicated that ‘normalising’ assessment for mental health concerns through incorporating it into regular appointments could reduce the stigma and fear attached to expressing such concerns [8]. Distance could also have been a contributor to some negative responses. The rural nature of the study area means that some attendees are likely to live more than an hour’s drive from the centre, making it inconvenient to come early, stay later or attend counselling at a time not related to their scheduled appointment. Future studies in this field should include data collection that will facilitate analysis of the correlation of distance from the centre with willingness to see a counsellor.

### Implications

The benefit of this study with its limited sample and response size raises issues beyond the yield of the results. In view of previous research evidence, it seems appropriate to utilize mental health counsellors as adjuncts in the treatment of patients with cardiovascular disease and depression [21]. Mental

health counsellors can be identified as potential interdisciplinary colleagues and supporters to cardiologists, cardiac nurses, and cardiac patients. Indeed, previous research suggests that physicians would value such counselling support to complement the skills available within an interdisciplinary team setting [8]. The counsellor, employing a series of evidence-based and gender-sensitive interventions can provide a valued service that has quality and length of life implications for the patients, as well as cost-prohibitive implications and considerations for the cardiologist and cardiac patient as we outline below.

Recent studies have documented the effectiveness of mental health provider interventions in treating depression [22]. Given that there is also ample research evidence supporting a relationship between mood disorders and premature morbidity and mortality in cardiac disease [23-27] it seems clear that effective interventions to address these can improve both quality and length of life. Although additional training for mood disorder screening and treatment are inferred here, what is perhaps more feasible is the interdisciplinary collaboration and infusion of mental health counsellors into the comprehensive treatment process. The cardiologist and nurse can continue providing the specialized care required, while the counsellor attends to the mood disorder screening and treatment.

In economic terms, if cardiac patients have a greater chance of well-being, morbidity and premature mortality complications due to the prevalence of mood disorders, then addressing the mood disorder(s) with positive counselling/psychology interventions [28] can mediate the mood disorder(s), and lessen the health complications, premature mortality, and subsequent additional medical costs [29]. A growing body of research continues to emerge supporting the belief that early intervention and prevention of mood disorders for older adults with medical health problems is efficacious, and multidisciplinary teams are best suited to provide the most comprehensive care [30]. Because research also supports the belief that high levels of phobic anxiety are related to sudden cardiac death for women and men, [31] attention must be given to the cost prohibitive considerations of prevention and early screening and treatment of which counselling intervention could form a significant part.

### CONCLUSION

A continuing challenge for cardiac teams has been how best to assist heart injury, illness, and diseased patients in achieving maximum health while navigating and negotiating the complexities of physical ill-health, with other life events and changes during and after physicians’ therapeutic interventions. There is a requirement to recognize the multifaceted mind-body and psychosomatic interconnections and to specifically address the connections between mood disorders and ischemic heart events, myocardial infarctions, and congestive heart disease. We suggest, following previous research, that the mental health counselling professional can be a valuable member of a multi-disciplinary team that can help recognize these connections and assist recovery and rehabilitation through added therapeutic interventions. The counsellor supports the cardiac treatment team by assisting in the identification, screening, and employing evidenced-based treatment for the mood disorders thought by many to contribute to the post complications and of time’s

premature morbidity and mortality of some ischemic heart event, myocardial infarction, and congestive heart disease patient.

The pilot work presented here suggests that many cardiac patients would be receptive to the provision of counselling as a valuable adjunct to current treatment. However, the acceptability of counselling does vary by age and particularly by gender. Recognizing gendered differences in amenability to receive counselling services, and how these might be addressed, are therefore of utmost importance and future research needs to consider in more detail if different settings or approaches may be more acceptable to men and to women if counselling input and its proven benefits are to be maximised. Although this study topic would benefit from an expansion of the survey form and multi-centre replication to insure larger sample and response size, this pilot study identifies a critical issue in the context of counselling and interdisciplinary partnerships to providing a comprehensive care plan to their cardiac patients. We therefore suggest that assessing for mood disorders and offering referrals to mental health counselling for the cardiac patients with such co-morbid mood disorders should become routine procedure and part of a minimum standard of care.

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**Cite this article**

Ekanem MA, Smith JM, Robertson S, Dickel CT, Rovang K (2017) Seeking Counselling for Mood Disorders in a Cardiac Centre: A Pilot Survey of Patients' Views. *Ann Nurs Pract* 4(2): 1080.