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Seek and You Will Find

Rozanski (1) reported in the July 8, 2014, issue of the *Journal* the need to integrate into cardiology practice awareness of the impact of the psychosocial risk factors on heart health and the need for effective interventions for relief of suffering in patients so affected. Although not named as such in his article, Rozanski's category "lack of sense of purpose" falls well into what is classified as "spiritual distress," according to 2009 palliative care guidelines (2). That 2009 clinical consensus report advocated that psychosocial and spiritual distress in patients should be treated with the same intent and urgency as the treatment of pain and any other medical problem. Healthcare professionals representing 27 countries recently suggested that "Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred" (3).

Is it time that we acknowledge and address, not only the psychosocial risk factors, but also spiritual distress among the issues that potentially influence outcomes in our patients with heart disease? We investigated these "matters of the heart" in patients attending cardiac outpatient rehabilitation (COR) at our hospital. We report here data on our 3-year prospective observational study of 438 patients in COR, suggesting that both psychosocial and spiritual distress were not only present and readily detected among our patients, but also resulted in an apparent impact on clinical outcomes.

We used relatively simple tools, easily applicable in the COR setting, including validated, self-administered psycho-social-spiritual questionnaires, such as the PHQ-9 for depression, at entry and exit to detect patients who suffered from moderate or greater psychosocial and/or spiritual distress (PSSD). Brief spiritual assessment by interview was included in the physician's initial medical history. For these 438 patients (247 men, 191 women; mean age 63 ± 12.1 years), who had recently experienced acute cardiac events, such as angioplasty/stenting (61%) or bypass grafting/valve surgery (43%), our testing tools suggested that a substantial number (38%) of our patients had PSSD at the time of entry into COR. Published reports have not only indicated that patients with psychological illness, such as major depressive disorder (MDD; which we found in 16% of our patients), but also those with spiritual distress (SD; present in 8% of our subjects) often have poor clinical outcomes and even increased mortality (4).

Lack of compliance to treatment programs is a factor among patients with psychosocial illness that is reported to increase risk of poor clinical outcome (5). Our data are consistent with such findings, suggesting that of the 71 patients who met the criteria for MDD (so classified by a score of 10 or more on PHQ-9) at entrance into COR, had a significantly ($p < 0.02$) higher dropout rate (43%) than patients who were nondepressed at entrance (29%). Whereas the number is small (8% of our study population), patients with SD at entry into COR had a significantly ($p < 0.04$) higher dropout rate (47%, or 17 of 36) than those with no SD at entry (30%, or 114 of 382). The odds of dropping out were more than 2 times greater (odds ratio: 2.1, 95% confidence interval:1.06 to 4.09) for those with SD than those without SD.

Although the generally accepted guidelines for cardiac rehabilitation programs recommend being aware of psychosocial needs and making appropriate referrals of such patients, we believe SD also needs inclusion in that awareness. There are no established treatment options for PSSD patients in COR, beyond referral. Of the 71 patients with MDD, 46, or 65%, were on no antidepressant therapy at entry to COR. We found trends toward improvement in both MDD (34 of 38, or 89%) and SD (10 of 18, or 56%) patients who completed COR. There is important need for research, not only to increase awareness of and assessment for PSSD, but also to develop interventions that prevent PSSD patients from denying themselves the hoped for benefits (including reduced 5-year mortality of at least 25%) that are expected from participating in COR.

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REPLY: Seek and You Will Find

I thank Dr. Gillilan and colleagues for their interest in my paper (1).

A wide variety of psychosocial factors promote coronary heart disease, including negative emotional states, such as depression, negative cognitive states, such as pessimism, chronic stress, and poor social support (1). These risk factors exert their effects through a variety of pathophysiological mechanisms (2) and the adverse effect of the risk factors upon health behaviors. More recently, having a sense of life purpose or meaning has been identified as another determinant of health and illness. The potential importance of purpose and meaning was popularized years ago by Dr. Victor Frankl, the 20th century psychiatrist who survived the Nazi concentration camps during World War II. As described in his book, *Man's Search for Meaning*, the slim chances of surviving the death camps belonged to those who were able to find either a sense of meaning in their experience or hold on to the hope of re-uniting with a loved one (3). Years later, Ryff and Keys (4) proposed that a sense of purpose is a basic psychological need that promotes vitality and initiative when present, and produces tension when lacking. The medical study of life purpose is only recent but consistently demonstrates that a lack of life purpose increases the risk for all-cause mortality or cardiovascular events (1).

Dr. Gillilan and colleagues suggest that a lack of purpose falls into what has been classified as "spiritual distress" by palliative care guidelines, spirituality being characterized as a dynamic whereby people "seek ultimate meaning, purpose, and transcendence." More precisely, logic suggests that individuals may pursue various levels of meaning which tend to vary over a person's life span. These range from the pursuit of physical needs, to social needs, altruistic goals, seeking creative endeavors, and transcendental pursuits. This notion, in fact, has been suggested by McGregor and Little (5), who note that young adults can be well satisfied with the mere accomplishment of "doing" goals (termed as a need for "efficacy"), but that as people age, they tend to acquire an increasing need to pursue goals that provide a sense of deeper personal growth and discovery (termed as a need for "integrity"). Further, as Dr. Gillilan and colleagues suggest, when individuals become ill, this can also produce soul searching and a "spiritual distress," which may sometimes become quite patent and potent, as any sensitive caregiver may well recognize.

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