Identifying the health and mental health information needs of people with coronary heart disease, with and without depression

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Abstract

Objective: To identify the health and mental health information needs of people with coronary heart disease (CHD), with and without comorbid depression.

Design and setting: A qualitative study conducted in Melbourne in 2006, using thematic analysis of semi-structured interviews on the types of health information that patients with CHD considered useful to assist with the management of their illness. Structured clinical interviews were used to assess current and prior depressive episodes in these patients.

Participants: 14 general practice patients (eight with current or prior history of major depression) who had experienced myocardial infarction, coronary artery bypass graft surgery, angioplasty or angina (confirmed via testing).

Results: Four themes relating to information on how patients could manage their cardiovascular health and improve their psychosocial wellbeing emerged: psychosocial; physical activity; medical; and information for family. The most prominent information needs included identification and management of risk-related physical symptoms, and psychosocial information, most notably to enhance patients' social support. Patients considered this information important for alleviating health anxiety and negative affect.

Conclusion: This small patient sample endorsed the need for health and mental health information on a range of psychosocial and physical health topics. Participants desired specific types of information to assist with the self-management of their health and to assuage their health concerns.

METHODS

Participants
The study was conducted in 2006, and was promoted directly to GPs in metropolitan Melbourne through presentations conducted by one of us (C.P) at several mental health training programs for GPs provided by the Victorian Divisions of General Practice, and by advertisements in print media such as newsletters of the Royal Australian College of General Practitioners. GPs who indicated an interest in participating were mailed written materials about the study and were contacted by telephone or in person to discuss referral of patients to the study.

Two GPs searched their patient databases to identify potentially eligible patients who met one or more of the study's criteria for CHD: myocardial infarction, coronary artery bypass graft surgery, angioplasty or angina (confirmed through testing). The GPs posted letters to the identified participants informing them of the study and asking them to contact the research officer if they wished to participate. Of these patients, 20 consented to participate. Four later withdrew (reasons not provided), leaving a total of 16 participants (14 men and two women). However, as prominent themes emerged from interviews with the first 14 participants, the remaining two men were advised that their participation was no longer required.

Measures

MINI Plus
The Mini International Neuropsychiatric Interview (MINI) Plus is a brief, structured clinical interview to assess Axis I disorders from the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) and the International classification of
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diseases, 10th revision (ICD-10), and one personality disorder. It includes questions to
differentiate disorders of organic origin or those due to alcohol or drug use.18 The
MINI has high validity and reliability and can be administered within 20 minutes.

Interviews
Interviews designed to obtain qualitative data were conducted in a private room and
took about 40 minutes to complete. The interviews were semi-structured, in that the
interviewers were guided by a series of open-ended questions supplemented by
spontaneous probes. Information was requested about patients' current access to
health information and the type of information they would find useful to help them
manage their heart health, including their physiological and psychological wellbeing.
The interviewers encouraged participants to talk freely about the subject matter but
redirected participants who deviated from the purpose of the interview.

Procedure and analysis
The study was approved by the Monash University Human Research and Ethics
Committee. Participants completed the clinical diagnostic interview (MINI) by tele-
phone after giving informed consent. On a separate day, each patient met with two
investigators (CP and JLF) to complete individual semi-structured interviews.

All semi-structured interviews were performed in a standardized manner, audio-
taped, transcribed verbatim after removal of identifying information, and analysed by
an independent investigator (KAS) using the thematic approach. Subsequent exami-
nation of the analysis by CP and JLF verified concurrence of the key themes
identified.

RESULTS

Complete data were collected for 12 men (mean age, 67 years) and two women (mean
age, 81 years) with CHD. Demographic and health characteristics of the participants
are shown in the Box. Eight participants had a current diagnosis or prior history of major
depression, as assessed by the MINI.19

All participants endorsed the view that further provision of health information
would be useful in helping them manage their CHD or psychosocial wellbeing. Four
common themes of information topics emerged from the data, categorised as: psy-
chosocial; physical activity; medical; and information for family.

Characteristics of the 14 participants

<table>
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<td>≥80</td>
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</tr>
<tr>
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<td>Type 2</td>
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<td>12</td>
</tr>
</tbody>
</table>

Psychosocial

Depression

Six participants indicated that information on depression would be useful for them-
selves or others with CHD, particularly information about how to recognise and
manage depressive symptoms and about the relationship between depressive symptoms
and physical health.

I've suspected for quite a number of
years that I've probably suffered depres-
sion, sort of apprehension, if you like, in
a way subsequent to that event [heart
attack].

Patients also suggested provision of information about particular strategies for
managing depression, such as positive self-
statements and a logbook to record activities
to stay motivated. Information on where to
seek help for depression was also considered
important, although most patients indicated
that they had not sought such information.

[Interviewer] Have you ever sought any
other information about the depression?
[Patient] No, not really. I've often won-
dered where one could gain some fur-
ther direction from it... I wouldn't
know where to go, to be quite honest.

Social isolation

Five patients expressed the view that social
connectedness is important, either in help-
ing them to manage depressive symptoms or
to gain support and understanding about
their medical condition from other people
with CHD. Several patients in this group
indicated the need for information on how
to establish social networks and access
appropriate social and support groups.

I suppose you gotta learn to get out and
do things and be faced with other people...
So those sort of things, it might be
hardly if that was sort of indicated...
[that] social support might be sort of
remedial treatment in depression...

Anger

Four patients reported feelings of anger or
irritability either soon after their first cardiac
event, or later, in relation to the burden of
managing their illness medically. They sug-
gested that information about how to iden-
tify precipitating symptoms of anger and
anger management would be useful.

Physical activity

Four participants reported a need for informa-
tion on physical activity, such as how
much postoperative exercise is too much.
Patients reported a need for information on
how to reduce their activity without stop-
ping altogether, and how to safely reintro-
duce physical activity and exercise options
after a cardiac event. They stated that this
information needed to be relevant to indi-
vidual variations in disease severity.

Medical

Nine patients reported a need for medical
information, particularly to assist in allevi-
ating anxiety levels. The suggested informa-
tion could be grouped into the two areas of
symptoms and prognosis, and surgery.

Symptoms and prognosis

Patients wanted information about symp-
toms that might occur, rather than only
those that will occur. They also endorsed
the need for information about how to deter-
mine when particular symptoms indicate
the need for medical assistance, such as
calling their GP or presenting to a hospi-
tal emergency department. Interviewees also
expressed a need for information about what
to expect regarding disease progression
and prognosis, and prevention of further adverse
cardiac events. Several also wanted statisti-
cal information, such as survival rates.

The most common experience regarding
anxiety, reported by eight patients, pertaining
to uncertainty about how to interpret physi-
cal symptoms. Patients indicated that
information about whether certain physical
symptoms are normal or a sign of an
impending cardiac event would help alleviate
their anxiety. For this reason, they also requested more information about medical procedures, as expressed by one patient:

The other thing, I suppose, that sort of causes anxiety is, how often can they do this sort of thing? How many stents can you actually have? I think that sort of information would be helpful to know, to at least sort of negate the anxiety...

The need for medical information relating to anxiety and depression was more frequently endorsed by participants who had experienced multiple cardiac events, compared with those who had experienced one.

Surgery
Four patients reported a need for more information before and after surgical intervention. They wanted procedural information to inform them of exactly what would happen during the operation and what to expect when waking from anaesthesia, particularly regarding the use of medical equipment such as respirators.

Information for family
Nine patients reported that information for family members and spouses would be useful. In particular, patients wanted information pertaining to the psychological aspects of the illness, such as how the patient might react emotionally to an adverse cardiac event or medical procedure. Information about how family members and spouses could manage their own anxiety about their loved one’s illness was also suggested.

DISCUSSION
This small sample of primary care patients with CHD in metropolitan Melbourne endorsed the need for health and mental health information to help them self-manage their physical and psychosocial health.

It is notable that most patients expressed the view that information about how to manage risk-related physical symptoms would alleviate their health anxiety. This finding suggests that improvements in subjective psychosocial wellbeing may result if this information is readily available to patients. The provision of such information may enhance patients’ perceived control over their medical condition.

Secondary prevention of CHD, including behavioural counselling, is primarily managed by GPs. However, time limitations and other constraints on GPs often preclude systematic provision of secondary prevention. This, combined with relatively low rates of attendance at cardiac rehabilitation programs, limits the opportunity for people with CHD to gain access to health and mental health information resources.

GPs need to be assisted to improve the health and mental health literacy of patients with CHD, which may in turn enhance patients’ self-management of their chronic illness. For example, affording GPs direct access to a range of health and mental health resources for patients may be useful. Such resources may provide patients with guidance on the self-management of various health concerns. The provision of health information tailored to the specific needs of individual patients is likely to be the most effective strategy. Therefore, innovative approaches, such as the use of technology for information delivery, may be required.

COMPETING INTERESTS
None identified.

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