



Relationships Between Illness Perceptions, Coping and Psychological Morbidity in Kidney Transplants Patients



Simon R. Knowles, PhD, David J. Castle, MD, Shellie M. Biscan,
Michael Salzberg, MD, Emmett B. O'Flaherty, RN
and Robyn Langham, PhD

ABSTRACT

Background: The aim of this study was to explore the effect of kidney transplantation (KT) on psychological distress and quality of life (QoL) in patients with end-stage kidney disease using the Common Sense Model of illness adjustment.

Materials and Methods: A total of 52 individuals (35 men and 17 women) with an average age of 53.54 years from a large metropolitan nephrology outpatient clinic participated.

Results: Poorer health status, illness perceptions and increased engagement in maladaptive coping were associated with psychological distress (specifically anxiety and depression) and poorer QoL. Hierarchical regression, after correcting for KT characteristics (years since most recent KT, number of transplants) indicated that poorer illness status and illness perception predicted QoL. After controlling for KT characteristics, poorer illness status and greater engagement in maladaptive coping predicted depression. In contrast, poorer illness perceptions and greater engagement in maladaptive coping predicted anxiety. Adaptive problem-focused and emotion-focused coping styles were not found to predict anxiety, depression or QoL.

Conclusions: The finding of the present study emphasize on the importance of exploring and understanding the effect of illness status, illness perceptions and coping patterns in patients who have underwent KT.

Key Indexing Terms: Anxiety; Depression; Coping; Kidney transplant; Quality of life. [Am J Med Sci 2016;351(3):233–238.]

INTRODUCTION

Impaired kidney function, or chronic kidney disease, is increasing in prevalence in our community. In some cases of chronic kidney disease, the loss of kidney function is progressive leading to permanent kidney failure, or end-stage kidney disease (ESKD), when life-sustaining renal replacement therapy is required, either in the form of dialysis or kidney transplantation (KT). Incident and prevalence rates of ESKD vary worldwide¹ as does the rate of KT in these groups. KT is accepted as the best form of treatment for those with ESKD without contraindications, allowing improved life expectancy, quality of life (QoL) and reduced cost to the community.² In spite of the marked benefits of life with a kidney transplant over that of long-term dialysis, patients with post-KT still experience ongoing health-related problems such as medication-related side-effects, pain, sleeping difficulties and sexual dysfunction³; hence, the problem that many KT recipients have ongoing psychological symptoms. It is well documented that dialysis patients experience higher levels of psychological distress than healthy controls, with approximately 20–30% of patients experiencing depression⁴ and 38% of patients suffering from anxiety.⁵ ESKD has also been shown to be related to poorer QoL.^{6,7}

Post-KT cohorts have also been shown to experience ongoing anxiety and depression,^{3,8} and although they may experience better post-KT QoL, overall QoL is still lower than the general population.^{9–11}

Several factors are likely to be associated with QoL and illness outcomes in patients with KT, including individual illness perceptions and coping styles. Leventhal and Meyer¹² have identified several aspects of illness perceptions, including identity (medical diagnosis and related symptoms), consequences (how the illness is perceived to effect a person's physical, social and psychological well-being), causes (factors relating to the onset or have an effect on the illness), timeline (whether it is a chronic, acute or cyclical illness) and cure or control (perceptions of whether the illness can be controlled or cured). Patients with ESKD with poorer illness perceptions report reduced QoL^{13–15} and in turn increased psychological distress.¹⁶ Similarly, KT cohorts with more negative illness perceptions have also been shown to report reduced QoL and increased psychological distress.^{17,18}

Individual coping patterns have also been identified to mediate illness outcomes^{19,20} For example, Patients with KT who employ avoidance or maladaptive coping styles (eg, wishing the problem away) have poorer QoL

and increased psychological distress whereas adaptive focused (primarily emotion based) coping styles (eg, problem solving, getting advice from others) are associated with improved QoL and reduced psychological distress.²¹⁻²³

The Common Sense Model (CSM), developed by Leventhal and Meyer,¹² provides a theoretical framework explaining the interrelationships between illness status, illness perceptions, coping styles and illness outcomes (including anxiety and depression). The CSM suggests that an individual's illness status has a direct effect on illness perceptions. Subsequently, illness perceptions have a direct effect on an individual's coping styles and illness outcomes, whereas coping styles also mediate the relationship between illness perceptions and illness outcomes. Numerous chronic illness studies have provided evidence that for the efficacy of the CSM.²⁴ However, the utility of the CSM in patients with KT has not hitherto been evaluated.

The aim of the current study was to explore the utility of the CSM in a group of kidney transplant patients. We hypothesized that poorer health status, illness perceptions and increased engagement in maladaptive coping would be adversely associated with psychological distress (specifically anxiety and depression) and poorer QoL. It was also hypothesized that adaptive problem-focused and emotion-focused coping styles would be associated with lower psychological distress (specifically anxiety and depression) and QoL. Finally, it was hypothesized that after accounting for KT characteristics (time since most recent transplant, number of transplants), health status, illness perceptions and coping styles would predict anxiety, depression and QoL.

MATERIALS AND METHODS

Participants

A total of 52 individuals (35 men and 17 women) with a mean age of 53.5 years (standard deviation [SD] = 10.77) participated in this study; all were from a large metropolitan hospital transplant unit. The mean time since the most recent KT was 7.02 (SD = 5.59; minimum = 1 year and maximum = 31 years) years. Regarding type of transplant, 29 (55.8%) had a deceased donor transplant, 12 (23.1%) had a live related donor transplant, 8 (15.4%) a live unrelated kidney donor transplant and 3 (5.8%) had a kidney-pancreas transplant. Most of the participants, (86.5%; $n = 45$) had received only 1 transplant, 4 (7.7%) had had 2 transplants and 3 (5.8%) had 3 transplants. Most of the participants (78.4%) of the study were married; 38 had been born in Australia, 8 in Europe, 5 in Asia and 1 in the Middle East.

Disease Assessment and Questionnaires

Health Perceptions Questionnaire (Health Status)

The *Health Perceptions Questionnaire*, *current health status subscale* is used to measure an individual's

current health status.²⁵ The subscale consists of 10 items (eg, "I'm not as healthy now as I used to be") where participants indicate the extent to which each item applies to them, where 1 = definitely false and 5 = definitely true (Internal consistency was 0.93). Health status score was calculated by summing the items, where higher scores indicate poorer perceived health status.

Brief Illness Perceptions Questionnaire

The brief illness perceptions questionnaire consists of 8 items to assess an individual's thoughts about their illness in areas such as concern, effect of their illness and feelings of control.²⁶ Each of the 8 items (eg, "How much do you think your treatment can help your illness?") is measured on an 11-point Likert scale where 1 = no affect at all and 11 = severely affects my life (internal consistency was 0.84). Illness perceptions score was calculated by summing items, higher scores indicating a more negative view of the illness (ie, poorer illness perceptions).

Carver Brief Coping Questionnaire

The Carver brief coping questionnaire scale assesses the different ways individuals respond to stress.^{27,28} Helpful and dysfunctional coping styles are differentiated on a 28-item scale, scored on a 4-point Likert scale where 0 = I haven't been doing this at all and 3 = I've been doing this a lot. Consistent with Carver et al,²⁷ 3 related coping styles were derived, maladaptive coping (12 items, eg, "I've been giving up the attempt to cope"), adaptive problem-focused coping (8 items, eg, "I've been taking action to try to make the situation better") and adaptive emotion-focused coping (10 items, eg, "I've been looking for something good in what's happening"). Coping scores were calculated by averaging the subscale item scores. Higher scores on the subscale indicated greater use of the coping style.

Hospital Anxiety and Depression Scale

The hospital anxiety and depression scale is a 14-item self-report questionnaire used to measure an individual's levels of depression (7 items) and anxiety (7 items) over the past week.²⁹ Each item (eg, "I can laugh and see the funny side of things") is assessed on a 4-point Likert Scale: 0 = most of the time and 3 = not at all. Using all 7 items depression had a strong internal consistency (0.87). Anxiety was also found to have a strong internal consistency (0.91) using all 7 items. Each of the subscale scores is calculated by summing the subscale items (subscale ranges: 0-21), with higher scores indicating a greater severity. Mean subscale values are interpreted as 0-7 (normal-to-low), 8-10 (mild), 11-15 (moderate) and 16-21 (severe).³⁰

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