



## Screening of distress among hospitalized patients in a department of internal medicine



Massimo Rosselli, Maria Vittoria Salimbeni, Caterina Bessi, Elisa Nesi, Stefania Caruso, Daria Arboretti, Elodie Migliorini, Elvira Caterino, Elisa Parentini, Sergio Generini, Massimo Zipoli, Roberto Giulio Romanelli, Matteo Rosselli, Fabio Marra, Giacomo Laffi, Cristina Stasi\*

Department of Experimental and Clinical Medicine, University of Florence, Florence, Italy

### ARTICLE INFO

#### Article history:

Received 28 October 2014  
Received in revised form 30 July 2015  
Accepted 9 August 2015

#### Keywords:

Hospitalization  
Consultation–liaison psychiatry  
Distress  
Anxiety  
Depression

### ABSTRACT

A psychosomatic approach to the basic screening of distress for patient care in hospitals and other health services is presented. The aims of this study were to verify association between: (1) medical illnesses and distress; (2) patients' needs and distress; (3) type of illness and patients' needs; (4) patients' needs and sense of coherence. One hundred and eighty-nine patients (78 F and 111 M, average age 65 years  $\pm$  8.43) were assessed by self-report questionnaires. We found that higher anxiety and/or depression levels were associated with urogenital ( $p = 0.026$ ), rheumatologic ( $p = 0.006$ ), oncological ( $p = 0.011$ ), neurological ( $p = 0.026$ ) and respiratory ( $p = 0.013$ ) illnesses. Higher distress scoring was associated with rheumatologic illnesses ( $p = 0.024$ ) and illnesses of the liver and digestive system ( $p = 0.037$ ) while a higher severity of distress was associated with oncological illnesses ( $p = 0.011$ ). Depression/anxiety were associated with the need to speak to a psychologist ( $p = 0.050$ ), to a spiritual advisor ( $p = 0.009$ ), to be more reassured by relatives ( $p = 0.017$ ), to feel less abandoned ( $p = 0.036$ ). Only low sense of coherence was associated with the need for greater dialogue with physicians ( $p = 0.012$ ), the need to participate less in treatment decisions ( $p = 0.041$ ), the need to feel less left to one's own devices ( $p = 0.023$ ). Several needs are associated with medical illnesses. In conclusion, these results indicate that early psychological screening could be important to avoid worse or chronic distress.

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### 1. Introduction

Consultation–liaison psychiatry (CLP) applies psychiatric theory and practice to patient care in hospitals and other health services. It aims to draw clinicians' and researchers' attention to the psychosocial aspect of all physical illnesses, and also to the possible psychiatric complications and comorbidity of every medical illness as affirmed by Lipowski (1992) a leading pioneer

in the modern practice of consultation–liaison psychiatry and psychosomatic medicine.

The association between depression/anxiety and symptom burden and functional impairment has been recognized (Katon et al., 2007). Helvik et al. (2013) examined perceived health of elderly patients, hospitalized for medical conditions, one year after hospitalization, and explored factors associated with the perceived health at follow-up. They found that improvement in carrying out ordinary daily activities and a reduction in depressive symptoms are important factors for the perception of health.

Australia and England show high rates of psychological distress and mental health problems in young people in primary care settings (Roberts, 2012).

Moreover, subthreshold psychiatric symptoms are more common than their respective DSM-IV Axis I disorders (Olfson et al., 1996).

**Abbreviations:** CLP, consultation–liaison psychiatry; ICD-9, International Classification of Diseases–9; HADS, Hospital Anxiety Depression Scale; PDI, Psychological Distress Inventory; BSI, Brief Symptom Inventory; NEQ, Need Evaluation Questionnaire; SOC, sense of coherence.

\* Corresponding author at: Department of Experimental and Clinical Medicine, University of Florence, Largo Brambilla, 3, 50134 Florence, Italy.  
Tel.: +39 055 7947154; fax: +39 055 7947154.

E-mail address: [cristina.stasi@gmail.com](mailto:cristina.stasi@gmail.com) (C. Stasi).

The study of Vermani et al. (2011) found that among 840 primary care patients assessed, 27.2%, 11.4%, 12.6%, 31.2%, and 16.5% of them met criteria respectively for major depressive disorder, bipolar disorder, panic disorder, generalized anxiety disorder, and social anxiety disorder. Mental problems were especially common in connection with gastritis, precordial pain and abdominal pain (Kebbon et al., 1985). Depression may increase the risk of mortality after an acute myocardial infarction by contributing to dysregulation of cardiac autonomic function and probably other pathogenetic factors (Carney et al., 2005).

However, physicians often underestimate the presence of such disorders in hospitalized patients. Although depressive disorders in surgery and internal medicine are approximately 25%, only a small number of patients are referred to the consultant psychiatrist (Kathol et al., 1990).

The most common reason for the non-recognition of mental disorders seems to be the “somatic presentation”: the patient presents to the doctor emphasizing physical rather than psychological symptoms. However, one should also consider beliefs, attitudes and the physician’s skills in assessing psychological distress with more detailed information (Bellantuono et al., 2002; Zimmermann and Tansella, 1996). Correctly diagnosing a depressive disorder in a patient with a medical illness is a clinical challenge that requires systematic, persistent clinical scrutiny, also due to physical symptoms that might belong to both pathological pictures (Cassem, 1995).

Psychiatric comorbidity negatively influences the length of hospitalization (Häuser et al., 2006). The association between psychiatric and organic disorders can also cause worsening of both with the presence of overlapping symptoms, making good therapeutic intervention later more difficult and increasing the risk of chronicity, especially of undiagnosed mental disorders (Kornfeld, 1996; Silverstone, 1990). Patients with psychiatric comorbidity showed higher disability than the group without psychiatric comorbidity (Aydin and Uluşahin, 2001) and longer hospitalization with higher costs (Levenson et al., 1992).

It is important for medical staff to gain awareness about patients’ physical, psychological and social needs, so that targeted and effective intervention can be implemented through the use of appropriate screening tools. In the same perspective, patients’ resources such as sense of coherence that may influence attitude towards illness, become a relevant part of the assessment. Sense of coherence is a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that the stimuli deriving from one’s internal and external environments in the course of living are structured, predictable and explicable (Antonovsky, 1987). In his theory, Antonovsky (1979) describes generalized resistance resources as coping resources that are effective in avoiding or combating a range of psychosocial stressors.

The aims of this study were to verify the association between: (1) medical illnesses and distress; (2) patient’s needs and distress; (3) medical illnesses and patient’s needs; (4) patient’s needs and sense of coherence.

## 2. Patients and methods

### 2.1. Patients

One hundred and eighty-nine patients were enrolled: 78 F (average age 63 years  $\pm$  12.72) and 111 M (67 years  $\pm$  14.14), in the Department of Internal Medicine, University Hospital Careggi, Florence, Italy. The study was conducted in accordance with the principles of the Declaration of Helsinki (revision of Edinburgh, 2000).

All diagnoses were made according to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).

Exclusion criteria were diagnoses of cognitive impairments, visual deficits, particularly disabling conditions linked to old age (such as dementia) and to disease (such as cognitive deficits following cerebral haemorrhage or infarction).

The study focuses on psychiatric symptoms and distress associated with cardiovascular, digestive and liver, respiratory, neurological, oncological, urogenital and rheumatologic diseases that were identified in hospitalized patients based on ICD-9-CM. The association was considered with the primary diagnosis of psychiatric symptoms/distress and medical illnesses.

### 2.2. Methods

The following self-report questionnaires were administered by psychologists of the Psychosomatic Service:

**Hospital Anxiety Depression Scale (HADS)** (Zigmond and Snaith, 1983). This is a 14-item multiple choice scale. Seven of the items relate to anxiety and seven to depression and coincide with mood and feelings experienced by patients. Each item is scored on the Likert scale from 0 to 3: patients are requested to mark which item better describes what she/he was experiencing in the preceding week. A cut-off score greater than 9 indicates the presence of anxiety or depression.

**Needs Evaluation Questionnaire (NEQ)** (Tamburini et al., 2000). This is a 25-item questionnaire which examines the following areas: information about diagnosis, prognosis, therapy (items 1–5); communication with clinicians (items 6–10); assistance/care by medical and nursing staff (items 11–12–14–15); relations: concerning the relationship with relatives (items 22–25). The other items (13–16–17–18–19–20–21) concern specific practical aspects (e.g. need to talk to a psychologist, need of economic help).

**Psychological Distress Inventory (PDI)** (Morasso et al., 1996). This is a rating scale of 13 items on a 5-point Likert scale. It evaluates a subject’s psychological distress in the week preceding test administration. A cut-off score above 29 indicates the presence of psychological distress.

**Brief Symptom Inventory – 18 items (BSI-18)** (Derogatis, 2000). This is an abbreviated version of the Brief Symptoms Inventory (BSI) with 53 items (Derogatis, 1993). The BSI-18 measures three primary symptom dimensions (Somatization, Depression and Anxiety) and a global index (Global Severity Index) that measures the overall distress level. This test is a rapid screening tool that helps measure and monitor symptoms of psychological distress. Respondents rank each item on a 5-point scale ranging from 0 to 4; rankings represent the intensity of symptoms of distress over the preceding week. In the present

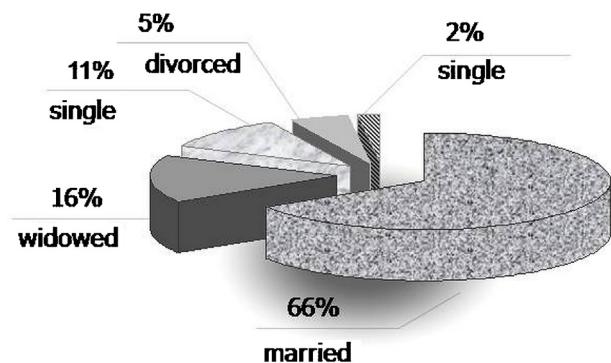


Fig. 1. Percentage distribution of civil status.

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