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# Assessing psychological distress in patients with facial paralysis using the Hospital Anxiety and Depression Scale<sup>☆</sup>

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## KEYWORDS

Facial paralysis;  
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Depression;  
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**Summary** *Objectives:* Anxiety and depression are seen among patients with facial paralysis (FP), but less is known about the exact prevalence. The aim of the current study is to assess the prevalence of anxiety and depressive disorders in the FP population and to investigate possible differences between patients with left- and right-sided FP.

*Methods:* Fifty-nine patients with FP and 59 healthy individuals were included in this study between March and December of 2014. The Hospital Anxiety and Depression Scale was used to assess the prevalence of anxiety and depression among these groups.

*Results:* The mean age of the patients and controls was  $56 \pm 15$  and  $40 \pm 16$  years, respectively. Twenty-eight patients had left-sided FP, 30 patients had right-sided FP, and one patient had bilateral FP. In the patient group, approximately 30% had anxiety and 25% had a depressive disorder. Compared with the control group, significantly more patients presented with mild anxiety ( $p = 0.031$ ), mild depression ( $p = 0.047$ ), and moderate depression ( $p = 0.006$ ). No significant differences were found in terms of the prevalence of anxiety between left- and right-sided FP. However, significantly more patients with left-sided FP had mild depression ( $p = 0.018$ ) than those with right-sided FP.

*Conclusion:* This study found a significant difference in anxiety and depression between

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patients with FP and healthy controls. No clinically significant difference was noted in the prevalence of anxiety or depression between patients with left- and right-sided FP.

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## Introduction

Facial paralysis (FP) is a palsy of the facial nerve, which can have various causes. The most prevalent form is Bell's palsy, which is acute and idiopathic.<sup>1</sup> Patients with FP may have a series of symptoms ranging from incompletely closed eyes, widened eye fissures, diminished facial movement, problems with eating and drinking, to a diminished sense of taste in the anterior two-thirds of the tongue.<sup>1,2</sup> Data from epidemiological studies show that the annual incidence of FP varied between 30 and 40 per 100,000.<sup>2</sup>

Apart from being a physical disorder, FP is a disfiguring disease that adversely affects the patient's psychological status and social interaction. Many studies have shown the prevalence of psychological stress in patients with FP.<sup>3–6</sup> VanSwearingen et al.<sup>7</sup> found that psychological stress was the single predictor of social disability for FP, using the Beck Anxiety Inventory and Depression Inventory. Both Sugiura et al.<sup>8</sup> and Stuart et al.<sup>9</sup> found high levels of psychological distress among patients with FP, three to five times higher than that in the normal population. Macgregor and colleagues<sup>10</sup> found that patients with FP suffer from daily psychological distress and find social interaction difficult.

However, less is known about the prevalence of anxiety and depressive disorders in patients with FP. The foremost objective of this study was to determine the prevalence of anxiety and depression among patients with FP, especially in comparison with the normal population. The second focus was placed on the possible differences in anxiety and depressive symptoms between patients with left- and right-sided FP. Our primary hypothesis was that anxiety and depressive symptoms are more prevalent in patients with FP than in healthy subjects and that patients with right-sided FP experience greater levels of anxiety and depression than those with left-sided FP, according to the possible social–aesthetic differences (based on both reading habits in Western society and functional differences in emotional recognition between the left and right hemisphere) determined by our previous study.<sup>11</sup> In our previous study, we found that patients with left-sided FP significantly preferred their mirror image in a neutral picture, mostly because they were familiar with their own mirror image (the FP is seen in the mirror also on the left side). Patients with right-sided FP preferred their true image more often. True image is a reversal of the mirror image; therefore, patients with right FP see their FP on the left side of the image. This is mostly due to an interaction between one's familiarity with one's own facial image and the functional differences in one's brain hemispheres.<sup>11</sup> Therefore, we postulate that these differences in cosmetic preference can also result in a difference in the prevalence of anxiety and depression between patients with left- and right-sided FP.

## Materials and methods

### Patients and controls

Ethical approval was obtained for this cohort study. This study was conducted according to the Strengthening of Reporting of Observational studies in Epidemiology (STROBE) statement. Patients with FP and healthy individuals aged 18–75 years were recruited between March 2014 and December 2014 at the Radboud University Medical Centre in Nijmegen, the Netherlands.

The inclusion criteria for patients were as follows: 1) a diagnosis of FP and 2) an adequate knowledge of the Dutch language to provide informed consent and to complete the questionnaire. The clinical severity of FP was measured using the House–Brackmann scale.<sup>12</sup> All healthy individuals (control group) were randomly chosen, without any history of facial palsy and/or psychiatric/psychological disorders. These factors can influence the outcome of the Hospital Anxiety and Depression Scale (HADS) according to the available literature.<sup>13–16</sup> One of the authors (SP) asked individuals at the entrance of a local community center in Nijmegen (the Netherlands) whether they wanted to participate in this study.

### Measures

The HADS was used to assess anxiety and depression in our study groups.<sup>13</sup> This instrument can be used as an indicative measurement of anxiety and depression. The HADS consists of 14 items, divided into two seven-item subscales. The total score for each subscale ranges from 0 to 21.<sup>13</sup> In the literature, different cutoff points are used, but in general a score  $\leq 7$  corresponds to "no depression or anxiety," a score of 8–10 minor depression/anxiety, a score of 11–15 moderate depression/anxiety, and a score  $\geq 16$  severe depression/anxiety.<sup>13,14</sup> The HADS has been well validated (also in Dutch<sup>15,16</sup>) and is commonly used in clinical practice to screen patients based on anxiety and depression. It excludes somatic symptoms of anxiety and depression, which may overlap with the physical illness.<sup>13,14</sup>

### Procedure

Participants were briefed on the nature of our study, who then gave their consent to complete the HADS questionnaire. Any missing information was extracted from the patient notes or inquired about during the treatment consult.

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