



EDITORIAL COMMENT

Brief psychological intervention in patients admitted after acute coronary syndrome: Essential or secondary?☆



Breve intervenção psicológica em doentes internados após síndrome coronária aguda: essencial ou acessória?

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Psychosocial factors have a significant effect on cardiovascular risk, to an extent that is comparable to that of hypertension or abdominal obesity.¹ Acute coronary syndromes (ACS) also trigger emotional reactions that can be severe,^{2,3} and an acute cardiac event or unexpected admission to an intensive care unit can be frightening and stressful.⁴ Studies on individuals who have suffered myocardial infarction (MI) reveal high levels of depression and anxiety (31% and 26%, respectively, before discharge,² as well as one and two years afterwards^{2,3}). These figures are important because depression and anxiety are independent predictors of reinfarction,⁵ due to a variety of pathophysiological mechanisms including hyperactivity of the sympathetic nervous system and of the hypothalamus-hypophysis-adrenal axis, alterations in platelet function, inflammation, and endothelial dysfunction.^{6–8}

Studies have shown a strong association between a major stressful event and the occurrence of MI and cardiac mortality. Cardiovascular mortality increases in the weeks following the death of a loved one^{9,10} and immediately after

a terrorist attack,¹¹ natural disaster¹² or an important football match.^{13,14}

In Hospital de Santa Marta, psychological assessments have revealed that in over 50% of MI cases there was an acute stress trigger: divorce, death of a close relative, moving home, retirement, or change of employment (Abreu et al., unpublished data, presented at the 2010 Portuguese Congress of Cardiology). These patients already have causal factors related to anxiety and depression that do not disappear with the MI. It can be speculated that these predisposing factors may worsen the patient's emotional state, beyond the acute stress caused by the MI itself.

Patients with depression or anxiety are hospitalized more often in the year following MI¹⁵ and those with depression are less likely to return to work, both full time and at reduced working hours.¹⁶

This negative impact on prognosis shows the importance of identification and prompt and appropriate treatment of the emotional problems arising from ACS.

A brief psychological intervention following ACS has both benefits and limitations. Nowadays, the psychological dimension should be central to any cardiac rehabilitation (CR) program, unlike in the past when such programs were mainly exercise-based.¹⁷ CR is a structured, wide-ranging, multidisciplinary intervention that includes functional, nutritional and psychosocial components and a variety of

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strategies, and as such is an excellent means for achieving the aim of optimizing patients' physical and mental state after an acute cardiovascular event. Appropriate interventions can modify the behavioral and emotional consequences of such an event; CR programs that include a psychological component have shown significant beneficial effects on morbidity and mortality following ACS,^{18,19} although unfortunately patients with psychological problems are less likely to participate in a CR program.²⁰

Educational interventions can have positive effects on the patient's psychological state, reducing anxiety and fear and correcting erroneous ideas about ischemic heart disease and its consequences, as well as increasing motivation to change habits and to adhere to therapy. It is essential to discuss patients' worries, fears and health beliefs with them. This can be done by individual counseling, which is more specific and covers only that patient's problems and risk factors, while group meetings enable cardiac patients to share their common concerns, provide mutual assistance, obtain useful information and receive guidance on how to return to their normal activities.^{21,22}

The article by Fernandes et al. entitled "Brief psychological intervention in phase I of cardiac rehabilitation after acute coronary syndrome"²³ in this issue of the *Journal* sets out to evaluate the efficacy of acting on the psychological status of patients following ACS, particularly MI, during hospital stay. The investigators applied two questionnaires, the Hospital Anxiety and Depression Scale (HADS)²⁴ and the Brief Illness Perception Questionnaire (BIPQ),²⁵ both translated into Portuguese, and both previously validated,^{26,27} to assess emotional adaptation and representations, respectively, of three brief sessions, one (1 hr 15 min) within three days of admission, one (1 hr 15 min) before hospital discharge, and a third (20 min) one month after discharge.

The clinical and demographic characteristics of the experimental and control groups were similar, although patients who underwent the intervention and improved were younger. As usual with ACS, the proportion of men (70%) was higher than that of women.

The results show that anxiety, depression and illness representations improved significantly in the group who underwent the psychological intervention compared to the control group. These improvements were maintained or enhanced at 1- and 2-month follow-up, whereas there was a deterioration in psychosocial adjustment in the control group. The authors concluded that a brief psychological intervention program delivered during hospitalization for ACS and combined with standard medical care can have positive effects in terms of psychosocial outcomes that have proven impact on cardiac rehabilitation and prognosis. A longer follow-up would be useful in order to determine whether the changes observed are maintained in the long term, and this is a limitation of the study that is acknowledged by the authors. A short-term effect is likely to be less valuable than one that is sustained over time.

The article does not report on the use of anxiolytic, antidepressant and sedative drugs. Anxious or depressed patients are frequently prescribed medication that can improve these states, which may be independent of any psychological intervention they have undergone. It is not stated whether the experimental group were taking different quantities or types of drugs compared to the controls, but

this information is essential to ascertain the independent effect of the psychological intervention.

Although other outcomes were not assessed, such as new ACS, hospitalization for cardiac cause, percutaneous coronary intervention (PCI) or compliance with drug therapy or exercise training, the reductions in levels of anxiety and depression, both well-known independent markers of cardiovascular risk following ACS,²⁸⁻³² point to an improved prognosis.

As pointed out by Fernandes et al.,²³ several investigators have suggested that emotional states and illness representations should be assessed early in order to optimize adherence to and benefits of CR by promoting better psychosocial adaptation following ACS.³³⁻³⁶ Patients' beliefs about their illness and treatment are known predictors of clinical and psychological outcomes post-discharge. High levels of social support can soften the impact of depression on mortality rates in post-MI patients.³⁷

Evidence in the literature points to the need for clinical interventions directed specifically at the psychological aspects of adherence to cardiological treatment and lifestyle modification. The cognitive-behavioral approach to modifying behavior appears to be the most effective strategy.³⁸ It is important to maintain flexibility in therapeutic approaches according to the needs of different types of patient.³⁹

Despite the benefits of this type of early psychological intervention, the question arises of length of hospital stay. Nowadays most ACS patients are admitted to the cardiology department, undergo diagnostic catheterization followed by PCI, and are discharged 3-5 days after the event if there are no complications. Psychological assessment and intervention take place after the patient leaves intensive care. In practical terms, if a patient has an ACS and is admitted to the cardiology ward on a Friday evening, they may immediately undergo PCI and, barring complications, be discharged on the following Monday. It seems more sensible, in at least some cases, to carry out the psychological intervention early in the outpatient phase.

An intervention during hospital stay can also function as preparation for the subsequent phase. CR programs are divided into three phases: in-patient (phase I), early post-discharge (phase II), and maintenance (phase III), each of which has different characteristics.

In phase I, following careful assessment, lifestyle modification should be dealt with from the outset, offering clear and firm guidance but in a calm and non-aggressive manner. In this phase, CR in general and psychological interventions in particular are limited by the short duration of hospital stay, as pointed out above. Furthermore, patients are often in a state of shock resulting from acute stress, especially if they are young or were unaware that they had coronary disease, and in this state are unlikely to remember later what they were told in the hospital. This phase of hospitalization is often accompanied by fear and insecurity, and hence the patient must be appropriately calmed and provided with both information and motivation to prepare them for the support they will receive following discharge from the multidisciplinary CR team, particularly the psychologist. Psychological support may be particularly important in certain cases. Especially in the immediate post-discharge period, training for lifestyle modification and control of risk

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