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Description of the Grieving and Depression in Patient with CAD in Intensive Care Unit

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ABSTRACT

Background: The grieving and depression can affect the treatment process and the condition of patients with CAD. The process experienced by the patient can be uncomplicated grief, complicated grief and depression. It is important to distinguish between that conditions in response to normal and healthy loss and with response to the stresses of personal disorders, that require more intensive intervention. The nurse is responsible for helping the patient go through the grieving so as to prevent the adverse effects on the patient, so that the grieving and depression are needed to determine the problems and to plan the nursing treatment.
Objective: This study aimed to identify the grieving and depression in patients with CAD in the Intensive Care Unit of Hospital Dr. Hasan Sadikin Bandung.
Methods: This research method was quantitative descriptive using Consecutive Sampling technique (n=34). Data collection used the Grief / Depression Assessment Inventory questionnaire that had been tested for validity with the face validity and content validity. The data were analyzed using analytic descriptive method with frequency distribution.
Result: The results showed that from 34 respondents, most of them (94.1%) had complicated grief while few of them (5.9%) had uncomplicated grief. The highest response to grieving and depression was in the domain of behaving, thinking, feeling, and loss.
Conclusion: Most patients with CAD experienced complicated grief. Therefore it was important for nurses to anticipate the complicated grief among patients and deliver nursing care that support patient situation, consult with family doctor, therapist, or religious leaders.

Introduction

The cardiovascular disease in 2015 represented 31% of global deaths. Of the total deaths, 7.4 million was caused by coronary artery disease (World Health Organization [WHO], 2017). Coronary artery disease which requires intensive care is increasing. Coronary artery disease (CAD) is a disease with the growth of atherosclerosis in the coronary arteries that causes silting or total blockage that will change the function of the heart (Urden, Stacy, & Lough, 2014). The growth process of atherosclerosis can occur from the form of silting to hard blockage that covers the coronary arteries. The blockage can occur in one location from one blood vessel to several blockages in all branches of the coronary arteries so that the heart experiences a lack of oxygen and nutrients (Urden et al., 2014).

Sudden heart attacks or acute attacks can occur at any time, which results in no blood flowing to the brain so that the patient loses consciousness within a few seconds followed by seizures, one-on-one breath and even death (Sitorus, 2004). This blockage in the coronoria artery can cause severe pain and death quickly if not treated immediately (Emaliyawati, Sutini, Ibrahim, Trisyani, & Prawesti, 2017). Therefore, patients need an intensive care as the initial phase to start treatment.

When patients are treated in an intensive care unit, patients will get an experience. The experience of patients who are treated in intensive care unit can be positive experiences and negative experiences. Positive experience is associated with feeling secured and security. Negative experience is associated with fear, anxiety, sleep disturbances, cognitive impairment, pain, and discomfort (Morton, Fontaine, Hudak, & Gallo, 2011).

Experience in intensive care unit can also lead to a response to critical illnesses and terminals, namely bio-psycho-social-spiritual response, which includes the loss response in the form of loss of health, loss of independence, loss of comfort, loss of situation, loss of physical function, loss of mental function, loss of self concept, and loss of roles in groups and families (Purwaningsih & Karlina, 2009). The threat of death and loss can cause the patient to experience the grieving.

Grieving can cause pressure / stress. Stress can interfere with heart health. Rozanski et al (1988) found that acute or chronic stress had a deleterious effect on the function of the cardiovascular system. Rozanski et al also stated that stress increased the risk of thrombosis and ischemia, and increased pletelet aggregation. Stress can stimulate autonomic sympathetic nerves to increase vasoconstriction which can increase blood pressure, blood fat, disturbances in blood clotting, changes in blood vessels, and atherosclerosis which can cause heart arrhythmias and myocardial infarction (Yaribeygi, Panahi, Sahraei , Johnston, & Sahebkar, 2017). These are some of the effects of the heart system when grieving. Grieving can also potentially disrupt health. The symptoms that are caused by grieving are anxiety, depression, weight loss, difficulty in swallowing, vomiting, fatigue, headaches, dizziness, excessive sweating, palpitations, chest pain, dyspnea, changes in libido, concentration , diet, sleep changes, activity and communication (Kozier, 2010).

Grieving can also be prolonged, and it is called Complicated Grief. Complicated Grief is the condition where the patients may be confused about his identity, his social role, the presence of anxiety, anger and even depression which may be related to physiological changes such as the increase of heart rate or blood pressure, cortisol levels, sleep disturbances and changes in the immune system (Buckley et al., 2012; Shear, 2015). Complicated Grief according to Pini et al (2015) related to the incidence of coronary artery disease. Pini et al found, in 149 subjects with coronary artery disease, 118 (79.2%) experienced Complicated Grief. Pini et al stated that the Complicated Grief had an impact on physical and mental health, increasing the risk for suicide, substance abuse, chronic medical conditions, and impaired global functioning.

In addition to grieving, serious / severe diseases such as coronary artery disease can also cause depression (Periyakoil et al., 2012). Depression in coronary artery disease affects

physiological losses in the form of increased platelet and inflammation, decreased heart rate, increased catecholamines, and endothelial dysfunction (Huffman, Januzzi, & Celano, 2010; Krisnayanti, 2017; Tengguna & Andri, 2015; Widiyanti, 2014) . Huffman et al., (2010) also explained that depression was related to worsening health that resulted in worsening the quality of life, recurrence of heart abnormalities, and mortality. The presence of depression in CAD patients is not only endangering their emotional well-being, but also aggravating their illness and hindering the progress of rehabilitation (Lubis, 2009).

It is important for nurses to distinguish between the grieving in response to normal and healthy loss with the grieving response in response to pressure and great personal distractions that require more intensive intervention (Potter & Perry, 2010). The importance of this study was to determine the right actions to distinguish between the normal grieving and the grieving that requires more intensive intervention. Whether the patient in the grieving process requires assistance, requires an intermediary for counselors to other professionals such as psychologists, religious leaders or psychiatrists became a study focus in this research.

According to Schneider, (2001) the grieving is divided into uncomplicated grief, complicated grief, and depression. Uncomplicated grief is a normal reaction to significant loss and is characterized by sadness, loneliness and fatigue. Complicated grief is loss that causes psychosomatic disease to psychosis, tends not to limit them selves, and interferes with the capacity of person to develop. Depression is a clinical syndrome characterized by negativism, helplessness, decreased mood, and decreased self-esteem. Therefore, it is necessary to conduct a research on the of grieving and depression, because there is no SOP clear to pay attention to psychological problems. According to the World Health Organization (WHO) and the World Organization of Famili Doctors (WONCA, 2008) in most countries including Indonesia, mental health problems are often ignored in planning patient care, based on existing prevalence, mental health problems patients in health services are often undiagnosed or untreated.

Method

Study Design

The research method used in this study was descriptive quantitative with a cross sectional approach. This research was conducted in Intensive Cardiology Care Unit at Hospital Dr. Hasan Sadikin. The data were collected in a month from April to May 2018. The sampling technique was consecutive sampling with inclusion criteria: 1) patients with stable hemodynamics who suffered from coronary heart disease and treated by cardiology doctor in patient status, 2) awareness of mentis compost, 3) patients with good communication; and exclusion criteria: 1) patients who suddenly experienced worsening, and 2) patients who could not communicate.

Instrument

Data were collected by giving a Grief / Depression Assessment Inventory questionnaire (Schnider, 2001) which had been tested for validity using face validity to 10 coronary heart disease patients who were treated in the Intensive Cardiology Care Unit and content validity to 2 expert lecturers at the Faculty of Nursing, Universitas Padjadjaran. The questionnaire consisted of 11 questions about: domain / sub variables of loss, behaving, thinking, feelings, physical, pain and pleasure, beliefs, dreams, self, support, and desire to live. Of the 11 sub-variables, 4 responses were obtained: grief, depression, grief and depression, and neither of them. If the patient / respondent choose a sad response in all questions, the patient / respondent experienced uncomplicated grief. If the patient chose more grief responses and also chose a depression response in some questions, the patient / respondent experienced a complicated grief. If the patient chose a depression response in most questions, the patient / respondent had depression. In this research the validity test consisted of a content test and construct test content. Test content by consulting each item in a question to two expert lecturers at the Faculty of Nursing,

Universitas Padjadjaran to determine the suitability of the contents of the questionnaire with relevant theory. Test constructs have been performed on as many as 10 patients with coronary artery disease patients in Intensive Care Unit (Intensive Cardiology Care Unit) Dr. Hasan Sadikin to find out whether the questionnaire can be understood or not. Face results validity there are some questions that are not understood so the research eradd or change information without changing the meaning of the statement.

Research Subject

The population in this study were patients with coronary artery disease who were treated in Intensive Cardiology Care Unit at Hospital Dr. Hasan Sadikin with an average number of 37 people per month. Consecutive sampling technique was carried out for one month with 34 respondents. Inclusion criteria: 1) patients with stable hemodynamics who suffered from coronary heart disease and treated by cardiology doctor in patient status, 2) awareness of mentis compost, 3) patients with good communication.

Ethical Consideration

Ethical clearance for data collection in this research had been obtained from the Research Ethics Committee of Dr. Hasan Sadikin Bandung General hospital No. LB.04.01 / A05 / EC / 112 / IV / 2018 on April 10, 2018. All respondents had obtained appropriate informed consent in the research.

Data analysis

The data analysis in this study was univariate analysis. The result of the research was frequency distribution in grieving variables and 11 domains / subvariables. How To Interpret Your Scores Uncomplicated grief: If you scored "grief" in all areas, you are clearly grieving normally, and probably do not need professional help, although you may wish to talk with someone. Complicated grief: If you score mostly for "grief," but also have some "depression" items checked in any area, you should consult with your family doctor, therapist, or clergy. Depression: If most items are checked as "depression," professional help is highly recommended. Notes: * Item 11: If you checked "depression" on "Will to Live," professional help is urgently recommended.

Results

The results of the study are presented in the form of tables of frequency distribution and discussion. Characteristics of respondents in patients with coronary heart disease are presented in the following table of frequency distribution:

Table 1. Frequency Distribution of Respondent Characteristics and Grieving response in Patients with Coronary Heart Disease in the Intensive Care Unit at the General Hospital of Dr. Hasan Sadikin Bandung (n = 34).

Characteristics	Respondent		*Uncomplicated grief*		*Complicated grief*	
	f	%	f	%	f	%
Age						
36-45 years (late adult)	3	8,8	0	0	3	8,8
46-55 years (early elderly)	12	35,3	1	2,9	11	32,4
56-65 years (late elderly)	12	35,3	0	0	12	35,3
>65 years (old man)	7	20,6	1	2,9	6	17,6
Gender						
Male	30	88,2	2	5,9	28	82,4
Female	4	11,8	0	0	4	11,7
Education						
Primary	13	38,2	0	0	13	38,2
Secondary	14	41,2	1	2,9	13	38,2
Higher Education	7	20,6	1	2,9	6	17,6
Job						
Labor	22	64,7	1	2,9	21	61,8
Jobless	12	35,3	1	2,9	11	32,3
Marrital Status						
Married	32	94,1	2	5,9	30	88,2
Widower	1	2,9	0	0	1	2,9
Not married	1	2,9	0	0	1	2,9
The duration of illness diagnosis						
1-6 months	27	79,4	1	2,9	26	76,5
6-12 months	1	2,9	0	0	1	2,9
>12 months	6	17,6	1	2,9	5	14,7
Treatment						
Medication	14	41,2	0	0	14	41,2
Medication and PCI	15	44,1	1	2,9	14	41,2
Medication and CABG	5	14,7	1	2,9	4	11,8
Religion						
Islam	32	94,1	2	5,9	30	88,2
Catholic	1	2,9	0	0	1	2,9
Budha	1	2,9	0	0	1	2,9
Culture						
Sundanese	30	88,2	2	5,9	28	82,4
Non Sundanese	4	11,8	0	0	4	11,8
Other desease						
Nothing	11	32,3	1	2,9	10	29,4
One desease	19	55,9	1	2,9	18	52,9
More than one desease	4	11,8	0	0	4	11,8
Heart desease diagnosis						
STEMI	24	70,6	2	5,9	22	64,7
NSTEMI	9	26,5	0	0	9	26,5
UAP	1	2,9	0	0	1	2,9

Based on table 1 the grieving process in patients with coronary artery disease who experienced a complicated grief most often occured in the late elderly respondents, male gender with primary and secondary education, married marital status, diagnosis period of one to six months, medication and medication and PCI, Islam, Sundanese, patient wtih one previous disease and with a diagnosis of STEMI.

The description of the grieving response of patients with coronary artery disease is presented in Table 2 below:

Table 2 Overview of the Grieving Response of Patients with Coronary Heart Disease in the Intensive Care Unit at the General Hospital of Dr. Hasan Sadikin Bandung by Domain (n = 34)

Domain	Grieving		Depression		Grieving and Depression		Neither of Them	
	f	%	f	%	f	%	f	%
Loss	15	44,1	9	26,5	10	29,4	-	-
Behaving	6	17,6	3	8,8	24	70,6	1	2,9
Thinking	14	41,2	1	2,9	14	41,2	5	14,7
Feelings	20	58,8	1	2,9	10	29,4	3	8,8
Physical	26	76,5	2	5,9	3	8,8	3	8,8
Pain and pleasure	31	91,2	-	-	1	2,9	2	5,9
Spiritual	27	79,4	-	-	5	14,7	2	5,9
Dreams	4	11,8	1	2,9	1	2,9	28	82,4
Self	29	85,3	-	-	5	14,7	-	-
Support	29	85,3	-	-	4	11,8	1	2,9
Will to live	20	58,8	-	-	1	2,9	13	38,2

Based on Table 2 above, the respondent's response to the following 11 domains is the response to the highest sorrow in pain and pleasure, self, support, and confidence. At the highest depression response to loss, behaving, physical, and self. Both responses (grieving and depression) are highest in behaving, thinking, loss, and feelings.

The grieving in patients with coronary artery disease is divided into uncomplicated grief categories, complicated grief, and depression. Data is present ed in table 3 below:

Table 3 Distribution of Grieving Process Frequency in Patients with Coronary Heart Disease in the Intensive Care Unit of Dr. Hasan Sadikin Bandung (n = 34).

Grieving Process	Frequency of Respondent Number (f)	Percentage (%)
Uncomplicated grief	2	5,9
Complicated grief	32	94,1
Depression	0	0
Total	34	100

Based on table 3 the description of the grieving in patients with coronary artery disease was that almost all / most of the respondents experienced complicated grief. A small percentage of respondents experienced uncomplicated grief.

Discussion

The grieving process in the study showed that most of patients with acute coronary heart (94.1%) experienced complicated grief while a few of them experienced uncomplicated grief (5.9%). Complicated grief where the patient may be confused about his identity, role socially, there are changes, responses and even depression that may be related with physiological changes such as increased heart rate or blood pressure, Increasing cortisol levels, sleep disorders and changes in the immune system body (Buckley et al., 2012; Shear, 2015). Complicated grief according to Pini, Gesi, Abelli, Cardini, Lari, Felice, ... & Borelli (2015) related to the incident coronary heart disease. Pini et al found in 149 subjects with the disease coronary heart disease, as many as 118 (79.2%) improve complicated grief. Pini et al, said complicated adversity on physical and mental health, increase the risk of escape, excretion, chronic medical conditions,and global malfunction.

Complicated grief as one of the stress responses which according to Rozanski (1988) found that acute or chronic stress had a deleterious effect on the functioning of the cardiovascular system. That study also found stress increased the risk of thrombosis and ischemia, and increased pletelet aggregation. Stress can stimulate autonomic sympathetic nerves to increase vasoconstriction which can increase blood pressure, increase blood fat, disturb blood clotting, change blood vessels, and to increase atherosclerosis which can cause cardiac arrhythmias and myocardial infarction (Yaribeygi, Panahi, Sahraei , Johnston, & Sahebkar, 2017). Stress can increase cortisol levels. Cortisol can cause inflammation so it is susceptible to the development of atherosclerosis and flak instability (Nijm and Jonasson, 2009). Cortisol can contribute to the development of coronary atherosclerosis (Battacharyya, Molloy & Steptoe, 2008).

Long-standing CAD treatment began during the first attack where the patient had a bad experience of pain. The pain caused him to be hospitalized and to follow several procedures for examination, treatment and recovery from this disease. The patient will experience some changes in his life, have a good dependence on people, drugs, health workers and health facilities. Patients can think negatively about themselves, their lives and their future. The things above can be the cause of complicated grief, this is in line with what Lobb, Kristjanson, Aoun, Monterasso, Halkett, & Davies (2002) suggested that the complicated grief predictor associated with dependence is related to cognitive behavior and illness and death traumatic.

Complicated grief in this study was seen from the respondent's response to both answers (grief and depression). The highest answer behaving (70,6%),thinking (41,2%),loss (10%) and feeling (10%). Behaving in the field of psychology is a term that relates to perception and behavior. Behaving is a way of reacting to a stimulus, a tendency to react to a stimulus or situation faced (Suharyat, 2009).

A supportive behaving would be able to manage the grieving response. However, in this case the characteristics of respondents were the late elderly. The late elderly had started to part with their children because their children were already married. Other children also had the possibility of having their own activities so that the support was only from their partners. Therefore, the patient had a dependency on the partner. An excessive dependence in relation to either their partners or their personality showed a more chronic trajectory of grief (Bonanno, Wortman, Lahman, Tweed, Haring, & Sonnega, 2002). Education could influence attitudes, in this study it was found that the most education of respondents was primary and secondary schools. Respondents with low education might be less aware of the impact and prognosis of the disease so that they did not know how their health conditions were. According to Potter & Perry (2010) when a person lacked education, the burden of loss became doubled, this might cause complicated grief.

Complicated grief from the second response of grieving and depression was the domain of thinking where patients with coronary artery disease experienced anxiety about their illness,

fear of death, and discomfort. In this response, the respondents found it difficult to concentrate, everything looked disorganized, they lost their identity, and they always thinking about why this could happen. Patients / respondents thought negatively about themselves and their future. Negative thinking, negative behaviors, and feelings of discomfort could bring patients to more serious psychological problems such as depression, trauma, and anxiety disorders (Muqodas, 2011). This was likely to result in a complicated grief.

The third domain of grief and depression was loss, this loss response was the condition where the respondents felt changes in their lives. In this case, some respondents felt that something that was missing happened quite reasonable, while others did not understand why this happened. Losses in critical patients could lead to a bio-psycho-social-spiritual response. The response to loss experienced by patients with coronary artery disease could include loss of health, loss of independence, loss of comfort, loss of situation, loss of physical function, loss of mental function, loss of self-concept, and loss of role in groups and families (Purwaningsih & Karlina, 2009) .

The loss which was associated with demographic characteristics in the grieving process of patients with coronary artery disease experiencing complicated grief occured in the late elderly (age 56-65 years). The elderly could experience loss of health because this age was associated with organ function that had begun to decline including decreased heart function. Coronary artery disease was mainly caused by myocardial abnormalities due to the insufficiency of coronary blood flow where atherosclerosis was a degenerative process, and also caused by other factors (Handajani, Roosihermiatie, & Maryani, 2009).

Beside the abnormal physical conditions due to increasing ages, the elderly were about to come to retirement where they were threatened with losing their jobs, losing friends, losing their children who might be married and have a family. Losing friends, losing life goals, having risk of illness and death threats, and living only with a partner could lead to mental disorders. This was in line with Irawan (2013) who stated that in addition to changes in physical appearance, the elderly began to lose their jobs, lose life goals, lose friends, have risk of illness, be isolated from the environment, and feel loneliness. This could trigger a mental disorder. Depression was a mental disorder that was often found in the elderly due to the aging process so that this might cause complicated grief.

The fourth response of griefing and depression was feeling. Respondents felt that they were getting worse with their illness, and sometimes they also felt angry, sad and disappointed in relation to their physical function which experienced a decline, causing respondents to be unable to work. In this study, respondents who worked more experienced complicated grief. In this case, patients with coronary artery disease were likely to experience health problems so that it would cause problems in their work due to fatigue or effect on absence. The patients with coronary heart disease would experience chest pain, shortness of breath and weakness (Smelzer, Hinkle, Bare, & Cheever, 2010). Patients also experienced excessive sweating and anxiety (Burn, 2014), fatique, and headaches (Urden et al, 2014), resulting in delayed work. This was contrary to Potter & Perry (2010) which stated that individuals who di not work or lacked work would experience multiple losses.

Besides the response of both grief and depression, the four domains of grieving response were pain and pleasure (91,2%), self (85,3%), support (85,3), and spiritual (79,4%). Complicated grief based on the highest grieving response to pain and pleasure happened to the respondents who felt pain due to loss, both physical and psychological pain. If the respondents remembered the pain, it became the worst experience in their lives. In addition to the experience of pain, respondents also experienced fear of a repeat attack. They were afraid if the pain was not handled, it could lead to death, according to Emaliyawati et al (2017), who stated that pain in CAD could lead to death if not treated immediately. The inadequate management of pain could be dealing with depression, isolation of social relationships and disability, and could also

cause cavaliery sleep disturbances (Aisyah, 2017). In this study respondents experienced pain in STEMI where the acute pain in STEMI had a harmful effect and discomfort. In addition to feeling disruptive discomfort, acute pain that did not subside could affect the system of pulmonary, cardiovascular, gastroinstestinal, endocrine, and immunologic (Smeltzer et al, 2010).

The second highest response to grieving was self. In self aspects of elderly ages, the elderly who were mentally unbalanced or felt down, the loneliness they experienced might lead to a sense of isolation and depression manifested in the form of anxiety and physical complaints (Prawitasari, 1994). Positive self-concept would have an impact on patients who had good knowledge of themselves, realistic expectations, and healthy self-esteem. Where as negative self-concept happened to patients who were lack of knowledge of themselves, unrealistic expectations, and low self-esteem (Elihami, 2018).

The support domain was the third highest response from the grieving response. Support in this study was of high value, where at the time of occurrence, the support from family and other people was high, but sometimes this condition made the patients very dependent. They wanted to be noticed, felt sad when seeing others healthy while they ere in a helpless condition so that they had high dependence. Excessive dependence in relation to both their partners or personality traits showed a more chronic trajectory of grief (Bonanno et al., 2002). Support in grieving was necessary for the effectiveness of coping with psychological distress during difficult and pressing times. Support also helped to strengthen immune function, to reduce physiological responses to stress and to strengthen the function to respond to chronic diseases (Maziyah, 2015).

Spiritual is the fourth highest response to griefing, the grieving response to the spiritual was that the patients always prayed when facing a problem. The patients / respondents felt whether there was still hope in the future, felt injustice why heart disease occured to them, were sometimes disappointed, and rejected what had happened, felt that they had lost something meaningful, and were afraid of of repeated attacks and the threat of death. The patients / respondents who experienced a complicated grief had persistent and disturbing spiritual regarding death and resistance to accepting painful reality (Shear & Shair, 2005). Negative beliefs about self, life and future and interpretations of threats could lead to complicated grief (Boelen, Bout, and Hout, 2006). In this study, respondents felt that their worship was disrupted because of the installation of a dower cateter or defecation and urination in the bed so that it was considered to be a barrier to prayer, even though defecation and urination in the bed could be cleaned and could do prayer, this was consistent with the research of Emaliyawati, Ibrahim, & Yudianto (2011) on the spiritual dimension stating that there were difficulties in performing worship.

The highest domain of grief, if seen from the depression response, was loss (26,5%), behaving (8,8%), physical (5,9%) . When the respondents knew that they had a heart attack, the initial response was shocked. This happened when they were told that heart disease was a serious / severe disease that needed an intensive management and long management because heart disease often had to experience loss of self-autonomy, increased vulnerability to illness, burden due to long-term treatment (Supriadi, 2017). Therefore, this loss could affect the physical condition, thinking, and self.

Conclusions

The results of research conducted on patients with coronary artery disease in Intensive Cardiology Care Unit at the General Hospital of Dr. Hasan Sadikin described that most of respondents experienced complicated grief and few of them experienced uncomplicated grief. A high tendency for response to complicated grief was in the domain of behaving, thinking, feelings, and loss. It mean patients with coronary artery disease in Intensive Care Unit at the General Hospital of Dr. Hasan Sadikin should consult with Family doctor, therapist, or clergy.

The results of this study can be used as an analysis in determining nursing problems. Therefore it was important for nurses to anticipate

the complicated grief among patients and deliver nursing care that support patient situation. It is necessary to facilitate the patients to consult with other professionals such as psychologists, religious leaders or psychiatrists, nurses act as collaborators.

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Author Contributions

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Conflict of Interests

There was no conflict of interrest because of voluntary respondent, there were two people who refused, and it was not included in this research.

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