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THE INFLUENCE OF CHRONIC ISCHEMIC HEART DISEASE ON THE SOCIAL LIFE OF PATIENTS

Marieta Todorova
Department of Nursing, Faculty of Public Health, Medical University - Plovdiv, Bulgaria
marietattodorova@gmail.com

Abstract: Chronic diseases, including chronic ischemic heart disease, have an impact on patients' daily life and social lives. On the other hand, behavioral and psychological risk factors, poor social adaptation are predictors of disease progression or acute coronary syndrome. The aim of the study is to analyze the impact of chronic ischemic heart disease on patients' social lives.
Methods: 146 patients with chronic ischemic heart disease and a control group of 146 subjects were interviewed. The two groups are equal by gender. A survey questionnaire containing questions about the demographic characteristics of respondents, issues related to social life and addressing personal and professional engagements is used to collect the data.
Results: Patients have lower self-esteem to deal with professional and family commitments compared to the control group. Difficulties have been identified in communicating with family and friends, creating new social contacts, organizing everyday life and opportunities for other activities. These problems are typical of patients living alone, in small settlements and aged over 65. There is a difference in the self-esteem of life between the two groups studied, with the patient's assessment being lower.
Conclusion: Information on factors related to social adaptation and dealing with everyday life is essential for the secondary prevention of cardiovascular disease and improving the quality of life of patients.
Keywords: social adaptation, health-related quality of life, chronic ischemic heart disease, risk factors.

INTRODUCTION

Ischemic Heart Disease (IHD) is one of the leading causes of morbidity and mortality in developed and most developing countries. The World Health Organization estimates that IHD incidence will reach 6% of total morbidity in 2020, of which 11% in developed countries and the remaining 89% in developing countries [5, 10]. In the Eastern European countries, there are higher values of indicators related to the socio-economic and health burden of Coronary Artery Disease (CAD). Countries that are members of the European Union have for a long time been less burdened on their societies [3].
Improved Cardiovascular diseases survival coupled with a reduction in the incidence of Acute Coronary Syndrome has changed the model of health care in recent years. Patients with Stable Ischemic Heart Disease, as well as those who suffer from Acute coronary syndrome, live longer and the use of healthcare services is rising, and healthcare costs also [7]. On the other hand, IHD patients experience problems related to everyday life and social adaptation [1, 2]. *The aim* of this study is to analyze the impact of chronic ischemic heart disease on patients' social life.

MATERIAL AND METHODS

146 patients with chronic ischemic heart disease and a control group of 146 subjects were interviewed. The average age of respondents is 61.15 ± 2.35. The two groups are equal by gender. The mean age of the control group individuals is 54.50 ± 2.12. A survey questionnaire containing questions about the demographic characteristics of respondents, issues related to social life and personal and professional engagements is used to collect data. The evaluation is carried out on a 4-point Likert Scale. Data processing and analysis was performed with SPSS v.19 statistical software. MS Excel for Windows was used for the graphical presentation of the results.

RESULTS

For 17.3% of patients, self-assessment for dealing with work and family commitments is "low". Men indicate average level -32 (43.8%) and women - 29 (39.7%). Higher is the relative share of respondents in the control group who have "high" and "average" self-esteem for professional and family commitments. The mean responses to this question were: 2.89 ± 0.96 for the patients and 3.34 ± 0.63 for the control group. There was a statistically significant difference in mean response rates in patients and controls (t = 4.73, P=0.000). The average values of the respondents in the two groups are presented in Figure 1.

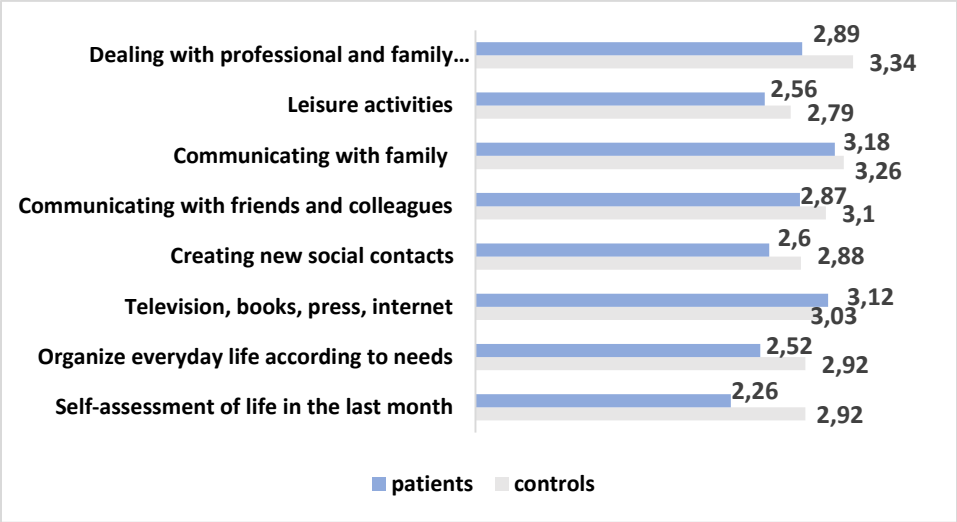

Figure 1. Average patient assessments and controls on some aspects of social life

Perform a parametric test of the working hypothesis with the t-test at a significance level P = 0.05. Only in two of the questions there is no statistically significant difference in the average values of the groups compared: communication with the family and frequency of internet use, television, books (P> 0.05).

Problems related to the disease have a negative impact on the opportunities for "family communication". The mean responses of the two study groups in terms of communication were: patients 3.18 ± 0.71, controls 3.26 ± 0.61. There is no statistically significant difference in the mean values of the assessment of this issue (t = 0.96, P> 0.05).

There were differences in the possibility of communicating with friends and colleagues between the patients and the control group. Patients who responded "often" to interact with friends and colleagues were 74 (50.7%). The relative share of men was 49 (67.1%); women 25 (34.2%). "Rarely" is the communication for 44 (30.1%) of the patients surveyed. There is a link between the frequency of communication with acquaintances, colleagues and friends and education (χ^2 = 13.25, df = 3, p = 0.001), and gender (χ^2 = 17.21, df = 3, p = 0.001). The rate of communication amongst the subjects in the control group was higher than in the patients. Response "very often" was reported by 18 (24.7%) men and 21 (28.8%) women. "Often" communicate with friends and colleagues 83 (56.8%) of this group. Of these, women 44 (60.3%), men 39 (53.4%) (Figure 2).

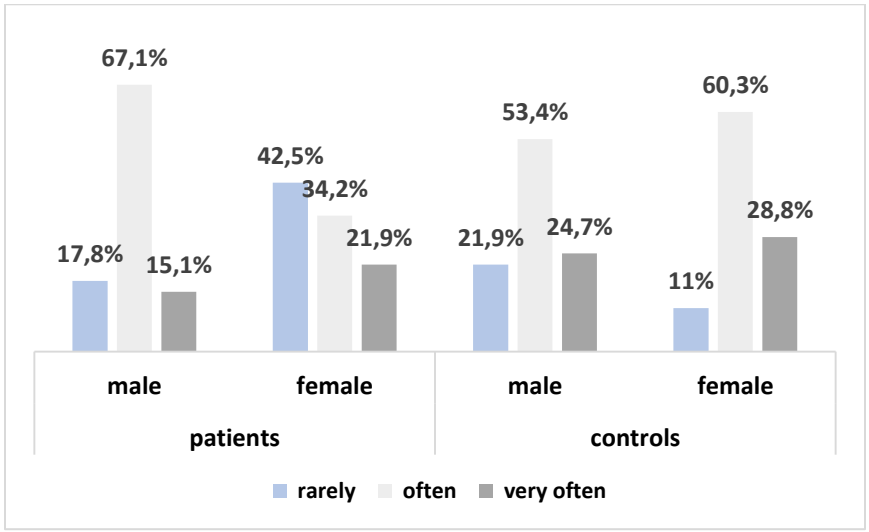

Figure 2. Comparative characteristics of patient responses and gender controls of the question: How often do you interact with friends and colleagues?

There was a statistically significant difference in mean response rates in patients and control group: patients 2.87 ± 0.70, controls 3.10 ± 0.65 (t = 2.93, P=0.004). This problem is characteristic of patients living alone, in small settlements and over 65 years of age.
To the question, "Are you trying to create new social contacts?" patient responses show that they are experiencing some difficulties in this area. The mean response rate for this issue was 2.60 ± 0.73 for patients and 2.95 ± 0.61 for respondents in the control group. A parametric test was performed to compare mean values and a statistically significant difference (t=3.53, P=0.000**)** was demonstrated.
An important aspect of social life is the ability to organize life according to needs. The relative share of patients who manage "very well" with the organization of life according to their state of health is (6.8%). For the control group, the relative share is (14.4%). A "good" day-to-day organization is present in 69 (47.3%) patients and 95 (65.1%) in the control group (Figure 3).

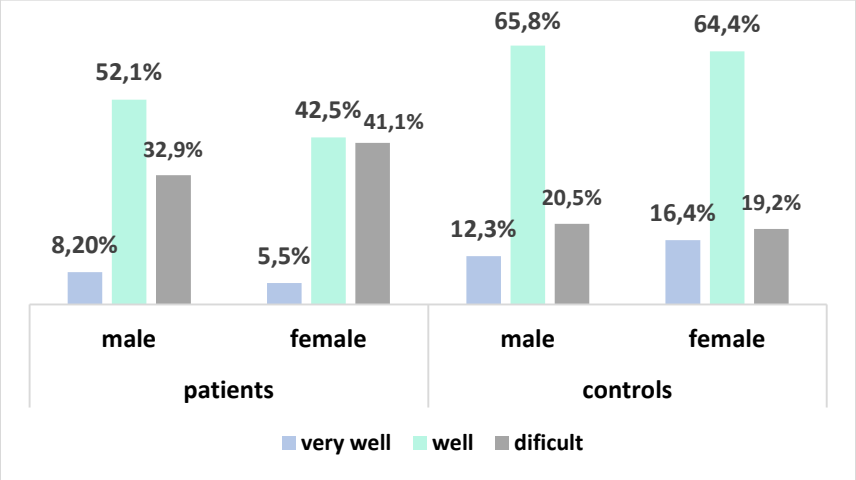

Figure 3. Comparative response between patients and controls: "Can you organize your life according to your needs?"

A statistically significant difference in the mean responses of the two groups (t=5.13, P=0.000**)** was demonstrated.
The subjective perception of quality of life and health is an important indicator of addressing the person with the disease. To the question "How do you set your life in the last month?" the following results were obtained: 8 (21.2%) patients and 30 (20.5%) controls gave "very good" self-esteem. "Good" is the estimated life for 53 (36.3%) patients. In the control group the relative share was higher 76 (52.1%). A "low" assessment was reported by 53 (36.3%) patients and lesser controls. The difference in mean responses in both groups was statistically significant (t = 7.11, P = 0.000).

DISCUSSION

The results obtained can be compared with similar studies of other researchers (Stoychev, 2012). Patients with IHD who are professionally involved show better social adaptability. There was a statistically significant difference between patients by age group and adaptation to social life. Persons over 60 and those who are not working have low social adaptation (pf = 0.082). The following issues are outlined: the feeling of isolation from the social environment, the reduction of friendship circle and anxiety [11].
According to the National Heart Foundation of Australia (2003), social isolation after myocardial infarction (MI) is a predictor of poor prognosis. Other factors such as work-related stress, dissatisfaction and emotional stress also adversely affect the lives of patients with IHD. The importance of these factors for the development of the disease is subject to lengthy studies. Patients with chronic IHD who live alone have a higher risk of cardiovascular death than those who have lived with someone (8.6% vs. 6.8%, P <0.01). Low social support from family and society is also a marker for poor prognosis and re-infarction rates. No studies in which the improvement or social support led to improving CHD results were found [4].
Although different scales have been developed to assess social support, there is still no scale that has been widely applied in clinical practice. A better option is the individual scarring approach for social adaptation through open

questions. Encouraging patients with problems in social adaptation to social activity can improve their health and lifestyle [9]. For a deeper understanding of the impact of social inequalities on cardiovascular diseases and conventional risk factors, specific health intersections and changes in social life should be explored [6, 8].

CONCLUSION

Self-assessment for dealing with professional and family commitments is lower for the patient group. Problems in social life consist of limitations in communicating with family and friends, creating new social contacts, dealing with routine activities, organizing everyday life and opportunities for other activities. The same group shows weak opportunities for other leisure activities.

Respondents give lower estimates of social life and dealing with everyday life. Difficulties have been identified with regard to family, professional circle communication and the creation of new social contacts. Self-assessment of the ability to organize everyday life according to needs is lower in the patient group. These results also relate to the quality of life that is considered satisfactory and good for the majority of the patients surveyed.

Social determinants and risk factors are an extremely important component of the epidemiology of Cardiovascular diseases and a challenge in the prevention, treatment and monitoring of these diseases.

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