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# Living With Depressive Symptoms: Patients With Heart Failure

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## Abstract

**Background—**Patients with heart failure often experience depressive symptoms that affect health-related quality of life, morbidity, and mortality. Researchers have not described the experience of patients with heart failure living with depressive symptoms. Understanding this experience will help in developing interventions to decrease depressive symptoms.

**Objective—**To describe the experience of patients with heart failure living with depressive symptoms.

**Methods—**This study was conducted by using a qualitative descriptive design. The sample consisted of 10 outpatients (50% female, mean age 63 [SD, 13] years, 70% New York Heart Association class III or IV) with heart failure who were able to describe depressive symptoms. Data were collected via taped, individual, 30- to 60-minute interviews. ATLAS ti (version 5) was used for content analysis.

**Results—**Participants described emotional and somatic symptoms of depression. Negative thinking was present in all participants and reinforced their depressed mood. The participants experienced multiple stressors that worsened depressive symptoms. The overarching strategy for managing depressive symptoms was “taking my mind off of it.” Patients managed depressive symptoms by engaging in activities such as exercise and reading, and by using positive thinking, spirituality, and social support.

**Conclusions—**Patients with heart failure experience symptoms of depression that are similar to those experienced by the general population. Clinicians should assess patients with heart failure for stressors that worsen depressive symptoms. Strategies that researchers and clinicians can use to reduce depressive symptoms in patients with heart failure include engaging patients in activities, positive thinking, and spirituality. Helping patients find enhanced social support may also be important.

Heart failure is a chronic syndrome that affects 5 million people in the United States[1] and is the most common cause of hospitalization in elderly adults.[2] Major depressive disorder is common in hospitalized patients with heart failure. One-third of hospitalized patients with heart failure have major depression, and 40% of these persons are still depressed 1 year later.[3]

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According to the American Psychiatric Association, a major depressive episode consists of 5 or more symptoms that are present most of the day for at least 2 weeks. One of these symptoms must be depressed mood or loss of interest in usual activities, and the symptoms must cause significant distress in social, occupational, or other areas of functioning.[4]

Individuals can experience significant depressive symptoms without a diagnosis of major depressive disorder.[5] Sometimes called subthreshold depression, depressive symptoms include depressed mood, guilt, hopelessness, low self-esteem, fatigue, sleep disturbances, appetite change, and inability to concentrate.[6] Researchers have proposed that depressive symptoms lie within a continuum of depressive illness severity that ranges from mild depressive symptoms to a diagnosis of major depressive disorder.[7]

It is estimated that up to 48% of outpatients with heart failure experience clinically significant levels of depressive symptoms.[8] The presence of depressive symptoms has important clinical consequences for patients with heart failure. Patients with heart failure who have depressive symptoms experience reduced health-related quality of life and an increased risk of rehospitalization and mortality.[8,9]

Although researchers have examined the predictors and outcomes of depressive symptoms in patients with heart failure, none have described the experience of living with depressive symptoms. Qualitative research can help researchers and clinicians understand a phenomenon from the patient's point of view and guide the development of future interventions. The purpose of this qualitative study was to describe the experience of persons with heart failure living with depressive symptoms. The primary research question was: How do persons with heart failure describe their depressive symptoms? Secondary research questions included the following: What factors influence depressive symptoms? What are strategies that persons with heart failure use to manage depressive symptoms?

## Methods

### Qualitative Description

This investigation was conducted by using a qualitative descriptive design. Qualitative description involves low-inference interpretation and is often the first step in exploration of a phenomenon. The result is a descriptive summary of the experience in everyday language.[10] This topic is particularly suited for qualitative description because little is known about how patients with heart failure describe their depressive symptoms.

### Participants

The study was nested in a clinical trial of biofeedback and cognitive therapy in patients with heart failure. The institutional review board provided approval before participants were recruited. Patients were eligible to participate if they had a diagnosis of chronic heart failure, were in stable condition on cardiac medications, had no coexisting terminal illness, and had not had a stroke or myocardial infarction within 3 months.

Purposive sampling was used to select 10 outpatients who had a self-reported history of past or current depression, or were experiencing a clinically significant level of depressive symptoms, defined as a score of 14 or greater on the Beck Depression Inventory-II[11] upon enrollment in the trial (Table 1). Purposive sampling ensured equal numbers of men and women and equal representation from the intervention and control groups. The intervention group received 6 weeks of biofeedback training and cognitive therapy from a psychiatric nurse practitioner, while the control group received 6 weeks of attention placebo, which consisted of self-selected relaxation exercises delivered by a psychiatric nurse practitioner.

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### Data Collection

One-time, semistructured interviews were conducted in the participants' homes after the intervention or placebo portion of the trial was completed. Results from 2 initial interviews indicated that patients had difficulty answering direct questions about symptoms of depression. Therefore, interviews began with questions regarding recent stressful events to elucidate depressive symptoms. Questions explored the participant's symptoms that occurred during the stressful event. Participants were asked to share techniques that they used to prevent or cope with depressive symptoms. Interviews lasted between 30 and 60 minutes and were audiotaped. Participants were reimbursed $30 for their time.

### Data Analysis

An inductive approach to content analysis was used in this study. Interviews were transcribed verbatim and transcriptions compared with the taped interviews to ensure accuracy. A codebook was developed to assist in the analysis. The codebook contained a priori codes based on a literature review, as well as codes that emerged from the data. We used Atlas ti (version 5.0) to code the data. Each interview was read, reread, and coded by the primary author (R.L.D.). The transcripts were compared to ensure that coding was consistent throughout, and codes were first sorted into categories and then into larger themes. Data displays that depicted the frequencies of the codes were developed to assist in the reduction of the coded data into categories.[12] The abbreviated data display for factors influencing depressive symptoms is provided in Table 2 as an example of the data displays used for data reduction.

### Trustworthiness and Credibility

To establish trustworthiness and credibility, we used 3 procedures recommended by Creswell.[13] First, we clarified bias before data collection by bracketing assumptions. Bracketing assumptions consists of writing down personal assumptions about the phenomenon; this process allows the researcher to collect data with as unbiased a viewpoint as possible. Second, the coauthors met frequently throughout data analysis to verify that the coding accurately reflected the content of the interviews. Third, the research results were returned to 3 participants to verify accuracy of the findings.

## Results

### Depressive Symptoms

The participants' descriptions of depressive symptoms were similar to symptoms of depression as defined by the Diagnostic and Statistical Manual-IV-TR criteria.[4] The participants described emotional symptoms of sadness, irritability, tearfulness, and anxiety. The participants also experienced somatic symptoms that they attributed to depression, including lack of energy, changes in appetite, sleep disturbances, and difficulty concentrating. Finally, the participants described experiencing negative thinking and cognitive distortions.

**Emotional Symptoms—**Eight of the 10 participants described sadness as part of their experience with depression. The participants used the terms "terrible sadness," "depressed," "moody," "bad blue mood," and "upset" to describe their mood. Six of the participants stated that tearfulness was a frequent symptom. One participant cried during the interview, stating: "It's just I'm sad. And I think it's just because there's a lot of sad stuff. It's just been really hard."

Half of the participants complained of feeling irritable. They expressed feelings of aggravation, frustration, and anger. In many cases, irritability resulted in strained relationships with children

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or spouses. As one participant said, "Sometimes I could just scream and 1 day I did, several times I have, about them not cleaning."

In addition to sadness and irritability, feelings of anxiety were described by 9 participants. The participants used "tense," "tight," "shaky," "nervousness," "worry," and "fear" to describe their anxiety. One participant shared: "At night I start thinking about it, the consequences of what could happen and what couldn't and what would come out good, and I just, just get in a knot again."

**Somatic Symptoms—**Seven participants described somatic symptoms attributed to depression that included changes in appetite, sleep disturbances, and lack of energy. Only 1 patient described an increase in appetite; 3 others described a loss of appetite. Three of the participants described sleep disturbances. One participant in particular spent much of her time sleeping. At her request, the interview took place in her bedroom, while she sat in bed. She said, "Sometimes I just come in the room, shut the door and go to, and just go to sleep, just lay here." Only 3 participants complained of a lack of energy.

**Negative Thinking—**All 10 participants described negative thinking or self-critical thoughts.[14] Participants described thoughts such as, "I can't justify my existence," "I have nothing to offer any more," and "I'm a failure." The participants stated that the negative thoughts reinforced their depressed mood. As 1 participant shared: "Sometimes it gets me down because I start thinking about other things…. You know, it just kind of moves up to keep going up the ladder."

Participants described cognitive distortions that accompanied negative thinking. Magnification is a cognitive distortion in which a person inflates the magnitude of the problem.[15] For example, when 1 participant underwent surgery, she could think only about the possibility of death: "Am I going to come out of this, am I going to die, you know, is this my last time, or I'm going to die in there on the operating table."

Another frequently mentioned distortion was dwelling. Dwelling is defined as long, uninterrupted series of depressive thoughts that worsen depressive symptoms.[15,16] When asked what advice she would give to someone in her situation, 1 participant answered: "I think I would tell them you know, from my experience, the more you dwell on it, the worse off you get."

## Stressors

Participants described stressors that worsened their depressive symptoms. The stressful experiences that the participants lived with included financial difficulties, family problems, health issues, and loss.

**Financial Difficulties—**Seven participants described financial difficulties, including bankruptcy, living on a fixed income, and being disabled. One participant said that finances were the primary contributor to her depressed mood:

> I think the main thing well that, that upsets me is finances. If my finances get to the point where I get to a week before payday and I don't have any money, then I get very stressed and I think that stresses everybody. But I think it especially stresses me.

**Family Problems—**Nine participants talked about stressful situations in their families. Problems that the participants dealt with ranged from children who were incarcerated to grandchildren who were having problems, to alcoholism and arguments among family members. The participants described feeling worried about family situations and saddened or

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irritated by conflict. One participant felt depressed because he was estranged from his only child:

> Well I felt sad there for a long time because my daughter, I wanted to be in contact with her and I felt hurt … I want to be somebody my daughter can depend on me being there when she needs me.

**Health Issues—**Interestingly, only 5 of the participants mentioned heart failure as influencing depressive symptoms. Three participants stated that depressive symptoms were present before the development of heart failure. One participant said that having heart failure did not make her depressed. Instead, she said, "it's just something else for me to be depressed about." The majority of participants described other health conditions as being stressful and contributing to depressive symptoms. Participants described dealing with cancer, diabetes, arthritis, and chronic pain.

**Loss—**The participants described numerous losses that worsened their depressive symptoms. Four of the participants described the death of a son or daughter. One participant had experienced the death of 2 children. Although some of these deaths had occurred years ago, it was clear that the participants still felt the effects of the loss. Complicating the bereavement process for these participants was the fact that all of the deaths were sudden. One participant said: "Well of course you know it's been in 2003 when my daughter died suddenly and I still haven't gotten over that and of course at night sometimes I cry over that."

Other participants did not discuss the loss of a loved one, but they experienced other losses. One participant described the loss associated with not being able to work: "I used to get really depressed. I can't work anymore; what am I going to? I mean, it really bothered me at first."

### Strategies for Managing Depressive Symptoms

The overarching strategy described by the participants was "taking my mind off of it." Four types of strategies were used by participants to take their minds off of depressive symptoms: activities, distraction, social support, and medical intervention.

**Activities—**Exercise was mentioned by 9 participants as being an important method of reducing depressive symptoms. The most commonly mentioned exercise was walking. The participants repeatedly said that walking made them feel better and that any amount of exercise was better than just "sitting around." One participant stated:

> I've started walking. It's fun. I put my, I take my radio and listen to my music and it makes me feel good because I kind of walk and do a little dance while I'm walking and so, so it has made me feel good when I was walking.

In response to the question "What are some of the things that help you feel better when you feel down?" 9 participants mentioned reading. The participants who had difficulty reading would listen to books on tape instead. As one participant said, "Rather than sit here and think about the bad things you know, I can get me a book to listen to." For most participants, reading allowed them to "take their mind off things" and focus on something other than the depressive symptoms.

Being active, or "staying busy," was mentioned by 6 participants as a behavioral tactic that kept them from thinking about depressive symptoms. Participants used a variety of activities to stay busy, such as bird watching, crocheting, and watching television. The simple act of getting involved in an activity helped relieve the participant's depressive symptoms: "Sometimes I like to do crafts. I like to work crosswords and do Sudoku. Other times that just gets my mind off things and just concentrating on that one thing."

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**Distraction—**For these participants, distraction is defined as the ability to redirect one's internal focus away from negative thoughts or emotions. For 7 participants, spirituality or religiosity was an important method of distraction. Participants received relief by praying, attending church, and reading scripture. One participant quoted Biblical scriptures several times. He said, "When we fill our mind and our heart with the scriptures, that's something that we can depend on."

A central component of spirituality was a relationship with God. One participant described God as "my other best friend." Another participant said:

> I feel I have a great relationship to God because I talk to him about a lot of things and when I do, I feel better. I feel that a burden has been lifted from me; not all the time right away but it's been, you know it's been lifted.

When asked "If you were talking to someone like you who felt depressed or down, what advice would you give them?" 9 of the 10 participants discussed positive thinking. Positive thinking is a central component of the cognitive therapy intervention that 5 of the participants had received. However, 4 of the 5 control group participants also discussed positive thinking. As 1 control group participant said:

> The main thing I think that I've found is trying to keep my mind off of things that make me sad. If I find myself drifting that way, well then I know right away I've got to think of 2 positives. Because that's a negative. And like I said, when you've got a negative, you've got to come up with 2 positive things to replace that.

Instead of dwelling on negative thoughts, the participants redirected their thoughts toward the positive. One participant focused on the future:

> Think about the future. Think about the future; don't dwell on the past, there's nothing you can do. It's happened; it is depressing. You know that your life has changed; it's changed your life completely. But think about the positive you know, life goes on.

Others focused their thoughts on affirmations. One participant read his affirmations out loud:

> My heart may be sick, but my mind and soul are strong and healthy. My problems are an opportunity for me to grow as a person. I'm a person of value even if I have heart failure, back trouble, knees and shoulder, and I'm old.

Additional examples of affirmations included: "I'm alive, I'm thankful for that, I'm alive," "Things are going to get better, going to get better," and "I might not be able to do the things I used to do but there's new things I can do."

**Social Support—**All 10 participants stated that social support was an important factor in reducing depressive symptoms. Family and friends provided emotional, physical, and financial support. The married participants all provided positive descriptions of their marriages. As 1 participant said:

> I do appreciate that lady [indicating his wife] over there. The Lord drawed us together and we were married after getting out of the service…. Yes we celebrated our 50th about 3 years ago. And pretty soon we'll come up with number 54.

**Medical Intervention—**Seven of the participants (5 females and 2 males) were taking antidepressants at the time of the interview, yet only 4 participants—all women—mentioned antidepressants as a strategy for managing depressive symptoms. One participant described how antidepressants helped her enjoy sunlight again: "I used to hate days like today where it was sunny. Like I couldn't stand to be in the sun and ever since I've been on antidepressants, I enjoy sunshine."

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## Discussion

The participants in this study described emotional and somatic symptoms of depression as well as negative thoughts that worsened their mood. Stressors such as financial difficulties, family problems, and health conditions exacerbated the depressive symptoms. Individuals described "taking their mind off" depressive symptoms through activities, distraction, social support, and medical intervention.

The depressive symptoms experienced by the participants were similar to those experienced by the general population with depressive symptoms. The majority of the sample experienced a depressed mood. This finding is particularly interesting because 7 participants were receiving antidepressant therapy. The finding that our participants experienced significant emotional symptoms contrasts with results from a prior study[17] in which a sample of outpatients with heart failure and major depression living in Germany had fewer emotional symptoms of depression, as measured by the Patient Health Questionnaire-9, when compared with patients with major depression who did not have heart failure. It is possible that the Patient Health Questionnaire-9 did not effectively capture the emotional symptoms that are experienced by patients with chronic heart failure. The participants in our study may also have been more likely to divulge emotional symptoms in their home environment as opposed to a clinic or research setting.

Few somatic symptoms of depression were mentioned by participants. Participants may have attributed somatic symptoms to heart failure rather than depression. Several common symptoms of heart failure, such as fatigue, anorexia, and sleep disturbances, overlap with symptoms of depression. This symptom overlap may contribute to the participants' difficulty in recognizing somatic symptoms of depression.[17] In addition, clinicians may also attribute somatic symptoms to heart failure instead of depression. This lack of recognition of the somatic symptoms of depression could contribute to the low treatment rates of depression in persons with heart failure,[3] as well as undertreatment, which results in individuals not receiving therapeutic doses of antidepressants.

An important finding of this study was that negative thinking was common and had a detrimental effect on the participants' mood. The presence of negative thoughts has been described as a characteristic of major depression.[15] This study was the first, however, in which negative thinking was described as important in patients with heart failure who have depressive symptoms. The participants experienced cognitive distortions that maintained their negative thought processes. Researchers have found that magnification is an independent predictor of depressive symptoms in the elderly.[16] In addition, depressed patients who "dwell" on negative thoughts experience a worsened mood and are less able to problem solve.[18]

The participants described a variety of stressors that worsened their depressive symptoms. This finding is consistent with results from other qualitative studies on living with heart failure. Investigators have found that patients with heart failure experience physical, emotional, and social turmoil in their everyday lives,[19] as well as multiple personal struggles and losses.[20,21] In combination, these studies demonstrate that having a diagnosis of heart failure is only 1 stressor in a life full of difficulties.

Many clinicians assume that patients with heart failure are depressed because they have received a diagnosis of heart failure. However, only half of the participants mentioned heart failure as influencing depressive symptoms. Future qualitative research should explore whether patients with heart failure attribute their depressive symptoms to heart failure. For 3 participants, depression was something that they struggled with for years before the onset of heart failure. Preexisting depression is an independent risk factor for development of heart

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failure.[22,23] Thus, the long history of depression may have increased the risk of heart failure developing in these participants.

Of particular interest are the multiple strategies described to counteract depressive symptoms. The overarching strategy was "taking my mind off of it." Participants used activities, distraction, social support, and medical intervention to alleviate their symptoms. Activity in the form of exercise appears to be as effective as antidepressants for the treatment of depression in the elderly.[24] Results from several small trials have shown that exercise improves depressive symptoms in patients with heart failure.[25,26]

The participants' use of social support to alleviate depressive symptoms is supported by the literature. Results from 1 study[3] demonstrated that an increase in perceived social support was the only factor that was a predictor of faster remission from depression in hospitalized patients with heart failure. In contrast, poor social support, defined as living alone, is an independent predictor of the development of depressive symptoms in patients with heart failure,[27] whereas single marital status also is predictive of depressive symptoms in patients with heart failure.[28]

For most of the participants, spirituality was an important method of managing depressive symptoms. Researchers have demonstrated an inverse relationship between spiritual well-being and depressive symptoms in patients with chronic heart failure.[29] In addition, researchers have demonstrated that older patients with heart failure who are involved in religious activities remit faster from depression than do nonreligious patients.[30]

The participants used positive thinking more than any other strategy to manage their depressive symptoms. They also expressed that affirmations were an important method of reducing negative thoughts. The evidence to support positive thinking and affirmations as effective strategies is found in cognitive therapy, which is based on the cognitive model of depression. The cognitive model proposes that redirecting negative cognitive processes into positive ones can improve the symptoms of depression.[31] The use of cognitive strategies was not surprising for the 5 participants who received cognitive therapy in the parent study. However, 4 of the 5 control group participants also discussed positive thinking as a strategy for managing depressive symptoms.

Although most of the participants were taking antidepressants, few mentioned medications as a method of managing depressive symptoms. It is possible that participants did not view their depressive symptoms as a medical condition. Thus they may not have considered antidepressants as a strategy for managing depressive symptoms. Selective serotonin reuptake inhibitors are often prescribed for depression in patients with heart failure because of the lack of cardiac side effects.[32] Currently, little evidence is available on the efficacy of selective serotonin reuptake inhibitors for treating depression in patients who have heart failure. However, a large randomized, controlled trial is currently under way.[33]

## Limitations

Because of the heterogeneity of depressive symptoms experienced by participants, it may be necessary to obtain more viewpoints to fully understand the experience of living with depressive symptoms in persons with heart failure. Similarly, only 1 interview was conducted with each participant. Additional interviews might have revealed other depressive symptoms and coping strategies or provided additional insight into the connection between heart failure and depressive symptoms. This study included participants who experienced a cognitive therapy intervention that may have influenced participants' experiences. This strategy can also be considered a strength because it included patients with a broad range of perspectives.

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## Conclusion

The results of this study have important implications for clinicians and researchers who work with patients with heart failure. Given the negative outcomes associated with depressive symptoms, clinicians must assess hospitalized patients with heart failure for the presence of depressive symptoms as well as stressors that might exacerbate depressive symptoms. It also is important for clinicians and researchers to note that depression in patients with heart failure may benefit from the same interventions that are effective for treating depression in the general population. Participants in this study managed depressive symptoms through the use of activities, distraction, and social support. These strategies are worthy of development and testing among patients with heart failure in the acute care arena.

This study is the first to indicate that negative thinking may be an important component of depressive symptoms in patients with heart failure. By targeting negative thinking, clinicians may be able to reduce depressive symptoms in patients with heart failure. Clinicians can teach hospitalized patients with heart failure to recognize negative thoughts and replace them with positive thoughts and affirmations. For example, an acute care nurse could ask a hospitalized patient with heart failure, “What kinds of thoughts are you experiencing right now?” After assessing for the presence of negative thoughts, the nurse can teach the patient how to replace negative thoughts with positive ones. Clinicians also may help alleviate hospitalized patients’ depressive symptoms by assessing their spiritual well-being and referring patients with needs to appropriate spiritual care. Encouraging patients to engage in activities such as walking or reading while they are hospitalized may also reduce depressive symptoms. Finally, helping patients’ significant others provide enhanced social support may be an important method for reducing depressive symptoms in patients with heart failure.

Clinicians can no longer ignore the fact that patients with heart failure experience levels of depressive symptoms that reduce quality of life and increase the risk for mortality. This study is the first description of the experience of living with depressive symptoms in patients with heart failure. Clinicians can use the results from this study to gain understanding of the patient’s perspective of living with depressive symptoms. Researchers can use the results to develop and test interventions to reduce depressive symptoms.

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**Table 1**

Characteristics of participants

| **Characteristic** | **Value** |
|---|---|
| Female, % | 50 |
| Age, y | |
| Mean (SD) | 62.5 (13.2) |
| Range | 37–81 |
| Minority, % | 20 |
| Married, % | 70 |
| New York Heart Association class, % | |
| I | 10 |
| II | 20 |
| III | 60 |
| IV | 10 |
| Some college education or greater, % | 70 |
| Employed, % | 20 |
| Beck Depression Inventory–II score | |
| Mean (SD) | 18.9 (11.8) |
| Range | 7–40 |
| Antidepressant use, % | 70 |

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**Table 2**

Data display for factors influencing depressive symptoms

| Code | Frequency | Example quote |
|---|---|---|
| Family problems | 9/10 | "Kids and grandkids … something is always going on in their lives. And at least one of them always has a problem of some kind to deal with." |
| Loss | 9/10 | "Even though it's been 11 years since my daughter died, I have days where I think about her a lot. I mean it never gets easy." |
| Finances | 7/10 | "We just went through a bankruptcy. And that was not easy. I don't like things like that, but there was nothing we could do." |
| Health problems | 8/10 | "I've been having a lot of problems with the back, a lot of pain and so on. I've had all kinds of treatments and nothing works." |
| Heart failure | 5/10 | "The only thing that stresses me really is, I want to be able to breathe better so that I can do more around the house." |
| History of depression | 3/10 | "See, I'm a person who's fought depression all of my life, I mean even when I was a child." |