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ASSESSMENT OF DEMAND FOR PSYCHO-SOCIAL SUPPORT FOR PATIENTS WITH CHRONIC CARDIOVASCULAR DISEASES

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Abstract: Introduction. Chronic diseases, including cardiovascular ones, constitute a serious social and health problem of the contemporary world. The crucial role in care for chronically ill patients lies within the widely understood psycho-social support that enables the satisfaction of basic needs of the ill. The aim of the work was the assessment of demand for psycho-social support for patients with chronic cardiovascular diseases.
Material and methods. The method of diagnostic survey was implemented with the use of a self-prepared questionnaire, which related to the subject of the research, as well as of the standardized Social Support Scale developed by Krystyna Kmiecik-Baran in the Institute of Social Studies.
Results. Results of the research, the main source of support for chronically ill people with chronic cardiovascular diseases was a family. The ill over 80 years of age, with a slight majority of men, used the social support more often.
Conclusions. According to the assessment of patients with chronic cardiovascular diseases, it was a family that constituted the source of non-professional support. A family to the greatest degree provided the respondents with a strong emotional, informational, instrumental and appraisal support. Nursing staff as well as doctors offered greater support for older people.

Key words: support, chronic cardiovascular diseases.

Introduction

According to the definition developed by the American Commission on Chronic Illness, a chronic illness consists of various disorders or derogations from the norm, which include one or more outstanding characteristics. They involve: long time of illness duration, etiology. Moreover, development and treatment are not equally defined and their consequences may include disability or irreversible changes in an organism. Additionally, a specialist care of a physiotherapist is also necessary. Minimal time of a chronic illness duration is three months [1, 2].

Diseases may be divided into serious and chronic. Serious diseases are characterised by fast course of a disease and they do not leave permanent consequences. Chronic diseases, on the other hand, once they are diagnosed, last until the end of life. The treatment does not give the opportunity to cure the disease completely, but only improves the comfort and quality of life [3, 4].

Social support is not clearly defined. It can be explained in a variety of ways [5]. Social support can be described as an impartial and common social network, which can be differentiated from the others by the existence of bonds, interpersonal contacts, sense of belonging. It is also practiced as a helpful function in relation to people in difficult life situations [6–8].

Social support is described by some as a decisive factor influencing the so called „biographical scenario of individuals". Easy access to the support has a big impact on people's functioning, their attitude to problems and their health condition [8, 9].

Social support is usually classified according to the House division, which distinguishes the following types of support: emotional, instrumental, informational, appraisal, in-kind and spiritual [8, 10].

Emotional support is based on emotional transfer, showing protectiveness, compassion, understanding, indicating positive attitude towards the supportive person. It is associated with the message 'you are loved'. This kind of help can be received by showing concern, understanding and recognition, encouragement, emotional stimulus and displaying appreciation for minor achievements. This can be the way to improve one's self-esteem [8, 10].

Instrumental support concerns precise information about the possibility of receiving assistance, which will improve health condition and life situation [8, 10].

Informational support involves the provision of information, advice as well as legal and medical counseling that help to understand the situation we found ourselves in. It is

mostly provided by professionals. They transfer knowledge concerning the available ways and means for problem solving. The essential task of this support is about sharing one's own observations, events. These kinds of stories, although not professional, act plausibly due to personal experience [8, 10].

Appraisal support involves showing acceptance, providing information that facilitates self-esteem improvement [8, 10].

In-kind support (material) consists of various forms of improving the situation through financial benefits i.e. allowance or subsidies e.g. food, pharmacological means, shelter for persons in need. The so-called informal support is also being distinguished, i.e. charity activity of churches and other religious groups and also donators [8, 10].

Spiritual support is usually present in hospice care. It is most frequently used in critical situations in patients who suffer from chronic pain and other symptoms, such as: dyspnoea, constipations, vomiting, nausea, dry mouth etc. [5, 10–12].

Patient's support is provided in various directions: physical, mental, spiritual and social.

Physical support involves elimination and reduction of physical symptoms. A nurse should observe a patient and have good contact with him. The task is to cooperate with the family, so as to provide maximum comfort for the ill, but also with the doctor and priests. Chronically ill persons, especially those who suffer from cancer, must often cope with strong pain. It is important to eliminate it by prescribing painkillers and improving the patients' quality of life [13].

Mental support involves employing all the means in order to minimize symptoms that go with the disease or the process of dying. The main task is to eliminate and alleviate the fear, anger and gloom. People who are chronically ill experience various emotions: anger, rage, wrath, sadness, sorrow, gloom, fear, anxiety, infirmity, shame, remorse. They are very often hidden and concealed from close people and medical staff. Patients can be offered a moment of relaxing and forgetting about the illness by reading books, magazines or listening to relaxing music. Contact with a psychologist or a priest helps to accept the chronic condition. A psychologist should possess empathy and patience towards the ill, be creative and by his presence should strengthen the sense of security [14].

Spiritual support refers to help in spiritual suffering. „Soul pain" is a practically unachievable sphere. Assistance is based on preserving the patient in his best condition as long as possible. Support from a family, a doctor, or a nurse causes that the perspective of death and dying can become delicate and calm. A nurse brings her patient closer to God by her presence, warmth and silent praying. „A person should not be isolated as it intensifies the scale of suffering" [14].

Social support means providing help to the ill and meeting his needs. We include here the aforementioned emotional, informational, instrumental, appraisal and in-kind [15–17].

The aim of the work was to assess the demand for social support among patients with chronic cardiovascular diseases.

Research Material and Methodology

The choice of the studied group was deliberate. The study was conducted on chronically ill patients from NZOZ Przychodnia Rodzinna (Family Health Care) Bartnicki, Boużyk-Masłowska, Dolińska – doctors in Białystok. 120 patients participated in the research. All of them were undergoing treatment due to chronic cardiovascular diseases: arterial hypertension, circulatory insufficiency, chronic coronary heart disease.

The method of diagnostic survey was implemented with the use of an original questionnaire, composed of 17 self-prepared questions, which related to the subject of the research, including a sociodemographic statistical part as well as the standardized Social Support Scale developed by Krystyna Kmiecik-Baran in the Institute of Social Studies [18]. The scale served to measure the strength and support received from social groups. The scale was divided into four types of support: emotional, instrumental, informational, appraisal.

Positions constituting the given subscales in the Social Support Scale developed by Krystyna Kmiecik-Baran [18]:

Informational support:

1. They patiently explain when I do not understand something.
2. They warn me when I am in danger.
3. Their pieces of advice proved valuable when taking important decisions.
4. It happened that I was misled on purpose – we reverse the scale – negative statement.

Instrumental support:

5. They lend me money when I am in need.
6. They sacrifice a lot of time for me.
7. They take care of me when I need it.
8. When I ask for specific help, they deny and do not hide anger – we reverse the scale – negative statement.

Appraisal support:

9. They assume that I cannot do anything right – we reverse the scale – negative statement.
10. Usually, they entrust me with very important tasks.
11. I feel somebody important in their company.

12. I often provide them with various pieces of advice.

Emotional support:

13. They understand me.
14. They accept me the way I am.
15. I feel ignored by them – we reverse the scale – negative statement.
16. I feel safe in their company.

Adopted grading scale:

4 – yes – a statement very strongly filled with a particular type of support
3 – rather yes – a statement strongly filled with a particular type of support
2 – rather no – a statement very weakly filled with a particular type of support
1 – no – a statement not filled with a particular type of support

Points allocation:

- for every „yes" answer – 4 points
- for „rather yes" – 3 points
- for „rather no" – 2 points
- for „no" – 1 point.

In case of negative statements, the allocation of points should be reversed.

Types of received results:

1. General result – defines the level of social support without differentiating into various types of support. The maximum number of points that can be achieved is 64 (receiving the full social support):

- up to 32 points – very low level of social support
- from 33 to 47 points – medium level of social support
- from 48 to 64 points – high level of social support

2. Results denoting a high level of informational support – the maximum number of points that can be achieved is 16:

- from 4 to 7 points – low level of informational support
- from 8 to 12 points – medium level of informational support
- from 13 to 16 points – high level of informational support

3. The result showing a level of instrumental support – the rules of calculating points similar to the ones used with informational support.

4. The result showing a level of appraisal support – the rules of calculating points similar to the ones used with informational support.

5. The result showing a level of emotional support – the rules of calculating points similar to the ones used with informational support [18].

Results

The research covered jointly 120 patients with chronic cardiovascular diseases. The majority of respondents were women (58%) and there were 42% of men.

The examined patients were mostly older persons. 27.5% of participants were above 80, in the age range 71-80 – 15.83%, 61-70 years – 17.5%, 51-60 years – 18.33%, 41-50 years – 6.67% and the respondents below 41 years of age – 14.17%.

The majority of the respondents came from big cities above 100 thousand of inhabitants – 73.33%. People living in towns from 10 to 100 thousand of inhabitants constituted 13.33%, in a small town up to 10 thousand of residents – 8.34% and in a village only 5%.

The conducted study demonstrated that social support was not provided to 38.33% of patients, because it was not demanded. 24.17% of the respondents did not receive social support, although they informed about such a need and 19.17% of the surveyed patients were not provided with social support, because they had never tried to receive one.

Generally, in spite of not receiving social support, 46% of the respondents did not have negative feelings connected with this situation. Negative feelings due to lack of social support were reported by 36% of the studied patients. The results are illustrated in Fig. 1.

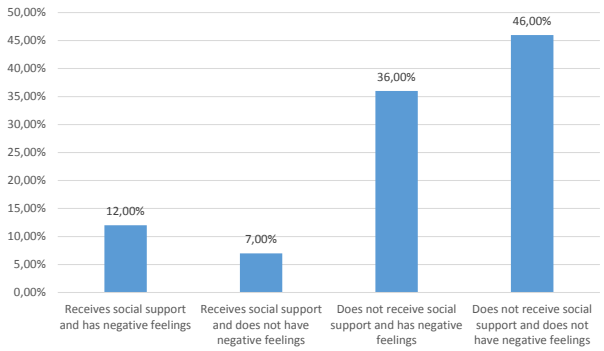

Fig. 1: Negative Feelings of the Studied People Receiving Social Support.

It the group of the studied patients, men used social support more often (10.83%) than women (7.50%). Women needed social support definitely less – 24.17%. The results are illustrated in Fig. 2.

Among the studied respondents, there were people over 80 years of age who mostly took advantage of social support (10.00%) as well as childless people (8.33%). The results are illustrated in Fig. 3.

Generally, patients with chronic cardiovascular diseases received emotional support in greatest extent from their families – 30.30%, next from nurses (18.18%), doctors (17.58%), neighbours (12.73%), friends (11.52%) and support groups

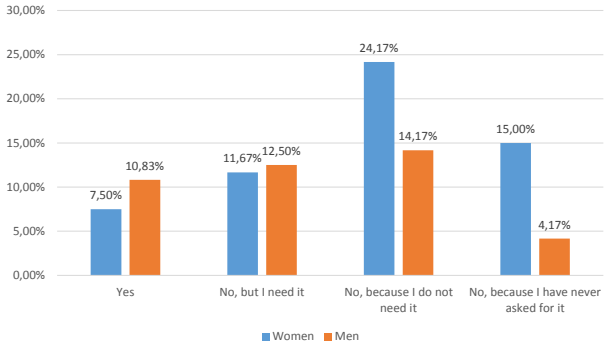

Fig. 2: Taking Advantage of Social Support According to the Respondents' Sex.

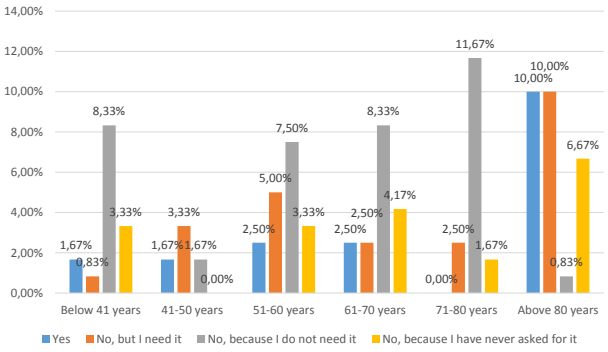

Fig. 3: Taking Advantage of Social Support According to the Respondents' Sex.

(7.88%). Only 1.82% of the respondents did not have any supportive person. Exact results are demonstrated in Fig. 4.

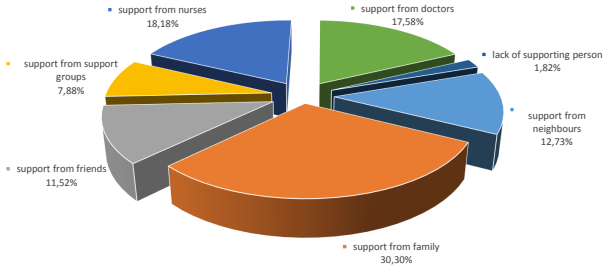

Fig. 4: Sources of Support for Patients with Chronic Cardiovascular Diseases.

Taking into account the fact that the group was mostly composed of patients with arterial hypertension, it was proved that those patients received emotional support mostly from their families (31.88%), next from nursing staff (17.87%), doctors (14.49%), friends (13.53%), neighbours (12.56%) and support groups (8.21%). Lack of supportive person was declared by 1.45% of the respondents. Exact results are demonstrated in Fig. 5.

Among the patients with arterial hypertension, the medical staff provided support to a greater extent to men (63.33%) than women (36.67%). Informational support was

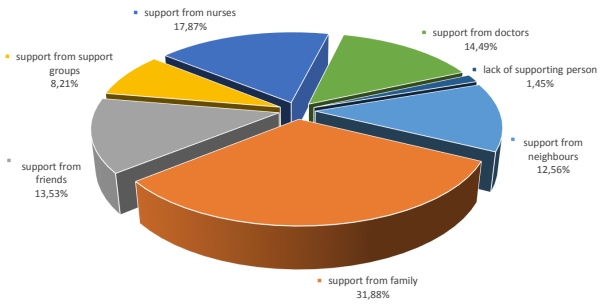

Fig. 5: Sources of Emotional Support Provided to Patients with Arterial Hypertension.

mostly given by families – 66.67%, in medium level – 17.78% and in low level – 15.56%.

Almost half of the respondents received a strong support from their families regarding instrumental support (48.89%), medium (35.56%) and low (15.56%).

Appraisal support was provided by families in a very low amount. The greatest number of people got a medium rate of support (44.44%) and then a strong one (36.67%) and weak (18.89%).

Discussion

Social support depends on numerous factors. By analyzing the data received from the conducted research, it can be stated that they were mostly influenced by: patients' age, sex, number of children, material status, or people living together with the ill as well as chronic nosological entity, which the studied patients suffer from. Social support can also be received from various sources, such as: family, neighbors, friends, nursing and medical staff or support groups.

Social support can play either a positive and a negative role. Participating in social groups, which provide various help, can be viewed positively. It enables the satisfaction of minimum needs, increases knowledge and abilities, creates a will to take care of one's health and cope with the disease. It has a positive influence on our mood and distresses in difficult situations, which helps to eliminate many health problems. The negative role includes dependence on help, loss of independence and the ability to cope with difficult situations. A person receiving constant support can complain about permanent control and overprotectiveness [19, 20].

Support can be divided into professional and non-professional. To professionals we include doctors, nurses, psychologists, physiotherapists. They have direct contact with patients [21]. **Non-professional support**, on the other hand, can come from various sources i.e. family, friends, neighbors and in exceptional situations from self-help institutions. Family and relatives constitute a supportive system. They are classified as initial support and they influence the patient's attitude to life and acceptance of the disease [22–24]. There

is also the so-called „social network" i.e. a person's activity with other people and connections between all of them (having children, friends, spouses, neighbors). A very important element of social support is a person's belief of being a member of his or her own network and being respected by it. Contact between people exists through a system of mutual favors. Support plays a significant role in improvement of health, protection from diseases and enhancement of recovery processes. Lack of assistance from families, on the other hand, in a great number of cases evokes anger, discouragement, bleakness and a decline in social value [25–27].

Secondary support involves various care, rehabilitation, social, medical or governmental institutions. These are the organizations or associations that bring together people with similar or identical problems as well as families of ill persons. Participation in such groups promotes renewal of social contacts, prevents isolation and fosters information flow [28].

Support can also be divided into pragmatic, behavioral, structural and functional. To a **pragmatic** one, we include help that is possible for an individual in difficult cases or consequences of participating in a social network. A **behavioral** support comprises of fulfillment of needs in difficult situations by support groups. **Structural support** is composed of neutral and accessible social networks, which take advantage of the possibilities connected with the existence of bonds, social relations. They also help people in need. **Functional support**, on the other hand, is defined as a social interaction undertaken by one or a couple of participants of a difficult, stressful situation. The objective is to minimize stress, prevent crises by accompanying, creating a sense of belonging and aiming towards overcoming and solving problems [8, 29].

According to own research, nursing and medical personnel more often and to a greater extent provided social support, in the studied group of patients with chronic cardiovascular diseases, to older persons over 80 years of age (10%).

From the studied patients' point of view, nurses most often provided emotional support and instrumental and appraisal ones were given by them moderately. Moreover, social support was provided to fewer than 20% of the patients and more often to men.

Slightly above 24% of the respondents had not received social support, although they really needed one. Almost half of the patients, who were not provided with support, did not have negative emotions towards this situation.

It may seem alarming that almost one fourth of the respondents faced a denial to receive support from social institutions, such as MOPS, GOPS. Those respondents, due to circumstances, felt negative emotions.

The examined people felt shame, anger, low self-esteem and less frequently fear, anxiety and wrath. What seems interesting is the fact that among the people with negative emotions, a majority were above 80 years of age.

Kurowska i Bystryk [29] in their research confirm also that nurses greatly support older people. According to those studies, the recipients receive the highest informational support from nurses and in own research – emotional one. Instrumental support is provided by children, appraisal one by spouses, so the situation is similar to the one present in personal data analysis from the immediate family [29].

In own research, it was noted that the best source of non-professional support was a family, then friends and neighbors. Neighbors support mainly older people above 80 years of age. Friends, on the other hand, support the recipients differently, but according to own research mostly those that are under 40. It is the time when friends and neighbors contacts are more active than later. Older people do not visit each other so often and do not support others, because very often they alone are ill and need help and social support. Similar results were achieved by Olejniczak in her research [29].

The results achieved by Kurowska and Kuźba [29] also demonstrate a low level of appraisal support in patients with hypertension and the greatest level of instrumental support. The other types look similar to those included in own research.

Other results were achieved by Gąsiorowski et al. [30]. In the studied group, more women than men with arterial hypertension received informational support from the doctors (the research was conducted in relation to family doctors) [30].

Conclusions

The achieved results provided grounds for drawing the following conclusions:

1. According to patients with chronic cardiovascular diseases, a family constituted the main source of non-professional support. The family provided the respondents with a strong emotional, informational, instrumental and appraisal support.
2. Nursing as well as medical personnel supported mostly people in old age. Only emotional support was strongly provided, informational one partly to a strong and medium degree and instrumental and appraisal ones moderately.

Literature

[1] A. Raniszewska-Wyrwa. Doświadczanie somatycznej choroby przewlekłej a poczucie jakości życia. perspek-

tywa filozoficzno – psychospołeczna. *Pielęgniarstwo Polskie*, 1(47):37–41, 2013.

[2] A. Ostrzyżek. Jakość życia w chorobach przewlekłych. *Problemy Higieny i Epidemiologii*, 89(4):467–470, 2008.

[3] P. Kardas. Schorzenia przewlekłe z perspektywy lekarza rodzinnego i jego pacjentów - jak wspólnie osiągnąć sukces? *Forum Medycyny Rodzinnej*, 4(6):415–422, 2010.

[4] R. Topór-Mądry. Choroby przewlekłe. obciążenie, jakość życia i konsekwencje ekonomiczne. *Zdrowie Publiczne i Zarządzanie*, 12(1):25–49, 2011.

[5] J. Szymańska, E. Sienkiewicz. Wsparcie społeczne. *Curent Problems of Psychiatry*, 12(4):550–553, 2011.

[6] H. Sęk, R. Cieślak. *Wsparcie społeczne, stres i zdrowie.* Wydawnictwo PWN, Warszawa, 2005.

[7] B. Dudek, J. Koniarek. Wsparcie społeczne jako modyfikator procesu stresu- wybrane problemy teoretyczne i narzędzie pomiaru. *Medycyna Pracy*, 54(5):427–435, 2003.

[8] J. Kirenko, S. Byra. *Zasoby osobiste w chorobach psychosomatycznych.* Wydawnictwo UMCS, Lublin, 2008.

[9] J. Modrzewski. *Pomoc - wsparcie społeczne - poradnictwo. Od teorii do praktyki.*, chapter Wsparcie społeczne jako czynnik wzorujący współczesne scenariusze biograficzne, pages 31–45. Adam Marszałek, Toruń, 2010.

[10] M. Kamińska, A. Bronikowska, M. Ferańska et al. The role of support in wrestling with cancer. *Studia Medyczne*, 30(2):115–117, 2014.

[11] B. Lelonek, E. Kamusińska. Analiza dostępnego wsparcia społecznego u pacjentów oddziału chirurgicznego. *Studia Medyczne*, 23(3):35–42, 2011.

[12] E. Rutkowska. Wsparcie jako element rehabilitacji kompleksowej osób z niepełnosprawnością. *Niepełnosprawność - zagadnienia, problemy, rozwiązania*, 3(4):39–52, 2012.

[13] T. Maszczak. Zdrowie jako wartość uniwersalna. *Roczniki Naukowe AWF w Poznaniu*, 54:73–81, 2005.

[14] P. Kardas. Schorzenia przewlekłe z perspektywy lekarza rodzinnego i jego pacjentów - jak wspólnie osiągnąć sukces? *Forum Medycyny Rodzinnej*, 4(6):415–422, 2010.

[15] Z. Szadowska-Szlachetka, A. Niewiadomska. Opieka nad pacjentem w hospicjum. *Pielęgniarska opieka nad osobami starszymi*, 10:15–44, 2010.

[16] D. Bazaliński, P. Więch, J. Przybek-Mita et al. Psychospołeczne aspekty opieki pielęgniarskiej nad pacjentem z przerzutową raną nowotworową. *Pielęgniarska opieka nad osobami starszymi*, 9:65–76, 2012.

[17] R. Lorentowicz, J. Jasik, E. Komer et al. Wpływ wsparcia społecznego dla jakości codziennego funkcjonowania osoby chorej na stwardnienie rozsiane. *Pielęgniarstwo Neurologiczne i Neurochirurgiczne,*, 2(5):205–215, 2013.

[18] Z. Juczyński. *Narzędzia pomiaru w promocji i psychologii zdrowia.* Pracownia Testów Psychologicznych Polskiego Towarzystwa Psychologicznego, Warszawa, 2012.

[19] J. Gąsiorowski, L. Kotkowiak, A. Sałacka et al.:. Postrzeganie wsparcia lekarza rodzinnego i jego zespołu a efekty leczenia i jakość życia pacjentów z pierwotnym nadciśnieniem tętniczym. *Problemy Medycyny Rodzinnej*, 3(28):33–39, 2009.

[20] P. Olejniczak. Wsparcie społeczne i jego znaczenie dla osób starszych. *Pielęgniarstwo i Zdrowie Publiczne,*, 3(2):183–188, 2013.

[21] L. Wiśniewska, B. Paczkowska, B. Białobrzeska. Zapotrzebowanie na wsparcie emocjonalne wśród pacjentów leczonych nerkozastępczo. *Forum Nefrologiczne*, 3(1):63–70, 2010.

[22] K. Kaleta, J. Mróz. Percepcja relacji interpersonalnych a pozytywne zachowania zdrowotne dorosłych. *Problemy Higieny i Epidemiologii*, 93(4):779–784, 2012.

[23] M. Keirse. *Życie z chorobą.* Polskie Wydawnictwo Encyklopedyczne, Radom, 2007.

[24] A. Głębocka, M. Szarzyńska. Wsparcie społeczne a jakość życia ludzi starszych. *Gerontologia Polska*, 13(4):255–259, 2005.

[25] H. Zielińska-Więczkowska, K. Pryka, M. Muszalik et al. Wsparcie w opiece pielęgniarskiej pacjentów w podeszłym wieku przed zabiegiem operacyjnym - na tle czynników socjo-demograficznych. *Psychogeriatria Polska*, 9(2):61–68, 2012.

[26] K. Kurowska, H. Kościelna. Orientacja życiowa a wsparcie społeczne u osób z kolostomią wyłonioną z powodu raka jelita grubego. *Współczesna Onkologia*, 12(5):228–233, 2008.

[27] B. Pacholec. Wsparcie społeczne pacjenta w samoopiece. *Pielęgniarska opieka nad osobami starszymi*, 9:12–19, 2010.

[28] R. Bogusz. Wsparcie pacjenta geriatrycznego w różnych sytuacjach życiowych. *Pielęgniarska opieka nad osobami starszymi*, 3:3–12, 2008.

[29] K. Kurowska, M. Kuźba. Wsparcie a radzenie sobie w chorobie przewlekłej na przykładzie nadciśnienia tętniczego. *Arterial Hypertension*, 15(3):177–183, 2011.

[30] J. Gąsiorowski, L. Kotkowiak, A. Sałacka et al. Postrzeganie wsparcia lekarza rodzinnego i jego zespołu a efekty leczenia i jakość życia pacjentów z pierwotnym nadciśnieniem tętniczym. *Problemy Medycyny Rodzinnej*, 3(28):33–39, 2009.