Chapter - 2

Review of the Literature
This chapter deals with the research conducted by previous scholars on the variables covered in the present study. As it would be clear from the review presented in this chapter, the variables covered in the present study have attracted the attention of scholars all over the globe. But the impact of psychophysiological disorders, especially on depression, death anxiety and quality of life have generally not been evaluated in our context. Some studies Schwartz et al. (1999) tried to determine whether subjective nighttime sleep complaints (trouble falling, sleeping, trouble sleeping staying asleep), exclusive of apnea, predicted myocardial infarction and other coronary events, a MEDLINE search was conducted for articles published between January 1976 through August 1997. 10 studies with explicit measure of association between an insomniac complaint and CHD were identified. Reported risk ratios for various sleep complaints and CHD events ranged from 1.0 for waking too early and CHD death in an elderly Hurth Carolina Community to 8.0 for the highest vs. lowest quintile of a sleep scale in finnish men. Higher quality studies showed risk ration of 1.47-3.90 between trouble falling
asleep and coronary events after adjusting for age and various coronary risk factors. While alternative explanations such as medications use still need to be ruled out, the author theorize that the a subjective insomniac complaint either may be part of a larger syndrome that includes poor health and depression, or it may be related to continual stressors, reduced slow, wave sleep, and autonomic dysfunction, which increase the risk of heart problems.

Tennat (1999) has reviewed the relationship between life event stress support and coronary heart disease. A literature search from 1978 to early 1999 using Medline, Psyc INEO, and EMBAE database was performed. It focused largely on prospective studies. Results show that both life event stressors and inadequate social support assessed by a variety of indicators and inadequate social support assessed by a variety of indicators and risk factors for acute coronary heart disease events. Poor social support does not particularly appear to moderate the relationship of life stress to coronary heart disease but rather both appear to be independent risk factors, the exact mechanism by which they impact on heart disease is not as yet, well elicited, although disturbance in mood would appear more to be the most likely interviewing variable.

Porcelli et al. (1999) examined the relationship between alexithymia and functional gastrointestinal disorder (FGIDs) in a group of 116 inflammatory bowel disease (IBD) patient and a group of 112 healthy Ss. The Ss completed the 20-item Toronto Alexithymic
Sxale and the Hospital Anxiety and Depression Scale. The FGID group was significantly more alexithymic than the IBD group, and the 2 gastrointestinal groups were more alexithymic than the normal healthy group. These differences remained even after controlling for the influences of education, gender, anxiety, depression and gastrointestinal symptoms. The finding of a high rate of alexithymia (66%) in the group of FGID patients is consistent with the propensity of these patients to somatization and to high levels of poorly differentiated psychological distress.

Pao (1999) reports the case of an adolescent female with lactose intolerance treated with setraline for generalized anxiety disorder. With the addition of buspirone for persistent anxiety, the adolescent’s nausea and vomiting worsened. When buspirone was discontinued, her gastrointestinal abated. Acquired lactose deficiency is common, with prevalence rates of 0% in Dutch populations to 100% in Asian populations, with White mericans reported at 24%, since lactose intolerance is quite variable, buspirone use in no a contraindication in these patients, but clinicians should be ware of this possible side effect.

Kilbourn, et. al. (2000) have reviwed the literture on depresssion & negative affect in post-myocardial infarction (MI) patients and on
the interaction between depression and other psychosocial risk factors. Also discussed are the possible psychological mechanism by which depression may affect post-MI prognosis and then present a selected review of psychosocial interventions for depressions in post-MI patients. Depression and negative affect in post-MI patient is associated with increased morbidity and mortality. This is of particular importance because it is estimated that up to 50% of post-MI patients suffer from some degree of clinical depression. It is hypothesized that a cognitive-based, psychosocial intervention aimed at high-risk post-MI patients will impact morbidity and mortality variables.

Kleinschmidt et al. (2000) Explored the incidence of depression and anxiety and measured the quality of life in women with idiopathic intracranial hypertension (IIH). 28 women with IIH were compared with 300 weight and aged matched women not diagnosed with IIH. And with 30 aged matched women of normal weight. Ss completed a questionnaire on health information and questionnaires measuring depression, anxiety and quality of life. Ss with IIH reported a greater number of adverse health problems than either of the control groups.
Non-health psychosocial concerns were equally prevalent among the 3 groups, but IIH patients were significantly more affected by hardships associated with health problems than the other two groups. The patients group also had higher levels of depression and anxiety than the control groups. These adverse health condition were reflected in decreased quality of life measure the IIH groups.

According to Clarke et. al (2000) Chronic heart failures patients of ten experience significant functional impairments. A better understanding of the bio-psychosocial correlated of functional status may lead to interventions that improve quality of life in this population. Social isolation, mood disturbance, low socio-economic status and non-white ethnicity were evaluated as possible correlates of impaired functional status in 2, 992 vs. patients with left ventricular ejection fraction < 35%. Even after controlling for age and clinical characteristics, all the psychosocial variables examined were significant predictors of risk for experiencing severe limitations in intermediate and social activities of daily living at yr. with adjusted odds ratios in the 1.5 – 2.0 range. The ability of psychosocial characteristic to predict future functional status also was independent of baseline functional status, co-morbid medical conditions, and deterioration in heart failure sign and symptoms over the intervening
year. These results suggest that psychosocial factors influence patient functional status even in the later phase of cardiac disease.

Knardanl (2000) has reviewed studies on enviromental and predispositional factore in the pathogenesis of cardiovascular disease (CVD). In humans, it is difficult to characterize the pathogenic environmental fctore due to the long time-span of pathogenesis. Perceived effort, control, social isolation, and absence of reward seem to increase the risk of CVD. There are several reported of associations between personality traits or behaviour patterns and CVD. Recent psychophysiological research has focused on hypereactivity to challenge, which seems to be common the offspring of hypertensive’s and may be psychophysiological rather than physiological studies in animals have shown that social interactions produce pronounced phychophysiological reponses. Differentiated response patterns may explain the contradictory findings of studies that measure low physiological parameters. Predisposition to behaviour and reactivity of physiological system may be accentuated by do minance subordinate interactions. The availability of control and the perception of mastery is seen as crucial in terminaty response to stressors. It is suggested that the focuse in cardiovascular phychophysiological should shift studies of behavioural and somatic responses during social interactions.
Steptoe (2000) has reviewed the role of psychosocial factors in human hypertension in studies with 3 research strategies: (1) epidemiological studies of blood pressure samples characteristics and life experience in population samples (2) naturalistic studies of the conversation between blood pressure, psychological state and everyday life events and (3) experimental studies of cardiovascular and neuro-endocrine responses to behavioural stimuli. Research is summarized on hypertension and psychological traits, job characteristics and social support, emphasizing the convergent knowledge deriving from complementary research strategies. The roles of stress-induced cardiovascular responses and prejudicial life styles as mediating influences on risk of hypertension are discussed.

Lawton (2000) examines relations among physical illness, depression and end-of-life attitudes and behaviours. The author’s review of the literature reveals that depression is neither inevitable in the terminal of life nor a necessary motivation for avoiding life sustaining treatment or ending one’s life. Although quality of life often erodes with declining health, the author proposes that may positive, non health-related aspects of life strongly influence the judgement of seriously ill elder, depression or otherwise, when thinking about life prolong treatment,. The author introduces a promising intervening variables, valuation of life (VOL), describes its
measurement and illustrates its utility in research demonstrating the 
VOL mediates the impact of both positive and negative aspects of 

one’s life (including illness and depression) on end-of-life attitudes. 
The chapter concludes with an insightful list of unanswered question 
to guide future research on end-of-life issues.

Lyness et. al. (2000) reviewed the literature regarding 
cardiovascular risk factors (CVRFs) and depression in later life. The 
author critically examines 2 patho-biological models in which CVRFs 
contribute to depression. The theories considered were a structural 
models in which CVRFs lead to brain parenchymal damage via small 
vessel ischemic disease and a cytokine model in which atherosclerosis 
leads to functional alterations in neurotransmitter systems underlying 
depressive pathogenesis. The authors also reviewed evidence for the 
role of depression in contributing to the pathogenesis of 
averotic heart disease. They also noted the potential roles of 
psychological and psychosocial routes in the interface between CVRFs 
and depression.

Mayou et. al (2000) investigated emotional distress immediately after 
myocardial infarction (MI) as a predictor of physical, psychological 
and social outcomes resources use. Demographic and cardiological 
data were obtained for 347-3079 Yr. later. 15% of patient sored
proble cases of anxiety and depression. They were more likely than noncase to report pre-MI distress and poor adjustment (as indicated on the 36-item medical outcome study short from). There was an improvement at 3 mo, but little overall or individual change after that time. Anxiety and depression (measured with the hospital anxiety and depression scale) did not predict subsequent mortality but did predict poor outcome at 1 yr. on specific measures of everyday activity and reports of chest pain, use of primary care resources nd secondary prevention life style change Ss who are distressed in the hospital are at high risk of adverse psychological and quality of life outcomes.

Sher (2000) comments on the report by C. Tennant regarding the relationship between Stressful life events, social support and coronary heart disease. The author notes that chronic stress in humans does not led to immunological adaptation to the level of healthy controls, nd that either is evidence that inflammation in the atherosclerotic plaque may be a causative mechanism for coronary heart disease. Tennant’s own previous research is noted, suggesting, that the development of infection and inflammation in the atherosclerotic plaque could be related to the psychological disorders that suppress the immune system. Also, it is noted that immune system may be involved in the effects of psychological factors on the cardiovascular system. It is argued that psychotherapeutic treatments
such as cognitive behavior therapy for stress reduction and anger control, muscle relaxation therapy and others may improve the state of the immune system, decrease the inflammation in the atherosclerotic plaques, and improve the condition of patients with coronary heart disease.

Drossman et al. (2000) examined the effect of different coping strategies on the health outcome of women with gastrointestinal (GI) disorders and how these coping strategies may modify the effect of education, GI disease type, neuroticism, and abuse severity on health outcome. 174-18-70 yr. old patients from a referred GI clinic were followed for 12 mo to assess their health status as a derived variable of daily pain, bed disability days, psychological distress, daily dysfunction, number of surgeries and procedures. GI diagnosis (functional vs. organic) neuroticism score (NEO personality inventory), sexual and/or physical abuse history, and scores on 2 coping questionnaires were obtained at baseline. Results show that a higher score on the catastrophizing scale and a lower score on the self-perceived ability to decrease symptoms scale predicted poor health outcome. Less education, a functional GI diagnosis, a higher neuroticism score, and greater abuse severity also contributed to poor
helth status. The effect of GI disease type and neuroticism on health outcome was significantly reduced by the coping measures.

Kubzansky et. al. (2000), considers the nature and function of emotions, reviews epidemiological evidence for an association between 3 negative emotions (anger, anxiety, depression) and coronary heart disease (CHD), discusses the mechanism by which emotions may be linked to CHD, and considers this evidence in light of theoretical insights provided by mainstream psychological research. The authors collected articles published between 1980-1998 on the relationship between each negative emotion and CHD. Review articles or chapters published during the same time period that considered mechanism by which emotions may increase CHD risk were also collected. The result show that anxiety is involved in the onset of CHD, whereas evidence for an association between anger and

CHD is limited but suggestive. Although depression has considerably been linked no mortality following a myocardial infarction, evidence for its role in the onset of coronary disease is quite mixed. It is concluded that numerous unsolved issues leave the current understanding of the emotion-health relationship incomplete. Psychological theories of emotion are considered to help address gaps in knowledge. Growing
evidence indicates that negative emotions may influence the development of CHD.

Stein et. al. (2000) investigated the relationship between depression and heart rate variability in cardiac patients. Heart rate variability was measured during 24 hr. amulatory electrocardiographic monitoring in 40 medically stable out-patients with documented coronary heart disease meeting current diagnostic criteria for major depression, and 32 non-depressed (mean age 60.4 yrs.), but otherwise comparable, patients. Patients discontinued β-blockers and antidepressent medications at the time of study. Depressed patients were classified as mildly (21 Ss, mean age 60.2 yrs.) or moderately-to-severely depressed (19Ss, mean age 60.5 yrs.) on the basis of Beck Depression Inventory scores. The results show that there were no significant differences among the groups in age, gender, blood pressure, history of myocardial infarction, diabetes, or smoking. Heart rates were higher and nearly all indices of heart rate variability were significantly reduced in the moderately – severely vs. the non-depressed group. Heart rates were also higher and mean values for heart rate variability lower in the mildly depressed-group compared with the non-depressed group, but these differences did not attain statistical significance.
Swenson et. al (2000) focus on definition and general concept underlying quality of life in patients with cardiac disease, the ways in which is is measured, and the uses and limitations of quality-of-life measurement. The relevance of psychosomatic medicine to quality of life research is also discussed. A Medline Search, from 1988-1998, was undertaken using the search terms ‘Cardiovascular disease and quality of life and “Cardiovascular disease and heath status.”’ Results of clinical trials of cardiovascular therapies using quality of life instruments were not reviewed. The finding show that quality of life can be defined as “the functional effect of an illness and its consequent therapy upon a patient, as perceived by the patient.”

“Domains of quality of life include physical, mental, social and occupational function, health perceptions, and symptoms of disease. It is concluded that psychosomatics medicine contribution to understanding patient’s reaction to physical illness and injury may offer enhanced insight into assessment of health perceptions and that generic health profiles and cardiac-disease specific quality-of-life measures would also be useful in psychosomatic investigations of personality, hostility depression, and social isolation in patients with cardiac disease.

According to Porcelli et. al. (2000), psychiatric assessment of somatutization (the tendency to experience and communicate
psychological distress in the from of physical symptoms and to seek medical help for them) currently rests on DSM criteria. An alternative diagnostic and conceptual framework has been proposed by an intentional group of psychosomatic investigators. The aim of this study was to compare these new criteria (Diagnostic Criteria for psychosomatic Research, DCPR) with DSM-IV in a population where a high prevalence of psychosocial problem to expected (functional gastrointestinal disorders, FGID) 190 Ss (mean age 37.5 yrs) with FGID in a tertiary care centre were assessed according to DSM-IV and DCPR diagnosis was almost double that of DSM diagnosis only 9% of the patients were not identified by DCPR criteria, whereas this occurred in 25% of patients using DSM criteria. While patients who were given a DSM diagnosis, many patients with DCPR syndromes did not fulfill any criteria. Four DCPR syndromes appeared to be particularly frequent and accounted for almost 75% of the total diagnoses (alexithymia, persistent somatozation, functional symptoms secondary to a psychiatric disorder, demoralization).

Winters et. al (2000) have clarify the role of anxiety in the etiology of coronary heart disease (CHD) and post myocardial infarction (MI) morbidity and mortality. Accomplishing this goal depends on anxiety. Anxiety will be viewed from a bio-behavioural control system designed to maintain physical and emotional health. The authors content that anxiety becomes a risk factor in the
pathogenesis of CHD when the subjective affective component of the emotional response to threat is suppressed. Anxiety is also a risk factor in CHD when coping resources are constrained by life circumstances. Implications for the function of anxiety in CHD with respect to health care services are discussed.

Jordaan et al. (2000) present the diagnostic dilemma of a case of a 13 yr. old girl with both superior mesenteric artery syndrome (SMAS) and anorexia nervosa. Although these disorders seldom occur together, they share both clinical features and etiological factors. The authors note based on the etiological interplay of psychodynamic factors and physical symptoms on a number of observations. Multiple referrals and investigations-reinforced the idea of the S’s being physically ill. Furthermore, the onset of illness was only a few months after a Sibling’ birth, suggesting that non-conscious memories of attention gained from bouts of gastrointesteritis and hospitalizations were operative. The authors speculate that pain, representing both physical and psychological discomfort, was relived through food refusal and emotional support, which in return reinforced the S’s symptoms.

According to Falyer et al. (2000) may be severely afflicted by patient’s and partners depressed mood. In this study, 170 cardiac patients (76% acute myocardial infarction, 24% coronary artery by
pass-graft operation, 86% male, mean age 55 yrs.) and their partners were assessed with respect to mutual QoL at 1,3 and 12 mo after hospital discharge. Self-reported depressed mood (Beck Depression Inventory > 10) was also assessed at these time points. Throughtout follow-up, 17 to 21 % of patients and 16 to 25% of partners reported depressed mood. In those patient and partners, at all timepoints, QoL was significantly poorer that in non depressed Ss. In stepwise multiple regression, both cross-sectional and longitudinal patients and partners depressed mood and QoL were independent strong predictors of mutul poorer QoL in both cardiac patients and partners should be carefully monitored and treated, as an integral part of standard care after a coronary event.

Levine et. al. (2000) tried to determine the effects of the Serotonin (5-hydroxytratamine$_3$) [5-HT$_3$]) receptor-ondansetron and granisetron on the development of gastric tachyarrhythmia, nausea and other symptoms of motion sickness. In a double-blind, counter balanced, repeated measure desing, 12 motion sickness susceptible college students participated in 3 serious with an intersession interval of 1 wk. participated received either 8. Mg. of ondansetron, 2 mg. of granisetron or placebo 1hr. before exposure to a rotating optokinetic drum. Electrogastrograms (EGGs) were recorded during a 6-min baseline period and a subsequent 16-min drum rotation period.
Subjective symptoms of motion sickness (SSMS) were obtained every 3 min during drum rotation. During drum rotation, gastric tachyarrhythmia increased significantly more during the placebo condition than during either of the serotonin (5-HT$_3$) receptor antagonist conditions. However maximum SSMS scores were not different among conditions. Thus, the serotonin (5-HT3) receptor antagonists inhibited the development of tachyarrhythmia, but did not prevent the development of nausea and other symptoms of motion sickness.

Friedman et. al (2001) investigated the association between mild hypertension as defined by both ambulatory and casual (clinic) BP measurements and various measures of personality and psychological characteristics in 283 men (aged 30-60 yrs). Using an ambulatory BP monitor and controlling for age, race/ethnicity and body mass index. Results show no consistent difference between Ss with mild hypertension and those with normal BP on any of the psychological variables assessed, including Type A behaviour pattern, state and trait anger, anger expression, anxiety, symptoms of psychological distress, locus of control or attributional style. Results were not due to the use of anti-hypertensive medication by some of the Ss with hypertension.
nor to the dichotomization of BP into those with and without mild hypertension. This contrasts with previous findings from this study showing a sizeable association of ambulatory BP and hypertension with Job strain (situational measure), age and body mass index. These null results suggest that situational, biological and perhaps behavioural factors are the primary determinants of mild hypertension and that the predictive significance of psychological or dispositional factors is low or negligible in those without overt cardiovascular disease.

Shnek et al. (2001) tried to determine whether learned helplessness, cognitive distortions, self-efficacy and dispositional optimism assessed at time 1 (T1, questionnaires mailed at 1 month postdischarge) would predict depressive symptoms at time 2 (T2, questionnaires mailed at 1 year follow-up) in a sample of 86 patients hospitalized with ischemic heart disease. Multiple regression result indicated that optimism and cognitive distortions at T1 were significantly associated with T1 depressive symptoms after controlling for confounding variables. When the T1 psychological factors were analyzed with T2 depressive symptoms, only optimism continued to predict depressive symptoms after controlling for confounds and T1 depressive symptoms. The global expectancies that beliefs of cognitive distortions and may have accounted for why optimism predict T2 depressive symptoms.
Smith (2001) is of the view that negative emotion have been claimed to be a cause of coronary heart disease (CHD) as well as a consequence of cardiovascular disorders. Early case studies of cardiac disorders of soldiers in battle drew attention to the possibility that strong negative emotional states could cause CHD. Subsequent reports of reactions to natural disasters supported the notion that intense negative emotions could precipitate somatic disorders such as CHD. Since then, numerous studies have investigated relations between negative emotions and CHD. Over the years, retrospective studies have found, for example, that negative emotion are often present before the occurrence of CHD. Cross-sectional studies have indicated that symptoms of depression and anxiety are often present in CHD patients. Prospective studies have shown that the likelihood of CHD tends to be higher for people with negative emotions than for those without them. Although the finding appears to support the notion of causal connections between negative emotions and CHD, they fail to provide conclusive proof of such relations. An alternative explanation that could also account for the findings is simply that negative emotions and CHD often co-exist.

Cohen et al. (2001) examined the relationship between a self-reported history of treatment for depression and subsequent myocardial
infraction among treated hypertensive patients. 5,564 adults Ss in a union sponsored hypertension control program who entered the program without a history of cardiovascular disease and were asked whether they had been treated for depressions were followed in prospective cohort study. The primary outcome of interest was hospitalization or death due to myocardial infarction. At entry, 3.5% of men and 6.4% of women reported a history of treatment for depression. During 4.9 yrs (average) of follow-up, 112 fatal and non-fatal myocardial infarctions were recorded. Controlling for known cardiovascular risk factors with multivariate proportional hazards models, history of treatment for depression was significantly associated with subsequent myocardial infarction. It is concluded that a self-reported history of treatment for depression in independently associated with subsequent myocardial infarction in treated hypertensive patients with out prior cardiovascular disease. Whether additional or different treatment for depression will be cardioprotective is known and merits further study. Lane et. al. (2001) attempted to determine the impact of symptoms of depression and anxiety on mortality and quality of life in 288 Ss (aged 31-89 yrs.) hospitalized for acute myocardial infarction (MI). The Beck Depression Inventory and the State-Trait Anxiety Inventory were completed by all of the Ss. 12 mo survival status was ascertained, and quality of life among survivors was assessed using the Dartmouth Coop charts. 31 Ss dies, 27 of cardiac causes, during the follow-up,
period. Severity of infraction and evidence of health failure predicted both cardiac and all cause mortality. The same findings emerged from supplementary analyses of data from patients who died after discharge from the hospital. Symptoms of depression and anxiety, measured at entry, predicted 12 mo quality of life among survivors, as did gender, partner status, employment status, living alone, previous frequency of exercise and indices of disease severity. In a multiple regression model in which all of these variables were entered, initial depression scores provided the best independent prediction of quality of life. It is concluded that symptoms of depression and anxiety did not predict either cardiac or all-cause mortality after MI, but they did predict quality of life among those who lived to 12 mo.

Krishnan et al. (2001) evaluated the safety and efficacy of sertraline in the treatment of moderate to severe major depression in 220 elderly outpatients (aged 60+ years) with comorbid vascular disease. An analysis of the pooled results for the sertraline treatment group drawn from 2 prospective, randomized, double blind studies (sertraline vs. fluoxetine, and sertraline vs. nortriptyline) was done. Patients were retrospectively categorized into one of 3 clinical groups: (1) patients with a current diagnosis of hypertension but no other past present cardiovascular illness, (2) patients reporting a current or past history of cardiovascular illness, but excluding hypertension, and (3) patients with no hypertension, and no other comorbid vascular illness. Patients
received 12 wks. Of double blind treatment with sertraline in flexible daily doeses. Sertraline treatment yielded comparable levels of response in all 3 groups at treatment end point on both a completer analysis and significantly higher response rates on a 12 wk. end point analysis Sertraline was found to be a safe, well-tolerated and effective as an antidepressant in elderly suffering from hypertension and other forms of vascular comorbidity.,

Flaherty et. al. (2001) reports on a cse of factious hypertension cused by the use of pseudoephedrine. The s was 36 yrs. Old male who presented with an extensive regimen of cardiovascular medications, suggesting his hypertension was extremely resistant treatment. While hospitalized, the S was non-compliant with medictions. Lthough detected during urinalysis, the s could offer no credibel explanation for the pseudoephdrine in this system. At discharge, the S continued to deny any conscious role in his illness, although he did vaguely acknowledge that unconscious factors might be contributing to his problem. The Ss psychiatric history is presented, and the characteristics of factitious disorders are discussed.

Porcelli & Decarne (2001) investigatied the criterion related validity of the Diagnostic Criteria for Psychosomatic Syndrome Research (DCPR) for alexithymia syndrome (DCPRA). A secondary aim was
to explore the relationship between alexithymia and depressed mood. The study included 190 consecutive outpatients with functional gastrointestinal disorders. Alexithymia Scale (TAS-20). Depressed mood was assessed on the basis of the depression sub-scale of the Hospital anxiety and Depression Scale (HDS) and the DSM-IV criteria. The sensitivity of the DCPR-A together with the TAS-20 was 70.2%, specificity was 81.6% positive predictive power 88.9%, negative predictive power 66.0% DCPR-A positives scored significantly higher than DCPR-A negatives on the TAS-20 scores. The TAS-20 scores. The TAS-20 was not associated with any measure of depression, while the DCPR-A was significantly associated with the HDS and DCM-IV criteria.

Strik et. al. (2001) discuss the possible relationship between depression and myocardial infarction (MI) and the epidemiology, clinical profile, risk factors, and treatment of post-MI depression. Higher are associated with higher morbidity and mortality due to cardiac events caused mainly by arrhythmia, although severity of MI is not related to the development of depression. Post-MI depression often goes unrecognized as only 10% of depressed MI patients are diagnosed. This underestimation is attributed to it’s a typical profile, tendency of
physicians to interpret depressive symptoms as transient or natural reactions to a life threatening event and the scarce knowledge of risk factors associated with Post-MI depression. The prevalence rate for depression during the first 18 mo following MI is 15-30%. Risk factors for developing post-MI depression include complication during hospitalization, prescription of benzodiazepines during hospitalization, previous history of depression and not being able to stop smoking. Selective serotonin reuptake inhibitors appear to be the first choice treatment in post-MI depression. As yet there is no information on the efficacy and safety of combined serotonin and noradrenergic reuptake inhibitors.

Tanum & Mal (2001) investigated the relationship between personality and reported pain and somatic distress in patients with functional gastrointestinal disorder (FGD) without psychopathology. 56 patients and 55 controls completed Buss-Durkee Hostility Inventory, Personality Inventory, Eysenck, Eysenck NEO Personality Inventory, Eysenck Personality Questionnaire and Geissener physical complaints checklist. Ss also completed Mc Gill pain and target symptom (abdominal distress). Ss displayed significantly higher levels of neuroticism and convert ggression than controls. Number of word chosen to describe pain and sensory pain index (MPQ), but not pain intensity on VAS, were predicted by indirect
aggression and less so by neuroticism in females and cobert aggression in males (stepwise regression models.). Ss reported for more extraintentional somatic complaints than controls.

Ballenger et. al (2001) present the author’s views on the detection of depression and anxiety in gastroenterology as well as management issues in the light of the evolving disease model and identifies further areas for research. Topics discussed include impact of anxiety and depression on prognosis, recognition of anxiety and depression, management issue, and treatment options.

Ballenger et. al (2001) present the author’s views on the management of comorbid depression and anxiety in the cardiovascular patient on the basis of the current state of knowledge and identifies areas of further research. Topic discussed included depression and anxiety as risk factor for cardiovascular disease, screening for depression and anxiety, management strategy for comorbid depression and anxiety in the patient with cardiovascular disease, and clinical guidelines for primary care management of comorbid depression, anxiety and cardiovascular disease.

In a study Ames et. al (2001) the role that major and minor life events play in the quality of life in low-income hypertensives was
examined. Participants were randomly recruited from primary care clinics at a public center. The study utilized a prospective design. Participants were determined to have hypertension and were being treated with anti-hypertensive medication prior to and throughout the duration of study. Ss were administered the life experiences the survey and the weekly stress inventory repeatedly during year 1 to assess major and minor stress, respectively. Ss, were repeatedly administered the RAND 36 item Health obtained from 183 patients. Analyses revealed that major and minor stress were significant predictors of all measured domains of quality of life, even after age and number of chronic illness were statistically controlled. Minor stress contributed uniquely to the prediction of each dimension of quality of life even when age, number of chronic illness and major life event were accounted for. Findings suggest that stress has a significant, persistent impact on the quality of life of low-impact patients with established hypertension.

According to Mayer et. (2001) functional disorders of the digestive system, such as irritable bowel syndrome are often associated with affective disorders, such as depression, anxiety, panic and posttraumatic stress disorder (PTSD). Some of these associations are observed not only in clinical populations, but also in population
based samples, suggesting a relationship with pathophysiologic mechanism underlying both gastrointestinal (GI) dysfunction and certain affective disorders. Sustained and acute like-threatening stressors play an important role in the onset and modulation of GI symptoms as well as in the development of affective disorders and PTSD. A neurobiological model is purposed that attempts to explain the development of visceral hypersensitivity, the neuroendocrine and autonomic dysfunction characteristic of functional GI disorders, as well as the overlap with affective disorders.

Lydiard (2001) examined the observed high prevalence of psychiatric disorder in patient with irritable bowel syndrome (IBS). The published literature indicates that fewer than half of individuals with IBS seek treatment for it of those who do, 50% to 90% have psychiatric disorders, including panic disorder, generalized anxiety disorder, social phobia, posttraumatic stress disorder and major depression, while those who do not seek treatment tend to be psychologically normal. Both psychologic and psychosocial variables appear to play important roles in the development and maintenance of IBS. Recent information suggests that the association of IBS and psychiatric disorders may be more fundamental than was previously believed. A brain-gut model for IBS is presented, and the role of traumatic stres and corticotrophin – releasing factor as modulators of
the brain-gut loop is discussed. Finally, the rationale for the use of psychotropic agents in the treatment of IBS with or without psychiatric symptoms is presented.

Roose (2001) states that depression in patients with cardiovascular disease is a significant risk factor for developing symptomatic and fatal ischemic heart disease. Moreover, depressed patients have a higher than expected rate of sudden cardiovascular death. Therefore, appropriate treatment of patients with depression or cardiovascular disease cannot be restricted to considerations of either depression or cardiovascular disease to considerations of either depression. Have various effects on the cardiovascular system, including Type 1A anti-arrhythmic activity that has been associated with an increased risk of mortality in post-myocardial infarction patients. The selective serotonin reuptake inhibitor (SSRIs) are not associated with adverse cardiac effects. On the basis of this favourable cardiovascular profile, the SSRIs should therefore be the preferred choice for the treatment of most patients with comorbid depression and cardiovascular disease. Investing of putative pathophysiologic mechanisms linking depression and cardiovascular mortality, such as the role of platelet activation, will form the basis for further investigation of antidepressant treatment in order to establish if the antidepressants have a beneficial effect on the prognosis of cardiovascular disease.

Sheps and Sheffield (2001) reported that up to one fifth of patients with cardiovascular disease, including those who have experienced a
myocardial, may have concomitant major depression. Studies have suggested that relative risk of major depression with cardiovascular disease ranges from 1.5 – 4.5. Further information is required to establish a dose response relationship between depression and coronary artery disease (CAD); however, such a relationship has been shown between anxiety and CAD. Development of a conceptual model of the pathophysiologic actions of stress in CAD will assist in the understanding of this relationship. In patients with angiographic evidence of CAD, the presence of major depressive disorder was the best single predictor of cardiac events during the 12 mo following diagnosis. Significantly, 6 mo cumulative mortality following diagnosis of myocardial infarction has been shown to be higher in depressed patients than in non-depressed patients. A decrease in heart rate variability may mediate the deteriorous effect of depression on post-myocardial infarction prognosis. Other factors such as mental stress and altered platelet function may also predispose depressed patients to a heightened risk of cardiac events.

Brug and Abrams (2001) opine that depression is an important predictor of morbidity in patients with coronary heart disease (CHD), particularly after myocardial infarction (MI), independent of previous cardiac history or CHD severity. Depression also is associated with poor long-term psychosocial outcomes. The prevalence of major
depression among post-MI patients is 15 to 20% with an additional 27% reporting symptoms of minor depression. This article briefly review the literature on depression in patients with coronary disease, including previously published efforts to treat the disorder in this group. A case review then is provided, highlighting important aspects of treatment.

Weidner et. al. (2001) evaluated the ability of mental stress testing to discriminate between women with and without different disease manifestation, taking into account history of hypertension and B blocker use. Analyses were based on data from a community based case control study of women aged (aged 30-65 years). The study group consisted of 292 women who were hospitalized for an acute event of CHD, either acute myocardial infarction (AMI) or unstable angina pectoris (AP) in Stockholm between 1991 and 1994. Controls were matched to cases by age and catchment area. Cardiovascular reactivity and emotional response to an anagram task solved under time pressur were measured 3 to 6 months after hospitalization. Results: Patients reacted with smaller increases in heart rate (4 bpm) than controls (7 bpm). Results for the rate-pressure product were similar. Cardiovascular reactions did not distinguish patients with AP from those with AMI. History of hypertension (present in 50% of patients and 11% of controls) was
related to enhanced diastolic blood pressure reactivity. Patients on B-Mockers (66%) had lower heart-rate levels throughout testing, but not differ in their cardiovascular stress reactions when compared with the remaining participants.

Li et. al. (2001) examined various dimension of quality of life (QoL) for patients following their first stroke and to identify variables that predict subsequent QoL. 121 Ss with a first stroke and 121 matched healthy controls from the same community were assessed at baseline and 1 year after discharge from hospital using a self-

administered General Quality of life Inventory. One year after discharge, the clinical condition of 84% of Ss following a stroke has improved or they had fully recovered. However, their QoL had not reached the level of the healthy controls. One year after discharge, family and social support had significantly with baseline, particularly for Ss experiencing deterioration of their condition. Multiple stepwise regression analysis showed that QoL was best predicted by the severity of the stroke, Ss outcome expectancy, their values of need level for life, and potential for neuroticism. Stroke was found to impair most aspects of Ss’ QoL. During rehabilitation Ss’ outcomes expectancy and their values of need level for life to a more realistic
level and ensuring sufficient psychosocial support as well as active drug and physical therapy.

Lave et. al. (2002) conducted a study to assess the prevalence and persistence of symptoms of depression and anxiety during the first 12 months following acute myocardial infarction (MI). In a prospective study, 288 MI patients were assessed for symptoms of depression and anxiety using the Beck Depression Inventory (BDI) and the State-Trait Anxiety Inventory (STAI) in hospital, 2-15 days following MI, and 4 and 12 months subsequently. Depression and anxiety were highly co-morbid, with 51% of patients expressing significant levels of depressive and anxious symptoms of baseline more than half the patients with complete BDI and state anxiety data experienced either elevated symptoms of anxiety or depression throughout the first year following MI. Symptoms of depression and anxiety are prevalent, persistent problems during the first year following MI. This study highlights the importance of routine psychological assessment for MI patients both in hospital and after discharge.

Nothwehr and Perkins (2002) examined the relationship between co-morbidity and health behaviours related to hypertension. Ss comprised 3,617 adults (mean age 60.0-67.09 years) diagnosed
with hypertension, hypertension and type 2 diabetes, or hypertension along with type 2 diabetes and a previous myocardial infarction (MI). Ss completed questionnaires concerning demographic characteristics, exercise, diet, smoking behaviour, recent weight loss, body index, general health and attitudes toward their current body weight. Results show that Ss with hypertension along with type 2 diabetes and previous MI were more likely to be older and less educated and less likely to be employed. No significant differences were observed concerning sodium intake and percent who quit smoking due to a health problem.

Strik et. al. (2001) investigated possible correlates from post myocardial infarction (MI) depression on an a priori basis. Based on the literature, 4 clinically easily attainable variables were selected as possible correlates for post MI depression. These were prescription of benzodiazepines during acute hospitalization, cardiac complication during acute hospitalization, history of depression, and not being able to stop smoking within 6 mo after MI. A consecutive cohort of 173 1st MI patients was screened with the 90-item symptoms check list depression scale and DSM-III-R criteria for major depression. Of this cohort 35 depressed patients were compared with 35 non-depressed post MI patients, matched for gender, age and severity of MI. In univariate analyses, complications during hospitalization, prescription
of benzodiazepines, history of depression and not being able to stop smoking were clinical correlates for post MI depression. Multivariate analyses showed that none of these variables were independent of the others in predicting depression. It is concluded that a number of measurable patient characteristics identify those MI patients at risk of post MI depression.

Bankier and Littman (2002) report that psychosocial factors represent significant risk factors for developing coronary heart disease (CHD), as well as having a worse outcome with established CHD. To summarize knowledge in this interdisciplinary field, the authors conducted a review of CHD in women taking into account psychosocial aspects, in particular psychiatric disorders. Medline searches using the key words ‘Psychiatric disorder’ and ‘coronary heart disease’ and ‘women and psychiatric disorder’ and cardiac disease and ‘women’ were performed, covering the time span from the beginning of the Medline database until January 1, 2001. Quoted items included depression, panic disorder, generalized anxiety disorder, mitral valve prolapse, chest pain, anorexia nervosa, menopause, alcohol abuse, cocaine use, sleep disorder, sexual dysfunction, hostility and type A behaviour, as well as other psychosocial aspects. Results show there is accumulating evidence of disorders and psychiatric symptoms and the development and recurrence of CHD in
women. However, in summary, the topic still seems to be neglected. Future research into psychiatric disorders and psychiatric symptoms and CHD in women is strongly suggested.

Vitaliano et al. (2002) tested a theoretical stress model cross-sectionally and prospectively that examined whether relationship of chronic stress, psychophysical and coronary heart disease (CHD) varied in older adult men (N = 47), older adult women not using hormone replacement therapy (HRT) (N = 64) and older adult women using HRT. Structural equation examined relationship of CHD with 1. Chronic stress (caring for a spouse with Alzheimer’s disease and patients functioning), 2. Vulnerability (anger and hostility), 3. Social resources (supports), 4. Psychological distress (burden, sleep problems and low uplifts), 5. Poor health habits (high-caloric, high fat diet and limited exercise), and 6. The metabolic syndrome (MS) (blood pressure, obesity, insulin, glucose and lipids) care giver men had a greater prevalence of CHD (13/24) than did non care-giver men 27 to 30 months after study entary. This was influenced by pathways from care giving to distress to the MS and the MS to CHD. IN men, poor health habits predicted the MS 15 to 18 months later, and the MS predicted new CHD cases over 27 to 30 months.

Treat-Jacobson et al (2002) evaluated the effects of peripheral artery disease (PAD) on health related – quality of life (HR-QoL) from the patient’s perspective establish a foundation for systematic PAD-specific HRQoL assessment in this population Open-ended
interviews were conducted with 38 patients (24 men, 14 women), 44-83 yrs. Old, to report patient experience of PAD and its perceived effects on HRQoL. Tapes were transcribed and analyzed to identify themes and conceptual domains pertinent to the experience of PAD in this population. Seven major themes were identified: 1. Delay in diagnosis and frustration with management of disease; 2. Pain; 3. Limitation in physical functioning; 4. Limitation in social and role functioning; 5. Compromise of self; 6. Uncertainty and fear; 7. Adaptation to the effects of the disease and demonstration of resilience. These findings indicate important psychosocial and emotional consequences of PAD that existing HRQoL questionnaires do not explore. More complete data might lead to greater understanding of the effects of PAD, which could serve as the foundation for a more sensitive instrument to assess HRQoL and the basis for more effective interventions.

Lesperance and Fresure (2003) review the various studies that link depression with coronary artery disease (CAD). Over the past decade, evidence has accumulated to suggest that depression may be a risk factor for cardiac mortality in patients CAD. In contrast to earlier evidence, 3 recent studies including the one by Clande Lanzon and
colleagues have not found an association between depression and mortality. The results, presented at the 2001 American Heart Association Annual Meeting showed that cognitive-behavioural psycho-therapy was in effective in reducing mortality from all causes and recurrence of non-fatal myocardial infarctions. The independent

risk associated with depression in patients with CAD appears to be at least as important as smoking, hypertension or diabetes and, for this reason, may be of enough clinical significance to constitute a target for improving prognosis, particularly given the number of patients with CAD affected by depression. We can safely say about 1 in 3 patients admitted to hospital for CAD shows some degree of depression and that this is true for patients after myocardial infarction heart failure and after catheterization or coronary artery by pass surgery.

In a study by Crane & Martin (2004), the association between the use of passive coping strategies to deal with pain and reported levels of anxiety, depression and parental reinforcement of illness behaviour was examined in individuals with Irritable Bowel Syndrome (IBS) and Inflammatory Bowel Disease (IBD). Individuals with IBS and IBD recruited primarily from outpatient clinics completed questionnaire measures of pain-coping (the vanderbilt pain management inventory, VPML) as well as measures of anxiety and
depressions, parental reinforcement of illness behaviour and physical symptoms. Factor analysis of the passive coping subscale of the VPMI indicated that it was comprised of two components corresponding to emotional and behavioural facts of passive coping. Higher levels of behavioural passive coping were associated with higher levels of depression, but only among individuals with IBS. In contrast emotional passive coping was only associated in both groups with higher levels of anxiety and depression. The degree to which the emotional component of passive coping, associated with psychological distress in both groups, can be considered in terms of coping strategies rather than markness of illness related distress, is discussed.

Bosworth et. al. (2004) opine that congestive heart failure (CHF) lowers survival and worsens the Quality of Life (QoL) of over four million older Americans. Both clinicians and standardized instruments used to assess the QoL of patients with CHF focus primarily on physical symptoms rather than capturing the full range of psychosocial concerns. The purpose of this study was to gather descriptions of the components of QoL as understood by patients living with CHF. Focus groups were conducted with patients with
known CHF, New York Heart Association (NYHA) Class I-IV and left ventricular fraction of < 40%. Focus groups were audio taped, transcribed, and reviewed for common and recurrent themes using the methods of constant comparisons. We conducted three focus groups (n = 15) stratified by NYHA stage with male patient ranging in age from 47-82 years of age. Five patients were classified with NYHA stage III/IV and ten with NYHA stage I/II. Thirty attributes of QoL were identified which fell into five broad domains: symptoms, role loss, affective response, coping and social support, expectedly patients reported the importance of physical symptoms; however, participants also identified concern for family, the uncertainty of prognosis and cognitive function as dimension of QoL.

In a study by Abdel-Khalek and Ahmed (2004) Kuwait undergraduate students (N = 215) completed the 60 individual items of the somatic symptoms Inventory (Abdel-Khalek, 2003) and 3 scales of depression the symptoms checklist – 90 Depression sub scale (SCL-90, D, Derogatis, 1994) the center for epidemiologic studies – Deression Scale (CESD : Radloff, 1977) and the Hopkins symptoms check list. Depression on Scale (HCS-D : Derogatis, Lipman, Rickels, Unlennuth & Covi, 1974) to determine the correlation between the 60 individual items of the SSI and 3 scales of depression. It was concluded that the following somatic symptoms can predict
depression in a non-clinical sample: tension, heart pains, sleep disorder, anorexia, weight gain, migraine and sexual disorders respectively.

According to you (2004) health failure (HF) has a profound impact on patients health-related quality of life (HRQoL). Little is known about factors relating to HRQoL, in elderly Chinese HF patients. The objective of this cross-sectional correlational study was to identify the demographic, psychosocial and clinical factors associated with HRQoL in this group of patient. Cross-sectional data were obtained from a consecutive sample of hospitalized HF patients (N = 227) with measures of HRQoL, psychological distress, perceived social support and health perception. Functional status was measured with the New York Heart Association Classification (NYHA). In stepwise regression analysis, four variables, including psychological distress, health perception, NYHA Classification and educational level explained 51.8% (P = .01) of the variance in HRQoL. These finding suggest that improving HRQoL of HF patients entails improving their psychological status, functional states and health perception.

Emery et. al. (2004) evaluated gender differences in quality of life and examined the degree to which social support was associated with quality of life. In the Methodology a sample of 536 patients (35%
women) was recruited during a 14 month period from the impatient cardiology service of a university based hospital. Participant completed assessments at baseline and at 3 month intervals over the subsequent 12 months for a total of 5 assessment measures at each assessment included quality of life [mental component score (MCS) and physical component score (PCS) from the medical outcomes study-short Form 36] and social support [Interpersonal support Evaluation List – Short Form]. In the results, a total of 410 patients completed the baseline assessment and at least one follow – up and were included in the data analysis. Linear mixed effects modeling of the MCS score revealed a significant effect of gender and time as well as a significant interaction of gender by social support. Modeling of the PCS revealed a significant a significant effect of gender and time. It was concluded that women with cardiac disease indicated significantly lower quality of life than men with cardiac disease over the course of a 12 month longitudinal follow up.

In a study of Wulsin (2004) the objective was examine systematically the status of the current evidence for and against depression as an independent major risk factor for coronary disease. From English-language reports on depression and coronary disease MEDLINE and psyc INFO, and from informal searchers, I selected all studies that
addressed the specific anestions related to the established criteria for risk factor status: (1) strength of association, (2) prediction, (3) specificity, (4) consistency, (5) close-response effect, (6) biological plausibility and (7) response to treatment. I find that the evidence for depression as a coronary disease risk factor is good for four criteria: strength of association, prediction, consistency and close response effect. My conclusion is that the evidence for depression’s role as an independent major risk factor for coronary disease is good in four area, but not yet conclusive in three, pointing to the need for three types of studies: (1) Prospective, observational studies that address specificity questions, (2) Studies of biological mechanisms linking depression and coronary disease and (3) clinical trials of treatments for depression in people with coronary disease or at high risk for developing coronary disease.

According to Lalonde et al. (2001) hypertension associated with lower health quality of life (HRQoL). Similar association may be found for dyslipidemia. We evaluated the HRQoL of cardiac patients with and without dyslipidemia and hypertension. In a cross sectional study, 284 cardiac patients rate their HRQoL using SF 36 Health Survey (SF-36) and three performance based measures (Rating scale, Time Trade – off and Sandrd Gamble). In the results: compared to those without dyliplidemia reported better than HRQoL on all preference based measures and most SF-36 scales particularly on the physical health scales. Adjusted mean differences and 95% confidence interval were equal to 4.5, 10.8 and 2.2 on the physical functioning, exactly the
opposite trends were observed among patients with hypertension. The adjusted mean differences were equal to -2.7, -10.9 and -2.9 on the physical functioning, the role physical and the physical component summary scales, respectively. It was concluded that cardiac patients with hypertension reported lower physical health than those without hypertension while cardiac patients with dyslipidemia reported better physical health than those without dyslipidemia.

Isyanon (2004) and Vivker et. al (2004) opine that depression in old age is associated with an increased mortality risk of cardiovascular disease but the mortality risk from non-cardiovascular causes is disputed. Objective : To investigate the effect of depression on cardiovascular and non-cardiovascular mortality in old age. Methods: We prospectively followed 500 subject from 85 years onwards within the population-based Leiden 85-plus study.

Depressive symptoms were assessed annually with the 15-item Geriatric Depression Scale (GD-15). Mortality risk were estimated in a cox proportional hazard. Model with the annual assessment of depression (GDC-15) 4 points as a time –dependent covariate. Results: During 1654 person years of follow-up (mean per person, 3.2 years), depression was associated with a two fold increase of all cause mortality [Relative Risk (RR), 1.83, 95% Confidence Internal (CI),
that was not explained by comorbid conditions. Both cardiovascular mortality and non-cardiovascular mortality contributed equally to the excess mortality (RR 1.95 and 1.75 respectively). Conclusion: Depression in old age contributes to an increase of both cardiovascular and non-cardiovascular mortality. Motivational depletion may play an important role in the increased mortality in elderly with depression.

Suzuki and Kasannki (2004) investigated the future of the psychosocial aspects of patients with atrial fibrillation and to explore the influences of the subjective symptoms of attack, perceived psychosocial inducers of attack and anxiety on the quality of life (QoL). The participants were 240 patients with paroxysmal atrial fibrillation (27.89± 13.78 years old.), who were requested to complete questionnaires on the subjective symptoms of attack, perceived psychosocial inducers of attack, anxiety symptoms, and QoL. The results of this study showed that 29.5% patients met the criteria of agoraphobic, of Diagnostic a statistical manual of Mental Disorders (4th ed.[DSM-IV], American Psychiatric Association, 1994). This percentage of prevalence was higher than the general prevalence of DSM-IV data. The subjective symptoms of attack (frequency, duration, and distress of attack) intensify their fear of attack and
agoraphobia symptoms, which worsen their QoL. Psychological stress is the main perceived inducer in daily life, and an attack induced by psychological stress affects their anxiety symptoms and QoL.

Carney et al. (2004) say that research on the relationship between depression and heart disease has evolved along parallel paths over the past 15 years. One has examined whether depression is a risk factor for incident coronary heart disease (CHD) and if these studies have had large, multi-center epidemiologic catchment area. INTERHEART, one of the largest studies to date, investigated whether depression and other psychosocial factors are associated with incident myocardial infarction. The other path has examined whether depression is a risk factor for cardiovascular morbidity and mortality in the context of established CHD. The criteria for analysis by Barth et al., were relatively broad in the sense that studies of patients an odds ratio of 2.24 (1.37-3.60) for mortality in patients with symptoms of depression compared with patients without depression symptoms. Van Melle et al., in context, limited their analysis to studies of past-MI patients. They reported odds ratio for all-cause and for cardiac-related mortality of 2.38 (1.76-3.22) and 2.59 (1.77-3.77), respectively.

Duschek and Schandry (2004) assessed cerebral blood flow in 40 subjects with chronically low blood pressure and 40 normotensive
control at resting conditions and during the execution of a cued reaction time task. Blood flow velocities were recorded by means of transcranial doppler sonography in both middle cerebral arteries. In hypotensives flow velocity at rest was reduced bilaterally. During the anticipation of the stimuli, which the subjects had to respond to, a predominantly right hemispheric increase of flow velocity was observed in both groups. Hypertensives showed longer reaction times, and there was a negative correlation between the extent of the flow velocity increase and the reaction times. This study is the first to demonstrate a reduced cerebral perfusion and maladaptation of blood flow to cognitive demands due to essential hypotension.

Dammen et al. (2004) conducted a cross sectional psychiatric and cardiological study to compare patients with and without coronary artery disease (CAD) with respect to psychiatric morbidity, psychological factors, pain characteristics, medical morbidity and the prevalence of coronary risk factors. The 199 participants had been referred to cardiological outpatient clinics for the investigations of chest pain and had no history of heart disease. Current panic disorder occurred significantly more often in non CAD patients (41% Vs. 22%). No significant differences were found for other psychiatric disorders and psychological variables. Non CAD patients reported significantly longer histories of pain and a higher prevalence of a
typical chest pain. In other respects, there were surprisingly few differences between the group. High morbidity of both 19%, any current psychiatric disorder, 72% and somatic conditions (musculoskeletal disease, 33%, dyspepsia, 23%) was found with no significant differences between the groups. In both patient groups. The physicians should attend to psychiatric disorders in non-CAD as well as in CAD patients.

Srinivasan and Joseph (2004) studied the prevalence of anxiety and depressive disorders in patient with chest pain presenting to an emergency department, Majority of the patient had coronary artery disease (CAD). Twenty three percent of patients with chest pain has a diagnosable psychiatric disorder according to ICD – 10 research criteria. Anxiety and depressive disorder were equally distributed among patients with co-comitant psychiatric syndrome. The level of psychological distress as measured on hospital anxiety and depression scale in patients of CAD with comorbid psychiatric syndrome was significantly more than patients with CAD alone and similar to non-CAD patients with psychiatric disorder. This finding is in agreement with an earlier study suggesting that the psychological distress seen in patients with CAD is related to the comorbid psychiatric condition and not to CAD.
According to Tan et. al (2005) irritable bowel syndrome (IBS) is a functional gastrointestinal disorder characterized by abdominal pain, distension, and an altered bowel habit for which no cause can be found. Despite its prevalence, there remains a significant lack of efficacious medical treatments for IBS to date. In this paper we reviewed a total of 14 published studies (N = 644) on the efficacy of hypnosis in treating IBS (8 with no control group and 6 with a control group). We concluded that hypnosis consistently produces significant results and improves the cardinal symptoms of IBS in the majority of patients, as well as positively affecting non-colonic symptoms. When evaluated according to the efficacy guideline of the clinical psychology Division of American Psychological Association, the use of hypnosis with IBS qualities for the highest level of acceptance as being both efficacious and specific. In reviewing the research on the mechanism of action as to how hypnosis works to reduce symptoms of IBS, some physiological and psychological mechanism of action.

Day et. al. (2005) opine that cardiac patients beliefs about the cause of their illness may influence their receptivity to psychosocial interventions. The purpose of this study was to determine whether, depression or anxiety influences patients attributions about the cause
of their disease. The primary hypothesis was that depressed or anxious patients are more likely to endorse negative emotions as among the causes of their heart disease than are patients who are not depressed or anxious. Sixty-nine patients with documented ischemic heart disease recruited from an exercise stress testing laboratory completed the Beck Depression and Anxiety Inventories and a heart disease attribution checklist. Univariate analyses confirmed that patient who are depressed or Anxious are more likely than other patients to endorse negative emotions as cause of their heart disease. Anxiety but not depression was retained as an independent predictor of negative emotion attributions in a logistic regression analysis. We conclude that mood state influences cardiac patients beliefs about the causes of their heart disease.

According to Creed & Olden (2005) the detection and treatment of psychiatric disorders in patients presenting to gastroenterologists is an important aspects of clinical practice. Wheres anxiety and depression have a more prominent role in functional, outcome and quality of life in patients with” organic gastrointestinal disorders as well.” Chronic hepatitis C infection is of particular concern, both because of it frequency in patients with serious mental illness and substance abuse and because of the psychiatric side effect associated with its treatment.

Kop and Gottdiener (2005) opine that relationship between depressive symptoms and coronary artery disease (CAD) is mediated
in part by immune system parameters. This review describes research on the psychoneuroimmunological path-ways accounting for the association between depression and CAD, and address conecptual and methodological imbues. Relationship between central nervous system correlates of depression and immune system parameter a age bidirectional and are mediated via neurohormonal and parasympathetic pathways. Evidence suggest e.g., typical depression verses atypical depression and exhaustion e.g., typical depression verses atypical and exhaustion, b) the duration and severity of depressive symptoms , and c) the stage of underlying CAD. Depressive symptoms are hypothesized to effect primarily the transition from stable CAD to acute coronary syndrome via plaque activation and prothrombotic processes and may play an injury at early stages of coronary atherosclerosis.

Carney et. al. (2005) conclude that depression is a risk factor for medical morbidity and mortality in patients with coronary heart disease (CHD). Dysregulation of the autonomic nervous system (ANS) may explain why depressed patients are at increased risk. Studies of medically well, depressed psychiatric patients have found elevated levels of plasma catecholamines and other marker of altered ANS function compared with controls. Studies of depressed patients
with CHD have also uncovered evidence of ANS dysfunction, including elevated heart rate, low heart rate responses to physical stressors, high variability in ventricular repolarization, and low-receptor sensitivity. All of these indicators of ANS dysfunction have been associated with increased risk of mortality vs. cardiac morbidity in patients with CHD. Further research needed to determine whether ANS dysfunction mediates the effects of depression on the course and outcome of CHD and to develop clinical intervention that improve cardiovascular autonomic regulation while relieving depression in patients with CHD.

Kurshid & Wearer (2005) presents a case report of a 44-yr old Caucasian man, Mr. A, with Conn’s syndrome. The authors state this is only the second case reported. Mr. A has a 3-year old history of decreased energy, easy fatigability, a sad mood, body aches, decreased concentration, decreased interest in previously pleasurable activities, insomnia, and anxiousness. He was diagnosed with hypertension and major depressive disorder. This case highlights the importance of vigilantly considering secondary causes of depression more so in the setting of other medical conditions such as hypertension of electrolyte disturbances.
Clarke % Black (2005) state that residual physical and cognitive impairments following a stroke can pose a significant threat to a survivor’s quality of life. Yet, there is not always a direct one to one correlation between functional disability and subjective quality of life. Quality of life after after stroke, using qualitative interviews. Results indicate that a stroke has a significant impact on the quality of life survivors, but some individuals find ways to adopt to their functional disabilities and report a high quality of life. Common elements of this process consist of reordering priorities to focus on those activities considered most salient to an individual’s identity; than drawing on existing resources, inducing health services and social supports, to maintain a customary individual’s identity and maintaining a sense of continuity in his or her life.

In a study by Fauerbach et. al. (2005) relationship between baseline depression and health related quality of life were examined in a cohort of patients after hospitalization due to acute myocardial infarction (N = 196). Patients were assessed for presence of mood disturbance, anxiety and quality of life at the time of hospitalization and again 4 month later. Baseline assessment was used to assign subjects to a depressed or a non-depressed group-adjusting for
preinfarction quality of life, in hospital anxiety and demographics variable, depression was prospectively and independently related to reduced global health at 4 months as well as reduced one all mental health – including vitality, psychological health, and social function and increased role interference from psychological problem.

According to Stewart et. al (2005) evidence supporting a link between clinical depression and cardiovascular disease has expanded rapidly over the last 20 years. Depression has been found to be an independent risk factor for the occurrence of cardiac disease in multiple studies. There is increasing evidence that the presence of depression worsens the course of heart disease. Multiple physiological processes have been hypothesized to underlie this oxide, platelet activation and reduced heart rate variance. Each one of these is a reaction that may be helpful following tissue injury. This article surveys new research regarding these mechanism. Recent studies also suggest that treatment of depression may activate biological adaptations that are helpful in crisis but harmful to health in the long term.

In a study by Creed et. al (2005) it was found that at baseline, depressive disorder (29% of patients), panic (12%) and nurasthenia, (35%) were associated with impairment, number of psychiatric
diorders was associated in a close-response fashion \((P = 0.005)\). At follow-up, depressive disorder and neurasthenia were associated with role limitation score. Improved depression was associated with improved role functioning. Conclusion: Depressive, panic and neurasthenic disorders contribute to poor outcomes in severe irritable bowel syndrome, and appropriate treatment should be available to these patients.

Salminen et al. (2005) describe the effect of a health advocacy, counseling and activation programme on depressive symptoms among older coronary health disease (CHD) patients. Depressive symptoms tended to decrease in IG and to increase in CG among scoring 45 ZSDs sum or more at baseline. The differences of the changes between IG and CG were significant in favor of IG. No similar changes were found among women. Conclusion: A health advocacy, counseling and activation programme aimed to increase knowledge about CHD, social activities, contacts, roles support and exercising was effective in reducing depressive symptoms among male CHD patients suffering from a moderate or high amount of depressive symptoms.

Bjerkeset et al. (2005) conducted a study with an aim examine the impact of the first myocardial infarction (MI) and the relative influence of pre-existing odds: A total of 23,693 participants 35-79 years of age at baseline, attended two population-based prospective
studies in 1984-1986 and in 1995-1997. Results: Five hundred twelve participants suffered their first MI in the last 5 years before follow-up. Women showed an increased risk for both anxiety and depression in the first 2 years post MI, followed by a significant symptoms reduction. In contrast, the risk for depression in men increased after 2 years post MI. Anxiety and depression, low educational level, obesity a poor psychiatric outcome at follow-up. Conclusion: Five-year follow up after MI revealed gender-specific outcomes of anxiety and depression not previously described.

According to Carels (2004) congestive heart failure significantly compromises quality of life by contributing to severe physical role, and social functioning impairment as well as increased psychological distress. Previous research examining quality of life in CHF patients has typically been conducted using global self-report instruments that may exceed a patient's ability to accurately recall their experiences. This investigation examines the impact of disease severity, functional status, and level of depression in daily quality of life (i.e., mean level and variability) in CHF patients during a 2 week monitoring period, indices of quality of life included emotional and physical quality of life, social support and conflict positive and negative mood and coping responses. Fifty eight patients with CHF participated in the
investigation. Depressive symptoms were positively associated with a number of quality of life indices (i.e., physical and emotional quality of life, social support and conflict, mood and coping behaviour). Left ventricular ejection fraction and functional impairment has a much weaker association with quality of life. These findings suggest that depressive symptoms may have a greater impact on quality of life in CHF patients than severity of cardiac dysfunction on or functional.

The hypothesis that increased blood pressure reactivity to stress is an early risk maker of hypertension was tested in a 1994 follow-up of the 1974 to 1978 (Ming et. al 2004). Air Traffic Controller Health Change sample. Methods: Assessments in 1974 to 1978 included physical examinations and recording (every 20 minutes for 5 hours) of both workload (Planes within controller airspace) and blood pressure reactivity were used to predict 1994 self report of ever having been told by a physician to take antihypertensive medication, assessed in a telephone survey of 218 respondents who were normotensive or stage 1 hypertensive in 1974 to 1978. Results: Each SD increase in baseline systolic and diastolic blood pressure at clinical examination, with effects comparable for baseline normotensives and stage 1 hypertensives. Conclusion: A 20-year follow-up of originally normotensive and stage 1 hypertensive workers suggests that increased systolic blood pressure reactivity to work stress is associated. With long-term risk of hypertension.

Chin & Balon (2004) presents a clinical case of an adult male who experienced depression following a recent acute myocardial infarction
(MI). Post MI depression is very common and is an independent risk factor associated with increased cardiac mortality. The complex interplay of depression and cardiovascular disease following the onset of acute coronary event can often prevent patients from complying with treatment regimens and disease-modifying behaviour. Furthermore, despite the availability of affective treatments, major depression remains underdiagnosed and undertreated. Thus, appropriate and acceptable treatments need to be built on a foundation of good therapeutic alliance with patients, so that they may feel heard and understood. Physician should be responsive and look for signs of depression in patients with recent myocardial infarction, as successful treatment of major depression can improve prognosis of cardiovascular disease and enhance the overall quality of life.

According to Delgado (2004), increasing evidence suggest that in some patients with depressive disorders a neurodegenerative process may occur, highlighting the importance of early and aggressive intervention. Serotonin (5-HT) and norepinephrine (NE) neurotransmitter systems influence neuroplasticity in the brain and both are involved in mediating the therapeutic effects of most currently available antidepressants. Some dulaction antidepressants here been shown to be effective in managing the pain symptoms
associated with depression. These agents may have advantages over others by treating a wider array of physical symptoms. Additionally, these agents may also have a role in modulating neurogenesis and other neuroplastic changes, thereby leading to more complete symptoms of chronic depression.

According to Sayers (2004) the co-occurrence of two highly common disorders, depression and coronary heart disease (CHD), has been the focus of research for several decades. Their relationship is highly complex, with depression implicated in the initial development of heart disease as well as a likely results of the burden of this chronic illness. The causal pathways is not one-way, with certain critical incidents, such as myocardial infarction (MI), leaving patients more vulnerable to depression. Thus, depression and heart disease are highly interviewed, requiring a careful conceptualization when comorbid. The implications of depression for heart disease in older adults is especially important, given that older adults have an ever-increasing risk of heart disease and cardiac death. This article addresses and cardiovascular diseases, with an emphasis on CHD and congestive heart failure (CHF). Also addressed is the role of depression in hypertension, which is associated is with the development of CHF. Even without solid evidence the treatment of depression contributes to lowered risk of cardiac death, continued
research into the detection and treatment of depression in this population is important.

Tomas-Sabado & Gomez-Benito (2004) examined the dimensional structure of Templer’s Death Anxiety Scale and Abdel Khalek’s Death Obsession Scale. The responses by 289 Spanish students to the Spanish form of both scales were evaluated by means of a principal components analysis with varimax rotation. Three significant factors were identified. Death obsession, cognitive affective and death anxiety. The distribution of the factor loading for the items of both scales on Factor 1 and 3 supported the discriminate validity of the constructs specific to each of the scales, while Factor 2 showed a common component in both scales characterized by cognitive and affective aspects in relation to the idea of death.

Thus, it becomes obvious that depression, death anxiety and quality of life have not attracted the attention of researchers to the extent, these actually deserve in our context in relation to CHD, hypertension and gastrointestinal disorders. This state of knowledge justifies the planning and execution of the present study.