Fear of exercise and health-related quality of life in patients with an implantable cardioverter defibrillator

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Several studies have reported improved survival rates thanks to the use of an implantable cardioverter defibrillator (ICD) in the treatment of patients with life-threatening arrhythmia. However, the effects of the ICD on health-related quality of life (HR-QoL) of these patients are not clear. The aim of this study is to describe HR-QoL and fear of exercise in ICD patients. Eighty-nine ICD patients from the University Hospital in Groningen, the Netherlands, participated in this study. HR-QoL was measured using the Rand-36 and the Quality of Life After Myocardial Infarction Dutch language version questionnaires. Fear of exercise was measured using the Tampa Scale for Kinesiophobia, Dutch version and the Fear Avoidance Beliefs Questionnaire, Dutch version. Association between outcome variables was analysed by linear regression analyses. Study results show that the HR-QoL of patients with ICDs in our study population is significantly worse than that of normal healthy people. Furthermore, fear of exercise is negatively associated with HR-QoL corrected for sex, age and number of years living with an ICD. After implantation of the ICD, patients with a clear fear of exercise should be identified and interventions should be considered in order to increase their HR-QoL.


Varios estudios han informado de mejoría de las tasas de supervivencia con la utilización de un desfibrilador cardioversor implantable (DCI) para el tratamiento de pacientes con arritmias peligrosas para la vida. Sin embargo, los efectos del DCI en la calidad de vida relacionada con la salud (CdV-RS) de estos pacientes no están claros. El objetivo de este estudio es describir la calidad de vida relacionada con la salud y el miedo al ejercicio físico en los pacientes con DCI.

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Introduction

An implantable cardioverter defibrillator (ICD) has been used frequently since the 1990s in the treatment of patients with life-threatening arrhythmia (Carroll et al., 1999). The ICD is used to pace, convert and defibrillate survivors of sudden cardiac arrest, ventricular tachycardia and ventricular fibrillation or in prophylaxis for patients with a left ventricular ejection fraction lower than 35% or with past myocardial infarction (Connolly, 1998; McHugh-Schuster et al., 1998). There have been a number of studies reporting improved ICD patient survival compared to patients without ICD (Bainger and Fernsler, 1995; Wever et al., 1996; Cappato, 1999; Hider, 1999; Connolly et al., 2000). The device, however, may have major effects on the health-related quality of life (HR-QoL) of those patients. HR-QoL consists of different domains that refer to areas of behaviour or experience. These domains include physical, psychological, social and occupational functioning (and other roles) and perceptions about health status (Swenson and Clinch, 2000).

One would think that an ICD would make patients less fearful than other cardiac patients. Although implantation relieves much of the fear of sudden death and is welcomed by patients, Lewin et al. (2001) indicate it also imposes new fears and has its own set of negative effects. The most potent source of distress that is unique to ICD patients is the effect of experiencing or anticipating firings. A firing is usually highly aversive and is accompanied by acute pain and anxiety. Often the patient becomes unconscious. Many patients report a feeling of dread or helplessness that can persist for hours or even days after a firing.

In some patients, the unpredictability of firings can produce an almost permanent state of anticipatory anxiety. Some may become reluctant to socialize and even become reclusive because of the social embarrassment a firing may cause. Approximately 90% of patients attribute each firing to a specific preceding cause. It is most commonly attributed to a physical activity such as walking or gardening, or related to stress or excitement, as can be the case when watching a football match or simply worrying. Attributing a cause this way can lead to an increasingly restricted and unsatisfying lifestyle as more and more activities are struck off the patients’ repertoire by themselves or their spouses (Lewin et al., 2001).

HR-QoL of ICD patients has been studied before but the results of these studies are not conclusive. In some studies an improvement in HR-QoL was found after ICD implantation (Lüderitz et al., 1994; May et al., 1995; Chevalier et al., 1996), but Bainger and Fernsler (1995) found no change and Carroll et al. (1999) found a decline in HR-QoL.

The outcomes of the different studies that compared quality of life of ICD patients, to that of normal healthy individuals are not consistent either. One study (Sauvé, 1995) reported a significantly poorer physical function in ICD patients but no differences in psychological functioning. Arteaga and Windle (1995) found quality-of-life scores in patients with an ICD similar to those of normal healthy individuals. Gallagher et al. (1997), on the other hand, found that recipients of an ICD are more depressed, stressed, confused and angry than the normal population. This suggests a poorer mental health of patients with an ICD than of normal individuals.

Fear of exercise is common in all types of patients. For example, patients with low back pain refrain from exercise and sports because they are afraid of recurring
The aim of this study is to describe HR-QoL, fear of exercise and physical activity in ICD patients. HR-QoL in ICD patients has not been studied explicitly. Until now, the relationship between fear of exercise and HR-QoL in ICD patients has not been studied explicitly. The aim of this study is to describe HR-QoL, fear of exercise and their relationship in ICD patients.

Materials and methods
Participants
Patients treated with an ICD between December 1995 and May 2001 at the Groningen University Hospital were eligible for participation in this study. Excluded were those under the age of 18, non-Dutch-speakers and patients with severe comorbidity or other factors that may influence the results of the study. Of the 179 eligible patients, 95 consented to participate. Of these 95, six were excluded because of the above-mentioned criteria.

Procedure
After informed consent, participants were asked to fill in a set of questionnaires. The questionnaires were completed at an undefined point in the treatment. HR-QoL was quantified using two questionnaires, the Rand-36 and the Quality of Life After Myocardial Infarction Dutch language version (QoLMI-DLV), originally composed by T.K. Hillers et al. in 1994. The Rand-36 consists of the following components: physical functioning, emotional functioning, mental health, pain, general health belief, change in health, restricted role due to physical problems, restricted role due to emotional problems and vitality. The higher the score on the Rand-36, the better the HR-QoL of the patient. The Cronbach's alpha of the Rand-36 varies between 0.71 and 0.92 for the different subscales.

Fear of exercise and quality of life

Fear of exercise was measured by the Fear Avoidance Beliefs questionnaire Dutch version (FABQ-DV) and the Tampa Scale for Kinesiophobia Dutch version (TSK-DV) (Vendrig et al., 1995; Vendrig et al., 1998). The FABQ-DV is divided into two parts. The first part consists of seven items on fear-avoidance beliefs with regard to work, the second part consists of four items and measures fear-avoidance beliefs regarding physical activity. The Cronbach's alpha of the first part when used in patients with low back pain is 0.90 and that of the second part 0.71, pointing out a satisfactory validity. The higher the score, the more fear-avoidance beliefs play a part (Vendrig et al., 1998).

The TSK-DV consists of four components: harm, fear of (recurring) injury, avoidance of activity and importance of exercise. The higher the score on a component of the TSK-DV, the greater the role that component has in the fear of exercise. The Cronbach's alpha was 0.77, which is fair. This information underscores the reliability of the TSK-DV when used in patients with low back pain (Vlayen et al., 1998).

These two scales have been designed for measuring fear of exercise and fear-avoidance beliefs in patients with low back pain. For this study they were modified so as to be applicable to patients with an ICD. Both the FABQ-DV and the TSK-DV consist of statements regarding chronic low back pain, such as 'physical activity would damage my back', 'because of my daily work my low back pain becomes worse' and 'because of my low back pain, my body is in danger for the rest of my life'. Respondents have to react to these statements by filling in the degree to which they agree or disagree with the statement. In the original statements, the words 'pain' and 'back' recur often. We changed these words to 'complaints' and 'heart' or 'ICD', respectively.

The internal consistency of the modified TSK-DV we used in our study was tested by the Cronbach's alpha and compared with the TSK-DV used by Vendrig et al. (1998) and the internal consistency of the modified version of the FABQ was tested and compared with the original English version (Waddell et al., 1993). In different studies the internal consistency of the TSK-DV ranges between 0.68 and 0.80, the internal consistency of the modified TSK-DV in our study is 0.80. The internal consistency of the FABQ work domain in the original English version is 0.88 and for the modified FABQ-DV in our study it is 0.87; the internal consistency of the original FABQ physical activities is 0.77 and for the modified version in our study it is 0.80.

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Statistical analyses
Data were analysed using SPSS-10. Means, SDs, medians and ranges were calculated. Association between outcome variables was analysed through linear regression. Statistical significance was defined at \( P < 0.05 \).

Results
The general composition of the study population was as follows. Full data-sets of 83 patients were taken for analysis (67 men and 16 women). The mean age (SD) was 58.1 (13.2) years. The mean (SD) number of years the patients had been living with the ICD was 2.2 (1.2) years (see also Table 1).

Table 2 shows the means, SDs and 95% confidence intervals of the Rand-36, the QoLMI-DLV, the TSK-DV and the FABQ-DV in our study population.

The 95% confidence intervals of the difference between our scores and those from a study on a normal population by van der Zee and Sanderman (1993) are shown in Table 3. The table shows that our population scored significantly worse than a normal population on general health, physical functioning, social functioning, pain and restricted role due to physical problems.

For each regression analysis, sex, age, number of years of living with the ICD and one of the components of the four questionnaires were used as independent variables. The dependent variable every time was one of the HRQoL domains of the Rand-36 and the QoLMI-DLV. Pearson correlation coefficients of these regression analyses were calculated. Thus, the correlation coefficients presented in Table 4 show the association between fear of exercise and HR-QoL, corrected for the influence of age, sex and amount of years that a patient has lived with the ICD.

Discussion
The results of our study show that HR-QoL is lower in patients with an ICD than in the normal population. The patients in our study scored significantly worse than the normal population on the following components of the Rand-36: general health, physical functioning, social functioning and restricted role due to physical problems. This is partly in accordance with the results of the study by Sauvé (1995), who also found that ICD patients have diminished general health and physical functioning. However, no difference in problems in social functioning was found in that study.

In our study population there were a considerable number of patients who reported a fear of exercise. This is an important finding, although our scores on the two fear-of-exercise questionnaires present a large range.

Next, HR-QoL in ICD patients appear to be negatively associated with fear of exercise. The regression analyses performed show relatively high correlation coefficients between these two variables. In our calculation of the correlation coefficients we had already excluded the influence that sex, age and amount of years of living with the ICD can have on this relationship. Our hypothesis that fear of exercise negatively influences HR-QoL in patients with an ICD is confirmed by this analysis.

Finally, because a cross-sectional study has been performed here, no causal relationships between variables can be taken from our data. To be able to do so, prospective cohort trials need to be carried out.

Nevertheless, our findings could be very important for planning treatment of ICD patients. Earlier studies have made it clear that several ICD patients benefited from joining social support groups that offer guidance and meet the psychosocial needs of patients with an ICD (Badger and Morris, 1989; Dickerson et al., 2000; Eads et al., 2000).
Cardiac rehabilitation is proven to result in improved quality of life in patients with conditions like myocardial infarction (Badger and Morris, 1989). Although researchers have stated that for most ICD patients it is safe to exercise (Lampman and Knight, 2000; Kelly, 1995), until now very little has been known about the guidelines and benefits of rehabilitation programmes or exercise training for such patients. Menard-Rothe and Callahan (1986) suggested patients who received an ICD be considered as an appropriate population to participate in cardiac rehabilitation programmes. According to Menard-Rothe and Callahan (1986), the guidelines for ICD patients should be similar to those used for individuals who have undergone coronary bypass surgery and valve replacement. Others believe that ICD patients need a specifically defined exercise programme and careful medical supervision during exercise by skilled staff (Friedman et al., 1996; Lampman and Knight, 2000; Vanhees et al., 2001). Further research on this topic, with a larger number of patients, is needed if one is to prescribe an exercise programme that fits the needs of ICD patients.

This study paid special attention to the relationship between HR-QoL of patients with an ICD and fear of exercise. There are probably other factors contributing to the quality of life of our patients that can affect our findings. For example, depression or fatigue can be highly relevant to quality of life as well as to fear of exercise. We have also learned from previous research that the number of ICD firings patients have experienced influences their emotional state (Gallagher et al., 1997). These factors should be considered in further research.

Conclusion
Fear of exercise is a significant determinant of HR-QoL in ICD patients. After implantation of an ICD, patients with a fear of exercise should be identified. Appropriate rehabilitation and interventions should be considered in patients with a clear fear of exercise in order to optimize their HR-QoL.

References
Cappato R (1999). Secondary prevention of sudden death: the Dutch study, the Antiarrhythmics Versus Implantable Defibrillator trial, the Cardiac Arrest Study

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Table 3 Comparison of Rand-36 scores with a normal population

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Mean (SD)</th>
<th>n (van der Zee and Sanderman, 1993)</th>
<th>Mean (SD)</th>
<th>van der Zee and Sanderman, 1993, 95% confidence interval of the difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>General health</td>
<td>83</td>
<td>57.3 (22.8)</td>
<td>1063</td>
<td>72.2 (22.7)</td>
<td>10.3–20.5‡</td>
</tr>
<tr>
<td>Physical functioning</td>
<td>80</td>
<td>72.3 (22.3)</td>
<td>1063</td>
<td>81.9 (23.2)</td>
<td>4.33–14.9‡</td>
</tr>
<tr>
<td>Social functioning</td>
<td>82</td>
<td>80.0 (22.0)</td>
<td>1063</td>
<td>86.9 (20.50)</td>
<td>2.23–11.5‡</td>
</tr>
<tr>
<td>Mental health</td>
<td>81</td>
<td>76.8 (19.3)</td>
<td>1063</td>
<td>76.8 (18.4)</td>
<td>–4.17–4.19</td>
</tr>
<tr>
<td>Pain</td>
<td>82</td>
<td>87.5 (18.4)</td>
<td>1063</td>
<td>79.5 (25.6)</td>
<td>–13.2–1.89</td>
</tr>
<tr>
<td>Vitality</td>
<td>81</td>
<td>64.3 (20.8)</td>
<td>1063</td>
<td>67.4 (19.9)</td>
<td>–1.44–7.6</td>
</tr>
<tr>
<td>Restricted role (emotional)</td>
<td>80</td>
<td>77.1 (36.2)</td>
<td>1063</td>
<td>84.1 (32.3)</td>
<td>–0.39–14.4</td>
</tr>
<tr>
<td>Restricted role (physical)</td>
<td>80</td>
<td>59.4 (42.4)</td>
<td>1063</td>
<td>79.4 (35.5)</td>
<td>11.8–28.2‡</td>
</tr>
<tr>
<td>Health change belief</td>
<td>83</td>
<td>53.9 (25.8)</td>
<td>1063</td>
<td>52.4 (19.4)</td>
<td>–5.87–2.93</td>
</tr>
</tbody>
</table>

*Significant at the 0.05 level.

Table 4 Correlation coefficients of linear regression analyses

<table>
<thead>
<tr>
<th></th>
<th>TSKtot</th>
<th>TSKh</th>
<th>TSKf</th>
<th>TSKaa</th>
<th>TSKi</th>
<th>FABQw</th>
<th>FABQp</th>
</tr>
</thead>
<tbody>
<tr>
<td>QoLMI-DV</td>
<td>0.587a</td>
<td>0.645a</td>
<td>0.478a</td>
<td>0.580a</td>
<td>0.258</td>
<td>0.550a</td>
<td>0.329</td>
</tr>
<tr>
<td>QoLphys</td>
<td>0.587a</td>
<td>0.645a</td>
<td>0.454a</td>
<td>0.547a</td>
<td>0.179</td>
<td>0.464a</td>
<td>0.414a</td>
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<tr>
<td>QoLemo</td>
<td>0.543a</td>
<td>0.613a</td>
<td>0.490a</td>
<td>0.525a</td>
<td>0.291</td>
<td>0.422a</td>
<td>0.254a</td>
</tr>
<tr>
<td>QoLosoc</td>
<td>0.484a</td>
<td>0.515a</td>
<td>0.395a</td>
<td>0.527a</td>
<td>0.279</td>
<td>0.614a</td>
<td>0.279a</td>
</tr>
<tr>
<td>Rand-36</td>
<td>0.572a</td>
<td>0.657a</td>
<td>0.402a</td>
<td>0.488a</td>
<td>0.169</td>
<td>0.451a</td>
<td>0.441a</td>
</tr>
<tr>
<td>Rand-pf</td>
<td>0.512a</td>
<td>0.568a</td>
<td>0.460a</td>
<td>0.434a</td>
<td>0.299</td>
<td>0.381a</td>
<td>0.399a</td>
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<tr>
<td>Rand-sf</td>
<td>0.428a</td>
<td>0.507a</td>
<td>0.352a</td>
<td>0.411a</td>
<td>0.206</td>
<td>0.362a</td>
<td>0.219a</td>
</tr>
<tr>
<td>Rand-mh</td>
<td>0.511a</td>
<td>0.593a</td>
<td>0.457a</td>
<td>0.500a</td>
<td>0.338</td>
<td>0.367a</td>
<td>0.285a</td>
</tr>
<tr>
<td>Rand-g</td>
<td>0.405a</td>
<td>0.487a</td>
<td>0.388a</td>
<td>0.322a</td>
<td>0.259</td>
<td>0.330a</td>
<td>0.332a</td>
</tr>
<tr>
<td>Rand-v</td>
<td>0.571a</td>
<td>0.666a</td>
<td>0.473a</td>
<td>0.510a</td>
<td>0.210</td>
<td>0.381a</td>
<td>0.350a</td>
</tr>
<tr>
<td>Rand-re</td>
<td>0.434a</td>
<td>0.466a</td>
<td>0.297a</td>
<td>0.399a</td>
<td>0.157</td>
<td>0.276a</td>
<td>0.194a</td>
</tr>
<tr>
<td>Rand-tp</td>
<td>0.471a</td>
<td>0.507a</td>
<td>0.344a</td>
<td>0.412a</td>
<td>0.203</td>
<td>0.409a</td>
<td>0.332a</td>
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<tr>
<td>Rand-hcb</td>
<td>0.312</td>
<td>0.329</td>
<td>0.238</td>
<td>0.306</td>
<td>0.232</td>
<td>0.342</td>
<td>0.339a</td>
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</table>

Tampa Scale for Kinesiophobia Dutch version (TSK-DV) components: TSKtot, total score on TSK-DV; TSKh, harm; TSKf, fear of (recurring) injury; TSKaa, avoidance of activity; TSKi, importance of exercise. Fear Avoidance Beliefs questionnaire (FABQ-DV) components: FABQw, work; FABQp, physical activity. Quality of Life After Myocardial Infarction Dutch language version (QoLMI-DLV) components: QoLtot, total score on QoLMI-DLV; QoLphys, physical; QoLemo, emotional; QoLosoc, social.

References
Cappato R (1999). Secondary prevention of sudden death: the Dutch study, the Antiarrhythmics Versus Implantable Defibrillator trial, the Cardiac Arrest Study


