The Effect of Hypnotherapeutic Ego Strengthening with Female Spouses of South African Coronary Artery Bypass Surgery Patients

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Abstract
In addition to exacerbating morbidity in male coronary artery bypass surgery (CABS) patients, their plight can also impose considerable strain on their female spouses’ mood states, resulting in compromised quality of life. The current study was aimed at determining the impact of pre-postoperative hypnotherapeutic ego strengthening (HES) on anxiety and depression in female spouses. It was conducted simultaneously with a recently published study of their CABS husbands’ response to HES. Spouses whose husbands had been randomly assigned to an experimental group, were designated the experimental spouse group (n = 25) and spouses whose husbands constituted the control group, likewise comprised the control spouse group (n = 25). Assessment occurred preoperatively, on the day of discharge and at six week follow-up. Spouses in the experimental group (n = 25) were introduced to hypnotherapeutic ego strengthening (HES), pre and postoperatively. In the postoperative assessment experimental female spouses showed significantly reduced morbidity levels, which were maintained at follow-up. In contrast, females in the control group (n = 25) showed no change. The results supported the value of brief hypnotherapy as a means of psychologically empowering spouses whose husbands were undergoing CABS.

Keywords: Female spouses, coronary artery bypass surgery, brief hypnotherapy, ego-strengthening,
Introduction

Coronary artery bypass surgery (CABS) is a major intervention in terms of physical severity and emotional costs to patients and families, particularly female spouses (Mahler & Kulik, 2002). The psychological distress imposed on female spouses may be equal to, or greater than the stress experienced by male patients (Revenson, 1994). Langeluddecke, Tennant, Fulcher, Barid, and Hughes (1989) demonstrated similar pre-operative psychological distress levels between CABS patients and female spouses. Furthermore, prior to surgery, 54% of female spouses were depressed with concomitantly elevated levels of state anxiety. Conway, Skelton, O’Rourke Cay, and Pentland (1994) found anxiety to be more prominent in female spouses (41%) than in patients (25%). In fact, female spouses were significantly more likely than male patients to be anxious preoperatively.

In addition to suffering from emotional distress, anxiety, depression and anger, female CABS spouses may also experience recurring mood swings (Shanfield, 1990). Frequently expressed as psychosomatic complaints, including non-specific chest pains, headaches, fatigue, infections, increased blood pressure, sleep and appetite problems in female spouses may persist months after their partners’ discharge (Delon, 1998; Mahler & Kulik, 2002). Notably, these feelings are disguised and rarely expressed and are negatively associated with female spousal capacity to endure emotional stress (Davies, 2000). Female spouses also commonly experience changed self-concepts and perceived spousal roles (Stern & Pascale, 1979). Dependent females are particularly prone to adjustment difficulties (Shanfield, 1990). Expecting support from formerly supportive, but now unresponsive or under-supportive convalescing male spouses, dependent spouses may crumble in a welter of anxiety, depression and confusion (Stern & Pascale, 1979). Those female spouses with a diminished capacity to express feelings appear to be particularly at risk of developing psychological problems (Shanfield, 1990). Fearing that overt expression of resentment could injure their recovering male partners, spouses may become overprotective and afraid to make demands, for fear of upsetting them (Dracup, 1994).

Worried and attentive female spouses report poorer physical health at 72 months after their male partners’ CABS (Sullivan et al., 2001). Miller et al. (1990) found increased family disequilibrium because of female spouses’ anxieties 6 months after CABS. In a pilot study by Goldschmidt, Brooks, Sethia, Wheatley, and Bond (1984), 68% of female spouses reported current emotional problems, attributed to difficulties stemming from their partners’ CABS. According to Dracup et al. (1984), female spouses described severe emotional distress at one-year follow-up. They all admitted feeling miserable and depressed, although these feelings were generally not rated as severe as the anxiety (Mulgan & Logan, 1990).

Some female spouses even contemplate suicide since they feel overwhelmed by circumstances, perceiving themselves to be alone, isolated and cut off from emotional support (Theobald, 1997). In severe cases, psychotic symptoms such as disturbed mood and thought processes, including paranoia and delusional thinking, may occur (Arefjord, Hallarakeri, Havik & Maeland, 1998). Female spouses also report frustration and difficulty dealing with their recovering partners’ mood swings, irritability and non-compliant behavior, which may be transmitted to themselves (Mulcahy, 1990). Since female spouses assume significant care giving roles during recovery (Van Elderen, 1994), these spousal duties have been operationalized as care giving burdens with potential outcomes of anxiety and depression (Kulik & Mahler, 1993). Up to 40% of female spouses continue reporting physical and emotional distress a year after their male partners’ bypass surgery (Ockene, Clemow, &
Ockene, 1995). Such stressful environments might contribute to poorer postoperative patient recovery (Dracup, 1994).

While considerable attention has been given to the psychosocial sequelae of CABS in male patients, its impact and concomitant stress load on female spouses remain largely unexplained and untreated. Perhaps resulting from concern with their stricken partners, the existential plight of female spouses of CABS partners has largely been overlooked by healthcare professionals. The current researcher found few references to therapeutic interventions with female spouses, in spite of wide recognition of their raised levels of distress in the context of their male partners’ CABS, as well as a broad acknowledgement in the literature of their primary, critical support role after CABS.

Relevant studies on female spouses of CABS partners focused solely on informational and educational interventions. Tooth, McKenna, Maas and McEniery (1997) postulate that pre-coronary angioplasty education and counseling could assist female spouses’ adjustment, by allowing them to anticipate recovery problems and obtain realistic expectations about long-term complications of restenosis. Females in the experimental group showed continued improvement in quality of life compared to those in the control group. It was concluded that education and counseling could impact favorably on female spouses’ quality of life.

In an even more relevant study, Mahler and Kulik (2002) investigated whether a videotaped informational intervention, targeted at female spouses of CABS partners, would influence their feelings of preparedness, distress levels, and, ultimately, the male patients’ recovery over a 6 month post discharge period. Female spouses who viewed either a tape on mastery or coping, experienced greater feelings of preparedness relative to control female spouses and were less uncertain about what lay ahead. Results also revealed that their problems decreased significantly over time at one, 3 and 6 months respectively.

Dracup, Baker and Edefson (1984) conducted a nursing intervention based on interactionist role theory to meet the special needs of male coronary patients and their female spouses. The program is currently used at four cardiac rehabilitation centers in the Southern California area and the groups are supportive and educational in nature. Consisting of 10 weekly, 90-minute group sessions for couples, findings endorse the view that role supplementation is an important adjunct to the physical conditioning provided in cardiac rehabilitation programs.

The dearth of interventions with female spouses of CABS patients that attend to their predominant mood states (and not just cognitive variables) clearly underlines how female spouses have been neglected, despite wide acknowledgment of their predicament. The inclusion of female spouses is critical as most of them are relatively isolated in their anxiety and fear and feel incompetent to deal with the changes required of them. Given the extremely high prevalence of coronary heart disease, the needs and distresses of female spouses have to be addressed urgently. Among other things, improved preparation of female spouses prior to their male partners’ CABS, could reduce spousal morbidity and facilitate emotional and physical recovery after male partners’ hospital discharge, when responsibility for their recovery largely shifts to their female spouses.

Since the principal researcher had already conceived the idea of a therapeutic program for male CABS patients, the added value of including their spouses, was inevitable. Time constraints inherent in male patients’ (and consequently their spouses’) brief hospitalization necessitated a brief therapeutic intervention with both patients and their female spouses. Thus hypnotherapeutic ego strengthening (HES) was selected as the technique of choice. The impact of the brief HES program to reduce morbidity in male CABS patients has been
reported recently (De Klerk, Du Plessis, Steyn & Botha, 2004).

Enlisting the support of female spouses may provide day-to-day positive reinforcement required for changes to occur and be maintained. Being a potent therapeutic modality, it is argued that HES could alter female spouses’ mood states associated with CABS by means of a rich diversity of techniques. It could also enable female spouses to develop new, ego-related coping skills. HES involves a procedure whereby female spouses are given a series of suggestions and imagery to reinforce their feelings of self-worth and confidence. It could allow female spouses to experience positive attributes and permit them to feel glimpses of hope. Positive reinforcement of female spouses’ attributes could eventually become part of their self-perceptions. Thus, HES could be a powerful modality to help females cope with the distress of their male partners’ hospitalization and surgery. It could also increase the scope and functional capacity of female spouses and utilize their inner strengths to reduce the impact of surgery and facilitate their coping abilities.

Since female spouses play a central role in facilitating adjustment during their male partners’ surgery and convalescence, the purpose of this study is to determine the effect of brief hypnotherapy on female spouses of male CABS patients. We hypothesize that female spouses participating in the experimental condition will show a significant positive effect on depression and anxiety as compared to female spouses participating in the no treatment control group. Our study was thus designed to evaluate the effectiveness of an HES intervention in reducing the distress of female CABS spouses, who have to maintain resilience for the sake of their stricken husbands.

**Method**

A two-group, three-time point experimental design was used.

*Participants*

The female spouses participating in the study were identified when their husbands were solicited for participation in a study of the effect of an HES intervention with male CABS patients. The males were randomly assigned to an experimental and control group (n = 25, both groups). They were all Afrikaans speaking, married, with a mean age of 55.9 (ranging from 42 to 56 years), middle class, protestant men with comparable family histories of CHD, facing their first, uncomplicated CABS.

The experimental female spouse group (n = 25) comprised women whose husbands had been randomly assigned to the experimental CABS patient group (n = 25), while the control female spouse group comprised females whose husbands had been assigned to the control CABS patient group (n = 25).

The female spouses were white, Afrikaans-speaking, legally married women, with a mean age of 51.8 years (ranging from 32 to 63 years.) The majority attained Grade 12 or postsecondary school diplomas as highest qualifications. No differences between average number of children were found and they were mostly employed full-time.

*Research instruments*

Measuring instruments were selected on the basis of relevance for stressed individuals and satisfactory psychometric properties. The instruments were chosen on their ability to measure the empirically validated constructs of anxiety and depression. The instruments for this study included the Beck Depression Inventory (BDI-II) and the Profile of Mood States (POMS).
Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996)

The BDI-II is a mood measuring device and multi-choice questionnaire composed of 21 categories of symptoms and attitudes associated with overt manifestations of depression. Each of the 21 symptom categories contains a graded series of 4 to 5 self-evaluative statements. Categories are rated on a 4-point scale ranging from 0 (minimal) to 3 (most severe). Female spouses were requested to indicate symptoms or attitudes in every category that best described their mood at the time of evaluation. Scores ranged from 0 to 13 (minimal), 14 to 19 (mild) and 29 to 63 (severe), with higher scores indicating progressively severe levels of depression. A highly significant test-retest correlation of 0.93 ($p < 0.001$) confirmed the test’s good construct validity. Furthermore a high correlation of 0.93 between the BDI-IA and BDI-II showed good construct validity when compared to other tests (Beck et al., 1996).

Profile of Mood States (POMS; McNair, Lorr, & Droppleman, 1992)

The POMS is a 65-item self-rating adjective checklist that provides ratings of six mood states, including anxiety and depression. Each adjective is rated on a 5-point intensity scale ranging from 0 (not at all) to 4 (extremely). Female spouses were asked to rate themselves on each adjective, which best described how they have been feeling. Though not scaled from mild to severe, the higher the score, the greater the degree of psychological distress.

The POMS showed acceptable levels of internal consistency (alphas from 0.90 or above) and a significant test-retest reliability of 0.61 to 0.69 (McNair et al., 1992). The POMS also correlates significantly with the Manifest Anxiety Scale (0.80) and Beck Depression Scale (0.61). Since all the correlations between the POMS and the MMPI-2 are significant at the 0.01 level (McNair et al., 1992), it also supports its validity.

Qualitative data, complementary to the above quantitative questionnaires were also used. On the day of discharge, a single question was posed, i.e. What did the HES intervention mean to you? The interpretation process included a semi-grounded theory, including the naming of concepts, defining sub-categories and developing core categories in terms of their properties and dimensions (Strauss & Corbin, 1998).

Statistical analysis

To determine preintervention group comparability, categorical biographical variables were compared by means of a chi-square analysis and the significance of differences between groups was determined by means of $t$ tests. $P$ values were noted in terms of which the degree of statistical significance between groups was established. A two-way ANOVA with a group factor and a repeated measure factor over time was performed, from which the group by time interaction was assessed. The software system Statistica (StatSoft Incorporated, 2003; data analysis software system, version 6, www.statsoft.com), was used for the statistical analysis of the data. A multiple comparison of means within and between groups was done by means of a Bonferroni-adjusted 0.0083 comparison-wise level of significance, which led to a family-wise level of at most 0.05. In the cases of BDI-II and POMS Depression, the normality of data was not clear, therefore, nonparametric analyses were performed using the Wilcoxon signed ranked test for within group and the Mann-Whitney test for between group differences. For statistically significant findings, effect sizes were calculated according to Cohen’s $d$ (Cohen, 1988) to determine the practical significance of the HES intervention. Using Cohen’s guidelines, large practical differences were indicated by ($d = 0.8$), minor possible differences by ($d = 0.2$), while an effect size of ($d = 0.5$), was regarded as indicative of a tendency towards practical difference. A 95% confidence interval was reported as interval estimate for each of the baseline, posttest and follow-up means (Easton & McColl, 2002).
Procedure

After male patients and their female spouses co-consented to spousal enrolment in the study, female spouses were assigned to the experimental and control group. They were interviewed to obtain biographical information, after which they completed measures of (i) mood, and (ii) anxiety, as described above. Follow-ups were conducted individually at discharge and at six weeks following their husbands’ hospital discharge.

The HES intervention

The principal researcher, an experienced clinical psychologist, trained in the use of hypnosis, conducted the intervention with the experimental group spouses individually and in two stages:

(i). Preoperatively each of the 25 female spouses attended one 60 minute HES session in vivo, in a private room, a day prior to her husband’s surgery, and one session on the morning of his surgery.

(ii). Postoperatively the intervention was repeated in three sessions, recorded by her on audiocassette, and presented once daily during spouses’ postoperative hospital visits. Broadly speaking, the intervention consisted of the following aspects: an atmosphere of trust was created by shaking hands with the spouse and assessing her concerns, including misconceptions about surgery, in order to ventilate fears and foster realistic appraisal of her situation (Evans & Stanley, 1991).

Next, a progressive relaxation induction was initiated, in which she was invited to close her eyes and visualize moving down a staircase, feeling more relaxed with each step. The trance was deepened by more visualizations, i.e. a place where she could feel comfortable, safe and relaxed (Gevertz, 1996). As she became more relaxed, communication with the unconscious mind was established, i.e: “In this special place you can receive what you need right now. I don’t know how you will receive it... but before awakening you will receive from your unconscious mind... a special gift... of an experience or a memory that gives you the understanding or the perspective or the feelings that you most need right now (Hammond, 1990, p. 131).

Next an inner strength experience enabled the spouse to feel and access spiritual resources within herself. A script by Frederick and McNeal (1999, p. 141) was used: “This is a part of yourself that has always been there since the moment of birth... even though at times it may have been difficult for you to feel... and it is with you now... It’s that part of yourself that has allowed you to survive... and to overcome many, many obstacles in the past... Just as it helps you now to overcome obstacles... May be you would like to take a few moments to get in touch with that part of yourself...And you can notice what images... or feelings... what thoughts... what bodily sensations are associated with being in touch with your Inner Strength...”

Female spouses in the control group (CG) received no treatment intervention prior to, or following their husbands’ surgery. Their assessments were scheduled similarly to those of the experimental group. Although all females in the control group were offered professional services at conclusion of the study, this was declined in all cases.

Results

Pre-intervention group equivalence

Although not evident in Table 1, the statistical analysis confirmed no significant differences between the experimental and control female spouse groups with regard to biographical variables, medical history, anxiety and depression. Thus, pretreatment group equivalence was endorsed for the female spouses (De Klerk, 2003).
### Postintervention Findings

Table 1: Descriptive statistics concerning scores of the Experimental and Control groups as attained during three assessments.

#### EXPERIMENTAL GROUP

<table>
<thead>
<tr>
<th>Description</th>
<th>Mean</th>
<th>SD</th>
<th>Lower CI (95%)</th>
<th>Upper CI (95%)</th>
</tr>
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<tbody>
<tr>
<td><strong>BECK Depression</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>17.08</td>
<td>6.51</td>
<td>14.39</td>
<td>19.77</td>
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<tr>
<td>Posttest</td>
<td>10.48</td>
<td>8.35</td>
<td>7.03</td>
<td>13.93</td>
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<tr>
<td>Follow-up</td>
<td>7.48</td>
<td>6.83</td>
<td>4.66</td>
<td>10.30</td>
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<tr>
<td><strong>POMS Depression</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>17.08</td>
<td>11.15</td>
<td>12.48</td>
<td>21.68</td>
</tr>
<tr>
<td>Posttest</td>
<td>9.36</td>
<td>9.95</td>
<td>5.25</td>
<td>13.47</td>
</tr>
<tr>
<td>Follow-up</td>
<td>8.04</td>
<td>8.37</td>
<td>4.58</td>
<td>11.50</td>
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<tr>
<td><strong>POMS Anxiety</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>24.32</td>
<td>5.05</td>
<td>22.24</td>
<td>26.40</td>
</tr>
<tr>
<td>Posttest</td>
<td>16.92</td>
<td>6.59</td>
<td>14.20</td>
<td>19.64</td>
</tr>
<tr>
<td>Follow-up</td>
<td>14.04</td>
<td>5.34</td>
<td>11.83</td>
<td>16.25</td>
</tr>
</tbody>
</table>

Note: $n = 25$ across all comparisons

#### CONTROL GROUP

<table>
<thead>
<tr>
<th>Description</th>
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<th>SD</th>
<th>Lower CI (95%)</th>
<th>Upper CI (95%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BECK Depression</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Baseline</td>
<td>14.80</td>
<td>9.75</td>
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<td>17.76</td>
<td>10.39</td>
<td>13.47</td>
<td>22.05</td>
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<td>Follow-up</td>
<td>15.40</td>
<td>11.49</td>
<td>10.66</td>
<td>20.14</td>
</tr>
<tr>
<td><strong>POMS Depression</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>16.28</td>
<td>12.71</td>
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<td>21.53</td>
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<tr>
<td>Posttest</td>
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<td>13.26</td>
<td>10.61</td>
<td>21.55</td>
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<tr>
<td>Follow-up</td>
<td>15.36</td>
<td>15.48</td>
<td>8.97</td>
<td>21.75</td>
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<tr>
<td><strong>POMS Anxiety</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Baseline</td>
<td>21.60</td>
<td>6.79</td>
<td>18.80</td>
<td>24.40</td>
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<tr>
<td>Posttest</td>
<td>20.96</td>
<td>5.00</td>
<td>18.89</td>
<td>23.03</td>
</tr>
<tr>
<td>Follow-up</td>
<td>19.48</td>
<td>5.70</td>
<td>17.13</td>
<td>21.83</td>
</tr>
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</table>

Note: $n = $ across all comparisons
Depression

Figure 1 shows that a significant group by time interaction for BDI-II depression ($p < 0.001$) was obtained. Multiple comparisons within the EG resulted in a significant difference between pre and posttests (means 17.08 vs. 10.48; $p = 0.009$; $d = 0.73$) and also in pre and follow-up tests (means 17.08 vs. 7.48; $p < 0.0012$; $d = 1.06$). For the female spouse CG no significant differences were obtained. As far as the comparison of groups is concerned, a significant difference occurred at the post test (means 10.48 vs. 17.76; $p < 0.02$; $d = -0.80$), as well as at the follow-up test (means 7.48 vs. 15.40; $p < 0.02$; $d = -0.87$). Interestingly, mean depression levels of the female EG remained, except for the pre-test, within the minimal norm (0 to 13), while the CG mean depression levels stayed within mild levels (14 to 19) in all test scores.
Figure 2 shows that a significant group by time interaction for POMS depression ($p = 0.031$) was also obtained. Multiple comparisons within the female spouse EG resulted in a significant reduction between pre and follow-up tests, which yielded a medium effect (means 17.08 vs. 8.04; $p < 0.013; d = 0.75$). No significant differences existed within the female spouse CG. The groups were not significantly different in either post or follow-up tests.
Anxiety

Figure 3 shows that a significant group by time interaction for POMS anxiety ($p < 0.001$) was obtained. Multiple comparisons within the EG firstly resulted in a reduction between pre and post tests, which was statistically and practically significant (means 24.32 vs. 16.92; $p < 0.001$; $d = 1.28$). Similarly, the pre vs. follow-up tests yielded statistically and practically significant findings in case of the female spouse EG (means 24.32 vs. 14.04; $p < 0.001$; $d = 1.78$). No significant differences occurred within the female spouse CG. The groups were not significantly different in either post or follow-up tests.
Discussion

Our research supports existing evidence that female spouses of CABS patients experience heightened levels of anxiety and depression. Thus, it is consistent with the findings of Mulgan and Logan (1990) concerning high levels of anxiety and depression in female spouses. According to them, 43% of female spouses reported significant levels of preoperative anxiety while 45% perceived their health to have suffered because of CABS. Female spouses in our study attained higher levels of depression preoperatively than their male partners (De Klerk, 2003). In this respect, the current findings are consistent with those of Engelman et al. (1994) who reported higher depressive symptom levels in female spouses, both preoperatively and throughout the recovery period than in male partners. Our findings thus endorse the finding that CABS can impose considerable strain on the female caregivers’ psychological functioning, which can arguably compromise their male partners’ recovery.

The current study was intended to explore the possibility of using a HES intervention with female spouses to alter their negative mood states and thereby influence their husbands’ reaction to surgery more positively. Our results show that levels of anxiety and depression of the experimental group of female spouses were significantly reduced and that the reduction was meaningfully maintained at follow-up. Such significant differences between the two groups suggest that preoperative HES reduces postsurgical anxiety and depression, increases coping strategies and enhances feelings of self-control. This suggests that female spouses who have access to a feeling of optimism and mastery are protected from the elevated levels of negative mood states that characterized the control female spouses who received no therapeutic input. Since no comparative findings could be located, it suffices to say that the HES intervention was apparently efficacious for male patients and female spouses in terms of reduced morbidity. The newly acquired relaxation skills helped female spouses to control and master the caregiving demands of CABS and enabled them to be actively involved in their husbands’ recovery.

The results of the qualitative data underscored the statistically significant benefits and effectiveness of the HES intervention by improving the competence of the female CABS spouses to deal with their distress. The qualitative responses of the female spouses also indicated that the HES intervention helped them develop positive feelings and maintain a brighter, more hopeful outlook by alleviating negative mood states.

Despite the positive outcomes reported here, the following design limitations are relevant. Firstly, it can be assumed that female spouses might have benefited more and sooner from the HES intervention if they had been exposed to a greater input, both pre- and postoperatively, as more interventions might produce better outcomes. Secondly, no intervention occurred between spouses’ husbands’ discharge from hospital and their postoperative follow-up. This is a shortcoming as quality of life of female spouses is often aggravated for several months after surgery (Mahler & Kulik, 2002). Thirdly, it was not feasible to assess female spouses’ hypnotizability due to time constraints. Although all female spouses were capable of experiencing hypnosis, it would have been worthwhile to test their hypnotizability to determine whether positive outcomes were produced by the treatment context or by their hypnotic capabilities (Sapp, 1997). Finally, omission of an attention/placebo group could arguably be perceived as a further limitation, especially coupled with the use of self-report inventories only. With only self-report responses and no attention/placebo group, it is unclear to what extent the results were due to non-specific effects associated with being offered an intervention which might relieve suffering, in contrast to
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the control group (De Klerk, et al., 2004).
Despite these limitations, the inclusion of female spouses in the primary study of male CABS patients was deemed highly meaningful because of the positive outcome reported. It became clear that therapeutic interventions with both CABS patients and female spouses are fundamental to reducing suffering associated with comorbid anxiety and depression. These convictions are not only warranted by the results, but were also endorsed by the qualitative statements of the participating female spouses.

Conclusion

The literature review yields general agreement among investigators on the responses of female spouses to a cardiac event. Clearly, female spouses as caregivers are at risk of a variety of negative outcomes after male partners’ CABS. Anxiety and depression have been documented up to one year following CABS. Psychosocial variables are now recognized as playing a critical role in the rehabilitation process for both male patients and spouses. Our experience supports the view that female spouses ought to be involved throughout the rehabilitative process. From the findings of the present study it was concluded that hypnotherapeutic ego-strengthening can significantly reduce pre and postoperative morbidity in female CABS spouses by alleviating negative mood states. Results show that female spouses who attended the HES intervention experienced a significant decrease in anxiety and depression, compared to female spouses who had not. The inclusion of hypnotherapy with female CABS spouses suggests that instilling ego strengthening contributed significantly to their reduced morbidity. Such interventions may well help to reduce stress and prevent development of unhealthy patterns of behavior. Psychological rehabilitation tailored to diagnosing and treating these negative mood states is therefore crucial in planning the best preparation and rehabilitation to assist couples to return to their normal physiological, emotional and family equilibrium.

In future studies the emphasis ought to be on both qualitative and quantitative investigations, focusing respectively on elucidating the experiences of female spouses throughout the CABS process to generate hypotheses for refining further quantitative investigations; and studying the impact of more intensive HES interventions on CABS couples to elucidate individual and interactive responses. Additionally, it is recommended that cardiac centers seriously consider providing professional services to female CABS spouses across the world.

References


