

Symptoms of depression and social support in people with heart failure: an integrative review

Sintomas de depressão e apoio social de pessoas com insuficiência cardíaca: uma revisão integrativa

Síntomas de depresión y apoyo social en personas con insuficiencia cardíaca: una revisión integradora

RESUMO

Objetivo: avaliar na literatura evidências acerca dos sintomas de depressão e do apoio social em pessoas com insuficiência cardíaca. Método: Trata-se de uma revisão integrativa de literatura, realizada nas bases de dados MEDLINE, PsycINFO e Scopus, com os descritores “Heart Failure”, “Depression” e “Social Support” indexados na plataforma Descritores em Ciências de Saúde. Foram selecionados artigos originais e na íntegra, publicados entre 2011 a 2020, em português, inglês e espanhol. Resultados: Compuseram o estudo 10 artigos, que qualificaram o apoio familiar como principal tipo de apoio social. Como fatores que influenciaram a incidência dos sintomas de depressão encontrou-se principalmente o baixo apoio social (70%), a idade (40%) e a classificação da New York Heart Association, em classes de maior gravidade (30%). Conclusão: Observou-se que a maioria dos artigos apresentou correlações entre o baixo nível de apoio social e o aparecimento de sintomas de depressão em pacientes com insuficiência cardíaca.

DESCRITORES: Insuficiência Cardíaca; Depressão; Apoio Social; Enfermeiro; Apoio Familiar de Paciente.

ABSTRACT

Objective: to evaluate evidence in the literature about symptoms of depression and social support in people with heart failure. Method: This is an integrative literature review, carried out in the MEDLINE, PsycINFO and Scopus databases, with the descriptors “Heart Failure”, “Depression” and “Social Support” indexed on the Health Sciences Descriptors platform. Original and full articles were selected, published between 2011 and 2020, in Portuguese, English and Spanish. Results: The study comprised 10 articles, which qualified family support as the main type of social support. The factors that influenced the incidence of depression symptoms were mainly low social support (70%), age (40%) and the New York Heart Association classification, in classes of greater severity (30%). Conclusion: It was observed that the majority of articles presented correlations between a low level of social support and the appearance of depression symptoms in patients with heart failure.

DESCRIPTORS: Heart Failure; Depression; Social support; Nurse; Patient Family Support.

RESUMEN

Objetivo: Evaluar la evidencia en la literatura sobre síntomas de depresión y apoyo social en personas con insuficiencia cardiaca. Método: Se trata de una revisión bibliográfica integradora realizada en las bases de datos MEDLINE, PsycINFO y Scopus, utilizando los descriptores “Heart Failure”, “Depression” y “Social Support” indexados en la plataforma Health Sciences Descriptors. Se seleccionaron artículos originales y completos publicados entre 2011 y 2020 en portugués, inglés y español. Resultados: El estudio incluyó 10 artículos, que categorizaron el apoyo familiar como el principal tipo de apoyo social. Los factores que influyeron en la incidencia de síntomas de depresión fueron principalmente el bajo apoyo social (70%), la edad (40%) y la clasificación de la New York Heart Association en clases de mayor gravedad (30%). Conclusión: La mayoría de los artículos mostraron correlaciones entre bajos niveles de apoyo social y la aparición de síntomas de depresión en pacientes con insuficiencia cardíaca.

DESCRIPTORES: Insuficiencia cardíaca; Depresión; Apoyo social; Enfermera; Apoyo familiar al paciente.

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INTRODUCTION

Hear Failure (HF) is one of the chronic non-communicable diseases (NCDs) with the greatest impact worldwide, affecting around 20 million people. ¹ In Brazil, it corresponds to the first cause of hospitalizations and the second of deaths due to cardiovascular diseases ², whose prevalence is approximately 2 million cases and incidence of 240 thousand per year. ³⁻⁴ According to the Brazilian Society of Cardiology, 6.4 million people are affected, of which 50% die, on average, five years after diagnosis. ⁵

It is a clinical syndrome in which a structural or functional change in the heart leads to the inability to eject or accommodate blood within physiological pressure values, causing

functional limitation ⁵⁻⁶ through compromised performance of basic activities, loss of productivity and reduced self-care. ⁷

Regarding the clinic, it is observed that patients affected by the disease present symptoms of fatigue, dyspnea, edema of the lower limbs, cough and dizziness, which may be accompanied by memory loss and difficulty concentrating. ⁶ This symptomatology can result in reduced functional capacity and loss of autonomy, causing the possible emergence of anxiety, symptoms of depression and cognitive impairment. ⁸⁻⁹

Depressive symptoms in people with HF can be triggered by the suffering of experiencing a heart disease, which often involves limitations and negative repercussions in the individual, family and collec-

tive biopsychosocial context ¹⁰, promoting a deficit in self-care, basic life activities and the adoption of behaviors and habits to maintain clinical stability. ¹¹⁻¹² These symptoms can be present in up to 40% of patients suffering from coronary disease, varying the degree of the disorder. ¹⁰

In this context, social support becomes essential for promoting adherence to HF treatment ¹³⁻¹⁴, since it is a sum of interpersonal relationships, developed throughout life and perceived as significant, which help to face difficult situations. ¹⁵⁻¹⁶ It thus constitutes an important tool for the patient's ability to cope and adapt and helps promote well-being and health, resulting in positive behaviors in the face of the disease ^{9,17-18}, with emphasis on the presence of family members

who act as a health protection factor in the face of the adaptive process of the disease.^{11,19}

Therefore, it becomes important that professionals, especially nurses, are able to identify early the emergence of depressive symptoms in people with HF, as well as getting to know your support network in order to develop a care plan aimed at the patient's needs. It is also important to highlight the need for these professionals to be part of this support network in order to strengthen the autonomy, independence and social support of this clientele.²⁰

Despite the impact of depression symptoms and the importance of a social network in the context of people with HF, studies that address the relationship between these variables are still incipient, and which can contribute to guiding professionals' actions. Therefore, the objective of this study is to evaluate evidence in the literature about symptoms of depression and social support in people with heart failure.

METHOD

This is an integrative literature review. This was carried out through the following phases: identification of the topic and selection of the hypothesis or research question for preparing the review; the establishment of criteria for inclusion and exclusion of studies/sampling or literature search; the definition of information to be extracted from the selected studies/categorization of studies; the evaluation of studies included in the integrative review, equivalent to analysis; and the interpretation of results.²¹ The searches and pre-selection of studies were carried out by two independent and qualified researchers, who were calibrated by checking the agreement index.

The databases searched were: MEDLINE, PsycINFO and Scopus, using the descriptors "Heart Failure", "Depression" and "Social Support/Self care" indexed on the platform "Descriptors in Health Sciences - DeCS (*Descritores em Ciências de Saúde*)" of the Virtual Health Library, using the Boolean operator AND. An adjustment was made to the search strategy according to the specificities of each database, maintaining

adequacy to the guiding question and its respective study inclusion criteria.

Original articles were included and made available in full, which addressed depressive symptoms and social support in people with heart failure, published between 2011 and 2020 and written in Portuguese, English and Spanish. Bibliographic research articles, reflection articles, theses, dissertations and monographs, and articles repeated in different databases were excluded from the study.

The searches resulted in 888 publications, with 218 publications identified in MEDLINE, 165 in PsycINFO and 505 in Scopus. After using the inclusion and exclusion criteria, 256 articles were selected, of which 66 were from MEDLINE, 84 from PsycINFO and 106 from Scopus. In the next stage, the title and abstracts were read, 217 publications were excluded. Of the remaining 39 publications, 9 from MEDLINE, 18 from PsycINFO and 12 from Scopus, 10 articles were ultimately included in the review, 2 from MEDLINE, 7 from PsycINFO and 1 from Scopus.

RESULTS

The articles were published between March 2011 and January 2019, mainly between 2013 and 2014, all in English. It was observed that eight (80%) publications had the United States as their country of origin, one from Canada (10%) and one from Spain (10%). The articles were found in the internationally recognized electronic databases MEDLINE, Psycinfo and Scopus, most of which were published in the journals "Heart&Lung" (20%) and "Journal of Cardiovascular Nursing" (30%).

The sociodemographic profile of study participants was predominantly made up of male patients diagnosed with HF (80%), with an average age between 53 and 73 years, married (60%), Caucasians (70%), with comorbidities such as obesity (10%), diabetes mellitus (30%) and high blood pressure (20%) and classified in classes II (50%) and III (50%), according to the New York Heart Association (NYHA), which assesses the severity of HF symptoms.⁵

Table 1 presents the main factors that

influenced the prevalence of depressive symptoms in patients with HF, as well as the instruments used to evaluate them and their respective results.

Among the 10 articles selected for the review, 7 identified the presence of depression symptoms in patients with HF. The main factors that influenced the occurrence of depressive symptoms in HF were the type of intervention applied by the study, such as Coping Skills Training – CST and Heart Failure Education - HFE²²; age^{24,27,29}; gender^{24,25,27}; patient-reported functional status of HF²⁴; the different treatment groups for the disease¹⁴; the severity of the disease¹⁴; race and/or ethnicity¹³⁻¹⁴; the low perceived control in the face of HF¹³; HF symptoms present^{26,28}; marital status²⁸; the presence of other comorbidities²⁷; the absence of a spouse or partners²⁸; the deficit of other types of support, in addition to emotional support²⁸; the Charlson Comorbidity Index (CCI) score²⁹, characterized as a measure of the presence of other comorbidities; in addition to the low level of social support^{13-14,22,25,28} and the New York Heart Association (NYHA) classification, especially in classes III and IV.^{13,23-24}

The characterization of social support, as well as the instruments used to evaluate and classify it, can be found in Table 2.

DISCUSSION

The predominance of the diagnosis in male patients stands out, also found in another study, in which 53.2% of the sample was made up of men.⁷ It is inferred that this result is due to the predisposition that men have in relation to the development of cardiovascular diseases, as well as the association with other contributing factors, making it a risk factor given the nature of the disease.

Associated with sex, factors such as aging and the presence of other comorbidities contribute negatively to the diagnosis of HF, such as obesity, diabetes mellitus and high blood pressure. The Brazilian Society of Cardiology presents a classification of HF stages in a study, according to the American College of Cardiology and the American Heart Association, in which obesity, diabetes and hypertension, as well as smoking, dyslipidemia and alcoholism, are considered risk

Table 1. Characterization of depressive symptoms in patients with HF.

Nº	Author/Year	Tools	Factors that influence the occurrence of depressive symptoms	Results
1)	BLUMENTHAL et al., 2019 (22)	Beck Depression Inventory-II (BDI-II);	Type of intervention applied by the study and low social support;	Of the 60 with low support, 36 (60%) had a low score on the scale;
2)	CHUNG et al., 2011 (23)	Beck Depression Inventory-II (BDI- II);	Low social support in patients with class III and IV HF on the NYHA scale;	Of the 71 (32.27%) participants who presented depressive symptoms, 50 (22.72%) have low social support;
3)	CHUNG et al., 2013 (24)	Beck Depression Inventory-II (BDI- II);	Age, sex, NYHA class, and self-reported functional status;	109 (30.1%) of participants presented depressive symptoms;
4)	FRIEDMANN et al., 2014 (14)	Beck Depression Inventory-II (BDI- II);	Low social support, age, treatment group and disease severity;	53 (49%) participants with symptoms of depression;
5)	PÉREZ-GARCÍA; OLÍVAN; BOVER, 2014 (25)	Hospital Anxiety and Depression (HAD) Scale;	Level of social support (low) and gender;	13.53 (22.55%) participants with HF presented depressive symptoms;
6)	GRAVEN et al., 2013 (13)	Integrative review on the CINAHL and Psyc-ARTICLES databases	Race/ethnicity, NYHA class, perceived control, and social support (low);	Eight studies (54%) investigated the impact of real and/or perceived social support on depressive symptoms;
7)	GRAVEN et al., 2017 (26)	Center for Epidemiological Studies – Depression Scale (CES-D);	Marital status, HF symptoms and low social support;	45 (22.4%) of the participants were diagnosed with depression;
8)	HEO et al., 2014 (27)	Patient Health Questionnaire (PHQ-9);	Comorbidity, age and gender;	Only emotional support was significantly related to depressive symptoms.
9)	MAUNDER et al., 2015 (28)	Hospital Anxiety and Depression Scale;	The presence of clinical symptoms of HF, absence of a spouse or partner and lack of other support;	Depressive symptoms were not associated with attachment type, but were significantly higher in people who did not have a spouse as the main provider of attachment functions.
10)	STAMP et al., 2014 (29)	Beck Depression Inventory-II (BDI- II);	Age, ethnicity, and Charlson Comorbidity Index (CCI) score;	46 (39.5%) of the participants presented depressive symptoms;

Source: Written by the author (2023)

Table 2. Characterization of social support in people with HF.

Nº	Author/Year	Tools	Main type of social support	Social support classification
1)	BLUMENTHAL et al., 2019 (22)	Enhancing Recovery in Coronary Heart Disease (ENRICHD);	Family;	High (119) or Low (60);
2)	CHUNG et al., 2011 (23)	Multidimensional Scale of Perceived Social Support Scale (MSPSS);	Family;	High (109) or Low (111);
3)	CHUNG et al., 2013 (24)	Multidimensional Scale of Perceived Social Support (MSPSS);	Family;	High (230) or Low (132);
4)	FRIEDMANN et al., 2014 (14)	Social Support Questionnaire-6 (SSQ-6);	Family, social and work;	There are no cutoff points to identify high or low social support;
5)	PÉREZ-GARCÍA; OLÍVAN; BOVER, 2014 (25)	Social Support subscale of the Quality of Life Questionnaire;	Family, friends and health support;	Perceived or not perceived;
6)	GRAVEN et al., 2013 (13)	Revisão integrativa nos bancos de dados CINAHL e Pysc- ARTICLES	Family, friends, structural and instrumental support;	Four studies investigated real and perceived support, 3 studies focused only on perceived support, and 1 study examined only real support;
7)	GRAVEN et al., 2017 (26)	Interpersonal Support and Evaluation List - 12;	Family;	High or low (average values on the scale);
8)	HEO et al., 2014 (27)	Multidimensional Scale of Perceived Social Support (MSPSS); Social Support Scale-Instrumental (Heart Failure); FES-Family Relationship Index (Cohesion and Conflict);	Familiar; social; suporte da saúde;	High or low (average values on the scale);
9)	MAUNDER et al., 2015 (28)	Medical Outcomes Study Social Support Scale (MOS-SSS);	Family;	Present or not;
10)	STAMP et al., 2014 (29)	Family Assessment Device Questionnaire (FAD); Family Care Climate Questionnaire-Patient Version (FCCQ-P); Family Emotional Involvement and Criticism Scale (FEICS-PC);	Family;	FAD= 1.96 (1 to 4, 1 as healthy family functioning and 4 as unhealthy family functioning); FCCQ-P= 5.85 (1 to 7, 1 as not true and 7 as true); FEICS-PC= 1.82 (1 to 5, 1 as almost never and 5 as almost always)

Source: Written by the author (2023)

factors for insufficiency, so their control becomes essential to reduce the clinical symptoms of the disease.⁵

Regarding the methodology of the studies, nine articles (90%) adopted a quantitative methodological approach. Regarding data collection, Blumenthal and collaborators (2019) randomly divided participants into two different interventions: Coping Skills Training – CST and Heart Failure Education - HFE (Heart Failure Education). The importance of health education aimed at this specific population, carried out, above all, by nursing professionals is highlighted, as they have a strong health education component rooted in their professional practice. Nurses can carry out educational actions at all levels of care and health, through different methods, such as the formation of therapeutic groups.²⁰

As for the symptoms of depression in patients with HF, they are associated with a decline in physical and functional status. Authors verified, through an assessment of the functional capacity of patients with cardiovascular problems, the presence of performance difficulties related to common activities of daily living, such as eating and dressing.²⁴

Associated with physical factors, perceived control stands out as one of the factors that influence the patient's well-being. Perceived control is understood as the idea that stressful events will have less negative impact to the extent that the individual believes they can control them, promoting positive consequences on their quality of life.^{13,30} In a survey carried out with 201 participants in Florida, it was found that low perceived control was one of the factors that, correlated with others, contributed to a variance of 41% related to depression symptoms.¹³

The NYHA functional classification, in turn, assesses the severity of symptoms. This classification is based on the degree of exercise tolerance and varies from the absence of symptoms to their presence at rest. It allows clinical assessment of the patient, assists in therapeutic management and is related to prognosis. Individuals with NYHA functional class III to IV present progressively worse clinical conditions, more frequent

hospital admissions and greater risks of mortality.⁵

Patients who present with HF symptoms at rest (NYHA IV), for example, may have higher mortality than those who only develop symptoms during physical activity.¹ In this case, the presence of a support network that can provide satisfactory support for this individual to maintain a good quality of life becomes even more necessary.²⁵

The low social support, found in seven of the ten articles, reinforces that the absence or reduction of this support network, in addition to compromising care assistance, directly influences the appearance of depressive symptoms. Other research has shown that a lack of social support, for example through lack of transportation or access to healthy meals, may contribute to the risk of hospital readmission in patients with heart failure.^{11,31}

In contrast, HF patients with higher levels of perceived social support had a reduced likelihood of having cardiac events over a 3.5-year period.^{11,32} It should also be considered that symptoms of depression accentuate clinical manifestations and worsen patients' outcomes. Therefore, greater attention should be devoted to these, highlighting the need to prevent, track or treat them.³³

It should also be considered that symptoms of depression accentuate clinical manifestations and worsen patients' outcomes. Therefore, greater attention should be devoted to these, highlighting the need to prevent them, track them or treat them. Social support in people with this diagnosis presented a variation that comprised simple structural support, such as the family nucleus covering the civil situation, as well as more complex combinations of structural and functional support. Structural support is understood as a simple support network, characterized by the presence of a spouse or partner, while functional support comprises individuals' perceptions of the resources that social networks provide (emotional support, instrumental support and relationships with health professionals).²⁷

Family relationships, in turn, can combine both types of support, because they do not include the existence of just one

social network, but comprise individuals' perceptions of the resources that family relationships can provide.²⁷ Despite covering much of the support that patients with HF need to maintain a satisfactory quality of life, the participation of health professionals in this continuous and longitudinal care is still incipient, only addressed in the articles by Pérez-García, Olivan and Bover (2015) and Heo and collaborators (2014).^{23,27}

It was observed that the main type of social support presented involves the family context, present in all studies (100%), followed by social interaction with friends and co-workers (40%) and support offered by health professionals (20%). The family is highlighted, as it is the first support network present in the patient's life, which offers both structural and functional support, since they include not the existence of a social network, but also individuals' perceptions of the resources that family relationships can provide.²⁷

Social support is associated with better treatment adherence in patients with HF.³⁴ Other studies reinforce that the presence of structural and functional supports were associated with higher self-care management scores, essential for maintaining the clinical symptoms of the disease and preventing injuries¹¹, and the more complete the support, consisting of family, social and health support relationships, the better results this patient will have.

Therefore, it is also necessary to evaluate the level of action that this support generates in patients with HF and their perceptions. The level of social support presented portrays what could be quantified by the scales or the perception of the individual with CI regarding the support offered to them. Six studies classified the level of social support as high or low (60%), one as perceived or not perceived (10%), another as present or absent (10%), another study presented eight articles that addressed the topic from the perspective of a literature review (10%), and one presented satisfactory results through the scale (10%).

Through a complete assessment of social support, carried out by the nurse, it is possible to establish a care plan that involves

all participants in this support network, so that subjective relationships between them occur in search of promoting significant well-being for the patient.³⁵ It is necessary to reinforce the importance of clinical nurses in the face of HF, assisting in therapeutic and self-care interventions, as well as their role as educators, at the primary and secondary levels of care, favoring improvements in quality of life, therapeutic adherence and avoiding new complications and hospitalizations.³⁵

Given this context, the role of health professionals in guiding, educating and monitoring these patients is essential, offering these individuals the psychosocial and educational support necessary to maintain a satisfactory quality of life. The role of the nurse in these cases is highlighted, as they have this educational component strongly rooted in their work practice, in addition to being a fully qualified professional to perform this role.^{5,20}

In addition to the educational nature, nurses can, in their professional practice aimed at HF, carry out a reliable clinical assessment during nursing consultations, guide medication adherence therapy and track the presence of depressive symptoms, as well as maintain monitoring of the patient's holistic

needs and the social support that covers them, adapting the care plan to possible emergencies.^{12,35}

CONCLUSION

The results of this study demonstrated that the majority of articles selected for this literature review presented correlations between a low level of social support and the emergence of depressive symptoms in patients diagnosed with heart failure.

The selected articles brought a sample composed of married men, with an average age between 53 and 73 years, with some associated comorbidity and at levels II and III of the NYHA classification. Although seven of the ten selected articles quantified the presence of depressive symptoms, in none of them it was possible to identify what these symptoms were, only the factors that influenced their incidence, with emphasis on the low level of social support and the NYHA classification.

Despite the divergence between the classifications by the scales, it was possible to characterize the level of social support in which, in most studies, the individuals' perception was satisfactory in relation to the support mentioned. The main component

present in these support networks were family members, who help the patient with their daily needs.

The findings of this study are useful, as they provide support for the planning and implementation of new proposals for care plans in nursing care that involve all the patient's clinical and subjective needs, covering your social support network with a view to strengthening it and making it an essential tool in preventing depressive symptoms.

It is highlighted the need for other, more in-depth studies to be carried out, seeking to identify gaps that have not yet been filled with regard to the topic in question. It is suggested that studies be produced with more comprehensive and reliable results, with longitudinal methodology, for example, which allow long-term monitoring and evaluation of participants. Furthermore, they provide greater visibility regarding the issue of depressive symptoms and social support in people with HF, highlighting the need for public health policies and programs aimed at these patients.

The limitations of this study refer to the scarcity of publications in the national literature and the unavailability of full articles, making it necessary, for the construction of this study, to rely on international publications.

REFERENCES

1. Rocha RC, Figueiredo LF. O perfil do paciente internado com insuficiência cardíaca no hospital das clínicas de Teresópolis. *Rev Facul Med Teresópolis* [Internet]. 2019 [citado 2021 Jun 20]; 3 (1). Disponível em: <https://www.unifeso.edu.br/revista/index.php/faculadadedemedicinade-teresopolis/article/view/973/699>
2. Oscalices MIL, Okuno MFP, Lopes MCBT, Campanharo CRV, Batista REA. Discharge guidance and telephone follow-up in the therapeutic adherence of heart failure: randomized clinical Trial. *Rev Lat Am Enfermagem* [Internet]. 2019 [citado 2021 Jul 20]; 27. Disponível em: <https://www.scielo.br/j/rlae/a/vLpYssHvPctQmtjZTQtnrjy/?lang=en&format=pdf>
3. Gioli-Pereira L, Marcondes-Braga FG, Bernardes-Pereira S, Bacal F, Fernandes F, Mansur AJ et al. Predictors of One-year Outcomes in Chronic Heart Failure: The Portrait of a Middle Income Country. *BMC cardiovasc. disord.* (Online). 2019 [citado 2021 Jul 17]; 19(1): 251-258. Disponível em: <https://bmccardiovascdisord.biomedcentral.com/counter/pdf/10.1186/s12872-019-1226-9.pdf>
4. Cestari VRF, Garces TS, Sousa GJB, Maranhão TA, Neto JDS, Pereira MLD et al. Distribuição Espacial de Mortalidade por Insuficiência Cardíaca no Brasil, 1996-2017. *Arq Bras Cardiol* [Internet]. 2022 [citado 2022 Ago 15]; 118 (1):41-51. Disponível em: https://abccardiol.org/wp-content/uploads/articles_xml/0066-782X-abc-118-01-0041/0066-782X-abc-118-01-0041.pdf
5. Rohde LE, Montera MW, Bocchi EA, Clausell N, Albuquerque DC, Rassi S. Diretriz Brasileira de Insuficiência Cardíaca Crônica e Aguda. *Diretriz Brasileira de Insuficiência Cardíaca Crônica e Aguda. Arq Bras Cardiol.* 2018 [citado 2022 Maio 20]; 111(3): 436-539. DOI: 10.5935/abc.20180190
6. Xavier SO, Ferretti-Rebustini REL. Características clínicas da Insuficiência Cardíaca associadas à dependência funcional admissional em idosos hospitalizados. *Rev Lat Am Enfermagem.* 2019 [citado 2022 Jun 14]; 27. Disponível em: <https://doi.org/10.1590/1518-8345.2869-3137>
7. Born MC, Azzolin KO, Souza EN. How long before hospital admission do the symptoms of heart failure decompensation arise? *Rev Lat Am Enfermagem.* 2019 [citado 2022 Maio 31]; 27:e3119. Disponível em: <http://dx.doi.org/10.1590/1518-8345.2735.3119>
8. Chiala O, Vellone E, Klompstra L, Ortali GA, Strömberg A, Jaarsma T. Relationships between exercise capacity and anxiety, depression, and

cognition in patients with heart failure. *Heart Lung* [Internet]. 2018 [citado 2022 Ago 18]; 47(5):465-470. DOI: 10.1016/j.hrtlng.2018.07.010.

9.Santos PA, Ruschel PP, Pfeifer PM. Apoio Social e Coping em Pacientes com Insuficiência Cardíaca. *Rev SBPH* [Internet]. 2021 [citado 2022 Ago 22];24(2):151-162. Disponível em:http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1516-08582021000200013

10.Hermann-Lingen C. Chronische Herzinsuffizienz und Depression. *Internist* [Internet]. 2018 [citado 2021 Jun 25]; 59: 445-452. Disponível em: <https://doi.org/10.1007/s00108-018-0405-6>

11.Fivecoat HC, Sayers SL, Riegel B. Social support predicts self-care confidence in patients with heart failure. *Eur J Cardiovasc Nurs* [Internet]. 2018 [citado 2021 Jun 21]; 17(7): 598-604. DOI 10.1007/s12529-016-9579-2

12.Lacerda MS, Prado PR, Barros ALBL, Lopes JL. Sintomas depressivos em familiares cuidadores de pacientes com insuficiência cardíaca: uma revisão integrativa. *Rev Gaúcha Enferm* [Internet]. 2019 [citado 2021 Jul 23]; 40:e20180057. DOI: <https://doi.org/10.1590/1983-1447.2019.20180057>

13.Graven LJ, Grant J.The impact of social support on depressive symptoms in individuals with heart failure update and review. *J cardiovasc nurs* [Internet]. 2013 [citado 2021 maio 12]; 28 (5):429-443. DOI:10.1097/JCN.0b013e3182578b9d

14.Friedmann E, Son H, Thomas SA, Chapa DW, Lee HJ. Poor social support is associated with increases in depression but not anxiety over 2 years in heart failure outpatients. *J cardiovasc nurs* [Internet]. 2014 [citado 2021 Jun 12];29 (1): 20-28. DOI: 10.1097/JCN.0b013e318276fa07

15.Faquinelto P, Marcon SS, Waidmann MAP. A rede social como estratégia de apoio à saúde do hipertenso. *Rev bras enferm* [Internet]. 2011 [citado 2021 Jul 18]; 64(5):849-856. Disponível em: <http://www.redalyc.org/articulo.oa?id=267022214007>

16.Aragão EIS, Campos MR, Portugal FB, Gonçalves DA, Mari JJ, Fortes SLCL. Padrões de Apoio Social na Atenção Primária à Saúde: diferenças entre ter doenças físicas ou transtornos mentais. *Ciênc Saúde Col* [Internet]. 2018 [citado 2021 Jul 16]; 23(7):2339-2350. DOI: 10.1590/1413-81232018237.21012016

17.Sousa MM de, Campos RP, Oliveira J dos S, Oliveira SH dos S. Adesão de pacientes com Insuficiência Cardíaca à terapêutica instituída. *Revista Baiana Enferm*. 2019 [citado 2022 maio 20]; 33. Disponível em: <https://periodicos.ufba.br/index.php/enfermagem/article/view/30442>

18.Silva MMBS, Marinho CS, Sampaio ES, Silva RS, Pires CGS, Fraga EN. Qualidade de vida de idosos com Insuficiência Cardíaca. *Ciencia y Enfermeria*. 2021[citado 2022 jun. 02]; 27 (8). DOI: <https://www.scielo.cl/pdf/cienf/v27/0717-9553-cienf-27-8.pdf>

19.Lima RJ, Pimenta CJL, Frazão MCLC, Ferreira GRS, Costa TF, Viana LRC, et al. Functional capacity and social support to people affected by cerebrovascular accident. *Rev Bras Enferm*. 2019 [citado em 2022 jun 03];72(4):868-73. DOI: <http://dx.doi.org/10.1590/0034-7167-2017-0854>

20.Campelo RC, Silva WC, Batista NJC. Atuação do enfermeiro nas orientações para a prevenção de fatores agravantes na insuficiência cardíaca congestiva: revisão integrativa. *Braz J Surg Clin* [Internet]. 2018 [citado 2021 maio 21]; 24(2):176-180. Disponível em: https://www.mastereditora.com.br/periodico/20181006_151416.pdf

21.Mendes KDS, Silveira RCCP, Galvão CM.Revisão Integrativa: Método de pesquisa para a incorporação de evidências na saúde e na enfermagem. *Texto Contexto Enferm* [Internet]. 2008 [citado 2021 Jun 20];17 (4): 758-764. Disponível em: <https://www.scielo.br/j/tce/a/XzFkq6tjWs4wHNqNjKlKXQ/?lang=pt&format=pdf>

22.Blumenthal JA, Zhu Y, Koch GG, Smith PJ, Watkins LL, Hinderliter AL, et al. The modifying effects of social support on psychological outcomes in

patients with heart failure. *Health Psychol*. 2019 [citado 2022 maio 15]; 38 (6), 502-8. DOI: <https://doi.org/10.1037/hea0000716>

23.Chung ML, Lennie TA, Dekker RL, Wu JR, Moser DK. Depressive symptoms and poor social support have a synergistic effect on event-free survival in patients with heart failure. *Heart Lung* [Internet]. 2011 [citado 2021 Jul 12];40: 492-501. DOI:10.1016/j.hrtlng.2010.08.001.

24.Chung M, Moser D, Lennie T, Frazier S. Perceived social support predicted quality of life in patients with heart failure, but the effect is mediated by depressive symptoms. *Qual Life Res* [Internet]. 2013 [citado 2021 maio 11]; 22:1555-1563. DOI: 10.1007/s11136-012-0294-4

25.Pérez-García AM, Oliván S, Bover R. Satisfacción vital, síntomas depresivos y apoyo social percibido en pacientes con insuficiencia cardíaca. *Rev de Psicopatol y Psicol* [Internet]. 2014 [citado 2021 maio 30]; 18(2), 93-105. Disponível em:<https://doi.org/10.5944/rppc.vol.18.num.2.2013.12766>

26.Graven LJ, Martorella G, Gordon G, Keltner JSG, Higgins MK. Predictors of depression in outpatients with heart failure: An observational stud. *Int J Nurs Stud* [Internet]. 2017 [citado 2021 maio 13]; 69:57-65. Disponível em:<http://dx.doi.org/10.1016/j.ijnurstu.2017.01.014>

27.Heo S, Lennie TA, Moser DK, Kennedy RL. Types of social support and their relationships to physical and depressive symptoms and health-related quality of life in patients with heart failure. *Heart Lung* [Internet]. 2014 [citado 2021 maio 15]; 43 (4):299-305. Disponível em:<http://dx.doi.org/10.1016/j.hrtlng.2014.04.015>

28.Maunder RG, Nolan RP, ParkJS, James R, Newton G.Social support and the consequences of heart failure compared with other cardiac diseases: The contribution of support received within an attachment relationship. *Arch Cardiovasc Dis* [Internet]. 2015 [citado 2021 maio 22]; 108:437-445. Disponível em:<http://dx.doi.org/10.1016/j.acvd.2015.03.005>

29.Stamp KD, Dunbar SB, Clark PC, Reilly CM, Gary RA, Higgins M et al. Family context influences psychological outcomes of depressive symptoms and emotional quality of life in patients with heart failure. *J cardiovasc nurs* [Internet]. 2014 [citado 2021 maio 23]; 29(6):517-527. DOI: 10.1097/JCN.0000000000000097

30.Pacheco NA, Pizzutti C, Wagner RF, Franceschetto I. O papel da dimensão temporal do controle percebido pelo consumidor em episódios de insatisfação. *Rev Adm IMED* [Internet]. 2017 [citado 2021 set 17]; 7 (1). DOI:10.18256/2237-7956/raimed.v7n1p291-312

31.Retrum JH, Boggs J, Hersh A, Wright L, Main DS, Magid DJ et al. Patient-identified factors related to heart failure readmissions. *Circ Cardiovasc Qual Outcomes* [Internet]. 2013 [citado 2021 jul 26]; 6 (2):171-177. DOI: 10.1161 / CIRCOUTCOMES.112.967356

32.Wu JR, Frazier SK, Rayens MK, Lennie TA, Chung ML, Moser DK. Medication adherence, social support, and event-free survival in patients with heart failure. *Health Psychol* [Internet]. 2013 [citado 2021 jul 15];32(6): 637-646. DOI: 10.1037 / a0028527

33.Guerra TRB, Venancio ICD, Pinheiro DMM, Mendlowicz MV, Cavalcanti ACD, Mesquita ET. Métodos de Rastreamento da Depressão em Pacientes Ambulatoriais com Insuficiência Cardíaca. *Int J cardiovasc sci* [Internet]. 2018 [citado 2021 jun 15]; 31(4): 414-421. Disponível em:<https://doi.org/10.5935/2359-4802.20180037>

34.Maeda U, Shen BJ, Schwarz ER, Farrell KA, Mallon S. Self-efficacy mediates the associations of social support and depression with treatment adherence in heart failure patients. *Int J Behav Med* [Internet]. 2013 [citado 2021 jun 23]; 20(1): 88-96. DOI: 10.1007 / s12529-011-9215-0

35.Galvão PCC, Gomes ET, Figueiredo TR, Bezerra SMMS. Diagnósticos de Enfermagem aplicados a pacientes com Insuficiência Cardíaca descompensada. *Cogitare Enferm* [Internet]. 2016 [citado 2021 maio 28];21 (2). Disponível em: <http://www.redalyc.org/articulo.oa?id=483653650013>