

Lived experiences of women with ischemic heart disease

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ABSTRACT

Background: Ischemic heart disease (IHD) is one of the leading causes of death and disability among young and older women, respectively. Researches in this area mostly focused on manifestations, risk factors, and treatment of the patients with IHD. Therefore, there is a lack of information on the aspects of affects and feelings of such patients. This study aimed to describe lived experience of women with IHD to provide a suitable guide for nursing practice.

Materials and Methods: This was a descriptive phenomenological study. Participants were 8 women with IHD who were hospitalized in critical care units (CCUs) and ambulatory cardiac care centers of Isfahan University of Medical Sciences in Iran. They voluntarily responded to open-ended questions of semi-structured interviews. Data was analyzed using Colaizzi's method to extract meanings and concepts.

Findings: After analyzing the statements of the participants, 14 subthemes forming 5 main concepts of pain and relief, resistance, introversion, loss of control, and mutual communication were emerged.

Conclusions: Ischemic heart event is an experience with multidimensional impact on various aspects of the patient's life. This study demonstrated this experience as having 5 fundamental elements. Women with IHD expressed their suffering from frequent cycles of pain that drove their feelings and thoughts toward themselves and provoked their sense of resistance. They also faced loss of control on various aspects of their lives and changes in their relationships with others, too. This image would help nurses design their care plan based on a better understanding of these patients.

Key words: Females, qualitative research, ischemic heart disease, life experiences

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INTRODUCTION

Ischemic heart disease (IHD), named also as coronary artery disease (CAD), is one of the leading causes of death and disability among young and older women, respectively.^[1,2] Out of every 3 American women, one dies due to IHD. It is among life-threatening diseases in women that presents as angina pectoris, myocardial infarction (MI), or sudden death.^[3]

Patients with MI are generally admitted to critical care unit (CCU). Their health care mostly focuses on physiotherapy, pharmacology, and their biological response. Little attention is thus paid to psychological support of patients.^[4] MI and acute angina pectoris remarkably affect quality of life of patients and their families and depict a major crisis in their life.^[5-7]

Knowing that the function of heart, as the core of life, is being disturbed is probably the most threatening experience for people with heart attack. It is evident that patients have a vague perspective of their life after having MI.^[8,9] The care given to women with IHD needs to be based on deeper description of their experiences. Women's experiences of IHD during hospitalization are an important field of study in nursing^[10,11] since nurses are

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a main part of healthcare system who spend more time with patients with IHD and have a unique opportunity to help patients overcome their problems.^[12] Nurses and other health care providers want to perceive the experiences of their patients, enter their world, and realize the social processes that clarify disease and health events.^[13] Therefore, it is necessary to attend to experiences of patients in order to propose effective solutions.

Considering the importance of the mentioned points and emphasis on personal experiences of patients and the significance of perception of nurses about these experiences in order to plan patient-oriented care, the researchers decided to evaluate the nature and structure of lived experiences of women with IHD.

MATERIALS AND METHODS

This qualitative descriptive phenomenological research was conducted on women admitted to CCU and post-CCU wards due to IHD (unstable angina or MI) or to cardiology clinics affiliated with Isfahan University of Medical Sciences (Isfahan, Iran). Purposive sampling was adopted for the patients who had experienced IHD and were willing to participate in the study. In a qualitative study, sampling continues until data saturation occurs, that is, when participants do not mention any new subjects or facts, and repeated information is received.^[14] In this study, the researcher reached data saturation after interviewing 8 women with MI or unstable angina.

Deep and semi-structured interviews were used to collect data. At a meeting with the participants, the nature, objectives, and method of the study and their role were explained. Informed consents were then obtained from the participants. Before the interview, participants had agreed with recording the interview. They were, furthermore, assured of the confidentiality of their information. Each interview took 30 to 60 minutes. The interviews were transcribed word by word and then checked with the recorded information again.

Rigor of the study was recommended by Polit and Beck in four aspects of credibility, dependability, confirmability and transferability.^[15] Credibility of the study was ensured by long and deep engagement of the researchers in data collection and analysis, using parallel analyses of several interviews by other researchers and comparing their results with those of the researchers, and also by returning the results to the participants for revision.

Dependability and confirmability were checked by an

audit trial. Two of the tapes along with the tapescripts were given to a qualitative study expert who did not take part in the study for analysis. The researchers tried to be objective by refraining from entering their ideas into the study. They thus avoided reading relevant studies until data was all analyzed. Transferability was maintained by diversifying participants and describing the findings and all procedures in detail.

Colaizzi's phenomenological method was used to analyze data. The tapescripts were studied and revised meticulously and statements related to the phenomena were extracted in order to understand the feelings of participants. Then, codes were organized in categories which were confirmed by participants. In the next stage, the results were integrated using a complete description of the studied phenomenon and revised to have clear concepts. The final results were returned to the participants to be validated.

FINDINGS

The participants were 8 women with IHD with an age range of 52 to 86 years old. Their experiences of their disease were categorized in 5 main themes of pain and relief, resistance, introversion, loss of control, and mutual communication (Figure 1).

Pain and relief

Ischemic pain is considered as a stressful physical pain accompanied by a period of relief. They expressed their experiences as burning pain in the chest, feeling of suffocation and extreme disability, and the kind of pain that took away the power of speaking. They called it the worst pain in their life.

"... I got up rashly. I felt my heart and shoulders were pressed. I couldn't talk. I returned to my place slowly..." said participant No. 5.

"I had chest pain. It was the worst pain I've ever had. Though I'm really patient, the pain was unbearable..." declared participant No. 3.

The core of these statements is an unpleasant mental and physical feeling, which is described as torment, a progressive torment that is transient and followed by a final relief. This relief of torment is a tangible experience that was reported by the patients as a subtheme. For patients, this relief was also transient and periodical.

"It takes about 10 minutes to half an hour. You think it's gone, but you see it comes back in 20 minutes..." stated participant No. 1.

Resistance

Women stated that they ignored the problem and considered it trivial at first, but they noticed it was serious when it repeated.

"I didn't take it [seriously]. I slowed down a little, and the pain was gone. I went on... I tolerated for a few days. I noticed it goes on every day." said participant No. 3.

However, in the next step, and after the problem became dominant, the patient accepted the problem. Resistance thus turned into denial of fear of cardiac pain in the statements of patients. They considered themselves dominant over the pain. They used sentences such as *"I'm not afraid at all. No way, I'm not scared at all..."* or *"Of course, I have good spirit, and try to keep it up."*

Recourse to spirituality and God was one of the mechanisms formed by participants to confront with problems. Participant No. 5 said: *"I repeat mantra, I pray and keep myself busy."*

Introversion

Patients considered their heart problem as a shock to awaken them to pay more attention to their physical and mental condition. Their experiences in this regard manifested the introversion theme. *"I know it's a warning that I'm down the drain. This is a serious warning for people not to continue their hard work anymore."* participant No. 3 declared.

Finding the root of the problem in the past events was extracted from the statements of participants. Past experiences of these people led them to pay more attention to themselves. These experiences included extreme stress, family's ignorance about another person's treatment and care, and death of a close relative.

"At first, my sister died. My [blood] pressure was 22-23 [mm Hg] in her ceremonies. I always had this problem." stated a participant.

Furthermore, patients described the sensitivity of their situation after the incident. Consequently, they paid more attention to themselves afterward. This issue reflected the association they perceived between heart disease and feeling of imminent death.

"Suffocation or death. I say to God, oh Lord! I've lived my life. If you want to take my life, take it in an easy way to become relieved. So, I don't visit my doctor very often." mentioned participant No. 7.

Expressing the attention to similar people and their

destiny depicts a kind of hidden fear in patients which can imply self-attention.

"My dad's relatives all had a heart problem. They all died because of this problem. Finally they died with heart [problem]." said participant No. 4.

Loss of control

Another aspect of lived experiences of patients with heart problems is loss of control on external and internal problems. The participants mentioned physical disability, treatment-dependent life, necessary medical care and survey, and loss of control over their life in future as experiences gained from the disease.

"I can't do anything. When I want to broom, I feel weak and my body starts to shiver." declared participant No. 2.

"I did a lot of housework in the past, but I can't anymore. I did a lot in the past, but I don't feel like doing now." stated participant No. 6.

Life under medical treatment is a different experience for patients with IHD. They hence considered their life to be dependent on treatment. Some even considered their life chaotic because of the disease, and felt that the process of their life was disturbed due to medical treatment.

"... One of my problems is that I see older people who can eat everything, but I have to be on a diet." said participant No. 8.

Fear of the future expresses loss of control over one's future. As participant No. 1 mentioned: *"...I said, oh my God! What happens? I was tormented, I had pain, I have stent. What happens next?"*

Mutual communication

One of the experiences of women with IHD was other people's reaction to their problem. The patients witnessed worries and fears of their relatives while they attempted to support the patients as soon as the diagnosed of IHD was made. The participants' words showed that most of the patients felt they needed more attention from their relatives. While too much attention sometimes leads to limitations in a patient's life, the ignorance of others results in their sadness. The following statements led the researchers to the concept of mutual communication:

"...My husband gave me hope and asked me not to worry. He said I'd get better... Now that I'm like this, I'm a little worried." said participant No. 6.

"... I myself was more dependent on my family." stated participant No. 3.

"They know I have a heart problem, but they slam the door. My heart hurts and I shake." declared participant No. 2.

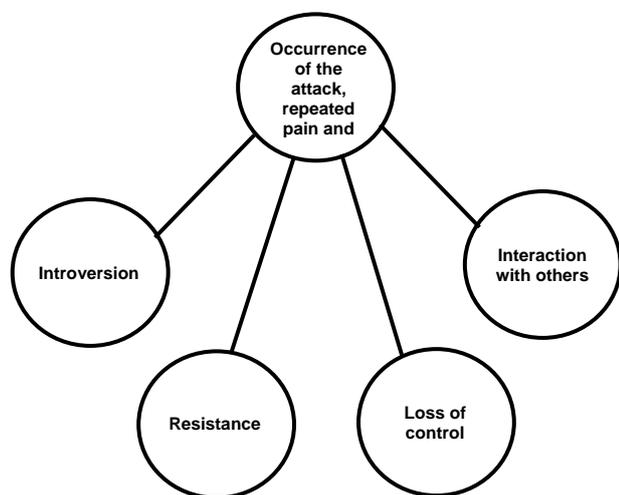


Figure 1. Themes and subthemes of the lived experiences of patients with ischemic heart disease

Each theme was categorized in the following subthemes:

- Interaction with others: Attention of relatives, ignorance of relatives;
- Loss of control: Physical disability, loss of control over conditions, loss of control over the future;
- Resistance: Lack of attention to the first symptoms, mental distancing after the incident;
- Self-attention: Focus on self, past survey and reasoning, perceiving the sensitive condition, finding similar cases.

DISCUSSION

One of the conspicuous findings of this study was the continued torments and reliefs experienced in a period of a few minutes to a few hours due to physical and mental pains caused by IHD. Such torment leads the patient to experience imminent death. This physical pain syndrome was described as a unique point in life by the participants. Physical pain due to heart attack has been previously studied as a complex including preliminary and acute symptoms as part of a series of preliminary awareness, logical justification, increased worry, and treatment seeking. Some symptoms that patients recall as torment are dyspnea, fatigue, sleep disorders, and dyspepsia.^[16]

This physical pain is followed by relief and reduced stress. This cycle repeats and the patient sees herself dangling between the two states. At the time of relief, she is anxious and stressed for the probability of another attack, and at the time of pain, she wishes the acute pain to end and for her to get relieved. In agreement with the description of our participants, Davidson et al. found that lack of certainty about the conditions makes patients express their condition as dangling. They thus feel disabled to get along with life.^[17]

Another theme was patients' resistance and fighting in different stages of experiencing IHD incident. Patients denied and ignored the first symptoms in order to mentally distant themselves from consequent problems of the incident. This distancing can be due to the fear from progress of the incident, but it is a kind of resistance and conforms to the first stage of grieving mechanism. In other words, this behavior is part of denial mechanism.^[17] It has been found that an important and effective, but not confirmed, factor in delaying treatment of MI is patient's denial. Furthermore, Lockyer found that women denied their symptoms and stated "not seeing oneself at risk" as the main reason behind this denial.^[18] In the next step, the patient admits the defeat and the heart event becomes a confirmed experience in her life. Although admitting replaces the denial, the patient resists against its effects on her life again and uses other mechanisms.^[19]

Another aspect of lived experiences of women was the concept of self-attention rooting in their enquiring about the past, understanding sensitive conditions, and finding similar cases. These experiences refer to the awareness of patients about their existence and realizing their role in the world. At this stage, participants tried to discover the reason behind their problem and attributed it to their own and their family's ignorance. This process might happen since finding reasons frees their mind from questions and allows them to moderate and compensate the effective factors. Finding and attributing problems to past reasons have been relatively expressed by Albarran et al. who claimed that most women experience some symptoms hours to weeks before MI, but ignore them.^[16] Emphasizing the reasoning in patients with heart problems, Petrie et al. stated that one of the factors effective on the process of treatment and returning to work is patient's idea about the cause of his disease and his attempt to clinically justify MI.^[20]

The results of this study showed that lack of control comprises subthemes of physical disability, lack of

control over conditions, and lack of control over the future which represent unpleasant effects of the disease on patient's living conditions and naturally her quality of life. Humans try to improve quality of life by more stability and more control over their internal and external environment. A disease is always one of the main causes of disturbing this balance which is manifested in patient's experiences. The disability due to the disease reduces a person's control over life and pushes him/her toward more dependency. Nurses should pay attention to the fact that physical ability has an important role for patients and affects all aspects of their life. Therefore, they have to focus on this aspect to improve it.^[21] Moreover, nurses should know that it is vital for patients to gain control over their conditions.^[17]

In the present study, one of the major experiences of the participants was the reactions of the family and relatives after patients had heart problems. Many studies have confirmed the role of relatives in all stages of the problem. MacInnes reported that most patients adopt mechanisms like changing posture or immobility in the first steps, but as soon as they give in, they adopt other mechanisms which induce interactional responses by their relatives. An appropriate response at this stage can be mental support and recommending the patient not to delay in seeking medical advice.^[19]

Kristofferzon et al. found that women with IHD needed support because of the existing conflict between their role as a wife, mother, employee, and supporter on the one hand and their independence on the other.^[7,22]

CONCLUSION

Based on the findings of the present study, IHD is a multifaceted and influential experience for women, which affects different aspects of their life. The structure of this experience has 5 domains that are depicted in 5 themes. IHD is a paradoxical experience of repetitive pain-relief cycles for women, which leads to self-attention and brings about their resistance. The patient witnesses changes in different aspects of self-control and experiences different interactions with relatives. In this framework, continued pain-relief, self-attention, lack of control over conditions, and others' reactions form the main aspects of IHD event in women.

Accordingly, nurses should focus on realizing the aspects of women's experience of IHD. They should then assess each aspect separately based on its structure and plan appropriate interventions in order to help

patients achieve the expected goals.

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