RESEARCH COMPONENT OF PORTFOLIO OF COURSE WORK

VOLUME ONE, Section A

"The psychological adjustment of West African men post myocardial infarction – a Counselling Psychology study using Interpretative Phenomenological Analysis"

Thesis submitted in part fulfilment of the requirements of
London Metropolitan University for the degree of
Practitioner Doctorate of Counselling Psychology

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VOL2

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Acknowledgements

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My thanks too go to my dear family and friends who have provided me unfailing support throughout the drawn out process of this research; I am forever indebted to you for your tolerance and understanding!

Preface

The bound copy of this thesis comprises only the research section of the portfolio, which is Volume one (Section A) of the portfolio. However, for the sake of completeness, the full portfolio is outlined below.

Introduction to the portfolio

This portfolio of work is presented to fulfill London Metropolitan University requirements for the awarding of the Practitioner Doctorate in Counselling Psychology. Due to the size of the work it is presented in two volumes. The first volume of the portfolio comprises a research study that focuses on the psychological adjustment process experienced by West African men after a myocardial infarction. The second volume of this collection of work consists of three separate pieces of course work that represent a range of different clinical experience and therapeutic contexts.

Although all four sections of work are independent, the portfolio is presented as one large piece of work, composed of chapters that move through both volumes and all four sections.

VOLUME ONE

Section A: Research

This is a qualitative research study that employs Interpretative Phenomenological Analysis (IPA) to explore the psychological adjustment process of West African men, who have experienced a myocardial infarction. This study arose out of experience I gained working with cardiac patients in a clinical health psychology department of a large National Health Service Trust hospital. The **first chapter** starts with an account about Counselling Psychology practice, which leads into a reflexive statement about my history and interest in the research area. The introduction then moves into a discussion about the nature of coronary heart disease and its psychosocial impact, and discusses how ethnic minority patients seem to be under represented in attendance figures at Cardiac Rehabilitation. The significance of this is that low attendance is associated with an increase in morbidity and mortality. The chapter goes on to discuss the distinct lack of research focusing on ethnic minority populations, within the area of post cardiac event adjustment, and thus outlines the focus of this study. The research aims to generate an account of the participant's post myocardial infarction experience, intending to capture their cognitive appraisal and coping strategies employed to manage their experience. It is hoped that this will then inform health professionals about any specific psychological care needs this population may have. The objective of this, in turn, is to increase service access and acceptability to this patient group.

Chapter 2 describes the methodology utilised to obtain the participant data. This chapter starts with an account of the epistemological stance assumed by IPA, and then goes on to explain the process of participant recruitment and the use of a semi-structured interview schedule. The IPA process of data analysis is then described. Ethical considerations are addressed, as are issues pertaining to the quality and evaluation of collected data. A section also explores the relationship between the men and the interviewer, and the effect on the interviews.

Chapter 3 presents the results in the form of tabulated emergent and super-ordinate themes. The analytic process is illustrated with a table of one participant's transcript quotes evolving into the emergent and subsequent super-ordinate themes. The final table of master themes is also then presented. The second part of this chapter comprises the analysis section which describes each super-ordinate theme in detail with supportive quotes from each of the participants. This chapter ends with a summary of the super-ordinate themes

Chapter 4 comprises the discussion section of the report, and considers the super-ordinate themes within the master theme structure, which is formulated as a chronological representation of participant experience. These results are discussed in relation to the aims of the study, the critical literature review of chapter 1, as well as other newly introduced relevant literature. An explanatory framework of the participants post cardiac event adjustment process is then presented.

Chapter 5 is the concluding section of the study, where implications for further research are presented, and the relevance of the study to Counselling Psychology is considered. A review of my learning is then given in terms of my personal growth, and my professional learning as a researcher and clinician.

The references, appendices and figures mark the end of the research part of the portfolio, which completes volume one. Volume two, which comprises the rest of the portfolio, commences with a case study.

VOLUME TWO

Section B: Case study

This case study demonstrates the application of brief psychodynamic work with a woman who had polio, whose condition was beginning to meet the diagnostic criteria for post polio syndrome. This piece of course work represents a period of my career when working within a psychology department of a NHS hospital. It reveals some of the difficulties associated with working with clients experiencing chronic illness, and in this case, illness that unexpectedly reoccurred in an aggressive form. The client was trying to come to terms with this reality that was set against a backdrop of difficult family relationships. **Chapter 6** describes the brief psychodynamic therapeutic orientation in detail. **Chapter 7** provides an account of the client's information, followed by **Chapter 8** which describes the assessment process. Details of the sessions and the application of the brief psychodynamic model are presented in **Chapter 9.** The case study report ends with an overview of the difficulties encountered, an evaluation of the efficacy of the therapeutic intervention, and a discussion of the learning afforded by the experience (**Chapter 10**).

References, appendices and figures complete Section B.

Section C: Process report

This second piece of course work centre's around a ten-minute excerpt taken from a therapeutic session with a client experiencing an underground tube phobia, which originated within the context of a London bombing. This case illustrates the application of Cognitive Behavioural Therapy (CBT) for a specific phobia, within a Primary Care Psychology department, and highlights difficulties related to treating clients with comorbidity. **Chapter 11** introduces the CBT model of phobic avoidance, followed (in **Chapter 12**) by details pertaining to the client and his presentation and problem formulation. **Chapter 13** comprises an outline of earlier sessional work, and a lead in to the session from which the transcribed excerpt is taken. This is then presented with a parallel commentary of the therapists understanding of the therapeutic process. **Chapter 14** concludes this section with an overview of the work in relation to the use of the CBT therapeutic framework, and an evaluation of the efficacy of the intervention for both the client and clinician.

References, appendices and figures complete this section.

Section D: Critical Literature Review

This marks the final piece of course work. This critical literature review focuses on the area of Cognitive Behavioural Therapy for Insomnia (CBT-I), and proposes a research study to extend that of a recently published report (Archer et al, 2009). This piece of work represents a recent position I held entailing the delivery of workshop based CBT-I interventions, within the context of Primary Care Psychology. I was also involved in some exploratory research in this area. Primary Care Psychology now tends to fall predominantly under the Increased Access to Psychological Therapy (IAPT) government initiative, which is fully recognised within this critical literature review.

Chapter 15 introduces insomnia and the psychosocial effects of sleep loss. CBT-I is described and different formats discussed. The evidence base of CBT-I is reviewed, including a critique of recent studies, with specific emphasis being made on methodological issues and data claims. The aims of the proposed study are then outlined, specifically regarding the running of a long term randomised control study to evaluate the efficacy of large CBT-I one day workshops, comprising a representative population of ethnic minority clients, and attracting people with physical and psychiatric conditions. **Chapter 16** presents the proposed design and methodology for the research study. The potential strengths and limitations of the project are then described in **Chapter 17**. The final chapter comprises a reflexive account where the researcher positions herself within the context of the proposed study (**Chapter 18**).

References and appendices mark the end of Section D, and of Volume two. This concludes the portfolio as a whole.

This portfolio of work reflects some different work contexts that I have experienced in my career to date, namely that of a clinical health psychology unit, a hospital psychology department, different primary care psychology settings, and a couple of research posts/ projects. This seems to appropriately reflect the expanding breadth of the Counselling Psychology profession. I reflect over these pieces of work in the reflexive statement in Chapter 1, and consider how they have been integrated into my sense of self as a practicing Counselling Psychologist

This portfolio of work is presented to fulfill London Metropolitan University requirements for the awarding of the Practitioner Doctorate in Counselling Psychology.

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VOLUME ONE

SECTION A: RESEARCH COMPONENT

“The psychological adjustment of West African men post myocardial infarction – a Counselling Psychology study using Interpretative Phenomenological Analysis”

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Abstract

Introduction: Increasingly effective medical practices and treatments for Coronary Heart Disease (CHD) have resulted in a growing need for Cardiac Rehabilitation programmes to improve morbidity and reduce further mortality. However, poor service uptake figures for the ethnic minority groups, especially of West African men, have highlighted the need for research, as this appears to be an unexplored area, and the National Service Framework (2000) also recognised the ethnic groups as a 'special' interest focus, requiring specific attention. This Counselling Psychology study, therefore, aimed to explore the post heart attach experience of these men to ascertain if their psychological adjustment may be deterring service uptake. More specifically this study attempts to investigate the adjustment experience of these men (their cognitive appraisal and coping strategies), seeking to assist in explaining their low attendance of health programmes, and highlight any specific needs that the cardiac teams and psychological services must address.

***Method*:** Five West African men, post myocardial infarction, were interviewed about their experiences using a semi-structured format. Interviews were analysed qualitatively using Interpretative Phenomenological Analysis (IPA). Results are presented in terms of the main themes emerging from the data.

***Results*:** The results are presented using a 4 stage chronological understanding of the men's adjustment process. The men's stories reveal how these stages are regulated by ongoing cognitive appraisal style and coping strategies. A main theme of Degree of trust in the Medical and social systems, featured throughout the phases of adjustment.

Discussion: The findings are presented in relation to the initial study aims and existing literature. Most results are well supported in the literature, and thus show little variation in psychological adjustment being associated with ethnicity. The theme regarding mistrust of health services warrants further research, interestingly this did not deter these men from service engagement. Recommendations for further research and clinical applications are outlined.

Chapter 1

INTRODUCTION

1.1 Counselling Psychology practice

Central to the practice of Counselling Psychology is the delivery of psychological intervention and research that recognises the importance of both rigorous empirical enquiry and the primacy of the psychotherapeutic relationship (Counselling Psychology Division of the British Psychological Society (BPS), 2005). Additionally, the Division states that the profession 'draws upon and seeks to develop phenomenological models of practice and enquiry' alongside that of traditional scientific psychology. Consequently, ethical practice as set out in the Division's (2005) *Professional Practice Guidelines,* encourages Counselling Psychologists to adopt such models that seek:

1. to engage with subjectivity and intersubjectivity, values and beliefs [of clients];
2. to know empathetically and to respect first person accounts as valid in their own terms; to elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing ... (p.1).

In defining the tenets of counselling psychology, therefore, Orlans and Van Scoyoc (2009) consider the profession to focus on humanistic ideas of a holistic kind with an emphasis on current well-being rather than diagnostic categorization. They recognize, as central to the profession, the importance of subjectivity and the inclusion of context in research and practice; consequently the therapeutic relationship emphasises subjective experience, collaboration, and seeking to make sense of the client's inner worlds and constructions of reality (Strawbridge and Woolfe, 2010). Here the relationship is characterized by 'being with' clients via the core conditions (empathy, acceptance and authenticity), rather than 'doing something' to clients (Woolfe, 2001).

Unsurprisingly, therefore, Counselling Psychologists are required to 'respect the diversity of beliefs and values held within society and [to] continually review their practice with due regard to changing societal norms' Professional Practice Guidelines (BPS, 2005, p.3). They are expected to 'make themselves knowledgeable about the diverse life experiences of the clients they work with [and] challenge the views of people who pathologise on the basis of such aspects as ... racial identity and religious and spiritual views' (BPS, 2005, p.7).

In keeping with these practitioner responsibilities this qualitative study aims to explore the experience of West African men who have gone through a heart attack, to identify and highlight any specific impact and adjustment difficulties which may be deterring their uptake of cardiac rehabilitation. As will be explained, this seems an important area of study, as a low uptake of cardiac rehabilitation services is associated with further morbidity. It is hoped that the study findings may help Counselling Psychologists working within the cardiac services to engage with this population more therapeutically and thereby facilitate an increase in the uptake of necessary health care to reduce mortality rates. The rationale and aims of the investigation and research question will be more thoroughly addressed in Sections 1.3. and 1.3.1.

This review will start with a reflexive account – firstly considering the relevance of reflexivity and then secondly a description of my position in relation to the study. This will attempt to provide some transparency and awareness of my subjective influence and thus co-construction of this work with the participants (or co-researchers). This, therefore, starts to demonstrate a central component of the Counselling Psychology identity, which is attempting to work as a reflective practitioner.

1.1.1 The relevance of reflexivity

Reflexivity describes the ability to firstly notice our responses to our world, others and events as they unfold, and then secondly, to utilize this awareness of response to inform our behaviours and understandings of our experiences (Etherington, 2004). The process of reflexivity, therefore, requires us being aware of our own past and present life contexts and how the impact of such influences the way we go on to interpret, and thus engage with our world. Reflexivity has significant relevance regarding the practice of Counselling Psychology, as well as that of all, and especially, qualitative research.

As the use of self is central in counselling, reflexive practice is very familiar and essential in the process of striving to become reflective practitioners. Through ongoing internal enquiry we aim to optimize our awareness of self knowledge as well as that of therapeutic skill, understanding that as we and our worlds are constantly changing this process is unending. In clinical practice, therefore, Etherington (2004) says reflexivity relates to working from two levels of awareness, firstly from a knowing of ourselves as active agents in the therapeutic process, and secondly, observing ourselves operating, that is, really knowing our stories that we tell ourselves in response to hearing our client's stories.

This two level awareness may have some parallels with the tension that Strawbridge and Woolfe (2003) describe as currently facing the philosophical identity of Counselling Psychology, namely, a tension between 'being-in-relation' and 'technical expertise', the reflective practitioner and the scientific practitioner stance. I feel too that this echoes the two very strong professional influences that have been exerted on my sense of professional identity that also produce tension, namely the humanistic tenets of my Counselling Psychology identity on the one hand, and my medical/ nursing background on the other. Whilst challenging to reconcile these two dominant and sometimes separate aspects of myself, paradoxically, I also hold an equally compelling view that these different experiences position me in a very privileged and rare place where I can access two sets of perspectives which provides an extremely rich foundation from which my way of thinking, practicing and approach to research has evolved. This awareness is necessary when considering researcher reflexivity, where I attempt to understand how my own sense of self – my thoughts, feelings, and culture, social and personal history – informs me as I proceed through the research,that is, as I engage in dialogue with my fellow co-researchers, transcribing our conversations and writing up a representation of our co-created work. As Etherington (2004) explains, reflexivity in research positions the researcher within a relationship of 'consultancy and collaboration' with participants (p.32), where issues of power and agency are enabled, and voices given to experience. In sharing my story and acknowledging my personal involvement in the work, reflexive research allows the reader greater understanding of the study's interpretations and conclusions. This will be discussed further within the methodological section of the work.

I will now proceed to position myself in relation to this study by firstly presenting my own personal history, and then secondly, NHS experiences which directly resulted in the formation of the research question.

1.1.2 Situating myself in the research – my starting point as researcher

My background

I grew up in what was Rhodesia in the 70's and witnessed the start of the country's transition to becoming Zimbabwe in the 80's. In the mid 60's the white government declared an 'illegal' Unilateral Declaration of Independence (UDI) from the UK, its colonial superpower. The Rhodesian political regime up to the point of political transition was one of apartheid, the legal enforcement of societal segregation based on racial category. Being white and of British descent, I remember being aware of a tension that existed between what was an anti-British sentiment (as the UK refused to recognize 'independence') on the one hand and a sense of determined white privilege on the other. During my childhood I existed in oblivion of what the world viewed as the injustice of the systematic oppression of the black population, such was the efficacy of this order in legitimizing the societal construction of white entitlement. This order became strengthened, to some degree, by a sense of national victimization felt firstly in connection with the imposition of British (and subsequently the world) economic sanctions, and secondly, as the war 'against terrorism' escalated, against the threat of 'communism'. It was only when I went to what was considered to be a very liberal South African university that I began to challenge that which I had not ever 'seen' before. A major paradigm shift in my view of the world began. At this time the long political and social transition process was taking place in Zimbabwe; although not planned, I was never to return to live in the country.

In South Africa I studied a nursing degree at a university with an affiliated Black medical school. The apartheid system was prevalent throughout my training, and my peers and I were active in challenging the political systems. I worked both in black and white hospitals, as well as in partially segregated hospitals. I went on to study midwifery as well as psychiatric nursing. All these experiences of health care, albeit segregated to some degree, provided me with much experience of living in a multicultural society where ethnic variation is the norm. Much of the health care I witnessed was not equitable at the point of access, delivery, or quality. I found this increasingly difficult to negotiate, probably relating to a significant level of guilt I experienced connected to my childhood years of apartheid oblivion.

Additionally, whilst training to be a nurse I became increasingly aware of people's variable understandings of illness, and the different health-related behaviours that they employed, often, it seemed, as a function of their cultural backgrounds as well as of the economic and societal disparity existing between ethnic groups. I went on to travel to Europe, and after a period of time in the UK decided to immigrate. My interest in psychiatric nursing led me to seek a career change, and to study Counselling Psychology; I qualified six years ago. This shift in profession felt like a natural progression from physical health to that of mental health and well being. My earlier nursing experiences led me to believe they are directly related, where each is significantly influenced by the other. I find it unsurprising given my life experiences that I sought a Counselling Psychology training, where issues of empowerment and equality form a cornerstone of therapeutic practice (within the definition of the Profession – in the BPS Counselling Psychology Division's *Professional Practice Guidelines,* 2005).

This is again represented by this current research, which focuses on the accessing of health care by a minority group.

So far in my life I have relocated to two different countries, and so am aware to some degree of the adjustment required when immigrating to a new country and the difficulties involved in attempting to assimilate a new and different culture. Being of English descent, this adjustment was relatively smooth, unlike the experiences of others for whom language poses a formidable barrier, as does the negotiation of major cultural differences.

For a few years since qualification I have worked in NHS hospital settings, primarily with adult patients who have experienced difficulties adjusting to the demands of chronic illness. The range of disease with which I have worked has been wide and varied, as has patients' understandings of their illness and their efforts to cope with the various restrictions and treatment programmes demanded by their conditions. This work has partially been represented in my portfolio of case work that has been submitted alongside this thesis. This comprises of clients' attempts to make sense of their illnesses and carve out a life that has value and quality as perceived by them. This is what I see as my therapeutic role, and central to my Counselling Psychology identity – trying to facilitate clients' deriving a sense of positive meaning in their day-to-day lives through interpreting and negotiating perceptions and world views, and making sense of feeling states, but being led by the client, with an understanding of the impact of the social and politico-economic influences that have served to construct their life experience. The case study in Section B of the portfolio demonstrates the application of brief psychodynamic work with a woman who had polio, whose condition was beginning to meet the diagnostic criteria for post polio syndrome. This therapeutic encounter reveals some of the difficulties associated with working with clients experiencing chronic illness, and in this case, illness that unexpectedly re-emerged in an aggressive form. The client was trying to come to terms with this reality that was set against a backdrop of difficult family relationships. This case allowed for the bringing together of my nursing knowledge, as well as psychotherapeutic skills to help make sense of this woman's deeply felt pain of despair and anguish at recurrent loss, and begin to work towards a form of acceptance of dependency, whilst still retain some degree of agency and empowerment.

This second piece of course work (Section C) centre's around a ten-minute excerpt taken from a therapeutic session with a client experiencing an underground tube phobia, which originated within the context of a London bombing. This case illustrates the application of CBT for a specific phobia, within a Hospital setting of a Primary Care Psychology department, and highlights difficulties related to treating clients with comorbidity, as this man was left with some physical disability and developed a degree of alcohol misuse whilst trying to cope with symptoms of post traumatic stress disorder. My nursing experience again seemed useful when thinking about the impact of sudden physical limitations experienced post injury, alongside the deeply disturbing experience of life threatening trauma. Although working from a CBT perspective the work demanded addressing the client's seemingly contradictory shifts in identity to 'dependent' whilst being a 'survivor', having to process associated feelings of anguish and guilt.

The third remaining part of the portfolio is Section D, a critical literature review of Cognitive Behavioural Therapy for Insomnia (CBT-I). I have experienced the delivery of CBT-I workshops to a variety of different clients, many of whom have a physical health complaint that may be initiating or maintaining their sleep difficulty alongside a resultant anxiety and/or anger reaction to their sleeplessness. I have been involved in a couple of research studies evaluating the efficacy of the workshop format, where results suggest a high level of positive change regarding both objective sleep patterns and people's subjective view of their sleep. Due to this, I have found this work extremely rewarding especially when working with many people for whom being an 'insomniac' has been an entrenched lifelong experience, a part of their self view, directly influencing their day to day life experience, and about which they feel powerless and hopeless. I have seen how this work has applicability for an extremely wide range of clients including those with physical health problems and the side-effects of medication, those experiencing psychological distress, as well as people negotiating normal life-cycle changes (menopause, pregnancy etc). For many becoming freed from sleep difficulties through the acquisition of knowledge and skills has led to a sense of reconnection with, and reclaiming of aspects of their lives and themselves, (I reflect on this further in Section D.)

This portfolio of work reflects some different work contexts that I have experienced in my career to date, namely that of a clinical health psychology unit, a hospital psychology department, different primary care psychology settings, and a couple of research posts/

projects. In an early post I was involved in the provision of psychological services to the Cardiac department, and it was during this time that I was exposed to patients coming to terms with the devastating impact of a cardiac event. Due to this work, and our department's plan to create close working links with the cardiac department, I presented a research proposal for the doctoral course which was initially supported and considered very relevant to our department's work agenda. The study, however, once it started was to unfold very slowly, and be drawn out over several years due in part to difficulties in recruiting, as well as changes in job posts and supervisors, and consequently did not enjoy the same level of support in the latter periods. I discuss this more at parts during the study, and more fully in the concluding section of the study. Nevertheless I found working with cardiac patients extremely interesting, and my nursing background to be very useful in understanding the physiological details of disease processes, as well as the technical aspects of various tests and treatments.

At times whilst working with patients I was aware of needing to keep a tendency to work from a medical model in check, rather than a psychotherapy model. Perhaps unsurprisingly given my general and psychiatric nursing background, and the fact that I have mostly worked in health and Primary Care Psychology departments since completing my training, I work by and large from a Cognitive Behavioural perspective. There is substantial evidence that Cognitive Behavioural Therapy (CBT) is effective for people experiencing anxiety and depression (Roth and Fonagy, 2005), which is the typical client group in primary care work, however is less as developed regarding the treatment of long term complex needs (Sanders, 2010). Whilst CBT can sit very easily alongside a medical model, this orientation does still provoke a tension between the sense of professional experts doing/ curing patients and that of the humanistic perspective of being-in-relation with the client who is the expert. However as time has progressed and my Counselling Psychology identity become more and more robust, the tendency to "medicalize" has become much less prevalent, and my efforts to deliver CBT in a more relational manner further pronounced. That said, Strawbridge and Woolfe (2010) stress that an emphasis on the attitudes entailed in being-in-relation with clients, rather than a focus on a specific range of skills/techniques or specific client group, is what distinguishes the profession from others. In fact it seems to me, whilst working in the NHS in adult mental health and communicating with the wider team, that I am able to highlight and voice the humanistic-valuing basis of my work in contrast to the more objective and medically biased approaches of other multi-disciplinary team members. CBT requires collaboration to determine if and how the client's idiosyncratic experience of their problem can be understood within a CBT framework, the client being the expert and having, often unknowingly, the ability to move towards where they want to be. Employing CBT I still work with moment-to-moment interactions where the therapeutic alliance is essential, and appreciate the broader context of cultural, economic and socio-political influences on life experience, both that of the client and myself as we engage in the shared exploration of their concerns, fitting with the ethos of contemporary counselling psychology (Sanders, 2010).

I believe that my various life experiences have definitely influenced the area of study, the selection of my research question, and the research process itself. I have come to deeply value equity of social and economic resources, which I am sure is probably driven by a deep sense of compensation associated with my childhood years where this was not so.

This, together with my professional trainings of nursing and psychology, has certainly informed my "self" view and my" world" view, and so undoubtedly influences all stages of this enquiry. Below, after I describe the development of the research question, I outline some of the specific presuppositions that I identified before setting off on the next stage of the research journey. Throughout my recording of the research process I will attempt to be as transparent as I believe I am capable of being, and will recount my attempts at managing these.

1.1.3 NHS experience - the early development of the research question

In 2004 interest in performing this study developed out of my experience of working in the psychology department at a London NHS hospital, servicing the boroughs of Lambeth, Southwark and Lewisham. Concern grew after departmental audits revealed very low uptake figures of cardiac rehabilitation by the ethnic minority groups, as well as that of psychological services. Given the link that this has with increased cardiac mortality (discussed in section 1.2.1), our psychology department began wondering what specific barriers to care may be operating, and specifically, if these may be of a psychological nature. The department uses predominantly a CBT orientation so the enquiry was interested in cognitive and behavioural psychological processes that this population group experienced, and if to any degree may be contributing to a low uptake of services. Support for the study was also due to the fact that the psychology department wanted to set up clear links with the cardiac department and given my interest in increasing health access to all communities I was enthused about the opportunity to investigate this further. Of all cardiac events the heart attack (myocardial infarction) was deemed a good starting point for this enquiry as can often present as a discreet cardiac problem as opposed to various cardiac conditions that present within a very complex clinical picture. The West African male population was specifically selected as the focus of study as this is the greatest of the minority populations served by the hospital. (More clarity about the studies inclusion criteria are discussed in Section 2.3.)

There is a significant lack of research in the experience of ethnic minority cardiac service users. Due to the personal and professional experiences I have outlined above, it is probably unsurprising that self enquiry uncovered a set of assumptions that I held connected to the research question, that I suspected the research findings might show. I will list some of the main ideas:-

That low cardiac rehabilitation attendance by Western African men may relate to difficult adjustment processes that are perhaps associated with the first generation migrant population; that the power differential between the medical service and possibly marginalized members of society may threaten vulnerable people; that different cultures may perceive and react to the experience of a heart attack with denial on the one hand or extreme fear on the other, both deterring cardiac rehabilitation uptake; that a lack of education may prevent some patient's appreciating the need to and benefit from attending cardiac rehabilitation; and that language difficulties may deter seeking further care from the health service.

These are the main themes that I suspected the study would reveal. Their identification and clarification was the first step in monitoring and checking their influence in the research process. At this point and throughout the different stages of the study I endeavored to 'bracket' off or put aside my presuppositions, driven by my own lived experienced, whilst being mindful that this can never be purely achieved, and actually forms part of the co-created research, in keeping with reflexive practice. Discussions with my supervisors also helped illuminate my efficacy at this, as well as support my continuous monitoring of assumptive biases.

1.2 The research context

The aim of the study is to gain a greater understanding of the psychological processes experienced by West African men after a myocardial infarction, to ascertain if such may be in part creating a barrier to their uptake of cardiac rehabilitation and psychological services. As I will go on to show, there is very little information about the cardiac experience of ethnic minority groups, and in order for this study to address this, it is important to be clear on the various contextual issues of the enquiry which I will now outline before exploring in some detail. The first area to clarify is that of the function of cardiac rehabilitation and why it is considered vital in the reduction of further cardiac complications; secondly, the nature of Coronary Heart Disease (CHD) and what is known about the psychosocial impact of it, so as to help situate the findings of this study. Thirdly, and more specifically, clarity will be sought around our current understanding of the adjustment and coping of patients who have experienced a heart attack and the little that is known about the experience of the ethnic minority groups in relation to the above issues; this again will facilitate this study's findings to be better placed within a wider context of experience. Lastly, consideration will be made of the broader contextual influences of socio-political factors regarding West Africans and include a discussion about attitudes to the health service, of the ethnic populations. These areas above comprise the main threads of the enquiry that will serve to weave the story of the low uptake of cardiac and psychological services by West African men. I will now present these individually, to obtain more understanding of their role in the enquiry.

1.2.1 Cardiac Rehabilitation

Cardiac rehabilitation is offered to patients after experiencing cardiac events to facilitate recovery and prevent further cardiac illness. Although cardiac rehabilitation programmes vary they all comprise support and education on exercise, behavioural change, counselling and strategies addressing CHD risk factors, and as such, cardiac rehabilitation is recognized as being an integral component of CHD care (Graham et al. 2007; NICE, 2007).

Meta-analyses and systematic reviews of the efficacy of cardiac rehabilitation, have provided evidence of significant reductions in the cardiovascular symptoms of angina and heart failure, as well as in the number of repeated myocardial infarctions, and a 20-25% reduction in total mortality (Oldridge, Guyatt, Fischer and Rimm, 1988; O'Connor et al. 1989), as a result of structured cardiac rehabilitation programme attendance (Wenger, Froelicher, Smith and Ades, 1996; Jolliffe et al. 2001; Taylor et al., 2004; Leon et al. 2005). Despite this, British Heart Foundation-funded research shows that well over 50% of heart patients who need cardiac rehabilitation are not accessing it (British Heart Foundation website). In America, some studies suggest annual cardiac rehabilitation attendance figures around 10-20% of eligible post myocardial infarction patients, or those who underwent revascularization procedures, (Taylor et al., 2004). In 2008, the second annual report of the National Audit for Cardiac Rehabilitation was published; whilst showing improvements in the provision of cardiac rehabilitation in the UK the report states that the majority of patients with heart disease still do not get cardiac rehabilitation, and the postcode lottery remains. The overall percentage of ethnic minority patients being referred has improved slightly, but that for both Black Caribbean and Black African patients remains respectively <1%.

1.2.1.1 Low attendance of cardiac rehabilitation and psychological resources, with a focus on ethnicity.

Significant numbers of post myocardial infarction patients fail to attend any rehabilitation or drop out prematurely (Goble et al., 1991; Petrie and Weinman, 1997; Cooper, Lloyd, Weinman and Jackson, 1999). Various studies state the rate of cardiac rehabilitation uptake to range between 15% and 59% of eligible patients. It seems that in practice, middle-aged men with uncomplicated myocardial infarctions would appear to dominate, with little attention having been paid to the broader demographic, of behavioural and clinical characteristics of non-attenders (Lane, Carroll, Ring, Beevers and Lip, 2001). Besides the poor availability of services in some areas reducing cardiac rehabilitation attendance (Lewin, 1999), some work has identified non-attenders as being more likely to be unemployed, female, living alone and coming from more deprived areas (Lane et al, 2001); additionally, a precardiac history of anxiety and depression, and low frequency exercise have been associated with poor cardiac rehabilitation attendance. Lane et al (1999) also suggests that ethnic minorities, the elderly, angina sufferers, and those with more serious cardiac disease who could potentially benefit the most, tend not to participate. Gregory, La Veist and Simpson (2006) found that White Americans were more likely to be referred for cardiac rehabilitation than were Black Americans, stating that their decreased utilization of such services could lead to further disproportion and inequality in cardiac outcomes.

A recent study found that older aged patients strongly endorsed cardiac rehabilitation barriers such as already exercising at home, confidence in their own ability to self manage their condition, perception of exercise as tiring or painful, not knowing about cardiac rehabilitation, lack of physician encouragement, experiencing co-morbid conditions, and the perception that cardiac rehabilitation would not improve their health (Grace et al, 2009). Some reports show less than 50% of cardiac rehabilitation attendees maintain an exercise regime for as long as 6 months after completion (Moore, 2003). The studies did not discuss the ethnicity of participants.

Cooper et al (1999) makes the case that the value of biological and socio-demographic characteristics (associated with cardiac rehabilitation attendance) is questionable given that these are not usually amenable to change. In contrast, focusing on an individual's beliefs or perceptions about their illness may be more accessible, and play a pivotal role in health behaviour and medication adherence (Horne, 1997), and functional status (Pimm, 1997; Pimm, Byron and Amos, 1994). More specifically, research has shown that cardiac rehabilitation attendees may have different individual beliefs or perceptions about their illness, compared to those who do not attend (Petrie, Weinman, Sharp and Buckley, 1996). Illness perceptions have been measured on admission, and associated with cardiac rehabilitation attendance, speed of return to work, later sexual difficulty, and recovery of social and domestic functioning, providing further support that patients' illness perceptions after a myocardial infarction are important determinants of their recovery post hospital discharge (Petrie et al, 1996). More distinctively, people choosing not to attend cardiac rehabilitation are less likely to believe that their condition is controllable, and that their lifestyle may have contributed to their illness (Cooper et al, 1999).

Ethnic minority groups in general, appear to have been neglected in the cardiac rehabilitation literature (Wild, 1998), despite a possible greater risk of reinfarction or recurrence due to lower levels of activity (Ferguson et al., 1997) and higher levels of morbidity (Young, Waller and Kahana, 1991). The majority of cardiac rehabilitation studies focus predominantly on white participants (Wild, 1998), and there is evidence from a few sources to suggest that the uptake of cardiac rehabilitation services is disproportionately low in South Asian populations (NHS Centre for Reviews and Dissemination, 1998), and in African Caribbean patients (Lane et al 2000, Cannistra et al, 1995). Whilst the most recent enquiry by the British Heart Foundation (National Audit of Cardiac Rehabilitation, 2010) suggests that attendance figures are beginning to indicate a greater representation by the ethnic minority groups, the report states that this may not be accurate as inequity of service uptake across the country continues and that often ethnicity data collection does not occur. In fact, a British Heart Foundation report (Ethnic differences in cardio vascular disease, 2010) states that in 2002/2003 over 30% of all hospital admissions in England were not coded for ethnicity, but by 2007/2008 this had dropped to less than 15%, however still meaning that much valuable ethnicity data is not available, (HESonline, 2009).

1.2.2 Coronary Heart Disease (CHD).

Coronary heart disease is amongst the biggest killers in this country (Department of Health 2000, National Service Framework for CHD), costing the health care system in 2006 an estimated £3.2 billion, and losses in work productivity in those of a working age, of £3.9 billion (www.heartstats.org/eucosts). Despite reduced CHD mortality rates over the last 30 years (Volmink et al. 1998), UK death rates for CHD are among the highest in the world (British Heart Foundation, 2010), and the rate of fall is slower than many countries. CHD by itself is the most common cause of death in UK (Coronary heart disease statistics, 2008) with around one in five men and one in eight women dying from the disease.

Migrants to the UK from the Indian subcontinent have a higher mortality from CHD than that of the indigenous population (Balarajan, 1996; Khattar, Swales, Senior and Lahiri 2000, Coronary heart disease statistics, 2008). Few UK studies focus on the black population, nevertheless, data is beginning to suggest that premature death rates (before the age of 75) from CHD for men born in the Caribbean and West Africa are lower than average, whilst women born in Jamaica and living in England are higher than the national average. CHD mortality data on West African women living in UK is lacking. Interestingly, black women in USA demonstrate a greater prevalence of coronary risk factors and a higher mortality post heart attack than white women (Cannistra, O'Malley and Balady, 1995), and male African Americans are also more likely than any other group to die of CHD between 35 – 65 years (ie 40% versus 21% of white men; Barnett et al., 2001). In recognition of the significant impact of CHD, in 2000 the National Service Framework for CHD (Department of Health) set out a ten year strategy to modernize CHD services, with a primary objective to address service inequalities that exist on the basis of social circumstances, gender and ethnicity.

CHD occurs when the walls of the coronary arteries become narrowed by a gradual build-up of fatty material called atheroma, resulting in the two main forms of CHD, namely heart attacks (myocardial infarctions) and angina (British Heart Foundation website). The main risk factors associated with the development of CHD are smoking, an unhealthy diet, lack of physical activity, a high alcohol consumption, poor psychosocial wellbeing, raised blood pressure, raised blood cholesterol, obesity and diabetes. Most deaths from CHD are caused by a myocardial infarction. Substantial advances in medical technology and treatments for heart attacks means that currently fewer patients are dying in the acute stage of the illness (Petrie and Weinman, 1997). Nevertheless, using 2006 UK CHD mortality data, it has been estimated that annually there are approximately 87 000 heart attacks in men of all ages (6.3% aged between 55-64 years and 14.4 % of all 65 – 74 year old men) and 59 000 in women (Health Survey for England, 2006).

This situation has prompted cardiac rehabilitation to shift towards the forefront of clinical practice (Lane, Carroll and Lip, 1999). As mentioned earlier, cardiac rehabilitation is offered to patients after cardiac events to facilitate recovery and prevent further cardiac illness. Given myocardial infarction survival rates, the risk of recurrent infarction, the current prevalence of angina, and the increased use of coronary revascularization, Lane et al. suggest that there are substantial numbers of patients who can benefit from cardiac rehabilitation. Research is therefore necessary to keep identifying and addressing the barriers to care in different populations, to optimise service access. I will now discuss some of the existing research concerning the psychological impact of a heart attack, in order to understand where to place the findings of this study, as well as to start considering the influence that psychological distress can have on the uptake of health services. This area of research obviously has direct relevance for Counselling Psychologists who work within cardiac or hospital environments, or even primary care settings, who may be requested to help cardiac patients process their experiences.

1.2.3 Psychosocial effects of CHD.

An association between psychological distress and heart disease has been recognized for many years (Crisp et al, 1984; Skerrit, 1983) with much research evaluating the degree of cause and effect within this relationship. That is, can psychological distress precipitate a cardiac event, and/ or the development of subsequent cardiac complications after a cardiac illness? The INTERHEART study (Yusuf et al. 2004) indicated that psychosocial factors (specifically work and or home stress, financial stress, stressful life events, depression and locus of control) may present a 33% risk of myocardial infarction (across all ages, a wide range of geographic regions around the world, and both men and women). In the post cardiac event situation, psychological distress has been shown to have a significant impact on a range of psychosocial factors, quality of life and on the rehabilitation process itself (Thornton, Bogg, Bundred and Davies, 1995). Research suggests that the problems that myocardial infarction patients face in changing their lifestyle, health care behaviours and returning to productive work can be more debilitating than the actual physical effects of the heart attack itself (Petrie and Weinman, 1997; Con, Linden, Thompson and Ignaszewski, 1999). Traditionally, cardiac rehabilitation targets have been related to survival, return to work and physical fitness, but psychological and behavioural reactions in particular have been found to have a significant impact on future well being (Lowe, Norman and Bennett, 2000).

As this study is interested in exploring the psychological impact of West African men having a heart attack, it is important to look more specifically at some of what is recorded regarding specific aspects of this experience, namely about the experience of depression and anxiety, and how social support and personality factors may influence this experience.

1.2.3.1 Depression

Research has addressed the psychological impact of having a myocardial infarction in terms of psychological morbidity and measures of anxiety and depression. The literature suggests that most patients and their families suffer initial emotional distress and practical difficulties, with 20-40% experiencing persistent psychosocial problems lasting up to a year post cardiac event (Mayou and Bryant, 1987; Lane, Carroll, Ring, Beevers and Lip, 2002; Thombs et al., 2006). The prevalence of depression among the post myocardial infarction population has been seen at between 17-37%, with anxiety at between 24-31% (Lane et al, 2002), however these frequently coexist. The most recent cardiac rehabilitation audit by the British Heart Foundations (2010) suggests that these figures continue with approximately 17% of patients being considered borderline or clinically depressed and approximately 28% experiencing a similar incidence of anxiety, with a small improvement noted at 3 months after commencing cardiac rehabilitation, and no further improvement at 12 months.

An earlier study by Lane, Carroll, Ring, Beevers and Lip, (2002) assessed mood changes during a one year period post myocardial infarction, more specifically, immediately post myocardial infarction (within 2 – 15 days), again at 4 months and then at 12 months. They found that 30.9% of participants reported elevated depression levels immediately post myocardial infarction, and 26.1% elevated anxiety levels, and additionally that these levels maintained throughout the year. Other studies have shown 25% of patients having persistent depression a year later (Doehrman, 1977; Mayou, 1984). Lesperance and Frasure-Smith (1996) also used a longitudinal design study to show depression in 16% of cases at 1 week post myocardial infarction, and 32% at a year after discharge; of those not depressed at baseline, 21% became depressed during follow-up. Of these cases a prior history of depression was present in 28%, suggesting an increase of the risk of depression following the heart attack. Depression assessed following a cardiac event is associated with a subsequent recurrence of cardiac problems and mortality (Frasure-Smith, Lesperance and Talajic, 1995; Creed, 1999). However, more recent studies are suggesting that a pre-cardiac history of depression is not associated with the occurrence of new cardiovascular events, whereas post heart attack depression (incident depression) is associated with new events (De Jonge, van den Brink, Spijkerman and Ormel, 2006.) This finding is supported by Parker et al., (2008) who demonstrated that incident depression had a higher association with cardiac complication and mortality than recurrent depression.

The mechanisms are unclear but the association between depression and poor cardiac prognosis may arise firstly from a lack of adherence to health behaviours, for example, diet and exercise, or to prescribed medication (Ziegelstein, 1999), and secondly, at a physiological level the possibility that emotional responses stimulate disturbances in the autonomic control of the heart, thereby having a direct physiological effect (Cameron, 1996; Krittayaphong et al., 1997). Another association that is being investigated is the possibility of a shared genetic process that increases vulnerability to both heart disease and negative emotional states (McCaffery et al. 2006).

Irrespective of a biological explanation, of stark importance is the need to treat for depression at a preventative level or as soon as identified. In order to do this we need to broaden our understanding of the psychological complexities of the post myocardial infarction experience; this is a driving motive behind this study.

It is important to note, however, that variations in depression levels post myocardial infarction may relate to the varied descriptive terms and actual measures and cut off points employed in research studies, for instance a study in Poland found that clinical depression was diagnosed in 10.8% of their inpatient sample, whilst depressive symptoms indicated by scores of 10 Beck points or more, (the lower cut off point for mild depression) were present in 40% of participants (Krzyzkowiak, 2007).

A recent US study has found no difference in the severity or prevalence of depressive symptoms for African Americans and White Americans, however did find that the rate of antidepressant use was 11.7% for African Americans, and 21% for whites (Waldman et al. 2009). No explanations for this were suggested.

1.2.3.2 Anxiety

As mentioned, high levels of both anxiety and depression often coexist post heart attack, (Lane et al., 2002). In the acute phase of illness, anxiety tends to relate to fears of recurrence and dying, and hypervigilence regarding any potential indication of cardiac difficulty. Nevertheless, for the majority of cases, fears subside depending on the coping styles employed, which will be explored in Section 1.2.4.2. For instance, some patients respond by using denial as a coping strategy, effectively reducing anxiety levels (Taylor, 2006).

Be that as it may, a study assessing the prevalence of anxiety disorders among people with CHD found approximately 36% met the diagnostic criteria for at least one current anxiety disorder, and 45.3% presented with an anxiety disorder at some point in their lives, (Todaro, Shen, Raffa, Tilkemeier and Niaura, 2007). Additionally, social phobia and generalized anxiety disorder were the most prevalent observed. A proposed patho-physiological pathway to explain the effect of anxiety on CHD relates to reduced heart rate variability (Yeragani et al. 1990), where chronically anxious patients are seen to have low heart rate variability, with a decreased capacity for heart change in response to stress. Diminished heart rate variability has been identified as a powerful risk factor for sudden cardiac death in patients recovering from myocardial infarction (Kleiger, Miller, Bigger and Moss, 1987).

Some research demonstrates that social support and religiosity can provide a buffer against distress, (discussed in Section 1.2.3.4), where higher levels of social support have been associated with lower levels of both state and trait anxiety (Hughes, Tomlinson, Blumenthal, Davidson, Sketch and Watkins, 2004), and religiosity related to lower state anxiety. Research results relating worrying to CHD may present a different mechanism. Stansfeld and Fuhrer (2002) propose that firstly the effect of prolonged exposure to adverse life/ environmental conditions (similar to the increased risk of CHD in people of a low socioeconomic status), may be mediated by high levels of worry. Secondly, they believe that worrying implies a perception of lack of control, which especially in the work place has been identified as an important psychosocial risk factor for CHD (Bosma, Marmot, Hemingway, Nicholson, Brunner and Stansfeld, 1997). Expressions of anxiety can also be associated with, or seen to reflect, personality traits.

1.2.3.3 Personality

Whilst much research identifies depression, anxiety, poor anger control, social isolation, low socioeconomic status and psychological defensiveness as likely to be contributors to disease as well as impede the healing process (Rutledge et al.; 2001; Kubzansky and Kawachi, 2000), these factors are very broad constructs. Consequently some researchers have tried to cluster the most influential into more cardiac-specific personality patterns (Linden, 2006). One concept is that of 'vital exhaustion' which represents a combination of both physical fatigue and depression, and has been found to precede myocardial infarction (Appels, Siegrist and De Vos, 1997).

In a similar way, the concept of the 'Type D personality' has been developed by Denollet (Denollet,1996; Pedersen and Denollet, 2006) which refers to a chronic negative affect combined with a simultaneous habit of social withdrawal. Linden states that Type D personality is a more accurate predictor of cardiovascular stress reactivity than many of the more traditional risk factors like depression or hostility.

The existence of a coronary-prone personality was initially conceptualised as the Type A behavior pattern, which has evolved to focus more specifically on hostility, as the other components of this behavior pattern did not have much predictive validity for cardiac mortality (Linden, 2006). Williams (2002) states that a meta-analyses of the body of research on the physical health consequences of hostility concluded that the psychological trait of hostility - cynical mistrust, anger and aggression - is a risk factor for CHD and virtually any physical illness (Miller, Smith, Turner, Guijarro and Hallet, 1996.)

Cynical hostility is characterized by suspiciousness, resentment, frequent anger, antagonism and distrust of others, including the perception that others are being antagonistic or threatening, prompting verbally aggressive behavior (Taylor, 2006). Experiences of racism by African Americans are associated with habitually stronger emotional and physiological reactions to general stress, which in turn is thought to be associated with long-term development of hypertension, (Brosschot and Thayer, 1998). Hostile behavior is likely to hinder efforts at either obtaining social support required from the environment, or failing to make effective use of existing social support (Holt-Lunstad, Smith and Uchino, 2008). This is a highly relevant point when thinking about factors that could deter uptake of important health services.

1.2.3.4 Social Support

The association between social support and the prognosis for patients following myocardial infarction is strong and very consistent. Early studies have shown more socially isolated men being at increased risk of death after a heart attack (Ruberman, Weinblatt, Goldberg and Chaudhary, 1984) and this has been confirmed in several subsequent studies. For instance, patients without a spouse or confidant have been shown to be twice as likely to die within 6 months of their first myocardial infarction, than those who were married or had friends (Case, Moss, Case, McDermott and Eberly, 1992). A lower risk has been suggested in a more recent study, where low social support at myocardial infarction was associated with a 10% risk of recurrent cardiac events at 9 months (Pedersen, van Domburg and Larsen, 2004). Frasure-Smith, et al.'s (2000) study also demonstrated how high levels of support helped to reduce the risk of poor prognosis.

The modes of action of the positive effects of social relations has been debated. It is suggested that either a direct physiological effect may occur, and/or an indirect buffering of acute or chronic stressors may be taking place (Pearlin and Schooler, 1978). Direct effects may occur through neuro-humoral responses to social relations. Positive relations may boost self esteem, reduce anxiety, increase perceptions of control over the environment, increase the meaningfulness of the social and physical environment, fulfill needs for attachment, and increase physical enjoyment and well being (Cohen and Syme 1985.) Stansfeld and Fuhrer

(2002) state that it is possible that the effects of a lack of social support on mortality following myocardial infarction, may be mediated by depression. It is possible that low social support and isolation could lead to depression, however this may possibly result from a person's distorted depressive perceptual biases of social support, or, possibly the fatigued carer withdrawing support, being unable to cope with excessive demands.

Research has stressed the importance of quality in intimate relationships, rather than purely their existence (Bergman and Berter, 2001). However, investigation is showing that many of the benefits may actually be derived from the perception that social support is available (Taylor, 2006). Consequently the term *perceived social support* is now frequently used in research. Supportive of this was Con, Linden, Thompson, and Ignaszewski's (1999) finding that the perception of available support is more important than the actual quantity of support.

Earlier studies sought to elicit some specific central components of effective social support; Waltz (1986) recognised commitment, concern and affection as major determinants of effective coping, whilst Rankin-Esquer, Deeter, Froelicher and Taylor (2000), related being part of a couple with increased adherence to cardiac rehabilitation programmes (post myocardial infarction). This is supported by Doherty, Schrott, Metcalf and Iasiello-Vailas, (1983), who found that supportive wives increased the compliance of partners with medication regimes. Unsurprisingly, Figueiras and Weinman (2003) found patients' recovery from a heart attack to be better in couples with similar positive perceptions of identity and perceived consequences of the cardiac event, compared with couples with similar negative or conflicting perceptions. In the former, patients showed better physical and psychological functioning, better sexual functioning, and less impact of myocardial infarction on social and recreational activities.

Overall, mainstream research has shown that good family support, and close confiding relationships enhance recovery; relationships with intimate others is a particularly significant factor in adjustment, (Ell and Haywood, 1984; Croog and Levine, 1982).

Given that this study is interested in understanding if the psychological impact of having a heart attack may be deterring West African men in taking up essential cardiac services, it is important to be able to place these findings within the body of knowledge that is known about peoples experience of adjusting back in to their lives after a heart attack,hence this next section.

1.2.4 Theories of adjustment and coping applied to myocardial infarction patients.

Immediately following medical diagnosis, patients are often in a state of crisis characterized by emotional distress and finding that their usual ways of coping do not work (Moos & Schaefer, 1984). Consequently, as discussed, patients may experience heightened levels of anxiety, and depression, until adaptation begins. Depending on how this process is negotiated, most patients reach a state of adjustment. I will briefly review some prominent theories that attempt to account for this process.

1.2.4.1 Cognitive theories of adjustment

In the Cognitive Model of Stress and Coping (Folkman & Lazarus, 1984), coping is proposed as the psychological process whereby a response is made to manage the stressor, which entails an evaluative process, namely appraisal. Coping has thus been defined as 'the constantly changing cognitive and behavioural efforts to manage specific external and or internal demands that are appraised as taxing or exceeding the resources of the person' (Lazarus & Folkman, 1984, p. 141).

This can be illustrated in the following study of men's psychological reactions post myocardial infarction. Sykes (1994) considered elevations in state anxiety to reflect patient's negative appraisal of their own coping ability, and to slow down the adjustment process. Further delayed processing could be seen to be derived from high levels of depression, possibly reflecting global and stable causal attributional reasoning, regarding the myocardial infarction and recovery. Sykes maintained, therefore, that for adjustment to occur, the patient needs to perceive a way forward or a solution to their specific problems posed by the heart attack. Central to adjustment, therefore, is the individual's interpretation and derived meaning of the event, and their subsequent view of the way forward.

This is supportive of other research which has demonstrated that the severity of heart attack is not related to psychosocial adjustment (Mayou, 1984; Trelawny-Ross and Russell, 1987), but that it is rather mediated by variables of cognition.

The Cognitive model of adjustment has evolved from Folkman & Lazarus' work (1984), and is also linked with Beck's cognitive model of emotional disorder (Beck, 1967), which is based on the premise that one's interpretation of events will determine one's reaction. This reaction is in turn, based on a person's underlying assumptions about the self, the world and others. Such assumptions become significantly challenged at times of adversity, and difficulties in moving forward can be seen where hold ups in the process of integrating this new information occur (Moorey, 1996). Additionally, Moorey states that time is required for a variety of cognitive interpretations and emotional responses to occur – referred to as 'emotional processing' by cognitive therapists, or 'working through' by more Psychoanalytically oriented therapists. Horowitz (1986) suggests that the greater the trauma, the greater the discrepancy and required readjustment to a person's existing internal working models or "schemas". An individual's adjustment to the adverse event is a result of the interaction between the interpretation of the stresses involved and the coping strategies perceived to be available. If these processes are interrupted, by excessively negative beliefs or further events, the adjustment reaction will be protracted. Moorey (2006), states that the individual's adjustment process is a dynamic interaction between the stressor, the individual and significant people in his or her life.

In investigating patients' <u>illness perceptions</u> (cognitive representations) and their association with adjustment and rehabilitation post myocardial infarction, researchers have drawn on <u>Leventhal's self-regulatory model</u> (Leventhal, Meyer and Nerenz, 1980). This has provided an alternative framework for understanding which illness perceptions may be important at various stages of the recovery process (Petrie et al, 1996; Petrie and Weinman, 1997). The model hypothesizes that two parallel processes are active - cognition, the objective interpretation of the experience, and emotion, the subjective reaction. These parallel processes are interactive, each having three components: Representation (interpretation of sensation or symptom), Coping and Appraisal. Representation influences Coping, which in turn impacts upon Appraisal which then feeds back into, and may alter, Representation. Research suggests that patients group their ideas about illness around five themes or cognitive dimensions, namely identity, cause, time line, consequences and cure/control. These illness representations enable patients to make sense of their symptoms and assess health risk, and direct their reactions during recovery.

There is growing evidence that beliefs play a vital role in the meaning attached to illness symptoms expressed by medical service users from culturally and linguistically diverse backgrounds (Rooney and Wright, 2001).

Leventhal et al. (1997) debate the direct effects of cultural factors upon the representations of disease, and believe that most of the so-called cultural-specific diseases and factors can be found, sometimes in somewhat different forms or labels, in all cultures. Nevertheless, factors such as personality type and cultural background have been acknowledged as being important (Diefenbach and Leventhal, 1996). Cameron, (1997) supports this by providing evidence that cancer-related perceptions and their impact on screening decision behaviours and participation in treatment programmes, do vary across ethnic groups. Obviously this is central to this current study – the investigation of West African men's meanings attached to their cardiac symptoms and the possible impact of such on the uptake of cardiac rehabilitation services.

<u>Association with Posttraumatic stress disorder (PTSD).</u> For many a heart attack is considered a near death experience, where there is no warning, and where the threat of recurrence is marked. The centrality of the heart in the disorder provokes a great sense of insecurity and vulnerability (Ginzberg, Solomon and Bleich, 2002). Unsurprisingly, emotional reactions have been likened to those associated with PTSD. Ginzberg et al. report

observable prevalence rates of PTSD of between 8-25% of patients one year post myocardial infarction. Rocha et al. (2008) found an incidence of 16% of myocardial infarction patients developed sub-syndromal PTSD, where the emotional status of the patient's at the time of the myocardial infarction increased the likelihood of developing PTSD symptoms. The authors state that Black patients were considered at increased risk of such symptomology.

Beliefs about the cause of illness have commonly been studied within attribution theory. It has been suggested that attributing cause for a myocardial infarction can reduce anxiety and increase predictability of the future (Petrie and Weinman, 1997). In some research, knowing the precise nature of the attributed cause is important in the adjustment process, for instance; the genetic risk of a heart attack has been perceived as not mediated by behaviour or physiological processes and thus not controllable (French, Marteau and Weinman, 2002). Patients who judged their myocardial infarction as less serious were less likely to attend cardiac rehabilitation (Ades, Huang and Weaver, 1992), while those not perceiving themselves to be at risk have been shown to be slower in recognizing symptoms (Pattenden, Watt, Lewin and Stanford, 2002). However, Affleck, Tennen, Croog and Levin (1987), found that people who attributed their heart attack to stress, had a better disease progression than those who did not make stress attributions, moreover, those who blamed their heart attack on others were more likely to suffer another when compared to those who did not. It seems, therefore, that in Western society, having a causal theory about one's illness has been related to better adjustment and coping (for example, Turnquist, Harvey and Andersen, 1988). However, in a study comparing lay beliefs about diabetes involving a UK sample and an Indian sample, it was seen that although the majority of participants were able to generate possible illness causes, more Indians were unable or unwilling to engage in this kind of causal reasoning (Sissons Joshi, 1995). In asking about their adjustment to their diabetes, the author found a tendency for the English sample to lean towards poor adjustment when they were unable to nominate an illness cause, conversely, within the Indian sample she considered there to be no indication that adjustment was associated with having a causal theory. Hampson (1997) concludes that this study underlies the importance of studying the cultural context of illness representations.

Thus differences in causal beliefs within different cultural groups in the Western world exist, however much of the causal belief research has been informed by a Western cultural tradition, where illness is viewed as an 'episodic, intrapersonal deviation caused by micro-level, natural etiological agents such as genes, viruses, bacteria and stress' (Landrine and Klonoff, 1992). By contrast, non-Western cultural groups are more likely to view illness as entailing '... macro-level, interpersonal and supernatural etiological agents' (Landrine and Klonoff, 1992). These authors suggest that a failure to consider non-Western causal beliefs accounts for the poor predictive power of scales such as the Multidimensional Health Locus of Control scale (Wallston et al 1978), and the Attributional Style Questionnaire (Peterson et al, 1982). Webster (1997) has also stated that established approaches to data collection need to be challenged if accurate and relevant ethnicity information is to be acquired.

Jayne and Rankin (2001) suggest increasing evidence to support a link between emotional appraisal and adjustment, while coping has been found to be both concurrently and predictively associated with outcomes post myocardial infarction (Lowe et al, 2000).

1.2.4.2 Coping styles

Coping styles focus on relatively stable individual differences in coping behaviour. Physical health is therefore effected indirectly by changes in behavior, and probably directly through actual psycho-physiological pathways (Partridge and Johnston, 1989). Various theories have been developed to attempt to explain different reaction patterns post myocardial infarction.

An interesting finding is that a Repressive Coping Style (a concept developed by Weinberger, Schwartz and Davidson, 1979) seems adaptive for both immediate and long term adjustment post myocardial infarction (Roth and Cohen, 1986). This coping style is characterized by a specific combination of anxiety and defensiveness, where low level anxiety is objectively evident to others, but not subjectively evident to the person, who still nevertheless, employs defensive strategies to avoid unconsciously perceived threats. This finding surprises some theorists who value emotion-based coping, for example Horowitz (1986), who argues that the avoidance of threatening emotions and cognitions may in fact impede the processing, assimilation and accommodation of the experience, considered necessary to achieve integration and to process the traumatic experience. However Ginzberg et al. (2002), reported finding that responses demonstrating more avoidance of affect, such as that seen with repressive coping, seemed to promote adjustment to a myocardial infarction in both the short and long term by protecting self esteem, promoting perceived ability to cope and evoking unrealistic optimism. A number of studies suggest that, while high deniers tend to be less compliant with medical advice, they do appear to represent less death, and have fewer problems regarding return to work, relationships and emotional distress (Frasure-Smith, 1987; Ketterer, Kenyon and Rhoads, 1991).

Johnston (1997) discusses how control cognitions have been defined, described and related to health. She considers Wallston, Wallston, Smith & Dobbins's (1989) research differentiating between the theoretical constructs of locus of control (social learning theory), self-efficacy (social cognitive theory, Bandura 1989) and attribution theory (discussed earlier). Studies have found that a greater belief in personal control over recovery tends to be linked with faster and complete recovery from disability (Partridge and Johnston, 1989, Johnston 1997). Patients who adopt a passive, dependent and helpless role following a myocardial infarction, a syndrome referred to as 'cardiac invalidism' (misinterpreting normal bodily sensations, avoiding vigorous activity, reassurance seeking), have been found to have a poor prognosis (Riegel, 1993). This syndrome is often supported by the patient's spouse or families who become overly protective and shoulder the responsibilities and previous role functions of the patient. This usually occurs because both the patient and family perceive the patient's abilities to be less than they are in reality. This form of adjustment is difficult to change and can become a self-fulfilling negative spiral (Petrie and Weinman, 1997). In a diabetes study on a Caribbean Latino sample, Quatromoni et al. (1994) found many participants to demonstrate a fatalistic attitude toward the course of their illness, thus inferring low control/cure beliefs to exist which suggest a potential reduction in self-management efficacy. This has also been identified in a Mexican sample as well as an Indian group of diabetics. The belief that an unhealthy lifestyle was the cause of a heart attack (high controllability) has been found more likely to result in behaviour change than stress (perceived low controllability) (French et al, 2002; Petrie et al, 1996).

Poor coping resources in cardiac patients are associated with unsatisfactory rehabilitation and poor prognosis. A pessimistic coping style has been found to be predictive of poor recovery post cardiac event (Scheier et al, 1989). Studies demonstrate how cardiac patients who respond to their disease process and their treatment with optimism, and with efforts to maintain high self esteem and a sense of mastery over their disorder, are at least risk of a new cardiac event and seem better adjusted (Helgeson, 1999; Helgeson & Fritz. 1999).

This summary of researched common coping styles provides a backdrop for the findings of this study, where the post heart attack coping styles of West African men may serve to shed some light on their reduced uptake of cardiac services.

1.2.5 The West African community in the UK

Who are the West Africans? The West African countries that have significant populations living in the UK are Nigeria and Ghana. During the post-war period London experienced a labour shortage and the 1948 British Nationality Act gave British citizenship to all people living in Commonwealth countries, and full rights of entry and settlement in Britain (Killingray, 1994). A few thousand migrants consequently arrived from mostly Nigeria and Ghana to work in London. It seemed that the settlement of migrant peoples then caused concern amongst the native English population, leading to calls to restrict immigration. The 1962 Commonwealth Immigrants Act was established which then greatly slowed down non-European immigration. Until the late 1980s, total migration of Black Africans was around 5000 a year; the total reached 20 thousand in a number of years in the 1990's (Labour Force Survey 2008, Office for National Statistics). The latest National Census (Census 2001 , Office for National statistics) showed 7.9% of the total UK population comes from a minority ethnic group (4.6 million), and of this figure the black population comprises 25%, (12.2% African Caribbean, 10.5% Black African).

Migration is the driving force that creates multi-ethnic societies states Bhopal, (2007) and goes on to explain how migration and the health of ethnic minority populations are closely linked. He suggests that most non-white immigrants, in general and in comparison to the White populations, tend to live on the margins of society, occupying poorly paid jobs, lower quality of housing and a lower social status - this is especially true in the early years of immigration but for some groups does persist over long periods. In fact a current poverty report (Parekh, MacInnes and Kenway, 2010), states that around two fifths of people from ethnic minorities live in low-income households, which is twice the rate of the White population. More specifically, this beaks down to 50% of the Black African population, compared to 20% of the White population, with around 25% of the Black African, Bangladeshi and Black Caribbean working-age households being workless, compared to 15% of White British households. 80% of Nigerians, Ghanaians and Ugandans reside in greater London.

As the Nigerian and Ghanaian communities have become more established in the UK, they tend to have had subsequent second and third generations born here (Feasibility study for health surveys among Black African people living in England, 2003). There is also the interesting demographic phenomenon of some members of the older generation returning to Africa, in part reflecting a deeply held attachment to their African backgrounds.

When considering the health status of this population, and obstacles to service uptake, it seems important to consider what is known about their views of the NHS.

1.2.5.1 Attitudes to health care

Various studies have been reviewed and main findings presented below in order to provide a broad context regarding health care seeking behaviours of Black African people. An extensive survey for the Department of Health, incorporating in depth interviews conducted with 48 African people now living in London (originally from Nigeria, Somalia, Ghana and Uganda),[1] revealed the following specific attitudes and ideas about health:

- Frequent comparisons were made between illnesses experienced in England which were largely absent in Africa and were attributed to the colder weather, such as arthritis, as well as those not thought to be experienced much in Africa, but seen a great deal in the general population in England, such as cancer and heart disease. No judgements about this were represented in the findings.
- A holistic philosophical stance in relation to health care was revealed, which was underpinned with ideas that good health depended on the care of mind, body and spirit. Whilst belief in God was generally considered a source of comfort, it did not limit the use of health care services.
- People's expectations of the health service were such that people sought medical help when ill, but also sought care, comfort and support from health professionals.
- Health views also depended on past experiences of health care (in Africa or the UK), which when poor, prompted the use of community support to assist in voicing rights; those who lacked such support, described feeling neglected and unable to express their needs.

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[1] Elam, McMunn and Nazroo, 2003; Feasibility study for health surveys among black African people living in England; Final report 2003.

These views do help to create the contextual background for the current study. Of use too, is an Iposos Mori report (Taylor, Page, Duffy, Burnett and Zelin, 2004), that identified significant differences in the way patients rate their NHS care, more specifically; ethnic minority and younger people tending to be more critical of the NHS and individual hospitals. Some explanatory views put forward consider very high expectations, as well as language and cultural barriers to be driving criticisms.

Another Ipsos Mori report commissioned for the Health Commission into 'Understanding Public and Patient Attitudes to the NHS' (2006), also identified that patients' general satisfaction with their hospital stay concerned being treated with respect and dignity, as well as experiencing good communication with health professionals (especially regarding information about medication and side effects), as well as hospital cleanliness. Nationally it seems that similar proportions of satisfaction were evident across all Ethnic groups regarding how the NHS is run as a whole, that is, 62% of Black service users, 60% of White users, 58% of Asian users (and an average satisfaction rating of 60%) were satisfied with how the NHS is run, the report revealed. However, once views on specific NHS services are sought, the findings revealed that Black and Ethnic minority groups tend to be more critical of the care they receive, for instance considering the care that they experienced from their GPs to be in need of a lot of improvement.

Another interesting finding of the earlier mentioned research by Elam et al., (2003) regards the meanings ascribed to health symptoms - that those regarded as indicating serious illness should be treated immediately, and the use of GPs and A&E departments could be associated with the onset of serious or life-threatening illness. Attitudes further informing treatment of illness seemed to be learnt from parents who were described by some as 'bringing up their children to not linger in bed when they were ill, but to get up and persevere', (Appendix B).

It would seem a natural extension of this enquiry to consider the relevance that Ethnicity has in relation to understanding the psychological adjustment, post heart attack, of the men in this study. Is it more than a collection of lifelong unique personal experiences that have served to inform the creation of a specific identity, relating to roles and labels ascribed by society? This study will go on to consider how and if this influences adjustment differently for these West African men.

1.2.5.2 Is ethnicity a variable in CHD?

Ethnicity is a multifaceted quality that refers to the group to which people belong, and or are perceived to belong, as a result of certain shared characteristics. Such characteristics include geographical and ancestral origins, but with a particular emphasis on cultural traditions and languages (Bhopal, 2007). Ethnicity is a fluid and imprecise concept, it "differs from race, nationality, religion and migrant status, sometimes in subtle ways, but may include facets of these other concepts" (Bhopal, p. 13).

Ethnicity and race are contested and controversial variables in epidemiology and public health, and yet they are of central and growing interest (Bhopal, p. 6). Whilst they are important in helping to understand disease aetiology and subsequent health needs, and in demonstrating inequalities in health care, they can also lead to stereotyping, stigma and racism (p. 28). Nevertheless, the analysis of such inequalities can lead to causal understandings and insights, and the subsequent actions required to shift towards greater equity in health care provision.

Researching ethnicity can provoke uneasiness as terms and concepts can be used inconsistently – as reflected in this quote below:

"Far too often ethnicity retains the flavor and tenacity of the old biological race categories producing the same dismal results in loss of information, diminished insight, and stagnancy. By distinguishing the valid biological dimensions of ethnicity, we place this sociological construct within its proper integrated biocultural context, and we empower researchers to use the term effectively to explore its broad consequences on human health and disease." (Jackson, 1992, p. 125).

I aim to be sensitive in recounting the stories and experiences of this study's co-researchers. Their accounts are extremely valuable in their own right, as well given the fact that although overall CHD mortality figures are dropping, they are not doing so proportionally for the black population (Coronary Heart Disease Statistics, 2008). Additionally, as stated earlier although the mortality rate for men of Black African or African Caribbean origin is lower than the national average, they still remain under- represented in cardiac rehabilitation programmes, jeopardizing their long term CHD prognosis.

Although race, ethnicity and cultural attitudes and practices are among variables that influence health behaviours, including adaptive health behaviours (Bagley, Angel, Dilworth-Anderson, Liu and Schinke, 1995), in UK there is a marked scarcity of research into the experience of CHD in the black population. In USA, Ell and Haywood (1986) studied the effects of socio-economic status and ethnicity on coping post myocardial infarction. They found elevated levels of anxiety, functional status and self-reported health status among lower socio-economic black and Hispanic populations, plus significant differences in personal sense of control, beliefs about recovery, coping responses and social support systems, compared to the upper socio-economic Anglo American population. A 2001 mortality study across all US states (Barnett et al., 2001) showed that African Americans were also more likely than any other group to die prematurely, that is, between 35 and 65 years of age; 40% of this group died premature deaths, compared to only 21% of white men.

As I have covered the various psychological variables associated with CHD I have attempted to include research findings from studies investigating the ethnic minority experience. Yet as can be seen in this introduction, there has been a significant paucity of such. This gap in the cardiac literature makes it difficult to adequately account for the low attendance rate of the ethnic minority population at cardiac rehabilitation programmes, and is a main reason for this study.

1.3 Rationale and aims of the current investigation

In setting the scene for this enquiry, I have considered firstly the benefits of cardiac rehabilitation and thus the need for attendance, the psychosocial impact of a heart attack which is important to reflect on in the face of low service uptake figures and theories of adjustment and coping. I have also described some aspects of West African history and some of their views of the NHS which may have an influence on uptake. In now considering the rationale for this study I will briefly reflect on it's relevance to Counselling Psychology, on the overall lack of ethnicity research in this area, the limited progress of government-lead initiatives in recent years, and thus some proposed advantages of the study.

As explained early in this account, it was my own personal experience of working in a national hospital, and reviewing departmental audits highlighting the significant low service uptake of West African men that prompted my interest in exploring this population's post heart attack experience. Given that racial and ethnic identity are critical aspects of self identity, and probably very closely associated with ways of behaving and reacting to the social environment, these men's stories may have important implications for health care (Bulatao and Anderson, 2004). This area of study, therefore, seems highly relevant and applicable to Counselling Psychology as it comprises issues of equality, allows voice to marginalised experience and champions subjective experience.

The general under-representation of the ethnic minority populations throughout the cardiac literature as a whole also provides rationale for this study. This may be due to many studies not reporting ethnicity data, as well as there being insufficient information about the reasons for ineligibility of ethnic group members (Jolly et al, BRUM study, 2005). The BRUM study which compared the efficacy of a home-based cardiac rehabilitation programme with a traditional hospital based programme, in a multi-ethnic population in UK, found a main reason for participant ineligibility was an inability of the study to support the range of minority languages spoken by referred patients. Additionally, because the people from Black and Minority communities make up a small proportion of the population, their representation in many quantitative research surveys is so low as to make it difficult to use the results with confidence (SEU: p.66).[2]

The National Service Framework (Department Of Health, 2000) has highlighted this omission as requiring attention and specific focus, and has recognized the significant value of cardiac rehabilitation, setting up a designated chapter to it. It proposed that cardiac rehabilitation programmes should address the psychological, lifestyle as well as physical needs of patients. Recommendations were made regarding the assessment of *individual* psychological needs and the provision of psychological intervention, at post discharge, up to four weeks post cardiac event, and throughout the long-term maintenance period. Such guidelines have initiated the development of cardiac rehabilitation programmes, and now provide standards against which they can be audited. In 2005 the British Heart Foundation alongside the British Association for Cardiac Rehabilitation, went on to create the National Campaign for Cardiac Rehabilitation "to fight for quality rehabilitation to be made available for all heart patients who need it." While the 2008 annual report of the National Audit for Cardiac Rehabilitation shows improvements in the provision of cardiac rehabilitation services, the majority of patients with heart disease still do not get cardiac rehabilitation. Additionally, despite an improvement in the percentage of ethnic minority patients being referred, the rate for both Black Caribbean and Black African patients remains <1%, respectively.

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[2] The former Social Exclusion Unit closed in 2006 and was transferred to the smaller Social Exclusion Task Force. The role of the task force is to co-ordinate the government's drive against social exclusion, ensuring that the cross-departmental approach delivers for those most in need. It champions the needs of the most disadvantaged members of society within government and the public service reform agenda

Qualitative exploration into this area would help develop a better awareness of such experiences and apply them to a theoretical framework. Such new information would possibly be useful in the following ways:

1. Provide information obtained without some of the quantitative methodological limitations discussed above.
2. Such detailed accounts of experience could yield very specific data, in itself being valuable, but also in terms of informing further increasingly accurate and extensive quantitative work. Additionally, such research can be replicated to explore the experience of other under-represented ethnic minority groups.
3. Assist in the development of an explanatory model of experience. This may allow for future studies to further explore the cognitive and coping styles of adjustment, within the context of ethnic minority experience.
4. Such an explanatory framework can be utilized to ultimately help improve service access, as well as service provision in meeting the needs of people in ways that are culturally, religiously and linguistically appropriate.

In improving service access and efficacy (in meeting specific ethnic minority health needs) perhaps greater equity of health care is more likely to be achieved.

This study focuses on one ethnic group of society to fulfil the homogeneity requirements of the methodology. However, all ethnic groups warrant such close investigation. For the purposes of this study West African men were selected over the other prominent ethnic minority group of South Asian men, mostly because of the larger population of such in the Borough, as well as the possibility of their lower CHD incidence prompting less research attention. The study has focused on men as CHD incidence is greater for this gender, but experiences of ethnic minority women are equally valuable and require exploration.

1.3.1 Investigation question

As mentioned earlier, the psychology department in which I worked primarily employed a CBT treatment modality and so was enthusiastic about me adopting a loose CBT model of adjustment to inform the creation of a semi-structured interview schedule, to guide the collection of the men's stories about their heart attack experiences. As is most commonly seen clinically, this population group is predominantly made up of first generation immigrants. Qualitative exploration into this area would help develop a better awareness of such experiences and apply them to a theoretical framework.

In particular, it was hoped that the semi-structured interview schedule would:-

1. Investigate the men's <u>cognitive appraisal</u> of the cardiac event and its impact upon their sense of self (beliefs about the self, others, the world in general and the future), behaviour (eg. smoking, exercise) and quality of life (work, social activity and relationships).
2. Explore the <u>coping strategies</u> that these men employed to deal with the cardiac event; ascertaining what was considered helpful and what potentially could help.

1.3.2 Justification for employing a Qualitative approach

Authors of ethnicity research have criticized some of the methodology commonly used in general research (Bhopal, 1997), and more specifically in cardiac studies (Webster, 1997; Wild, 1998; Todd, Wadsworth, Asif and Gerrish, 2001). A main concern is the large numbers of studies within the cardiac literature that frequently specifies participant criteria which effectively eliminates the ethnic minority population. For example, such research may stipulate the exclusion of participants on the grounds of being 'non-English speaking', or 'if English is not a first language', or 'if unable to speak or read English'. Additionally, studies are performed on populations attending cardiac centers that are in predominantly white areas. Further more, Webster (1997) , with regard to the South Asian population, describes how cultural factors influence the way Asian people perceive the heart and health care practices and, consequently, their interpretation of research tools/ measures. Webster suggests that established approaches to data collection may need to be challenged if accurate and relevant feedback is to be achieved.

In response to the National Service Framework's (Department Of Health, 2000) set standard for cardiac rehabilitation, many cardiac teams have initiated an ongoing assessment of the rehabilitation process at 4 different time points (hospitalization, pre cardiac rehabilitation, post, and at 6 months). In the hospital I worked in, the measures utilized are the MOS 36-Item Short-Form Health Survey (SF-36; Ware and Sherbourne, 1992), a health-related quality of life questionnaire, and the HAD scale (Zigmond and Snaith, 1983), as well as various information on health related behaviours. This is extremely valuable data, but due to the initial low ethnicity attendance rate that typically erodes further as cardiac rehabilitation progresses, this is not a complete source of ethnicity data. Patients who are referred for psychological assessment are also requested to complete the Revised Illness Perception Questionnaire (IPQ-R; Moss-Morris, Weinman, Petrie, Horne, Cameron and Buick 2002), the Type D Scale-14 (DS14; Denollet, 2001), which measures negative affectivity and social inhibition, and repeat the SF-36 and HAD scales, all providing yet another source of important data. However the proportion of patients accepting this offer is low (36% between

February 1999 and February 2000), as is the completion figure for ethnic minority referrals. As a result, sparse ethnicity data exists.

Given a) the general lack of cardiac research incorporating ethnic minorities, and

b) some of the methodological issues involved in the quantitative assessment methods described above, and

c) the low numbers entering and furthermore, completing cardiac rehabilitation and psychological therapy,

it would seem appropriate for research to be performed which firstly, allowed for the generation of qualitative information about the adjustment process of West African men post myocardial infarction, and secondly, that accessed these cases within 6 months of discharge, independently of cardiac rehabilitation.

Research using methods that can explain variations in response to cardiac events has been neglected (Ruston, Clayton and Calnan, 1998). It is increasingly recognized that using qualitative research methods can "reach the parts other methods cannot reach" (Pope and Mays, 1995). Qualitative research methods are appropriate for detailed exploration of cultural attitudes and norms (Hunt, Emslie and Watt, 2001). Such methods have been portrayed as antithetical to quantitative ones (Pope and Mays, 1995), with qualitative research characterized as hypothesis-generating and quantitative research as hypothesis-testing (Britten, Jones, Murphy and Stacy, 1995). However, both research can compliment each other (Hunt et al, 2001) and jointly contribute to the meeting of needs in this post myocardial infarction population.

Yardley (2000) discusses the value and relevance of the qualitative approach in the health context by clarifying the distinction between it and the quantitative approach. The latter is closely associated with a 'realist' conception of our knowledge of the world which assumes the existence of a stable reality which is independent of the observer. Accurate understanding of this reality is considered best achieved by means of precise, controlled, objective observation, often employing quantitative measurement and statistical analysis to optimize precision and objectivity. The aim of this type of research is to obtain measures of objective, physical reality which are uncontaminated by subjective mental processes – whether these are of the investigator or the research subject's 'biases' in perception or reporting. However, when the research is concerned with phenomena that can be viewed as either totally or partly subjective; such as loss or illness perceptions, a quantitative approach can be problematic.

Conversely, a qualitative approach to gaining knowledge is based on the understanding that the 'reality' of any individual is created by an interaction between his or her beliefs, goals and activities, and the constraints and possibilities of the physical, socio-historical and linguistic background and context. This approach fully acknowledges that this applies to both the beliefs and perceptions of the 'participants' in the study, and also to the views of reality that the researcher holds. For Counselling Psychologists this reflexive understanding of research is an extension of reflexive practice which, as explained at the start of the introduction, is a central component of the profession's identity. The developing of 'a detailed, multilayered, insightful interpretation of a phenomenon', Yardley continues, and considering explicitly the way in which the context, the participants and the researcher have jointly contributed to the understandings acquired in the course of the research, is considered a much more realistic research pursuit, rather than attempting to attain a neutral, objective perspective.

According to Smith, Flowers and Osborn (1997), while quantitative research is able to work at a macro level to produce broad models of understanding, qualitative research has the advantage of working at the micro level to explore the context of particular individual's beliefs and responses, thus illuminating the processes operating within the models. The benefits of qualitative methods of research lie in their ability to determine the extent to which a particular population faces a particular condition and to compare these findings against established norms (Shaw, 2001). This crucial evidence has the potential for use in developing and informing policy, and in influencing practice in the field.

1.3.3 Rational for the use of Interpretative Phenomenological Analysis (IPA)

I will outline the process by which IPA became the chosen methodology for this work, over other qualitative approaches, as well as other phenomenological methods.

As I mentioned earlier, the (clinical health) psychology department that I was working in predominantly used CBT as the main therapeutic orientation. Quantitative study was the dominant form of research in the form of audits and service evaluations, as well as ongoing work being produced by my well known Clinical Health Psychologist line manager, who has a very strong research career alongside her clinical work. Qualitative research was just beginning to be evident at this time, and another member of staff embarked on an IPA doctorate as I began mine. Within the department IPA was probably considered the most acceptable of the 'soft options' due to its apparent ability to access cognition, (how people make sense of their experience) which fitted in with the cognitive oriented tone of the unit. That said, there was a growing recognition that it was necessary to qualitatively explore these areas of study due to the real lack of known information about these areas (my colleague was looking into women's experiences of cardiac disease). Another motive behind department support was pressure to create strong links with the cardiac department; and so enquiry into the areas of study were relevant in ascertaining the level of psychological support that could be offered. At this time IPA was beginning to enjoy much popularity and considered an appropriate research methodology in health and psychology departments.

So, in summary, the choice of IPA as this study's research methodology resulted from the following various influences - a strong CBT work environment where little qualitative research was being performed; working within the health context where IPA was gaining significant recognition, and considered especially appropriate given its focus on cognition and perception; a colleague simultaneously embarking on an IPA study which meant research support would be available; IPA sitting well along side my CBT background, whilst still allowing for an adherence to my primary humanistic principles of championing and providing a voice to individual subjective experience, and recognizing the relevance of the broader contextual influences of both researcher and co-researcher on experience. This latter point is important with regard to ensuring that the research methodology fits well with the central tenets of Counselling Psychology. I will now go on to outline features of IPA, and compare it to other forms of qualitative methodologies.

IPA is primarily concerned with how individuals make sense of their personal and social worlds, and their perceptions of such rather than aiming to produce an objective statement of the event experienced (Smith and Osborn, 2003). Smith, Flowers and Osborn (1997) argue that looking at how individuals talk about a particular phenomena and how they deal with it, allows a much richer picture of what it actually means and thus enhances it's potency as a valid construct. At the same time as being phenomenological, IPA emphasizes that the research exercise is a dynamic process, where access to the participant's experience is dependent on, and complicated by, the researcher's own conceptions - symbolic interactionism states that meanings can only be obtained as a result of social interaction and through a process of interpretation (Smith et al, 1997). IPA (Smith, 1996), has the advantage of involving both interaction and interpretation. By tapping into a natural propensity for self-reflection, IPA aims to explore participant's views, getting closer to how they perceive their experiences and capturing the process of their attempts to cope with it (Smith et al, 1997). IPA thereby involves a 'double hermeneutic' where the researcher makes sense of the participant making sense of their own experience – which demonstrates the co-researcher status of the participant. This approach seems to fit well with the enquiry into the men's adjustment after a cardiac event. Overall, quality and texture are more important than cause and effect, the aim of IPA being to describe and explain, not to predict.

Smith, Jarman and Osborn (1999) make the comparison between IPA and discourse analysis (for example, Potter and Wetherell, 1987). They state that both methodologies share a commitment to the prioritization of language, but that IPA goes on to centralize the status of cognition. Discourse analysis as used in general contemporary social psychology, is considered to be skeptical of mapping verbal reports on to underlying cognitions, and focuses rather on attempting to highlight the tasks being performed by verbal statements, and recognize the pre-existing discourses that are drawn on by speakers. The verbal reports, therefore, are regarded as behaviours in their own right warranting functional analysis. Conversely, IPA is concerned directly with cognitions, that is, attempting to derive an understanding of a person's specific set of beliefs and about the topic being investigated. IPA does recognize that access to such thinking is not available direct from the transcript, but is derived through a process of analysis. In IPA the individual's experience is the topic, the research units of analysis are the individual and their meanings, and the process of information gathering involves hermeneutics, and an idiographic and contextual understanding (Smith et al. 2009).

As IPA is primarily concerned with the analysis of cognitions, understanding and meaning, it is not surprising that the methodology has become very popular in the area of health psychology. Consequently, it would seem to lend itself well to the investigation of 'cognitive appraisal' and 'coping strategies', and so has been employed in this study. Additionally, as would be expected, IPA has the capacity to investigate human experiences within a cultural context (Shaw, 2001), where IPA can reveal and deal with both the idiosyncrasies of individuals' experiences (subjective and unshared) and those elements that are shared, that are constructed by external forces within a culture.

Grounded Theory is often considered as a main alternative qualitative research methodology to IPA (Smith et al, 2009), and constructivist grounded theory (for example, Charmaz, 2006) currently seems the most widely used in psychology. Whilst both methodologies share an inductivist approach, grounded theory often requires large scale sampling to enable the generation of a theoretical-level account of a particular phenomenon. Smith claims that IPA is more likely to offer a more detailed analysis of the lived experience of a small number of participants with a focus on the convergence and divergence between participants. As opposed to a grounded theory study which is likely to move towards a conceptual explanatory level analysis, using individual accounts to illustrate the resultant theoretical claim. Smith et al.(2009) suggests that it is possible for IPA studies to lead on to a subsequent grounded theory study, depending on the purpose of the research. Willig (2001), suggests that IPA adopts a more realist stance compared to discourse analysis and grounded theory which may be viewed as more positivist. In this sense, IPA is viewed as attempting to discover individual experiences - subjective knowledge - rather than constructing an objective reality.

The field of narrative psychology comprises another methodological approach to qualitative research, which has developed from social constructivism but overlapped and integrated with many aspects of phenomenological psychology (Smith et al., 2009). Some narrative researchers are interested in the content of people's stories, whilst others focus on the structure of such stories, while others still are interested in the relationship between people's stories and the stories upholding the societal and cultural realms. It can, therefore, be seen how the position of IPA in relation to these research stances, will vary. Nevertheless, the central focus of IPA is that of people's experiences and their perceptions and views of such, as they make sense of the phenomenon being explored.

I will now elaborate on why IPA methodology was selected for this study. I have briefly considered three other phemenological approaches out sof a large number of others, which have been developed in recent years. Firstly, I will look at that of Amedeo Giorgi

(Giorgi and Giorgi, 2008), then Van Manen (1990) and lastly Ashworth's phenomenological psychology (Ashworth, 2006).

Giorgi's approach attempts to sit very closely to Husserl's phenomenological method, whilst IPA has expanded by also drawing from a wider field of phenomenology, namely hermeneutics and an idiographic commitment (Smith et al., 2009). Giorgi's approach entails a similar methodological process to IPA but seems primarily concerned with creating descriptions rather than being highly interpretative, as is the case with IPA (Smith et al., 2009). Finlay (2009) also suggests that Giorgi recognises the researchers subjective involvement in creating the research outcome, and thus supports the use of bracketing of own personal life experience. Central too, to IPA, is the recognition that research outcomes have been created with interpretation, however specifically on an iterative basis, and that an awareness of personal history and assumptive biases is highly desirable, and that it is not possible 'or even desirable' to fully set aside or bracket researchers experiences (Finlay, 2009). Additionally, Giorgi's method centers around the creation of accounts of commonality of the phenomenon, while IPA holds fast to its ideographic aim in capturing the richness of each participant, and seeking out both the areas of divergence and convergence, across all cases. Smith et al., (2009) explains that that this results in research outcomes with a different appearance: Giorgi's work appears more of a summary statement outlining general structural detail of the phenomenon in question; IPA attempts to produce work representing more of an 'ideographic, interpretative commentary', which is interwoven with participant extracts of their accounts. Eatough (2005) suggests that IPA 'digs deep' in comparison to the work of Giogi.

As IPA is a hermeneutic phenomenology it holds common ground with related approaches such as that developed by Van Manen (1990) – this approach has been used to explore experiences of the everyday, focusing on people as they exist in their 'lifeworld'. It has a reflective and practical focus on understanding lived experience, and is seen to be especially relevant to researchers in education, health and nursing (Smith et al., 2009). Smith et al (2009) highlight the point that Van Manen emphasises the centrality of writing – recommending modes beyond the scientific, such as art, literary prose and poetry, and encouraging the writing up of phenomenological research to include an artistic dimension (Finlay 2009). Finlay challenges this by suggesting that perhaps the researcher needs to attend closely to the readership they are trying to communicate with and consider which mode of communication is likely to have the most impact and relevance. She goes on to explain that whilst in some instances this means that research arguments will have best effect when emphasizing the systematic nature of the research methods applied and their scientific credentials, however in other contexts the research may make greater impact when more creatively presented.

Another phenomenological approach to research is that of Ashworth's phenomenological psychology (Ashworth, 2006) which shares with IPA an interest in studying the lifeworld with an idiographic focus (Eatough, 2005). This manifests as a rigorous interrogation of the lifeworld in specific contexts such as health and education. He has identified several aspects of such can be analysed using the phenomenological method, such as selfhood, sociality, embodiment, temporality, spatiality, project and discourse, seeing these fragments of lifeworld as moments of the broader whole individual (Ashworth, 2003).

This rigorous questioning of experience sits closely alongside IPA principles, especially its concern with presenting the single person case study as a legitimate form of research inquiry in psychology. However, such was not the endeavour of this study, where although depth of enquiry was sought, it was aimed to be employed across a group of co-researchers.

The IPA methods of Smith (1995, 1996) and Smith, Jarman and Osborn (1999) will be utilized in this proposed study. I will discuss my epistemological stance taken for this enquiry, at the start of the next chapter.

Chapter 2

Method

2.1 Epistemological stance underlying IPA methodology

In seeking to understand the experiences of the West African men of this study, and their post heart attack experience, I adopted a constructionist epistemological stance whereby I support much of the social constructionist's critique of the naive realism, reductionism, individualism and scientific positivist characteristics of psychology. Consequently, this study assumed a recognition of the influences of historical, social and cultural aspects of our lives – in terms of how we experience and understand ourselves, as well as the stories we tell ourselves about these lives. However, I argue against a social constructionism which denies human agency and reduces psychological beings to social processes (Eatough, 2005) Instead of this I position myself within the phenomenological and hermeneutic traditions which emphasise experience, intentionality and human meaning-making practices. Phenomenology considers the way in which things appear to us in experience; IPA focuses on lived experience and our perceptions of these lived experiences. The interpretation – or hermeneutic - aspect of IPA refers to the recognition that our understanding of an event is mediated by an already existing knowledge base, which is bounded by cultural and historical context. IPA involves a 'double hermeneutic' in which the researcher is tasked with making sense of the participant who is his or her self attempting to make sense of their world. Accordingly IPA can be seen as descriptive in so far as it is concerned with how things appear and letting things speak for themselves, and it is also interpretative as it recognises that 'there is no such thing as the uninterpreted phenomenon' (Eatough, 2005). Consequently IPA has been described as contextual constructionist research', which is research that is 'based on the assumption that all knowledge is necessarily contextual and stand-point dependent', (Willig, 2001, p. 145.)

I consider this account of epistemological positioning to sit very comfortably with the philosophical underpinnings of the Counselling Psychology profession which have been described at various points so far. Additionally, as will be seen towards the end of this section, when considering issues of quality and evaluation, the values and ethos of the profession are embodied in IPA methodology (for instance, original transcripts were handed in when the thesis was originally submitted, text extracts are displayed in the work, reflexive statements and clear declarations of presuppositions have been presented etc). This point will be returned to later in the section and in the concluding section of the work.

2.2 Design

A qualitative methodology was employed to investigate the adjustment process of West African men post myocardial infarction. The men's experience was obtained through the utilization of a semi-structured interview, which was recorded, transcribed and analysed using IPA (Smith, 1996; section 2.4 of this report for details).

2.3 Participants

2.3.1 Participant characteristics

For the research data to provide information that may help towards creating an explanation for the research question, the following inclusion criteria were required:

1. Male
2. To be of West African ethnicity
3. To have experienced a myocardial infarction
4. To have experienced a myocardial infarction within the last 6 months
5. To be between 50 and 70 years old

Participant details are tabulated in Table 1, (section 3.1), in the Results section.

Men have been selected for this study, as by far the majority of ethnic minority cases admitted with cardiomyopathy have been male. Additionally, at the hospital I worked in, in the first couple of years of the direct cardiac rehabilitation route of referral to psychological services existing, no female ethnic minority referrals were made.

Definition of 'ethnicity' and 'West African' classification codes: Hospital policy operates a patient self-categorization method of recording ethnicity data, where usually the country of birth denotes ethnicity. The target sample here is that of West African.

This study was directed at men diagnosed with having experienced a myocardial infarction. The interviews were performed within six months of the cardiac event. (Up to three months is the usual period for cardiac rehabilitation to be taking place as well as psychological referral. If poor attendance of these services relates to adjustment difficulties, this is the period of time that requires investigation. From three to six months post cardiac event, delayed or ongoing adjustment difficulties can still be evident.) Additionally, participants with no other major active medical condition were included, that could actively interfere with the eliciting of information pertaining specifically to post heart attack adjustment.

Due to the extreme difficulty encountered in recruitment, three of the five participants of the study had experienced a myocardial infarction previously. This was not desirable but did, nevertheless, most interestingly highlight their common experience of having had an initial good adjustment process with their first heart attack, which was different to that of their second. The common difference between their experiences is discussed in the results and discussion chapters of this report.

The age range of the sample was between 50 and 70 years of age, as this age bracket typically represents the highest levels of mortality. The adjustment process after experiencing a heart attack earlier or later than this age period is likely to include more complicated reactions associated with 'early' heart disease, or conversely, other medical states associated with the elderly.

2.3.2 Recruitment

Once ethical approval was gained in both the hospital sites, five participants were recruited via the Specialist Cardiac Rehabilitation nurses. It had been hoped that letters could be sent directly to prospective participants once identified from the department's database, however the introduction of tighter research controls regarding patient access prevented this being possible. Consequently the nurses handed information packs (*Appendix I*) to potential participants who attended cardiac rehabilitation and who met the study's inclusion criteria; interested patients contacted me via returning an 'opt in' slip in a SAE. I then contacted each respondent by telephone, and clarified that they did meet the study's inclusion criteria, and offered further information about participating in the study and provided the opportunity to ask questions. An appointment time was then arranged to gain formal consent (using either of the hospital standard research consent forms – *Appendix II*), and to carry out the initial interview.

At the start of the study it was hoped that firstly, the nurses would be able to recruit men prior to discharge from their initial hospital admission, in an attempt to access patients who may go on to decline cardiac rehabilitation, and secondly, that because all patients receive a home visit from the cardiac liaison nurse about six weeks after discharge, regardless of their interest in participating in the cardiac rehabilitation programme, it was hoped that there may be access to those not wanting to attend cardiac rehab. However, none of these patients showed interest in accepting the research invitation at that point in their illness, unsurprisingly perhaps considering the short time since the cardiac event,.

2.4 Interview schedule

The interview schedule (*Appendix III*) was devised to address three main areas, firstly the impact of the myocardial infarction, with an intent to elicit the participant's cognitive appraisal of their situation, secondly, questions to explore the coping strategies employed at a cognitive, emotional and behavioural level and, thirdly, questions to investigate the participants understanding of the cause of their heart attack. The final schedule evolved out of creating three question branches (*Appendix IV*). Although the schedule set out to direct the interview, the participant's were free to introduce other issues, which did happen frequently throughout the data gathering process. Nevertheless, the funneling process (Smith, 1995) was attempted to allow participants to speak freely and then to focus in on specific aspects of their life that the myocardial infarction may have impacted upon. Throughout, participant perceptions relating to the three areas were sought, to provide insight into individual understanding and meaning. It was hoped that participant's accounts of their own story or experience, with interpretation, would naturally reveal cognitive and emotional processing.

The interview schedule is loosely based on a similar clinical cognitive assessment format which is used by the psychology department, thus in part, is known to be effective in clinical work. However, the schedule was piloted to evaluate its efficacy with the target sample, in obtaining information to address the research aims. Piloting was also required to assess whether any assumptions were being made regarding the men's experiences following a heart attack.

2.4.1 Data collection

Interviews took place either in the psychology department at the first hospital, or the cardiac rehabilitation department at the second hospital, or in the participant's home if this was considered more convenient.

Before each interview was conducted, each participant signed formal consent (*Appendix II*) and was reminded that they could terminate the interview or withdraw their data at any point. Each interview, which lasted approximately 60 minutes, was tape-recorded and later transcribed verbatim. A standard debriefing took place at the end of each interview where the participant had the opportunity to reflect over the experience of the interview process.

2.5 Sequence of analysis

All transcripts were made anonymous by applying a coding system, and then analysed using IPA (Smith, 1996). Analysis followed an idiographic approach where the first transcript was analyzed, yielding particular examples of information which were slowly worked up to more general categories and a theory. Once the first transcript was completed, the analysis process was applied to the second, then third etc. The analysis followed six steps (Smith, Flowers and Larkin, 2009). Each transcript was set out in a series of columns, with the raw text in a broad left hand column, and then three columns to the right to accommodate the note making involved in the next three steps of analysis. Each transcript was allocated the participants pseudo initial, and the numbered line of text, allowing each piece of text to be identifiable (for example, Mr S, 229).

Step 1: The first transcript was read and re-read, as well as the audio-recording being listened to concurrently to start with.

Step 2: Initial noting of any data of interest. I adhered to Smith's suggestion of making three forms of notage: descriptive comments (focusing on the participant's speech content), linguistic comments (focusing on exploring the participant's specific use of language) and lastly, conceptual comments (focusing on engaging at a more interrogative and conceptual level with the data). This process of initial noting utilized a broad margin to the right of the transcript column.

Step 3: The data set grew with the development of provisional notes, and the analyzing of these exploratory comments led to the identification of emergent themes. These were recorded in a further right sided column. These themes begin to reflect not only the participant's original words, but also the analyst's interpretation, and aim at capturing an essential quality of what is represented in the text.

Step 4: The chronological set of themes were then assessed for patterns and connections, and an understanding developed about how they clustered or opposed each other. These clusters were re-named to capture their essence, creating *super-ordinate themes*. A table of such from the data of one participant (Mr Aj) illustrates this process in the Results section, (*Table 2).* As new clusterings of themes emerged, they were constantly checked against the primary source material. At this stage some order of the vast array of extracted concepts and ideas became apparent, and a certain level of analysis or type of explanation emerged, which needed clarification, this mainly comprised of a chronological account of experience. This emerged in tandem with the analysis, and formed the basis framework of interpretation. One participant transcript (Mr Aj) is presented in *Appendix VI*, illustrating theme development from raw text to super-ordinate themes.

Step 5: The rest of the transcripts were analyzed using the same procedure, where in each case new themes were allowed to emerge.

Step 6: The final stage of analysis comprised searching for patterns across cases, looking for connections at more of a theoretical level, and for higher order concepts. This is shown in *Table 5* (section 3.2), showing how the predominate super-ordinate themes were integrated into an inclusive *master list* of themes reflecting the experiences of the men as a whole.

The integrated master list of themes was finally consolidated into a diagrammatic representation of the adjustment experience of the participants, presented in *Figure 1* (section 4.1.2). This representation was then compared to the existing literature about adjustment following a cardiac event, in the discussion chapter.

2.6 Ethical considerations

Research Ethical Committee approval was sought and obtained at both hospital sites (*Appendix V*), as well as Research and Development approval.

There seemed to be two main areas of ethical consideration:

1. Informed consent was obtained from those participants willing to be involved in the research. As the participants were fully informed of the research topic and procedure it was assumed that potential distress would be minimal, which did seem to be the case. During the

interviews participants were explicitly not pressed to talk about experiences they appeared to find uncomfortable, and knew they could stop the interview at any time. Mention was also made of the psychological resource linked in to the cardiac rehabilitation department, should the participants feel the need to continue processing the experiences discussed in the interview.

2. Data protection. Participant transcript material was anonymised with the use of a coding system, in order to ensure confidentiality and anonymity of the data. No names or identifying details were transcribed from tape to transcript. No identifying characteristics were used in the writing up of the study, where the meaning of the research was not compromised. Some personal details were changed to ensure anonymity.

Tape-recordings and transcribed text were kept in secure premises, in a Psychology Department. Transcripts will be kept for approximately 2 years after complete successful examination of the research, after which time they will be destroyed. Data stored on computer is anonymised, password protected and only accessible by the researcher. It will be kept until the end of the research period. The tape-recordings, will be erased after the study is completed. None of the participants requested their recordings although they knew they were entitled to have them returned on completion of the study.

2.7 Reflections on methodology – the researcher and researched relationship

Given my years of living in Zimbabwe and South Africa I am acutely aware of the societal power imbalances that exist between different racial groups in general, as well as, more specifically, between the medical/ mental health professional identity and that of the service user. People of ethnic minority groups may have experienced discrimination in the past which could potentially influence their reaction to the research interview, especially given the fact that I am white, have a Zimbabwean accent and am a woman. So a great many differences existed between us, which were not directly addressed in the interviews except at the end in the form of the debriefing when asked generically how they found the interview. Their responses invariably revolved around their current cardiac health.

So during the interviews I was aware of some of my thoughts about possible assumptions the men may have had given the various aspects of my identity that were opposite to theirs, and what the impact might be on their story telling. I wondered if they interpreted my being a psychologist as something to be cautious about, that may inhibit their responses out of concern of being misunderstood or judged unwell when describing how they coped with their difficult heart attack experiences. I wondered too if having some interviews in the hospital prompted strong associations with their past treatments and did that cause concern about being open and considered potentially jeopardizing of any future care. Of course these issues were addressed in the introduction of the interviews; nevertheless I still wanted to try to create as good a rapport as possible to attempt to offset any concerns, within the short period together. The interviews on the whole, however seemed to reveal graphic accounts of difficult experiences which seemed to infer little inhibition of dialogue, or concern about negative consequences of the conversation. Another interpretation of this was that a couple of the men were very open as they hoped the interview could lead to medical help – in the form of communicating with outpatients or doctors on their behalf. In fact Mr M did seem to think I could do this. I was reassured with the fact that they were all, at the time of the interview, linked in to resources and receiving care from the health system. However I explained my limited role but did provide specific contact information for him to use. I also wondered if these men's apparent frank openness was a form of complaint that they had not felt able to make formally – perhaps this was an opportunity for their voice of dissatisfaction to be heard and documented, regarding some aspects of their care, and possibly they considered it actually less threatening than a formal process.

With specific reference to me being white, I speculated in accordance with my presuppositions, if the men were able to recognize my Southern African English accent, and if so, would it ber associated with apartheid. I think my accent has become much less pronounced and people tend to not recognize it unless they have experience of the region, however I still had concerns about this possibility, although it would have added extremely rich texturing to the interaction . Again, however, there did not seem any obvious indication that I was being judged negatively, to support this idea. Nevertheless, I was still probably seen as being part of the health system which for some marginalized communities may be considered as representing a broader social system of inequality – no matter how true, I was mindful that this was an ongoing researcher bias that I was trying to be aware of! Another question I had considered prior to the interviews was what would my gender matter to the men? Considering the older generation men, and certain cultural beliefs that my past experience in Africa had exposed me to, I speculated that speaking openly about frightening experiences (near death situations) might be difficult. Again I was not aware of this being the case, given the depth of detail recounted by the men in their stories, and their engaging approaches to the conversations. I speculated that perhaps this may relate to the likelihood they had all experienced many women health personnel during their hospital and outpatient care, and that they had all lived in UK for some time and had become familiar with such.

The interview process also threw up a challenge with regard to me needing to be aware of an automatic inclination to be therapeutic in the dialogue exchange. It was difficult to set aside the Counselling Psychology therapst in me, whilst living out from the Counselling Psychology researcher. I was very aware of wanting to meet the needs of the participant as they became apparent, for instance to explain a procedure or discuss a cardiac drug, or to normalize feelings when it would have seemed appropriate in a therapeutic setting etc especially when asked questions directly by the men. I experienced discomfort at what felt like allowing their experience, often painful, to 'hang' in the room. Here the skills of exploring through making sense of feelings or of summarizing were used to help the men to feel heard. Whist I did try to keep the interviews focused on their experiences rather than on my providing information or apparent therapeutic support, their need to focus on certain aspects of their experience did sometimes sway the dialogue and direction of the conversation. This usually still provided richly layered valuable experience.

On the two occasions where wives had unexpectedly attended the interviews, their presence seemed to have provided some influence. In the case of Mr Aj, it seemed the interview allowed him to voice his concern and sadness about how disturbing his medical experience had been for his wife, and I wondered if it was not so easy to have that conversation between themselves; that the interview gave him a voice or legitimacy perhaps. She seemed to respond with sadness and appreciation of his concern for her. Regarding Mr M, he seemed to use the interview to communicate frustration to his wife about his perceived 'fussing', her seemingly oppressive attending of him – out of concern that he not overdo things and also constant checking his heart was alright. However she seemed unperturbed by this, perhaps as she saw it as being her wifely role, or perhaps she had heard this message many times before but was unable to alter her behavior. Nevertheless, in both of these situations, the interviews seemed to allow for the communicating of messages between partners, and in both situations the wives seemed very supportive of their partners' cardiac experiences, providing emphasis and clarity in some instances.

Mr M's interview took place in his own home. The impact of this can be speculated – whilst it may have helped address the power differential which is likely to be exacerbated when using the hospital venue, it may have prompted a sense of exposure and perhaps contamination having a health professional in their home, discussing past difficult experiences. Conversely, as mentioned above, Mr M had asked if I could assist regarding his wanting to communicate with the cardiac team, and given he had experienced occasional GP home visits and community cardiac care visits in the past, perhaps the notion of health care professionals in his home did not seem unusual.

During the interviews I tried very hard to be aware of the various thoughts and ideas mentioned above, in order to attempt to a) bracket off (as much as is possible), and b) be mindful of their moment-by-moment influence in the exchange. I found it helpful to remind myself of these before the interviews. Throughout the process, use of supervision and discussion with fellow researchers assisted in reinforcing this awareness. Overall I attempted to convey respect and empathy regarding the men's very personal experiences, to build good rapport and trust. On reflection, I believe that they were deeply honest in their accounts, which infers they felt a degree of safety to be open and sincere in their stories.

Further critical reflection of the methodology is presented section 4.2.2 (critique of IPA).

2.8 Issues of quality and evaluation

While it is suggested that the use of traditional criteria for assessing qualitative research quality are often inappropriate (Yardley, 2000) it is widely recognised that qualitative methods require strict quality evaluation. Although the concepts of reliability may not be suitable, the same broad concepts of quality, validity and relevance are. However, these need to be operationalised differently to take in to account the distinctive goals of qualitative research (Mays and Pope, 2000). A number of guidelines have been produced to ensure the robustness of the analytic process. A sophisticated and pluralistic stance is that of Yardley (2000; 2008), who suggests criteria that are broad ranging and appropriate for qualitative research irrespective of the particular theoretical orientation being employed (Smith et al., 2009):

Sensitivity to context: It is hoped that this has been demonstrated in this study by, firstly, the choice of IPA methodology which in itself has allowed very close engagement with the idiographic and particularity of the participants, thus showing sensitivity to the socio-cultural context. This has been evident throughout the research process from the interview process (recognizing the interactional difficulties such as negotiating the power imbalance between 'research expert' and 'experiential expert' {Smith et al., 2009}, as well as that between 'health professional' and 'service user', and that of 'white woman' and 'Black man') and continuing through the analysis stage. The latter requires analytic discipline and immersive attention to participant accounts, to derive an understanding of how participants make sense of their experience. Secondly, the reader will also be able to judge the researcher's sensitivity to the raw material through reviewing the large number of verbatim accounts included in the writing (and *Appendix VI*) and the subsequent interpretations being made. Thirdly, the researcher has attempted to show sensitivity to the context through conveying an awareness of the existing literature, and relating the findings of the research in the discussion section.

Commitment and rigour: Yardley refers to commitment being demonstrated both during the interview and in analysis by attending closely to the men's accounts and being guided by their story. The main areas of the research process demonstrating the rigour principle are the appropriateness of the sample of men to the research question, the quality of the interviews and the completeness of the analysis. This study has restricted the sample group to those for whom this research question is meaningful, thus the sample has some specificity and is as homogenous as has been possible (given the significant difficulty in the recruiting of participants over the long duration of the study). Given this constraint, I have attempted to keep the participants as close to the inclusion criteria as possible and examined the psychological variability within the group, analyzing the patterns of convergence and divergence. Rigour is also evident in the fact that many of the analytical themes have been illustrated by all participants (displayed in *Table 6,* section 3.3 of the results).

Transparency and coherence: Yardley refers to the principle of transparency as the clear description of each stage of the research process, evidenced in the detailed write-up of the study, which I have tried to achieve. The principle of transparency is also associated with Smith et al's (1999) **reflexivity** principle, which refers to the process by which the researcher scrutinizes, monitors and reviews their role in the research and acknowledges the influences of prior assumption and experiences. The start of this report contains a reflexive statement where I attempt to be open about my past experiences and their probable influences on the research. Throughout the research process too, I have tried to recount a reflexive research commentary, again being aware of the need to be clear on my influence on the work, and measures taken to reduce this. Additionally, supervision and qualitative peer group discussion have provided essential checking opportunities to test out my degree of awareness regarding where the lines exist between my stories and those of the men, and where the co-constructed accounts are not swayed unacceptably by my experience. The transparency principle links directly with that of **Auditability** – whereby the clear process of the research can be followed closely by the reader. To achieve this all procedures for gathering data; specific questions posed; ways of organizing data and methods of analysis have been reported in this section. The principle of coherence in measuring the quality of the research can be judged by the reader, and refers to the claims or the argument that the research makes for upholding the identified themes and their final explanatory arrangement.

Transferability – Smith, Jarman and Osborn identify this principle as replacing the notion of generalisability as applied to quantitative research. I have attempted to describe the participants and their life circumstances, and to provide a rich, transparent and contextualized analysis of the accounts, hoping to enable the reader to evaluate the transferability of such to persons in contexts which are more or less similar. My attempts to situate the sample of participants in the existing literature, has been aimed at assisting the reader in determining the transferability of the study's findings.

Impact and importance: Yardley maintains that the research's real test of validity is the degree of interest and importance it holds. I have attempted to convey the relevance of this research throughout the study. It is believed to stretch from that of validation for the participants to that of creating more awareness of need, and consequently more effective and equitable health care.

The Independent Audit – this refers to the reader's ability to follow the chain of research evidence that leads from initial raw data, to extracted themes, to tabulated super-ordinate themes, to a master list of higher order concepts, to the final report. In order to allow for this a transcript sample and a full list of theme coding is placed in *Appendix VI.*

Additionally, two independent audits of two transcripts were carried out to check the validity of the analysis process (Smith et al, 2009). The audits entailed an assessment of data analysis, as described above, from raw transcribed text to the final master theme level. The auditors were asked to evaluate the credibility of the final themes, not necessarily a consensus relating to the interpretation of text. The independent audit allows for the possibility of a number of legitimate interpretations and final accounts being derived from the data (Smith et al, 2009) the concern relates to the systematic and transparent nature of analysis. The outcome of this process is shown in the Results section.

Inter-rater reliability of the categorization of data was also evaluated by recruiting an independent rater to recode some of the data, and consider the positioning of themes. Their suggested changes and the final verdict on the emerging and super-ordinate themes/codes are described in the Results chapter, section 3.3.

Respondent Validation – Smith et al (1999) describe this validity principle as the obtaining of feedback from the participants. The objective is to ensure that participants are free to challenge and, if necessary, correct the researcher's interpretations, and that these reactions to the analyses are fed back in to the study findings. A copy of each participant's transcript was attempted to be returned for feedback, however two were no longer resident at their initial addresses. Of the remaining three, only one returned the feedback form, stating agreement with the noted themes.

Chapter 3

Results

This chapter comprises two sections. The first commences with a description of the study's participants, and goes on to present a summary of the results in tabular form. This depicts the thematic analytical process of evolution from raw text data to super-ordinate, and then master themes, illustrated with one participant's text. Independent audit, and inter-rater reliability and respondent validation will then be discussed. The second section of this chapter provides a detailed description of the main themes emerging from the analysis, and concludes with a summary of such.

3.1 Participant details

Table 1 depicts the details of the men who participated in this study. Their age and time since MI, were that at the time of interview.

Table 1: Summary of participant characteristics

Participant	**Age**	**Time since MI (mths)**	**Country of birth**	**Age when immigrated to UK**	**Marital status**	**children**	**Employment**
Mr Aj	61-70	4	Nigeria	Mid 20's	Married	6 adults	Retired (security manager)
Mr S	41-50	5	Nigeria	8 years	Divorced	2 sons (in teens)	Unemployed
Mr B	41-50	3	Ghana	14 years	Single	0	Accountant
Mr N	61-70	2½	Nigeria	27 years	Married	1 adult	Retired (civil servant)
Mr M	61-70	3	Ghana	25 years	Married	0	Retired

3.2 The development of emergent and super-ordinate themes

The IPA process of data analysis is illustrated with the data from one participant, Mr Aj. A copy of his transcript can be found in the Appendices (*Appendix VIa*). Sections of his transcript are shown in *Table 2* below, illustrating the process of thematic evolution from raw data. The first level of analysis is that of initial coding of the raw text, which then leads to the second level of analysis, namely the development of emergent themes, which in turn are clustered into super-ordinate themes (third level analysis). Further analysis of these themes leads to the final development of a master table of themes.

Table 2: Text from Mr Aj's interview illustrates the analytical process of IPA thematic Analysis

Text – raw data (in brackets – participant initial, line of transcript)	**Initial coding**	**Emergent themes**	**Super-ordinate theme [master theme]**
I was very, very depressed and scared, and cried a lot (Aj, 8)	Emphasised very depressed	Expressing intense emotions	Emotional response [Initial impact of cardiac event (c/e)]
And I had such strong feelings but there was no one to talk to, to say this is what you should do. (Aj, 14)	No help or advice available	Isolated from help	Hospital experience [Impact of diagnosis]
They didn't tell me anything ... (Aj, 22) *... they didn't, they didn't tell me any procedure (Aj, 26)*	No information about what to expect	Lack of medical information	Hospital experience [Impact of diagnosis]
I woke up on the Friday at midnight, you know, then, then I started asking the nurses questions (Aj, 92)	Asking nurses questions	Asking questions	Coping style [Impact of diagnosis]

Table 2 (cont.)

Text – raw data (in brackets – participant initial, line of transcript)	**Initial coding**	**Emergent themes**	**Super-ordinate theme [master theme]**
Yes, and also I was having some pain at some of these places, the places where all those tubes and things were going in to me. By the time I got home I was having flashbacks to those days. Still having these pains, so sore.(Aj, 243)	Pain at drip sites ? drain sites	Physical experience	Hospital experience [Impact of diag]
	Flashbacks to ward experience	Flashbacks	Self appraisal [Immediate post d/c]
	Ongoing experience of pain	Negative meaning of pain	How far have I come? -cognitive appraisal [Few months post cardiac event]
... I walk for 30mins every day now with my wife, and will start at the gym soon.(Aj, 540)	Exercises with wife	Family support positive health behaviours	Support in recovery [Few months post c/e]
Yes ....but, but you see the nurse told me before I went for the operation that I was going to be 'clinically dead' for about 1 hour .... (Aj, 135)	Explanation for misunderstanding	Misunderstanding of medical information	Hospital experience [Impact of diagnosis]
And so that when I got home I had to go and see the GP. But I was very worried because they hadn't told me when I left the hospital, what to expect.... you know, ... I had some pamphlets we had picked up from the ward, and so I read them and then 'phoned the cardiac rehab for advice. Yes and it was then that I spoke to the cardiac rehab nurse who didn't know who I was, I had to tell her about my operation, you know. They said to me I must have slipped through the net. (Aj, 250)	Worried, uncertainty	Worry, uncertainty	Emotions [Immediate post d/c]
	No post op advice given	Lack of medical information	Support from others [Immediately post d/c]
	Attempts to gain information	Help seeking	Managing change - coping strategy [Immediately post d/c]
	'slipped through the net'	Lack of medical support	Support from others [Immediately post d/c]

Table 2 (cont.)

Text – raw data (in brackets – participant initial, line of transcript)	**Initial coding**	**Emergent themes**	**Super-ordinate theme [master theme]**
Yes, maybe because you meet other people there who have some of the same problems, because you think they are peculiar to yourself, you know, it's very helpful to see that most people have the same.(Aj, 533)	CR normalises some of the problems, feel less alone	CR facilitates positive change	CR – facilitates or hinders positive change
Well ... I have to be organised, and I don't think I'm ready yet, soon we will though. I am getting back my confidence. And also to do some coach trips, we used to do a lot of those too.(Aj, 552)	Belief in ability to improve	Plans for the future	View of future [Few months post c/e]
	Confidence improving	self appraisal	How far have I come? - cog appraisal [Few months post c/e]
	Plan to start old activities	Regain former life style	Reasons for change [Few months post c/e]
Yes ....but, but you see the nurse told me before I went for the operation that I was going to be 'clinically dead' for about 1 hour .... (Aj, 135)	Explanation for misunderstanding	Misunderstanding of medical information	Hospital experience [Impact of diagnosis]
Yes and they had a follow-up too, they told me what would happen, I did everything they told me and after about 6-9 months I stopped seeing them (Aj, 358).	Good continuity of past medical care, informed care	Good past medical experiences	Degree of trust in medical system [Pre cardiac event]
I was thinking of myself, how would I look after him? (Aj wife, 40)	Wife had a stroke	Family problems	Current other stressors [Pre cardiac event]
I have still stopped smoking, that was, I stopped just before the surgery, but I am still not smoking. The CR nurses are	Enforcing habit change, positive reinforcement of such	Healthy behaviours/ life style	Causality [Causality]

very pleased with that! (Aj557)			

Text – raw data (in brackets – participant initial, line of transcript)	**Initial coding**	**Emergent themes**	**Super-ordinate theme** **[master theme]**
Yes, much too frightening, I was telling them that I wanted to go home and see my family. And they said no, that "You can't go home, you're in the ward". And they were asking me what was going on, and I was telling them ... oh ... they said that they didn't understand me ... I wanted to write it down, ... I thought they would give me something to write ... a pen ... but they brought a dish .... (AJ, 132)	Staff preventing him leaving	Fear	Emotional response [Impact of diagnosis]
	Powerless to make self understood	Helplessness	Challenging sense of self [Impact of diagnosis]
	Mutual inability to be understood	Cannot communicate needs	Hospital experience [Impact of diagnosis]

Table 2. (cont)

As the analysis incorporated more transcripts, labels were adapted to more appropriately reflect the data and the concepts identified. (Alterations to the original list of themes can be seen in *Appendix VIa* after Mr Aj's transcript.) *Table 3* below, represents the integration of the super-ordinate themes from all five transcripts, and depicts the evolving of super-ordinate themes from emergent themes.

Table 3: Final table of emergent and super-ordinate themes

Emergent themes	**Super-ordinate themes** (brackets are master themes)
Family and relationship problems	Current other stressors (Pre cardiac event)
Other stressors	
Past medical experiences	Degree of trust in medical and social systems (Pre cardiac event)
Suspicious of systems – gen and medical	

Anxiety	Mood state (Pre cardiac event)
Anger	

Table 3 (cont.)	
Emergent themes	**Super-ordinate themes**
Problem with medical information	Hospital Experience (Impact of diagnosis)
Physical experience	
Isolated from help	
Helplessness, dependency	Challenging sense of self (Impact of diagnosis)
Believed would die	
Confusion	
Asking questions	Coping style (Impact of diagnosis)
Expressing intense emotions	
Denial and disbelief	
Depression	Emotional response (Impact of diagnosis)
Fear	
Others reactions	Impact on others
Depression	Emotions (Immediately post discharge)
Fear, worry, uncertainty	
Can't cope alone	Self appraisal (Immediately post discharge)
Lack of confidence	
Seek help from GP	Managing change - coping strategies (Immediately post discharge)
Seek help from family and friends	
Distraction	
Lack of medical support	Support from others (Immediately post discharge)
Family support	
Family fears	
Facilitates positive change	Cardiac Rehabilitation Facilitating or hindering positive change
Negative aspects of CR	
Self evaluation	How far have I come? - cognitive appraisal (Few months post cardiac event)
Fears of complications	
Negative meaning of pain	
Positive evaluation of health	
Avoidance	Getting on - coping strategies (Few months post cardiac event)
Dependence	
Behavioural change	
Family support positive health behaviours	Support in recovery (Few months post cardiac event)
Medical system	
Optimism	View of the future (Few months post cardiac event)
Plans for the future	
Health behaviours/ life style	Causality
Genetics	

This allowed for the production of a final Master table of super-ordinate themes, *Table 5*, over page. The Master table is ordered around the rough chronology of the participant's cardiac experiences, which very much characterised the structure of the interviews. This will be discussed fully in the discussion section of this report, where I will go on to propose an explanatory framework of these findings regarding the psychological adjustment process that the study's participants seemed to reveal.

Table 5: The Master list of super-ordinate themes

Super-ordinate themes	**Master list of themes:** **The Adjustment Journey**
	I Pre Cardiac Event ***"Slightly stressed and solitary"***
Current other stressors	
Degree of trust in medical and social systems	
Mood state	
	II Initial Impact of the cardiac event: ***"I just couldn't deal with it in my head"***
The hospital experience	
Challenging sense of self	
Coping style	
Emotional response	
Impact on others	
	III Immediate post discharge period: ***"trying to get back to normal"***
Emotions	
Self appraisal	
Managing change - coping strategies	
Support from others	
	IV Cardiac Rehabilitation: ***facilitating or hindering positive change?***
Facilitates positive change	
Negative aspects of CR	
	V Few months after the cardiac event: ***"trying to just get on with life"***
How far have I come?- cognitive appraisal	
Getting on - coping strategies	
Support in recovery	
View of the future	
	VI Causality
Causality	

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3.3 Audit and validation

Different methods have been employed to address these issues.

Demonstrating the prevalence of theme recurrence

To enhance the validity of the research findings, Smith et al (2009) recommends demonstrating the recurrence of super-ordinate theme support across all the participant cases. This information is tabulated below.

Table 6: Identifying participant support for emergent and super-ordinate themes

Participant text					Emergent themes	Super-ordinate themes:	Total %
Aj	S	N	B	M			
		√		√	Other stressors	Current other stressors (Pre Cardiac event)	100%
√	√	√	√		Family and relationship problems		
√	√	√		√	Past medical experiences	Degree of trust in medical and social systems (Pre ce)	100%
	√	√	√	√	Suspicion of systems		
		√		√	Anxiety	Mood state (Pre cardiac event)	80%
	√		√		Anger		
√				√	Isolated from help	Hospital Experience (Impact of diagnosis)	100%
√	√	√	√	√	Problem with medical information		
√	√		√	√	Physical experience		
√	√		√	√	Helplessness, dependency	Challenging sense of self (Impact of diagnosis)	100%
√		√			Believed would die		
√	√			√	Confusion		
√			√		Asking questions	Coping style (Impact of diagnosis)	100%
√			√		Expressing intense emotions		
	√	√	√	√	Denial/ disbelief		
√					Depression	Emotional reaction (Impact of diagnosis)	80%
√	√	√		√	Fear		
√	√	√	√	√	Others reactions	Impact on others	100%
√		√	√		Depression	Emotions (Immediately post discharge)	100%
√	√		√	√	Fear, worry, uncertainty		
√	√		√	√	Can't cope alone	Self appraisal (Immediately post discharge)	100%
√		√			Lack of confidence		
√			√		Seek help from GP	Managing change – coping strategies (Immediately post discharge)	100%
√	√			√	Seek help from family and friends		
√	√	√			Distraction		
√				√	Lack of Medical support	Support from others (Immediately post discharge)	80%
	√			√	Family support		
√		√		√	Family fears		
√	√	√	√	√	Facilitates positive change	Cardiac Rehabilitation Facilitating or hindering	100%
	√	√			Negative aspects of CR		

						adjustment	
Table 6 (cont)							
Participant text					**Emergent themes**	**Super-ordinate themes:**	**Total %**
Aj	**S**	**N**	**B**	**M**			
√		√	√	√	(Negative) meaning of pain	How far have I come? - cognitive appraisal (Few months post cardiac event)	100%
√	√	√	√	√	Fears of complications		
√	√	√			Positive evaluation of health		
√	√	√	√	√	Self evaluation		
√	√	√		↑	Avoidance	Getting on - coping strategies (Few months post cardiac event)	100%
√	√				Dependence		
√	√	√	√	↓	Behavioural change		
√	√	√			Family / friends support positive health behaviours	Support in recovery (Few months post cardiac event)	100%
√		√	√	√	Medical system		
√	√	√	√	√	Optimism	View of the future (Few months post cardiac event)	100%
√	√	√			Plans for the future		
√	√		√		Health behaviours/ life style	Causality	80%
		√	√		Genetics		

Independent audit and respondent validation

Two auditors were each requested to comment on the researcher's coding of two different transcripts (see method section, 2.8 for more detail). Overall the auditors were in agreement that there was sufficient transparency of the data analysis process, which permitted for the existence of a credible chain of evidence (supporting the deductions made.)

Inter-rater reliability

The categorization of data was also evaluated by recruiting an independent rater to recode some of the data, and consider the positioning of themes. Their suggestions led to a number of theme changes, which are described below:

1. Deciding to collapsing a super-ordinate theme of the master theme of "Pre cardiac event", namely "Type of Support" into "Current other stressors" as the former was not well supported by text.
2. Dropping of the super-ordinate theme of "Reasons for Change" from the master theme of "Few months post Cardiac event", again this was not adequately supported by the men's text.
3. Merging the two emergent themes of "Family" and "Relationship problems" of the super-ordinate theme of "Current other stressors", within the master theme of "Pre cardiac event", due to theme similarity and thus not warranting separate categorisation.
4. Collapsing the emergent theme of "Confusion" with "Problem with medical information" within the super-ordinate theme of "Hospital experience", of the "Impact of cardiac event" master theme. These two themes were too closely linked to illustrate separately.
5. The joining of emergent themes "Cannot communicate needs" with "Isolated from help" within the super-ordinate theme of "Hospital Experience", of the super-ordinate theme of "Impact of the cardiac event", again due to high similarity.
6. The dropping of the "Less" of both the emergent themes "Less avoidant" and "Less dependent" to accommodate text representing those men at the other end of those two continuums.
7. Since the review of the results was requested, my description of the superordinate themes below comprises the collapsing of the emergent themes within the super-ordinate themes.
8. Review of all superordinate themes as requested – most retained, but a deeper analysis of the narrative obtained.

Respondent validation

The objective is to ensure that participants are free to challenge and if necessary correct the researcher's interpretations, and that these reactions to the analyses are fed back in to the study findings. Each participant was sent a copy of their transcript, with a letter listing the main themes arising from their information (*Appendix VII*). Participants were requested to comment on this feedback. However two were no longer resident at their initial addresses. Of the remaining three, only one returned the feedback form, stating agreement with the noted themes.

3.4 Main Themes emerging from the Interviews

Tabular representations of the participant's text supporting the development of all 18 super-ordinate themes, were created (numbered A-T). *Table N (Appendix VIII)* is one such table that represents the super-ordinate themes of "How far have I come? - cognitive appraisal", of the broader master theme "Few months post cardiac event". The rest of this chapter comprises a description of each of the tabulated super-ordinate themes.

Text representation: The interviewer's dialogue is indicated as Int: , and the participant is identified in brackets at the end of the quote, alongside the line number of that participant's transcript, from where the quote commenced, for instance (Mr S, 235).

The men's accounts were all presented in the interviews as a reflection over time – they described moving through a sequence of experience and as such, one interpretation that I felt highly relevant was to reconstruct their accounts using their sense of journeying through time. This then became the scaffolding on which to layer their narratives of lived experience.

The men's journey of adjustment

3.4.1 Pre-cardiac event – "slightly stressed and solitary."

Analysis of the men's accounts revealed that they all seemed to bring to their heart attack encounter, a picture of life experience that had a slightly, and in some cases markedly, negative tone. Analysis revealed this period of experience to comprise their negotiating various life stressors – the main three characteristics (emergent themes) of this master theme, being that of "Current other stressors", "Degree of trust in medical and social systems," and "Mood state". It seemed as if these concerns were also rather isolating for the men. Each will be illustrated.

3.4.1.1 Current Other Stressors

All of the participant's accounts contained descriptions of stressors that seemed to pertain mainly to the two areas of "Family and relationship stress", and 'Other stressors' which related respectively, for two participants, to a long standing fear of death, and financial worries. All five participants supported this super-ordinate theme.

Family and relationship stress: The men described various concerns in relation to family members:

> *"... but they tire us out as we are doing baby-sitting and looking after them, they're more attached to us, sometimes I think about them, 'Oh, will I see that child again?' or if something happens to me, what'll happen to them, and now they've got some er, kind of a sort of sheltered problem or something, as some children are ... very inwardly drawn in the sense they don't want to socialise, that sort of thing, eh one of the grandsons is like that sort of thing, we worry about him sort of thing, 'Oh, what'll happen to him?'"*
>
> (Mr N, 882)

> *"... so he [grandson] really wants to be with us, rather than anybody else, so every time I think how will he be if we were not there, what'll happen? Sometimes I think about my daughter's relationship and will it continue, because nowadays marriages break up for the flimsiest of reasons,"* (Mr N, 904)

Mr N's concerns range from the well being of his grandchildren to that of his daughter, especially once he dies and is no longer able to help in their day to day lives. Other participant concerns revolve around the health of their partners:

> *"Because I take a lot of tablets and um, some of them worries me as well, and that adds to the problem, and this all added to the problem" [recovering from a stroke]*
> (Mr Aj's wife; 56)

Mr S and Mr B highlight their experience of lack of support, resulting from difficult relationships:

> *"I was good to her, you know, but she has a really bad attitude. But I'm much better about it all now, [few months post MI] I think of her maybe once or twice a week now only, I'd never have her back. I still get angry cos she's never explained anything, just went, but I'm ... well, [... sigh] ... what can you say? ..."* (Mr S, 539)

Mr B describes the difficulties of being involved in an enduring family feud:

> *"No, the sad thing is that no one in the family wants to get involved. Um, I've always been um ...... not a great person to share my personal problems with ..... um ...."*
> *Int: "Because? Why do you think that is?"*

> *"Um, well, the family is like that. There have been 2 or 3 incidents in the past that have revolved around .... where I've not been able to deal with the generation gap with my parents. It's complicated, it's difficult for them to adjust and accept differences in cultural values."* (Mr B, 331)

> *Int: "How did your family respond to the news of your heart attack?"*
> *"I haven't told them."*
> *Int: "Why's that?"*
> *"Well a) because there's no communication ..."*
> *Int: " You can't talk to them?"*
> *"No, communication wise, I've just cut it off completely, a little with the brother I live with (older) and my sister, other than that it's only through the legal channels that I communicate with the others."*
> *Int: "That lack of communication must add to the stress in some ways too ... not knowing exactly what's been thought by the others?"*
> *"It is stressful, but um practically I tell myself 'It doesn't matter', you know, but deep inside it is a little hurtful."* (Mr B, 431)

Other stressors: Two other stressors described by participants in the interviews were that of death and finances:

> *" ... and one thing leads to another, um, but I've always been er what do you call er, not frightened but er fear of death"*
> *Int: "Ok ..."*
> *" ... and what is there in the future at all, I mean, we're all here and then suddenly I mean what happens? Where do we go, like ... ?"* (Mr N, 236)

> *"I think it's just ... suddenly ... not being there type of situation, I don't know how to put it into words, but eh umm .... If you were, if you were there living as usual, you'd know that you are still travelling by tube, travelling by train, travelling by bus or what*

> *ever, watching the TV or um looking at your grandchildren, looking at your wife, things like that, suddenly, what happened? That, that is basically a question that doesn't seem to have an answer."* (Mr N, 524)

Financial concerns were voiced by Mr M:

> *"Yes because I like to go and support my family and I did that by working [in the past] and we had not to worry about bills and shopping"*
> *Int: " Right"*
> *"And I must help my family"*
> *Int: "Mmm"*
> *"But I can't work [now]and I only get enough money to get the necessary things" (Mr M, 872)*

3.4.1.2 Degree of trust in medical and social systems

All participants revealed information that positioned them on a continuum of trust or distrust regarding the systems of care and/ or society in general. Their text was grouped into the three emergent themes of "Past medical experience", "Suspicious of general systems" and "Suspicious of medical systems."

Past medical experience: all three participants with a history of a previous myocardial infarction provided mostly positive descriptions of past experiences, which seemed to relate to their having adequate medical information as well as experiencing positive signs of good health:

> *"The surgeon explained my arteries were then alright, during the angiogram, I saw everything that he did."*

> *Int: " So that was helpful? They were able to explain .... "*
> *"Yes that was helpful, I could see that they had sorted it out, yes, and the medication was good, after that weekend I was discharged."* (Mr Aj, 346)

> *"Yes and they had a follow-up too, they told me what would happen, I did everything they told me and after about 6-9 months I stopped seeing them."* (Mr Aj, 351)

Mr Aj describes a very positive past experience which differs dramatically to his more recent cardiac experience which will be described shortly. Another participant was also pleased with aspects of his earlier medical care.

> *"But er, when I saw Dr X, she said er, I was on minimum medication at that time and the medication was primarily for blood pressure, and um, and nothing else, even the diabetes was diet controlled I wasn't taking a tablet or anything, and I had no awful symptoms of angina or pain or anything at all, and my quality of life was very good."*
> (Mr N, 29)

Some aspects of this positive experience are shared by Mr M, however, as his condition started to show signs of change he began to worry.

> *"Yes, mmm, I was with my family, I was feeling quite good after one month or so, and I thought the operation had fixed my heart and I was getting on again, ... so, after 6 months when it started changing again I felt worried I wasn't getting better like I thought"* (Mr M, 669)

> *"Yes , it was good, I was with the family, I nearly stopped worrying, mmm"*
> (Mr M, 694)

> *"Yes – I wanted to get back to normal life and I didn't worry about the pain ... "*
>
> (Mr M, 704)

> *"It was like I didn't have thoughts like this before. "[Compared to current negative thoughts]* (Mr M, 713)

One participant had experienced a past non-cardiac related difficult medical experience which had ramifications for his recent first time, myocardial infarction experience.

> *"Did I worry? Maybe tiny, not a lot, the only time I did worry was when I had to go down for a, the operation, like to get the stent in, to get the stent put in, and then they had to check the stent out, I don't like operations – because I'm very unlucky with operations"* (Mr S, 363)

Suspicious of general systems: Here Mr S's account illustrates the existence of this theme in two unrelated contexts, namely that of the areas of mental health and the police:

> *"Well, um you being a psychologist, you're not going to lock me up or send me away or anything?" [If he talks to me]* (Mr S, 6)

> *" 'cos when I use my bike, it's around Brixton, yeah? And the police always do stop and search, you know? With a story like 'Oh you fit the description of a man who stole a handbag, or whatever, ... he was on a bike like yours' etc etc And it's not true, they just waste your time, you know, they are looking for black people to stop and search.*
> *Int: "Oh that must be very annoying, does it happen often when you're cycling?"*
> *"Yeah, of-course, "* (Mr S, 507)

Mr M seemed to indirectly consider a question about the influence of ethnicity on his care:

> *Int: "So would you say your experience, do you think in anyway is linked to you being of ethnic colour?"*
> *(Mr M pausing)*
> *Int: " Some people do think there is a link, it's not definite."*
> *"Some people I know, some people they might think so, and think more complicated about it. They try and um, learn about what, what is really going on ..."*
> (Mr M, 1112)

Suspicious of medical systems: This theme is represented strongly with text revealing doubt about the risks entailed in health care, and that associated with Doctors having inconsistent diagnosis and treatment views within the health system.

> *"Mm, you see I can deal with most things but I'm just not very good with operations as they don't really turn out as they should do. I'm unlucky with them, you know. If they say there are 1500:1 likelihood of all being ok, I'll be that 1 it could happen to."*
> *Int: " So did they talk to you and give you the odds for a successful angio?"*
> *"Yeah (laughter) and I thought 'I've heard this before!'"* (Mr S, 381)

> *"But of course when I went to see the surgeon, er surgeons are quite different to physicians."*
> *Int: "And they're quite happy to cut ... ?"*
> *"They say, say can you come in tomorrow!! Sort of thing (much laughter from both) um, and then also they do things by telephone saying suddenly somebody's dropped out and can you come in, and things like that, so because then I said 'I'm still under Dr X's advice to not have surgery', but then she said 'let's forget about the surgery for the time*

> *being' because I was on a waiting list for over 6-9 months, but they said they could bring it forward depending upon the circumstances."* (Mr N, 83)

A final text representing a degree of scepticism about the health service was displayed by Mr B, whose initial belief that the hospital was concerned about patient litigation played a role in his understanding of his diagnosis.

> *"Um .... It took me some convincing that I had indeed had a mild ... heart attack ..... I was automatically thinking 'Be realistic, what ever happens, happens, but is it the flip side of the coin that there are more litigation from patients who've had heart problems maybe missed ... or what ever ...'"*
> *Int: "Oh, I see .... being cautious ...?"*
> *"Is the hospital being very cautious and labelling it in the highest of the worst possibilities and working their way down? That's what I was wondering ...".*
> (Mr B, 109)

3.4.1.3 Mood state

Four of the five participants discussed their negative mood state prior to their myocardial infarction experience. This often related to their current stressors as described, and predominantly seemed to fall into the emergent theme categories of "anxiety" and "anger":

Anxiety: for one man this was understood as a chronic issue, for the other man this related to cardiac health concerns:

> *"But um, sometimes it's worrying, it's, the problem is that I've always been a very anxious person"*
> *Int: "Oh I see."*

> *"Oh right from the beginning, and so anything small um worries me and um I think er when I was working, most of the time, you tend not to think about other um because you have no time to think about other things."* (Mr N, 219)

> *"It was ok and then I started getting worried ... after 6 mths I worried things weren't going well any more, I, I wasn't getting better ... and my family started to worry ..."*
> (Mr M, 725)

Anger: for one man this was understood as resulting from the conflictual ending of a relationship, and for another, this was explained as resulting from a long standing family feud:

> *"The split was really bad but I was obsessed with her, crazy in love, that I didn't care about much else, cos we knew each other from school, you know, and on and off we were together. ..."* (Mr S, 33)
> *"I think of her maybe once or twice a week now only, I'd never have her back. I still get angry cos she's never explained anything, just went, but I'm ... what can you say."*
> (Mr S, 41)

> *"Yes, the others have been able to get their anger out of their systems, whereas I've just sort of, sort of, taken it on board, and probably put it inside, I s'pose. But I think over time it has taken it's toll, but then by nature I'm a giver, and I think to a large degree they've taken advantage of that".* (Mr B, 399)

3.4.2 Initial Impact of cardiac event. *"I just couldn't deal with it in my head."*

Five super-ordinate themes create this master theme, they are "Hospital Experience", "Challenging sense of self", "Coping style", "Impact on others" and "Emotional response." These were all extracted from the men's stories which reflect the deep sense of overwhelming fear of ultimate loss, resulting from confusing hospital experiences which served to significantly test their sense of self.

3.4.2.1 Hospital Experience

This super-ordinate theme comprises three emergent themes, with 'Problem with medical information" and "Physical experience" being the most prolifically supported. The other theme is "Isolated from help".

Problem with medical information: The main issue that seemed to be revealed was that of medical indecision, another being that of feeling overwhelmed with a lot of information, and lastly that of a participant who misunderstood medical information. Four of the five participants experienced the first theme:

> *"I could not believe they were saying these things, 'My God', one saying it's nothing then the other telling me it's my heart."* (Mr M, 213)

> *"Then after that, sometime the one doctor says no surgery and the other doctor says surgery, saying like."* (Mr M, 168)

> *"One Dr said I must have operation and another said I don't - so after being there I had a talk with my wife, but if I can't do it I can't do it. After seeing me they said I can go now and then after that they went out the room." (very muffled)* (Mr M, 91)

> *"I walked into the A&E department at about 9 o'clock in the morning, telling my colleagues I was just going for a quick check-up and I'd see them later. And um when I*

> *was sitting in the CDU unit, the blood tests were marginal, elevated, the ECG was perfect. They couldn't decide what the matter was ... "*
> *Int: "Mmmmmm"*
> *"Until the middle of the night when they did more tests and found enzymes. Um, even then they couldn't decide if I'd had a heart attack or not. So I was admitted to the medical ward during the night, um ... where further tests confirmed my heart attack. And on the following day, I had an angioplasty, and they found 3 blocked vessels."*
>
> (Mr B, 26)

> *"And out of the blue. So ..., but but Dr X was quite a .. calm and said look there's, said you've got no symptoms and the medication is really on the minimum, why don't you just bide your time, and then um, see what happens. In the meantime I refer you to surgeon at XXX hospital and um, then we can take it out from there. But she said if worst comes to worst and your symptoms get really bad can increase the medication or if something else comes up in between then we can think that when we cross the bridge, you see."*
> *Int: "Yes."*
> *"But of course when I went to see the surgeon, er surgeons are quite different to physicians."*
>
> (Mr N, 73)

In addition to receiving differing information, Mr S seemed to consider the amount of information given to be overwhelming:

> *"Yeah, but the Drs were saying different things, 'don't do this, don't do that, you've got to use the spray and you've got to ring the hospital every 5mins' and all that kind of thing. Oh ...I had too much in my head."* (Mr S, 39)

Mr Aj experienced a traumatic admission, in part this seemed to relate to his misunderstanding of medical information:

> *"Yes ....but, but you see the nurse told me before I went for the operation that I was going to be 'clinically dead' for about 1 hour ...."* (Mr Aj, 185)

When he awoke after the operation, he believed he had died, and for some time after experienced flashbacks to that terrifying time.

Physical experience: Within this theme a main area of discussion centred on the pain experience:

> *"I said I had that pain, I had a lot of pain here."* (Mr Aj, 198)

> *"Yes, and also I was having some pain at some of these places, the places where all those tubes and things were going in to me."* (Mr Aj, 243)

> *"Being realistic, I um although I was fully prepared to accept the reality of whatever it was um ... because the ECG [was alright], and there was not cardiac pain, I didn't feel any pain in the heart ..."* (Mr B, 105)

In addition to the pain experience, some accounts contained reference to the sequence of events of their cardiac admission and treatment, and interactions with staff.

> *"The ambulance came, told me if I could walk, I was tired I said, went to hospital, so after 2 days nothing changing and they gave me some tablets and medicine and say go home then after 1 week very bad 'cos I walked. I don't think I'll do anything like that again, like to go home and come back. I can't move my whole body and my arms, and the pain was there and then I see doctor after one week and he do an exercise test so I*

> *went. And he completed (muffled) and then must wait. So after some time I went into that room and he telling me but I don't understand, so that afternoon had an angiogram...no more they can do."* (Mr M, 46)

> *"Yes. So while I'm in the hospital at that time the doctor told me some regimen or something, [so after 2 months they gave me medicine to take so before they read the angiogram then, at last], ... no at that time the doctor was writing, then err while I was lying on the table, they were talking like I didn't hear."* (Mr M, 141)

Mr S mentioned an apprehension about operations due to past complications – these quotes have been used to represent his mistrust of systems as clearly both themes can be supported by his narration. Below he refers to a past problematic surgery experience ... which caused unease during his inpatient period.

> *"I had a varicose vein that went wrong ..."* (Mr S, 370)

Mr Aj discussed in much detail the complications he experienced.

> *"You see what happened was they were worrying about him because his blood wasn't clotting, I was there, they gave him 6 units of blood and it wasn't clotting, it was, I was worried as well, ... they were worried."* (Mr Aj's wife, 100)

> *"Yes, and he couldn't move as he had so many gadgets attached to him, some here some here, and machines too ..."* (Mr Aj's wife 189)
> *"Yes and so frightening."* (Mr Aj, 192)

Isolated from help: At times during their inpatient period, both Mr Aj and Mr M reported experiencing difficulties in communicating with the medical staff:

> *"And I had such strong feelings but there was no one to talk to, to say this is what you should do."* (Mr Aj, 13)

> *"They didn't tell me anything ..."* (Mr Aj, 22)

> *"... they didn't, they didn't tell me any procedure."* (Mr Aj, 26)

Mr Aj's wife had to intervene to try and improve communication:

> *"But then he was crying as well "I don't want to die, I don't want to die" speaking in my language."*
> *Int: "That you speak in Nigeria?"*
> *"They couldn't understand what he was saying, I had to translate for them, and was saying "You're not going to die" you know, "You've survived", you know ..."*
> (Mr Aj's wife, 172)

> *"Mmm, I don't know and no-one was telling me."*
> *Int: "Maybe patients coming in that they wanted to..."*
> *"Well, I know I was sitting and people were going in before me that I didn't think were more urgent."*
> *Int: "But in the meantime sitting there, waiting, costing them money ..."*
> *"Yes well I think I have a heart problem and that's quite necessary."*
> (Mr M, 1352)

3.4.2.2. Challenging sense of self

The prominent emergent themes supporting this super-ordinate theme are "Helplessness and dependency", "Belief they would die" and "Confusion".

Helplessness and dependency: The cardiac experience (as covered by the other themes) for four of the five men, seemed to induce a sense of helplessness and dependency, as a result of physical limitation as well as that (for Mr M) imposed by the medical system, (many quotes used to support the earlier themes).

> *"... Oh ... they said that they didn't understand me ... I wanted to write it down, ... I thought they would give me something to write ..."* (Mr Aj, 137)

Mr M appeared to experience this restriction from the medical system:

> *"I couldn't do anything. I had to wait, one month, one month, even thought we had to wait further one month because can't do anything, don't want to have to choose private medical."* (Mr M, 250)

Believed would die: This theme was supported by the accounts of two participants:

> *"But then he was crying as well "I don't want to die, I don't want to die" speaking in my language."*
> *Int: "That you speak in Nigeria?"* (Mr Aj, 172)

> *"... other half, you see, that's right, what happens? Where do I go? What happens? Er ... and so that has been quite er I think that's been the worries sort of feeling."*

> *Int: "The centre of everything?"*
> *"The centre of everything, er but that er luckily, I mean, I know ... because er I read a lot about it and things like that, that they're irrational fears and I'm being silly. And I can talk myself out of it, but in spite of myself pulling my socks up, and getting positive thoughts and words, it over um overruns my sort of other thoughts and then for a few seconds and minutes it suddenly sort of, becomes a sense of unrealism, what is going to happen?"* (Mr N, 250)

Confusion: In trying to make sense of their cardiac event, three of the men appeared to experience much confusion, significantly challenging their sense of self:

> *"Yeah 'cos I couldn't lift nothing, and got to walk. .... Um ... it's too much things they were telling us to do and I just couldn't deal with it in my head"* (Mr S, 48)

> *"Yes, much too frightening, I was telling them that I wanted to go home and see my family. And they said no, that "You can't go home, you're in the ward". And they were asking me what was going on, and I was telling them ... oh ... they said that they didn't understand me ... I wanted to write it down, ... I thought they would give me something to write ... a pen ... but they brought a dish ...."* (AJ, 132)

> *"And in the room, other people going into the operations and I'm still there*
> *Int: "So how did you understand that, with all the other people coming and going because they had minor things?"*
> *"I wonder why I'm not important and I might have emergency ..."*
> *Int: "But you felt you were hanging around waiting?"*
> *"Mmm yes yes. I knew that I would have to wait for other people who need emergency operation."* (Mr M, 343)

3.4.2.3 Coping style

The men's efforts to cope with the impact of their cardiac diagnoses seemed to fall into three main coping styles which create the following emergent themes – "Asking questions", "Expressing intense emotions" and "Denial and disbelief."

Asking questions:

> *"I woke up on the Friday at midnight, you know, then, then I started asking the nurses questions."* (Mr Aj, 93)

> *"And I was pretty blunt and honest with the specialist, the cardiac surgeon, ... I said "Look, try to be realistic, try and be sensible, you are prepared to accept the reality of what the tests show ... what is the clinical evidence?" It took 2-3 days to say that the blood test showed elevated enzyme levels."* (Mr B, 117)

Expressing intense emotions: Although depression and anxiety appeared to be the characteristic emotions experienced (detailed in the next super-ordinate theme of "Emotional Response"), there seemed little actual dramatic expression of such, except for the experience of Mr Aj:

> *"I was very, very depressed and scared, and cried a lot."* (Mr Aj, 8)

Denial and disbelief: Four of the five men's accounts revealed aspects of this theme, in trying to describe the impact of their cardiac diagnosis, three are quoted below:

> *"Yeah ....um, it does pass through my mind, but I must say that I um, that I never thought at 50 I'd have a heart attack, you'd never thought that 20yrs ago, or 10yrs, you'd have a heart attack."* (Mr S, 81)

At the same time, Mr S also seems to perhaps minimise some of the impact:

> *"Well it was, to be perfectly honest with you, it didn't really bother me, just you know, what really bothered me most, to be honest, was my ex-girlfriend, which I guess is a bit weird to say."* (Mr S, 27)

Mr B's sense of denial in the diagnosis could be understood in terms of his belief that the hospital was exaggerating the severity of his condition in case of patient litigation, if the diagnosis was inaccurate.

> *"I didn't feel any pain in the heart ....."*
> *Int: "Mmmm."*
> *"Um .... It took me some convincing that I had indeed had a mild ... heart attack ..... I was automatically thinking 'Be realistic, whatever happens, happens, but is it the flip side of the coin that there are more litigation from patients who've had heart problems maybe missed ... or whatever ...'* (Mr B, 107)

Mr M's denial response seemed fuelled by firstly his belief that he was fairly well, secondly the diagnostic indecision of the medical staff, and thirdly fears of negative ramifications:

> *"Me, no problems before so I could not believe."*
> *"I could not believe they were saying these things, 'My God', one saying it's nothing then the other telling me it's my heart."*

> *Int: "Yes."*
> *"Yes it was a shock when the doctor told me that."*
> *Int: "How did you deal with that?"*
> *"I tell my family, and my wife mm could not believe, ... I am walking, feel good."*
> *Int: "I know it's a little while ago, but it must have had a huge impact?"*
> *"I thought the doctors were 99% wrong. I got three under 17 at home, they need me, so what are they doing telling me this."* (Mr M, 206)

3.4.2.4. Emotional response

As mentioned earlier, the emergent themes of "Depression" and "Fear" characterise this super-ordinate theme.

Depression: Only Mr Aj verbalised this as being an emotional response to the diagnosis and treatment.

> *"I was very, very depressed and scared, and cried a lot."* (Mr Aj, 8)

> *"And then I woke up on Saturday and I was crying and crying ...."* (Mr Aj, 111)

> *"It was, it was so depressing that I was crying, a lot."* (Mr Aj, 59)

Fear: Four of the men described their feelings of fear when being told their cardiac diagnosis, and also in relation to their ward experience:

> *"And the angiogram predicted as I said three quite severe arteries blocked, and then when we went back of course, that, I, not panic but it looked sense of unrealism, out*

> *there yesterday I was ok, today they are saying that I should get bypass, and five years ago it was a bit more frightening than it is now, because now it's becoming commoner and we see more people going to the bypass today and coming back tomorrow. And happily ok. But five years ago, and also depends on the individual, it was a bit more dramatic, you see."* (Mr N, 63)

> *"Yes, much too frightening, I was telling them that I wanted to go home and see my family. And they said no, that "You can't go home, you're in the ward". And they were asking me what was going on, and I was telling them ... oh ... they said that they didn't understand me "*
>
> (Mr Aj, 132)

Mr M's fears appeared to pertain mostly to the wait for intervention

> *"I thought the doctors were 99% wrong. I got three under 17 at home, they need me, so what are they doing telling me this?"[nieces and nephews]*
> *Int: "They tell you quickly don't they?"*
> *"Yes I was waiting for operation for a while and wonder why they are waiting, waiting, waiting? ..."* (Mr M, 230)

3.4.2.5 Impact on others

This super-ordinate theme comprises the single emergent theme of "Others reactions", which has resulted from the collapsing of a few sub themes which were deemed better presented as a whole. These texts reveal the emotional impact of the men's cardiac problems on family and friends, ranging from high levels of worry to rational and fatalistic stances assumed by loved ones. Descriptions of practical assistance are also presented, as well as some of the men's concerns to not divulge some of their experience out of fear of not receiving support.

Mr M describes his family's reaction of shock at his diagnosis:

> *"I tell my family, and my wife mm could not believe, ... I am walking, feel good!"* (Mr M, 224)

Worry characterises the responses of Mr M and Mr Aj's wives. This seems to be in relation to the services not responding as they think they should, and also in terms of fearing their own ability to cope.

> *"They tell him problem, then nothing happens."*
> *Int: "Yes, so were you very stressed?"*
> *"He worried, me I worried, don't know how long 'til we know"* (Mr M's wife, 271)

> *"Because I take a lot of tablets and um, some of them worryies me as well, and that adds to the problem, and this added to the problem."* (Mr Aj's wife, 56)

Mrs M describes how she copes with the situation:

> *Int: "So, now how do you feel whilst you're waiting for Mr M's news?"*
> *"It's hard to be seeing things."*
> *Int: "Hard? How would you describe?"*
> *"I try not to think about it."*
> *Int: "Is it possible to not think about it? Are there enough distractions to help you not think about it?"*
> *"I do the house and I follow him and speak to the children." [nieces and nephews]*
> (Mrs M, 766)

Mr N describes a different type of reaction from his wife, comprising a more rational and fatalistic position:

> *"A bit worried I suppose but not unduly, because she says, eh, ... it just, I think you know that, at the end of the day, if the time comes, things does happen we've got no control over that, umm, we've got to be lucky in identifying the problem, first you've got to be lucky in the treatment that you get, you've got to be lucky in the surgeon whose going to operate on you, if you've got a good day on the day he's operating, you've got to be lucky on the medicines and the after care, eh have people who do this kind of work properly, eh so there're all these things and all that must sort of come together."*
>
> (Mr N, 741)

And then he considers her reaction if the worst situation did occur, and he did die ...

> *"... and if it doesn't happen there's nothing that you can do. if the surgeon, is some, for whatever reason, is doesn't do the work on the day, there's nothing much I can do, or she can do to come in and rectify it, so eh, so from that point of view she's quite fatalistic in the sense that what's going to happen will happen, so there's no point in worrying about it, but still, still apprehensive, after I go in and come out from these things, but other than that, eh she doesn't in any way add, to make me more worried or something."*
>
> (Mr N 752)

> *"When I was by myself, at first I'd play some of my favourite music and it did help, but after that it seemed that the only thing that helped was talking to someone. At first I was 'phoning anyone at all, you know. We have 6 children, 2 here and the rest are in Nigeria. At first I was on the 'phone crying and crying ...."*
> *Int: "Was that because you thought you might not see them again?"*
> *"Mmm, I was very upset. My wife had to 'phone them back to tell them I was alright, not to worry. The children here are at work, I couldn't ring them at work."*
>
> (Mr Aj, 508)

Mr N discusses feeling unable to discuss some issues with his wife, it seems out of fear that she may not be supportive:

> *"Um, but they don't sort of necessarily talk about it because death is the sort of subject that nobody wants to talk about."*
>
> (Mr N, 495)

Similarly, in some ways, Mr B explains not telling many of his family as there are no lines of communication between them:

> *Int: "How did your family respond to the news of your heart attack?"*
> *"I haven't told them."*
> *Int: "Why's that?"*
> *"Well a) because there's no communication ..."*
> *Int: "You can't talk to them?"*
> *"No, communication wise, I've just cut it off completely, a little with the brother I live with (older) and my sister, other than that it's only through the legal channels that I communicate with the others."* (Mr B, 431)

Other people's reactions:

> *"He kept wanting me to get better" [son].*
> *Int: "And your other relatives?"*
> *"They were all ringing around, 'phoning the hospital and checking I was alright."*
>
> (Mr S, 68)

> *"They try to understand but, but they ask when I go, why do I wait? .. "* (Mr M, 1005)

3.4.3 Immediate post discharge period. *"Trying to get back to normal."*

This period of time responds to the experience the men had when returning to their homes. This master theme comprises four super-ordinate themes that seem to illustrate the main thrust of the men's descriptions of this part of their cardiac journeys. These are "Emotions", "Self appraisal", "Managing change - coping strategies" and "Support from others".

3.4.3.1 Emotions

This super-ordinate theme comprises the two most strongly supported emergent themes of "Depression" and "Fear/ Worry/ Uncertainty." All participants supported at least one of these themes.

Depression: Three of the men mentioned feeling low, depressed and down at times post discharge.

> *"Sometimes it's er worrying, it looks like it, see the problem was there, that how can it suddenly go away type of disappear or situation, er but it's like a a when sometimes when you're er low in spirits it's something you seem to think about."*
> *Int: "Sure."*
> *"But when you're high in spirits it doesn't really matter, and say it's one of those things, and you look on the positive side, that's the only way to do it other than the negative. But um, sometimes it's worrying."* (Mr N, 212)

> *"Yes and after that one week, I was very depressed ... that kind of fear ... "* (Mr Aj, 66)

> *"Well, having had a few problems, physically, I was quite unwell. I had a hernia operation 2 weeks prior to my angioplasty, so that slowed me down with my fitness training, for about 3 months. It is true that after my heart attack I have thought a lot about the limitations it may cause in my life. For example, watching a talk about the Olympics. Although I'm not an athlete, it reminded me that now there are certain limitations to what I can and can't do. My choices are reduced. Sometimes I'll sit and think 'I don't need these physical limitations in my life,' you know, that gets me down for a bit."* (Mr B, 231)

Fear/ worry/ uncertainty:

The men who felt very anxious did so in relation to specific contexts – such as a lack of medical information, to fears of being lone in case of having a health crisis, and lastly fears about physical exertion. Unfortunately the quotes to support these have been used instead to discuss these specific different contexts later on (the contexts provoking anxiety in the men). Nevertheless, below Mr B's worry centres specifically around medication side effects:

> *"Now you see I'm on very high doses, um, and my GP will not change my medication um I'm not reducing it, (coughing) or the drugs to different ones. That is the biggest problem that I have".*
> *Int: "So, so given that's, that is the biggest problem that you have, in terms of your, um ..... how you're coping emotionally ..."*
> *"It's, it's be there from the start, causing a lot of stress in that a) I can't sleep ..... it's a downward spiral ... and this persistent dry cough makes me physically weak and stressed out (coughing) ..."* (Mr B, 81)

Mr M's concerns seemed to revolve around his pain, but mostly his wait for treatment.

> *"So .... and then I went home but had some pain and think, is everything alright?"*

(Mr M, 86)

3.4.3.2 Self appraisal

This super-ordinate theme is supported by text from the "Can't cope alone" and "(Lack of) Confidence" emergent themes, pertaining to the immediate post discharge period. All men provided material to support this super-ordinate theme.

Can't cope alone: The self evaluation of not being able to cope alone seemed difficult for the men; four men describe this.

> *"I had to talk to someone then it was good, if I had no one to talk to, um, you can't ring everyone all the time. When I was by myself, at first I'd play some of my favourite music and it did help, but after that it seemed that the only thing that helped was talking to someone."* (Mr Aj, 506)

Despite Mr M's apparent frustration at his wife's close surveillance of him, he does seem to need to be physically close to her.

> *"My wife, she watches me , she watches me and she worries."*
> *Int: "In case."*
> *"Yes, in case – that's the reason."*
> *Int: "How do you feel about that?"*
> *(laughs) "It can't be good -sometime I think, uh, always coming behind me, checking me and I tell her go away, do your business, and then I watch her because she worries and I try to be alone then but want to be by her."*
> *Int: "That's natural; sounds like you're really concerned." [Directed at Mrs M] "You need to be at the ready . On the other hand you feel that "I need a bit of space"? [Directed at Mr M]*

"Yes.... Mrs M needs me and I need her but sometimes it's not easy." (Mr M, 784)

Mr S describes needing the physical assistance of his son:

Int: "And I remember you saying that you got your son to do much of the shopping?"
"Yeah 'cos I couldn't lift nothing, and got to walk ...

(Mr S, 48)

Mr B 's account reveals the difficulty of not having people to rely on for assistance:

Int: "How did you feel about picking up the pieces and carrying on with your life after you were discharged from the hospital?"
"A little bit isolated, um ..."
Int: "At the start. Isolated in so far ... ?"
"Isolated in that it limited me in my life style, you know, the changes I needed to make."
"Was that difficult?"
"I've managed to do everything bar the smoking." (Mr B, 221)

(Lack of) Confidence: This small emergent theme comprises text from two men who support both ends of the confidence continuum:

"I could call if I needed help ... yes, I'm not on my own, you see? It's when I'm indoors, I used to have no confidence on my own, then I had that fear ... I couldn't sit down, I must stand up. I couldn't concentrate, it didn't last long, maybe 2-3 mins, then it's then I'd have to talk to someone." (Mr Aj, 498)

> *"Um but practically the very next week, er next week, under the doctor's advice I went back on the machine doing 45 minutes walking and I could do the sustained slope with a bit of discomfort er... but I managed to go up without needing to use any of the sprays and things like that, but er the pain was still there, ... but not that I needed to stop or anything, as I had before."*
>
> (Mr N, 183)

Another issue that Mr Aj had to negotiate was that of experiencing flashbacks, which served to heighten his apprehension about managing his situation.

> *By the time I got home I was having flashbacks to those days. Still having these pains, so sore."* (Mr Aj, 243)

3.4.3.3. Managing change - coping strategies

The emergent themes that supported the development of this super-ordinate theme (within the immediate post discharge context) are "Seeking help from GP", "Seeking help from family and friends" and lastly "Distraction". All five men yielded text to develop this super-ordinate theme.

Seeking help from the GP: Mr B mention their experience in this regard:

(Mr Aj quotes used to highlight a lack of medical care despite his efforts to draw on support)

> *"So thinking about the risk factors .... did you smoke?" Nodding*
> *"And does that still happen?"*
> *"Unfortunately yes. Now I'm fully aware of it and I have spoken to rehab and my GP and I've just started a smoking cessation course."*
>
> *(Mr B, 197)*

Seeking help from family and friends: Mr M describes this in relation to financial needs re private medical intervention.

> *"Can't do anything else because it's only the surgeons who can plan so we waiting, waiting. He said we will do it if you pay anytime, quite quick, that's the choice."*
> *Int: "So you still went private?"*
> *"Private."*
> *Int: "But without the insurance?"*
> *"Yes."*
> *Int: "So how did you feel when you thought about the price situation? You used your own savings? So how did you feel, ' if you have the money, you can have the service.?"*
> *"You know we can't pay so I ask my brother if he can do without the money."* (Mr M, 296)

Mr Aj sought help in the form of communication with his children, and then that of his wife to help manage the children's anxiety.

> *"I had to talk to someone then it was good, if I had no one to talk to, um, you can't ring everyone all the time. When I was by myself, at first I'd play some of my favourite music and it did help, but after that it seemed that the only thing that helped was talking to someone. At first I was 'phoning anyone at all, you know. We have 6 children, 2 here and the rest are in Nigeria. At first I was on the 'phone crying and crying ...."* (Mr Aj, 506)

> *"I hated being on my own, you know, I was very, very anxious .... I kept thinking I was going to die, so even if my wife was in the kitchen for more than 10mins I couldn't be on my own, I'd call her or go and find her."* (Mr Aj, 270)

Distraction: This coping strategy seemed to be employed by three of the men.

> *Int: "Mmmm. So would you say then, that you've coped really well?"*
> *"Yeah, yeah, but I've had distractions you see ."* (Mr S, 342)

> *"I think the distractions were maybe in the forefront of my mind all the time."* (Mr S, 360)

> *Int: "So how do you think you'd have coped without the distraction?"*
> *"Not in the same way, completely different, maybe more apprehensive, as I said, I had the distractions, big distractions, so it was that much in my mind, really. But if I didn't have the distractions, I s'pose I'd have focused on it more than I did."* *(Mr S, 404)*

> *"But er when you've got leisure and when you have spare time on hand, um you tend to think of other things you shouldn't be thinking of and then you start dwelling on your problems longer than you should."* (Mr N, 231)

In addition to wanting to distract from his thoughts, Mt Aj also tried to distract from flashbacks:

> *"During this time I couldn't sleep, also I would sit in the sitting room on my own watching TV but for no longer than 5-10 mins. I hated being on my own, you know, I was very, very anxious .... I kept thinking I was going to die, so even if my wife was in the kitchen for more than 10mins I couldn't be on my own, I'd call her or go and find her, I couldn't be on my own for long."* (Mr Aj, 267)

3.4.3.4 Support from others

This is the final super-ordinate theme of the master theme "Immediately post discharge", and is developed from three emergent themes of "Lack of medical support", "Family support" and "Family fears". Some of the text will be familiar to the reader as some has already been sited to support other themes.

Lack of medical support: Mr Aj and Mr M seemed to experience this immediately on discharge from hospital:

> *"But I was very worried because they hadn't told me when I left the hospital, what to expect.... you know, ... I had some pamphlets we had picked up from the ward, and so I read them and then 'phoned the cardiac rehab for advice. Yes and it was then that I spoke to the cardiac rehab nurse who didn't know who I was, I had to tell her about my operation, you know. They said to me I must have slipped through the net."*
>
> (Mr Aj, 251)

> *"And worrying about the pain, worrying about the money and still waiting."*
> *Int: "And it lasted quite a while?"*
> *"Yes yes, a long time, a long time."*
> *Int: "So, how did you cope with this then? How did you hold it together?"*
> *"Can't do anything else because it's only the surgeons who can plan so we waiting, waiting. He said we will do it if you pay anytime, quite quick choice."*
>
> (Mr M, 286)

Family Support, immediately post discharge:

> *"Umm. He [son] was there for me, wouldn't leave me and plus I knew I had to be there for him because if I didn't ... I don't want him to turn out like some of the children on the street, like so much you see now a days. That's what kept me kind a sane, you know."*
>
> (Mr S, 201)

> *"Ah... they are trying to understand and they ask questions but um, really, um they just be nice and tell me I will be ok and then maybe, um ... they ask about somebody else."*
>
> (Mr M, 1092)

Support from others may be influenced by the degree of fear that family members may have regarding the physical health of their loved one.

Family fears: The concerns of the family members may serve to increase the worry of the men as they attempt to adjust to this phase of their recovery.

> *"A bit worried I suppose but not unduly, because she says, eh, ... it just, I think you know that, at the end of the day, if the time comes, things does happen we've got no control over that, umm.."*
>
> (Mr N, 741)

> *"But then, when I was discharged the dressings were still needing to be done and my wife found this difficult, you know? She was worried about doing them."* (Mr Aj, 282)

> *"When I was by myself, at first I'd play some of my favourite music and it did help, but after that it seemed that the only thing that helped was talking to someone. At first I was 'phoning anyone at all, you know. We have 6 children, 2 here and the rest are in Nigeria. At first I was on the 'phone crying and crying ...."*
>
> (Mr Aj, 509)

> *"Mmm I was very upset. My wife had to 'phone them back to tell them I was alright, not to worry."*
>
> (Mr Aj, 519)

> *"They know his problem and still don't explain what can happen."* (Mr M's wife, 510)

> *"Yes, I believe the doctors and then I look at him and I see that he has changed."*
>
> *Int: "I can understand."*
>
> *"And I have to wait, same as him, for letters from the hospital and for the bloods and results."*
>
> *Int: "Mmm"*
>
> *"It is not nice for ... every day to, to umm, to worry what will happen next."*
>
> (Mr M's wife, 751)

3.4.4 Cardiac Rehabilitation: *'Facilitating or hindering positive change?'*

This master theme comprises just one super-ordinate theme of the same name, which contains text material supporting two emergent themes, namely "cardiac rehabilitation - Facilitates positive change" and "Negative aspects of cardiac rehabilitation". All five men had attended a cardiac rehabilitation programme and speaking positively about their experience supported the former theme, whilst two men also discussed negative aspects.

Cardiac rehabilitation facilitates positive change: the most valued aspects of the programme seemed to be the shared experience and understanding that arose from the group and mutual support, followed by information regarding exercise and introducing positive health behaviours.

> *"Yes, maybe because you meet other people there who have some of the same problems, because you think they are peculiar to yourself, you know, it's very helpful to see that most people have the same."*
>
> (Mr Aj, 533)

"Yeah, I mean I was trying to be as practical as possible, um, I wasn't .... I mean, one of the best features of the treatment, I think, is the rehab course ... with other patients. The overwhelming feeling that comes across is ... um ... (coughing) people feeling so scared and isolated and angry, 'Why me?' sort of thing. I didn't feel isolated or angry, and um, as I say, having muscular aches and pains for the last few years" ...
Int: "Mmmm." "I've learnt to cope with pain and to listen to my body."

(Mr B, 159)

"I found it very useful, um especially seeing how others coped quite well, you know, and learning from them – as it usually feels it's only me going through this, so the other's show it's not. Although people are very different, we all have this cardiac problem in common."

(Mr N, 949)

"But um I spent much time with this man, we often got paired up together to do the exercises. He was have difficulties getting his taxi licence thing – he'd failed an exercise test so and we were worried he was pushing himself a bit too much, um yes, so I was helping him, um sort of advising him type thing you know."
Int: "Oh, so you were really supporting him."
"Yes, I s'pose, sort of thing."

(Mr N, 964)

The social support was clearly valued greatly by these men – it seems that they found other peoples similar experiences very validating. The other more practical aspects of the course were also considered very important:

"Well yes, they explained why we have to do regular exercise," (Mr Aj, 540)

"But um I think the CR staff were very helpful, helping us all to get further with exercise, and um, giving us information about the heart you know. Although I'm quite

aware of much of this stuff, because I um I try and read up, you know. I like to know what's going on, sort of thing."

(Mr N 972)

"They put it down to ... bad, um not eating too much processed food, which I was. So eating too much processed food, not looking after yourself, not sleeping properly and stuff like that. And then they said smoking had, um ... contributed to it."
Int: "So they thought that those factors ...."
"Plus stress."
Int: "Plus stress, um but then do you feel it was only the stress?"
"Yeah, ... and not eating properly." (Mr S, 132)

"Yes. It can be, um, making you stronger if, when they same like you."
Int: "It's very shocking when you are diagnosed with a heart problem."
"Yes mmm, more than the heart, it's other things – you want to ask them what they are doing, see if you can do the same." (Mr M, 924)

My GP has been very understanding and is very helpful, despite not wanting to alter my medications. And CR ....."
Int: ... "And CR? The cardiac nurses?"
"They've been very knowledgeable, and helpful, but it does seem that it is only the cardiologist who can alter the medications and/ or their doses, and I think that is my main problem. Nevertheless, I do think that cardiac rehab has been the best aspect of the whole care ... picture....But um, you see, the downward spiral is that the side effects are so severe that I can't sleep ..... (Mr B, 295)

Negative aspects of CR: two men discussed their negative experiences of firstly receiving a lot of information and differing views, and secondly, one man's experience of having his ethnicity directly discussed by another patient on the programme.

> *"Yeah but I think they also scared us because they, they said we couldn't do this and that, so when I had finished I think I didn't want to do too much, I was a bit scared, you know."* (Mr S, 59)

> *"Yeah, yeah as I said the Drs said different things, you know, so I was a bit scared ... I didn't start then, but they were saying we had to do exercise."* (Mr S, 500)

> Int: *"Were there other black men in your group?"*
> *"No"*
> *Int: "Did that effect your experience do you think?"*
> *"Well once, in the beginning, when I was um being assessed i think, there was a white man who said he'd never seen a black man in CR, 'cause he'd been to CR before."*
> *Int: "What did you think then?"*
> *"Well I was unsure how to take that, I thought "Heart disease doesn't differentiate, type thing, you know – it effects everyone"."* (Mr N, 954)

3.4.5 Few months post cardiac event. *"Trying to just get on with life."*

This master theme incorporated the participant's text that related to their life experience at the time of the interview – the time post cardiac event varied for each man, but generally fell to a few months post cardiac event. Four super-ordinate themes made up the content of this master theme, namely that of "How far have I come? - cognitive appraisal", "Getting on - coping strategies", "Support in recovery" and "View of the future".

3.4.5.1 How far have I come? - Cognitive Appraisal

This super-ordinate theme comprised of three emergent themes, the most strongly supported was that of "Self evaluation", followed by "Fears of complication", the "Negative meaning of pain" and lastly, "Positive evaluation of health".

Self evaluation: This theme contains the men's self view in terms of their sense of identity, and evaluation of personal attributes.

Mr Aj discusses the improvement he feels that has occurred over recent months:

> *"Yes, but now it's much, much better – now I don't cry on the 'phone."* (Mr Aj, 525)

> *"Even up to now, but it's much, much better, but I still don't like to be on my own for a long time. it's got much better since seeing my GP who started to sort things out, you know and then the CR nurses. Over time it's much better."* (Mr Aj, 277)

> *"Well ... I have to be organised, and I don't think I'm ready yet, soon we will though. I am getting back my confidence."* (Mr Aj, 552)

Mr S adamantly states his refusal to now not worry about life (since the worry and anger effects of his broken relationship) as well as to believe that the cardiac experience has not altered who he is.

> *"I don't worry about nothing, nothing that will keep my stress levels up."* (Mr S, 158)

> *"Int: Do you think it's changed you?"*
> *"Not really."*
> *"Int: As some people may think that stopping those [habits] makes them feel very differently about themselves."*
> *"I'm the same person."*
> *Int: "So the way you see yourself now, is there a difference compared to how you used to see yourself, before the heart attack?"*
> *"No".* (Mr S, 215)

His self view is one of strength, and disciplined will power to maintain positive health behaviours.

> *"Yeah yeah, 'cos that's the mind isn't it, well all the thinking and worrying, the assuming and presuming, one could send themselves crazy thinking and doing things like that."*
> *Int: "But you didn't go off the rails ..?"*
> *"Yeah, I'm kind of a strong person, yeah"* (Mr S, 187)

> *"Plus, um, I was speaking to someone who said I have a good reason not to smoke, 'cos another guy had a cardiac operation and he smokes, he does everything, he doesn't stop, and he says 'Oh I wish I was like you 'cos you're really good.' And I think maybe, maybe it's about the amount of pain, maybe he's forgotten about the pain he was in. But they said I had a good reason not to, but then if I tell you about how much will power I've got, I said you'll never know how much will power I've got, they said what you mean, I said well I'm not telling you, but the will-power, I got ... at home ... I've got at home some stuff and it just sits there .."* (Mr S, 244)

> *"No. I don't think so, I don't look at it, I just know it's there, and if someone comes around I can offer it to them, but I can't have any, I say 'no it's ok, you enjoy it.' And they look at me funny!"* (Mr S, 280)

> *"Yeah I think I'm playing games with myself. But the big game is I don't touch it. And since I came out of hospital I've had, I've had some there."* (Mr S, 286)

> *"Oh yeah. My whole attitude is better, I can't just sit back and get old, and go down, I've seen other people do that, I won't do that. You know? If I do then that means she's won. The split was really bad but I was obsessed with her, crazy in love, that I didn't care about much else, cos we knew each other from school, you know, and on and off we were together ..."* (Mr S, 530)

Mr N's concern about death seems to have worsened with age and he worries that it may continue to do so if not challenged.

> *"But it wasn't eh how can I say, gave me the same amount of fears then as it does now because then I was young, and it didn't worry me so much, and I didn't have so much time to think about it as now, being 65 and now it's sort of the twilight years. So I think that's the, the difference."* (Mr N, 318)

> *"No no no, it's just like something at the back of the mind, is something there like a back burner, it is there, but eh, but all that I'm trying to do is to see whether I can stop it from getting worse"*
> *Int: "So you're worried that it could just fuel itself."*
> *"Yeah, I'm confident in myself that I, I have the thinking power, and the ability to get over it when I get those kinds of thoughts and feelings."*
> *"Int: Sure, yeah"*
> *"But I just don't want to let it fester and then suddenly it becomes more difficult, and might need some different help and action."* (Mr N, 614)

Mr B believes he has an accurate ability to determine his body's well being, and attributes this knowledge to his osteopath.

> *"I went to see my osteopath this last weekend, and I told her, I said (laughing) "It's thanks to you, I'm sure, had I not listened to my body, and I would have just gone to work and ummm."* (Mr B, 143)

Mr M seems demoralised at not moving forward with his treatment and recovery:

> *"I take the meds and I feel that there is no end, I should be getting back to normal..."*
> *Int:" So how do you feel? Do you have any fear?"*
> *"What can I do, I can't (laughs) ... I'm not, uh, I'm not; uh sometimes it's really unjust."* (Mr M, 392)

> *(laughs) "Yes yes normal life is like err past life."* (Mr M, 1075)

Fears of complications: All five men voiced concern about the possibility of experiencing cardiac complications.

> *"Fairly well .... not quite, I think I'm, in some ways, maybe kidding myself. I'm still, I'm still looking behind my back and thinking what next? You know? What are the limitations, do I know them?"* (Mr B, 273)

> *"Yes it's always in my mind, and still I am waiting, for someone to say that sometimes after the test it will be alright, I know somebody else with the same and the pain got worse I don't want to feel like that and I want the pain to go see, sometime!"* (Mr M, 459)

Mr B is concerned ongoing stressors could affect his heart.

> *"Having analysed myself, it must be said that yes, I've got the confidence to cope with it. But if that was the final trigger ....um .. how much more can my heart take? You know, will it be affected again?"* (Mr B, 326)

Mr M believes that his ongoing waiting for treatment is detrimental to his cardiac function.

> *"You know? Thing go on in my mind, something is supposed to have happened and I worry it won't happen soon."*
> *Int: "You mean now. Before – you needed..."*
> *"Something to happen quickly."*
> *Int: "And that you needed quick intervention. So then that sounds like you feel what he said, that it would be something quick and easy, but it dragged on."*
> *"Yes I have been told only some chances of surviving, if I hadn't been waiting for my doctor, nobody came."*
> *Int: "So does that mean you wonder if somebody had arrived on time there would be less damage to your heart?"*
> *"Yes Yes."* (Mr M, 468)

As Mr Aj has experienced complications with his recent cardiac event, he is apprehensive about further problems, and associates pain with the possibility of such.

> *"... before the operation they told me about possible complications, the surgeon said that in about 3% of cases there are complications and the surgery may not help, and not be successful, and then when I had the complications with the blood clotting problem, and others, I thought maybe I'll get an infection and cause more complications, and the surgery, you know, won't be successful ...... Sometimes I think of the pain .... now, as further complications."* (Mr Aj, 381)

Previous surgical complications unrelated to his cardiac function, have caused Mr S to believe he is unlucky regarding surgical procedures, and likely to suffer complications. More detailed quotes have been used to support his distrust in systems theme, hense not possible to elaborate here, but these do highlight his concerns.

> *"They (Drs) cut my main artery, and then I had a haematoma, and that was removed .. "*
>
> (Mr S, 372)

> *"I'm unlucky with them, you know. If they say there are 1500:1 likelihood of all being ok, I'll be that 1 it could happen to."*
>
> (Mr S, 384)

Mr N voices difficulty believing a medical problem can be completely resolved.

> *"Sometimes it's er worrying, it looks like it see the problem was there, that how can it suddenly go away type of, disappear, or situation."* (Mr N, 212)

> *"Sometimes when I have a a, a consultant's appointment for something, just a couple of days before that I think about it, is he going to pick something up that's going to be terminal (laughing)."* (Mr N, 818)

Negative meaning of pain: Four men discussed their tendency to interpret pain as signifying a problem.

> *"... and then when I had the complications with the blood clotting problem, and others, I thought maybe I'll get an infection and cause more complications, and the surgery, you know, won't be successful. ...... Sometimes I think of the pain .... now, as further complications."* (Mr Aj, 325)

Mr Aj and Mr N accounts reveals the importance of having an explanation for the pain.

> *"I don't know why this pain is here now. It's changed it's position now, from the left side on discharge from the hospital, to now the right side, and I don't know why."* (Mr Aj, 370)

> *"But um so er, and after that things are ok but I still had some pain when I was climbing, and and I had a follow-up appointment with Dr X after this, and he said quite often it does happen because er traditionally you've got um .. arteries like branches going all over the place, and although there might be a blockage in the in the middle somewhere, of the main artery, my .."*
> *Int: "The collaterals."*
> *"My collaterals were all working quite well before, but now when they put the stent in, that might have blanked out some of the collaterals, um"*
> (Mr N, 143)

> *"I s'pose that really before the stent operation, eh any aches and pains used to sort of make me feel or wonder if there was something serious, umm, and quite often I'd um, um I s'pose it's just a worry of illness."* (Mr N, 806)

Pain can also be considered a diagnostic criteria:

> *"You see there's another part, in that when filling in the little boxes, you know, and thinking about a cardiac history in the family, when looking at reasons for cardiac problems, despite not feeling any pain in the heart, that's what ... I remember when filling in the little boxes that 5 out of 6 are 'yes', but I didn't have any pain."*
> (Mr B, 190)

Pain can also be directly associated to medication:

> *"Yes, I missed the one night, I was tired and fell asleep and missed the medicine and the next day I thought I haven't taken them the way the doctor said."*
> *Int: "Ah, ok – so were you worried?"*
> *"At first I didn't think the heart would blew up and then I got the pain 3 times when I was lifting things."* *(Mr M, 1169)*

Positive evaluation of health: four of the men supported this final emergent theme:

> *"With the operation now I'm much better. My wife says I'm a little slow, but we see it as exercise. I'm better now, I'm sure I'll get there, I'm ok."* (Mr Aj, 408)

> *"Yeah yeah I've done some big changes in the last few months."*
> *Int: "So when you think about these do you think you've done pretty well? You've achieved a lot?"*
> *"Yeah. I think I've done well, I've done well. I could have ended up in the mental house, so I've done well.."* (Mr S, 167)

> *"Yeah, my daily routine is completely different."*
> *Int: "Despite this, as a person you don't see yourself as having changed?"*
> *"No, just a bit more angry, to do with the relationship."* (Mr S, 425)

> *"Yes, I think, although I've had all these problems health wise I've been reasonably fit."* (Mr N, 491)

Some of the men have made specific changes which they view as evidence of positive health change.

> *"I don't really miss smoking, yeah I have done well, in the smoking department, in the exercise department. I've done well all around, yeah"* (Mr S, 440)

> *"Yes, I've just felt very sad, in that 'how is it going to limit my enjoyment of life?' I must give up the smoking. I guess I'm addicted to the nicotine. I'm ashamed of it ... (laughter) I've been able to cut out tea and coffee, I'm not a control freak as such, and I think this stems from my osteopath who has really taught me a more holistic approach to life, I'm pretty healthy, . I've learnt to live a clean life style besides the smoking."* (Mr B, 253)

3.4.5.2 Getting on - coping strategies

This super-ordinate theme comprises three main emergent themes, namely "Avoidance", "Dependency" and "Behavioural change", and discusses the ways the men sought to manage their lives with regard to their attempts to 'just get on with life'.

Avoidance: for three of the four men who provided text to support this theme, their tendency towards avoidance had significantly reduced, as Mr Aj illustrates this regarding his increased tolerance to view the News, and imminent plans to return to taking coach trips:

> *"At night I watch the sports channel on TV and the Christian channel, and now a little of the News, now. Before I couldn't watch the News because, at all, because it was all about the Iraq war .... Seeing so many dead, so many people killed ..... and I used to think of that fear ...."* (Mr Aj, 383)

Mr S describes not being limited by his memory of the cardiac event:

> *"How do I cope with it now? I just get on with it, just get on with life, get on with it. I still think of it now and again, but it's not a big thing, just when I take my tablets, twice a day. That's about it really."* (Mr S, 415)

Mr N recounts his experiences of returning to physical activity quickly after discharge, and maintaining his exercise programme.

> *"Um but practically the very next week, er next week, under the doctor's advice I went back on the machine doing 45minutes walking, and I could do the sustained slope with a bit of discomfort er but I managed to go up without needing to use any of the spays and things like that, but er the pain was still there but not that I needed to stop or anything, as I had before."* (Mr N, 183)

However, Mr M who was still awaiting some treatment, reported active avoidance of some activity:

> *"Yes... I can walk for one bit and then I worry it's too much."*
> *Int:" So now you are waiting, and it's playing on your mind – how does it influence your day to day life now?"*
> *"I want to do some other things but then I have to be in hospital, waiting for the doctor and sometimes I have to go often – last Wednesday, so we don't have time ..."*
> (Mr M, 183)

Dependency: Mr S and Mr Aj discuss their stopping or reduction in their earlier use of nicotine and sleeping tablets.

> *"Sleeping tablets were quite useful then, when I was discharged, but now I don't take them all the time, I worry that I might become addicted to them. But I don't need them all the time now anyway."* *(Mr Aj, 391)*

> *Int: "So you sort of felt a bit mixed up? But that didn't last that long did it? I mean in so far as when did you start doing the shopping and carrying things?"*
> *Mr S "In 2-3 months"* (Mr S, 52)

Behavioural change: four of the men reported experiencing specific positive health behavioural changes, whilst Mr M described frustration at not being able to engage in such due to his having to wait for further treatment .

> *"I don't eat processed foods anymore."* (Mr S, 143)

> *"The biggest change, the biggest change is not smoking - cigs and dope - and that I've cut out the alcohol every day, drinking alcohol ...."* (Mr S, 212)

> *"Well ... I have to be organised, and I don't think I'm ready yet, soon we will though. I am getting back my confidence. And also to do some coach trips, we used to do a lot of those too. Oh yes and also, I have still stopped smoking, that was, I stopped just before the surgery, but I am still not smoking. The CR nurses are very pleased with that!"*
> (Mr Aj, 502)

Mr B describes his belief that the current amount of family feud stress is halting his plan to give up smoking at the moment.

> *" ... I've just started a smoking cessation course."*

> *Int: "Ok"*
> *"But I think for the highly stressful situation that I am in at the moment, it is the main reason for my being unable to give up."* [Regarding family feud]
> *Int: "Mmmm, so it sounds as if maybe it would be more stressful to give up now?"*
> *"Well, I've cut it down to a bear minimum, I was smoking 6 until Sunday, 6 in a 24hour period."*
> *Int: "And what was it before?"*
> *"About 15."*
> *Int: "For how long?"*
> *"About maybe 27years."* (Mr B, 202)

> *Int: "At the start, isolated in so far ...?"*
> *"Isolated in that it limited me in my life style, you know, the changes I needed to make."*
> *Int: "Was that difficult?"*
> *"I've managed to do everything bar the smoking."* (Mr B, 232)

Mr N describes some of his activities that he shares with his wife:

> *"The yoga, one yoga we do together, and eh another yoga that is we do separately, and Tai Chi we do together, so um, just for the convenience factor. But we take eh, sort of a, try to do different things, because our interests are slightly different, because I'm more of a ... external person. I like to walk about and ... external person. I like to walk about and go about, rather than sit at home, she's quite happy indoors, all the time. Um, but I'm, I get frustrated if I'm indoors for a long time so I tend to potter around in the garden, go for walks and things like that."* (Mr N, 605)

3.4.5.3 Support in recovery

This super-ordinate theme comprises the experience of support during the 'Few months post cardiac event' period, and is supported by the two emergent themes of "Family and friend support of positive health behaviours", and the "Medical system."

Family and friend support of positive health behaviours: three of the men provided comments describing the support they received in maintaining their behavioural changes:

> *"... I walk for 30mins every day now with my wife, and will start at the gym soon.."*
> (Mr Aj, 540)

> *"Plus, um, I was speaking to someone who said I have a good reason not to smoke, 'cos another guy had a cardiac operation and he smokes, he does everything, he doesn't stop, and he says 'Oh I wish I was like you 'cos you're really good.' And I think maybe, maybe it's about the amount of pain, maybe he's forgotten about the pain he was in. But they said I had a good reason not to, but then if I tell you about how much will power I've got, I said you'll never know how much will power I've got, they said what you mean, I said well I'm not telling you, but the will-power, I got ... at home ... I've got at home some stuff and it just sits there ..."* (Mr S, 244)

> *"... the big one says I'm good, the little one, just accepts me for who I am.[two sons] The big one says 'you're really good, you know, you're really good, I couldn't do that.'"* (Mr S, 296)
> *"Yeah, he says I'm really good because he knows I used to puff a lot,"* (Mr S, 303)

> *"Some we go [together], not all, probably have some of our own space so to speak, the yoga, one yoga we do together, and eh another yoga that is we do separately, and Tai*

> *Chi we do together, so um, just for the convenience factor. But we take eh, sort of a, try to do different things, because our interests are slightly different,."* (Mr N, 931)

Mr N also describes his belief that some concerns, if verbalised, will not be understood and thus not elicit support from his wife, as a result he does not speak about his concerns about death.

> *"Um, but they don't sort of necessarily talk about it because death is the sort of subject that nobody wants to talk about."*

However if it is spoken about it seems to objectified. He also has concerns that voicing fears without receiving support can exacerbate the fear.

> *"Um, if we do talk about it it's with or by philosophers and um sages, or people like that, they are on a different plane, eh, so so you don't have people like me talking to another person like me, about what it is and what or why, so I think that seems to add to the problem, eh, and also at a domestic level, it's not something that you want to discuss saying 'I'm feeling frightened about this', and there's no body to hold your hand, and I know I read somewhere which said that sometimes if you have any phobias and fears that if you find there is no empathy or sympathy then it becomes more pronounced and thing, but eh, on the other hand eh it can have the other effect that somebody getting sympathy can then want more and more wanting sympathy."* (Mr N, 495)

> *"It's quite difficult to find out if it is a common problem. I think it's a problem, is that, if you're not worried, then you don't understand why that other person is worried about, 'What's there to worry about?' They can't understand what you're worrying about, and think they should snap out of it as there is nothing to worry about, but think outside those lines." (Mr N, 784)*

Medical system: Mr B and Mr Aj describe how helpful the GP and CR have been, and Mr N discusses how he found follow-up medical explanations from the Cardiac consultants to be very useful:

> *"Well I'm still off work, mostly because of the sleeping problem, but soon I will return part time. I'm looking forward to that, to get back in to the old routine. My GP has been very understanding and is very helpful, despite not wanting to alter my medications. And CR ... "*
> *Int: ... "And CR? The cardiac nurses?"*
> *"They've been very knowledgeable, and helpful."* (Mr B, 295)

> *"Even up to now, but it's much, much better, but I still don't like to be on my own for a long time. it's got much better since seeing my GP who started to sort things out, you know and then the CR nurses. Over time it's much better."* (Mr Aj, 277)

> *"My collaterals were all working quite well before, but now when they put the stent in, that might have blanked out some of the collaterals, um"*
> *Int: "Because it takes the big flow ... ?"*
> *"No be because the stent hides it so to spe, so he said that might be the reason why the pain is still there, or it might not necessarily be the same thing but is a good reason now. So he said um, come back in six months time and then if things, maybe they'll revisit the thing and the situation and see what, what needs to be done. So at the moment I've got another treadmill test geared up for soon and then subsequently I'll see him and then, then we'll take it from there."* (Mr N, 143)

Two men, however, provide text that illustrate difficulties with the medical system:

> *Int: "Right, so when do you next see your cardiologist?"*
> *"Interesting question! Because I was meant to see him in the coming week, but the date that they have in my records is a Saturday, which must be impossible, so I'm s'posed to be seeing him the last week of this month and they will confirm when it is on Thursday. You see the date I have in my records is the 28th August which is a Saturday, the last week of August."* (Mr B, 72)

Mr M and his wife discuss their difficulty in understanding delays in his treatment:

> *"They tell him problem then nothing happens."*
> *Int: "Yes, so were you very stressed?"*
> *"He worried, Me I worried, don't know how long til we know."* (Mr M's wife, 241)

> *"I can't understand, why the waiting ...."*
> *Int: "I think from my experience, it makes it difficult when it is inexplicable, if it can be explained it can help us know what to do."*
> *"We want to know what the end is, what we have to think about. We want it over but we want to understand it"* (Mr M, 1118)

3.4.5.4 View of the future

This is the final super-ordinate theme of this "Few months post cardiac event" master theme. It comprises two emergent themes – "Optimism" and "Plans for the future".

Optimism: All the men, despite their various experiences, voiced optimism when considering their view of the future.

> *"You've just got to keep, ... well. They said as long as I keep exercising and keeping the heart at the right heart rate, nothing should really happen, and you're eating properly.*
> (Mr S, 447)

> *"With the operation now I'm much better. My wife says I'm a little slow, but we see it as exercise. I'm better now, I'm sure I'll get there, I'm ok."* (Mr Aj, 407)

> *"Yeah, once my foot, once I get my foot back in working order, I'll be fine again."*
> (Mr S, 340)

Mr S's appraisal of life after MI is one of no restriction:

> *"I s'pose I'll just put it down to just like any kind of accident, say like getting knocked down in the street, think of it like it's just a part of life."*
> *Int: "Mmm."*
> *"'cos actually when people have had a heart attack they go on and climb mountains and so on, don't they!"* (Mr S, 397)

And Mr B comments on looking forward to returning to work:

> *"Well I'm still off work, mostly because of the sleeping problem, but soon I will return part time. I'm looking forward to that, to get back in to the old routine. My GP has been very understanding and is very helpful, despite not wanting to alter my medications!"* (Mr B, 285)

Mr N describes his view that his cardiac treatment has been effective, however if more is required in the future, he believes that technical advancement would resolve any problems easily:

> *"So hopefully, touch wood, um, I think there's some people, how they view things that if things happen to the, to the bad, so to speak, then it could be for reasons other than the heart. So many other things can take place in between. So, so I mean there's an equal chance now, um so from that point of view the prognosis is good that er, but again in 2 years time technology may have improved so fast, so rapidly that things may be easier to, to accommodate everything."* (Mr N, 175)

> *"Yes, no they don't say I might not need surgery at all, but, but the chances are that I may not, but things can change, for example the, I mean, they say that a stent can be done again and again, say if in six months time the Dr finds that a, if it's still blocked up or something and they re-stent it or whatever, and there is no problem with that one, but er we just hoping that that would be the case."* (Mr N, 202)

Despite his situation being different to the other men, Mr M still voiced optimism in the efficacy of his prospective treatment:

> *"Well I think that because no one is rushing, sort of thing, yes because ah, it has not happened then I have a good chance it's ok, will be ok."* (Mr M, 1021)

> *Int: "Do you have any expectations?"*
> *"... I believe, I think my heart can be nearly normal I believe."* (Mr M, 1062)

> *"They said they have done this before. It's a normal thing and it will take the pain away and help my heart to work properly."* (Mr M, 1208)

Plans for the future: Three men explicitly referred to future plans. Mr Aj and Mr S describe these:

> *… , and will start at the gym soon."* (Mr Aj, 540)

> *" I am getting back my confidence. And also to do some coach trips, we used to do a lot of those too."* (Mr Aj, 552)

> *"Well I'm saving much more money than I did, having stopped smoking, and I'm thinking to go to the America again next year, and not thinking, I AM going!"*
> *Int: "Oh, right. Are you going to take your son?"*
> *"Yes!"* (Mr S, 446)

Mr N explains how sometimes his fear of death interferes with his view of the future:

> *"So that sometimes colours it [fear of death] for example, eh ... if I was to say, we'll make a proper plan and we'll build a house, to have 6 mths to live in, so sometimes I think what's the point, in making things, if something was to happen to me, eh so in other words, that type of thing."* (Mr N, 842)

3.4.6 Causality

This super-ordinate theme became a master theme, and reveals the men's beliefs about the origin of their cardiac problems. It comprises two emergent themes, namely "Health behaviours/ life style" and "Genetics".

Health bahviours / life style: Four of the men discussed their causal views. Mr S and Mr B primarily attribute their MIs to stress:

> *"I think that what happened, happened through stress."*
> *Int: " So you feel ..... that's how you understand it?"*
> *"Yes."*
> *Int: "So if you hadn't had the stress ...."*
> *"I wouldn't have had the heart attack."* (Mr S, 94)

> *Int: "So did the heart attack cause the split?"*
> *"No, did it contribute to it, or did it happen because of the split? Yeah I think it happened* ***because*** *of the split. It didn't contribute to it."* (Mr S, 430)

> *"No I think, um, I went through a very highly stressful time for the last 2 years, emotionally and particularly with problems with my mother and family. I've found this very stressful, and I think my GP got the feeling that that stress was the last straw."*
> (Mr B, 173)

> *"Having analysed myself, it must be said that yes, I've got the confidence to cope with it. But if that was the final trigger ....um .. how much more can my heart take? You know, will it be affected again?"* (Mr B, 315)

Mr S also considered diet to be an influencing factor:

> *"They put it down to ... bad, um not eating too much processed food, which I was. So eating too much processed food, not looking after yourself, not sleeping properly and stuff like that. And then they said smoking had, um ... contributed to it."*
> *Int: "So they thought that those factors ...."*
> *"Plus stress."*
> *Int: "Plus stress, um but then do you feel it was only the stress?"*
> *"Yeah, ... and not eating properly"* (Mr S, 132)

> *"Yeah, 'cos processed food has got so much salt in it. You eat that every day of the week, and you don't look after yourself, you must become sick."* (Mr S, 145)

Mr Aj believed that the main reason for his heart attack was smoking:

> *"Oh yes and also, I have still stopped smoking, that was, I stopped just before the surgery, but I am still not smoking. The CR nurses are very pleased with that!"* (Mr Aj, 556)

Mr S supports both a fatalistic view of his cardiac health, as well as that of having some agency over his condition.

> *"No, no, if something happens to my heart, it happens. You've just got to keep,... well. They said as long as I keep exercising and keeping the heart at the right heart rate, nothing should really happen, and you're eating properly. But if it happens, it happens ... you can't change it." (Mr S, 315)*

Genetics: Two men acknowledged a belief in their inherited predisposition to their cardiac illnesses:

> *" ... that Dr who I went to see, used to on a yearly basis, was happened to be in some research scheme or something and he said look, these three are common factors which sometimes go hand in hand, since you've got the first two ..."* (Mr N, 39)

> *"My father, yes there is unfortunately (coughing). My father had a heart attack in 1995 and died of prostate cancer in 1997. Um, my older brother ... had some sort of cardiac*

> *complaint, but, but I don't quite know what, (cough) um ... and one of my younger brothers is also a diabetic. So there is a cardiac history in the family."* (Mr B, 180)

3.5 Summary of super-ordinate themes

The interviews with the men generated an account of their cardiac experiences that followed a chronological sequence of events (from the onset of initial symptoms through to their coping at the time of the interview) and provided the master theme structure of the study. The following is a brief outline of the main points of each super-ordinate theme, which are then discussed more fully in relation to the study aims in the next chapter.

Pre Cardiac event

This master category reflects aspects of the life experience of the participants, prior to their cardiac event. The main features of their accounts seemed to comprise the three super-ordinate themes of ***Current other stressors***, ***Degree of trust in medical and social systems*** and ***Mood state***.

Current other stressors: All participants reported experiencing stressors prior to their cardiac event. These fell into the category of *Family and Relationship stress* and *Other stressors*. Four of the men discussed their concerns regarding family difficulties, this included concern about the long term futures of children and grandchildren, the ill health of family members, and the lack of support resulting from the sudden ending of a long term relationship, and a long term family feud. For two men *Other stressors* included a fear of death and financial worries.

Degree of trust in medical and social systems: All participants provided text that indicated either a degree of trust or distrust in these societal systems, this text was displayed within three sub-themes. In *Past medical experience* the men who had experienced a previous MI reported mostly positive experiences. This seemed to relate to the provision of clear explanations of treatments, adequate follow-up care, and thorough monitoring of health. One man had experienced complications regarding relatively non-complicated, non-cardiac surgery in the past, which caused a degree of weariness when experiencing his MI. Under the *Suspicious of general systems* theme, one man discussed general mistrust of the police system, as well as of psychology. The sub-theme of *Suspicious of medical systems* was supported by one man's belief that earlier problematic surgery indicated his being 'unlucky' regarding surgical procedures, and also by another man's earlier experience of differing medical opinions about his condition. Lastly, this theme was also supported by a man's belief that hospital's fear potential patient litigation, and that this can determine initial diagnosis and treatment.

Mood State: four of the men described their pre cardiac event mood state explicitly, and their text fell into the emergent themes of *Anxiety* and *Anger*. Those men of the former category understood their anxiety as being either a chronic state or resulting from health concerns. Those experiencing anger explained this in relation to the conflictual ending of a relationship, and for another man the experience of a long running family dispute.

Initial impact of cardiac event. *"I just couldn't deal with it in my head."*

This next master theme comprises the following super-ordinate themes: ***Hospital experience***, ***Challenging sense of self***, ***Coping style***, ***Emotional response*** and ***Impact on others***.

Hospital experience: All participants described aspects of their hospital experience, which included *Problems with medical information, Physical experience* and *Isolation from help.* Regarding the former theme, the main problems included medical indecision about diagnosis and treatment, being given too much information and participant misunderstanding of medical information. The men described the physical aspects of their cardiac event mostly in terms of the level of pain experienced, where the presence or absence was perceived as a measure of condition severity. Experiences also entailed sequential accounts of departmental changes and interactions with different members of staff. One man's account entailed descriptions of significant cardiac complications. The *Isolation from help* theme was supported by two men who had difficulty in communicating with the staff, significantly increasing misunderstandings on both sides.

Challenging sense of self: the participant support for this super-ordinate theme fell into three sub-themes, namely that of *Hopelessness and dependency, Belief they will die* and *Confusion.* For four out of five of the men the cardiac experience seemed to induce a sense of helplessness and dependency, as a result of physical limitation as well as that imposed by the medical system. Two of the men described fearing they were going to die. Three of the men expressed a high degree of confusion when trying to make sense of their cardiac situation, being then heightened by the staff not providing clarity about their care.

Coping style: three main methods of coping seemed to be employed by the men to cope with the initial impact of their cardiac event. The men either seemed to *Ask questions, Express intense* emotions or engage in *Denial and disbelief.* Asking questions was directed to nurses and Consultants, mostly in an attempt to gain clarity about confusing information. Regarding the expression of intense emotions, although both anxiety and depression were characteristic of the men's emotional response, only one participant experienced expressing a high level of emotion. However, four of the men described denial and disbelief at their diagnosis. This seemed to be in relation to believing they were too young to have heart disease, or too well, or that the cardiac event was unpredictable and so totally unexpected.

Emotional response: two categories of emotional response to the men's cardiac event were identified, that of *Depression* and of *Fear* – the latter was the most supported. The main fears that the men described revolved around misunderstandings of the cardiac problem, the suddenness of the event, and for one man the wait for ongoing treatment intervention. Depression for one man was experienced alongside fear, and they were both expressed with much crying. His main concern was not being understood, as well as himself not understanding his condition and treatment, despite his ability to speak good English.

Impact on others

This super-ordinate theme comprises the single emergent theme of *Others reaction.* This is supported by text revealing the emotional impact of all the men's cardiac problems on family and friends. This ranged from high levels of worry and shock where the men were considered to need very close monitoring, through to more rational and fatalistic positions assumed by family members, implying less active support being necessary. Two of the men felt unable to discuss some, if not all, of their cardiac experiences and concerns. The reasons range from fearing a lack of understanding to not having an open line of communication.

Immediately post discharge. *"Trying to get back to normal."*

This master theme comprises four super-ordinate themes, ***Emotions, Self appraisal, Managing change - coping strategies*** and ***Support from others***.

Emotions: two main emergent themes captured the emotional reactions verbalised by all of the men, as they returned to their homes and lives after their hospital admission. These sub-themes were *Depression* and *Fear, worry and uncertainty*. The men who complained of feeling low and depressed associated this with beliefs of recurrence, and perceived permanent physical limitations. Those expressing fears were concerned about a lack of follow up information, fears about being alone and experiencing further symptoms, concern about experiencing pain, fears about the negative effects of physical exertion, and uncertainty about medication side-effects.

Self appraisal: The emergent themes supporting this super-ordinate theme are *Can't cope alone* and *(Lack of) Confidence.* All the men provided text to support these themes. Four men supported the self evaluation of not being able to cope alone, demonstrated by their descriptions of needing to be near their partners or in contact with family members, and needing the assistance of family members with physical tasks. There is support for both ends of the confidence continuum with one man stating that when alone he felt little confidence to do the things he used to, as this tied in with his experience of flashbacks to the hospital experience whilst another participant described reengaging in his exercise regime the following week after discharge.

Managing change - coping strategies: A number of different coping methods were discussed by all five men. The three dominant themes were *Seeking help from the GP, Seeking help from family and friends*, and *Distraction.* The GP was seen to have helped one man link into the health service after he had 'fallen through the net', and another man to help stop smoking. Regarding the seeking of support from family, one man describes actively seeking his wife's presence as well as regularly telephoning family members, whilst another approached his brother for money to get private health care. Distraction was considered a useful coping strategy by three of the men; this took the form of focusing on other stressors, work, leisure activities and TV.

Support from others: This is developed from the three emergent themes of *Lack of medical support, Family support*, and *Family fears.* Two of the men experienced the former as soon as they were discharged, one was told that he had 'fallen through the net' as no follow-up care had been organised for him, and the other began a long wait for medical intervention. Regarding *Family support*, one of the men described his son's support as keeping him sane, whilst another felt that that which was offered by friends was just reassurance. The men went on to describe some of the *Family fears* associated with their going home post discharge. Examples of such included partners worrying about performing wound dressings, children (of adult age) receiving intensely emotional telephone calls, partners waiting for medical treatment for the men, and fearing that complications could occur if their partner is not observed closely.

Cardiac Rehabilitation. *"Facilitating or hindering positive change?"*

This master theme is also a super-ordinate theme that is created from two emergent themes, namely *Facilitates positive change*, and *Negative aspects of cardiac rehabilitation.* All the men had attended cardiac rehabilitation, and spoke positively about their experience. Two of the men also spoke of negative aspects of this experience. The most valued features of cardiac rehabilitation seemed to be the shared experience and mutual support, followed by information regarding exercise and positive health behaviours (especially diet and smoking). The two men who discussed their negative experience of cardiac rehabilitation did so with reference to one firstly being 'scared' to not overdo activities which resulted in him delaying the start of his exercise programme; secondly an experience of a white attendee remarking that he had not seen a Black man attend cardiac rehabilitation before, leaving the participant unsure about continuing his attendance. Interestingly, he chose to stay, and as their programme continued, describes these two men becoming very supportive of each other.

Few months post cardiac event. *"Trying to just get on with life."*

This master theme comprises the men's experiences as they were at the time of the interview; because for all five men this was a few months post their cardiac event, albeit varying a little per participant. There are four super-ordinate themes that make up this master theme, and they are ***How far have I come? -cognitive appraisal, Getting on - coping strategies, Support in recovery*** and ***View of the future.***

How far have I come? - cognitive appraisal: Three emergent themes created this super-ordinate theme, namely *Self evaluation, Fears of complications*, the *Negative meaning of* *pain* and *Positive evaluation of health*.. The self evaluation theme entails the self beliefs and personal attributes that the men perceive of themselves. Some positive examples include feeling much better, that confidence levels are improving, that they are able to control their stress levels, and being a strong personality with high levels of will power. One participant believed that getting older was exacerbating his fear of death, and one man discussed feeling demoralised at not moving forward (delays with his treatment intervention). Fears of complications were discussed by all the men, including concerns that ongoing stressors could still have a negative impact, that previous experiences of complications could recur, and voicing doubts that medical problems can ever be fully resolved. Four men discussed their tendency to interpret pain as signifying a problem, and consequently seeking an adequate explanation for the pain, as well as associating pain with medication side effects. Four men supported the theme of Positive health evaluation with self congratulatory statements regarding their progress in accomplishing health behavioural changes, as well as some men discussing specific changes in life style.

Getting on - coping strategies: This super-ordinate theme comprises three main emergent themes, namely *Avoidance, Dependency* and *Behavioural change*, and discusses the ways the men sought to manage their lives with regard to their attempts to 'try to just get on with life'. Three men revealed a significant reduction in their tendency towards avoidance, for instance watching TV more independently, feeling more confident, and continuing with an exercise regime. However, one man was becoming more avoidant of activities whilst he awaits medical treatment. Regarding dependency, two participants discussed their respective reduction and stopping of smoking and sleeping tablets. Four of the men reported experiencing specific positive health behavioural changes, whilst one described frustration at not being able to engage in such due to his having to wait for further treatment. The positive changes include dietary changes, stopping smoking of cigarettes and cannabis, adopting exercise regimes, and carrying out activities with partners.

Support in recovery: this super-ordinate theme is created by the two emergent themes of *Family and friend support of positive health behaviours*, and the *Medical system.* Examples of the support of positive health behaviours includes accompanying the men walking and going to the gym, friends who are envious of the men's ability to stop smoking, and attending activities together. One of the men voiced concern, that if verbalised, some needs may not be understood and thus not elicit support from his wife. A couple of the men voiced how helpful the GP , CR and the medical system had been, with regard to understanding the need to return to work slowly, for connecting one of the men back into the medical service, and for providing adequate explanations for ongoing pain. Conversely, one of the men still felt let down by the services and had difficulty understanding why he was waiting for treatment.

View of the future: this final super-ordinate theme of this master theme comprises two emergent themes, *Optimism* and *Plans for the future.* All of the men, despite their various cardiac experiences, all voiced an optimistic view of their future. This was with regard to their increased ability to exercise, their belief that if they are compliant with the health advice that their health should be alright, voicing enthusiasm to return to work, and that having a cardiac history should not impose restrictions physically. One man's optimism related to his belief that technical advances in cardiac treatments, means that future cardiac complications will probably be treated more easily. The man still requiring ongoing cardiac treatment was also optimistic about the probable efficacy of his treatment, when he obtains it. Regarding the men's plans for the future, some voiced plans to expand exercise regimes, to also re-engage with activities that were enjoyed pre cardiac event, and to travel overseas. However, for one of the men, his fears of death occasionally lead him to question the point of making future plans.

Causality

This final master theme comprises one super-ordinate theme which itself is created by two emergent themes, these are *Health behaviours/ life style*, and *Genetics.* Four of the men had views on the cause of their cardiac problems, and these fell mostly into the former emergent theme. Examples of the men's beliefs regarding causative health behaviours were stress, diet, and smoking as well as some concurrently held fatalistic ideas. Beliefs in their inherited predisposition to cardiac disease were held by two men who discussed their family cardiac history.

Chapter 4

Analysis and discussion

This discussion chapter will be presented in two sections. The first section will discuss the study's findings in relation to the initial aims and with regard to previous research outlined in the introduction, as well as other relevant literature. A diagrammatic representation of the findings will then be presented at the end of this section. The second section highlights some methodological problems and limitations of the study.

4.1 Discussion of the findings

4.1.1 Findings in relation to study aims and previous research

The findings of this study are useful given that the majority of cardiac rehabilitation research focuses predominantly on white participants (Wild, 1998), and the evidence from a few sources suggest that the uptake of cardiac rehabilitation services is disproportionately low in Black African patients (Lane et al 2000, Cannistra et al, 1995). The overall aim of the study was to explore the men's psychological adjustment after their heart attacks, to help determine if it may be contributing to reluctance in taking up support services (cardiac rehabilitation and psychological support). The significant difficulties I had in recruiting non cardiac rehabilitation attendees unfortunately meant that only attendees volunteered to take part in the study. An exploration into their adjustment experience was nevertheless considered highly valuable in light of the sparse ethnicity research in chronic illness (Stanton, Revenson and Tennen, 2007), allowing the experiences of these men to be situated within the adjustment literature.

The more specific aims of the study were to firstly explore how the participants *cognitively appraised* the cardiac event and its impact upon their sense of self (beliefs about self, others, the world in general and the future), on their behaviour (e.g. smoking, exercise) and on their quality of life (work, social activity and relationships). The study's second aim was to investigate how the men *coped* with their cardiac experience in terms of the specific strategies they employed and evaluate how helpful these were. The results seemed to show that across the chronological phases of their adjustment journeys these men's reactions incorporated various forms of ongoing self and myocardial infarction appraisal, prompting a variety of coping strategies. It seemed that in each of the chapters of their adjustment journeys the men faced certain processing tasks or experiences, which then characterised that chapter. Consequently, due to its dominance in their stories, the results have been assembled around a chronological structure.

Towards the end of the study I was encouraged to revisit and review the super-ordinate and master themes as they were considered too descriptive, and not of sufficient depth to capture more of an interpreted analytical level of enquiry. In performing the review I remained convinced of the use of a chronological interpretative structure to convey the dynamic journeyed nature of the men's coming to terms with their past heart attack experiences. The changes in their physical and psychological well being were bound closely to transformation over time. Indeed Stanton, Revenson and Tennen, (2007) state that one conceptualisation of adjustment is that it unfolds over time, as well as it being required across multiple life domains, and is very variable across individuals. I endeavoured to review the analysis of the men's stories within each of the stages of their journeys, and tried to thereby breathe more life into the analysis of this material, identifying deeper meanings embodied in the men's accounts. This was very challenging and demanded some rewriting which overall I considered to allow for a more valuable and also reverent reflection and interpretation of the men's lived experience.

While exploring the West African men's experiences, this study does not intend to make direct comparisons with that of white men. However, in attempting to situate these findings in the current literature where there is a dearth of ethnic minority investigation, the themes do seem generally consistent with what is known about white men's appraisal and coping following myocardial infarctions, for example, fears of recurrence and dying, and hypervigilence regarding any potential indication of cardiac difficulty (Lane et al, 2002). Nevertheless, areas of possible difference are also suggested; for example, the degree of distrust that these men verbalised in relation to the medical system and broader societal systems, throughout their adjustment journey, which may be associated with (for some men) ineffective communication with health providers, delayed uptake of services, and the misunderstanding of medical and care interventions.

I will now move through the journey stages encapsulating the men's experience of each.

The 'Pre cardiac event' period: *"Slightly stressed and solitary"*,

In the 'Pre cardiac event' period, and of significance to their impending cardiac problems, all men reported seeing themselves as being under stress prior to their myocardial infarction. This took the form of concerns about the futures of family members and their health, fears related to financial difficulties and for one, a chronic fear of death. The self appraisal of being a chronic worrier was also verbalised. As mentioned in the introduction, the literature is strongly supportive of this finding where for many years an association between psychological distress and heart disease has been recognised (Crisp et al, 1984; Skerrit, 1983). The INTERHEART study (Yusuf et al. 2004) indicated that psychosocial factors (specifically work and or home stress, financial stress, stressful life events, depression and locus of control) may present a 33% risk of myocardial infarction (across all ages, a wide range of geographic regions around the world, and both men and women).

Two of the men discussed experiencing elevated levels of anger, in relation to the ending of relationships or chronic family feuding, and both attributed this to their myocardial infarction. In the introduction of this report, evidence was discussed that supports the hostility component of the earlier conceptualised Type A personality behaviour pattern, in relation to identifying cardiac prone personality features. Williams (2002) states that a meta-analyses of the body of research on the physical health consequences of hostility concluded that the psychological trait of hostility - cynical mistrust, anger and aggression - is a risk factor for CHD and virtually any physical illness (Miller, Smith, Turner, Guijarro and Hallet, 1996). Williams makes the point that it has become increasingly clear that hostility and other psychosocial risk factors do not occur independently of one another, but rather tend to cluster in the same individuals and groups. The low threshold for negative emotions such as anger, anxiety and sadness in persons with psychosocial risk factors, could contribute to the acute precipitation of cardiac events over the space of a few minutes to hours. For instance, studies show that anger is as potent a trigger of acute ischaemic episodes as strenuous physical exertion during ambulatory electrocardiographic monitoring of CHD patients (Gabbay, Krantz, Kop, et al., 1996); the risk of suffering a heart attack is doubled during the 2 hours following an episode of intense anger (Mittleman et al., 1995), and trebled in people of lower educational attainment (Mittleman, Maclure, Nachnani, Sherwood and Muller, 1997).

The issue of cynical hostility is very pertinent to this study, when considering the super-ordinate theme of 'Degree of trust in medical and social systems' of the master theme of 'Pre cardiac event.' Here all the men discussed varying levels of trust about the ability of the health service to meet their needs (based on past experiences) as well as suspicion about some other aspects of the broader societal structure (for example, the police and psychology service). Their opinions and experiences highlighted their *views of the world.* Cynical hostility is characterized by suspiciousness, resentment, frequent anger, antagonism and distrust of others, including the perception that others are being antagonistic or threatening, prompting verbally aggressive behaviour (Taylor, 2006). Experiences of racism by African Americans are associated with habitually stronger emotional and physiological reactions to general stress, which in turn is thought to be associated with long-term development of hypertension (Brosschot and Thayer, 1998). Whilst some studies lend support to the vulnerability model of hostility in African Americans, they tend to suggest that this relationship is moderated by socioeconomic factors (Grothe, Bodenlos, Whitehead, Olivier and Brantley, 2008). Nevertheless, hostile behaviour has been seen to hinder efforts at either obtaining social support required from the environment, or failing to make effective use of existing social support (Holt-Lunstad, Smith and Uchino, 2008). That said, all the men in the study did fully engage with services. This, and the relevance of the distrust theme, will be discussed as this account moves further along the men's adjustment journey.

There is some American support of the scepticism that the men voiced about the health service - some racial and ethnic minorities express greater levels of mistrust of healthcare providers and of medical establishment than white Americans (Smedley, Stith and Nelson, 2003). Additionally, surveys indicate that ethnic minority patients perceive higher levels of racial discrimination in health-care settings than non-minorities. Past experiences of discrimination are associated with delays in seeking medical care, and poor adherence to health recommendations (Casagrande, 2007). In light of this, it is interesting to consider the views of ethnic minority groups described in Section 1.2.5.1, where the 2004 Iposos Mori report into health care views (Taylor, Page, Duffy, Burnett and Zelin, 2004), revealed higher levels of NHS criticism, regarding both hospital treatment and that of GP's. As mentioned, however, the men in this study did not withdraw from the health service, or terminate their care prematurely. It would have been very interesting to have directly enquired about the men's views on this in the interviews.

In the 'Pre cardiac event' period, the men discussed how they had coped with past medical experiences. Those who had experienced a previous myocardial infarction recounted mostly positive past experiences, explaining this in terms of receiving clear explanations of treatment, experiencing adequate follow-up care, and thorough the positive monitoring of health. This left these men having a high level of trust in the medical system. One of the other men discussed experiencing complications regarding a simple non-cardiac surgical procedure that had left him feeling anxious about any possible future surgery, and a sense of distrust in Doctors as well as a belief that he was an 'unlucky person.' It is unsurprising that a past medical problem preceded this man's concerns about surgery and Doctors.

Interestingly, during this pre heart attack period, two of the men discussed not experiencing support from family resulting from an acrimonious breakup of a relationship for one man, and the other not communicating with family members resulting from a long standing family dispute. These two men described rather isolated lives. There overall concerns with a range of stressors seemed to position the men away from others – physically in some cases, but emotionally in all. The literature shows higher levels of social support to be associated with lower levels of both state and trait anxiety (Hughes et al., 2004), and thus being protective against CHD (Stansfield and Fuhrer, 2002). It would seem, therefore, that the features characterising the men's experience of this pre cardiac event period, are their degree of isolation and lower tone of mood, and their rather distinctive sense of mistrust about systems.

Initial impact of the cardiac event: *"I just couldn't deal with it in my head."*

The next master theme of 'Impact of the cardiac event' revealed the men's *sense of self being challenged*, as evidenced by their accounts of feeling hopeless and dependant, experiencing beliefs that they would die, as well as high levels of confusion. These appraisals and resultant high levels of depression and fear, are consistent with previous findings (Lane et al., 2002; Mayou, 1984; Lesperance et al., 1996). Additionally, for two men this was exacerbated by a difficulty in communicating with staff, despite their English being good, associated with the men's perception of staff not providing clarity about their care, and mutual misunderstandings.

Similarly, for three of the men medical indecision about their diagnosis and thus subsequent treatment also heightened confusion and distress, as well as for one man feeling overloaded with information. For all, these experiences supported their beliefs of mistrust about the reliability of the medical system. As stated, this did not prompt any of the men to disengage from the service, but did delay one taking up subsequent care. A future study could investigate why people remain in the health care service, despite beliefs of mistrust. It could be speculated that this may perhaps relate to a perception of high need, and being too afraid of negative health consequences if the service was not utilised.

The coping styles employed by the men to deal with the impact of their cardiac diagnoses ranged across three main styles. Firstly, some of the men asked questions in their attempts to make sense of their circumstances (especially where problems with medical information were experienced). This represented a problem-focused coping attempt (Lazarus and Folkman, 1984); however these efforts did not lead these men to the desired clarity of their medical situation, which for one man resulted in a second coping style, namely adopting a very emotionally expressive response, of crying and shouting in his native language. This further worsened the level of misunderstanding between this man and the medical staff. Lastly, some men engaged in denial and disbelief, especially in relation to believing they were too young or healthy to have heart disease. This points to the relevance of developmental issues in influencing the adjustment process, such as the men asking themselves if the heart attack is "on time" or "off time" regarding the life-cycle (Revenson, 2003). Regarding denial, research findings are mixed regarding the value of denying aspects of one's illness. Some studies suggest denial predicts shorter ICU stay and fewer cardiac symptoms during initial hospitalisation, but also more non-compliance and days of rehospitalisation (Levine et al., 1987). Other studies have shown that deniers can experience fewer problems regarding return to work, relationships and emotional distress (Frasure-Smith, 1987; Ketterer, Kenyon, Rhoades et al, 1991). The men tended to reveal the latter experience towards the end part of their adjustment journey descriptions. It is understandable that some problem-focused coping strategies do not prove helpful within the context of dealing with the impact of the cardiac event, as the men were restricted by enforced passivity in the face of clinical procedures (Salmon, 2000).

The men's coping styles did not seem supportive of the 'Type D' personality suggested by Denollet (1996) as no descriptions of social withdrawal were given, except Mr B who voiced a long history of separation from most of his family. Additionally, no support of a repressive coping style (Weinberger, et al., 1979) was identified from any of the participant's text.

At the time of their myocardial infarctions, the men described the reactions of their family members as ranging from that of high levels of worry and shock, where the men were considered as requiring very close monitoring, through to one man's partner assuming a more rational and almost fatalistic response, implying less active support being necessary. Most of the men in this study seemed to believe the degree of support they received to have been useful, although one man did report his wife being overprotective. Whilst partner support can protect against lapses from healthier behaviours, particularly if the partner is positive about and engages in them (Jones, 2002), perceived over-protectiveness post myocardial infarction impedes improvement in self-efficiency during rehabilitation (Berkhuysen, Nieuwland, Buunk, Sandermann and Rispens, 1999). To be fair, the man in question was still awaiting further medical treatment.

This theme also seemed to reveal support for the general findings recorded in the adjustment literature, regarding the impact of a sudden traumatic illness.

Immediately post discharge: *"Trying to get back to normal".*

In the 'Immediate post discharge' period, the men's cognitive appraisal was characterised by beliefs of not being able to cope alone due to their fears of the threat of myocardial infarction recurrence and perceived permanence of physical limitation. This was also a finding of Hutton and Perkins (2008) study. This resulted in experiencing great fear as well as uncertainty regarding a lack of follow-up care, information about medication and the negative interpretation of pain. This threatened their confidence levels, with one man experiencing flashbacks to his hospital experience, whilst conversely, one of the men returned to his exercise regime the following week. The difference in threat appraisal for these two men was probably related to the different amount of information they each received about their condition and treatment, which for the latter man allowed for the construction of accurate positive expectations.

In their efforts to *"get back to normal"* the men described two dominant coping strategies that characterised the 'Immediate post discharge' period. Their efforts to manage change included help seeking from the medical services (GPs and cardiac rehabilitation) as well as family members, and secondly employing distraction techniques. The help sought included seeing the GP and consequently being linked back into the health services after 'falling through the [care] net', and help to stop smoking; additionally, seeking financial support from family to turn to the private health care system for quicker intervention, was described. Family members were also requested to assist with physical limitations. All were considered examples of problem-focused coping, unlike the employment of distraction. This could be seen as an example of emotion-focused coping, employed to shift focus from worries, especially fears of not being able to cope alone, which may be considered protective and helpful in the short term.

'Immediately post discharge' the men described two factors that directly affected their experience of support, these were the lack of medical support, and family fears. The former related to one man who had no follow-up care set up for him, and another who began a long wait for medical intervention. The former man seemed to adopt a passive, dependent and helpless role on discharge, seeming to illustrate the 'cardiac invalidism' coping style, however this was related to apparent medical neglect, rather than his misinterpretation of normal bodily sensations leading to avoidance and reassurance seeking (Riegel, 1993). For the second man, the seemingly overly protective behaviour of his wife related to her anxious wait for his ongoing treatment. Again, this seemed more understandable rather than evidence of spousal support for the 'cardiac invalidism' theory.

The men's description of family fears included examples such as partners worrying about performing wound dressings, children (of adult age) receiving intensely emotional telephone calls, partners waiting for medical treatment for the men, and fearing that complications could occur if their partner is not observed closely. The literature suggests that negative interaction may lead to increased anxiety and depression and a heightening of physiological arousal, potentially being detrimental for cardiac function (Stansfield and Fuhrer, 2002). Nevertheless, none of the men voiced concern about any negative consequences as a result of family members being frightened by aspects of the men's condition or behaviour.

The men did not speak of feeling they needed to support and care for their partner and family or protect them by concealing the extent of their illness, which is the opposite finding to that of the White, Hunter and Holttum's (2007) study on women post myocardial infarction, but the same as Hutton and Perkins (2008) study on men post myocardial infarction. These findings are both supported by the wider research that suggests that post heart attack men tend to reduce work activities and be nurtured by partners (Stanton, Revenson and Tennen, 2007), whereas irrespective of whether women are the patient or caregiver, they often focus on others and maintain their domestic roles, (King, 2000).

However, one of the men feared that the expressing of some of his fears about death (which had pre-existed his cardiac problem) may not elicit understanding and support, and so consequently did not share some aspects of his concerns. Previous studies have shown that those who conceal worries from their wives were likely to adjust poorly over time compared to those able to communicate their concerns (Suls, Green, Rose, Lounsbury and Gordon, 1997). Again, as with the other phases of these men's adjustment already discussed, there seems nothing markedly different from the general literature about heart attack adjustment, soon after the event.

Few months post cardiac event: *"Trying to just get on with life".*

The 'Few months post cardiac event' chapter of the men's adjustment journey, was generally at the time of the interview, and the men's cognitive appraisals (as illustrated with the 'How far have I come?' super-ordinate theme) were firstly characterised by the ongoing fears of complications which were again linked with the experience of pain, and secondly that of positively evaluating their health and progress. The former, as said earlier is a common finding (Lane et al., 2002; White, Hunter and Holttum, 2007). The men feared that ongoing stressors could have a negative effect, and that previous experiences of complications could recur, feeding doubts that health problems can never be fully resolved. These concerns have the potential to predispose these men towards a pessimistic coping style which has been found to be predictive of poor recovery post cardiac event (Scheier et al, 1989). However, on balance, this did not become evident as this group of men generally held concurrent positive self beliefs about their progress and held optimistic views of their futures, as will now be discussed.

The second set of appraisals that the men expressed pertained to a general sense of feeling much better, experiencing improved confidence, feeling more able to control their stress levels, and for one man believing that he was actually a very strong person illustrated by his robust willpower to end unhealthy life style habits. Four of the men assumed quite a self congratulatory stance with regard to their progress in accomplishing positive behavioural changes. The literature strongly supports the men's sense of seeming to have been able to integrate their experience of having a heart attack into their more general life experience (Hildingh, Fridlund and Lidell, 2006). This is also in line with Petrie, Buick, Weinman, and Booth's (1999) finding that about 60% of first time myocardial infarction patients reported positive changes from their illness, the most common being healthy life style changes. In this study two of the men reported feeling older (men who experienced their second heart attack) and this is in line with the illness perception model (for example, Petrie and Weinman, 1997). These perceptions and changes can be interpreted as evidence of holding a 'chronic illness' view of their cardiac illness, largely caused by behavioural risk factors and requiring long-term lifestyle change, but also a condition that can be successfully managed in this way. Such understanding links in with the following finding that the men appraised their futures with optimism (despite the two men feeling older.)

Within this period of their adjustment journey the men expressed a general sense of optimism that they would continue to experience improvements in their health, and additionally voiced making plans for the future. Despite their varying experiences, all the men verbalised optimism, mostly with regard to their increased ability to exercise, their belief that compliance with the health advice would ensure good health, voicing enthusiasm to return to work, and that having a cardiac history should not impose physical restrictions. This finding is consistent with Aalto, Heimans, Weinman and Aro's finding (2005) that perceived capacity to cope with illness was related to a less negative view of illness. One man's optimism related to his belief that technical advances in cardiac treatments implied future cardiac complications will probably be treated more easily. The man still requiring ongoing cardiac treatment was also optimistic about the probable efficacy of his treatment, when he obtains it, supporting the idea that perception of recovery is more related to functioning than to symptomatology per se (Orem, 1999). This seems to support the claim by Sykes (1994) that for adjustment to occur, the patient needs to perceive a way forward or a solution to their specific problems posed by the heart attack.

The men's 'getting on' coping strategies employed in the 'Few months post cardiac event' period revealed the men's tendency to less avoidance and dependency that had been noted earlier. Emotion-focused coping, in particular avoidance, has been identified as maladaptive when it continues past the immediate impact period of adjustment (Bennett, Lowe, Mayfield and Morgan, 1999). This reduction in avoidance and dependence allowed the men a high level of engagement with positive health behaviours, illustrating their overall sense of 'wanting to just get on with life'. This was evidenced by the stopping of smoking, altering diets, and the incorporation of exercise into their life styles. Optimism, mentioned earlier, is associated with greater success in changing risk factors (Shepperd, Maroto and Phert, 1996), lower fear and perceived susceptibility to and severity of illness, and engagement in more adaptive coping strategies (Desharnais, Godin, Jobin, Valois and Ross, 1990). Lowe et al., (2000), emphasise the adaptive influence of problem-focused coping, such as employing these behavioural strategies, may also be a means of regaining control.

Support during the 'Few months post cardiac event' period seemed to comprise mostly of descriptions of family and friends being supportive of the positive health behaviours the men were engaging with, including active joining in as well as voiced envy from friends. This finding is supported by Doherty, Schrott, Metcalf and Iasiello-Vailas, (1983), who found that supportive wives increased the compliance of partners with medication regimes. Bennett, Perkins, Lane, Deer, Brater and Murray, (2001) therefore state that sound social support can help explain trajectories of psychological adjustment. Recovery post myocardial infarction is best for married men, and married patients who receive more hospital visits from partners take less pain medication and recover more quickly. Support may lift mood and provide encouragement and direct assistance in making lifestyle changes (Con, et al, 1999). As Moorey (2006) states, the individual's adjustment process is a dynamic interaction between the stressor, the individual and significant people in his or her life.

Overall, mainstream research has shown that good family support, and close confiding relationships enhance recovery; relationships with intimate others is a particularly significant factor in adjustment, (Ell and Haywood, 1984; Croog and Levine, 1982).

Many aspects of the men's coping do fit with Leventhal's self-regulatory model (Leventhal, Meyer and Nerenz, 1980), however it does not seem to address or account for some processes that seemed to be involved in the men's adjustment process. This includes ideas that the men held about themselves, as well as that about their context or their world – hospital and societal structures. Although Leventhal et al. (1997) debate the direct effects of cultural factors upon the representations of disease, and believe that most of the so-called cultural-specific diseases and factors can be found, some of the prejudicial and discriminatory appraisals which can drive emotional responses and behaviour do not seem accounted for in the model. Nevertheless, some concepts are consistent with the model such as the men deriving causal explanations for their myocardial infarctions, as well demonstrating ways they sought control through changing behaviour and increasing independence over time.

It is useful to consider the men's use of ***causal beliefs***, revealing their attempts at trying to understand their experiences, and having a direct bearing on the coping styles employed. Attributing cause for a heart attack can reduce anxiety and increase predictability of the future (Petrie et al, 1997). Most of the men subscribed to the belief that life style factors (diet, stress and smoking) were largely responsible as well as some concurrently holding fatalistic beliefs. Affleck, Tennen, Croog and Levin (1987), found that people who attributed their heart attack to stress, had a better disease progression than those who did not make stress attributions. A couple of the men described their support of a genetic explanation for their myocardial infarctions, describing their family's cardiac history; whilst having a genetic risk of heart attack has been perceived as not being mediated by behaviour or physiological processes, and as such not controllable (French, Marteau, Senior and Weinman, 2002). The men of the study with a familial tendency did seem dedicated to adhering to the health advice provided by cardiac rehabilitation and their care staff. Despite the ethnic differences of these men, their causal understandings of their cardiac conditions seemed to replicate studies of western samples of cardiac patients. This is interesting considering the major differences in causal beliefs within different cultural groups in the Western world, as discussed in the introduction of this report.

During this last chapter of the men's adjustment period, support also included that from the medical services, where the men's experiences generally seemed positive for instance obtaining adequate explanations for pain, as well as general advice from the cardiac rehabilitation and cardiac rehabilitation nurses. This point leads into the next discussion of the men's views of cardiac rehabilitation:

All the men attended ***cardiac rehabilitation*** and all spoke positively about their experience. The men mostly valued the shared experience and mutual support aspect of the programme, as well as the explanations about the positive effects of maintaining health behaviours and guidance about such. This fits in with research support for supervised exercise (Hutton and Perkins, 2008).

Conversely, a couple of men also discussed negative aspects of their cardiac rehabilitation experience. One man felt 'scared' about overdoing things physically, and complained of receiving contradictory information, subsequently significantly delaying the start of his exercise regime. Hutton et al., found similar findings regarding the use of associated safety behaviours in managing persistent anxiety. In the current study this may have also related to this man's sense of distrust of health personnel and systems, however research findings that some cardiac rehabilitation staff are perceived as providing inconsistent information, and being overly negative may provide some support to these findings (Clark, Barbour, White and MacIntyre, 2004). Another man experienced a comment about his ethnicity, made by another attendee, which initially prompted thoughts of scepticism about continuing with the programme. Interestingly he did continue, and went on to develop a very supportive bond with the person who voiced the comment. This was another situation in which one of the men experienced a perceived potentially provocative and insulting incident, yet he did not remove himself from the service as a result. Further studies exploring why he chose to remain engaged with the service would be valuable.

Interestingly, none of the men explicitly referred to any cultural beliefs or behaviours that bore any relevance to their cardiac experience, which I had assumed would have been a central component of this report. Perhaps that relates to the fact that they had all immigrated to UK either, a) when they were young (average age of immigration was when 19.8 years old, current average age is 59.4 years old), or b) they have lived a long period in the UK (average length being 39.6 years). Perhaps this led to a high level of acculturalisation, to the point that Western understandings of life experience have been largely assimilated. Of relevance may be the socioeconomic status of the men – where one was unemployed, one on long term sick leave (having to live with family and experiencing strained relationships), and three retired. From their descriptions of their stressors, finances ran central to all except one of the men.

Stanton et al., (2007) states that low socioeconomic status is associated with firstly experiencing more stressful life events of a greater magnitude and having fewer social and psychological resources to manage them, contributing to poorer mental and physical health (Gallo and Matthews, 2003). It may be that this factor had a greater influence on these men's lives than their ethnicity, given that they described being "slightly stressed and solitary" before their heart attacks struck.

Stanton et al., (2007), state that very few longitudinal studies have been performed in the chronic illness area, to understand how predictors of illness-related adjustment may be moderated by culture or ethnicity, (Alferi, Carver, Antoni, Weiss and Duran, 2001; Taylor, Lamdan, Siegel, Shelby and Hrywna, 2002). They found group cross-sectional studies to be slightly more numerous, which showed very few pronounced differences in broad indicators of disease-related quality of life, although elevated psychological symptoms or disease related concerns have been seen in some groups. It seems that there are some group differences in approaches to confronting some diseases, for instance with African Americans and Latina cancer patients being more likely to turn to spiritual practices than white patients (Lee, Lin, Wrensch, Adler and Eisenberg, 2000). Stanton et al. state that the mechanisms for these differences have not been established, and that 'it is clear that very little is known about the implications of culture and ethnicity for disease-related adjustment'. (p. 571) Theygo on to say that this pertains to 'the intersections between ethnic identity, acculturation, socioeconomic status and experiences of racism as they affect disease-related adjustment.' (p.579). That said, as mentioned earlier, despite this study attempting to explore adjustment no new information was revealed, except regarding aspects of mistrust in societal systems, but this did not preclude service uptake.

At this stage it is important to reflect over my presuppositions that I had prior to the research, that I thought could explain the low uptake of services, in order to think about my level of influence on the work. One of my early ideas was that the research findings would relate to the migrant/ first generation standing of the men – this seemed to not be raised at all in the men's accounts. I also wondered if the West African men may feel disempowered in the face of the NHS, which may support disengagement. Although this did not seem apparent in the interviews, it may be that there is a link to the mistrust theme that was identified. I also suspected that a lack of education in some men may mean that they are not as fully aware as others about the benefits of cardiac rehabilitation, however all the men were literate with good spoken English. I also speculated that a culturally specific reaction may lead to excessive fear or denial, prompting disengagement; however this was seen to be in keeping with the broader population, so no specific findings related to their responses to illness were identified in the men's accounts. Consequently, my specific assumptions were not represented in the research findings which helps me to understand how useful the 'bracketing' off of assumptions can be.

4.1.2 Developing a framework to make sense of the Journey of Adjustment

An objective of this study was to explore the post heart attack accounts of West African men to gain some information about their psychological adjustment process. The importance of this was to ascertain how health services may adequately accommodate any needs seen to be specific to this population, to optimise their involvement in health care, which is shown to decrease both morbidity and mortality rates. The exploratory question, therefore, that arose out of the men's accounts was to what degree did the features of their experience help or hinder their adjustment process? In other words, what were the barriers and facilitators that they encountered, which if addressed may significantly increase the current low uptake of services, and thus improve the overall quality of the health and life of West African men post heart attack?

In so doing, the qualitative research approach subsequently aimed to explore the men's appraisal and consequent coping strategies, and has lead to the development of an explanatory framework. *(Figure 1, over page).* This structure is totally informed by the men's experiences and attempts to illustrate their adjustment process. Of note is the understanding that within each chapter in the flow of this framework, there exists the potential for a barrier or facilitating influence to be exerted on the adjustment process.

The model depicts the men moving through a sequence of chapters in which they processed aspects of their experience. It shows how their accounts suggested that prior to the heart attack they were all experiencing a degree of stress, and of trust/ mistrust in the medical system. The impact of their heart attack was then appraised by these men initially in terms of their own self beliefs, as well as their hospital experience; different coping strategies were then drawn upon to manage their intense emotional response. Their chapters flow from one to the next, each being moderated by the men's appraising and coping styles, in an ongoing manner. The model attempts to show the powerful influence of social support throughout the process, and that this influence is bidirectional. The model illustrates the men's journey through adjustment, ending at the point where the men were regaining their lives and feeling optimistic about their futures, regarding their lives and their health. The model hopes to convey the idea that each chapter in the adjustment process can yield either a facilitatory or

The men's journey of adjustment

A framework suggesting the relationships between identified influencing factors

obstructive influence on the adjustment process as a whole, and engagement with health care services. So the manner in which the men address their adjustment processing tasks of each chapter, will determine if the overall adjustment process is smooth, faltering or arrested. Given that CHD is a chronic illness, relapses in illness will mean that this model is probably re-engaged with repeatedly in the men's lives.

4.2 Discussion of Methodology and limitations of the study

4.2.1 Validity:

A number of steps were taken to attempt to ensure the validity of the findings, these will be only touched on here as they have been discussed in section 2.8 of the study:

Reflexivity - I have attempted to be reflexive about the different stages of the research as these sections have been described. This section will end on a reflection of the difficulties encountered in the study. I have tried to be open with assumptions and presuppositions that must have influenced the creation and analysis of the men's accounts, although I have tried to 'bracket' such as much as is realistically possible. (Elliot, et al., 1999).

Transferability – The participants were described in Table 1, details being reduced so as to not compromise the confidentiality of the study. The men did vary in age, employment, as well as prior cardiac history. This latter variable refers to three of the men having experienced a prior MI; this was not intended in the initial proposal of the study, but due to significant recruitment difficulties was eventually allowed. This did prove interesting as for all their first experience seemed straight forward and uncomplicated, in comparison, for two of the men, to their reactions to the cardiac event that they were currently recovering from. As only one man was working (about to return to work), three were retired and one unemployed, measuring adjustment, therefore, in accordance with employment was not meaningful. Future studies including greater numbers of working men would yield this data. Conducting the interviews at a consistent set period post myocardial infarction (rather than the 2½ – 5 month range of this study) may have enhanced the homogeneity of the sample, however the recruiting difficulty did not allow for this. Overall, however, the post heart attack I experience seemed to generate more common themes (from the men's accounts) than differences.

All the men had either completed the cardiac rehabilitation programme or were about to do so, making it difficult to generalise the findings to men who had not attended. This was disappointing as one of the initial objectives of the study was to interview men who also chosen not to attend cardiac rehabilitation, allowing for an exploration of their adjustment experience, as well as reasons for not attending. It may be that one reason men choose not to attend rehabilitation is because of denial or avoidance, or being less optimistic regarding their adjustment process, which is what the study would have been curious to explore.

Respondent validation - was conducted and discussed as stated in 2.8.

Independent Audit - The process of analysis was made as transparent as possible. This included firstly, providing the reader with transcript material (*Appendix VI),* depicting the annoted evolution of text from initial coding into emergent themes, into super-ordinate themes, and finally the master theme list. Tables representing this were also placed within *Appendix VI. Appendix VIII* contains one of the super-ordinate themes displaying its supporting participant text. Secondly, parts of this material have been presented in the results section of this report. Thirdly, an independent auditor reviewed the transparency of the material, and it was deemed sufficient.

Smith et al. (2009) has presented Yardley's criteria (2000) as a useful set of principles to standardise the process of evaluating the quality of qualitative research. These have been applied and discussed in section 2.8.

4.2.2 Critique of IPA

I acknowledge that in order to be transparent in choosing a specific methodology, there needs to be recognition of its inevitable shortcomings. Willig (2008) highlights some practical and conceptual limitations with IPA which I perhaps should have given more consideration when selecting the methodology for the study, and also during the analysis stage of the research. She raises four issues that I will now address – the limitations of the role of language, the applicability of its method, it's limited explanatory power, and whether it is 'genuinely phenomenological' (Willig, 2001, p. 65). Firstly, Willig's view on the role of language is that an interview transcript can only represent how a participant talks about their experience rather than the experience itself. Consequently it may be that some of the richness of their emotional experiences is not expressed, and only a partial story is shared with the interviewer. However, IPA responds to this view with the point that it recognises that language shapes, as opposed to represents lived experience (Eatough, 2005), and considers the interview to be only a localised interaction, and as such accesses a partial story. IPA understands too, that because a person talks about an experience in a certain way at one time, does not mean this is a consistent view or stance.

Willigs' second point argues that what is talked about is restricted by the participant's skill at articulation and use of language - this allows for the accurate conveying of their story. I thought about this point in relation to the men's ability to understand and speak satisfactory English. Smith (2004) however, suggests that the richness of an account will be determined by the degree of importance that the participant gives to their experience, and the level of engagement they feel in the interview process, rather than their articulation skills. He also states that cultures are frameworks for making sense – and that although IPA's focus lies with understanding experience, it is inevitably 'always already' enmeshed with language and culture.

Thirdly, Willig suggests that IPA pays insufficient attention to explaining the origin of particular lived experience, and so consequently is unable to expand the researchers understanding of why particular experiences occur. Eatough (2005) argues that the phenomenological aspect of IPA expects that an explanation become understood for participants experience. Additionally she argues that it is debatable if pure description is possible; Spinelli (2005, p.21) says a purely descriptive account is an impossibility as it comprises explanatory elements. He describes explanations as existing on a continuum, where concrete description sits at one end opposite abstract, more concept-generalising description, at the other.

Willig's final criticism is to do with a concern that IPA's focus on cognition suggests it may not be compatible with phenomenology. Eatough disagrees saying firstly that cognition is a central aspect of human existence and secondly, that cognitions are not separate functions but form part of the experience of being-in-the-world – "Thinking is not detached reflection but part of our basic attitude to the world." (Mingers, 2001, p.110). Smith et al. (2009) try to explain that IPA's use of cognition is that referring to a much broader model than that view held by main stream psychology. IPA view of cognition is one comprising the range of layers of reflective activity which makes up everyday experience, thereby being able to be the focus of phenomenological enquiry.

4.2.3 Reflection on the research process and difficulties

I will end this section by reflecting over the various difficulties encountered within the study experience so far.

Sample:

It was originally hoped that more than five men would be recruited for this study, however as already stated this was not possible. Smith et al., (2009) suggests a suitable number of participants to range between four and ten for a Doctoral study, however University requirements tend to vary from this. Three recently published IPA studies in this area of interest comprise five, six and ten participants respectively (White, et al., 2007; Hogg, Garratt, Shaw and Tagney, 2007; Hutton and Perkins, 2008). On attending an external workshop with Jonathan Smith mid study, small numbers were recommended, and even the case for a single case study strongly made, again contrary to this were the University pressures requesting of a minimum of 10 cases, which stimulated much tension throughout most of the study. The nature of recruitment also made it difficult to recruit men who had not attended cardiac rehabilitation or had chosen to disengage completely from the health service immediately following discharge from hospital. To achieve this, it would seem necessary to recruit from, and position the research as, separate from the cardiac rehabilitation department.

That said, I did try to do this with the use of posters across London, resulting in only one participant being recruited in this way.

Recruitment:

This was the main difficulty of the study, resulting initially from sudden changes in the cardiac department policies regarding patient access, making it very difficult to recruit from outside the cardiac department. It was hoped that the recruitment of a dedicated psychologist to the cardiac department would facilitate the research recruitment process, however the long process of setting up and eventual recruiting into post severely slowed down the research process. And unfortunately, once in post some political changes regarding the management of the cardiac team further interfered with the psychologist being able to help with participant recruitment. I then went on to change jobs, in fact three times over the duration of the study (two being part-time posts, and one to work one another member of staffs research!) This all significantly interfered with my ability to actively recruit, especially as staff within the cardiac rehabilitation unit also changed.

Additionally, due to the difficulty finding participants, I felt compelled to retain two interviews of participants who attended with their wives. Both requested this because of concerns of talking to a psychologist without family support; further explanations seemed difficult to articulate. Both interviews were conducted with their wives contributing at times. Consequently, the transcripts comprise some of their partner's views and material, and whilst I was concerned that their presence may have influenced some of participant's dialogue detrimentally, I suspect that it actually enriched the contacts, providing another layer I have discussed this in more detail in section 2.7.

Setting the specific question

Although the research question looks at the adjustment of participants to their myocardial infarction, using specifically a cognitive and coping framework, the interviews were very open and clearly directed by the participants rather than the interview schedule. That said, this framework clearly aimed to cover what the participants thought and did as they tried to continue with their lives, and it was thought it likely that their thinking styles would elicit an affective component of their reaction. In so doing, the interview hoped to tap into the participant's cognitive, behavioural and affective experience, which it was anticipated would yield sufficient data to explore their adjustment processes. As a result, I do not believe that the research question limited the research findings. The question and the interview schedule do not deter any positive experiences. Therefore, whilst I consider there to be a very sound fit between the IPA focus on cognition, and the research question, I do not believe that the research design or employing IPA methodology has led to the 'construction' of the research findings. When considering how the research could have been performed differently, as discussed in the cardiac rehabilitation section 1.2.1, the use of quantitative methods has been problematised in this area, for reasons, for instance, of difficulty in questions used in questionnaires conveying accurate meaning, or language and illiteracy difficulties.

Research interviews

I have discussed reflections on this area under section 2.7 when considering the 'researcher-researched relationship', where I discuss my thoughts about the impact of my own identity characteristics on the co-researchers and our co-constructed conversations. Discussions with supervisors and fellow researchers greatly helped me to try retain awareness and then to separate out my presuppositions, to understand their influence in the work.

Analysis

Throughout the analysis of the men's accounts the various questions about my impact on the interviews (as discussed in section 2.7), were addressed and considered in memo writing, enabling me to pause and think about our relationship – asking myself for instance, to what degree the men feel did enabled to share their stories, was it cathartic? As through their words it seemed that some rarely felt able to speak about their experience in such detail, and thus seemed to derive some sense of validation from our interview. Whilst some were especially animated in recounting their emotional experiences, their narration generally seemed unproblematic, they did not seem to reveal any concerns about the interview being non-containing, but I wondered if although not conscious, there may have been a need for such during the unfolding of their accounts. I wondered about my duty of care towards the men, and as mentioned earlier, the tension between my researcher identity and that of clinician. Awareness of this helped me manage and gain clarity about which aspects of myself needed to be dominant in the exchange, and how the debriefing process served to meet my clinician needs/ component of my identity.

When analysing the results and writing up the discussion, I tried not to be naive, and was clear in my understanding that the findings were only one interpretation of many possible interpretations. Whilst it was extremely difficult to capture what I considered to be a meaningful co-construction and understanding of the men's lived experience, as recalled by the men, I do think that in essence, the shared experience transformed by recording and transcription, shares a likeness with the men's lived experiences. I believe that the emergent themes were pivotal to the men's narratives. Due to very few people engaging in the doctoral course, and the drawn out nature of the study, I formed a small qualitative support group with a colleague which was valuable in developing skills and helping me to try to keep the themes well grounded in the participants' words.

AS mentioned, towards the end of the study I was encouraged to revisit and review the super-ordinate and master themes as they were considered too descriptive, and not of sufficient depth to capture more of an interpreted analytical level of enquiry. I have endeavoured to so this, and still felt that a chronological framework reflected the men's stories in an authentic and constructive manner. This was very challenging but I think helped me to be clearer on the findings and their relationship with the study's aims.

This requested review of the study and its findings has provided me with the invaluable opportunity to re-engage with my professional identity, and try to re-write aspects of this study to openly reflect the distinctive characteristics of what it is to be a Counselling Psychologist, albeit, a very broad identity. I discuss this further in the concluding sections of the study.

Contextual and personal hurdles

- **Supervisor changes**

As the study has now stretched out over 7 years, it is perhaps unsurprising that my supervisor changed twice. The difficulties associated with this comprised of firstly, experiencing a variation of research priorities and foci across the duration of the study, as well as secondly, needing to adjust to different individual styles of supervision. However, on balance, the opportunity to experience three different supervisors was also very interesting and afforded me the opportunity to learn more about the type of supervision that I personally responded to more effectively. My experience was especially refreshing and highly motivating in the last instance. It is likely that my supervision experience was also influenced by where I was positioned along the research journey, as well as probably being a function of my gaining more maturity in my professional career.

- **Procrastination and disillusionment**

The difficulties with recruitment and the first change in supervision (which also entailed the difficulty associated with actually seeking a new supervisor), led to considerable researcher despondency and resulted in major procrastination, contributing to the study stretching over a long period. An additional obstacle to moving forward more quickly was that of working full-time, for the duration of the study. Ironically, two of my posts entailed working on other people's research studies, which I had hoped may propel me forward with enthusiasm, but which seemed to have the opposite effect. I think this was so because the difficulties of my study were not being experienced in either of the two research posts. Throughout the study, disillusionment seemed to evolve out of situations where hope of recruitment was invested in strategies that did not yield the participants, for instance, waiting for the posting of a dedicated cardiac psychologist, which when eventually materialized did not produce participants, asking GP's who were encouraging at first but not productive, approximately 200 posters were put up throughout areas of London with high Black populations producing only one participant, moving to a post where cardiac rehabilitation links (via a colleague) were expected, took a long time to develop, but once made, still did not yield participants.

Most annoying was the fact that just before I commenced the study, a colleague had performed similar research - just prior to the changes in the Cardiac department, and had completed her work in 18 months.

- **Job changes**

As mentioned above, during the study I have held four different jobs – a couple being part-time research contracts. All, except the first, have been unrelated to the context of the study. I now believe this to be highly undesirable, especially from a recruitment perspective. It is extremely difficult to recruit participants if not actively involved with the recruitment source in some form.

- **Ethics approval**

This has become a detailed and very time consuming process. Due to the prolonged nature of this study I had to go through two separate ethics approval procedures at the two different National Health Trust hospital sites hosting the study. Each process took approximately 6 months. For the ethics approval process to operate more smoothly, the University needs to become far more familiar with the NHS ethics procedures and the requirements involved in the sponsoring and supervising of studies comprising NHS participants. I believe it to be very important for the profile of Counselling Psychology that students are encouraged and seen to be actively engaging with and utilizing the rich and diverse resources found within NHS settings. I believe this to be important also, when considering how the work of our profession compares with that of other post graduate psychology courses.

Chapter 5

Conclusions

This chapter concludes the report with considerations of further research, the general clinical applications of the work and its relevance for Counselling Psychology, and finally, a consideration of the layers of learning that has occurred as a result of the work.

5.1 Implications for further research

The results of this study are useful given that the majority of cardiac rehabilitation studies focus predominantly on white participants (Wild, 1998), and that there is evidence from a few sources to suggest that the uptake of cardiac rehabilitation services is disproportionately low in African Caribbean patients (Lane et al., 2000; Cannistra et al., 1995).

However, further research could address the limitations of this study as well as explore some of the themes that arose out of this work. Regarding the former, a main limitation was that of not having a homogenous sample, so further research that comprised first time myocardial infarction sufferer, or second time heart attack sufferers only would be useful. Additionally, a study with more participants is likely to yield more participant experience to allow greater analysis of convergent and divergent views. This would also perhaps reduce the tendency that I had in this study, to use some rich text to support a range of different themes, which I was asked to amend. I am sure a wider range of text to support themes would be more satisfying for the reader. Another main limitation of this study was the aforementioned fact that all of the men attended cardiac rehabilitation, so a study incorporating the experience of those who did not, would be extremely valuable in exploring their adjustment experience. Additionally, if the interviewees could be interviewed at much the same time post myocardial infarction, this would allow for a greater level of consistency in understanding the findings.

Considering the findings of this study, it would be very interesting if further research could enquire more deeply into the theme of "distrust of medical and societal structures". More specifically, exploring why people holding such beliefs remain in the service, and importantly what enabled them to do so. It could be assumed that some people who do not engage with the health services may hold such belief structures, in which case further understanding could help address this probable barrier to health care and adjustment. Additionally, studies that are spread over a longer period, perhaps assuming a 3, 6, 12 and 18 monthly model, would yield valuable information about long term adjustment patterns.

Another area of interest would be conducting a similar study with the partners and family members of myocardial infarction sufferers to understand how family views may differ from that of the patient, for instance, in terms of their appraisal of roles and available support. This current study did have two wives present during the interviews with two of the men,but what is being suggested here is not having both partners in the same interview, so allowing for any difference of views to be apparent. At the end of this study I wondered if the research could have been greatly enhanced by a single case study of Mr Aj and his wife's conversation – where had she would be included more fully in the dialogue. This would have created an interesting adjunct to the broader study, as well as provide a useful explorative account in its own right.

Studies focusing on different ethnic minority groups are very important given the dearth of such research and the need to widen the literature base on post myocardial infarction adjustment. This is especially so regarding South Asian men for whom the prevalence of CHD is highest. Additionally, the experience of ethnic minority women is also an extremely unexplored area, warranting investigation.

5.2 Relevance for clinical practice, and relevance for Counselling Psychology

This study highlights some important considerations in relation to cardiac services. The National Service Framework for CHD (Department of Health, 2000) makes recommendation for specific attention to be paid to the needs of patients from ethnic minority groups. These considerations are apparent from the themes that arose from the interviews, as well as from some of the explicit descriptions made by the men.

The first theme that emerged was that of distrust of the medical and broader societal structures, which featured throughout the men's adjustment journey. This yields a series of opportunities for Medical/ therapeutic intervention to address the types of difficulties the men encountered. Medical personnel and all psychologists need to be fully aware that mistrust beliefs are commonly held by members of ethnic minority groups, well before a myocardial infarction is experienced. (Early ward screening for significantly elevated anxiety and depression may also assist in appropriate early intervention.) The mistrust theme can then continue to influence experience within the hospital context where some men complained of not being provided with explanations regarding diagnosis and treatment, and/ or not being able to understand some of the medical information. This resulted in elevated emotional distress. All psychologists may then have a role to play in supporting such men either directly or through consultation with medical and nursing staff. High levels of emotion too would warrant intervention (normalising and clarifying needs). Petrie (2002) found that intervention during hospitalisation assisted patients to alter perceptions of myocardial infarction and thus later adjustment, and impacted on cardiac rehabilitation attendance. The mistrust theme was also supported by some of the men's comments on experiencing medical indecision – related to past medical experiences as well as within their immediate situation. This points to a clinical need to provide greater support despite the difficulties involved in diagnosis and consequent treatment, as well as the need for being explicit with information even if at times verdicts are not conclusive. Again, direct or indirect psychological support during such times may be warranted.

The men's accounts describe how this theme continued into the cardiac rehabilitation situation in relation to receiving too much information, as well as it being communicated in a way that left one man 'scared' to exercise at all, effectively leading him to delay the start of his exercise programme. It seems, therefore that a tailored cardiac rehabilitation approach, as suggested by the National Service Framework for CHD, is required for ethnic minority attendees, that may incorporate more accuracy in checking needs are being met. The role for psychological input during cardiac rehabilitation seems important, and is a feature of some programmes. The men did describe the camaraderie experienced as very valuable, perhaps cardiac rehabilitation groups could be more appropriately matched for attendees, for instance in relation to age, or type of cardiac problem. One of the men described receiving a direct comment about his ethnicity, which caused him to be indecisive about continuing the programme. Perhaps there is scope for staff to be explicit about the universality of CHD, and to closely follow-up cases of drop-outs. There may be call for the involvement of partners and/ or carers to become involved in cardiac rehabilitation, given the emotional impact of myocardial infarction on significant others. This may comprise the opportunity of psychological intervention, which would benefit both partners.

There may also be scope for counselling psychologists to assist such men to process this transitional life event. In my view each of the men interviewed could have benefitted from some psychological intervention (short term at least) to assist with the range of difficulties they presented in the interviews. As stated this ranged from stress related to other life issues, fear of death, and general anxiety management. Perhaps a sub-group within the cardiac rehabilitation programme could address some of these issues, and also provide a screening opportunity for any individual support if deemed appropriate. Additionally, a longer term follow-up programme may be of benefit. After completing cardiac rehabilitation, people are encouraged to join community led support groups (where these exist) which undoubtedly provide camaraderie and support in maintaining positive behavioural changes for those who attend, but uptake figures are difficult to obtain, and it is suspected are very low (the case with first hospital's support group).

In summary, whilst the men "a few months post MI" seemed to be coping well with their adjustment process, only one actually considered his lifestyle to have significantly improved. Two others had regained their pre myocardial infarction quality of life (one of the others was still increasing his activity level and the last was awaiting more treatment.) Generally, therefore, it would seem that the men would have benefitted from support in addressing some of the issues just described in this section. Particular attention may be paid to mistrust beliefs and providing a more explicable care service, clarifying expectations, and creating the opportunity to process the range of evoked emotions.

5.3 What was learnt from the research process

The research process, unsurprisingly, has provided me with the opportunity to extend my professional identity to incorporate that of researcher. This has meant still engaging with the counselling psychology tenets as described at the start of the study, but within a research capacity. In other words, engaging with clients inter-subjectively, respectfully exploring their values and beliefs to go on to interpret and negotiate between their (and my) perceptions and world views (*Professional Practice Guidelines,* BPS 2005). This has allowed me to keep the Counselling Psychology identity central - of upholding and deeply valuing and giving a voice to all people, especially those who may have been socially marginalised due to aspects of their identity. The research recognizes the collaborative nature of the enquiry, and that the researcher, as in therapy, is not a neutral bystander, but a co-constructor of experience and meaning. The research has allowed me to acquire many layers of experiential learning, some of which I will outline below.

5.3.1 At a personal level

Given that IPA is always interpretative, and that there are points in the analytic process where one is expected to draw on our own perceptions and understandings (Smith et al., 2009) - to sound out meanings of key events and processes for the participant - there is an element of personal reflection, especially in the conceptual coding process of initial coding. However, this interpretative process must be both stimulated by and tied to the text. To that end I have endeavoured to document this process, and as the analysis progressed, these early interpretative claims were checked at later points in the process.

During this analytical phase of the study, my full time work focus has been predominantly Cognitive Behavioural, which may have strengthened a CBT bias in interpretation, whilst expecting that, as mentioned earlier, I have reflected upon this throughout the research process and attempted to 'bracket' this off with other presuppositions that I have discussed earlier. In addition to the ideas born out of my life experience described above, I was aware after analysis had been completed of surprise that i) I had held some assumptions that I had not been aware of, only discovering this when ii) they were not supported by the participants text. For instance, I discovered that I held the assumption that the men would display a more submissive, perhaps even reverent approach to their health care, which I speculated may transfer into the 'cardiac invalidism' coping style post myocardial infarction, incorporating greater dependency than that which the findings revealed.

The reflexivity demanded by this work has reminded me of the origin of some of my personal aims and values; unfortunately, such knowing can be very easily pushed out of day to day focus but which is nevertheless, central to my sense of self. The process has stirred up a need for me to be more purposeful about my career direction and goals for the future, and for greater congruency to exist between my core values of equality and justice, and my everyday face to face work. Although the research process has been extremely slow and emotionally draining at times, I have thoroughly enjoyed working with the material and within the area of investigation. Many of the reflections that have been documented throughout the whole process of enquiry have resulted from the experiential learning that this research has afforded me.

5.3.2 As a researcher

When reviewing this study in the end stages of its development, it was clear that in order to be recognized as a counselling psychology enquiry, it had to represent my professional identity far more than I had done originally. In conversations with my supervisor it became apparent that I had fallen prey to a list of researcher identity traps (Kasket and Gil-Rodriguez, 2011) which prompted me to address the various identity gaps in the work. As a result of addressing these 'traps' I have become much clearer about my profession and my practice. I will briefly run through my efforts to attend to these issues.

Firstly, I set about trying to ensure that reference to the profession was apparent throughout the work, and recognized that the dominant Clinical Psychology influences in my training and career since qualifying, had shifted my focus away from my own identity. I addressed by positioning the profession squarely in the title too. Secondly, I also worked hard at expressing the ways that I considered the study to have relevance for the profession, including a section on the professions identity at the start of the work to create a context for it. Thirdly, I tried to address the fit between the philosophical underpinnings of the profession, and that of IPA, in an attempt to demonstrate the counselling psychology ethos in the work. Fourthly, I tried to make sure that I made myself as transparent as possible through creating a reflexive commentary throughout the study, as opposed to only at the end of the work, to illustrate the awareness of the influences I had of the co-constructing of the work. These considerations, therefore, within the context of this work have greatly assisted me in gaining clarity about my own professional identity both as a clinician and a researcher.

Additionally, the research experience provided me with some specific learning points, listed below:

i) I developed a far greater appreciation of the nature of performing qualitative research, and the significant importance of it especially in exploratory research.

ii) This study has highlighted the need for high levels of sensitivity when performing ethnicity based research. That said, everyone has unique cultural differences of which we should endeavour to be mindful, and as a researcher, be respectfully curious.

iii) I leant to understand the difficulty between wanting to adhere to the interview schedule, whilst still allowing the participant to take their dialogue in their own direction. I believe that in some cases, my efforts to not redirect the interview probably cost the study specificity regarding certain aspects of the men's stories, although this possibly benefited some participants in allowing validation of their experiences and in delivering the account they chose to use.

iv) As my main difficulty of the research process was recruitment, I learnt the real importance, if at all possible, of trying to position oneself within the pool of prospective research participants, rather than being reliant on others whom one does not know. As this is often not possible, the researcher is required to be respectfully assertive, persistent and resourceful from the outset, in liaising with staff of relevant organizations. Despite this perhaps generating some discomfort, I recognise that as I embarked on this study I had not fully appreciated the degree of effort that would be required to achieve this, and would have saved much time and probably disappointment if I had been more assertive from the outset.

5.3.3 As a practitioner

My understanding of adjustment within the context of illness has improved. I believe too, that my ability to empathise with people experiencing life threatening conditions as well as chronic illness has also become greater. Additionally, by the end of this research journey I feel more confident within myself as a practitioner, than when I started, however given the drawn out nature of the study and the fact that the duration of the work has now equaled that of my entire qualified life, it may well be that it is a combination of both acquired research and practitioner experience that is responsible for my increased sense of confidence.

The study has reinforced the fact that not only in qualitative research, but in general therapeutic practice, we co-construct new meanings through conversing. This is essentially the objective of therapy where the creation of new meanings in response to the critical reflections of others, as well as those of our selves, allows for the checking of understandings in interpretation. The old meanings may perhaps be based on past experiences held outside of our full awareness, or based on rules of personal or social cultures that may have been accepted in childhood without challenge (Etherington, 2004). The research has therefore, been directly relevant to therapeutic practice. This study, alongside the rest of the portfolio pieces of work, serves to reflect my career to date, highlighting a range of client difficulties as well as the different work contexts in which I have practiced. I consider myself immensely privileged to have had the opportunity to perform this study and also to work within the profession.

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Appendices

Appendix I	Information letter for participants
Appendix II	Participant Consent form: a) Guy's & St Thomas' participant consent form b) City & Hackney PCT participant consent form
Appendix III	Interview Schedule
Appendix IV	Original three question branches to interview schedule
Appendix V	Ethical Approval Documentation a) St Thomas' Hospital Ethics Committee Approval letter b) Ilford Ethics Committee Approval letter c) City & Hackney PCT R & D approval letter d) Homerton University Hospital R & D approval letter
Appendix VI	Annoted Transcripts with tables of evolving themes for a) Interview with Mr Aj
Appendix VII	Participant Feedback Letter s a) City & Hackney PCT b) Guy's & St Thomas' NHS Foundation Trust
Appendix VIII	Table 4 (N): Participant quotes illustrating the super-ordinate theme of 'How far have I come?' – cognitive appraisal, forming part of the master theme of 'Few months post cardiac event'.

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APPENDIX I

Information Letter for Participants

City and Hackney NHS
Teaching Primary Care Trust

Primary Care Psychology
2nd Floor – D Block
St Leonard's
Nuttall Street
London N1 5LZ

Tel: 020 7683 4673
Fax: 020 7683 4156

Dear ....

Research into the Adjustment of Black Men Following a Heart Attack

The Cardiac Rehabilitation Specialist Nurse, Maureen Barry, has kindly agreed to hand you this letter to invite you to take part in the above research project, which I am undertaking as part of my Doctoral course in Counselling Psychology (London Metropolitan University). Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with other people if you wish. If there is anything that is not clear or if you would like more information, please feel free to contact me on the number given at the end of this letter, but do take time to decide whether or not you would like to take part.

Purpose of the study

The focus of the research is on how black men adjust back to their lives after having experienced a Heart Attack, and the coping strategies that are used to do this. This entails looking at how men see their relationships, their work, the quality of their lives and their future. Additionally, the research is interested in what black men have found both helpful and unhelpful in dealing with their heart attack experience, and what they believe could be helpful in the future.

Much of the research that has been done in this area has not paid sufficient attention to the experiences of people who come from an ethnic minority, or who were not born in UK. The concern, therefore, is to create awareness of all the needs of our population groups so that the existing cardiac services can be more effective in meeting such needs. The study aims to provide a detailed exploration of such people's personal experiences of a heart attack and how they deal with it.

Why was I chosen to take part?

In order to obtain valuable research information about black men's experiences following a heart attack, I am hoping that men aged 50-70 (who have been admitted to the Homerton Hospital following a heart attack in the past 6 months), would be interested in discussing their views and experiences with me in an interview. The Cardiac Nurse has agreed to pass on this information letter to all men meeting these criteria, regardless of their interest in participating in the Cardiac Rehabilitation Programme. This is so that I can hopefully interview a range of men who have and have not attended the programme.

Do I have to take part?

It is entirely up to you whether you take part in this project. If you do decide to take part and later change your mind, you are free to withdraw at any time without giving a reason, and this will in no way alter the treatment or care you may receive in the future.

What is involved?

You will be interviewed, focusing on your heart attack experience. This interview will take approximately 60-90 minutes and will take place at the Homerton Hospital, or St Leonard's or in your own home if this is more convenient for you. For the sake of accuracy, all interviews will be tape-recorded and later transcribed, however, any identifying characteristics will be removed from transcripts and will not appear in any reports or publications on this research, so all you say will remain anonymous.

The interview will be followed up by a brief telephone call after about 2-3 months. This is to find out how things are going for you and check your agreement with the information gathered in the first interview.

Potential benefits of the study

Although it is not anticipated that this research will have any direct benefit for you individually, we hope that the information we get from the study may help to improve future care and support for people of various backgrounds, in their recovery from a cardiac event.

As a token of my appreciation of you taking part in the study, and to help off-set any inconvenience you may feel it may cause, I am offering £20.00 to each participant, and to cover any transport costs you may incur coming to the interview.

Confidentiality

All information, which is collected during the course of the research, will be kept strictly confidential. No information will leave the Primary Care Psychology Department with your name or address on it and all tape recordings will be kept securely and destroyed as soon as they have been transcribed. Transcripts will not contain any identifying information about you and will also be destroyed at the end of the study. However you may have the tape recording of your interview returned to you if you prefer.

If you are interested in taking part in the research, please complete the slip on the next page and return it in the self-addressed envelope provided. If you decide to return the slip I will telephone you so that we will be able to discuss the study in more detail and you can ask any questions that you may have. You are not committing yourself to participating in the project by returning the slip as you can decide whether you would like to go ahead once you have had the opportunity to discuss things in more detail and meet with me. If after our telephone conversation you feel that you may still be interested in taking part, we can arrange a time to meet where you will be able to ask any further questions before making a decision about whether to go ahead with the interview itself. If, however, you would like to discuss the project with me before returning the slip, please feel free to contact me directly at the Primary Care Psychology department on **020 7683 5004**, where you can leave a message for me on my answer machine. I will telephone you back as soon as possible.

I look forward to hearing from you,
Yours sincerely
Shirley Coventry
Chartered Counselling Psychologist

This response slip is to be sent by interested people to shirley coventry

I am interested in participating in the research you are undertaking, please telephone me so that we can discuss it further.

The best time to contact me is: ………………… (Day) ……….. Am/ pm*
(*Please delete)

NAME: ……………………………… DATE OF BIRTH: …………

ADDRESS: ………………………………………………………………

……………………………………………………………………………

……………………………………………………………………………

……………………………………………………………………………

TELEPHONE NUMBER: ……………………………………………

Please return this page/ slip to Shirley Coventry in the self-addressed envelope.

Thank you!

- -

St Thomas' Hospital Research Ethics Committee

Guy's and St. Thomas' Hospital NHS
NHS Trust

CONSENT FORM FOR PARTICIPATION IN RESEARCH PROJECTS & CLINICAL TRIALS

Title of Project:
A Qualitative Exploration of the Nature of Adjustment Following an MI or Heart Surgery, in a Sample of South Asian and Black Men.

Principal Investigator:	Shirley Coventry	**Ethics Committee:** University Hospital Lewisham
Other Investigator/s enrolling patients:	None	**Code No:** **LREC Ref No: 03/11/19** **Version No:** / **Date:**

Outline explanation:

Aims of the study

The aim of this study is to develop a better understanding of:

a) Views from men of ethnic minority groups on how a Myocardial Infarction (heart attack) / heart surgery impacts on:

- i) How they see themselves
- ii) Their relationships with other people
- iii) Their work
- iv) Their quality of life
- v) Their views about the future

b) How they deal with their experiences of a heart attack; what has helped or could help in the future?

Procedure for participants

Participation in the study involves taking part in an interview where you will be asked to discuss issues relating to your experiences of adjustment to the heart attack/ surgery. The interview will take approximately 60 minutes and will take place either at the Psychology Department at St Thomas' Hospital or in your own home if that is more convenient. Interviews will be tape recorded and later transcribed and any identifying characteristics will be omitted from the transcripts, on computer and on printed material. All tapes will be kept securely and destroyed at the end of the study.

Direct quotations from the interviews may be use when the project is written up or the findings published, but identifying details will be changed in order to maintain the same level of confidentiality normally applied to medical records. Information provided will not be distributed or used for purposes other than this project.

If at any point in the study you do not wish to answer certain questions or wish to withdraw from the study, you may do so without giving your reasons and this will not affect your treatment on a Cardiac Rehabilitation Programme.

I (name) ______________________________

of (address) ______________________________

____

hereby consent to take part in the above investigation, the nature and purpose of which have been explained to me. Any questions I wished to ask have been answered to my satisfaction. I understand that I may withdraw from the investigation at any stage without necessarily giving a reason for doing so and that this will in no way affect the care I receive as a patient

SIGNED (Volunteer) ____________________ **Date** ____________

(Doctor) ____________________ **Date** ____________

(Witness, where appropriate) ____________________ **Date** ____________

3 copies required:- one for researcher, one for patient/volunteer, one for patient's notes

RESEARCH COMPONENT OF PORTFOLIO OF COURSE WORK

VOLUME ONE, Section A

"The psychological adjustment of West African men post myocardial infarction – a Counselling Psychology study using Interpretative Phenomenological Analysis"

Thesis submitted in part fulfilment of the requirements of
London Metropolitan University for the degree of
Practitioner Doctorate of Counselling Psychology

SHIRLEY COVENTRY
BSocSc (Hons), BSc (Hons), MSc,
PPDipCounsPsych

July 2011

London Metropolitan University

NDON
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ersity

FORM FOR RESEARCH PARTICIPANTS

City and Hackney
Teaching Primary Care Trust

Title of Project: **Psychological Adjustment post heart attack (MI), in Black Men (A Qualitative Exploration)**	
Principal Investigator: Shirley Coventry **Other Investigator/s** None	**Ethics Committee Code No:** 09/H0701/28 **Version No:** 3 **Date:** 31st May 2009

Outline explanation:

Aims of the study
The aim of this study is to ascertain
a) the impact of diagnosis and acute adjustment at a physical and emotional level. This will entail learning how you i) see yourself ii) your relationships with other people iii) your work iv) your quality of life v) your views about the future
b) How did/ are you dealing with your experiences of a heart attack - what has helped or could help in the future?
c) Have you experienced cardiac rehabilitation and if so what are your views of it?
d) What are your main current concerns?

Procedure for participants
Participation in the study involves taking part in an interview where you will be asked to discuss issues relating to your experiences of adjustment to the heart attack. The interview will take approximately 60 minutes and will take place either at the Cardiac Rehabilitation department of the Homerton Hospital, or in St Leonard's or in your own home if that is more convenient.

Is this procedure acceptable? YES ☐ NO ☐ Sign and date: ....

Interviews will be tape recorded and later transcribed and any identifying characteristics will be deleted from the transcripts, and not recorded on computer or in printed material. Direct quotations from the interviews may be use when the project is written up or the findings published, but identifying details will be changed in order to maintain the same level of confidentiality normally applied to medical records. Information provided will not be distributed or used for purposes other than this project.

Is this procedure acceptable? YES ☐ NO ☐ Sign and date: ....

All tapes will be kept securely and destroyed at the end of the study. However, should you would like to keep the recorded interview, it will be returned to you.

Is this procedure acceptable? YES ☐ NO ☐ Sign and date: ....

You will be contacted after approximately 2-3 months to check you agree with the information obtained at the interview. If at any point in the study you do not wish to answer certain questions or wish to withdraw from the study, you may do so without giving your reasons and this will not affect your treatment on the Cardiac Rehabilitation Programme.

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APPENDIX 11b

City and Hackney
Teaching Primary Care Trust

FORM FOR RESEARCH PARTICIPANTS

I (name) ______________________________

of (address) ______________________________

____

hereby consent to take part voluntarily in the above study, the nature and purpose of which have been explained to me. Any questions I wished to ask have been answered to my satisfaction. I understand that I may withdraw from the investigation at any stage without necessarily giving a reason for doing so and that this will in no way affect the care I receive as a patient.

SIGNED (Participant) ______________________ **Date** ____________

(Primary Investigator) ______________________ **Date** ____________

3 copies required – one for researcher, one for the participant, one for the patient's file

INTERVIEW SCHEDULE

TO ELICIT THE ADJUSTMENT EXPERIENCE OF BLACK MEN FOLLOWING A MI

INTRODUCTION:

Thank you for agreeing to speak with me about the heart attack you experienced approximately ……ago. In our interview I was wondering if I could ask what effect the heart attack had on you, and how things may be different for you now and secondly, how you have dealt with these changes. Please talk as openly as you feel comfortable with and let me know if you want a break at any time.

1. BACKGROUND INFORMATION:

(Aim: creates context and assists build rapport)

But before we start the main part of the interview I'd just like to gather a few pieces of background information: Age, Marital status, Dependants, Former/ current occupation, Nature of cardiac event, Dates, Treatment, history of heart problem

2. IMPACT OF CARDIAC EVENT:

(Aim: ascertain impact of diagnosis and acute adjustment.)

I'd like to begin by asking generally about what happened before and then during your hospital admission, and how you found that experience. Can you describe how you reacted when the Drs told you your diagnosis? What was it like on the ward? How did you feel about going home? How did your partner/ family and/ or friends cope with the news, and manage when you went home?

Given your past experience, (quick reference/ sum*) I'm wondering how have things been for you since being discharged from hospital? And how the cardiac event has impacted on your life?*
(Take cues from acct. so far, comment on aspects already mentioned, positive/ negative)

A) *Physically*

(Aim: assess basic level of functioning and explore health related behaviours/ risk factors – compliance with exercise/ diet advice etc and then work; compare pre and post event; any envisaged problems in future? Look for any shifts in role, expectations etc).

B) *Emotionally*

(Aim: assess cognitive appraisal, and emotional status and perceived related specific **'causes'** note key cognitions relating to self, **future** and meaning of cardiac event.)

Self -How do you see yourself now - have you changed in any way? How do others see you?
Relationships With your partner, children, other relatives, friends – treated differently, seen as often? Any ended, do different things now?

(Assessing **social support** – before and current)
Ascertain any differences between pre-morbid and current self image/ physical functioning/ affect, thereby clarify quality of life, concerns for the future?

3. EXPERIENCE OF CARDIAC REHABILITATION (plus medical services).

(If chose not to attend, what were the reasons? If did attend, how helpful was it? How could it be more so/ what would have been preferred? What has changed? Also, what is your general view on your overall care and services?)

INTERVIEW SCHEDULE

4. CURRENT MAIN CONCERNS

(Probably covered already – summarise and lead to their evaluation of current quality of life)

5. OVERALL PATIENT EVALUATION OF COPING (DURING AND SINCE)

What sort of informal and formal support have you had (if not covered already)? And what was your view of it? What else has helped you in dealing with the situation (avoidance, talking etc) Is there anything else that you think is important for me to know about, to understand your experience?

6. DEBRIEFING (at the end, with the tape-recorder turned off)

How has it been talking with me today? Did you find it difficult and would like to talk further about some of your experiences?

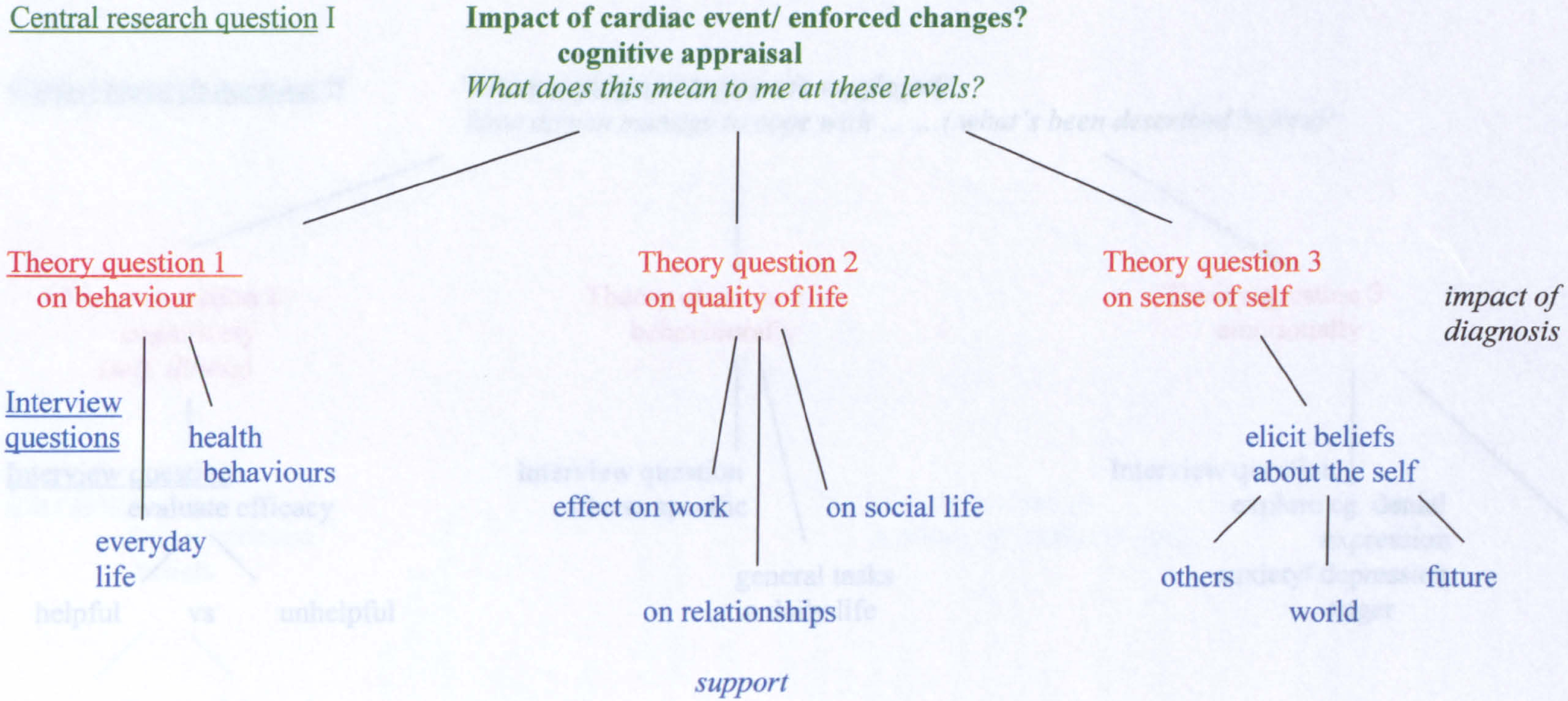
Set up the date of the 2 month follow-up telephone call

Thank you very much for speaking with me, and discussing your most valuable experiences.

B: PICK UP ON ANY CULTURAL REFERENCES, THEN ASK EXPLICIT ETAILS.

(Question branches)

<u>Research purpose</u>: What is the post Cardiac event adjustment process?



<u>Central research question</u> I

Impact of cardiac event/ enforced changes?
cognitive appraisal
What does this mean to me at these levels?

<u>Theory question 1</u>
on behaviour

<u>Interview questions</u>

health behaviours

everyday life

Theory question 2
on quality of life

effect on work

on social life

on relationships

support

Theory question 3
on sense of self

impact of diagnosis

elicit beliefs about the self

others

world

future

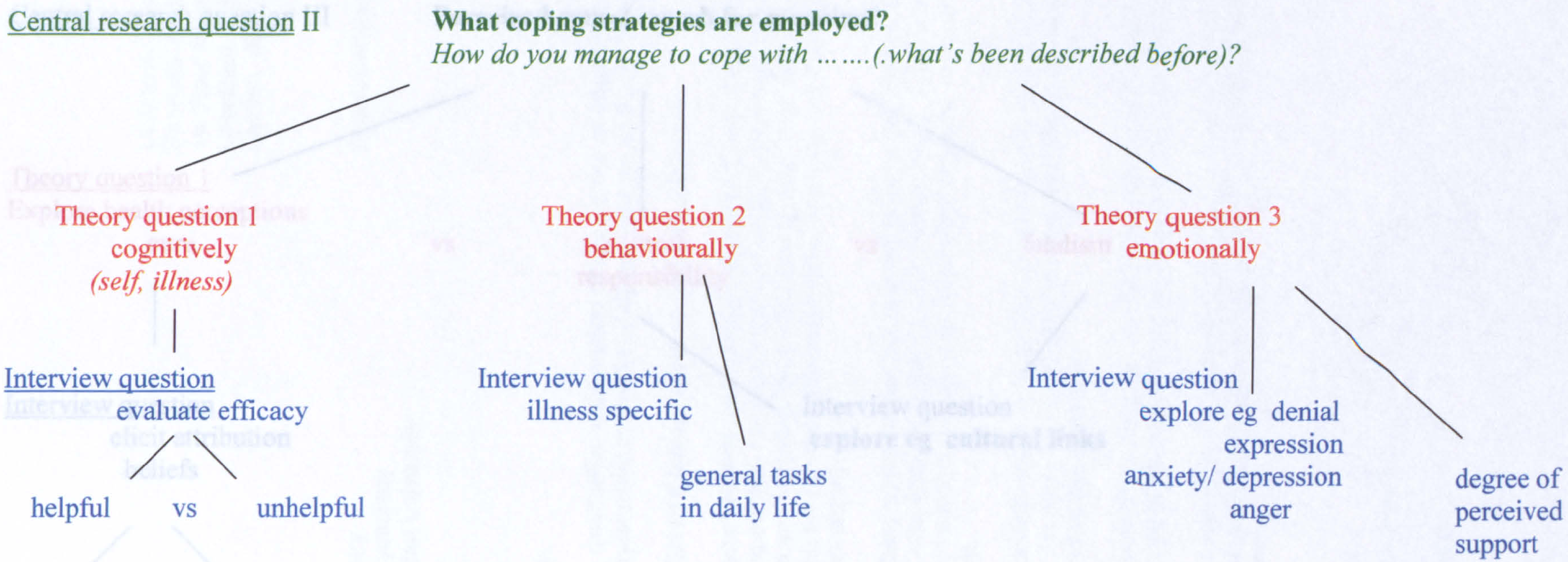
Avoidance vs adaptation
Premorbid vs current

NB: Cultural specificity

APPENDIX IV

(Question branches)

Research purpose: What is the post Cardiac event adjustment process for Black African men?



Central research question II

What coping strategies are employed?
How do you manage to cope with ……(what's been described before)?

Theory question 1
cognitively
(self, illness)

Interview question
evaluate efficacy

helpful vs unhelpful

Theory question 2
behaviourally

Interview question
illness specific

general tasks
in daily life

Theory question 3
emotionally

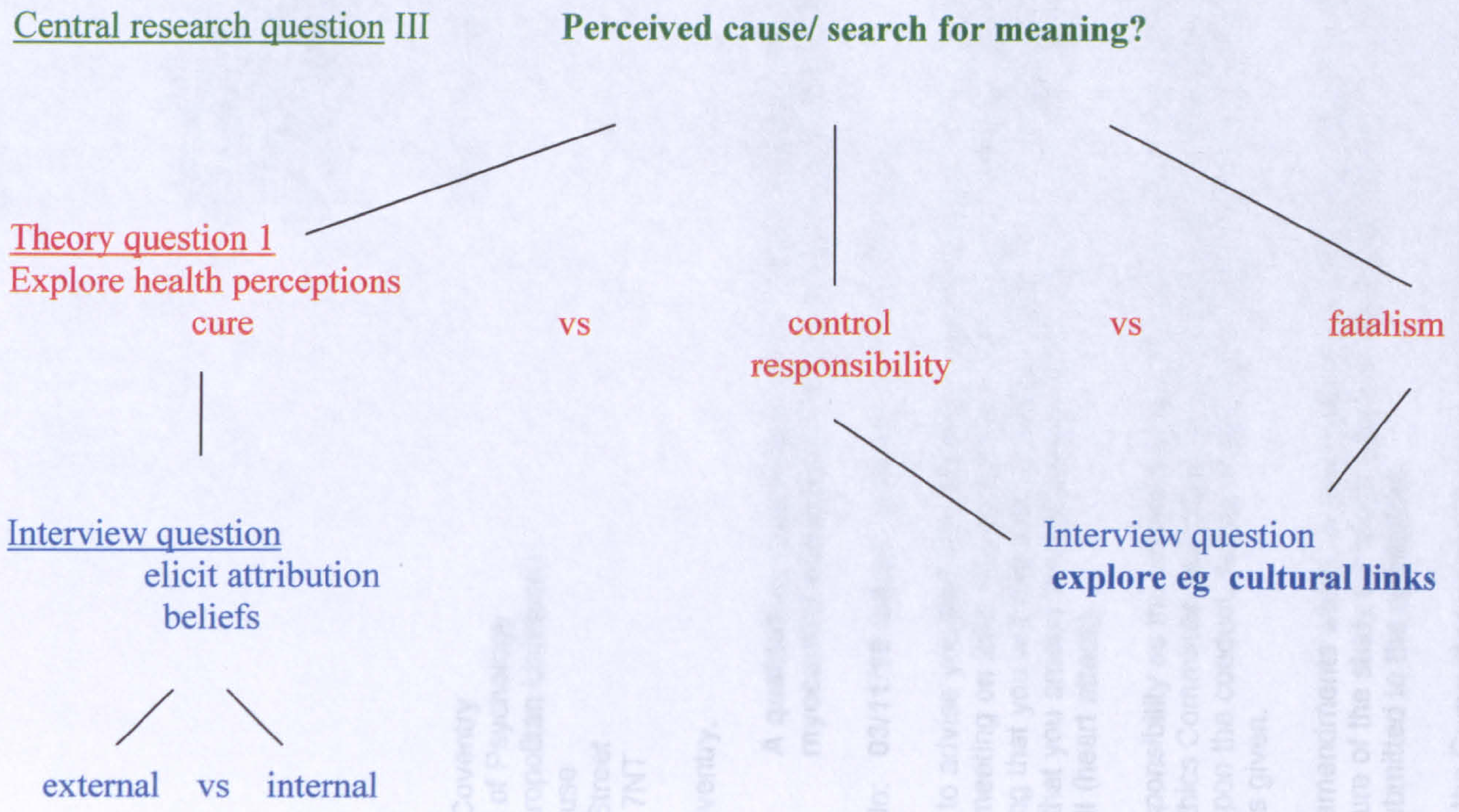
Interview question
explore eg denial
expression
anxiety/ depression
anger

degree of
perceived
support

NB: cultural specificity

(Question branches)

Research purpose: What is the post Cardiac event adjustment process for Black African men?



APPENDIX Va

NHS

University Hospital Lewisham
Research Ethics Committee
1st Floor Research Centre
Lewisham High Street
London, SE13 6LH

Ref: AJ/PM

26th November 2003

Ms Shirley Coventry
Department of Psychology
London Metropolitan University
Calcutta House
Old Castle Street
London, E1 7NT

Dear Ms Coventry,

Protocol: **A qualitative exploration of the nature of adjustment following a myocardial infarction (MI) in a sample of South Asian & Black men**

LREC Ref No: **03/11/19** (*please quote in all correspondence*)

I am writing to advise you that the Lewisham Research Ethics Committee considered your study at its meeting on 25th November and are happy to give their **approval** on the understanding that you will follow the protocol as agreed. The only change they would like to be made is that you amend the Information Sheet to simply use the term 'heart attack' instead of MI (heart attack).

It is your responsibility as the researcher who made the application to notify the Local Research Ethics Committee immediately you become aware of any information which could cast doubt upon the conduct, safety or an unintended outcome of the study for which approval was given.

If there are amendments which, in your opinion or opinion of your colleagues, could radically alter the nature of the study for which approval was originally given, a revised protocol should be submitted to the committee.

Members of the Committee would like to know the outcome of the study and therefore ask that a report or a copy of the results is sent to the administrator in due course.

Please note that ethical approval does **not** give you approval to carry out research within the University Hospital Lewisham Trust. For this approval you will need to contract the Research & Development Team.

Yours sincerely,

Pat Mark

pp Annette Jeanes
Chair, Lewisham REC

APPENDIX VIb

Outer North East London Research Ethics Committee
Board Room A
2nd Floor
Becketts House
2/14 Ilford Hill
Ilford
Essex
IG1 2QX

Telephone: 0208 9265025
Facsimile: 0208 926 5009

RECEIVED
12 JUN 2009

11 June 2009

Ms Shirley Coventry
Specialist Counselling Psychologist
(studying at London Metropolitan University) City & Hackney Teaching PCT
Primary Care Psychology Department
Second Floor - D Block
Nuttall St, London
N1 5LZ

Dear Ms Coventry

Study Title:	**A Qualitative study of the psychological adjustment of black men post myocardial infarction; does this relate to the low uptake of cardiac rehabilitation by black men?**
REC reference number:	**09/H0701/28**
Protocol number:	**1**

Thank you for your letter of 31 May 2009, responding to the Committee's request for further information on the above research [and submitting revised documentation], subject to the conditions specified below.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised].on the 11th June 2009

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

The favourable opinion applies to the following research site(s):

Research Site	Principal Investigator / Local Collaborator
City & Hackney Teaching PCT	Ms Shirley Coventry

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. *Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
response slip for participants	2	01 March 2009
flow chart	1	01 March 2009
Participant Consent Form	2	01 March 2009
Participant Information Sheet	2	01 March 2009
Interview Schedules/Topic Guides	2	01 March 2009
Compensation Arrangements		
Letter from Sponsor		
Summary/Synopsis		
Covering Letter	1	
Protocol	1	01 March 2009
Investigator CV	1	01 March 2009
Application	1	01 March 2009
letter from Unv. Hospital Lewisham dated 26.11.03		26 November 2003
letter app amendment Sub-Com Lewisham REC	1	25 April 2005
response slip	3	31 May 2009
Response to Request for Further Information	1	31 May 2009
Participant Consent Form	3	31 May 2009
Letter of invitation to participant	3	31 May 2009
Letter from Sponsor	1	16 March 2009
Covering Letter	1	31 May 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0701/28 **Please quote this number on all correspondence**

Yours sincerely

Janet Carter

Rev. Dr Joyce Smith
Chair

Email: janet.carter@redbridge-pct.nhs.uk

Enclosures: "After ethical review – guidance for researchers"
SL- AR2 for other studies]

Outer North East London Research Ethics Committee

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	09/H0701/28	**Issue number:**	1	**Date of issue:**	11 June 2009
Chief Investigator:	Ms Shirley Coventry				
Full title of study:	A Qualitative study of the psychological adjustment of black men post myocardial infarction; does this relate to the low uptake of cardiac rehabilitation by black men?				

This study was given a favourable ethical opinion by Outer North East London Research Ethics Committee on 11 June 2009. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

Principal Investigator	*Post*	*Research site*	*Site assessor*	*Date of favourable opinion for this site*	*Notes* [(1)]
Ms Shirley Coventry	Specialist Counselling Psychologist	City & Hackney Teaching PCT	Outer North East London Research Ethics Committee	11/06/2009	
Ms Shirley Coventry	Specialist Counselling Psychologist	City & Hackney Teaching PCT	East London & The City REC Alpha	11/06/2009	

Approved by the Chair on behalf of the REC:

Janet Carter........ (Signature of ~~Chair~~/Co-ordinator)
(delete as applicable)

………………………………………………… (Name)

(1) *The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.*

City and Hackney
Community Health Services

Mrs Cindy Hall
City and Hackney Community Health Services
Strategic Development
1st floor D Block, St Leonard's
Nuttall Street
London
N1 5LZ
United Kingdom

11/08/2009

Ms Shirley J Coventry
NHS City and Hackney Teaching Primary Care Trust
Primary Care Psychology Team
2nd Floor, D Block
St Leonard's, Nuttall Street
London
N1 5LZ

Dear Ms Shirley J Coventry,

Full Trust Approval: *A Qualitative study of psychological adjustment of black men post myocardial infarction; does this relate to the low uptake of cardiac rehabilitation by black men?*

Thank you for forwarding full details of the above study. As NHS City and Hackney Community Health Services Lead for R&D I am writing to confirm full approval of this research. This approval applies only to the specific protocol and informed consent procedures approved by the Outer North East London Research Ethics Committee (09/H0701/28), and any deviation from the approved protocol and/or informed consent procedures will be deemed research misconduct. Amendments will require further approval from the relevant Research Ethics Committee, and further approval from this Trust.

I note that the NHS City and Hackney Community Health Services will be taking on the role Sponsors for this study, and have ensured that the appropriate indemnity or suitable financial arrangements are in place for compensation in the event of harm to research participants.

Approval is provided on the basis that you agree to adhere to the Trust's requirements for Research Governance including:

- As Chief Investigator and/or Principal Investigator for this study you have familiarized yourself with, and accept the responsibilities commensurate with this position, as outlined in the Research Governance Framework (http://www.dh.gov.uk/PolicyAndGuidance/ResearchAndDevelopment/fs/en).

- Compliance with all policies and procedures of the Trust which relate to research, and with all relevant requirements of the Research Governance Framework.
- Co-operating with the Trust R&D Office's regular monitoring and auditing of all approved research projects, including complying with requests for written progress reports.
- Informing the Trust R&D Office *immediately* of any adverse events or complaints, from participants recruited from within this Trust, which occur in relation to this study.
- Co-operating with the Sponsor organisation in managing, monitoring and reporting of the research study.
- Sending a copy of any reports or publications which result from this study to the Trust R&D Office.

Failure to abide by the above requirements may result in the withdrawal of the Trust's approval for this research.

Please note that researchers who will have a 'direct bearing on the quality of care' of a patient, or accessing identifiable patient information/data may be required to hold an honorary contract with the Trust or the relevant Practice before they start work on this study. Details of the application process for Research Passports and Honorary Contracts with the Trust are available from myself, or Tanvir Ahmed, Clinical Audit and R&D Co-ordinator tanvir.ahmed@chpct.nhs.uk

I wish you every success with this study.

Yours sincerely,

C Hall

Cindy Hall
Clinical Effectiveness and R&D Manager

BEST COPY

AVAILABLE

TEXT IN ORIGINAL IS CLOSE TO THE EDGE OF THE PAGE

APPENDIX Vd

Homerton University Hospital NHS
NHS Foundation Trust

Research & Development Committee
Chair: Dr Narendra Aladangady

Linda Stephenson
Research & Development Manager
linda.stephenson@homerton.nhs.uk

Research & Development Office, Picton Suite,
Homerton Hospital
Homerton Row
London E9 6SR

Tel: 020 8510 5134
Fax: 0208510 7850
www.homerton.nhs.uk

Ms Shirley J Coventry
NHS City and Hackney Teaching Primary Care Trust
Primary Care Psychology Team
2nd Floor, D Block
St Leonard's. Nuttall Street
London N1 5LZ

13th August 2009

Dear Ms Coventry

Re: Research study: A Qualitative study of psychological adjustment of black men post myocardial infarction; does this relate to the low uptake of cardiac rehabilitation by black men

R&D No: CA0901 Research Ethics No: 09/H0701/ 28

Thank you for sending all the relevant documents for Homerton University Hospital Trust Research and Development Approval of the above research study. As part of the Research and Development approval process we have conducted a site specific assessment for this study. I am happy to inform you that the Trust has approved the conduct of the study and that the Trust will indemnify against negligent harm that might occur during the course of this project

I would like to draw your attention to the following conditions of the approval of this research project with which you must comply. **Failure to do so may result in the Trust withdrawing R&D approval which allows you to conduct this research project at Homerton University Hospital NHS Foundation Trust.**

Untoward events - Should any untoward event occur it is **essential** that you complete a clinical incident form and write on the form **'R&D'**. Contact the R&D Office immediately and if patients or staff are involved in an incident you must also contact the Risk Manager on 020 8510 7649.

Status of Research - Inform us if your project is amended or if your project terminates early/requires an extension as well as informing the Research Ethics Committee. This is necessary to ensure that your indemnity cover is valid and also helps the office to maintain up-to-date records. A copy of any publications arising from the research should be sent to the R&D Office for use in the R&D Annual Report. Please be reminded that this hospital should be acknowledged in any publication.

Research Information - You will be required to complete a project update as required by the R&D Office to ensure that we have up to date information so that we can send accurate reports to the DoH and research networks. The project update form will be emailed or sent to you by the R&D Office.

Research Governance - As part of research governance, all investigators accessing identifiable personal information are required to comply with current data protection requirements.

Intellectual Property - If you believe that protectable intellectual property may arise from your research, please contact the Linda Stephenson R&D Manager on ext 5134 who will advise you on the proper course of action.

Monitoring of Studies – You must comply with the Trust's legal responsibility as host of this research project to monitor and audit the research to ensure that the Research Governance Framework and Good Clinical Practice (GCP) if applicable is being adhered too. Monitoring questionnaires will be sent to you and random audit visits will also take place across the trust and will be conducted following at least a seven day notice period. **Failure to respond to any of these monitoring or auditing requests may result in the Trust withdrawing your R&D approval to conduct this research at Homerton University Hospital NHS Foundation Trust.**

Please note that all NHS and social care research is subject to the DoH *Research Governance Framework*. If you are unfamiliar with the standards contained in this document, you may obtain details from the Trust R&D Office or from the DoH website (www.dh.gov.uk).

Please do not hesitate to contact Linda Stephenson, Research and Development Manager or me if you have any further questions.

Yours sincerely,

Brown

Pauline Brown
Deputy R&D Director

CC Study Sponsor: Cindy Hall, City and Hackney PCT
Encs Copy of Approved Data Protection Form

APPENDIX VI a

Mr Aj Transcript accompanied by his wife

Blue = descriptive; Green = linguistic pink = conceptive

	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
	Aj and his wife started talking from the moment we met, so the tape only commences after he had started to recount his experiences				
	--				
Int	So if I can just clarify, because all that's	1.			
	happened that night has been really	2.			
	upsetting, hasn't it, with regard to what	3.			
	seems like a bit of mismanagement	4.			
	perhaps?...	5.			
Aj	That's right, yes.	6.			
Int	and I'm sure that was frustrating.	7.		Expressing intense	Hospital
Aj	*I was very, very depressed* and scared, and	8.	Very depressed emphasised,	emotions	experience
	cried a lot.	9.	*scared; cried a lot*	Depression	
Int	Would you say that the tears were because	10.		fear	
	you didn't understand what was happening	11.		crying	
	and um ...	12.			
Aj	And I had such strong feelings but there was	13	Intense feelings	intense emotions	Hospital
	no one to talk to, to say this is what you	14	Isolated, no help or advice	isolated from help	experience
	should do.	15	available, helpless	needs not met	
Int	So how long were you in hospital for?	16	Needs not met	helplessness	Impact of diag
Aj	After I was discharged, after the operation, I	17	One week hospitalised	dependency	Coping style
	had been in a week.	18			
Int	And so at discharge, when you were allowed	19			
	to go, what did they tell you would be the	20			
	following procedure ...?	21			
Aj	They didn't tell me anything ...	22	d/c with no info, no advice,	Lack of medical	Hospital
Wife	I was trying to speak with someone to try	23		knowledge	experience
	and help us, i was desperate ..	24			

APPENDIX VI a

Mr Aj Transcript accompanied by his wife

Blue = descriptive; Green = linguistic pink = conceptive

	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
Int	Mmm, So, um	25			
Aj	they didn't, they didn't tell me any	26	isolated from info, not know	Not know what to	Hospital
	procedure	27	what to expect	expect	experience
Int	And they didn't tell you what was to happen	28			
	next?	29			
Aj	No, they didn't tell me anything, all they	30			
	told me was to come back to the hospital on	31			
	that Saturday, I was going there for my	32			
	warfrin blood test ...	33			
Wife	I kept asking them for an assessment, of his	34			
	ccondition	35			
Int	*And what did they say?*	36			
Aj	They say, they said it was um too expensive	37			
Wife	Yeh they said it was too expensive	38			
Aj	Plus, she's she's not ..	39			
Wife	I was thinking of myself, how would i look	40			
	after him,	41			
Int	You were physically worried?	42			
Wife	Yeh	43			
Int	When did you have your stroke?	44			
Wife	It was 2000 actually, but I had another one,	45			
	so it was twice	46			
Int	Uhhh	47			
Wife	But i'm better because i used to use a	48			
	wheelchair, then i went on to 2 sticks, and i	49			
	used a frame, then 2 sticks then one stick	50			
	now.	51			
Int	So that's very good, but it sounds like it has	52			
	been still difficult ...	53			

Mr Aj Transcript accompanied by his wife

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	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
Wife	It depressed me actually	54			
Aj	Yeh yeh yeh	55			
Wife	Because i take a lot of tablets and um, some	56			
	of them worrys me as well, and that adds to	57			
	the problem, and this added to the problem	58			
Aj	It was, it was so depressing that i was	59			
	crying, a lot.	60			
Int	But now, when was it that you , um was this	61			
	straight after,	62			
Aj	Um after a week I got home	63			
Int	Um right, so after a week's stay in hospital	64			
	you then got home,	65			
Aj	Yes and after that one week, I was very	66	very depressed,	Depression	Immediate post d/c
	depressed … that kind of fear …	67			
Int	Was that quite soon after you got home?	68			
Aj	Yeh	69			
Int	And that fear was... ?	70		Fear of being alone	Immediate post d/c
Wife	That he couldn't stay on his own	71	fear/ hated being alone		
Int	Because, what was the fear ..?	72			
Aj	I don't know, I had some flashbacks, you	73	flashbacks to time in	Flashbacks to event	Immediate post d/c
	see when I had the operation, I thought	74	operation, belief awoke		
	maybe I don't know, I woke up, I thought	75	during op		
	maybe I woke up too early.	76			
Int	What did you see? Or made you think that?	77			
Aj	I saw, I saw, I started asking questions, I	78	trying to make sense	Confusion at event	Hospital
	thought I was amongst the dead people …	79	asking if amongst the dead	Trying to understand	experience
Int	Mm, mm, and where was that, in the	80	people		
	recovery room?	81			
Wife	Yes. The recovery room.	82			

Mr Aj Transcript accompanied by his wife

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	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
Int	Which is where you would have been	83			
	revived anyway?	84			
Wife	Yes	85			
Int	But you thought you were still having the	86			
	operation?	87			
Wife	Yes, they sent him back	88			
Int	What was ..	89			
Wife	No they gave him ummm sedation,	90			
Aj	I woke up, woke up I had the operation on	91			
	the Friday, I woke up on the Friday at	92			
	midnight, you know, then, then I started	93	Confused, asking nurses	Asking for	Hospital
	asking the nurses questions.	94	questions	information	experience
Int	In the ward?	95			
Wife	No in the recovery room?	96			
Int	Ok. And that's where they gave you more	97			
	anaesthetic?	98			
	(confused discussion, all speaking at once!)	99			
Wife	Yes, you see what happened was they were	100	Staff concerned about him,		
	worrying about him because his blood	101	medical complications	Aware of medical	Hospital
	wasn't clotting, I was there, they gave him 6	102		concern	experience
	units of blood and it wasn't clotting, it was,	103			
	I was worried as well, … they were worried.	104			
Int	So then, so they were concerned, and um	105			
	you think they gave you some more	106			
	anaesthetic because maybe they wanted you	107			
	to relax some more,	108			
Wife	Yeah, yeah,	109			
Int	to calm down, and then ….	110			
Aj	And then I woke up on Saturday and I was	1111	Awoke crying, very	Expressing intense	Hospital experienc

Mr Aj Transcript accompanied by his wife

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	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
	crying and crying	12	distressed	emotion	
Int	Gosh, that must have been very alarming	113		crying	
	because it's disorientating, you've had the	114			
	anaesthetic, you wake up and are not sure	115			
	what is happening, a bit of you is aware and	116			
	a bit of you is still under the influence of the	117			
	drugs, and it's all mixed up ... very	118			
	confusing.	119			
Aj	All mixed up	*120*	*Confused,* all mixed up	Confusion during	Hospital
Int	When one is drowsy but hears people	121		*hospitalisation*	*experience*
	talking and perhaps understands some of	123			
	that, and imagines the worst, that must be all	124			
	very upsetting.	125			
Aj	Yes very, and I was telling the nurses ... at	126	Telling staff wanting to	Wanting to leave	Hospital
	that time, that I wanted to go home.	127	leave	confusion	experience
Int	And that was all on that day, immediately	128			
	after the operation?	129			
Aj	nodding	130			
Int	Because it was too frightening?	131			
Aj	Yes, much too frightening, I was telling	132	overwhelming, wanting to	Overwhelming fear	Hospital
	them that I wanted to go home and see my	133	leave to be with family, not	Desperate to be with	experience
	family. And they said no, that "You can't go	134	allowed, staff preventing	family	
	home, you're in the ward". And they were	135	leaving, powerless	powerlessness	
	asking me what was going on, and I was	136			
	telling them ... oh ... they said that they	137	staff trying to make him		
	didn't understand me ... I wanted to write it	138	understand, they can't		
	down, ... I thought they would give me	139	understand him, he can't	Can't communicate	Hospital
	something to write ... a pen ... but they	140	communicate, desperate to	needs	experience
	brought a dish .... and then I didn't know	141	be understood	Desperate to be	

Mr Aj Transcript accompanied by his wife

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	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
	what happened. Then I woke up ...	142	no control, no agency	understood	
Int	And then you woke up in the ward?	143			
Aj	I woke up no, you see, that was the problem,	144		No control	
	that was Saturday. I only went to the ward	145		No agency	
	on Sunday.	146			
Int	So throughout that period of time that you	147			
	were in the recovery room, 2-3 days, that's	148			
	where the difficult memories come from?	149			
	Waking up, not feeling understood, feeling	150			
	very upset and feeling that you want to go	151			
	home but can't .... ?	152			
Wife	The second time he woke up i was there	153			
Aj	the first time, is to when I had that flashback	154	Flashback to image of dead		Hospital
	... that kind of fear ... that I asked if I was	155	people, terrified, want to	Flashback to distorted	experience
	lying there with dead people, they said no,	156	leave,	image	
	then I really wanted to go home ... that kind	157		Intense fear	
	of fear.	158		Desperate to leave	
Int	And the fear was ..... that you're not	159			
	amongst dead people, that you've actually	160			
	survived and come through, so what was the	161			
	fear ....?	162			
Aj	Yes but the fear was that I was dead	163	Believed he was dead		
Int	That you were dead, so you didn't really	164		Believed death was	Hospital
	believe what they were saying?	165		immanent	experience
Aj	No, you see it was midnight and it was very	166			
	dark ... all dark ..., I was crying and crying,	167	Emphasis of darkness.		
	because ..... there were maybe about 3	168	Explanation of fear –	Pleading to live	Hospital
	people lying on beds, ... but, but they	169	believed image of being in a	Crying because of	experience
	looked like corpses ... even when I saw my	170	morgue,	belief of the distortion	

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	Dialogue	**Id**	**Analysis 1 Initial code/ exploratory comments**	**Analysis 2 Emergent theme**	**Analysis 3 Super-ordinate theme**
	wife by my side.	171	Believed would die,		
Wife	But then he was crying as well "I don't want	172			
	to die, I don't want to die" speaking in my	173		Confusion	Hospital
	language.	174	Staff couldn't understand,	Being misunderstood	experience
Int	That you speak in Nigeria?	175	he was disoriented, pleading		
Wife	They couldn't understand what he was	176	in own language,		
	saying, I had to translate for them, and was	177	misunderstood, wife could		
	saying "You're not going to die" you know,	178	not console or reorient	Inconsolable	Hospital
	"You've survived", you know ...	179			experience
Int	Right, so the second time you woke up and	180			
	your wife was there, you were crying and	181			
	you were very sure that you might die, even	182			
	though you came through and were	183			
	oriented?	184			
Aj	Yes ....but, but you see the nurse told me	185	Reason for belief: pre-op		
	before I went for the operation that I was	186	explanation of clinical death	Misunderstanding of	Hospital
	going to be 'clinically dead' for about 1	187	(medical procedure)	medical information	experience
	hour	188	misunderstood		
Wife	Yes, and he couldn't move as he had so	189			
	many gadgets attached to him, some here	190	Wife trying to reassure, but		
	some here, and machines too ...	191	unable to physically move,	Feeling physically	Hospital
Int	Yes and so frightening	192	trapped by much equipment	trapped	experience
Wife	Yes, hanging here and there. At one time he	193			
	had like here a team of them, some here,	194			
	some here, before they removed the	195			
	machine through which he was breathing.	196			
	Some were dangling.	197			
Aj	I said I had that pain, i had a lot of pain here,	198	Pain	pain	
Int	Right, so, so just to clarify that, you	199	Explanation given when	physical experience	Hospital

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	Dialogue	**Id**	**Analysis 1 Initial code/ exploratory comments**	**Analysis 2 Emergent theme**	**Analysis 3 Super-ordinate theme**
	remember the nurses saying to you that you	200	given pre-med		experience
	would be 'clinically dead' during the	201			
	operation, and it sounds like that .... Um	202			
	when did she tell you that ...?	202			
Aj	Um, I think that was when she, um, she was	203			
	giving me some medication or something.	204			
Int	Was that just before you went to have the	205			
	surgery?	206			
Aj	Yes ...	207			
Int	Maybe it was what they call the 'pre-med',	208			
	medication to help you relax just before the	209			
	surgery.	210			
Aj	Yes, yes.	211			
Int	So, if I understand correctly, that was maybe	212			
	one of your last, if not the last conversation	213			
	that you had, that conversation with the	214			
	nurse when she told you about being	215			
	'clinically dead' during the operation, before	216			
	they took you to theatre? So do you think it	217			
	was possible that when you woke up in the	218			
	High Dependency Unit, or wherever that	219			
	was, that you thought you were with dead	220			
	people because death had been the last thing	221			
	you had spoken about before going under	222			
	anaesthetic, your last memory before	223			
	waking up?	224			
Aj	Yes, yes you see I thought maybe I woke up	225	Belief that woke during		
	too early, you know ...	226	'clinical death' part of op;	Belief in distortion	Hospital
Int	That maybe you were woken up in the	227			experience

	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
	middle of that 1 hour of 'clinically dead'	228			
	time?	229			
Aj	Yes, that's it, I kept thinking 'No, I don't	230	Refusal to die, pleading for		
	want to die' and I was crying and crying	231	life, terrified, crying a lot	Expressing intense	Hospital
Int	Very frightening, I'm sure........ it does	232	dramatic	emotions	experience
	make it much more understandable though,	233		Desperate to live	
	doesn't it, it's no wonder that you were so	234			
	terrified when one understands what had	235			
	happened just before the surgery, thinking	236			
	about death just before the anaesthetic and	237			
	then waking up in darkness with what	238			
	looked like bodies around you, it's not	239			
	surprising perhaps for you to have thought	240			
	you were dead. So that is the fear that comes	241			
	back to you when you have a flashback?	242			
Aj	Yes, and also I was having some pain at	243	Pain from equipment sites, ?	pain	Hospital
	some of these places, the places where all	244	triggering flashbacks to time		experience
	those tubes and things were going in to me.	245	thought dead; still having	Ongoing flashbacks	
	By the time I got home I was having	246	flashbacks and pain post d/c	Continuing pain	
	flashbacks to those days. Still having these	247	too		
	pains, so sore.	248			
Int	Mm	249			
Aj	And so that when I got home I had to go and	250	Worried because not	worry	Emotional response
	see the GP. But I was very worried because	251	advised about post op care,		(post d/c)
	they hadn't told me when I left the hospital,	252	? felt abandoned		
	what to expect.... you know, ... I had	253	Problem solving	Not know what to	Coping strats (post
	some pamphlets we had picked up from the	254	attempts to sort out,	expect	d/c)
	ward, and so I read them and then 'phoned	255	unknown to system' having	Worry as not have	
	the cardiac rehab for advice. Yes and it was	256	to re-engage,	information	Lack of medical

	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
	then that I spoke to the cardiac rehab nurse	257	Breakdown of system		support post d/c
	who didn't know who I was, I had to tell her	258	'Slipped through net'	Seeking help and	Coping post d/c
	about my operation, you know. They said to	259		advice	
	me I must have slipped through the net.	260			
Int	Right....	261		Medical system broke	Lack of medical
Aj	This is what they explained must have	262		down	support post d/c
	happened, so instead of the doctor coming to	263		'slipped through the	
	me, I had to go to the GP, and the GP said	264	system unhelpful, having to	net'	
	that a mistake had happened, and she should	265	rely on self. GP said mistake	Having to be self-	
	have visited me at home, you see.......	266	no follow-up.	reliant	
	During this time I couldn't sleep, also I	267			
	would sit in the sitting room on my own	268			
	watching TV but for no longer than5-10	269	Sleep probs due to fear, TV	sleep difficulties	
	mins. I hated being on my own, you know, I	270	not effective distraction,	hate being alone	Emotional response
	was very, very anxious .... I kept thinking I	271	hated being alone,	highly anxious	post d/c
	was going to die, so even if my wife was in	272	very anxious, feared dying	seeking company to	Coping strat post
	the kitchen for more than 10mins I couldn't	273	Sought company to alleviate	alleviate fear	d/c
	be on my own, I'd call her or go and find	274	fear		
	her, I couldn't be on my own for long.	275			
Int	How long did this carry on for?	276			
Aj	Even up to now, but it's much, much better,	277			
	but I still don't like to be on my own for a	278		fear of being alone	Few months post
	long time. it's got much better since seeing	279	Fear when alone still	still prevalent	ce
	my GP who started to sort things out, you	280	prevalent, improved over	Much improved since	
	know and then the CR nurses. Over time it's	281	time, system kicked in,	system of care in place	
	much better. But then, when I was	282			
	discharged the dressings were still needing	283	CR nurses and dr helpful		
	to be done and my wife found this difficult,	284	'over time it's much better'	Home care worrying	
	you know? She was worried about doing	285	Wife own concern about	for wife	Support from

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	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
	them.	286	giving home care		others post d/c
		287			
Ir	*Mm. So then when you* were discharged you	288			
	felt that the hospital had now finished *with*	289			
	you? That they would no longer be involved	290			
	in looking after you, but you still obviously	291			
	had ongoing problems, it's not surprising	292			
	that you were worried.	293		Belief of system	Lack of medical
Aj	Yes because I had slipped through the net	294	'slipped through the net'	failure	support post d/c
	really.	295			
Ir	So the fear and anxiety that you felt related	296			
	to your concerns about your cardiac	297			
	condition – you said that you were still in	298			
	much pain – and not really having a medical	299			
	system or medical help set up? As it would	300			
	have been had you not 'slipped through the	301			
	net'?	302			
Aj	Yes	303			
Ir	Right, so I understand the fears that you had	304			
	while in hospital, just after your operation,	305			
	linked to the fears that you might die. So,	206			
	looking back, there were firstly the	307			
	frightening experiences in the recovery	308			
	room/ or maybe High Dependency Unit, and	309			
	then secondly after discharge, the fears	3103			
	about your health and being cared for then,	11			
	with the fears associated with the flashbacks	312			
	(to your inpatient recovery room	313			
	experience). So looking at your situation	314			

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	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
	now, now that you know that you are in the	315			
	medical system, with cardiac rehabilitation,	316			
	do you feel a little more reassured about	317			
	your follow – up care?	318			
Aj	Oh yes, I would say so, but now I still don't	319			
	like being on my own for very long. Also,	320	despite medical help, still	Problems still exist	Few months post
	before the operation they told me about	321	problems,	despite medical help	c/e
	possible complications, the surgeon said that	322	Hates being alone	Dislike being alone	
	in about 3% of cases there are complications	323			
	and the surgery may not help, and not be	324	Fears reoccurrence of	Previous	Few mths post c/e
	successful, and then when I had the	325	complications due to earlier	complications drive	
	complications with the blood clotting	326	complications	current fears of	
	problem, and others, I thought maybe I'll	327	Low probability not allay	recurrence	
	get an infection and cause more	328	fears		
	complications, and the surgery, you know,	329	Fear surgery won't be	Pain triggers fear of	Few mths post c/e
	won't be successful …… Sometimes I think	330	successful,	further complications	
	of the pain …. now, as further	331	Pain triggers fear of further		
	complications.	332	complications		
Ir	Right, I see. Right ……..	333			
	Can I ask you now about, about when you	334			
	had your heart attack in 2001, and your	335			
	recovery from that ….. how would you	336			
	describe it?	337			
Aj	Oh … it was a shock, I was in for over a	338			
	week, and then I had another one in the	339			
	ward, and they had to resuscitate me, on the	340	Previous MI and resus	First MI shocking	Pre MI
	ward.	341	shocking		
Ir	Gosh, that must have been a very difficult	342			
	experience to get over?	343			

	Dialogue	ld	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
Aj	Yes, but I didn't think I was going to die.	344			
Int	Why was that do you think?	345		Good pst med	
Aj	The surgeon explained my arteries were	346	But no fears of dying,	experience	Degree of trust in
	then alright, during the angiogram, I saw	347	Due to clear explanations,	No fears of death post	medical system
	everything that he did.	348	helpful, witnessed	1st MI	
Int	So that was helpful? They were able to	349	procedure	Clear verbal	
	explain	350		explanation supported	
Aj	Yes, that was helpful, I could see that they	351		by visual evidence	
	had sorted it out, yes, and the medication	352	Witnessing = evidence of	allayed fears	
	was good, after that weekend I was	353	success		
	discharged.	354	And effective treatment	Witnessing provided	
Int	So that time you were sufficiently reassured	355		evidence of success	
	by what they had done, and, and what they	356		Positive effects of	
	had told you?	357		medication	
Aj	Yes and they had a follow-up too, they told	358			
	me what would happen, I did everything	359	Continuous care,		
	they told me and after about 6-9 months I	360	Given info about what to	Benefit of continuous	
	stopped seeing them.	361	expect	care	
Int	So that was quite a different experience in	362	Compliant with hospital	Information given	
	so far as it was all quite well managed.	363	recommendations	about what to expect	
		364		Compliance with	
		365		treatment led to	
Int	So if you didn't have the pain now, you	366		recovery	
	would feel more sure that there aren't going	367			
	to be any complications? Is the pain a	368			
	reminder that things can still go wrong?	369			
Aj	That's what I believe, I don't know why this	370			
	pain is here now. It's changed it's position	371	Needs explanation about the	Pain explanation	Few months post
	now, from the left side on discharge from	372	pain,		c/e

APPENDIX VI a

Mr Aj Transcript accompanied by his wife

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	Dialogue	ld	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
	the hospital, to now the right side, and I	373	Concern about change in	Altered pain	Cog appraisal
	don't know why.	374	pain presentation, belief that	presentation	
		375	pain means future problems,	Pain is inexplicable	
	(Discussion about the extent of surgery.)	376	uncertainty	Pain indicates future	
		377		problems	
Int	How often do you experience the flashbacks	378			
	now?	379			
Aj	Oh now? Hardly ever, only occasionally	380			
	when I am alone, when my wife goes out to	381	flashbacks rare,		
	the shop and sometimes before I go to sleep.	382	occasionally when alone,		
	At night I watch the sports channel on TV	383	↑ fear when isolated	Flashbacks less	Few mths post c/e
	and the Christian channel, and now a little	384		prevalent over time	
	of the News, now. Before I couldn't watch	385	Now watches little TV		
	the News because, at all, because it was all	386	news, before was avoidant		
	about the Iraq war .... Seeing so many dead,	387	of the news, feared		
	so many people killed ..... and I used to	388	reminders of death, used to		
	think of that fear .... when, you know, I was	389	trigger flashbacks to	Less Avoidant of	Few mths post c/s
	lying there with the dead people.......	390	'morgue' image,	images of death	Coping strats
	Sleeping tablets were quite useful then,	391			
	when I was discharged, but now I don't take	392	Sleeping tabs useful then to		
	them all the time, I worry that I might	393	cope, now improved		
	become addicted to them. But I don't need	394	Concern about addiction,		
	them all the time now anyway.	395	but less need for night	Sleeping tablets useful	Few mths post c/e
		396	sedation,	early on	Coping strats
		397		Less dependent	
	Long explanation about cardiac rehab and	398			
	the usual follow-up services, in trying to	399			
	understand how Aj was missed by the	400			
	services.	401			

Mr Aj Transcript accompanied by his wife

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	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
		402			
		403			
j	Before, before the operation I had um,	404			
	breathlessness, bad breathlessness. We live	405	Severe pre-op symptoms of	Severe breathlessness	Pre mi sx
	on the 2nd floor, by the time I had finished	406	breathlessness,	before operation	
	with the first flight of stairs I had no breath.	407			
	With the operation now I'm much better.	408	Operation relieved	Symptoms relieved	
	My wife says I'm a little slow, but we see it	409	symptoms, pleased, still	post op	
	as exercise. I'm better now, I'm sure I'll get	410	slow but		
	there, I'm ok.	411	Optimistic about future	Optimistic about	Few mths post c/c
nt	So that sounds optimistic	412	improvement	ongoing recovery	View of future
j	Oh yes	413		Positive eval of health	
nt	I'm just thinking about the fear that you	414			Cog appraisal
	talked about earlier, about being left alone,	415			
	at that time that your fear heightened with	416			
	the worry that you might die, but at the same	417			
	time in your head it sounds like you also had	418			
	the conversation in your head that 'I've had	419			
	heart surgery which has really relieved my	420			
	previous suffering with breathlessness'. So	421			
	there seems to be kind of contradictory	422			
	kinds of thoughts in your head?	423			
j	Yes. Just before I went into hospital I	424			
	thought I was dying, I felt very sick, feeling	425			
	I was dying, feeling so sick ... "Please get	426			
	me to the hospital", that Thursday, just like	427	Felt dying before admitted,	Believed would die	
	that. Afterwards the surgeon was happy, he	428	desperate for admission	before admitted	
	told us when he came to the ward. I must	429			
	say that, but before, I know that man was	430			

Mr Aj Transcript accompanied by his wife

Blue = descriptive; Green = linguistic pink = conceptive

	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
	disturbed by me, he didn't know what the	431	Surgery successful, but Dr	Aware of doctor's	Hospital
	devil was going on .... And afterwards there	432	struggled,	concerns	experience
	was a lot of blood, blood oozing out ...	433	Pick up on Dr's fears,		
	When they had problems getting the blood	434	Much blood loss post op,	Physical experience	Hospital
Int	to clot?	435	fearful	complications	experience
	Well yes, when the dressing was looking	436			
Aj	very bad, that was my first fear before they	437			
	said we could go home.	438	Fear of coping at home with		
	What did the staff say when they saw that?	439	dressings when saw bloody	Fear of self care	
Int	What was their understanding?	440	dressings		
	The staff said it was because of the warfrin.	441			
Aj	Mm, ok, which is true but it's very alarming	442			
Int	for you to see, I'm sure?	443	Blood loss caused by	Physical experience	Hospital
	It is very alarming because it's a lot of	444	warfrin, but also fear to be		experience
Aj	blood, on the dressing,	445	d/c		
	Mm	446			
Int	When I went to the loo, that day, I could see	447			
Aj	the dressing , it was still oozing. Mm. I had	448			
	to come back to Guy's for another warfrin	449			
	check, but the day before I had to see the	450			
	GP, 32 steps to our door ... up and down, it	455	Care of dressing difficult,	Consequences of	Immed post d/c
	was very difficult, and the wound was still	452	too much exertion,	having to be self	
	fresh. After that the GP came to see me.	453		reliant	
	It does sound to me, after everything that	454	Medical services starting to		
Int	you have described, that there's been so	455	sort out irregularity		
	much misunderstanding and not enough	456			
	information being given to you, for you to	457			
	feel quite disgruntled and worried that	458			
	maybe you've been missed out ..... by the	459			

Mr Aj Transcript accompanied by his wife

Blue = descriptive; Green = linguistic pink = conceptive

	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
	medical people, so generally your anxiety	460			
	would naturally go up because you'd be	461			
	thinking well these are the experts., but I've	462			
	been missed out, or so. So that would be a	463			
	major factor in the story, plus the fact that	464			
	you had that experience about 2-3 days after	465			
	your operation.	466			
	…………	467			
		468			
	When the flashbacks used to happen I had	469			
Aj	this kind of fear, that I remember from	470			
	when I woke up in the ward.	471			
	So then when you had a flashback to when	472	Flashbacks involve fear		
Int	you woke up in the ward .... and you were	473	from post op distortion		
	terrified … that triggered your anxiety?	474	(waking in the morgue).		
	Oh yeah, yes. When I talk about it, or say …	475			
Aj	when we're eating and, and my wife goes	476			
	into the kitchen … I don't like to be on my	477	Remembering the ward		
	own, I'm not happy on my own, even within	478	experience, as well as being	Anxiety caused by	Few mths post c/e
	the house.	479	on his own, causes anxiety	recalling experiences	
	And when we talk about the situation as we	480	Dependent on others	Dependency	
Int	are doing now.... does or did that cause a	481		Anxiety when alone	
	flashback to occur?	482			
	It does hardly now but it used to … well I'm	483			Few mths post c/e
Aj	remembering it you see.	484			
	Yes, that's what we'd expect.	485	Discussion of past used to		
Int		486	trigger flashbacks, now		
	(Long discussion about flashbacks and the	487	improved		
	management of them. and ICU syndrome.)	488			

Mr Aj Transcript accompanied by his wife

Blue = descriptive; Green = linguistic pink = conceptive

	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
		489			
	The flashbacks were about when I thought I	490			
Aj	was in a room with dead people and I was	491			
	telling everyone that I didn't want to die.	492	Emphasises that the main		Immed post d/c
	The flashbacks were the main, main	493	problem was the flashbacks	Flashbacks used to be	Coping strats
	problem, they didn't happen on the street or	494	which only occurred when	the main problem	
	when I was out, I was always fine when	495	alone	Flashbacks occurred	
	there were people around me.	496		when alone	
	And that's because ..... ?	497			
Int	I could call if I needed help … yes, I'm not	498			
Aj	on my own, you see? It's when I'm indoors,	499			
	I used to have no confidence on my own,	500	Can call for help if other		Immed post d/c
	then I had that fear … I couldn't sit down, I	501	people are around; main	Can call for help if	Coping strats
	must stand up. I couldn't concentrate, it	502	impact was sense of no	others around,	
	didn't last long, maybe 2-3 mins, then it's	503	confidence if alone, become	dangerous to be alone	
	then I'd have to talk to someone.	504	fearful, restless, no	No confidence when	Immed post d/c
	To distract you from the thoughts?	505	concentration, seeks	alone	Self appraisal
Int	I had to talk to someone then it was good, if	506	company	Impact on sense of	
Aj	I had no one to talk to, um, you can't ring	507		self	
	everyone all the time. When I was by	508	Compelled to talk, if unable	Fear of being alone –	
	myself, at first I'd play some of my	509	and alone try	Fear caused	Immed post d/c
	favourite music and it did help, but after that	510	Tx strategy = music for a	restlessness	Coping strats
	it seemed that the only thing that helped was	511	while, then desperate to talk.	Could not concentrate	
	talking to someone. At first I was 'phoning	512	distraction	Seeking company	
	anyone at all, you know. We have 6	513	On d/c 'phoning children		
	children, 2 here and the rest are in Nigeria.	514	constantly and crying	Needing to talk	Immed post c/e
	At first I was on the 'phone crying and	515		Needy and dependent	Coping strats
	crying ….	516		Strategies to cope	
	Was that because you thought you might not	517		when alone	

	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
Int	see them again?	518			Immed post d/c
	Mmm I was very upset. My wife had to	519		Seeking company	
Aj	'phone them back to tell them I was alright,	520			
	not to worry. The children here are at work,	521	wife needing to reassure the		Support from
	I couldn't ring them at work.	522	children		others
	This was mostly in the first week after you	523			
Int	were discharged?	524		Wife explaining to	
	Yes, but now it's much, much better – now I	525		others	
Aj	don't cry on the 'phone.	526			Few mths post c/e
	What do you put that down to?	527	Not crying on 'ph anymore,	Less distressed	Less emotional
Int	No I don't cry now, after I was discharged I	528	not sure why did in past		
Aj	was crying all the time – day after day – I	529			
	don't know why.	530			
	Has cardiac rehabilitation helped you with	531			
Int	this?	532			
	Yes, maybe because you meet other people	533			
Aj	there who have some of the same problems,	534			
	because you think they are peculiar to	535	CR = Feel less alone,	CR reduced loneliness	CR: facilitates
	yourself, you know, it's very helpful to see	536	normalise some probs	CR normalises some	positive change
	that most people have the same.	537		problems	
	Right. Did CR help you in any other specific	538			
Int	ways?	539			
	Well yes, they explained why we have to do	540	CR educative focus	CR explained the need	CR: facilitates
Aj	regular exercise, I walk for 30mins every	541	Explanations for exercise.	for exercise	Positive change
	day now with my wife, and will start at the	542	Wife joins in exercise		
	gym soon.	543	Plan for future exercise	Plans for future	Support in recovery
	That's good progress.	544		exercise	
In		545		Wife joins in	
	Yes things are much better than they were, I	546	much improvement,	programme	Few mths post c/e

	Dialogue	Id	Analysis 1 Initial code/ exploratory comments	Analysis 2 Emergent theme	Analysis 3 Super-ordinate theme
Aj	still can't go travelling around London, my	547	Still not fully indep,	Positive eval of health	Cog appraisal
	wife and I used to do this, by bus, before I	458	Not back to pre-event way	Still not fully	
	was in hospital, um ..	459	of life	independent	
	What is it that stops you, do you think?	550			
Int		551			
	Well … I have to be organised, and I don't	552	Waiting for more		Few mths post c/e
Aj	think I'm ready yet, soon we will though. I	553	improvement to be ready to		View of future
	am getting back my confidence. And also to	554	travel; feeling more	Confidence improving	Cog appraisal
	do some coach trips, we used to do a lot of	555	confident and optimistic	Planning outings	
	those too. Oh yes and also, I have still	556	keen to start pre-op outings/	Belief and optimism in	Coping strats
	stopped smoking, that was, I stopped just	557	life style, still not smoking,	capacity to regain	
	before the surgery, but I am still not	558	positive health behavioural	former life style	
	smoking. The CR nurses are very pleased	559	change maintained, pride,	Maintaining positive	
	with that!	560	motivated,	health changes	
		561	positive reinforcement from		CR: facilitating
		562	CR nurses,	Positive reinforcement	
		563		from CR	
	Much discussion about the departments and	564	we = with wife		
	pragmatic attending of appointments,	565			
	wanting to discuss the system and	566			
	medication	567			
	Wanting to know about the problem re	568			
	slipping through the net.	569			
		570			
		571			
		572			

APPENDIX VIIa

Feedback Letter for Participants

LONDON
metropolitan
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City and Hackney NHS
Teaching Primary Care Trust
Primary Care Psychology
2nd Floor – D Block
St Leonard's
Nuttall Street
London N1 5LZ

Tel: 020 7683 4673
Fax: 020 7683 4156

Dear ....

Research into the Adjustment of Black Men Following a Heart Attack

Thanks you for taking part in the above research. I am currently in the process of looking in detail at all the interviews and shall be sending a summary at the end of the research. In the meantime I am enclosing a copy of the transcript of your interview for you to keep, should you be interested.

Below is a summary of the main ideas and themes from your interview that I felt were significant. As this is only my personal interpretation of your experience I would be grateful for your thoughts. You may want to read through your interview to refresh your memory. Please then complete the attached slip and return it to me in the envelope provided as soon as possible.

Themes:

a)

b)

c)

d)

e)

f)

g)

With best wishes

Shirley Coventry
Counselling Psychologist

City and Hackney
Teaching Primary Care Trust

LONDON
metropolitan
university

FEEDBACK FORM - Research into the Adjustment of Black Men Following a Heart Attack

1. Overall do you consider that the above list of themes is a good representation of your experience?

   YES / NO

2. Are there any other particular ideas that you feel should have been included in the list?

   YES / NO

……………………………………………………………………………

……………………………………………………………………………

3. Please feel free to make any other comments if you wish:

……………………………………………………………………………

……………………………………………………………………………

……………………………………………………………………………

Please return this page/ slip to Shirley Coventry in the self-addressed envelope.

Thank you for your assistance

- -

Feedback Letter for Participants

LONDON
metropolitan
university

Guy's and St. Thomas' Hospital NHS
NHS Trust

Department of Psychology
Lower Ground Floor
Adamson Centre for Mental Health
Block 8, South Wing
St Thomas' Hospital
Lambeth Palace Road
SE1 7EH

Dear ....

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Themes:

a)

b)

c)

d)

e)

f)

With best wishes

Shirley Coventry
Counselling Psychologist

Guy's and St. Thomas' Hospital NHS
NHS Trust

LONDON
metropolitan
university

FEEDBACK FORM - Research into the Adjustment of Black Men Following a Heart Attack

1. Overall do you consider that the above list of themes is a good representation of your experience?
   YES / NO

2. Are there any other particular ideas that you feel should have been included in the list?
   YES / NO

....

....

3. Please feel free to make any other comments if you wish:

....

....

....

Please return this page/ slip to Shirley Coventry in the self-addressed envelope.

Thank you for your assistance

How far have I come? - Cognitive appraisal

Table 4 (N) : Participant quotes illustrating this super-ordinate theme, which forms part of the broader master theme of 'Few months post cardiac event'

Emergent themes	***Participant quotes***	***Reference***
Negative meaning of pain	*... and then when I had the complications with the blood clotting problem, and others, I thought maybe I'll get an infection and cause more complications, and the surgery, you know, won't be successful ...... Sometimes I think of the pain .... now, as further complications* .	*Mr Aj, 325*
	I don't know why this pain is here now. It's changed it's position now, from the left side on discharge from the hospital, to now the right side, and I don't know why.	*Mr Aj, 370*
	*But um so er, and after that things are ok but I still had some pain when I was climbing, and and I had a follow-up appointment with Dr * after this, and he said quite often it does happen because er traditionally you've got um .. arteries like branches going all over the place, and although there might be a blockage in the in the middle somewhere, of the main artery, my ..* *Int: The collaterals* *My collaterals were all working quite well before, but now when they put the stent in, that might have blanked out some of the collaterals, um* *Int: Because it takes the big flow ...* *No be because the stent hides it so to spe, so he said that might be the reason why the pain is still there, or it might not necessary be the same thing but is a good reason now. So he said um, come back in six months time and then if things, maybe they'll revisit the thing and the situation and see what, what needs to be done. So at the moment I've got another treadmill test geared up for soon and then subsequently I'll see him and then, then we'll take it from there.*	*Mr N, 143*
	I s'pose that really before the stent operation, eh any aches and pains used to sort of make me feel or wonder if there was something serious, umm, and quite often I'd um, um I s'pose it's just a worry of illness.	*Mr N, 806*
Fears of complications	*My father, yes there is unfortunately (coughing). My father had a heart attack in 1995 and died of prostate cancer in 1997. Um, my older brother ... had some sort of cardiac complaint, but, but I don't quite know what, (cough) um ... and one of my younger brothers is also a diabetic. So there is a cardiac history in the family. You see there's another part, in that when filling in the little boxes, you know, and thinking about a cardiac history in the family, when looking at reasons for cardiac problems, despite not feeling any pain in the heart, that's what ... I remember when filling in the little boxes that 5 out of 6 are 'yes', but I didn't have any pain.*	*Mr B, 184*
	Yes, I missed the one night, I was tired and fell asleep and missed the medicine and the next day I thought I haven't taken them the way the doctor said *Int: Ah, ok – so were you worried?* *At first I didn't think the heart would blew up and then I got the pain 3 times when I was lifting things.*	*Mr M, 1169*
	Fairly well .... not quite, I think I'm, in some ways, maybe kidding myself. I'm still, I'm still looking behind my back and thinking what next? You know? What are the limitations, do I know them?	*Mr B, 273*
	Yes it's always in my mind, and still I am waiting, for someone to say that sometimes after the test it will be alright, I know somebody else with the same and the pain got worse I don't want to feel like that and I want the pain to go see, sometime	*Mr M, 459*
	You know? Thing go on in my mind, something is supposed to have happened and I worry it won't happen.soon. *Int: You mean now. Before – you needed... Something to happen quickly.* *Int: And that you needed quick intervention. So then that sounds like you feel what he said, that it would be something quick and easy,*	*Mr M, 468*

How far have I come? - Cognitive appraisal

	but it dragged on. *Yes I have been told only some chances of surviving, if I hadn't been waiting for my doctor, nobody came.* *Int: So does that mean you wonder if somebody had arrived on time there would be less damage to your heart?* *Yes Yes.*	
	Having analysed myself, it must be said that yes, I've got the confidence to cope with it. But if that was the final trigger ....um .. how much more can my heart take? You know, will it be affected again?	*Mr B, 326*
	sometimes when I have a a, a consultant's appointment for something, just a couple of days before that I think about it, is he going to pick something up that's going to be terminal (laughing)	*Mr N, 818*
	... before the operation they told me about possible complications, the surgeon said that in about 3% of cases there are complications and the surgery may not help, and not be successful, and then when I had the complications with the blood clotting problem, and others, I thought maybe I'll get an infection and cause more complications, and the surgery, you know, won't be successful ...... Sometimes I think of the pain .... now, as further complications.	*Mr Aj, 321*
	Mm, you see I can deal with most things but I'm just not very good with operations as they don't really turn out as they should do. I'm unlucky with them, you know. If they say there are 1500:1 likelihood of all being ok, I'll be that 1 it could happen to. *Int: So did they talk to you and give you the odds for a successful angio?* *Yeah (laughter) and I thought 'I've heard this before!'*	*Mr S, 381*
	Sometimes it's er worrying, it looks like it see the problem was there, that how can it suddenly go away type of disappear or situation	*Mr N, 212*

How far have I come? - Cognitive appraisal

Positive evaluation of health	*With the operation now I'm much better. My wife says I'm a little slow, but we see it as exercise. I'm better now, I'm sure I'll get there, I'm ok.*	*Mr Aj, 408*
	Yeah yeah I've done some big changes in the last few months. *Int: So when you think about these do you think you've done pretty well? You've achieved a lot?* *Yeah. I think I've done well, I've done well. I could have ended up in the mental house, so I've done well.*	*Mr S, 167*
	Yeah, my daily routine is completely different. *Int: Despite this, as a person you don't see yourself as having changed?* *No, just a bit more angry, to do with the relationship.*	*Mr S, 425*
	Yes, I think, although I've had all these problems health wise I've been reasonably fit.	*Mr N 491*
	I don't really miss smoking, yeah I have done well, in the smoking department, in the exercise department. I've done well all around, yeah.	*Mr S, 440*
	Yes, I've just felt very sad, in that 'how is it going to limit my enjoyment of life?' I must give up the smoking. I guess I'm addicted to the nicotine. I'm ashamed of it ... (laughter) I've been able to cut out tea and coffee, I'm not a control freak as such, and I think this stems from my osteopath who has really taught me a more holistic approach to life, I'm pretty healthy, . I've learnt to live a clean life style besides the smoking.	*Mr B, 253*
	[illegible]	[illegible]
Self evaluation	*Yes, but now it's much, much better – now I don't cry on the 'phone.*	*Mr Aj, 525*
	Well ... I have to be organised, and I don't think I'm ready yet, soon we will though. I am getting back my confidence.	*Mr Aj, 552*
	Even up to now, but it's much, much better,	*Mr Aj, 277*

	but I still don't like to be on my own for a long time. it's got much better since seeing my GP who started to sort things out, you know and then the CR nurses. Over time it's much better	
	I don't worry about nothing, nothing that will keep my stress levels up.	*Mr S, 158*
	Yeah yeah, 'cos that's the mind isn't it, well all the thinking and worrying, the assuming and presuming, one could send themselves crazy thinking and doing things like that. *Int: But you didn't go off the rails ..?* *Yeah, I'm kind of a strong person, yeah*	*Mr S, 187*
	Int: Do you think it's changed you? *Not really.* *Int: As some people may think that stopping those [habits] makes them feel very differently about themselves.* *I'm the same person.* *Int: So the way you see yourself now, is there a difference compared to how you used to see yourself, before the heart attack?* *No.*	*Mr S, 215 -*
	Plus, um, I was speaking to someone who said I have a good reason not to smoke, 'cos another guy had a cardiac operation and he smokes, he does everything, he doesn't stop, and he says 'Oh I wish I was like you 'cos you're really good.' And I think maybe, maybe it's about the amount of pain, maybe he's forgotten about the pain he was in. But they said I had a good reason not to, but then if I tell you about how much will power I've got, I said you'll never know how much will power I've got, they said what you mean, I said well I'm not telling you, but the will-power, I got ... at home ... I've got at home some stuff and it just sits there ..	*Mr S, 244*
	Yeah I think I'm playing games with myself. But the big game is I don't touch it. And since I came out of hospital I've had, I've had some there.	*Mr S, 286*
	No. I don't think so, I don't look at it, I just know it's there, and if someone comes around	*Mr S, 280*

	I can offer it to them, but I can't have any, I say 'no it's ok, you enjoy it.' And they look at me funny!	
	Oh yeah. My whole attitude is better, I can't just sit back and get old, and go down, I've seen other people do that, I won't do that. You know? If I do then that means she's won. The split was really bad but I was obsessed with her, crazy in love, that I didn't care about much else, cos we knew each other from school, you know, and on and off we were together. ...	*Mr S, 530*
	But um, sometimes it's worrying, it's the problem is that I've always been a very anxious person *Int: oh I see* *oh right from the beginning, and so anything small um worries me and um I think er when I was working, most of the time, you tend not to think about other because you have no time to think about other things*	*Mr N, 219*
	er but that er luckily, I mean, I know ... because er I read a lot about it and things like that, that they're irrational fears and I'm being silly. And I can talk myself out of it, but in spite of myself pulling my socks up, and getting positive thoughts and words, it over overruns my sort of other thoughts and then for a few seconds and minutes it suddenly sort of, becomes a sense of unrealism, what is going to happen?	*Mr N, 254*
	but it wasn't eh how can I say, gave me the same amount of fears then as it does now because then I was young, 22, and it didn't worry me so much, and I didn't have so much time to think about it as now, being 65 and now it's sort of the twilight years. So I think that's the, the difference	*Mr N, 318*
	No, no I don't think at that time I was so much worried about kinds of things, only very recently and because I've got older now and also I've retired now for five years.	*Mr N, 382*
	No no no, it's just like something at the back of the mind, is something there like a back	*Mr N, 614*

APPENDIX VIII

How far have I come? - Cognitive appraisal

	burner, it is there, but eh, but all that I'm trying to do is to see whether I can stop it from getting worse *Int: So you're worried that it could just fuel itself.* *Yeah, I'm confident in myself that I, I have the thinking power, and the ability to get over it when I get those kinds of thoughts and feelings.* *Int: Sure, yeah* *But I just don't want to let it fester and then suddenly it becomes more difficult, and might need some different help and action. But it doesn't in any way effect my life*	
	Yes, I've just felt very sad, in that 'how is it going to limit my enjoyment of life?' I must give up the smoking. I guess I'm addicted to the nicotine. I'm ashamed of it ... (laughter) I've been able to cut out tea and coffee, I'm not a control freak as such, and I think this stems from my osteopath who has really taught me a more holistic approach to life, I'm pretty healthy, . I've learnt to live a clean life style besides the smoking.	*Mr B, 253*
	I went to see my osteopath this last weekend, and I told her, I said (laughing) "It's thanks to you, I'm sure, had I not listened to my body, and I would have just gone to work and ummm ....."	*Mr B, 143*
	I take the meds and I feel that there is no end, I should be getting back to normal... *Int: So how do you feel? Do you have any fear?* *What can I do, I can't (laughs) ... I'm not, uh, I'm not; uh sometimes it's really unjust.*	*Mr M, 392*
	(laughs) yes yes normal life is like err past life.	*Mr M, 1075*