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ORIGINAL ARTICLE

A qualitative study: Perceptions of the psychosocial consequences and access to support after an acute myocardial infarction

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Summary

Objectives: The aim of this study was to describe individuals' perceptions of the psychosocial consequences of an acute myocardial infarction (AMI) and of their access to support one year after the event.

Methods: The study included 20 participants (14 men and six women) who lived in rural areas and had experienced their first AMI. Eleven were offered contact with a mentor. The participants were interviewed one year after their AMI.

Results: The findings are presented in three themes: having a different life, having to manage the situation and having access to support, with 11 subthemes. During their recovery, the participants experienced psychosocial consequences, consisting of anxiety and the fear of being afflicted again. Most mentees appreciated their mentor and some of those without mentors wished they had received organised support. Participants were often more dissatisfied than satisfied with the follow-up provided during recovery.

Conclusions: After an AMI, follow-up is important during recovery, but the standardised information provided is inadequate. During recovery, people need help dealing with existential crises. After discharge, receiving peer support from lay people with similar experiences could be valuable. The knowledge gleaned from this study could be used in education at coronary care units and in health care outside the hospital setting.

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Implications for clinical practice

- This study offers a reminder that it is important to provide information and follow-up during recovery after an AMI.
- Nurses within CCUs have to prepare patients for the possible consequences of an AMI. Patients should be told that existential crises are normal and can occur when least expected.
- It should be natural to find out what kind of support; within and outside families; those afflicted have access to during the recovery.
- An open telephone line manned during both days and evenings at least some days a week, should be offered to those afflicted.

Introduction

Following an acute myocardial infarction (AMI), many people experience high levels of emotional distress and anxiety (Alsén et al., 2010; Eriksson et al., 2009), which are associated with negative consequences such as uncertainty as to whether they can trust their heart (Grewal et al., 2011; Steen Isaksen and Gjengedal, 2006). The mistrust results from a fear of dying, which is prevalent during the acute phase post-AMI (Baldacchino, 2011; Wingham et al., 2006). How people react depends on their ability to manage serious events (Theorell et al., 2004); however, strategies for managing anxiety can be taught (Frazier et al., 2002; Moser, 2007). Those who report a lack of social support may be at increased risk for depression (Frasure-Smith et al., 2000), and during recovery, they may need help from their families or others (Baldacchino, 2011; Eriksson et al., 2009; Wingham et al., 2006). However, they might find it difficult to depend on the people closest to them in ways they had not before their AMI. Some women have revealed they did not like being dependent on others after their AMI; in other words, the increased need for help induced feelings of guilt (Svedlund and Axelsson, 2000). People may prefer to receive help managing their illness from outside their private sphere, and one potential source is cardiac rehabilitation (CR) programmes. According to the Swedish national guidelines for the treatment of heart disease, CR is intended to 'optimise the patient's physical, psychological and social functions' to prevent further illness (Socialstyrelsen, 2008). Health care follow-up is also valuable during recovery; for example, visits to coronary care nurses (CCNs) can be a source of help (Lanuza et al., 2011).

It has been shown that people with coronary heart disease principally desire counselling and connection with others. Consequently, mentorship/peer interactions provide opportunities to discuss their psychosocial needs (Pagé et al., 2012). This is in line with Coull et al. (2004), who reported that people with heart disease who participated in mentor-led groups appreciated discussing issues related to their disease; after one year, they were more motivated than the control group to make lifestyle changes. In a study by Steen Isaksen and Gjengedal (2006), others with heart disease said talking with others with the same experiences had even promoted their recovery. In evaluating a mutual aid model, Arndt et al. (2009) reported that support groups, including those comprising lay people, were valuable as secondary prevention activities during cardiac rehabilitation. The notion of lay people having a role in the post-infarct context is supported by Hildingh and Fridlund (1997), who recognised their importance as a source of support for women following their first myocardial infarction.

Mentorship, according to Bozeman and Feeney (2008), is a way to receive support and is useful in many contexts, for example, as an informal transfer of knowledge or psychosocial support. They defined mentoring as a process with a reciprocal interchange between the parties concerned. In this context, mentoring is an informal communication running over a period and containing, for example, social support. Wright et al. (2001) showed that peer mentorship was very meaningful to people with heart transplants; they considered their mentors to be friends with whom they could discuss medical and psychological issues.

Early discharge from the hospital places greater responsibility for recovery on patients in rural areas than on those in urban areas (Williams et al., 2006) because cardiac rehabilitation services are not available to any great extent for rural inhabitants who have suffered an AMI. However, receiving home-based cardiac rehabilitation by phone and the internet has been shown to be effective (Varnfield et al., 2011). Those who had that opportunity benefited from not having to travel to receive cardiac rehabilitation. This suggests that there should perhaps be alternative approaches to rehabilitation for patients in rural communities.

The literature suggests that mentorship in the form of peer relationships seems to be an effective form of support and might be more effective if the mentors had themselves suffered an AMI. The authors wished to investigate the effect of offering mentorship by lay people who had also experienced an AMI on patients who have suffered an AMI and live in sparsely populated areas in Sweden. Therefore, the aim of this study was to describe individuals' perceptions of the psychosocial consequences of an acute myocardial infarction (AMI) and of their access to support one year after the event.

Methods

Ethical approval

The regional ethical committee at Umeå University gave permission (09—100 M) for this study, which conformed to the principles outlined in the Declaration of Helsinki (1964). Written permission to recruit patients was given by the directors of coronary care at three hospitals. All participants and mentors received verbal and written information stating that their participation was voluntary and that they had the right to withdraw whenever they wanted, without any