

“When what is taken for granted disappears”: Women’s Experiences and Perceptions
after a Cardiac Event

Elisabet Hellem, Master of Health Sciences, PT, Associate Professor

Kari Anette Bruusgaard, Master of Philosophy, PT, Assistant Professor

INTRODUCTION

International guidelines recommend that all heart patients following an acute coronary syndrome, coronary artery bypass surgery (CABG), or percutaneous coronary intervention (PCI) be referred to exercise based cardiac rehabilitation (CR) (Smith et al, 2011). Despite compelling evidence on the numerous benefits (Heran et al, 2011; Lavie and Milani 2011a; Smith et al, 2011), international literature shows that cardiac rehabilitation programs are largely underutilized (Sandesara et al, 2015; Santaularia and Jaarsma 2013), especially by women (Daniels, Arena, Lavie, and Forman 2012; Suaya et al, 2007; Sundararajan et al, 2004). The reasons why women are missing from CR programs are numerous and relate to the healthcare system, the provider, and patient level factors (Scott, Ben-Or, and Allen, 2002).

For both men and women, the experience of a cardiac event (CE) is associated with an insecure existence and with considerable physical and emotional burden. Approximately 50% of patients experience increased anxiety (Huffman et al, 2008). Studies indicate that women's psychological and social profile on entering CR is different from men's. Female cardiac patients frequently experience greater anxiety, uncertainty, and depression. They also report lower self-rated health, lower quality of life, and a greater fear of relapse (Brink, Karlson, and Hallberg, 2006; Daly et al, 2000). In general, women also engage less in exercise, a likely predictor of lower participation in CR (Hunt-Shanks, Blanchard, and Reid, 2009; Todaro et al, 2004). This may indicate that gender is not without significance in the care and follow-up of cardiac patients. Fortunately, there is increasing evidence to support the positive impact of exercise and interdisciplinary cardiac rehabilitation programs (CRP) on improving psychological factors, such as anxiety and/or depression (Duarte Freitas et al, 2011; Gellis and Kang-Yi, 2012; Lavie, Milani, O'Keefe, and Lavie, 2011b; Milani and Lavie, 2007; Rozanski et al, 2005). In Norway, however, a major challenge is the availability of CRPs. At what point in the course of the recovery process patients

are offered an organized cardiac rehabilitation program, if it is offered at all, varies widely (Aandstad, 2014).

Although fear of overexertion and an overwhelming sense of uncertainty are recurring findings in studies of the female cardiac population (e.g. Astin, Horrocks, and Closs, 2014; Johansson and Ekebergh, 2006; White, Hunter, and Holttum, 2007), there seems to be a lack of qualitative studies exploring how the recovery process is affected by the individual's bodily experiences, focusing on depth of thoughts and feelings.

Recovery

In CR as in other care areas professional clinical models are said to focus on treatment and improvement of symptoms and function, as opposed to recovery models which place greater emphasis on the individual's own experiences of health and empowerment (Mueser et al, 2002; Slade and Hayward, 2007). Thus, the recovery concept refers not only to the improvement of clinical symptoms and functions, but also to the patient's life situation as a whole. The concept of recovery is not clearly defined, hence there are different interpretations in healthcare (Slade, 2009). Although there is a distinct difference between recovery and rehabilitation, the terms are often used interchangeably (Deegan, 1988). Slade and Hayward (2007) draw attention to the two different dimensions of the recovery concept, namely the concept of "clinical recovery" and "personal recovery". Clinical recovery is said to focus on the reduction of symptoms and improving function as seen from the professional perspective. Clinical recovery could be said to correspond to rehabilitation (Mancini, Hardiman, and Lawson, 2005; Slade and Hayward, 2007). Personal recovery is the person's own ongoing multidimensional process of regaining health. This process is a gradual and ongoing personal one. It is about the individuals' ability to adapt to the new situation and successfully reorient themselves to a new or different life situation. The process is not linear, but a series of victories and setbacks. The importance of hope, support, being able to take responsibility for oneself and establishing a positive identity are some of the dimensions

described as common and essential in the recovery process (Mancini, Hardiman, and Lawson, 2005; Slade, 2009). Mueser et al. (2002) suggest that the patients need support to promote their personal journeys. Thus, it is not enough for health care professionals to focus solely on clinical recovery after a CE, but also they should recognize the need for a holistic view of women's recovery processes and actively work to promote the patients' personal recovery.

Clark and colleagues emphasize the importance of gaining insight into heart patients' levels of confidence as well as how they view and experience their bodies after a CE, and they suggest that these factors may affect participation in CR (Clark, Barbour, White, and MacIntyre, 2004). According to Wieslander and colleagues there is a large knowledge gap in the study of women's recovery processes, especially beyond the initial stage in emergency care (Wieslander, Martensson, Fridlund, and Svedberg, 2013). They argue that in order to develop successful CRPs one must understand more of the factors involved in successful recovery and they conclude by calling for further research grounded in the personal experiences of women in particular (ibid, p. 26). The purpose of this study is to describe how women experience the recovery process after a CE. The aim is to explore the impact the event has on emotional and bodily experiences, and how this influences activities and participation.

MATERIAL AND METHOD

Research Design

A qualitative, descriptive design was used to capture the women's experiences with the recovery process. This design is suitable for exploring and describing human qualities such as experiences, thoughts, expectations, and attitudes. The design is inspired by a phenomenological approach (Malterud, 2012). The phenomenology provides guidelines on how one can be as open as possible in encountering lived experiences (Giorgi, 2009; Van Manen, 2016).

Participants and Settings

Participants were recruited through colleagues at four different cardiac rehabilitation facilities: two different local hospital settings and one municipal health service center on an outpatient basis, and one specialized CR facility on an inpatient basis. The study was approved by the (blinded) and was authorized by the privacy protection (blinded). The women were informed about the aim of the study and the procedures, both verbally and in writing, and their written informed consent was obtained. They were assured of anonymity and confidentiality.

Sampling was purposive in the sense that we chose to interview women who either had participated in or were currently participating in primary cardiac rehabilitation programs. We assumed that having this experience would give additional perspectives from the early recovery process, especially related to their readiness to engage in physical activity. The inclusion criteria selected women who had experienced an acute myocardial infarction (AMI) and/or cardiac surgery and/or percutaneous coronary intervention (PCI), age ≥ 40 , living at home. The exclusion criteria discarded women who did not understand or speak Norwegian, who had suffered from mental illness, and/or substance abuse. The ages of the women ranged from 42 to 74, with an average of 64.4 years. In total 20 women participated, of whom 15 were interviewed in four different focus groups and five with individual interviews.

Data Collection

Focus groups and individual interviews were used to get in-depth insight into the women's experiences. In addition, background information on the participants was collected using a questionnaire. A summary of the participants' demographics is presented in Table 1.

In a focus group, the facilitator takes advantage of the group dynamic that emerges in discussions among participants who share common experiences. The objective is to facilitate in-depth discussions through the dynamic interaction the process generates (Halkier, 2010). The strength of the focus group discussion is that it allow participants to agree or disagree with each other in a relatively open and informal atmosphere. This provides insight into the range of experiences,

opinions, and ideas of the group. In this way, information that might otherwise not emerge during individual interviews is brought out. Weaknesses of the focus group method are that participants do not always speak up, and that it may lead to polarization or conformity within the group, both of which may stifle the variation of material collected (ibid). The qualitative in-depth interview is useful for studying the meaning of social phenomena as perceived by the individual, and thus for understanding and gaining deeper insight into the personal experiences of the people involved (Brinkmann and Kvale, 2015). We chose to combine the two qualitative methods to complement the strengths and weaknesses of each of the methods.

The interviews took place at different locations according to the wishes of the informants, based on practical considerations. They were conducted towards the end of or after completed rehabilitation. The time span between the cardiac event and the time of the interview varied between 2 and 16 months. Our approach to the individual and focus group interviews was based on an interview guide. We aimed at maintaining an open, non-judgmental attitude when listening to the women's responses to open-ended questions. Understanding their perspectives requires an ability to meet their lived experiences with an open mind, not letting prior understanding overshadow new meanings (Gadamer, 2011). One of the authors led all the interview sessions. The other author noted keywords related to processes of communication throughout the interviews. All interviews were tape recorded and transcribed verbatim. Data collection continued as long as it gave the researcher new information. The material comprised 9 interviews covering a total of 20 women.

Ethical Considerations

The study was approved by the REK, Southeast (Norwegian Regional Ethical Committee), and was authorized by the privacy protection ombudsman of NSD (Norwegian Social Science Data Services). The women were informed about the aim

of the study and the procedures, both verbally and in writing, and their written informed consent was obtained. They were assured of anonymity and confidentiality.

Data Analysis

The transcribed material formed the basis for a qualitative method of systematic text condensation (STC), following Giorgi's phenomenological method (Giorgi, 2009) as modified by Malterud. STC aims for thematic analysis of meaning and content of data across cases (Malterud, 2012). In the process, we searched for patterns of commonalities and differences in the descriptions the women gave. Giorgi (2009) recommends that the analysis should go through four steps: (1) the purpose of the first step is to establish an overview of the material. Both authors read all the transcripts carefully searching for meanings, bracketing previous preconceptions. (2) The purpose of the second step is to identify and organize data elements that may elucidate the study question. This process started by systematically reviewing the transcript line by line to identify different aspects of the women's experiences of the recovery process, and how this influenced activities and participation. Malterud (2012) refers to this as identifying "meaning units", which she defines as text fragments containing information about the research question. The identified meaning units were sorted, labelled with a code and classified into different code groups, potentially related to the previously negotiated themes. (3) The purpose of the third step is to abstract and condense the meaning within each of the coded groups established in the second step of the analysis. At this stage, empirical data were reduced to a decontextualized selection of meaning units, across individual participants. Based on the analysis of this text the sub-themes appeared. (4) In the fourth step, the disconnected text elements are put together again, checking that the analytical text corresponds with the original text, and that the wholeness of the original context is preserved. Summarizing the contents of each subtheme reflecting the most important aspects of the women's experiences generated three overarching themes representing phenomena that can offer meaningful knowledge in similar situations and contexts (Malterud, 2012). Both researchers

carried out every step of the analysis, negotiating the final subthemes and themes, attempting to make the themes comprehensive with as little overlap as possible.

RESULTS

The findings reveal that the heart event has changed the way the women perceive their bodies. Living with an unreliable body and an unpredictable future is associated with fear and insecurity, which influences activities and participation. The event changed the women's identity; it was no longer a matter of course to participate in all the activities they had not thought twice about before. The body was now sensitive to potential strains and suffered increased awareness. The heart was no longer just a physical object they could take for granted and the uncertainty about what the "new" body would tolerate was ever present. The women needed support and someone to whom they could address their uncertainty. In reestablishing control over themselves, the women were trying to restore confidence in their bodies and to maintain a positive belief in the future. In this process, they emphasized that how health professionals communicated their messages does shape thought and action.

The results are organized in three main themes: 1) Going home with an unreliable body; 2) A changed sense of self; and 3) Finding a new balance. The quotes illustrating the descriptions in the subthemes correspond with the number of the participants in Table 1.

Going Home with an Unreliable Body

This theme identifies how the women experienced the initial period after discharge from the hospital and how their experiences influenced their readiness to exert their bodies and engage in daily activities. The theme emerged from two subthemes: 1) "Feeling lost when left by myself"; and 2) "Regaining the body involves more than physical repair".

Feeling Lost When Left by Myself

The abrupt change from being monitored 24/7 and taken care of by medical experts to coming home and having to fend for yourself left the women feeling vulnerable, fragile, and insecure. Their experience of this phase varied, but the common denominators were, nonetheless, that they felt anxious and insecure and missed being able to confer with and seek support and advice from a health care professional. A recurring theme was the fear of doing something wrong, resulting in reluctance to engage in activities that they thought might overstrain the heart. The women said that the uncertainty started to sink in when daily life caught up with them. When they described their feelings, they used the whole spectrum of experiences from “full of anxiety” and a “state like war” to words like “anxious”, “fragile”, “uncertain and insecure”:

“I wasn’t given any guidance before discharge. ...I had a conversation with the doctor in which she said something about the pills and...like here’s the stack of prescriptions...So I was a little unsure ...how much I could start doing on my own.....you don’t dare really push yourself...especially those first weeks....If I exert myself.....maybe something will happen to the stent... Things like that started going round and round in my head. I was a bit of a sissy, I think...and I’m not really a nervous and anxious person...but... you become a little afraid of making a mistake (I 18).

Those who lived alone said that being alone with the fear was an extra burden. Not having a person nearby if something should happen could easily lead to a feeling of panic and become paralyzing, both in view of a new incident and in terms of daring to challenge the body.

Regaining the Body Involves More than Physical Repair

The women expressed gratitude and relief that their hearts had been “repaired”, but underlined that their bodies felt unfamiliar after the event. The women realized gradually that it was difficult to understand and deal with their new bodies and they were confused about how they should manage the next steps forward:

“At first I was very relieved of course, and thought... I’m in a way done with it... but when your head catches up...then I felt like it was a little worse to deal with than the physical, actually. In a way I wanted to be done with it, but then I could feel that my head wasn’t...But I believe that in order to have the courage to start with physical rehabilitation, in a serious way, I think you have to also understand with your head what you have been through”... (I 18).

Regaining the body involved more than recovering from the physical repair and it took time to “internalize the experience” and to realize the consequences fully. The process of being able to depend on their bodies again was affected by emotions, thoughts, and ideas that surfaced. The women indicated that in hindsight, after having experienced the benefits of taking part in a CRP, they realized they could have been spared many worries had they had more support and interaction with health professionals while in search of or waiting for an available CRP.

A Changed Sense of Self

This theme deals with the women’s self-image and identity following the CE, and describes how experiencing a life-threatening event disturbs and changes the women’s control and sense of self. The theme emerged from two subthemes: 1) “Hypersensitivity and thoughts of disaster”; and 2) “A more boring version of myself”.

Hypersensitivity and Thoughts of Disaster

On one hand, the women felt both grateful and happy about life and did not think of themselves as sick. On the other hand, even the most optimistic, admitted to feeling a threat of impending danger that made them feel fragile, vulnerable, and inclined to have thoughts of disaster. Several of the women described their CE as a traumatic experience that left deep scars. Others described the situation in a less dramatic way, seemingly not particularly affected by the actual event. Nevertheless, during the interviews it came out that their anxiety was easily aroused, often initially hidden behind a smiling face. They all described an increased awareness of their bodies, with a

tendency to interpret a faster heartbeat, shortness of breath, and sensations of pain as potential heart problems. The women were also concerned with how easily these signals were awakened and to what extent the body stole their attention:

“Palpitations could easily trigger fear that my heart might stop.” (I 19).

“But... the thought is there...(is this related to the heart?). So you.. ...you... kind of keep watch over your body more” (F 10).

The threat of a new event was always in the back of their heads. Several admitted that they were more anxious about going on walks alone and that they had become hesitant about travel in general, especially to remote places where access to and the quality of health services were questionable:

“...I don't want to travel to exotic places where there isn't good hospital coverage...I was in Edinburgh this fall. Lots of good cardiologists there, fantastic” (F 10), (Everyone laughs).

The women discussed how the underlying anxiety tended to make them read between the lines and bring forward hidden messages of potential threats. When elaborating on this increased sensitivity they talked about their experiences when pushing the limits during outdoor interval training with the physiotherapist. The women admitted they read between the lines when the physiotherapist reassured them about the safety of pushing their limits and at the same time underlined that she always carried a cellphone and there were always two physiotherapists present, one in front and one at the back.

A More Boring Version of Myself

Even though the women for the most part described everyday life as being good, they agreed that the CE had given them another perspective on life and what they previously had taken for granted was no longer a matter of course. They admitted that they prioritized things differently in their everyday lives, even if they did not want to think of themselves as sick. Some said having to change their habits and trying to live as healthily as possible felt like an obligation and brought on feelings

of aversion. Others said they were living a healthier life now and were in better shape than they had been for a long time.

A younger informant got support from the others in the focus group when she said that she felt sad over not being the person she used to be. She attributed this to self-imposed limitations, vulnerability, and fragility:

“I mean, it’s wonderful, of course, we’re alive...but for me it’s a little painful to think that before I had fun swimming in cold water....and now I’m not supposed to do that any more. ...It makes me feel a bit restrained...so then you think... “Dammit, this is the pits”. I can’t stay up late any more either ...I’m dreading New Year’s Eve.... my God, it’s so stressful... I can feel that I...have become a little...a more boring version of myself” (F 10.)

When the women were talking about fragility, they related this to a reduced tolerance for stress, both physical and emotional. After the CE they were less tolerant of exertion, sounds, and large social gatherings, and they did not sleep as well as before. They had to be more careful about how they used up their energy and part of what they once took for granted had disappeared.

Finding a New Balance

This theme deals with how the women tried to come to terms with their altered situation and their changed sense of self, a denominator being building hope and optimism. The theme emerged from the subthemes: 1) “Trying to regain lost confidence in the body”; and 2) “Framing the message – a powerful potential to influence thoughts and action”.

Trying to Regain Lost Confidence in the Body

Even though the women would like to project themselves as healthy, ambivalence emerged when they described how they perceived themselves:

“Heart disease is what I have...had more than have. But I do have it, of course. But...I am in a way...define myself as cured from it. If I just take the meds, I’ll stay healthy, I think” (I 18).

The women described different strategies for confronting this ambivalence and the increased vigilance that they felt in the body. They tried to think positively and found individual ways of coping. Some described how they accepted the uncertainty without speculating any further:

....”if there’s an extra beat or flutter...or whatever, then you think ‘oh well,...that’s just the heart saying that I’m beating. I just think that that’s the way it is ...I don’t get frightened. And then I just continue working” (I 18).

Others engaged in a dialogue with themselves, trying to figure out what the uncertainty was about (e.g. checked out the “symptoms” against the classic danger signs they had learned and heard about from others). In this way, they worked through the ambiguity cognitively and found a natural explanation. A third way of handling unpleasant thoughts was to intellectualize them and “talk away” pains and problems. One of the women described herself as being very good at verbalizing and characterized this as a survival technique. She admitted that this also could be a curse as there was often a lot of sadness behind the talk.

Framing the Message – A Powerful Potential to Influence Thoughts and Action

The women had an overall optimistic perspective on the future, despite the underlying feeling of uncertainty. When they elaborated on these thoughts, they admitted that they scrutinized the meaning of health care professionals’ words in order to find support for a positive outlook. They said that how “medical authorities” conveyed information and addressed the problems had an impact on emotions and shaped thoughts and action. Good explanations and messages that inspired optimism nourished constructive thinking. One of the women, who had had stents put in, enthusiastically illustrated this by quoting her physiotherapist:

“You have to remember that after you’ve had stents put in, things have opened up, so you’re in better shape now than before...and better off than many others in your age group... .., who don’t even know they have it (heart disease)” (F 11).

On the other hand, focusing on the negative or scaring with admonition created anxiety and interfered with thinking positively about the future. In one of the focus groups, the women illustrated this point by referring to how the doctor framed his message in a group session:

“Remember that you all have heart disease” ...then I say ... “now that I’ve had a stent put in, I think of myself as healthy...I don’t want to go around thinking about myself as someone with heart disease”....I mean, maybe that is a reality, but, well... there is a life after a heart attack too, ...and that should be the best possible (F13).

“That’s right, you can’t exactly put your life on hold because you have to take pills and have had a.....Then it’s all over and you’ll have a mental illness as well” (F12, with a resigned sigh).

DISCUSSION

Support in Getting Control over Self and Building Confidence in the Body

The women in this study said that having experienced a cardiac event meant living with an imminent threat, an unreliable body, and an altered sense of self, challenging everyday life, activities, and participation. Our daily life is based on being able to depend on our body, and loss of confidence can lead to negative thinking linked to feelings of hopelessness and frustration (Bury, 1982). When in good health, our body does not demand our attention. Conversely, when illness forces itself into our lives, it grabs all our attention. It threatens our control of self, resulting in unpredictability with focus on anxiety, loss, and problems (Charmaz, 1993; Charmaz, 2000). Access to the world is through the body (Merleau-Ponty, 2012), and illness may change how we relate to the world. The body receives data about the states of the world and the body, and acts through its behavioral responses and stress responses (Peters, McEwen, and Friston, 2017). From this perspective, the women’s experiences cannot be solely understood as physical attributes of disease but must be understood as embodied experiences.

After the CE, the women experienced anxiety, uncertainty, and increased bodily awareness. As we understand the women in this study, they needed help to resolve their uncertainty and get more familiar with bodily reactions to internal and external stressors, what they express and entail. Uncertainty alerts emotions and reactions based on how the person consider the situation and how comfortable he or she is with the emotions the situation triggers. From a theoretical perspective of neurobiology, Peters, McEwen, and Friston (2017) argue that the essence of stress is uncertainty. The first and immediate response to a stressful challenge is arousal. Arousal includes an increase of attention and vigilance. The failure to resolve uncertainty leaves the body in a hypervigilant state and demands extra energy. If the stressful situation is left unresolved the organism is burdened by "allostatic load", described as "the wear and tear on the body" (ibid).

Siegel has introduced the term "Window of tolerance", which he describes as the range of what an individual can tolerate of stress while remaining alert and optimally functional (Siegel, 1999). When exceeding the upper limit of one's window of tolerance a state of hyperactivation occurs, resulting in anxiety, turmoil, and chaos. Conversely, when the level of activation fails to reach the lower border of the window of tolerance, hypoactivation occurs, resulting in inactivity, a sense of powerlessness, and a feeling of emptiness (Dezelic and Ghanoum, 2016; Siegel, 1999). Subjected to prolonged strain, the individual often develops a narrow window of tolerance and a weak regulating system. From a physiotherapy perspective, one could argue that by helping the women to a greater understanding of the coherence of body, thoughts and emotions the emotional state can be regulated and bodily vigilance reduced. Experiencing the stress level as manageable widens the individual's window of tolerance and the body perceives new possibilities to react and to act (Dezelic and Ghanoum, 2016; Siegel 1999). The window of tolerance is influenced by predictability, a feeling of control, and secure social relationships (Siegel, 1999). Our ability to cope with stress and change depends on the degree to which we feel that the world is comprehensible, manageable, and meaningful (Antonovsky, 1987). By helping the women

explore, reflect upon, and interpret bodily experiences it is possible to infuse processes with meaning and new insight. The way physiotherapists work involves regular advice and treatment sessions over a period of time and thus provides a good framework for processes that direct attention toward feelings, bodily experiences, and cognitive processing (Hellem, Bruusgaard, and Bergland, 2012).

Promoting a Culture and Language of Hope and Optimism

The findings demonstrate how the women tried to cope with existential challenges. They were doing their best to maintain a positive focus and deliberately replaced negative or self-defeating thought patterns with positive, constructive ideas. Optimism is said to be a cornerstone of successful recovery (Boehm et al, 2018) and there is evidence of a significant positive relationship between optimism and physical/mental well-being (Conversano et al, 2010). In the process of re-establishing faith in the future, the women talked about the influence health care professionals had on their thoughts and prospects. What the professionals gave weight to and how they conveyed their messages was decisive. The women scrutinized the meaning of their words and were particularly sensitive and vulnerable to hidden messages and information that could be associated with fear and pessimism. These findings are consistent with previous research demonstrating how patients listen for hidden messages while in an exposed situation following open-heart surgery, and that inattentiveness from health professionals hurts deeply and is not easily forgotten (Karlsson, Johansson, and Lidell, 2005). Recent research has shown that language is a powerful tool that has the potential to influence patients' thoughts and actions (Nickel et al, 2017) and that word choice can cultivate optimism and reduce physical and emotional stress (Briley, Rudd, and Aaker, 2017). Our study shows how health professionals are in a special position regarding supporting or disrupting the work of hope and optimism among their patients. Very probably, health care providers are unaware of how they can unintentionally contribute to patients' anxiety and pessimism by giving inadequate or careless information. Supporting constructive thinking and

helping patients to turn negative thoughts and worries into positive affirmation, improves the communication process and helps patients regain self-control and confidence (Hansen and Bejenke, 2010).

A Need for Cultural and Organizational Changes Supporting Personal Recovery

When the women tried to regain control of their lives, they felt lost with many unanswered questions, especially in the initial phase. They expressed a need for someone to whom they could address their questions, and they missed having a plan of action for after the CE. Follow up care is critical, especially for patients living alone, as unexpected problems often arise after discharge (Altfeld et al, 2013). Karlsson, Johansson, and Lidell (2005) state that being left in a vacuum influences the recovery process. Support and affirmation from health professionals is often absent in the initial phase after homecoming (Stoicea et al, 2017; Parker and Adams, 2008). Before discharge, most of the women in our study did receive information about medication and somatic concerns, and some were given a brochure with general recommendations for physical activity. Brochures and general information are likely inadequate when dealing with anxiety and uncertainty. In order to achieve the best possible quality of life and re-engage in activities previously taken for granted, we argue that the women need a predictable plan for follow-up right from the beginning, with more focus on the women's personal recovery process and individual needs. In a synthesis of qualitative research on patients' experiences, Astin, Horrocks, and Closs (2014) underscore the importance of aligning care and follow-up with both the psychological and physical dimensions of recovery, which are inextricably linked together. Reducing anxiety and withdrawal by bridging the gap between discharge and enrollment in a CE program would likely not only improve the women's well-being, but also their motivation to participate in a CRP. This presumption is supported by a recent study on perspectives of post-acute transition of care by Stoicea et al. (2017). They state that improvements in transitional care will improve patients' recovery, as measured by activities of daily living and attending rehabilitation. As of today follow-

up routines and referral to CR in Norway are scarce and given randomly. Peerson et al. (2017) highlight the value of early systematic follow-up routines with systematic referral to CR for all eligible patients. They conclude with the need for future research addressing new targets for intervention with CR better tailored to the patients' personal profile and underlying problems.

Methodological Reflections

Lincoln and Guba discuss four criteria for trustworthiness, namely, credibility, confirmability, dependability, and transferability (Lincoln and Guba, 1985). Credibility refers to establishing confidence in the “truth” of the findings. We have attempted to describe the research process as precisely as possible and have faithfully followed the steps in the described process of analysis. Effort was made to gather rich data and to create strong links between data and analysis. In the process, the researchers checked, discussed, and rechecked the evolution of the final themes, attempting to make the themes comprehensive with as little overlap as possible (Malterud, 2012). Both researchers carried out the analysis. We argue that this has helped strengthen credibility by creating an analytic space with more nuances. “Confirmability” describes the degree of neutrality or the extent to which the findings are shaped by the respondents and not the researchers' bias, motivation, or interest. To ensure concordance between the content of the interviews and our themes, we have illustrated the subthemes using quotations labeled with a code that refers to the person who made the statement. However, one cannot rule out that the analyses have been colored by the “experiential lenses of the researchers” (Gadamer, 2011), even though the authors were conscious of bracketing previous preconceptions. “Dependability” means that the findings are consistent and could be repeated (Lincoln and Guba, 1985). To strengthen the dependability, the two authors had frequent discussions and continuous dialogue to establish consistency of differences and similarities of the content over time. Corresponding findings from other studies could also be said to strengthen the dependability of our study. “Transferability” means that the findings can be applied to other contexts. In terms of transferability the sample size was 20 women,

the number required to attain saturation. We tried to get a varied group with respect to type of cardiac events and demographic data and we recruited the women from 4 different hospitals and rehabilitation settings, both inpatients and outpatients. A varied group is said to create additional perspectives (Halkier, 2010). Despite this, we might have missed important nuances, as our informants represented a relatively conforming group, especially with regard to socioeconomic background and ethnicity. Still, we hope to have highlighted some phenomena that may have relevance for comparable patient populations and situations. By providing sufficient details through thick descriptions, the reader can make a judgment regarding the study's applicability to other contexts. The use of thick descriptions is a way of providing a solid framework for comparison from which transferability may occur (Creswell, 2014).

CLINICAL IMPLICATIONS

The findings from this study provide new and important knowledge on recovery processes after a CE, as seen from female patients' perspectives. If the ambition is that health services should be patient centered we need to understand what matters for the individual. The knowledge brought out indicates a stronger emphasis on supporting the personal recovery processes in cardiac care, recovery being much more than reducing symptoms and improving function, as seen from a professional perspective. Unlike in somatic medicine, the support of personal recovery now represents a stated goal for many modern mental health services (Slade et al, 2014). The study also demonstrates new insight into factors women consider to influence the process of regaining confidence in the body and help in finding ways back to activities and participation. The knowledge presented reveals unmet needs of predictability and follow-up with support and supervision. At a system level, this indicates a need to establish systematic follow-up routines in the early recovery phase, bridging the gap between discharge and enrolling in CR programs. To help identify patients requiring further professional support after discharge, we suggest introducing

a simple screening tool for anxiety and depression in the early recovery phase. The findings reinforce the call to recognize the importance of words in shaping patients' outlook toward the future.

CONCLUSION

Our findings demonstrate that a woman's recovery process after a CE can occupy a rather lonely and difficult time, which not only affects the women's well-being but also their activity levels. A lack of follow-up and continuity seems to disturb the progress of the recovery process. The study underscores the significance of helping the women resolve uncertainty by establishing a systematic follow-up plan from the early recovery phase. The women's own perspectives on what they need to resume activities of daily life is often overlooked. Health care professionals primarily focus on the medical care and clinical recovery in the initial recovery phase, with little attention toward the patients' feelings, bodily experiences, and thoughts. Follow-up with management of post-discharge issues as well as encouragement fostering constructive thinking seem to be key-factors in the recovery process. One could argue that physiotherapists have a valuable contribution in the immediate follow-up post discharge as physiotherapists have the professional knowledge and skills to empower patients through bodily experiences and by providing advice on activity that the patients could follow up.

We believe that a small change in transitional care delivery would lead to an improvement in the personal recovery process after a CE. Further research is required to understand in what way physiotherapists can best contribute to supporting women in their recovery processes and empower more women to start and complete CR programs.

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Declaration of Interest

The authors report no conflict of interest.

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ID	Age	Marital status	Inclusion	Education	Occupational status	Perceived health	Months after CE interviewed	Rehab. facilities
F1	60	Divorced	PCI Aortic stenosis	Certified nursing assistant	50% Nursing home	Satisfactory	2	A
F2	59	Widow	Cardiac failure	Higher education	50% Guard service	Poor	4	A
F3	64	Widow	Unstable angina	Certificate of apprenticeship – health care	94% Nursing home	Satisfactory	5	A
F4	58	Married	CABG	Primary school	30% Office work	Very good	5	A
F5	61	Married	Angina, PCI, AV-block	Higher education, Registered nurse	70% Nursing	Satisfactory	5	A
F6	70	Widow	PCI	Higher education	Pensioner, earlier office work	Good	12	B
F7	63	Single	CABG	Certified nursing assistant	Pensioner	Good	12	B
F8	66	Married	CABG	Higher education	Pensioner, earlier office work	Very good	13	B
F9	65	Married	PCI	Primary school	Pensioner, earlier office work	Good	14	B
F10	42	Cohabitant	SCAD, MI	Higher education	Part time, Public relations	Good	15	B
F11	69	Married	MI, PCI	Higher education	Pensioner, earlier office work	Good	8	C
F12	74	Married	MI, PCI	Secretary education	Pensioner, earlier office work	Good	8	C
F13	69	Married	MI, PCI	Higher education, Registered nurse	Pensioner	Satisfactory	8	C
F14	72	Divorced	MI, PCI	Higher education, Reg. social worker	Pensioner	Good	7	D
F15	72	Widow	MI, PCI	Primary school	Pensioner, earlier office work	Very good	3	D
I16	56	Single	MI, PCI	Junior high school	Unemployed	Good	3	D
I17	61	Cohabitant	CABG	Higher education, Registered nurse	90% Nursing	Good	9	D
I18	65	Married	MI, PCI	Higher education	100% ministry officer	Satisfactory	4	A
I19	68	Widow	CABG	Senior high school, Medical secretary Certified nursing assistant	Pensioner	Satisfactory	4	C
I20	74	Cohabitant	MI	Junior High school	Pensioner, earlier office work	Satisfactory	3	C

Table 1: Summary of the participant demographics

F: Focus group participants; **I:** Individual participants

A = 4 weeks inpatient, specialized CR; **B** = 12 weeks outpatient; **C** = 10 weeks outpatient local hospital; **D** = 8 weeks outpatient local hospital

CE	cardiac event
PCI	Percutaneous coronary intervention
AV-block	Atrioventricular block
CABG	Coronary artery bypass surgery
MI	Myocardial infarction
SCAD	Spontaneous coronary artery dissection