Spouses of patients with coronary heart disease had varied perceptions about its aetiology and drug treatment

Kärner A, Dahlgren MA, Bergdahl B. Coronary heart disease: causes and drug treatment—spouses' conceptions. *J Clin Nurs* 2004;13:167–76.

Q What are the perceptions (or conceptions) of spouses of patients who have had a cardiac event regarding the causes of coronary heart disease (CHD) and effects of drug treatment?

DESIGN

Qualitative study using an empirical and inductive approach.

SETTING

Norrköping and Jönköping in southeast Sweden.

PARTICIPANTS

25 spouses (mean age 55 y, 68% women) who were living with a partner who had had a cardiac event about 1 year earlier. 18 patients had had a myocardial infarction (MI), and 19 had received revascularisation. 12 spouses were working, 2 were unemployed, 10 were retired, and 1 was a student.

METHODS

Data were collected using semistructured interviews that lasted 60–90 minutes and focused on spouses' conceptions about 5 domains related to possible causes of CHD: physical activity, diet, stress, smoking, and drug treatment.

MAIN FINDINGS

Conceptions concerning causes of CHD. All spouses regarded physical exercise as a positive factor in the rehabilitation of patients with CHD. However, most did not mention inactivity as a cause of CHD. Some spouses identified the negative consequences of both inactivity and excessively rigorous exercise during the early stages of rehabilitation, believing that inactivity accelerated the CHD process or that physical exercise presented a risk of relapse.

Unhealthy diets, with a predominance of fatty foods, were considered to be an important cause of CHD by several spouses, who also mentioned that changing to a healthy diet was an important preventive step. Most spouses believed that fat hindered blood circulation in coronary vessels and led to an MI; others believed that fat affected blood viscosity, although they did not really understand its effect on blood vessels.

Approximately half of the participants mentioned stress in the initial discussion about causes of CHD. Some held the perception that stress strained blood circulation and caused vessel wall obstruction and MI. Most perceived stress to be generally negative but were not able to link it to consequences related to CHD development.

All spouses regarded smoking as negative for the body, and about half considered it to be a cause of CHD. Some spouses believed that smoking contributed to atherosclerosis, thrombus formation, and MI. Most spouses believed that smoking negatively affected physical fitness, blood vessels, and working of the heart, but they did not elaborate on how it would affect the development of CHD. Most spouses also believed that smoking negatively affected blood vessels and indicated a non-specific connection between smoking and CHD.

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Conceptions concerning drug treatment. All spouses expressed opinions regarding their partners' drug treatment, as well as confidence in the physicians' prescriptions. Some believed that drugs prevented atherosclerosis, clot formation, MI, and the need for bypass surgery. Most believed that drugs were necessary for the heart but harmful for other organs. Others perceived that constant drug intake damaged function and led to disease.

CONCLUSIONS

Spouses of patients who had developed coronary heart disease (CHD) a year earlier displayed a wide variety of perceptions about the causes of CHD and drug treatment. They correctly attributed CHD to several aetiological factors including unhealthy diet, stress, smoking, and physical inactivity, and mostly considered the treatment as necessary but risky. However, spouses had misconceptions around key areas of cardiac rehabilitation activities and advice.

Commentary

The study by Karner *et al* took a different perspective from previous studies of spouses of patients with CHD by exploring the depth of their knowledge about causes of CHD and their beliefs about drug treatment. Whereas many spouses had some understanding of the causes of CHD at 1 year after the coronary event, others had misconceptions that have relevance for planning and implementing rehabilitation programmes for patients with CHD. Spouses' reliance on lay sources for information raises questions about information accessibility and the ways in which it is made available.

It is important to note that this study considered the findings in relation to spouses of both sexes. Further interpretation of the results would be aided by subgroup analysis of the responses of spouses of patients with MI, revascularisation, and those who had both. Given that spouses may have attended an education session before the patient's discharge, it would have been helpful to know if those who attended had different levels of understanding about CHD than those who did not attend.

The authors point out that the extent to which the spouses' knowledge base about causes of CHD and drug treatment influences patients is unknown. Although it is tempting to link spousal level of understanding to patient behavioural change, caution must be exercised when extrapolating these findings to suggest that providing more information is better. Before making such an extrapolation, it is necessary to determine what information spouses use and what is necessary to optimally influence patients' behaviours and lifestyle changes. Future efforts should be directed at understanding the association between depth of spousal knowledge and the adoption of therapeutic patient behaviours, and when this influence is greatest during the recovery process.

This study reinforces the need for nurses to include spouses of patients with CHD in educational activities and to explore perceptions about CHD causes and medication effects to ensure that spousal influences during patient recovery are informed by an accurate knowledge base.

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