Myocardial Infarction and Wives

Accounts of the problem of a group of wives during their husbands' recovery from myocardial infarction

Gillian M Dyche

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Introduction

The effects and impact of an illness on the patient's wife and family have been emphasized by a number of authors (Boon, 1972; Crawford, 1971; Binger, 1969; Klein, 1967). It has been suggested that wives are important support structures for family members whilst they are ill. For example Petroni (1969) and other writers, e.g. Mechanic (1959), Parsons and Fox (1958), Nagi (1966) have pointed out the link between illness behaviour and the patient's perceived support from significant others. Petroni described the influential role of wives in the health behaviour of their spouses whilst noting that, ideally such perceptions may be defined from the variety of points of view of a number of relevant others. Vincent (1963) has also observed that patients will often consult a doctor as the result of the way in which their symptoms are perceived by an unaffected family member. A similar relationship between significant others and illness behaviour has been noted in studies of mental patients (Miller, 1967) where re-admission to hospital was related to the reactions of immediate others. Skelton and Dominian (1973), in their work on heart disease, and other writers, e.g. Schwartz (1957), have found that the emotional consequences of an illness had a considerable effect on family life, and in particular on the wife concerned and her attitude and ability to cope with the social context of the recovery within the home. Thus it can be argued that the effects of an illness such as myocardial infarction on the patient cannot be considered in isolation since it is bound to have an impact on the wife and family also.

As well as the variety of established clinical criteria involved, a patient's recovery from heart disease must also be seen amongst the range of social factors involved (Croog, 1968). Such things as return to normal social and domestic roles are vital for the patient's recovery and the management and quality of family relationships are also important. Together with this there are many personal and individual factors which can be relevant, such as satisfactory definitions of self (Litman, 1962; Litman, 1968), independence and personal contentment perceived by individual patients and families. It is often useful to draw out the perceptions of participants themselves as Cowie (1976) has done, about what is unsatisfactory in their eyes or what might be causing problems.

Many factors affect recovery and are well known such as the patient's age, the severity of the illness, whether there are complications, or

other diseases present, the treatment received, the nature of the occupation pursued, a person's economic position and so on. In addition to this the whole area of personal psychological and social characteristics of the patients and the families concerned have become increasingly prominant areas of attention.

In a recent review by Doehrman (1977) many of the social and psychological factors experienced during recovery were dealt with. Doehrman emphasized the social, emotional and family problems felt by a significant minority of patients. Research by Mayou (1976) and his colleagues in the rehabilitation field has pointed to the major role the wife had to play in the patient's recovery in terms of her attitudes and behaviour as well as the general quality of family life. Particular emphasis was given to the need for more advice and practical help during the hospital and convalescent period, for patients and wives. The Report of the Joint Working Party on Cardiac Rehabilitation (1975) has made similar observations and stressed the need for some anticipation of problems not only in the patient but in his family.

A brief consideration of the major variables associated with cardiac recovery shows that there are many factors involved in recovery. Exercise programmes for myocardial infarction patients do not appear to have beneficial or harmful consequences for the patients according to the Report of the Joint Working Party but are thought, overall, to be a good thing for the patient and may improve his physical fitness. The personal and social aspects of the illness, which has increased in emphasis in recent years have been widely discussed. Factors such as driving (Taggart, 1969), sexual behaviour (Naughton, 1973), diet and activities such as leisure pursuits have all drawn attention from researchers. Psychological factors are also thought to be influential in determining the effect of the illness on the patient and his general well-being (Whitehouse, 1960). Some writers have pointed out that factors such as depression, anxiety, and changes in personality are well known accompaniments to heart disease which can and do cause some unnecessary and increased suffering which in turn may influence recovery and reaction to the illness. For example Garrity (1973) noted that the heart patient's perception of his health was related to morale at six months after the infarct had occurred. Wynn (1967) (although looking at a specially referred group of cardiac patients) focused on the emotional distress caused by the infarct. This kind of evidence tends to produce a picture of a variety of psychological

and personal problems associated with the illness which may persist for a year after the illness (Finlayson, 1977) but with Doehrman's review in mind it appears that the pattern of anxiety and depression tends to reduce gradually over this time.

The patient's ability to return to work after a heart attack is a factor which is generally considered most important for all aspects of recovery and may possibly be of positive therapeutic value, (Joint Working Party, 1975). In fact the recent Joint Working Party emphasized it as a chief aim during recovery and Doehrman's review identified the fact that roughly 75% of surviving patients previously employed return to some type and amount of work within six months of the infarct and 85% returned by one year. However apart from clinical impressions, such as those mentioned by Rahe (1975) there tends to be little information about the problems of adjusting to work and adaptation during convalescence. It has been suggested that 20% of those returning do modified work involving factors like changing jobs, reducing hours or reducing levels of activity within the job (Kushmir, 1975). In a recent study by Finlayson (1977) it was pointed out that men with this illness had various problems at work and accompanying anxieties about return to work.

A further area of importance is that of giving instructions to patients about their illness. The benefits of so instructing patients have been clearly demonstrated by Egbert (1964) in the reduction of post operative pain. Skipper (1968) has also reported a reduction in stress and better adaptation to hospitalization and surgery for children, and their mothers accompanying them, for tonsillectomy. The more effective communication with patients and their families has also been advocated by Bennett (1976), Fletcher (1973), and Cunningham (1977). These authors emphasized the importance of advice and counselling patients and family about the nature and course an illness may take and its possible effects on work, daily life, exercise, sexual activity, diet and smoking. It has also been shown that frequent follow up visits at home accompanied by continued advice have been able to help patients stop smoking in a small study which looked at techniques of intervention for patients who smoked and had heart disease. It is not clear yet who could best produce such information however recently it has been shown by Mayou (1976) that there was considerable felt need for such counselling and advice services about aspects of heart disease and their impact on the patient and family. Such information and advice giving, together with patient education does have certain

problems, such as whether the doctor is the best person to do this. Who else might be suitable for the role, and the fact that even in circumstances which are favourable the recall and understanidng of information and advice can sometimes be low (Ley, 1967; Cartwright, 1964).

Rahe has suggested that the setting up of a group therapy regime enabled patients to know more about the nature of heart disease and its implications than patients not receiving therapy and that it went some way to overcoming anxieties about the illness and meeting the patient's special needs during recovery. Studies where the nurse (Pozen, 1977) and doctor (Woodwark and Gautier, 1972) have been used as providers of information, have also shown how improving knowledge about an illness helped compliance with treatment, longer term recovery, work prospects and tended to reduce the patient's level of social disability. Patients given very strong advice about smoking in a further study (Burt, 1974) demonstrated that a 'dogmatic' approach resulted in a much higher proportion of patients giving up smoking completely than with conventional methods of giving advice. The accumulating evidence from studies such as these, tend to indicate that education, counselling, group therapy, and specific advice both written and verbal may effectively help in recovery and problems after heart attack, particularly as these patients seem fairly highly motivated to accept such help.

Myocardial Infarction

Myocardial infarction is an acute illness arising from a blockage of the coronary artery. For a thrombosis to occur the artery must be affected with atheroma. Acute myocardial infarction is a major cause of death in middle and old age and chiefly affects men from about the age of forty, but is less common in women. The condition is fatal in a substantial number of cases, for example Colling (1977) cites an overall fatality rate of 50.5% by twenty eight days and other community surveys (Pedoe, 1975) suggest a rate of 35% in a similar period. Cases treated in hospital have risen sharply in recent years and data from the Hospital Inpatient Enquiry (1972) suggest that 25,000 hospital deaths occurred in 1972. For those who survive there is the risk of another attack and the development of complications. Recent studies (Prevention of Coronary Heart Disease, 1976) indicate that people with certain characteristics form high risk groups where the chances of death from myocardial infarction are greater. Although there is no means of preventing the condition certain factors, such as plasma lipids, smoking, blood pressure, obesity, physical activity, stress, diabetes and dietary factors have been associated with proneness to the disease.

Aims of the Study

The study was set up to explore the views of wives about the effects of myocardial infarction on patients and their families and focuses on the way wives perceived and were affected by the illness - the emphasis being on the subjective perceptions of wives.

Information was gathered from wives about family background and for the three interviews the following themes were explored.

The Personal Effects of the Illness
Domestic and Social Aspects of the Illness
Problems Arising from the Illness
Employment and Leisure

This exploratory study was supplementary to another study in the Health Services Research Unit examining the needs for rehabilitation of a series of hospital patients, who were followed up for one year.

Methods

This study was a depth study of the wives of men who had a myocardial infarction. Three interviews were held with a consecutive series of wives of those married male patients admitted to hospital aged between 18 and 59[1] years over one year. Cases were accepted until the limit of twenty[2] was reached, a manageable number for the part-time researcher. The fieldwork interviews, organisation and analysis of data was undertaken by the researcher. Interviews lasted two to three hours, roughly one hundred and sixty hours were spent with wives over the year. The group is open to criticisms of atypicality and bias associated with selection and small numbers, however in a small exploratory study it was thought that this should not be a major drawback, where the aim was to explore in depth a small group, rather than a representative sample of wives.

The patients themselves were asked if they minded their wives being approached for interview, then the wives were contacted separately and all those contacted consented to be seen. Interviews started at two to three weeks after admission when most patients had been discharged though two were still in hospital. Interviews were arranged in the patient's home which was found to be a convenient and suitable place.

The method employed to collect information was a depth study approach, a formal interview schedule was not used but instead a check list of topics. The method yielded qualitative rather than quantitative material and was chosen because of the exploratory nature of the study which was not aimed at testing a specific hypothesis. Advantages of the approach were that it provided a wider range of detail and a variety of data, although there were known limitations such as reduction in reliability and generality of findings, reliance on unsystematic description and the 'control effect', where the researcher might unwittingly change the factors studied.

The strategy used in the study was to present a number of topics to the wife and allow her to describe and emphasize relevant points. It relied on the idea of self-perceived problems and accounts of the facts. The order in which the topics were presented was similar for each case.

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[1] This age limit was chosen to avoid patients who might retire.

[2] The total number in the patient series was 52.

Role of the Researcher

In the discussions with wives there was a tendency for the researcher to be positive about issues raised and to share assumptions with wives. The image of a sympathetic and interested person trying to gain knowledge about the subjective experiences of heart disease was cultivated, and arising from this two factors occurred. Wives tended to treat the researcher as a source of advice and counselling, and there was a problem of how to reciprocate for the time and information given. The role of the research worker tended to change over time with an improvement in the quality of replies and rapport and as time passed a certain amount of dependency developed. These problems were difficult to resolve as no help or assurances could be given whilst the study was ongoing.

Depth Interviews

Unstructured depth interviews are highly suited to exploring the effects of heart disease on wives and families, but as with all fields of survey technique they have certain methodological problems. Such interviews whilst providing a favourable climate for discussion rely on replies which are taken at face value.

Tape Recording Depth Interviews

This study was assisted by the use of tape recorded transcripts of some of the interviews and this provided powerful insights into the subject under investigation. Tapes were not used in the first interview as it was noticed in the pre-test that this tended to be initially off-putting to wives. When a rapport was established the use of a small cassette tape recorder was invaluable, and if the researcher explained that the recorder could help him because he could not write quickly enough to get everything that was said, fears were allayed. Use of a recorder meant the researcher could concentrate on the interview and its flow. It enabled the researcher to identify regularities, and common problems not as easily traced from written notes and provided information which was highly comparable in specific areas. There is value for the researcher in being able to listen through the tapes and piece together various aspects. Emotions, emphasis, tone of voice all give insights into how the subject is feeling, listening through tapes can provide feedback on possible bias and technical defects in the interview.

The use of data which has been recorded is expensive in terms of transcribing resources and the amount of time needed for editing and listening through. Recorded qualitative data provides numerous sheets of typed material requiring reading, checking and organising by the researcher. Although it is doubtful whether other methods can match the use of taped transcripts for providing full and insightful information, this must be weighed against the limited amount of a researcher's time and his imaginative ability in dealing with the vast idiosyncratic output.

Characteristics of Wives

The following paragraphs outline some of the social characteristics of the cases studied. The ages of the twenty wives in the study ranged from the youngest aged 18 years to the oldest, aged 77 years, however most of the wives were in their forties or fifties. The patients' ages ranged between 18 years and 59 years. The youngest husband was 21 years and the oldest 59 years. The majority of the families in the group could be described as intermediate and skilled manual as indicated by the husband's occupation, and thus fell into the following Social Classes,

Social Class I	0
Social Class II	7
Social Class IIINM	0
Social Class IIIM	8
Social Class IV	4
Social Class V	0
Unemployed	1

Subjects were drawn from various parts of East Kent,

Canterbury	4
Faversham	2
Folkestone	1
Herne Bay	7
Sandwich	1
Shepherdswell	1
Sittingbourne	1
Sturry	2
Tankerton	1

Most of the families were on the telephone (14) and 6 were without telephone. All the families were the elementary nuclear type, 8 were at the procreation stage on the life cycle, 5 were at the dispersal stage, and 7 were at the final stage. The majority were owner occupiers, living in housing fairly typical of the area.

House, semi-detached	7
House, terraced	3
Bungalow (semi-detached)	5
Flat	1
Tied Cottage	1
Council House	2
Rooms	1

TABLE 1 CHARACTERISTICS OF RESPONDENTS

Case	Wife's Age	Husband's Age	Children	Wife's Occupation	Husband's Occupation	Social Class
1	48	47	8	Fulltime Housewife	BBC TV Producer	II
2	51	59	Adult 2	Part-time Teacher/ Demonstrator	Stores Control Officer GPO	II
3	47	48	2	Part-time Domestic Cleaner	Foreman Car Sprayer	IIIM
4	44	45	2	Part-time Typist	GPO Overseas Telegraphist	II
5	46	52	Adult 2	Fulltime Housewife	Gas Conversion Mechanic	IIIM
6	59	55	Adult 2	Part-time Cleaner	Self employed Commercial Artist	II
7	54	54	Adult 2	Fulltime Housewife	Electrical Fitter Power Station	IIIM
8	39	47	2	Part-time Secretary	Sealink Steward	IIIM
9	53	53	Adult 2	Part-time Cashier	Lecturer Graphic Design	II
10	57	59	Adult 2	Fulltime Housewife	Printer	IIIM
11	54	55	-	Fulltime Clerical Officer	Draughtsman	II
12	52	56	Adult 2	Part-time Clerk	Maintenance Manager Factory	II
13	55	59	Adult 2	Part-time Fruit Picker	Farm Fruitman	IV
14	53	57	Adult 2	Part-time Playground Supervisor	GPO Installations Engineer	IIIM
15	48	52	Adult 1	Fulltime Cashier	Printer	IIIM
16	42	45	1	Part-time Cleaner	Unemployed	Unemployed
17	77	55	Adult 2	Housewife	Handyman on Caravan Site	IV
18	40	45	2	Part-time Domestic	Lorrydriver	IV
19	49	56	Adult 3	Housewife	Off-Licence Manager	IIIM
20	18	21	-	Fulltime Doctor's Receptionist	Builder's Labourer	IV

Summary of Main Themes

This study describes selected aspects of the detailed accounts that wives gave of the impact of Myocardial Infarction on them, and their husbands. The present report has concentrated on those areas of the study which make a new, or distinctive contribution to the existing body of knowledge (Finlayson, 1977) arising from its use of the wife's point of view.

The emphasis in the approach to the study was on the subjective perceptions of the wives as to how the patient was reacting to his illness, and not just to 'facts' about the illness. It sets the aspects of the individual patient's recovery in the social contect of his relationship with his wife, and suggests that the entire process of the patient's recovery is likely to be substantially affected by the broad range of family processes he experiences, particularly his wife's perception and subsequent treatment of him. Information produced in the study has tended to be about the more subjective experiences of the ill-defined social and psychological factors involved in illness and recovery. These factors have been illustrated in two recent papers by Mayou (1976) and Skelton and Dominian (1973).

Certain themes characterise the accounts throughout the year during which they were taken which represent the illness as not only a patchy episode but one with very varied individual consequences for both the patient and his wife. It was not easy to establish clear cut stages of recovery, particularly as the accounts given by the wives were so individual and the problems which occurred for patients involved periods of adjustment which were often followed or merged imperceptably into periods of improvement or stress. This picture of recovery described by wives was personal and individual and as such not easily categorised but nevertheless gives insights into the personal and social aspects of the illness, wives found meaningful. Wives are important and significant because they are usually faced, from the outset of the illness, with the worry of the attack together with the increased physical and emotional demands of coping with its practicalities. With this in mind it can be said on the basis of this series that wives were involved in four kinds of process during this year of recovery. These processes can be identified as themes which characterise the details of the accounts.

An early theme which emerged from all the accounts was that of uncertainty. Wives, like the patient, were uncertain about how to behave and what the long term implications of the illness were and how protective they should be. This uncertainty among wives as to what was the right action to take often resulted in considerable role strain. Uncertainty characterised the major areas of life such as work, domestic life, personal health. Feelings of uncertainty may have been rooted in the way the attack itself occurred which was sudden and without warning. It tended to produce reactions of shock and surprise, and wives and families were suddenly changed from healthy individuals into the wives and family of someone who was now threatened and dependent because of the illness. Hilbourne (1973) has noted the effect on the family and its members which occurs in most areas of life when a key member becomes ill or disabled:

> "other members of the disabled persons' family will experience handicaps and disabilities which arise from his physical deficiency and in the ways in which it is perceived."

This view is also supported by the Klein et al. study which argues that the illness exerts a significant effect on the well members of the family also.

Another recurrent theme which occurred amongst wives studied and was also reported on in this series of patients throughout the year was that of depression and social disorientation. This depression often began for the men when they were discharged from hospital and when adjustments to some kind of recovery in the home environment were necessary. Depression was not helped amongst those who attempted to regain some of their normal activities at home and were surprised how little they could manage to do or were met by wives who urged them to be restrained in their activities. For wives there was a fairly constant level of reported depression during the first year of illness which, in the early part of the attack, was accompanied by anxiety and tension and ill health. Wives who tended to have an anxious disposition and were dependent upon their husband found coping with illness most difficult. Depression and emotional disturbance were characterised by minor illness, the need for sedatives and social disorientation, but women found work and continued employment was a helpful antidote, in part, to this depression.

A further theme which occurred during the study was that of lack of information about the illness and its physical and social effects and

the way it would affect the patient's work and in turn the family which he supported. Medical staff may be aware of the practical needs of patients and their wives but unsure of what information and advice they should give, particularly in the case of myocardial infarction, where medical knowledge has changed rapidly and there is a considerable amount of uncertainty and disagreement. Wives felt the lack of relevant specific information as soon as the illness occurred and frequently mentioned their need for early and full advice. In such circumstances it may be preferable for doctors to offer more firm advice to patients and their wives even if it is ineffective (provided there is no danger to life) rather than give very qualified advice, or no advice at all. In some cases lack of information buttressed the existing feelings of uncertainty and tended to produce a situation where wives brought their own lay definitions and ideas of appropriate action to the situation and as such acted as rather protective conservative influences on the patient's recovery. This was, for example, characterised by the way they restricted certain activities and felt others were unsuitable and tended to protect the patient from any potential stresses and strains. Wives tended not to encourage patients to return to normal roles and responsibilities within the family,also they tended to themselves take over tasks within the household which had previously been the patient's concern. Wives wanted to know more about the disease, its implications and how to prevent it recurring. This was an early and pressing need because wives were the people who had to deal with the immediate consequences of the attack yet were often the ones who were told little or nothing about it. Patients who were informed in hospital often needed fuller and further explanation later in convalescence during their hospital stay and subsequently at home. It may be valuable to see both patient and wife together when giving advice and information because it was noticeable from the wives' accounts that patients and their spouses did not tend to talk to each other or communicate well about the illness, possibly because the fears and questions each had tended not to be ones they could bring up in conversation. This emphasis on the needs of wives and possibly other relatives for full and early advice and information has also been pointed out by other writers such as Mayou (1976).

A fourth theme was the tendency of the wives studied to displace many of their social and domestic problems such as troubles with children, coping with elderly relatives, and marital problems onto the illness and describe these difficulties as in some way related to or due to

the illness. In a few cases such problems were genuinely associated with the illness, but, on the whole, wives in this series often tended to use the illness to find solutions to these other difficulties. As such they sometimes 'expected' health service staff to be able to deal with the problems or offer advice. Had the illness not occurred it is likely that wives concerned would have coped with these problems without help.

This study of a small series of wives of myocardial infarction patients has illustrated some of the factors and effects which wives felt were important. One of the more significant problems mentioned at each stage of interview was the failure to obtain adequate advice and information from medical staff on the course and management of the illness. Often this meant finding alternative ways of coping with difficulties in daily life, work and personal life arising from the illness for wives and patients. The inefficiency of doctors as providers of information and their reluctance to do so has been highlighted by a number of writers, Byrne and Long (1976), Bennett (1976), Fletcher (1973), as an area of potential change. However, further consideration of how best to educate and inform patients and their wives and families could be beneficial in meeting many of the highly individual needs which arise during ill health; particularly a chronic condition such as heart disease.

I ACCOUNTS OF MYOCARDIAL INFARCTION AT THREE WEEKS

Wives' Emotional Reactions to the Illness at Three Weeks After the Attack

There has been a considerable emphasis in the literature on the emotional distress which occurs after myocardial infarction which has shown a variety of personal forms for most patients mainly in terms of fear, anxiety and depression. These kinds of response are normally most severe in the early stages of the attack, and according to Doehrman's review, show a decline in patients experiencing various forms of emotional distress as time passes. For wives in this series there were also strong feelings of anxiety and depression, particularly at three weeks after the infarct. The wife's emotional reaction to the illness took many forms, fifteen wives described their predominent reaction to the attack as one of 'fear' and 'shock'. This reaction was tempered by a sensation amongst some wives that the attack was 'not entirely unexpected'. Many wives were able to describe indications which had gone before which made them feel something was wrong, such as symptoms and warning signs in the patient which had alerted them in some way, and in three cases, previous attacks had occurred and in two cases a family history of heart disease meant the actual occurrence of the attack was not surprising. A main reaction in early days was to normalise the attack in everyday terms and to see it as part of the day to day problems which occurred in life. Other early reactions were anxiety and a great uncertainty about what would happen and what the future would hold for the patient.

Although all wives were grateful for the care their husbands received in the Coronary Care Unit, six wives mentioned the adverse reactions they had to the treatment they received whilst the patient was in the Coronary Care Unit. They mentioned feeling excluded from the patient at a critical time, a time when he might even die. They were not permitted to sit beside the bedside and felt it was wrong to be kept away from the patient by medical staff. Some wives mentioned that the technical equipment of the ward was alarming for them and the patient, and others that they were left for long periods alone and ignorant of their husband's condition in a small waiting room some distance from the Coronary Care Unit. Although all wives mentioned a need to talk to someone at this time they were often overlooked by busy medical staff or were too shy to mention their anxieties to someone for fear they were inappropriate.

The pressure of children in the home can be set beside the wife's reaction to the illness in its early stages as they were often a source

of related stress. Wives were asked how the illness affected children living at home. Families who had children living with them particularly young children, experienced more stressful reactions to the illness[1], often because they had to put a brave face on for the sake of the children. The younger children who were often described as fearful that their father was going to die suffered most. For example, one child became withdrawn, another argumentative and a further child of five in some way blamed her mother for her father's illness. One wife who had adolescent children felt their difficulties clashed unfortunately with the illness and made coping particularly difficult at a stressful time. At home the effects on children were to reduce freedom within the home. If the patient had returned home by this time they had to help more, to be quiet and vacate the main living area in order that the patient could rest. They also lost social and emotional contact with the father who could often no longer do things he used to do with them, such as hobbies and putting them to bed.

It was thought valuable to ask who were perceived by wives as giving immediate practical help in the early period of the illness. Adult children living nearby emerged mainly as potential helpers for the wife and they reacted with offers of help as McKinlay (1971) has reported. They were used by the wives as important sources of regular contact and assistance, providing emotional support, practical help, such as lifts to and from the hospital, and assistance with shopping, and were described as valuable in helping wives through this early crisis period. The amount of help adult children could provide depended upon how near to or far from the family home they were, and the extent of their own domestic tasks and commitments. The effects of the illness on adult children were often more indirect but they shared a similar reaction, that of shock about the attack, with the wife. Adult children often felt the need to keep in close contact with the wife by frequent telephoning and visits.

The reactions and involvement of the wider family members was predominantly restricted to the wife's kin. It was the wife's sister or sister-in-law who was most heavily involved in so far as it was sisters who gave up their time to provide practical help in a variety of ways, such as looking after children, housework, visiting and emotional support. Fourteen wives described how valuable the help they had received from sisters

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[1] Finlayson, A. & McEwan, J. (1977) have suggested that difficulties relating to children, particularly younger children, and adolescents, may exacerbate difficulties coping with the illness.

or sisters-in-law had been to them. The presence of a capable and available sister to help with the family during such an illness might be something that doctors could take into account in assessing whether such a family needed additional help. The emphasis on the help sisters provided arose because of the excessive age of many of the parents of the families concerned where in such circumstances the substituting[1] of kin occurred.

Wives' Views of the Effects of the Illness on Patients' Behaviour and Personality

Wives in the series were asked about the kinds of effects they perceived the illness as having on their spouse in terms of his behaviour and personality, at three weeks after the infarct. About sixteen of the men were seen by their wives to be experiencing significant but broadly defined personal and emotional problems during this initial period. Patients were frequently described as depressed and psychologically disturbed by the illness. They were described as showing nervousness, lack of confidence, excessive worry and an inability to talk to people. In fact six patients so bottled up their feelings even to the extent that they could not talk about it with their wives. This is a topic which has also been examined by Cowie (1976) where he looked at the personal aspects of cardiac illness, in particular the way in which patients see themselves in relation to others. Most of the patients were described as having quite noticeable psychological effects from the illness at this stage. A key effect among these was that of a 'shattered self' and a sense of lost identity. Patients were variously described as interpreting their experience of the illness at this early stage, in such a way that they felt they would 'never be the same again'. That in a sense they had become 'devalued' as a person now they had suffered this heart attack. Associated with this, feelings of shock and disbelief that the attack had occurred at all were frequently mentioned. The wives thought that in six cases the patient was trying to deny the illness to himself by attempting to do things, or arrange for his return to work much earlier than they considered suitable. The younger men were particularly seen by their wives as trying to regain independence through this type of action whilst this often conflicted with what the patients were physically capable of doing. Six patients were described as dwelling on the reasons why they had not foreseen or interpreted the warning signs of their attack and forstalled it. This

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[1] Townsend, P. (1957) The Family Life of Old People, describes the process of substitution where a sister takes on the role of the aged or deceased mother.

had the consequence of making them rather nervous and anxious about any small pain or discomfort that occurred. In some cases patients tended to become rather dependent, although in the context of wanting to fully recover. This often meant they would not bath, climb an extra stair or do any small thing which might to them jeopardise their progress. This personal and emotional distress identified by wives in the series amongst the patients has also been noticed in other studies. (Wynn, 1967; Kay, 1972; Finlayson, 1977). Such distress may be related to the level of understanding and the available information open to patients and their wives in making sense of the illness at an early stage such as this. It may perhaps be possible to offer more firm advice from medical staff in the circumstances rather than give the existing, very limited and qualified advice and information. This could go some way to alleviating the pattern of stress, which can for some patients (and their wives) persist for a year or more.

Wives: Information and Advice About the Illness at Three Weeks

The wife's desire to know more about the disease was shown at an early stage of the illness. As soon as it occurred all wives in the study group were aware that their spouses had suffered a heart attack partly because they had recognised the warning signs which occurred before the attack and partly because they had made an intelligent guess which was subsequently confirmed by the attending doctor. Seventeen of the wives in the study described how they would very much have liked fuller explanations of the disease particularly the frightening early symptoms or where complications occurred and that fuller explanations could help alleviate the initial worry and uncertainty they had experienced. For three of the wives it was the patient's second attack and because of this the wife concerned found dealing with it considerably easier, as previous experience of what to do when an attack occurred made coping and prompt action easier, but these wives were far more anxious about death and the possibility that their husband would die this time.

In these early days of the attack a search for a cause was often uppermost in the wife's mind as she attempted to put the event into a context and make sense of it. When questioned about the attack fifteen of the wives thought work, or factors associated with work, were causal[1], three thought

[1]This is similar to findings that Finlayson and McEwan have reported, i.e. that 'lay beliefs about causation predominate, especially that of excess work or leisure as being stressful'.

it due to the patient's personality type and habits (such as smoking and drinking) and two wives identified certain stressful events. All the wives questioned expressed a desire for more detail on the likely causes of such an illness and fifteen felt that someone on the medical staff should perhaps explain about the disease to wives as well as patients in view of their close and immediate involvement with the illness. Wives in the study commented that they seldom received any advice about the illness and its impact on day to day activities but all felt they needed information and advice from medical staff during the early phases of the illness. When a wife in the study needed help in this early period she tended to call upon close family or friends rather than health services staff (Finlayson, 1977) who were less accessible for a variety of reasons when a question or problem arose. In spite of the infrequency of contact with medical staff there was a high level of reported need for and interest in, advice about the illness amongst the wives in the study which was felt to be something only medical staff could give. The kinds of things wives wanted to know about varied from advice on the management of the condition at home (this involved fairly detailed aspects of the illness) to how to deal with its day to day general problems, information on the course and future nature of the illness and its implications for subsequent life, in particular those consequences which might affect social and domestic life and the patient's work, were frequently mentioned. Comments about the lack of available information and the opportunity to find out more from staff were common. Another frequent comment was the felt need to ask a lot of questions straightaway about the illness, especially about how to deal with its detailed management at home. But often wives had the feeling that even when the doctor or other member of the medical staff had spoken to them they felt they were told something which was meaningless to them or that they did not fully understand or grasp it straight away, or that the questions which concerned them were too trivial to bring up.

Mrs. G. "I wish they had explained a bit more when he was discharged from hospital about what I should expect. I did ask if I could speak to the doctor to see if he could explain anything to me but he didn't really, he just said that his blood count was high, but that was not what I wanted to know, I wanted to know what he was allowed to do and what he wasn't allowed to do."

Some wives felt they had to pester medical staff for information but that this was disapproved of, and others felt their attempts to find out

more were discouraged. However the need to talk over the illness and its implications with someone able to answer certain of the medical questions was a continually recurring theme in this early period, and some wives actually mentioned the beneficial effect of conversations with the researchers involved in the study.

Four wives reported how discussions and reassurances from general practitioners had been helpful and all patients were given a short duplicated sheet of advice when discharged from hospital mentioning briefly such items as domestic routine, exercise, work and leisure[1]. The need for information amongst this group of wives led them to deal with the 'vacuum' by recourse to lay sources of advice. Those who could, spoke to friends with personal experience of heart attacks, others consulted informed members of the family and one wife actually sent away for a leaflet about the disease.

For the wife concerned coping with an illness such as a heart attack often means calling upon various sources, various types of helpers within the family and friendship network available to her. Wives in this study reported that family sources tended to provide a close and intimate support and help that they needed particularly in the early period and that friends and neighbours gave assistance which was more 'removed' from the immediate problem and as such complimented the rather closer support of the family. These two were important sources of help for the wives particularly for immediate problems and pressing matters which had to be dealt with straight away.

The Advice from the Wife to the Patient

It is suggested by the Joint Working Party that advice from the wife (and family) may be of a rather over protective nature and tend to influence the patient's recovery in this way. This point has also been mentioned by other writers (Mayou, 1978), who have drawn attention to the link between the effect of advice from the wife and the quality of outcome. Wives were asked about the kinds of advice they gave to the patient to see if indeed any effect such as this might be detected. Twelve wives reported that they had given advice to their husbands, although they often felt that they could not offer 'proper advice', and that the kinds of things they suggested had been unwelcome and were, for the majority of patients, not acted

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[1] See appendix I: Hospital Advice Sheet.

upon. However eight wives felt it prudent not to offer any personal advice at this early stage of the illness and this was done in order to avoid any potential conflict over what should or should not be done. The actual comments and advice that were forthcoming from wives to the patient tended to be given in a climate of uncertainty which reflected what the wives felt about the illness and how to approach it. Thus their advice tended to be rather cautionary and conservative urging restraint and advising against any activity which might be threatening and thus shifting responsibility for working things out onto the patient himself. Often this approach tended to clash with what the patient saw as desirable. Over half the wives felt that the advice they had given was resented by the patient, many of whom found it irritating when the advice was directed to their attempts at testing out their physical limitations and exploring new roles to see how far they could regain normality. Thus a situation developed where husband and wife tended not to speak to each other about the heart attack. Wives explained this by saying that it was in order not to worry the patient. But wives often were deeply aware that their husbands were very worried and anxious about the illness too, but even so did not want to discuss it, perhaps because both partners found it upsetting for one another and thus avoided talking over matters, in a sense the attack became 'a taboo subject'. Where both patient and wife were prepared to talk to outsiders (for example the researchers involved in the study, or friends) considerable advantages were found.

The emphasis on a cautionary and protective approach tended to be reflected in the offers of help and advice from other members of the family. Caution and inactivity were stressed and the importance of 'not doing too much', and 'taking it easy' were often mentioned. Some wives commented that they felt that they had reacted adversely to advice from the family because, in some way they saw it as a criticism of them and the way they were handling the illness. However, as mentioned earlier, it appears, from the experiences of these wives, that having available a sister or sister-in-law to cope with practicalities such as domestic chores, children, shopping and so on was a valuable resource for the wife in this early period.

The on the spot help and assistance of friends and neighbours in particular with tasks such as gardening, carrying heavy dustbins and other domestic and social activities were seen as main sources of support in the early part of the illness by the wives and often wives would

mention the value of having reliable friends and neighbours they could call upon if the need arose.

Wife's Views on Exercise

After the patient had left the hospital and come home a foremost concern amongst the wives was that he should not overdo it and strain himself, possibly bringing on another attack. When it came to the problem of exercise and how much or how little the patient should do this was often a source of anxiety and uncertainty for both the wife and the patient. The standard advice on exercise was given on the hospital advice sheet which included advice on other specific items. Exercise was an issue which as soon as the patient came home became critical, nearly all the wives in the series expressed some degree of uncertainty about how much or how little exercise the patient should take. Lay beliefs about the fragility of the heart and the potential harmfulness of activity tended to permeate the wives' views on exercise because of the absence of firm, individually based guidelines for action and full information about what the limitations and drawbacks might be. Seven of the wives who felt very unclear about the appropriate exercise for their spouse 'erred on the side of caution', in other words decisions about exercise were often delayed or abandoned as this course of action tended to involve no risks or the development of frightening symptoms such as pain or breathlessness. Six wives saw exercise only in terms of a very gradual build up over time but none were clear about what level they were aiming for. The ambiguous phrasing of the hospital advice sheet, together with the fact that it did not refer to individual cases, or the specific needs of particular patients, tended to begin to produce the situation where the views of wives of what was appropriate prevailed for the patient. Unlike the generalised medical advice from the hospital advice sheet, wives' definitions of the situation were concerned with the immediate and specific instances that faced the patient such as whether to go out if it was windy, how far to go, whether to climb the stairs for the third time that day, and so on. This tended to produce a situation where the patient was protected to some extent from resuming normal role responsibilities, a factor which has been looked at by Monteiro (1973) and where frequently there was disagreement between partners about what constituted appropriate exercise. In these circumstances the wives tended to define the situation in a rather cautious and protective way so as not to be caught in a situation where another attack might occur.

It has been mentioned earlier that information from wives in this study suggests that wives acted as rather restraining influences on the patients concerned by not allowing them to take part in and help with normal social roles in the home and by employing friends or neighbours for assistance with various difficult tasks.

According to fourteen of the wives, patients had not taken on new family roles due mainly to the wife's feeling that their spouse should do nothing at all at home yet at this three week stage. Six wives reported that the patient had taken on some tasks often against their better judgement but usually because they were so bored with convalescence at home.

The wives in the study laid considerable emphasis on the patient 'not overdoing things' whilst recovering at home. The patients' continued survival was seen as conditional on not undertaking 'too much' and certain things were perceived by them to be particularly unsuitable.

Items Mentioned by Wives Which Were Considered Unsuitable and Might Bring on an Attack at Three Weeks

Driving, especially long distances,
Going out of the house,
Smoking,
Drinking,
Over-eating,
Regular exercise,
Bathing,
Lifting,
Reading,
Jobs in the house,
Moving furniture
Completing decorating (begun before the attack),
Gardening,
Going upstairs,
Mowing grass,
Any activity at all.

The fact that patients were not now able to do all the things they could before the attack was described as one of the worst aspects of the illness, and in some cases wives felt it was difficult to insist on patients not doing things which they, the wives, felt were particularly dan-

gerous. This sometimes resulted in conflict between partners as patients often attempted to do more than they were allowed in the wife's view and disagreement centred on these conflicting definitions of appropriate action.

The wives in the series were questioned about the kind of help they felt they were giving the patient in his recovery. Wives tended to see their role as helping the patient in terms of manipulating the expressive climate of the home so that the patient was not worried or upset by anything and was able to recover in an atmosphere of reassurance. They tended, as mentioned earlier, to restrain their husbands from activity and advise 'taking in easy', 'taking plenty of rest'. Wives felt their major contribution at this early stage was that of protecting the patient from anything that could lead to him 'overdoing things'. Over half the wives mentioned that it was important to provide him with a calm exterior, in spite of their own personal problems and anxieties. Some emphasized a nursing type care which tended to carry on the kind of care given in the hospital at home during early recovery. But all wives stressed the importance of shielding the patient from worry, domestic and financial problems and any difficulties at work. Also it was unanimously felt that too many visitors in this early stage could be harmful and thus wives tended to regulate the amount of social contact the patient received in terms of visitors to the home.

When the wives in the series were questions about their expectations for the patient's recovery over the next three months, when the second interview would take place, most wives felt that favourable expectations for continued survival were conditional on 'being careful', 'doing as he is told', and 'taking it easy'. The wives questioned continually emphasized the idea that the patient should never over-tax himself and that this was very important. Also mentioned was their concern about the illness and its implications for the future. Wives were already forming questions, even at this early stage, about how adaptations to life and, in particular, employment might be accomplished and what practical applications for the future having such an illness would pose.

The Wife's View of the Patient's Employment at Three Weeks

At this stage of the illness patients and their wives were already worrying or beginning to worry about the husband's employment and the way it might be affected by the illness. This concern amongst wives meant that they were mentally exploring alternative possibilities for

their husbands and starting to look to the future and how it was going to plan out within the need to adjust to the illness.

The early effects on employment varied according to the patient's economic position, class, and occupation and within an occupation with the security of tenure and conditions of work, sickness benefit and other similar factors. Those wives who had husbands with more secure and skilled and professional jobs tended to be in a more fortunate position because these occupations allowed them better sickness schemes, longer recovery times, job flexibility and fringe benefits, and where state run concerns were involved they appeared to have better schemes covering illness than some other concerns. The eight wives of those patients with favourable job prospects where return to the same work was highly likely, nevertheless joined the rest who were even now beginning to express concern about adverse factors at work which might make it difficult for the patient to continue or return. Eight wives described the reservations they felt the patient had and expressed anxiety about aspects of the job which they knew their husbands were worrying about. A main theme of these early concerns was 'worry about the future of the job', and 'possible changes in the job because of the illness'. Sixteen wives reported that the patient was, at this three week stage 'very discontented at being at home', and almost all wives mentioned that the patient 'felt lost' and 'depressed because of not being at work' and 'missing the company and interest of work'. These feelings of loss and depression were successfully pushed into the background when it was possible for the men concerned to maintain a link with work. In three such cases the wives concerned variously described how the patient had 'had a man from work round to keep him in the picture', 'a man is coming each week to tell him what they are doing', and in another case, that of a television producer, the patient concerned was using the time to write a book and to prepare future ideas for programmes. The wives involved thought that there was a benefit in this kind of link with work which had the advantage of combating the frequently mentioned problem of boredom in recovery, and also made the men concerned feel that they were not entirely 'useless' now. However, where a link with work occurred the men concerned were in professional and intermediate occupations and it may not be possible or perhaps desirable for this to occur with other kinds of occupations where possibly such a link may not be so beneficial.

Some wives, mainly those whose husbands were in skilled occupations, described how the fact that the employer concerned had contacted the patient and made it clear that his job would be available when he got well, and in some circumstances outlined proposals for changes in the job to accommodate him, had eased the felt concern about work and the illness. Almost all the wives in the group questioned were beginning to see the implications and probably long term effects of the illness at this stage and for those in manual occupations, the wives concerned mentioned how they felt that their husband was trapped in a work situation associated with certain adverse factors, which were unalterable unless he could get another job. This was often thought to be unlikely due to the man's age and to local and national employment difficulties. Nine of the wives of patients in skilled manual occupations had begun to envisage problems concerned with the nature of their husband's work (i.e. reaching, lifting, driving, hard labouring, and so on). The conditions of the job, such as long and irregular shiftwork, internal tensions and the journey to work and its hours were a worry, although wives often said it was too soon to say what would happen yet.

This early period after the attack emerged as one where wives were involved in the process of contemplating return to work. There was a strong feeling of shared concern, and in some cases practical involvement in accommodating to the patient's plans for return to employment. Both wife and patient were thinking over the possibilities in connection with the husband's work. But often they did not speak to each other about their feelings about the illness for fear of arousing worries in the other during this transition period. Other effects on the wife and family associated with employment, such as money worries, were not noticeable as yet, except in two cases where the financial consequences of a sudden illness such as a heart attack were felt immediately. Wives tended to feel that counselling on the possible implications of the illness on employment and the patient's working life would be very helpful if done at an early stage perhaps even in hospital, when according to them patients began to form doubts and worries about employment and their future.

The Wife's Employment

In view of the threat this kind of illness posed for the patient's employment, the wife's employment tended to assume greater importance as a source of family income should the patient be unable to work. Of the

wives in the series fourteen were in paid employment outside the home, six had no jobs at the time of the heart attack, eleven worked part-time and three worked full-time (table 2).

TABLE 2

To Show Occupation of Wives of Patients

Total 20	
Not working	6
Working part-time	11
Full-time	3
Teacher/Demonstrator	1
Clerk	1
Cleaner	3
Fruit Picker	1
Typist	1
Helper, Old Folks Home	1
Legal Secretary	1
Cashier	2
School Play Supervisor	1
Clerk, Social Services Dept.	1
Doctor's Receptionist	1

In this series of wives, at three weeks after the heart attack, little change in work role occurred. This is confirmed by the results obtained by Mayou. Those changes which did occur were minor, such as reducing the hours of work, taking unpaid leave to cope with the crisis of the attack, or re-arranging the numbers of hours or the times that the hours were worked during the day, so that the wife could take care of the patient. The illness itself appeared to make little impact on the work of the wives in the study and they reported that going to work had helped them to keep from excessive worry as well as providing the reassurance of a second income. For the women who worked full-time coping with the effects of the attack and making the relevant adjustments at home was potentially more of a problem and successful coping depended on the degree of co-operation and help from the employer, and in many cases from fellow workers, as well as the type and flexibility of the job itself. Conflict between duty as an employee and the family obligations to care for the patient at home sometimes arose. Wives who were part-time employees were often able to arrange things at home such that domestic and employment duties could be managed so that neither suffered, although many wives

described the feeling of unease about continuing to cope with both sets of demands, and leaving the patient alone at home whilst at work. Three wives began to describe their intentions to give up work because of this anxiety about leaving the patient at home when he might possibly have another attack. This picture of the wife's employment is similar to that described by Skelton and Dominian and Finlayson and McEwan in two recent studies. Whether wives who went out to work contributed to difficulties in the patient's recovery remains to be seen. However many wives often referred to their job as the reason why they did not need to worry about the financial implications of their husband's heart attack. Some non-working wives mentioned that they would have liked to have had something which took them outside the family at a time like this and helped with family income now that they were in this difficult situation.

The Effects of Myocardial Infarction on Family Life and Routines from the Wife's Point of View

The wives in the series could all describe various minor changes in family life and routines due to the illness which affected the day to day running of the home. One of the main early effects was on the kind of food eaten in the household, the method of cooking and meal times. Eleven of the wives described how the food that they normally bought and cooked had changed. The changes mentioned were, to buy more vegetable and protein foodstuffs and provide meals which avoided fatty foods and carbohydrates. Another change was concerned with the methods of cooking. Methods of cooking tended to alter to mainly grilled dishes and avoiding frying. The timing of meals was often changed in the household to provide a main mid-day meal for the patient in order that he could rest and take a little exercise afterwards and not retire for the evening, as many patients were reported to have done before the attack, after a heavy meal. Changes in domestic routine which were also fairly noticeable were those concerned with bedtimes. Bedtime for the patient tended to be earlier with a corresponding later getting up time. Wives tended to go to bed later and have to get up earlier in order to fit in all the additional tasks which were necessary in the convalescent period. Another important change which affected domestic life quite radically during this early period was the patient's need for rests during the day and accordingly for a peaceful and quiet environment in the home within which to have his rest. This need tended to impinge on other family members. Disruption in family life appeared to be more common in the families with young or teenage children where previously their needs had been paramount, now routines were adapted to fit the patient's needs.

It was noticeable that to some extent the decision making process in the home had changed. Seven of the wives in the series stated that normally decision making was a joint affair both before and after the attack. Three thought that the patient was the sole decision maker, five thought that it was they, the wife, who took this role, and five felt that a change had occurred from their spouse to them. In other words that the wife had taken on more responsibility for decision making in the home because of the illness.

Family Income

The wives in the series were asked about the financial situation and whether there were any problems or difficulties because of the effect of the illness, on family income. Ten wives mentioned that they had minor financial problems and ten had no such difficulties or problems. This latter group felt that their lack of problems was probably due to the benefits associated with their husband's non-manual occupation, which meant that either a full salary or a substantial sickness benefit was paid. It was also associated with the fact that some of these wives themselves had jobs which meant they were not too concerned about money in the immediate term. Thus almost all this group of wives had no substantial change in income to cope with during the crisis of the attack. A number of wives mentioned that they were able to cushion the effect of the attack by calling upon the extra resources available within the family such as savings, pensions, stocks of food, gifts from friends and cash from siblings and parents in cases of sudden need for money.

The wives who did perceive some minor problems, described them as, access to money in their husband's bank account, cash liquidity, the problem of dealing with money and the fact that they were not used to doing this, and the red tape surrounding claims for sickness benefit for the patient. One wife described how she could not obtain sickness benefit for her husband because he was not conscious enough to sign the relevant documents. Several wives mentioned the problem of needing additional resources for extra expenses such as fares, taxis, petrol, new nightwear for the patient, fruit, magazines, hiring such things as a comode, buying a baby alarm (to listen to the patient who was sleeping downstairs). Three wives mentioned the costs of large numbers of tablets for the patient as an unexpected extra and it was evident that they did not know about the season ticket method of paying for large regular amounts of

medicines, or, as in one case, that medicines were free if a family was on supplementary benefit. For two families where income reduced suddenly at the end of the week in which the illness occurred financial difficulties arose more quickly. None of the wives regretted spending money on these extras for the patient but they did tend to find that these kinds of expenses began to erode a small budget when they were beginning to foresee greater financial difficulties in the coming weeks. The worry of possible future reductions in income, especially for the wives of manual workers, meant that many wives were beginning to work out ways of coping with these possible future problems. Meanwhile in many ways the costs of small extras arising because of the illness were sharp reminders to some of the wives that the financial aspects of the illness were beginning to bite.

Problems in Family Life

Sexual Activity

It could be expected that myocardial infarction would have a considerable effect on family life, one aspect of which is sexual activity. Kushnir (1975), Skelton and Dominian (1973) and others have found that myocardial infarction cases experience reduced levels of sexual activity after the infarct. Other papers, such as that by Kent (1975), have stressed the need for improved communications between doctors and patients about adjusting sexual activity during illness. In the early stages of recovery all but two wives reported that sexual activity had ceased. The effect of sexual activity on someone who had had a myocardial infarction was viewed as an area about which wives were confused and uncertain. Twelve wives mentioned their fears that sexual activity would be 'harmful to the heart' in some way, or that 'it might spark off another attack'. A further eight wives reported that their husbands were unable to take part in sexual activity due to physical incapacity, or unwilling because they were worried about the effects and timing of resuming sexual activity. Two of the younger wives in the group drew attention to the fact that they felt their spouse needed the emotional reassurance and closeness sexual activity gave but could not take part, this they said was most upsetting for the patient and often a source of worry.

Limited advice on sexual activity was provided for the patient on the hospital advice sheet (Appendix 1) although nothing specific was provided for wives. Wives in the series frequently expressed dissatis-

faction with this state of affairs as the advice sheet only suggested "sexual activity should be resumed when normal physical activity had been resumed". It was felt that this advice was ambiguous and some wives (and patients) felt they did not really know what constituted 'normal physical activity', others felt more detail on timing and phasing would have been helpful. Most of the wives in the study reported that they had not talked over their anxieties with anyone except the researchers. However, in one or two instances when medical staff were specifically approached by a wife about this aspect of the illness they were not felt to be very helpful, possibly due to the lack of time available to devote to such problems or poor communication with patients and wives or perhaps the uncertainty themselves as medical staff felt about what to advise in this area where opinions and fashions in treatment are rapidly changing.

However, it was evident that even at this early stage concern about sexual activity was as much a subjective problem for the wife as for the patient. Wives were beginning to voice three sorts of fear about sexual activity, that of precipitating another heart attack, anxiety about when to resume sexual activity and what constituted 'normal physical activity'. Some of the younger wives were also worried because the patient himself was worried by his own incapacity (possibly the patient's medication may have contained some kind of ganglion blockers, which unknown to him might explain this). Guidance on sexual adjustment was a topic where wives described themselves and the patient as wanting help but in many cases not knowing how best to obtain it. In the cases where a general practitioner had actually been asked for help this had not been useful, possibly because the GP himself saw such advice as best provided by the hospital or he himself was uncertain about what to suggest.

Travel

Wives in the series were asked if they had any particular problems at this stage of the illness. One frequently mentioned cause of concern was travel. For just under half the wives in the series, travel connected with the illness caused problems. This occurred for those wives without a car or use of a car. Difficulties began to arise when visiting the patient in hospital and were often due to poor public transport services. The cost of fares, the long tiring journey often done twice a day, and the necessity of catching buses on the journey were also mentioned as

problems. The case of children whilst making a hospital visit was also a difficulty for younger families and some wives felt that taking children on the long journey visiting was inadvisable as well as costly.

There were also other difficulties associated with travelling, for example those associated with doing the family shopping. Some wives and families lived in inaccessible places, distant from local shops and bus routes and found they had heavy shopping bags to carry and frequent trips to make now that their husband's regular help with shopping had ceased. For some wives getting to and from work was difficult now that the normal lift with the spouse was not available. Usually those wives who had problems with travel tended to have multiple problems, i.e. with children the cost of travelling on public transport, shopping and getting to work. Not all the wives mentioned that they had travel problems, however, and those who could drive and had the use of a car managed well. Also those wives who could call upon relatives, usually adult sons and daughters, for help with lifts and shopping were better able to cope. However, there was a small, fairly easily identifiable group who would have had a far less stressful and difficult time in this early period of the attack if they could have made use of something like a hospital car service for some or part of the journey visiting the hospital if only for the period when the patient was in a serious condition.

II MYOCARDIAL INFARCTION AT THREE MONTHS

The Social Effects of Myocardial Infarction at Three Months as Perceived by Wives

After three months had elapsed the wives in the series were revisited and questioned again about the effects of the illness, its problems and how they and the patient were adjusting to it. Expectations of what was normal varied between each family but for the majority of wives and patients family structure remained stable, with few changes except minor ones such as adult children who had recently left home. No one in the series had moved house nor had other members of the family or friends come to stay.

Wives' Emotional Reactions at Three Months After the Illness

When the wives in the series were revisited at three months after the attack there was amongst them a general feeling of depression. Many commented that they felt 'dejected' or 'in low spirits', this has been noticed in other recent studies of heart disease (Finlayson and McEwan, 1977; Mayou, 1978; Skelton and Dominian, 1973).

There were often feelings of uncertainty amongst the wives about what was going to happen to their lives and half the wives mentioned how insecure they felt because of the variability in outcome associated with an illness such as myocardial infarction. Some wives had accommodated to the illness by this time by constructing a specific domestic routine at home for the patient which they felt would be beneficial. Three wives reported that they were now changing roles with the patient in order to make the most suitable arrangements for the illness. Although this role reversal did not work for all partners. Two wives did in fact mention the irritation of having the patient 'under my feet all the time', and 'taking over things in the kitchen' which could become a source of conflict. In the wives' emotional response at three months emphasis was laid on the importance of providing a supportive background for the patient. There was quite a high degree of acceptance of the illness for all but one of the wives and none of the wives thought their husband would be completely well again. It was felt that the wives had come to terms mentally and emotionally with the fact that life would not be as it was before the attack. Four wives thought their husbands still looked very ill, even after twelve weeks of recovery and this persistence of symptoms often made them over anxious. This anxiety was often built upon by the presence of any unusual symptoms of the disease such as unnatural sounds

and patterns of breathing during the night and pronounced behaviour difficulties such as moodiness, irritability and oddness in behaviour which also added to the concern of the wives in the group.

Wives' Views of the Effects of the Illness on Patient's Behaviour and Personality at Three Months

Many wives highlighted the personality change in the patient that they had been observing over the twelve weeks of recovery and now felt that it was a permanent feature of the patient. Wives reported on personality and behaviour changes associated with employment, psychological and personal difficulties. Quite a few wives reported that for those men now working there was significant change in how they went about work and an alteration in routine associated with work had occurred. According to Finlayson and McEwan (1977) this could be expected in the early period of return to work, as the men adjusted to their new capacities. However, the wives in the group felt it was the psychological and personal difficulties of the illness which predominated in terms of their effects on both the family and the men themselves.

Many wives reported the feeling men had of being given 'a second chance' or a 'new life'. This meant in practical terms the patients, fully realising the implications of the illness, began to take a fresh look at their lives and what they wanted from them and in this context started taking careful stock of their particular health problems so as to minimise future risks of illness. Twelve wives reported that the patient was still frightened about his health, although he did not tend to voice his fears openly. In fact both partners tended to avoid arguments which might spark off distressing symptoms.

Most wives consistently mentioned how the patient's personality had tended to change. In some cases this meant for the wife that the man concerned had become more agreeable to live with as he was perhaps more easy going, in other cases wives noticed changes towards marked irritability and quick temperedness. And in a few cases personality change was quite dramatic. Wives reported generally that the men were particularly depressed and very bored if it was still necessary for them to remain at home. Boredom at home was a very real problem for those without absorbing hobbies or compensatory roles to occupy them. This situation contributed to feelings of depression, which, coupled with the significant reduction in the level of social activity for both partners, was a source of discontent and strengthened the patient's feeling of isolation.

Wives: Information and Advice About the Illness at Three Months

When wives discussed the topic of information and advice at the three months stage they continued to express the desire to know more about the illness and how to manage it. There was general feeling that it was difficult to gain access to a doctor, or other medical staff, when an unexpected need for information, help or advice arose. Thus when such needs occurred wives tended to turn to family members or friends or to rely on their own lay opinions. Also at this stage there was a feeling that wives had to 'make the best of the situation' they now found themselves in and 'put up with the conditions' surrounding the illness as best they could.

Where there was some contact with medical staff the general practitioner was the main source of that contact and six wives reported that the patient had seen a GP. Two wives gave very favourable reports of the practical help the GP had been, and four wives expressed the feeling that the general practitioner tended to concentrate on the technical aspects of the illness and when this ceased to be important the interest declined, even though a 'social need' for care persisted. Twelve wives mentioned that neither they nor the patient had received advice about the illness and six patients had spoken to their general practitioner generally about the illness. Wives were often critical of the kind of contact with the doctor which often consisted of just a friendly chat and very general advice such as 'don't do anything too soon', or 'take it easy'. For two or three wives contact with the GP had heightened their anxiety about the patient's health because, for example, they felt they did not know what to expect from what he had said but on the other hand one wife felt she had got a lot of personal reassurance from the GP. Others felt the doctor could have said more to them, or the patient about the important aspects of the illness. Two patients had been visited by a health visitor and one patient by a district nurse who did dressings for a thrombosis which had had surgery. In these cases patients and their wives had found the contact and resulting advice extremely helpful. Wives often used this type of visit from nursing staff to ask a variety of questions about the illness which had been troubling them or the patient and to discuss in their own language the social and emotional difficulties of the illness. Sixteen of the wives felt that they and the patient had specific needs for advice but they also felt that the burden of finding out what was necessary fell on them as wives. Those wives who had spoken to the GP mentioned feeling a little dissatisfied with the resulting discussion, either they did not get the kind of answers they wanted to their

questions or they were often too ill at ease to ask about what was troubling them, or in some other cases could not quite understand what was being said by the doctor. Yet there were clear needs amongst some of these wives for some kind of professional advice at three months after the infarct. Such needs tended to be for individual counselling and for reassurance and what to expect in the next few months. Wives often found it would have been useful to have had an explanation of persisting signs and symptoms and some more specific directions on what could be safely done by the patient.

Clearly many wives and patients often felt a need for sympathetic support, information and advice on specific things related to the illness from time to time. The problem was how best to organise this. Some wives in the series specifically mentioned their dislike of the lack of personal involvement and interest shown by doctors. It is however somewhat unrealistic to expect health service staff to be able to give more time to satisfying these kinds of needs with the existing limited resources available to them. But given the existence of such needs it may be possible to find other methods of coming to terms with them, such as the use of written material, self help groups and perhaps enlisting the help of past patients, who could offer sympathy and discussion of common problems.

Advice from the Wife to the Patient at Three Months after the Infarct

At the three months stage wives continued to be advice givers concerning aspects of the illness. Eighteen wives in the series mentioned that their husband resented and resisted much of the advice given by them and in general did not take it although most wives continued to give advice which did strongly influence the patient's behaviour and feelings. The advice they gave continued to be of a rather protective nature urging men against activity with admonitions of 'slow up', 'relax more', 'don't do too much', 'rest and take it easy', which were very commonly mentioned. Such advice relating to their general activities, many patients found irritating. This was particularly so for those spouses who were determined to get back to their pre-infarct state as regards to activities and life in general. Three wives in the series mentioned how they had stressed to their husbands the importance of developing new interests to take the place of old ones which were no longer possible because of the effects of the illness. But even though such wives felt they were giving good advice they mentioned that they did not know how best to go about encouraging the patient to develop new interests.

A second area of advice stressed by wives at this stage of the illness was the importance of the patient 'not to feel stigmatised by the illness' and the need 'to boost his self-confidence', many wives reported that they tried always to be sympathetic towards the patient and not to react or answer back to his irritable or unreasonable behaviour. This sympathy at home extended to keeping life quiet and calm and easing worries and fears about things such as employment.

Help and advice from the family continued to act as a support to that advice offered by wives. At three months thirteen wives in the series were still receiving assistance with domestic tasks and sisters and sisters-in-law and adult children continued to be main sources of practical help with tasks such as cleaning the house, looking after children, household jobs, repairs and gardening. Some of the younger wives with children had begun to receive help with children's clothing, foodstuffs and electricity bills from their family. A few wives commented that their husband was resentful of such help because it made them feel that the illness had got the better of them and taken away their independence and ability to support the family. The advice that the family gave was only found useful by wives when it was based on a relative's own experience of a similar attack and as such meant that useful hints about coping with the various stages of the disease could be learned. Also in the case where a relative had professional knowledge of the condition, this often provided a useful source of information.

Help and advice from friends and neighbours had considerably diminished at three months. Thirteen wives were not receiving help from this source now although almost all felt that it was available should they need it in an emergency. However, wives felt that regular inquiries and 'phone calls from friends and neighbours did give them moral support although such people tended to be on the periphery of the main help network now.

Exercise

The level of exercise seen as desirable and necessary for patients to take on was still a noticeable problem at three months after the infarct. The level of exercise that patients were perceived by their wives as taking tended to be lower than most wives felt it should be although interestingly only four wives recommended that the patient

should take more exercise at this stage of the illness. Wives continued to favour some kind of careful exercise routine that did not overtax the patient. Many thought that walking was a good way to attain this; however this was not a popular activity with the patients who were reported as viewing it as a rather solitary activity and wives often mentioned the patient's fear of having another attack whilst out alone. A frequent comment from wives about the amount of exercise the patient should be doing was that the advice sheet from the hospital, which the patient received on discharge, only covered the early part of his recovery. Now at three months patients felt even more at a loss as to what was appropriate for them, particularly when they did not feel back to normal. Wives still felt there was a need for specific and individually based advice about appropriate activity. Patients were unsure how far to exert themselves and what the physical signs and symptoms they experienced meant in the context of taking exercise. If guidelines for each patient had been given and reinforced it is probable that wives would have been less restrictive influences on the exercise the patient took.

When wives in the series were asked about what kinds of activities they considered the patient should be doing at three months after his illness, views were characterised by feelings of uncertainty about what was good or bad and how far to go with what activities. In the context of this uncertainty wives tended to feel that the safest course of action was to avoid taking action and they often said 'leave it a little longer', 'it's too much for him', 'just take things easy a little longer', 'I'm afraid if he does that he'll have another attack', 'I'm not sure whether he should yet'. These kinds of phrases applied to large numbers of activities concerning the patient. The exception to these was walking which tended to be an activity most wives felt the patient could safely take part in. Some wives reported a problem concerned with walking as a form of exercise and activity especially for those men not yet back at work. Several of the men felt that going out alone was embarrassing 'he's too embarrassed about himself to walk down the street', 'he won't walk in case he meets anyone'. Wives felt that their husband now felt different or 'stigmatised' in the eyes of friends and neighbours because they had suffered a heart attack. This feeling of in some way being different was sometimes carried on into activities within the home such as not taking a bath or climbing stairs for fear of the effect it might have on the heart.

Several wives mentioned their anxiety about the patient taking up driving and smoking again and wives in general felt and voiced their concern about the patient 'over-doing things'. There was unnanimous agreement as to the inappropriateness of some of the more tiring and strenuous activities associated with work and domestic life such as heavy lifting, digging, reaching up and climbing.

When wives were asked about their expectations for recovery at a year after the illness, almost all the wives were hopeful, that the outcome at a year would be a good one, however this was still seen, as at three weeks, as conditional on behaving carefully. Wives' expectations at three months were however qualified by the feeling they now had that their husband's health and life would not return to what it had been before the attack. Therefore the emphasis was on adapting and accommodating to any residual disabilities and limitations produced by the illness. When asked if they could identify any particular factors which might be helping or hindering recovery the wives in the series were able to identify factors which they felt were important at the three month stage. Eight wives felt that the patient's return to work was an important aspect which had greatly helped the return to normality. Four wives thought that worry about work, its future prospects, and the possibility of not having a job, was harmful. Three wives described how beneficial a short holiday had been in the intervening period and three thought that rest and a certain domestic routine had been of great importance. For two wives the patient's poor health and lack of knowledge of the illness and its implications was felt to be harmful and a further two cited money and exceptional family problems as hindrances to a full recovery. Over half the wives in the series felt very certain that patients who were able to resume their old social habits and activities fairly soon after the infarct, even though in modified form, had benefited enormously from this.

The Wife's View of the Patient's Employment at Three Months

Wives in the study were asked about their views of the patient's employment situation at three months and reported that ten patients were now back at work, with the same employers.

Patients' Employment at 3 months	
Back at Work	10
Not Working	7
Unemployed	3
Total	20

Seven were not yet back at work and three were unemployed. The wives questioned felt that going back to work had been an important aspect of recovery for the men concerned because it had served to reassure them about their state of health and assisted in getting them back to a normal life. In two cases redundancies had occurred in the firms employing the men but the wives concerned felt that the patients had been kept on and not made redundant even though in line for it because they had had the heart attack.

For the patients who had not yet gone back to work there was still a general feeling of anxiety reported by wives. This anxiety was concerned with how long their job would remain secure. Both patients and their wives shared this anxiety about job security. The men who were back at work were also said to feel anxiety, but this was about such matters as whether the work was going to be too much for them and, if it was, how they would manage financially and what would happen about their pension. The wives of these working men also mentioned other problems such as patients who tended to overdo certain tasks at work to keep proving to themselves and their workmates of their capability to do the job. However, these men who were already back at work certainly had less anxiety about how the illness would affect their work. Ten wives were able to describe adjustments made by men at work to cope with the practical problems and demands of each particular job. In the case of some men (mainly non-manual workers with more flexible jobs) they were able to return part-time to begin with. Other working men changed aspects of the job, such as daily routines or did shorter hours or had heavy tasks taken away from them temporarily, revised shifts, did only office work, and so on. However, it was noticeable that there were fewer re-arrangements for the manual workers than one might have expected given the serious nature of the illness. On the whole the men who were back at work were described as happy to be there by their wives but to some extent manual workers felt their role at work was eroded by the incapacity produced by the

illness. Some of these patients were ill at ease about their temporary lighter work arrangements and felt that it was unfair to fellow workers for them to be relieved of heavy tasks. It made them feel awkward and somewhat stigmatised by the illness and although many men knew it was bad for them they took on tasks they should not have done. Nevertheless there were aspects of work where some men had to rely on the assistance of their workmates, such as with heavy lifting and reaching, in spite of feeling somewhat unhappy at being sheltered in this way.

On the whole most of the men seemed to be able to fit back into their employment role without too much difficulty. There were one or two problems, for example, one patient, in order to return to work, has to accept a lighter, less responsible and interesting job and into the bargain lost a tied cottage. This was particularly depressing for the man concerned because he saw it as a stage of unemployment. Another man was given alternative work which was unsuitable by a well-meaning employer who did not fully understand what the man's work restrictions were in terms of his physical capacity:

> "when it came to doing the job it meant using the top half of his body, especially his arms and it became a problem. He couldn't steer the polishers and make them go in the right direction and then when he had to paint the swimming pool he had to work above his head a lot and this caused pains and the fumes got down on his chest".

From the themes discussed with wives it seems the needs of men who have recently returned to work after myocardial infarction for advice about adjusting to employment could be met by some form of counselling. It may also be desirable to educate employers about the kinds of limitations such an illness produces and this could help in alleviating some of the fears and worries men experienced at work. It was often mentioned by wives that the doctor's advice, if given, was something like 'do only light work' but this was by no means clear. What does light work mean in terms of the actual work each individual should do? Some of the men felt that a 'light work only' label would stigmatise them in the eyes of their employer. It may be that such cases might be helped by consultation with the local DRO[1] as has been suggested by Brewerton and Daniel (1969).

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[1] District Rehabilitation Officer.

Some of the wives in the study whose husbands had already returned to work, felt they had returned too soon, an example of this was the case of a self employed commercial artist, who it was felt, returned earlier than was medically advisable due to financial pressures on him to run his business. Two other wives, who also felt that the patient had gone back to work too soon, explained it in terms of his fear that if he did not return soon he might not be able to work again.

It was clear from the discussions with wives that the seven men still recovering at home felt greater anxieties about work than those who had already returned as they had time to brood over and contemplate possible employment difficulties. All these patients had reservations about how they would manage certain tasks and procedures at work and whether inability to do so would lead to their dismissal. Concern was also voiced about the security of their employment in the longer term, should they be away from work much longer, and whether the work would be manageable after an illness of this nature, particularly things like shift work, heavy machine work and work involving long travel times. Two men in the unemployed group were already working out how they were going to make work easier to cope with on their return and mentioned using the lunch hour as a resting time and avoiding a lot of walking in the job.

The three unemployed men in the group were previously in heavy manual work and obviously had to face the fact that they must seek alternative employment when they had fully recovered. The difficulties associated with facing this prospect tended to lead to depression and demoralisation in the patient and his wife and this was not helped by the generally poor employment opportunities in the area. At three months after the illness there was a general feeling that wives in the series were fairly involved in the process of returning to work for many of the men in the group. In some cases wives suggested alternatives and encouraged those with difficulties to seek help. This feeling of shared concern could perhaps be utilised by rehabilitation agencies in encouraging those with employment difficulties, by enlisting the support of the spouse.

On the whole aspects of the altered employment situation for the patient did not affect the family greatly according to the reports of these wives. Adjustments in the patient's employment for those men now working had little effect and there were no major financial consequences.

Changes which did affect the family tended to be 'removed' from the actual employment. Return to work affected the patient in so far as he was 'over-tired' or 'tired all the time', 'miserable', ill-tempered', 'worried' because of work or aspects of it. This was the kind of difficulty which transmitted itself to the wife and family. One or two patients found it hard to readjust to their job and in one case a whole family helped the patient to do his job in the early stages until he could manage fully by himself. The wives of those patients who were unemployed mentioned fairly serious effects on the family, at the three month stage. This occurred in three cases and meant a much lower family income, a reduced standard of living and problems with the payment of large bills such as gas and electricity.

The Wife's Employment

Wife's Employment at 3 months	
Not working	6
Working part-time	7
Working full-time	3
Given up work	4
TOTAL	20

At the three months stage it was reported that six wives were not working (and had not previously been in employment). Three part-time workers had given up work because of the illness and four who had taken leave of absence, had begun work again. Seven of the wives continued in the same occupation as before with no break. Four wives in the group who were not employed now expressed a desire to work and some of them were actively looking for employment at the time of questioning because they felt this would be a way of helping the family income and alleviating the worries they felt about financial insecurity should anything happen to the patient. The effects of the illness on working wives continued to be marginal as in most cases the work they did was well integrated with family routines already. In fact, for some wives it was easier to work because they now had someone at home who could prepare the evening meal or mid-day snack and who could do the domestic chores so that these tasks did not have to be done after they got home from work. For those wives who felt they had to give up work the loss of income was described as

very noticeable and often meant cutting down on all extras provided by the wife's salary. It also meant that she herself had less money to budget with and was consequently quite seriously affected by it.

The Effects of Myocardial Infarction on Family Life and Routines from the Wife's Point of View, at Three Months

At the three months stage wives in the series continued to describe changed family life and routines arising from the illness. At this time just under half the wives reported that they still served different kinds of food and continued in their altered methods of preparation of food. It was often mentioned that wives tried to ensure that the patient in particular, and sometimes the whole family, ate little red meat and bacon and substituted fish and chicken with more salad and vegetables taking care not to provide fattening foods such as cakes, pastries and potatoes. Some wives mentioned that this was a bit of a strain on the patient as he often wanted to revert to his previous kind of diet, particularly when other family members did so.

Many of the men who were recovering at home still continued with longer rest periods during the day and wives felt that this was still necessary even for those who were back at work. Thus they tended to encourage the taking of rest after meals, early bedtimes, daytime rests (during the lunch break if working) and rests after tasks or activities such as gardening. All the men in the group tended to get up later than was their habit previously and to go to bed earlier, in some cases when they were at work at about seven or eight o'clock at night. The wives continued to be affected by these changed routines and many mentioned feeling excessively tired such that they themselves retired earlier, and were glad to do so.

The patient's influence in decision making within the family was described as having lessened at this stage of the illness. Wives often thought that decision making was stressful for the patient and thus tried to take on this job for themselves. At three months two wives said that decisions in the home were a joint affair, five said the wife took decisions, two said it was the husband and eleven now felt that the largest share of such responsibility rested with them.

Decision making		
	Two/three weeks	Three months
Joint	7	2
Patient	3	2
Wife	5	5
Changed to wife	5	11

Family Income

The situation described at three weeks was similar to that experienced by wives at three months. Fourteen of the wives whose husbands were now back at work described mostly minor financial worries and there were few serious anxieties. Worries varied according to the individual circumstances of the families concerned and such things as whether there were dependants, the amount of savings available within the family to call upon and the general resources available to the family. Six wives felt free from any financial worries at all but in spite of this they were looking to the future, where problems might possibly occur. For those wives who had minor worries three kinds of problem were described, that associated with a low family income (often supplementary benefit level) and the problem of lost employment or a small amount of sickness benefit; the extra expenses arising from the needs of the patient while he was ill, things like diet, food, extra heating in the home; and thirdly the worry of having to spend accumulated family savings thus leaving the family vulnerable if anything serious should happen in the future. Two wives mentioned that they were heavily reliant on gifts of money and food from parents and kin and often wives with children at home felt they were quite hard hit by the financial cutbacks they had to make within the family budget. Almost all of the wives of patients who were still recovering at home found the extra cost of food consumed by the patient whilst at home was a strain particularly when it consisted of costly high protein foods, often wives went without themselves to provide a wholesome meal for the family and the patient.

Problems in Family Life at Three Months

Sexual Activity

There was a general reduction in the level of sexual activity in the group as reported by this series of wives three months after the infarct.

Seventeen wives reported what they felt to be some minor problems with sexual activity. Three wives felt that they were more or less back to normal though not to that level before the attack. In general wives, especially the younger ones, reported feelings of disappointment and concern at the slowness of adjustment in this area of personal life, and most wives (sixteen) mentioned that they felt they ought to be back to normal by now. The areas of anxiety identified at three weeks, persisted at the three months stage and wives continued to mention their subjective concern about harmful effects of any sexual activity on the patient's heart and their fear of his bringing on another attack. These fears were especially strong when the patient had experienced complications associated with the illness. A lack of interest in sexual activity on the patient's part was often seen as part of the psychological change in the patient that wives had observed generally. A concern that sexual activity had not returned to normal was often mentioned especially by the younger wives who tended to report their own feelings of disappointment and depression about the matter. Four wives saw the loss of sexual activity as the 'price' they would have to pay for not putting their husband at risk of another attack and some rationalised this by relating it to their age.

"you can't expect it at my age"

"at my age I have to accept that
sex is not important any more
especially if it means risking
another attack"

Two wives reported that their husbands were now impotent because of the effects of the attack. Wives in the series with problems would have liked to discuss them with a doctor or person who could give advice. Wives felt their husbands would probably only discuss the matter with a doctor in private and some not even this. At three months wives' perceptions of sexual adjustment continued to be a source of anxiety for almost three-quarters of the series.

Travel

Wives were again asked whether they had had any difficulties or problems with travel. The acute travel problems which beset some wives soon after the attack disappeared by the three months stage for all except eight wives who mentioned that they were still having difficulties.

The wives who were affected were those who lived in isolated inaccessible areas poorly served by public transport and who had no husband to drive the family car. These wives continued to have problems with shopping, taking the children to and from school and getting to work. In addition some mentioned the extra expense of taking children on the bus when they had to go out. Two wives began to see another problem occurring which was related to the fact that their husband was too afraid to drive the car any more having suffered such an illness. The patients concerned were described as fearing that an attack might happen whilst they were driving. Another kind of travel problem also occurred for the men who were now back at work. Many had the problem of a long tiring journey to work and mentioned the unsuitability of public transport in the early morning and late at night for a person who had had an illness like this. Two wives whose husbands had complications arising from the illness required specialist treatment in a London teaching hospital but felt that the length and cost of the journey to London to obtain the treatment was a considerable strain both on the patient and financially. In some cases a small grant towards the cost of fares could have eased a difficult situation by perhaps allowing the patient to make use of a taxi at certain points on the journey and thus save the wear and tear on him. It may also have allowed the wife to accompany her husband on these journeys.

III ONE YEAR AFTER MYOCARDIAL INFARCTION

Life at One Year After the Illness

At one year after the infarct the final interview with this series of wives was undertaken which completed the longitudinal profile of wives' perceptions and reactions to the infarct. The families in the group remained stable with only minor changes such as one man who now lived in a caravan near his work during the week and another couple who moved into council accommodation from a tied cottage. One young couple had started a baby, one patient had died, three had second attacks and two had developed serious complications.

The Emotional Reactions of Wives at One Year

There was a general feeling and climate of optimism for life in the future, at one year, amongst seventeen of the wives in the series, both for them and their husbands' prospects. But this did not mean that those in the group were without problems and anxieties altogether, although wives' reactions showed considerable accommodation to living with heart disease and its constraints on the individual patients concerned. A majority of wives in the group felt that emotionally they had come to terms with the illness at one year. Seven wives described themselves as thankful that their husband was as well as he was at the one year stage and many felt more emotionally settled now that he had accommodated to his changed level of health which usually meant accepting a certain amount of ill health. Five of the wives in the group felt that they were still reacting in an 'over-protective way' towards their husband. They became anxious at the slightest symptom or pain and were still reluctant to go out for fear of leaving him alone and were careful to monitor everything he did in case it led to the symptoms of another attack. For these wives there was a problem about lessening this protective attitude. All the wives spoken to at one year felt that they had made the appropriate emotional adjustment to the illness although this was often not without difficulty because, for example, a wife could no longer rely on her husband to take part in family decisions. On the other hand some patients had, over the year, suffered second or third attacks which meant their wives were now experienced in coping with the social and emotional effects that accompanied such an attack. Periods of emotional strain for wives were often associated with the patient's bouts of illness or problems that he felt at work arising from aspects of the illness such as overtiredness.

After one year wives reported few reactions from their children associated with the illness. As reported at the earlier stages it tended to be the younger children living at home who were most affected and this was mainly in terms of the patient's continued irritability or his changed personality. Adult children continued to keep in close contact with the patient and spouse by frequent visits and telephone calls. Only two of the nineteen wives in the series now received close and regular contact with other family members at one year. Although all mentioned that contact was more frequent than it had been before the illness.

Wives' Views of the Effects on the Patients' Behaviour and Personaltiy at One Year

In their reports of the patient's progress at one year after the infarct most wives in the series when asked about the patient's general progress felt that it had been only average (eight) or poor (eight). Three wives thought their husbands were getting on well.

Wives' Perceptions of Patients' Progress at One Year

Getting On:-	
Well	3
Average	8
Poorly	8
Died	1
TOTAL	20

The earlier more hopeful expectations for improvements in health were not entirely realised and most wives now accepted the patient's slightly impaired level of health as something that would probably not get any better now. Some patients, with complications, were in a worse state of health now.

The effects of the illness on the patient's personality and behaviour were such that almost all (seventeen) wives could point to some change which had taken place at an emotional and psychological level. Eight wives were able to describe a change that had been beneficial to the family in their view.

"he's a new person now"
"he's forced to relax"
"it's changed him for the better"

Often such changes meant the following, "adaptations in life style" (three), becoming more relaxed about work" (three), being "more definite about what he wants to do with his life" (two), being "determined to enjoy and get more out of life" (four), "slowing down and realising the physical limitations he now has" (three). Six wives drew attention to the persistent difficulty of learning to live with and cope with the patients' increased irritability and moody behaviour and changed personality. This was often accompanied by general nervousness, worry and feelings of insecurity. Seventeen wives commented that their spouse had continued to have an almost subconscious need to take precautions against another attack occurring and that this need generated residual levels of worry about the illness which would probably persist.

When the wives were asked whether they felt the illness was over now, most (seventeen) thought that their spouse was still affected by it and only two thought the illness was over. The reason wives gave for the feeling that the illness was still present was bound up with their predominant view that it was always necessary to be prepared and on the look out for another attack and that heart disease was such an ever present unpredictable condition that it could never really be described as over. Some wives mentioned that the patients' need to take medicines to contain aspects of the illness was a constant reminder of it always being there, and others stressed the intermittant occurrence of symptoms (i.e. pins and needles, palpitations, chest tightness and pain, panting and breathlessness and excessive tiredness). Also that, due to his physical health, their husband's social functioning was reduced, meaning both he and his wife could not do all the things which they had previously been accustomed to doing.

Wives: Information and Advice about the Illness at One Year

After one year of adjusting and coping with the heart attack and its effects, thirteen wives described how they still wanted information about the illness and six felt that their knowledge was adequate. The thirteen who wanted more information had clearly in mind the questions they wanted to ask, which covered predominantly medical questions but also behavioural and management aspects of the illness, for example:

"why does he get such bad diarrhoea?"

"I would like to know why he still needs pills and checks on his blood pressure?"

"why has he got colitis as a side effect?"

"why are there side effects with heart attacks?"

"why is his blood pressure high?"

"why is it he seems so tired and lacking in energy?"

"I'd like explained about his change of character?"

"I would like to know all about the drugs and the effects they provide?"

"why did he have another attack?"

"why they said diseased heart, is it the same as heart attack?"

"why is he so out of breath all the time?"

"why does he have to keep on taking these tranquilisers?"

A further six wives mentioned again how helpful it would have been to have known what to expect with such an illness and the kind of pattern it would take over the first year.

Most patients who had not recently had treatment for complications or suffered a further attack and their wives, had not received help or advice from medical services, according to the wives. Those who had seen a general practitioner (three) tended to be dissatisfied with the general and rather vague advice given, and continued to draw attention to the rather unspecific phrases used by the doctor, such as:

"Take it easy"

"Don't attempt too much"

"Lose weight"

"Just carry on as best you can"

Three people had received help, one had seen a firm's social worker about the amount of travelling he had to do, another was assisted by a letter from his GP to move to council accommodation, a further man severely affected by the illness had received a cheque from the Chest and Heart Foundation.

Five wives mentioned the need both they and their husband felt for regular checks on his health, to make sure everything was normal. Some had in fact requested tests on blood chemistry looking into cholesterol levels, and one patient with great anxiety requested referral to hospital for a thorough check up.

Help and advice from members of the family was only sustained at one year when there had been further illness, the remainder of the group did not receive any help. However sisters and sisters-in-law were still providing support and help quite widely. Help and advice from friends, although plentiful in the early period of the attack tended to have faded out by one year.

Advice from the Wife to the Patient at One Year

At one year the wives in the series tended to feel that there was not a great deal they could do to help except create a suitable domestic climate in the home and continue to be supportive and provide a calm domestic environment. Ten wives said they now tended not to openly offer advice to their husband about his health, mainly because of his stated dislike of it. The remaining wives strongly expressed the view that it would be very helpful to know what would be the best advice and help to give at one year after the illness. Wives mentioned the importance of reassurance and continued encouragement for the patient and seventeen stressed the need for the patient to avoid dwelling on depressing aspects of the illness and the limitations on life it produced. Thus many wives described how they organised themselves at home so as to eliminate as many as possible of the frustrations and reminders of the illness for the patient.

Exercise

The earlier uncertainties about exercise often persisted at one year later, and twelve wives felt that their husband was not getting enough exercise, and in some cases hardly any at all. There were a variety of reasons for this perceived lack of exercise, such as being unable to fit it in during the working week, fear of harming himself, dislike of poor weather conditions, further illness or complications and disability (i.e. Pagets disease). Such exercise as tended to be done was fairly routine, such as walking, cycling and gardening. All wives expressed interest in receiving further guidance about suitable exercise and twelve wives reported that there had been no advice given about exercise since the last interview. Seven wives mentioned that a doctor had suggested rather general activity, or a pastime such as golf or walks, but these had not been taken up on the whole. All wives felt there was need for more specific suggestions taking into account individual problems and life style.

Smoking

	First Interview	Second Interview	Third Interview
Given up	11	11	12
Smoking	6	6	4
Non-smoker	3	3	3
TOTAL	20	20	19*

*One patient who smoked had died.

There was little change in the patients' smoking habits as reported by their wives, and those who had already given up smoking tended to continue to do so. Of the six smokers, one had recently given up smoking, and one had died, but four patients continued to be very heavy smokers (forty a day). Smoking was strongly opposed by most wives in the group, many of whom had made their disapproval apparent to their spouse from an early stage of the illness.

At a year after the illness the wives in the series identified a number of factors which they felt affected the patient's full recovery. These were slightly different from those mentioned at the earlier stage of three months. Amongst the factors, which wives in the series felt had helped recovery, the patients' personal determination to overcome the illness and its effects was described as very important, especially in an illness like this. Other helpful factors were the sustained help of the wider family, the lessening of domestic conflict and having absorbing hobbies to do at home. Wives also re-emphasized the substantial social benefit gained from returning to work especially where allowance was made in the employment for the patient's readjustment and gradual getting back to a full work role. In two cases early retirement from work was mentioned as a necessary factor in helping recovery because the occupations of the men concerned were just too much for them to cope with, resulting in the attempt to do so affecting their general health.

By one year after the illness most problems affecting recovery had ceased. But the wives in the series described two remaining hindrances which they felt affected full recovery for the patient. One was associated with a lasting concern about health which (in six cases) often meant

excessive worries and another related to continued worries about employment. Things such as continuing to be able to do the work, keeping up with fellow workers, changes at work and the threat of unemployment should a man not be able to cope remained background anxieties.

At one year after the attack fifteen wives continued to report activities which they felt the patient should not undertake, and this was a source of conflict for some partners, although four wives now felt there were no limitations, most of the wives mentioned that they kept a check on their husband's activities and intervened in anything they considered unwise. Certain things were still considered very unwise by the wives, amongst these things were: smoking and drinking, aspects of working, especially long hours, heavy work, digging, and so on. Four wives felt that their husband was 'very slowed up' in everything he did, and others (four) mentioned things which now took three or four times longer for him to do; a further four patients had difficulty climbing stairs, and four felt symptoms of the illness when reaching or bending.

The wives in the series were asked about their expectations for the patient in the future in the last interview at one year. In general the wives in the series expected the future to be one of gradual improvement, but this was seen as dependent on keeping to what the wives called 'a sensible way of life' and taking notice of any symptoms of recurrence of the illness. The wives of men who were still not back at work tended to be more pessimistic because they were demoralised by their spouses unemployment and its consequences. For these wives, a previously hopeful outlook was now replaced with one which was resigned to a difficult future.

Wife's View of Patient's Employment at One Year

At one year after the illness the wives in the group reported that 13 men had returned to work to the same employment. Five were unemployed, one had died and one had retired early at 50 years. As has been mentioned earlier return to work for the patients concerned was not without its initial difficulties but many of these had lessened considerably at one year. Almost all those who were now working had initially returned to a lighter or modified job to start with which often meant doing different work, e.g. some men were put on to clerical work for two or three months. In most cases patients avoided all strenuous tasks attached to their work. But many of the men although now back to their regular job disliked the feel-

ing of being 'carried' by their workmates, and as such often attempted certain tasks at work which were too strenuous for them. Underlying anxieties and strains coupled with the effort of work often meant that many of the men got over-tired and irritable and this sometimes resulted in tensions within families, particularly where the presence of young or teenage children within the home created additional stresses. On the whole the patients who were back at work at one year had tended to receive cooperation from their employers in matters such as keeping jobs open for them, reducing working hours, cutting out overtime and rearranging holiday times and these factors were seen as very helpful by the wives in easing back to the work role.

The Wives' Perceptions of Return to Work

When questioned at one year wives described half the men who had now returned to work as having returned at about the right time and six felt the return had been too soon. But wives' and patients' views about return were not in agreement. The wives usually thought return was too soon but had agreed to it because of the patient's insistence that he needed to get back to work for social and psychological reasons. Another problem for patients who were now back at work was the long tiring journey to work which often took two or three hours. Wives felt this was very stressful and a worrying aspect of return to work and although they felt it was a hazard to the patient's health saw no way of easily altering it due to the lack of local employment. The five unemployed men who tended to be the younger manual workers in the group all had additional health problems arising from second attacks or the development of complications which tended to create additional employment difficulties for them. Eleven wives in the series mentioned they felt there was a need for information and guidance or retraining possibilities for patients who had had heart attacks. This was particularly evident for those men who were now unemployed (5) or in work which the wife considered not suitable for them. Three patients had actually received some retraining help or advice but this had not been helpful in finding them alternative employment.

Wives in the series reported that some men who were back at work had anxieties about changes which had been necessary within their work. For example, those men who had been allocated less responsible work often felt a loss of self-esteem and some feelings of resentment. Resentment also occurred when co-workers took on strenuous tasks for the men although for

the best of motives. Some men mentioned that they now did lighter work which had the disadvantage of being boring and repetitive and others had anxieties that they were not able to work as hard or put as much into the job as they had been able to do before the attack and this led to feelings that they might be sacked or made redundant. Others mentioned feeling very slowed up by the illness and exhausted by the journey to work. The effect on patients and their reaction to these employment changes often had an effect on the wife and family. Many wives of those men now working described how anxieties and tension associated with work tended to be 'bottled up' by the men, and wives often found it difficult to encourage discussion of these problems saying 'he keeps it to himself'.

The Wife's Employment

The employment situation of the wives in the series has tended to be stable and relatively unaffected by the illness. At one year after the attack a similar picture is seen. Six wives were not working although half of them were actively seeking work, and two part-timers sought full-time work to provide additional security should another attack occur. Three wives continued to be employed full-time and seven part-time. Three had given up employment, one for health reasons, one to enable her to look after her husband and one to have a baby. The wives who worked wanted and needed to do so, but often mentioned the costs involved, e.g. irregular or evening hours, leaving their husband alone at home and feeling very tired.

The Effects of the Illness on Family Life and Routines from the Wife's Point of View at One Year

For most wives and families in the series life had resumed its normal domestic routine at one year after the attack except in the cases where further attacks had occurred or there were complications to the illness. However many wives described how the level and pace of life slowed down a lot for the patient and his wife particularly for the older men in the series. The patients were still reported as keeping to earlier bed times and rising later wherever possible and also needing to take a rest during the day, on some occasions.

Many wives had now worked out for themselves what they thought to be an appropriate diet for their husband and some showed some considerable interest in factors like what 'cholesterol' and 'lipids' were and how many eggs 'were safe to eat'. Decision making in the family had substantially

moved in favour of the wife, ten wives said decisions were now made jointly and six that they now made the main decisions and only three felt it was their husband who took this role.

Problems in Family Life at One Year

Financial

For those thirteen wives whose husbands were now working there were no serious financial difficulties at one year although seven wives thought that the financial effects of the past year's illness were still felt in minor ways. For those five wives whose husbands were not working the loss of income was felt quite sharply particularly where there were dependent children. For this group financial problems were described as becoming very much worse at about five to six months after the attack when financial and other resources had been used up. Four of the wives did part-time work and mentioned how this helped the family income, however, in spite of this they had to spend all their current income on necessities such as food and heating. Large bills for electricity, household repairs, the telephone, were often a great financial strain and in some cases had to be paid by the social security system or spread on an instalment system. Wives described how heating costs were in particular a problem during the winter months when the patient was at home all day, and two wives described how they had applied for exceptional needs payments, but had subsequently resented distasteful investigations and searching questions which accompanied the grant. In one case a wife had to attend a tribunal only to be awarded 50p a week, a sum she felt not worthy of attending the tribunal about.

Sexual activity

At one year many of the wives in the series, particularly the older ones, were prepared to completely forego this aspect of personal life 'for the sake of his health'. The younger wives expressed concern that sexual activity was not normal after one year after the attack and many wives reported some difficulties. Fears and anxiety about the effects of exertion on the heart still remained as a source of worry for wives.

Travel

For seven of the wives in the series at one year there were no travel problems. For the twelve remaining wives the problem of not being able to use the family car or the patient's unwillingness or inability to drive continued to be a problem. Four wives reported that their husbands found driving too stressful and two said they only went for very short distances, whilst three reported being very anxious about driving with their husband in case he had an accident or another attack whilst driving. One man had taken up riding a bicycle everywhere and given up driving.

Reversal of Roles

At one year it was noticeable that many tasks normally done by the husband had now been taken over by the wife. Eleven of the wives now did the gardening, especially jobs like mowing the lawn, and decorating the house. Two men had permanently reversed roles with their wives and now did the household tasks such as washing up and making beds whilst their wives did the work that was too heavy for them.

IV CONCLUSIONS

The effects of myocardial infarction can never be considered in isolation as they are bound to have an impact on the wife and family. Most wives experience appreciable difficulties which gradually diminish over time particularly when the patient is fit enough to return to work.

The reports given by the wives in this series tend to suggest that the social effects of myocardial infarction are lasting and affect most aspects of life. The period of time after discharge can often be very stressful when adjustments in domestic life and emotional circumstances are made and patients and their wives must become used to the characteristics of the illness. Most of the serious effects are felt soon after the attack occurs and can continue for a year or more. Sisters and sisters-in-law were reported to be of prime importance as sources of substantial practical help and support during the early part of the illness, and it may be useful for medical staff to know whether such capable help is available when considering the patient and the family's need for helping services.

The areas of life which seem to be most affected by the illness for the patient and his wife tend to be the patient's work, social and leisure activities, tasks in the home, psychological state and sexual activity. Nearly all wives found their employment unaffected and that to continue work was helpful. For some patients back at work, and others who were unemployed, vocational guidance and realistic retraining opportunities could be of assistance in reducing anxieties about work and in enabling men to find alternative employment.

Wives and patients experience a wide range of highly individual difficulties associated with the illness, predominantly concerned with their day to day life but with which there is little involvement from the professional services. The varied subjective experiences of the illness colours the way both partners tend to perceive and react to it during recovery. Many feel perplexed and unsure about aspects of the illness and activities it is suitable to undertake, because they lack understanding of the condition which could help them gain insights into the illness and adjustment to it. This picture is reflected in the under emphasis of patient education about heart disease and the high degree of largely unmet needs for advice and information about the illness which in turn tends to create uncertainty in the minds of wives and patients. Much unnecessary distress and inconvenience in daily activities could be

alleviated either by increased support from hospital and family doctors and social workers or by a wider use of written information and advice backed up by visits from the family doctor and health visitor.

The importance of informing the wife of the medical and social problems of the illness and involving her in the management of the illness must not be overlooked. Spouses have expressed a desire to learn more about and take an active part in, their husband's recovery. They represent a considerable untapped resource which could beneficially be used in the care of patients, but such involvement is hampered by poor information about the illness at the moment.

Some of the subjects of the study, both patients and wives, gained considerable support from sharing their emotional experiences and discussing common problems with informed laymen. Relatives or friends who had similar experiences of coping with a heart attack enabled those with allied difficulties to talk over common problems informally. It could be helpful for others feeling this need, to share experiences and make contact with other sufferers willing to talk informally about the social consequences of the illness.

Problem Areas

The following major problem areas have been identified in this series of wives, and these are similar to those established by studies of heart disease and other conditions (Finlayson and McEwan 1977; Cunningham, D. 1977).

1. More information and advice is wanted, by patients and wives, particularly about understanding the illness, its course and nature and its relationship to daily activities. Full discussion with a hospital doctor about the condition and its consequences for life and employment could be helpful particularly as each patient's anxieties about the illness are individual. Discussions could beneficially include the wife or appropriate family member if relevant in order to alleviate the worry and uncertainty surrounding the illness for the patient's family, and to encourage wives not to become over cautious about the patients' activities.

2. Difficulties with daily life should be helped and patients and family encouraged to overcome these by perhaps exploring helpful strategies and using self help groups. Individual advice about items such as

diet, exercise, rest, sexual activity, and personality problems could be helpful. Verbal and written advice, reinforced by general information about the condition, i.e. such as that produced by the Chest and Heart Association and British Heart Foundation, might be utilised by medical staff and those involved in counselling.

3. Patients often had problems and difficulties related to work, especially those not able to return to their previous employment. Vocational guidance, information and suggestions about employment could be helpful early in recovery, and throughout the year.

4. Patients require individual guidance and specific advice, perhaps involving making contact with someone who has had a similar illness and who can talk over the common problems. Development of self-help groups, or making available lists of people willing to discuss their experience could be helpful.

It would be useful in the light of such cumulative information from the various studies, for future work to seek not to collect more descriptive material, which although adding to our knowledge of the detailed social and psychological characteristics of the illness, does not begin to tackle the now well established difficulties. It may now be more appropriate to mount a major attack on some of the problems so outlined. A helpful beginning may well be to evaluate ways of improving patients' knowledge and understanding of their conditions and how to manage them. It is not clear which person could best provide additional verbal advice and information. However the use of written advice, perhaps reinforced by visits from the family practitioner or health visitor might go some way to assessing the value of this approach to the problem of increasing wife and patient knowledge.

It is evident from recent writers such as Bennett (1976) that there are problems involved in educating and giving advice and information to patients and families about their illnesses. The style and content of the information has to be appropriate to the needs of the groups of patients identified, and it may be necessary to develop a variety of ways of presenting the same material, as for example was done by Midgley and Macrae (1971). Questions of whether the individuals can understand what is written or said, how receptive they are, what they may be prepared to listen to or read, and how much of the material is retained afterwards are relevant.

In the context of patient education, it has been suggested that arming the patient with a checklist of questions (Herxheimer, 1976) to ask the doctor can help to share the responsibility for the illness with the patient and increase understanding. Other studies, such as Moll and Wright (1973) have found booklets about particular diseases were highly satisfactory as communication aids, but that details of management and treatment were less well remembered than information about the general nature of the disease.

APPENDIX I

Advice Sheet Distributed to Myocardial Infarct Patients in Kent and Canterbury Hospital

As a result of your heart attack a part of the heart muscle has been damaged temporarily. This has already healed but it is preferable not to make any undue demand on the heart for the next few weeks.

This guide is to help you plan your activity when you leave hospital.

It has been suggested that the first two weeks following your discharge from the hospital be an extension of your hospital routine, i.e. you should rest following breakfast and two hours following lunch. You may climb one flight of stairs per day, but on the whole you should take things gently and relax at home, preferably wearing your night attire.

In the third week you can move about freely in the house and if feeling well you may go for short walks.

In the fourth week the amount of exercise may be increased gradually, i.e. you may take longer walks, but at a gentle, even pace.

The fifth and sixth weeks should be geared towards preparing yourself for a return to your normal routine, so if possible, may we suggest that you take a relaxing holiday.

It should be emphasised that if you are a smoker you should stop smoking altogether. If you are overweight the doctor in charge of you will instruct you regarding reduction. Alcohol may be consumed in moderation. For the first three months it is not advisable to subject yourself to the stress of driving. Sexual intercourse may be resumed normally when you have returned to your normal physical activity.

All patients are encouraged to return to their previous occupations, or in the case of a housewife to normal household activity, but obviously there are some exceptions. The doctor in charge of you and your own general practitioner will be able to provide further guidance on this point.

Exercise is encouraged but should be kept within personal limitation. You should not go beyond the first signs of fatigue. exercise such as swimming, cycling, golf and walking are recommended, whereas lifting heavy static objects is discouraged. This exercise should of course be in moderation, commensurate with your physical well-being and should be regular.

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